BIRMINGHAM CITY COUNCIL

HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

TUESDAY, 18 APRIL 2023 AT 10:30 HOURS
IN COMMITTEE ROOMS 3 & 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1 **NOTICE OF RECORDING/WEBCAST**

The Chair to advise/meeting to note that this meeting will be webcast for live or subsequent broadcast via the Council's meeting You Tube site (www.youtube.com/channel/UCT2kT7ZRPFCXq6_5dnVnYlw) and that members of the press/public may record and take photographs except where there are confidential or exempt items.

2 **APOLOGIES**

To receive any apologies.

3 **DECLARATIONS OF INTERESTS**

Members are reminded they must declare all relevant pecuniary and other registerable interests arising from any business to be discussed at this meeting.

If a disclosable pecuniary interest is declared a Member must not participate in any discussion or vote on the matter and must not remain in the room unless they have been granted a dispensation.

If other registerable interests are declared a Member may speak on the matter only if members of the public are allowed to speak at the meeting but otherwise must not take part in any discussion or vote on the matter and must not remain in the room unless they have been granted a dispensation.

If it is a ‘sensitive interest’, Members do not have to disclose the nature of the interest, just that they have an interest.

Information on the Local Government Association's Model Councillor Code of Conduct is set out via http://bit.ly/3WtGQnN. This includes, at Appendix 1, an interests flowchart which provides a simple guide to declaring interests at meetings.

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4 **ACTION NOTES – 14 MARCH 2023**

To confirm the Action Notes from the meeting held on 9 December 2022.

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5 **HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE ACTION TRACKER**

To review and note the actions from previous Health and Social Care Overview and Scrutiny Committee meetings.

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6 **INTEGRATED CARE SERVICES REPORT**

Report from David Melbourne, Chief Executive, Integrated Care Board, NHS Birmingham, and Solihull.

63 - 130

7 **IMMUNISATION REPORT UPDATE**

Report from Mary Orhewere, Assistant Director, Environmental Public Health, Health Protection & Place; Andrew Dalton, Screening and Immunisation Lead, Vaccination and Screening, NHS England– Midlands; Kate Woolley, Director of Immunisation, NHS Birmingham and Solihull and Leon Mallett, Head of Immunisation and Vaccination. This report to be presented as a scoping paper for a possible future inquiry based on previous scoping paper for Infant Mortality.

131 - 226

8 **STAYING INDEPENDENT AT HOME ADAPTATION AND IMPROVEMENT SERVICE PROCUREMENT STRATEGY**

Timsey Deb, Head of Service, Ops and Partnership, Adult and Social Care, and Michael Walsh Service Lead, CCoE, Adult and Social Care. To receive an update report on cabinet decision.

227 - 248

9 **HOSC WORK PROGRAMME 2022/23**

To review the Health & Social Care Overview and Scrutiny Committee work programme of the past year

10 **REQUEST(S) FOR CALL IN/COUNCILLOR CALL FOR ACTION/PETITIONS RECEIVED (IF ANY)**

To consider any request for call in/councillor call for action/petitions (if received).

11 **OTHER URGENT BUSINESS**

To consider any items of business by reason of special circumstances (to be specified) that in the opinion of the Chair are matters of urgency.

12 **DATE AND TIME OF NEXT MEETING**

To note that the next meeting is scheduled for Tuesday 6th June 2023 at 10.00am

13 **AUTHORITY TO CHAIR AND OFFICERS**

Chair to move:-

'In an urgent situation between meetings, the Chair jointly with the relevant Chief Officer has authority to act on behalf of the Committee'.

BIRMINGHAM CITY COUNCIL

HEALTH AND SOCIAL CARE O&S COMMITTEE

PUBLIC MEETING

Tuesday 14th March 2023. Committee Rooms 3 & 4, Council House, Victoria Square

Action Notes

Present

Councillor Mick Brown (Chair)

Councillors: Kath Hartley, Gareth Moore, Rob Pocock, Julian Pritchard, Paul Tilsley and Mariam Khan.

Also Present:

Dr Temitope Ademosu, Assistant Director, Adult and Social Care

Karl Beese, Commissioning Manager – Adults Public Health

Graeme Betts, Director, Adult and Social Care

Paul Kelly, RedQuardrant

Linda Tarpey, RedQuardrant

Jo Tonkin, Assistant Director, Partnership Insight and Prevention

Fiona Bottrill, Senior Overview and Scrutiny Manager

Ceri Saunders, Cabinet Support Officer

Gail Sadler, Scrutiny Officer

Adewale Fashade, Interim Scrutiny Officer

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1. **NOTICE OF RECORDING/WEBCAST**

   The Chair advised that the meeting would be recorded and subsequently broadcast via the Council's meeting You Tube site www.youtube.com/channel/UCT2kT7ZRPFCXq6_5dnVnYlw and that members of the press/public could record and take photographs except where there were confidential or exempt items.

2. **APOLOGIES**

   No Apologies.

3. DECLARATIONS OF INTEREST

Councillor Gareth Moore declared he is a Trustee of Birmingham LGBT and Birmingham Citizens Advice.

4. ACTION NOTES/MATTERS ARISING

The Action Notes of the last Health and Social Care Overview and Scrutiny Committee (HOSC) meeting held on were submitted.

RESOLVED

That the minutes of the meeting held on February be approved as a correct record.

It was agreed that the Action Tracker will be included in agenda going forward, as agreed for all Overview and Scrutiny meetings.

5. CABINET MEMBER FOR HEALTH AND SOCIAL CARE, COUNCILLOR MARIAM KHAN – UPDATE ON PRIORITIES

The committee received a presentation from Councillor Khan, on progress made over on her key priorities since she presented these to the Committee back in September 2022. The following key points were highlighted: -

- An overview of the key priorities; *Tackling Inequalities, Post-Pandemic Situation, Cost of Living Crisis, Maternal Health, Mental Health, and Integrated Care Partnership work.*
- Regarding the Cost of Living crisis, there has been a concerted cross-partner effort to help those in need in the city within the key priorities of health inequalities, maternal and mental health.
- Ongoing community engagement and co-production activities and delivery of Local Delivery pilots. This included a visit from Sport England to see the pilot in practice
- Hosted a delegation from the United Nations
- Food delivery and social prescribing activities post-pandemic is still ongoing.
- In response to the Cost of Living situation, Cllr. Khan has worked with the Food System and supporting their work across the city as part of BCC's Food Provision workstream Cost of Living response.
- The Public Mental Health Team has successfully become a signatory to the Prevention Concordat for Better Mental Consensus Statement which is a system wide commitment to working towards the improvement of mental health.
- There was a visit to Brussels as part of Euro Cities and shared good practice from Birmingham especially around citizen engagement
- A specific working group to focus on the opportunities for action relating to NHS provision. ICS partners have presented their implementation plans already and will be progressing those within their organisations, using the co-produced standards.
- The Committee was informed that several of BCC's submissions for the recent LGC national awards have been shortlisted, including Dr Varney's

personal contribution and work during the pandemic, and with the ICS, and in tackling health inequalities

In discussion, and in response to Members' questions, the following were among the main points raised:

- The number of vacancies is currently not available. However, no staff losses. 162 job offers have been made.
- Community profiles are published on websites and there are webinars which explains context. The link will be provided and circulated.
- In relation to visit to Brussels, Birmingham City Council (BCC) is still a part of Euro Cities and part of the Urban Food Policy Pact. This was an opportunity to share good practice from Birmingham
- In relations to work on Fast-track cities, BCC is still involved. Update will be shared with Committee members.
- Regarding details on the commissioners, there are 10 community and 8 civic commissioners and focus on some key priority need areas such as housing and food supply. Further details of the commissioners and their findings will be provided to the Committee and made publicly available
- In response to BCC paying real Living Wage, the aspiration is to pay the best possible levels of wages to staff and providers are made aware of this
- On recruitment, there will be better clarity on process, as well as updates and details of job offers in future
- List of membership of the Integrated Care Partnership will be shared with members
- In relation to Place committees, this is locality focused and connected to communities. More details/update on community input in the Place committees and process involved will be shared with members. Members emphasised that Place committee members should take on the role of decision makers and not just delegates
- The Food System Schemes provide food aid benefits to youth centres and communities
- On the issue of care homes recruitment, the proposed Adult and Social Care Reform that the government is still working on will provide a steer on this. Currently, BCC is doing what it can to stabilise the market
- The carers hub provides an avenue for engagement and building good relations with local groups and general support to informal carers as well as specific specialist support as required. A report on the carers hub and how it works will be shared with members

- In relation to young people in the neighbourhood scheme transitioning to Adulthood, Cllr. Khan stated that more details will be provided to members on how this is working.
- On bereavement support for unpaid carers, this is available to them and a briefing on how the support scheme works will be provided for next meeting
- On management of technology in terms of information input and associated risks, this will be duly considered, and HOSC may want to have input on development in this area of work. Ideas on this to be shared with Committee members.

RESOLVED:

- That the report is noted.
- Update on work of Fasttrack cities will be shared with Committee members.
- That details of the commissioners and their findings will be provided to the Committee and made publicly available
- List of membership of the Integrated Care Partnership will be shared with members
- More details/update on community input in the Place committees and process involved in relation to delegated powers will be shared with members
- A report on the carers hub and how it works will be shared with members
- More details in relation to young people in the neighbourhood scheme transitioning to Adulthood and how this is working will be provided to members.
- Briefing on bereavement support scheme for carers will be provided for next meeting

6. CO-PRODUCED REVIEW OF DAYS OPPORTUNITIES

Dr Temitope Ademosu, Assistant Director, Adult Social Care introduced representatives from RedQuadrant, who are in attendance to deliver presentation and on the review of Days Opportunities. The review was co-produced with service users (Empowering People Team) who were also present at the meeting and spoke about their experiences and involvement in developing the review.

Paul Kelly from RedQuardrant gave an overview of how RedQuardrant engaged and worked with service users on the review. 14 people were trained, and this led to 35 engagement sessions. In total, 400 people were involved.

The service users also spoke about their experiences in being involved in the Review. Key points expressed were:

- The sessions were informative and engaging.
- Provided opportunity to share ideas and experiences

- Opportunity to come together and agree on questions to ask the audience at engagement events
- They wanted to be part of something that provided a purpose and a future
- They were able to establish a collective identity for themselves and are now known as the Empowering Team
- Engagement was made with schools and colleges.
- Explored challenges of transitioning from one stage of life to the next
- Overall, a worthwhile and valuable experience

In discussion and response to Members' questions, the following were among the main points raised:

- Participants on the Review all had lived experiences and came together to share their experiences of being in the care system
- Majority of the participants in the review were new to this type of exercise
- All were recruited as volunteer. Process began in 2018 and appropriate training was provided. Engagement events took place in various day centres and were inclusive and accessible. While a lot of effort was put into bringing together diverse voices, there was recognition that the team may not have reached everyone
- Attendees were able to take part with support from Day Centre staff and professionals
- This co-production exercise is not a one-off but will continue for future reviews and next steps going forward.

In response to ensuring sustainable support for Day Centres and strengthening its functions, as well as activities outside of the Day Centres, Graeme Betts said an update on this, including benefits to service users will be provided to the Committee.

RESOLVED:

- In terms of next steps, the Review report will be presented to the cabinet in April for consideration. The plan is for findings from the Review to feed into key strategies going forward. Cllr Moore asked that this is also brought to the HOSC for consideration.
- Update on ensuring sustainable support for Day Centres and strengthening its functions, including benefits to service users, will be provided to the Committee.
- Committee to note report

7. Q3 ADULT SOCIAL CARE PERFORMANCE MONITORING

Graeme Betts, Director of Adult Social Care (ASC) presenting the ASC performance monitoring Q3 report. Some of the key points highlighted in response to discussion, and questions from members:

- Client review and assessments is showing red. Priorities still being impacted by Covid-19
- There is still recruitment crisis in the ASC sector, with 50% fewer staff. However, the team is doing its level best
- Aiming to increase support to people recovering at home
- Delivering sustained improvement overall despite present challenges
- Day Centre visits dropped due to various circumstances; cost of living, post-pandemic impact on visiting trends i.e. people losing confidence in going out. Current review may hopefully provide some outputs to build on to improve visits and use of day centres. An update report will be provided to inform members on how this is being done
- In response to provision of support to schools and colleges during summer months, members were informed that services will be affected by the withdrawal of European Fund. The funding issue will need to be looked at.
- On Safeguarding, the service is looking to measure personalisation. Keeping a close eye on this.
- On backlogs, this is being closely looked at and we are monitoring this
- On Constituency breakdown, demographic profiles could be an impact in relation to take-up rates of different ethnic groups and ages, so we are currently monitoring levels of needs. Also, there are staffing issues with current turnover of staff. Aspiration is to have more consistency of approach in terms of effectiveness.
- It was pointed by Cllr. Moore that a commentary on this table would be useful in the report. Graeme Betts responded that this can be built into future reports.
- In response to question on Direct payments, it was pointed out that this is not going down in real terms so may not be able to make much difference on this. Management team are meeting to see what can be done in terms of step change and improving the situation by reviewing direct payments process.
- On Safeguarding and numbers of enquiries responded to, the Safeguarding board has this information, and this will be circulated to members
- On the Care Act, this should be reviewed by everyone once the year. Most Local Authority do not reach up to 90%
- On the question of how BCC compares with co-cities on Direct payments, the committee was informed that the council is in the top quarter among cities.

- Carers are being supported, and we are keeping in touch with them regularly. Local groups are also involved in keeping in touch with carers.
- Councillor Tilsley pointed out the increase in isolation and tendency to stay more at home due to long covid. This has affected people's confidence across the board.
- In response to whether members can have absolute numbers of clients/service users and the conditions they are presenting, with constituency breakdowns, this can be provided in future reports
- In response to whether BCC is getting in the top quarter on Adult Social Care provision, our vision in major areas such as going into residential homes, personalisation and safeguarding, we are on the way to fulfilling our stated aspiration.

RESOLVED:

- That the Q3 Adult Social Care performance report be noted.
- An update on current review of Day Centre visits will be provided to inform members on how this is being done.
- A commentary on constituency breakdown and demographics table will be built into future reports.
- Safeguarding information and number of enquiries on this will be circulated to members.
- Absolute numbers of clients/service users and the conditions they are presenting, with constituency breakdowns, to be provided in future reports.

8. WORK PROGRAMME

The date of the next meeting is scheduled for Tuesday 18th April 2023 (TBC). Agenda items for that meeting at this stage are:

- The Integrated Care Board report
- Immunisation report.
- Update on Place Committee and decision-making powers within the ICS

Other updates are that the Education, Children and Social Care Scrutiny committee is meeting on 5th April and the Birmingham Safeguarding Partnership will be attending. HOSC members are invited to attend this to ask questions.

Next JHOSC meeting will meet in Solihull to consider the Berwick report. (Date To Be Arranged).

Also, on the Quality Accounts, proposal is to circulate report to members to provide comment rather than bring to meeting for discussion.

With regards to the UHB (Berwick Review) report, JHOSC may want to consider this as it covers Birmingham and Solihull. Issues raised can feed into the Work Programme on 23/24.

In reference to reports and presentations presented today and Review of Days Opportunities, members are requesting that in future, drafts cabinet reports should come to Committee for appropriate scrutiny before it is ratified and goes to Council.

There was discussion on date of next meeting as it clashes with Full Council (later in the day). Date of meeting will be confirmed in due course.

Members also discussed about having draft reports from Cabinet submitted to the presented to the Committee in draft form, and for the Committee to check for accuracy before being finally approved by Cabinet.

9. REQUEST(S) FOR CALL IN/COUNCILLOR CALL FOR ACTION/PETITIONS RECEIVED (IF ANY)

None.

10. OTHER URGENT BUSINESS

11. AUTHORITY TO CHAIRMAN AND OFFICERS

RESOLVED: -

That in an urgent situation between meetings the Chair, jointly with the relevant Chief Officer, has authority to act on behalf of the Committee.

The meeting ended at 1221 hours.

HEALTH & SOCIAL CARE O&S COMMITTEE ACTION TRACKER

DATE OF MEETING	ACTION	UPDATE
19/7/22	**Q4 ADULT SOCIAL CARE PERFORMANCE MONITORING 2021-22** • Councillor Pocock's suggestion of a new indicator which measures the length of time from when someone is discharged and the wait before a care package is in place. Andrew Marsh agreed to look at trying to capture that information and would let me know how this was being progressed. • Maria to confirm which HOSC meeting would be best for you to report detailed constituency level data on an annual basis? • Cllr Brown would like to take up your offer of bringing a Safeguarding Lead to the 20th September meeting.	Constituency data will be reported 14 March meeting.
19/7/22	**HEALTHWATCH BIRMINGHAM ANNUAL REPORT 2021-22** • The Day Opportunities report which is due to be published by end of July be forwarded to members before the informal briefing on 16th August. • Circulate the Healthwatch England report dentistry.	Circulated 16/8/22
20/9/22	**REPORT OF THE CABINET MEMBER FOR HEALTH AND SOCIAL CARE** • Professor Graeme Betts to provide a copy of the 'Winter Pressures' report that was presented to the ICB.	Briefing note circulated on 12/10/22.
20/9/22	**TACKLING PERIOD POVERTY AND RAISING PERIOD AWARENESS TRACKING REPORT** • A meeting is set up between Councillor Brown and the Chair of the Education and Children's Social Care OSC, Councillor Kerry Jenkins, to discuss a joint piece of work to ensure that the tool kit that the public health team is developing is rolled out across schools, including non-local authority schools and faith schools, and that female and male staff in schools are provided with the information and resources. • Monika Rozanski to provide a breakdown of male and female staff who attended the event at George Dixon Academy.	Meeting took place on 4/10/22. Email sent 9/11/22.

18/10/22	**ACTION NOTES/MATTERS ARISING** Outstanding Action 19/7/22 Andrew Marsh to provide a briefing on the process and causes of a failed discharge i.e. is it due to the hospital or social care and how significant the problem might be. Andrew to advise whether written or informal briefing. Email sent 24/10/22.	Briefing on 15/11/22.
18/10/22	**FORWARD THINKING BIRMINGHAM** Further detail required on:- • age/distance of young people being placed out of area and the trajectory for reducing that. • the number of weeks a patient has to wait before treatment starts. • Further information requested. See FTB Further Information Requested document in committee file.	Email sent on 25/10/22
18/10/22	**INFANT MORTALITY TRACKING REPORT** A copy of the 22nd March 2022 report to the Health and Wellbeing Board is circulated.	Email sent on 25/10/22
18/10/22	**AN UPDATE ON FUTURE ARRANGEMENTS FOR ADULT SOCIAL CARE PERFORMANCE MONITORING** Merryn Tate to provide a table that depicts the alleged type of abuse/neglect to the location where it has taken place.	Circulated on 21/11/22.
22/11/22	**BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM TEN-YEAR STRATEGY** • That a note is provided on what long-Covid services are available in Birmingham. • Provide a note on the membership of the ICS Partnership, ICS Board and Place Board. • A further update to be scheduled on the work programme early in the new year.	Circulated 12/1/23

22/11/22	**SUBSTANCE USE: BIRMINGHAM'S ADULT TREATMENT SERVICES** • To provide information on the association between people living in HMOs and exempt accommodation and in treatment for drug and alcohol abuse by Wards. • CGL to provide information regarding the training that has been given to housing providers.	Circulated 31/1/23
20/12/22	**ADULT SOCIAL CARE QUARTERLY PERFORMANCE REPORT** • That the information requested in relation to the adult social care precept would be obtained and circulated to Members. • That the new measures on discharges would be followed up with Andrew Marsh.	Circulated 5/1/23 Informal briefing 27/1/23
24/1/23	**ADULT SOCIAL CARE REFORMS** • Take stock of the 'Financial Position' early in the next municipal year.	
24/1/23	**APPROVED MENTAL HEALTH PROFESSIONAL** • To provide information on how many occasions people have been refused admission to hospital from a private provider. • Joanne to forward a copy of the latest AMHP report for circulation.	Verbal update from the Chair at 21/2/23 meeting. Circulated 31/1/23
14/2/23	**BIRMINGHAM SEXUAL HEALTH SERVICES – UMBRELLA** • Provide further clarification about why the contract spend per head of population was above the mean average compared to other core cities, but Birmingham was ranked in the lower part of the performance table. • Review online testing kit process for heterosexual men in relation to not being offered a clinical appointment at Umbrella based on their responses.	

14/2/23	**STRATEGIC OVERVIEW OF IMMUNISATIONS IN BIRMINGHAM** • More data regarding evidence of decline in uptake of various immunisation programmes because of Covid vaccination hesitancy and can this be clearly linked to the type of vaccine i.e., is there less hesitancy with established vaccinations. • Geographical data across the city by Ward and demographics to assist Members with identifying where and which communities need enhanced communication to be provided in advance of the 18th April meeting. To include:- ▪ Roles and responsibilities. ▪ How to make every contact count across all agencies. ▪ How to use Councillors support and city networks to communicate key messages. ▪ Resources Plan and risk mitigations • A Chair's pre-meeting is arranged before the 18th April meeting Paul Sherriff, Mary Orhewere and Leon Mallett. • Mary Orhewere to request that a representative from NHS England is also present at the 18th April meeting.	Update to be provided on 18th April
14/3/2023	**CABINET MEMBER FOR HEALTH AND SOCIAL CARE UPDATE ON PRIORITIES** • Update on work of Fasttrack cities will be shared with Committee members.	Further update on developments to be

		provided when appropriate.
	• That details of the commissioners and their findings will be provided to the Committee and made publicly available • List of membership of the Integrated Care Partnership will be shared with members • More details/update on community input in the Place committees and process involved in relation to delegated powers will be shared with members • A report on the carers hub and how it works will be shared with members • More details in relation to young people in the neighbourhood scheme transitioning to Adulthood and how this is working will be provided to members. • Briefing on bereavement support scheme for carers will be provided for next meeting	To be provided at a future meeting in new Municipal year.
	DAY OPPORTUNITIES REVIEW	In the process of arranging a briefing on review for HOSC members

	• The plan is for findings from the Review be brought to the HOSC for consideration. • Update on ensuring sustainable support for Day Centres and strengthening its functions, including benefits to service users, will be provided to the Committee	
	Q3 ADULT SOCIAL CARE PERFORMANCE MONITORING • An update on current review of Day Centre visits will be provided to inform members on how this is being done • Safeguarding information and number of enquiries on this will be circulated to members • A commentary on constituency breakdown and demographics table will be built into future reports. • Absolute numbers of clients/service users and the conditions they are presenting, with constituency breakdowns, to be provided in future reports	To be provided in future meetings when required. To be provided in future meeting when required.

Birmingham City Council

Health and Social Care Overview and Scrutiny Committee

Date 18th April 2023

Subject:	Integrated Care Partnership 10 Year Strategy
Report of:	David Melbourne, ICB Chief Executive NHS Birmingham and Solihull
Report author:	David Melbourne, ICB Chief Executive NHS Birmingham and Solihull

1 Purpose

1.1 The 10 year strategy for health and social care: *'A Bolder, Healthier Future for the People of Birmingham and Solihull'* has been published by the Integrated Care Partnership on behalf of the ICS. The strategy, which was developed following extensive engagement with citizens, partner organisations and frontline professionals, highlights the ICS vision for the future and the conditions we need for change, so that people who live, work and receive care in Birmingham and Solihull can live longer, happier and healthier lives by 2033.

1.2 It is ambitious and aspirational – it needs to be able to withstand future changes and challenges to the health and social care system. As well as setting clear goals, we have illustrated what the future could be like for our citizens if we are able to work in a more integrated way.

1.3 While being ambitious, the strategy is also realistic. We know there is already many innovative examples of people working collaboratively that are making a huge impact in tackling health inequalities in real time – and we've showcased some examples throughout the document. What we need to be able to do next is consider how some of these could be upscaled to benefit more of the population or adapted to help tackle other heath inequalities.

1.4 We believe that if we can direct our collective action into improving life expectancy in **five clinical areas**, we will make significant progress in reducing health inequalities across Birmingham and Solihull:

- Circulatory disease
- Infant mortality
- Respiratory disease
- Cancer

- Mental health

2 Recommendations

2.1 For the committee to support the integrated delivery of the strategy.

3 Any Finance Implications

3.1 None

4 Any Legal Implications

4.1 None

5 Any Equalities Implications

5.1 None

6 Appendices

6.1 A Bolder, Healthier Future for the People of Birmingham and Solihull.

Birmingham and Solihull
Integrated Care System
Caring about healthier lives

NHS
Birmingham and Solihull

A Bolder, Healthier Future for the People of Birmingham and Solihull

Strategy for Health and Care 2023 - 2033

"We have the biggest opportunity in a generation for the most radical overhaul in the way health and social care services in Birmingham and Solihull are designed and delivered."

Our ambition is that in Birmingham and Solihull we close the gaps, we address the holes in life expectancy...and make a difference to people's lives. We do this through working in partnership, so that people experience health and social care in ways that work for them. We're a partnership of change that is building a better future together.

Dr Justin Varney, Director of Public Health, Birmingham City Council

Contents

Introduction

The fact that 40% of Birmingham and 12% of Solihull residents live in the most deprived communities in Britain and that one in three children in Birmingham are living in poverty cannot, and should not, be something we accept.

These are not just statistics – they directly impact on the lives of people in our communities - life expectancy in the most deprived areas of Solihull being 12.8 years lower for men and 11.1 years lower for women, while Birmingham has the highest infant mortality rate of all local authorities in the country.

We can and must act to improve this, and in doing so improve the life chances for the people and families we serve.

While the social care and health challenges faced by different neighbourhoods and communities across Birmingham and Solihull may vary dramatically – all have one thing in common: they can be much better addressed by creating the strong platform for local authorities, the NHS, the voluntary, community, faith and social enterprise (VCFSE) sector and other partners to work in a joined-up way delivering a shared vision to tackle inequality and genuinely improve the life chances of the citizens they serve.

It has always been true that where these organisations work well together much more can be achieved, but the 2022 Health and Care Act introduced new legislative measures that will make it much easier for health and care organisations to deliver joined-up care for people in the future.

The Act has created 41 Integrated Care Systems (ICSs) which are made up of two components: Integrated Care Boards with responsibility for planning and funding the NHS; and Integrated Care Partnerships - bringing together a broad set of system partners, including local government, VCFSE sector, NHS organisations and others to develop a health and care strategy for the area.

This 10-year Integrated Health and Care Strategy has been developed by the Integrated Care Partnership for the Birmingham and Solihull ICS, setting out our vision for the future and the improvements that we want to see over the next ten years for everyone who lives, works and receives care within Birmingham and Solihull.

"It's aim is a simple one: to improve life expectancy for the people of Birmingham and Solihull."

Our strategy identifies the five key clinical condition areas which, through sustained improvements in outcomes, will give us the best opportunity to achieve that aim; but this can only be done by transforming the planning and delivery of health and social care in Birmingham and Solihull and by working alongside our communities as an integral partner at the heart of the change we need to achieve.

The five clinical condition areas are:

- **Circulatory Disease**
- **Infant Mortality**
- **Respiratory Disease**
- **Cancer**
- **Mental Health**

In its Inception Framework published in February 2022 the Birmingham and Solihull Integrated Care System made a commitment to engage with local communities and frontline staff in every major piece of work they do: this strategy has been developed throughout 2022 after extensive consultation and discussion with citizens, partner organisations and frontline professionals from across Birmingham and Solihull.

As part of that consultation, we've run a variety of different online and in-person events through engagement leads in NHS Trusts, the voluntary sector, trade unions, webinars run by our Directors of Public Health and our health and care scrutiny committees in Birmingham and Solihull.

We've made a big effort to ensure every voice can be heard – our online content around the strategy has been produced in six languages and we've worked with 18 voluntary, community, faith and social enterprise groups to run engagement sessions targeting the 'seldom heard' communities.

A full and detailed report on the outcomes from that engagement will be published alongside this strategy.

But amongst the many messages our citizens and colleagues repeatedly emphasised was the need to be ambitious in both the short and long term, and to create a strategy that could stand the test of any future health or social care re-organisations.

Ultimately, we want to eradicate health inequalities and increase life expectancy and comorbidity-free life expectancy for everyone in Birmingham and Solihull.

Getting there won't be easy, especially given that Birmingham and Solihull is one of the most challenged areas for health inequality in the country. However, by setting ambitious goals to be achieved by 2033 and ensuring everything we do in the coming years helps to achieve those goals, we can make a very real difference to people's lives.

Over the course of the next 10 years we want to ensure that we:

- **increase life expectancy at birth and at 65 years for all; to at least be on a par with West Midlands average in 2033;**
- **increase healthy (disability-free) life expectancy for all; to at least be on a par with West Midlands average in 2033;**
- **reduce gaps in life expectancy between the least and most deprived and between different ethnic groups;**

We'll only be able to achieve these goals by developing a vision that enables real ambition for everyone involved in designing and delivering health and social care and creating the space to shift much more of our focus onto tackling the determinants of poor health and improving outcomes, year by year, as we strive toward delivering our aims. This strategy gives us that vision and charts a new course for an integrated approach to planning and delivering health and care in Birmingham and Solihull.

Professor Patrick Vernon
Interim Chair
Birmingham and Solihull
Integrated Care Board

Councillor Mariam Khan
Joint Chair
Birmingham and Solihull Integrated Care Partnership Board

Councillor Karen Grinsell
Joint Chair
Birmingham and Solihull Integrated Care Partnership Board

Understanding the scale of our challenge

Birmingham and Solihull Integrated Care System (ICS) supports 1.36 million people, with more than 1.14 million people living in Birmingham and more than 217,000 in Solihull. The infographic helps give some context to the diversity of our populations. The ICS is privileged to serve a globally diverse population but also one which has significant health needs and inequality.

The fundamental purpose of the ICS is to improve the health of the people it serves. The core challenge for Birmingham and Solihull ICS is that too many people die before they should from causes that are potentially preventable and that too many people are living for too long in poor health, including many with long-term conditions, which could be improved by better management. These gaps exist within both local authority areas.

> *"Have they (BME communities) been engaged? No, they have not. Have they actually understood what services are available and how to get a service? No. It's not about ignorance, it's actually about ignorance within the system that doesn't empower people to know what the support mechanisms are."*
>
> Naeem Qureshi, Sparkbrook resident

Figure 1: A table showing the life expectancy at birth of people born in Birmingham and Solihull compared to the West Midlands and England averages

	Birmingham	Solihull	West Midlands	England
Life expectancy at birth (2018-20)				
Male	*75.8*	*79.1*	*77.6*	*78.7*
Female	*80.5*	*83.1*	*81.8*	*82.6*
Life expectancy at birth (2018-20)				
Male	*59.2*	*67.4*	*61.9*	*63.1*
Female	*60.2*	*65.7*	*62.6*	*63.9*
Disability free life expectancy at birth (2018-20)				
Male	*60.2*	*63.1*	*61.6*	*62.4*
Female	*58.3*	*61.0*	*59.9*	*60.9*
Inequality in life expectancy at birth (2018-20)				
Male	*9.5*	*11.6*	*10.1*	*9.7*
Female	*6.2*	*10.1*	*7.9*	*7.9*


Sweet
69p
2 for £1

A picture of our population in 2021

Birmingham and Solihull Integrated Care System
Caring about healthier lives

Total population (2021)

1,361,158 living in 513,000 households

96,800 Students (2021 Census)

Sexual orientation

2.8% of our population identify as lesbian, gay, bisexual, another non-heterosexual identity.

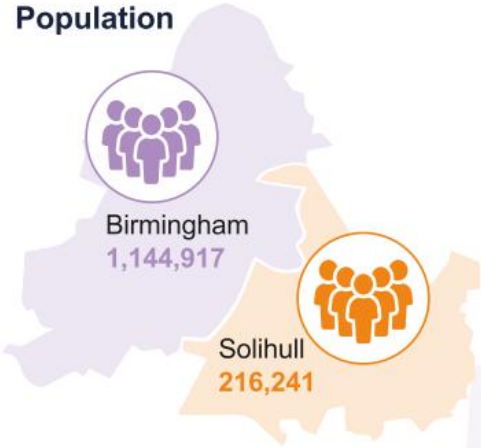
Under 18yrs conception rate (2020)

<18 Years

16.1

8.1

Population



Disability (2011 Census)

17.3 / 17.2 — Disabled under the **Equality Act**

8.1 / 7.3 — Disabled under the **Equality Act: Day-to-day activities limited a lot**

9.2 / 10.0 — Disabled under the **Equality Act: Day-to-day activities limited a little**

Economic activity status

9.9 5.0

Economically active (excluding full-time students): **9% Unemployed in total**

Economically active (excluding full-time students): **91.7% in employment in total**

91.0 95.2

Diabetes

8.9

Birmingham and Solihull patients are recorded as having diabetes

68.7

Number of patients with diabetes who had a foot examination.

Ethnicity (2019 ONS estimates)

	Birmingham	Solihull
① Asian, Asian British or Asian Welsh	31.0%	11.0%
② Black, Black British, Black Welsh, Caribbean or African	11.0%	1.8%
③ Mixed or Multiple ethnic groups	4.8%	3.5%
④ White	48.6%	82.2%
⑤ Other ethnic group	4.5%	1.5%

3.9% of people cannot speak English well or at all, this is **just under 48,000 people**

Faith and religion

Christian	36.7%
Muslim	26.0%
No religion	25.5%
Not answered	6.0%
Sikh	2.8%
Hindu	2.1%
Other religion	0.5%
Buddhist	0.4%
Jewish	0.1%

Flu 2021/22 - vaccine uptake

65 UP 78.4

Pregnant 28.7

50→65 In a clinical risk group 60.6

Cancer

Birmingham and Solihull ICB had **6,384 emergency admissions** with cancer, with a rate of **406 admissions per 100,000 population** compared to 514 Nationally.

There were over **5,317 new cases of cancer diagnosed** across Birmingham & Solihull. This is a rate of **344 per 100,000 patients** compared to a National rate of 456.

Physical health checks

47

Percentage of patients in Birmingham and Solihull on SMI registers were in receipt of all six elements of the health checks in the 12 months to the end of December 2022.

All information provided by the 2021 Census

Birmingham and Solihull statistics · Birmingham statistics · Solihull statistics

A picture of our population in 2021

Birmingham and Solihull Integrated Care System
Caring about healthier lives

Age (2021 ONS population estimates)

Poverty £

People in Birmingham **earn £49 a week less than the national average in full-time employment** whereas in Solihull they **earn on average £80.4 a week more**. In both areas, there are **significant disparities between those on the highest and lowest income**.

Unemployment

70,900 workless households across Birmingham and Solihull.

5.3% of people with health conditions or illness >12 months are unemployed in Birmingham and Solihull compared to **2.8% nationally**, and **49.7% are economically inactive**.

(Apr 21-Mar 22)

Children in relative low income families (under 16yrs)

97,119 children

Infant Mortality Rate (2018-2020)

Patients with known coronary heart disease immunised against flu (2020/21)

7 GP practices achieved **more than 90% coverage** and **15 GP practices** achieved **less than 60% coverage**

Women aged 25-49yrs who have had a cervical cancer screen in the last 3.5 years (2020/21)

22 GP practices have **over 75%** and **11 practices** have **less than 50%**

Child development

Percentage of children with a good level of development – Early years foundation stage (2021/22)

Percentage of children achieving a good level of development at the end of reception (2018/19)

Young people aged 16-17yrs not in education, employment or training (NEET) (2020)

2,820 young people

Patients with severe mental health issues having a comprehensive care plan (2020/21)

25 GP practices had a care plan in place for over **90% of patients** whilst **74 GP practices** had it in place for **less than 50% of patients** with severe mental health issues

Hospital admissions caused by injuries in children 0-14yrs (intentional & unintentional) (2020/21)

Population vaccination coverage

MMR one dose by 2yrs old (2021/22)

All information provided by the 2021 Census

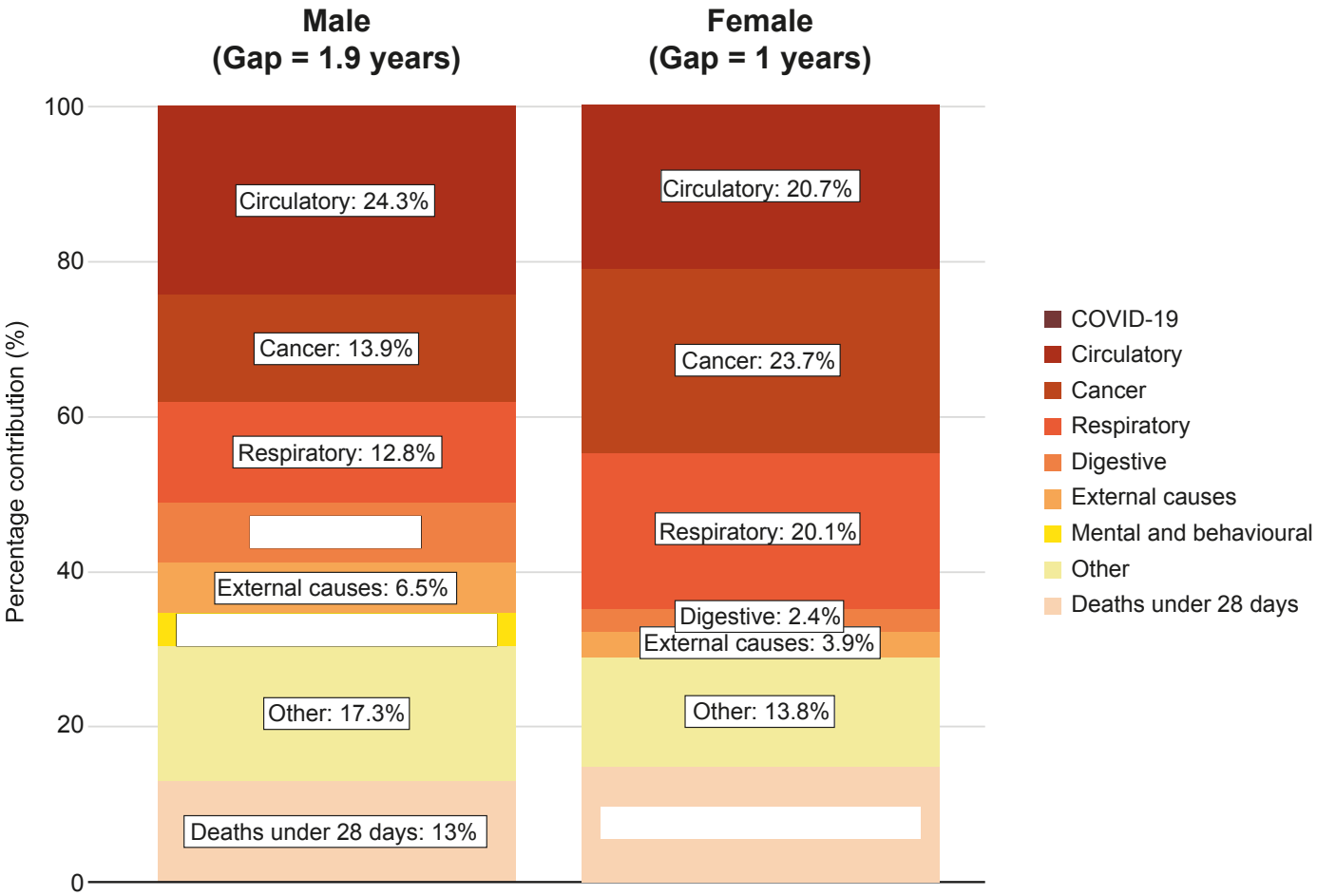
Birmingham and Solihull statistics | Birmingham statistics | Solihull statistics

Understanding the scale of our challenge

The gap in life expectancy in Birmingham and Solihull populations links strongly to diseases which are either preventable, or at least adaptable to not be fatal. The main diseases causing inequalities in life expectancy are infant death, lung disease, heart disease and cancer. It is important we also remember the connection between physical and mental health as mental health issues can also be a cause of potentially preventable death.

Figure 2:

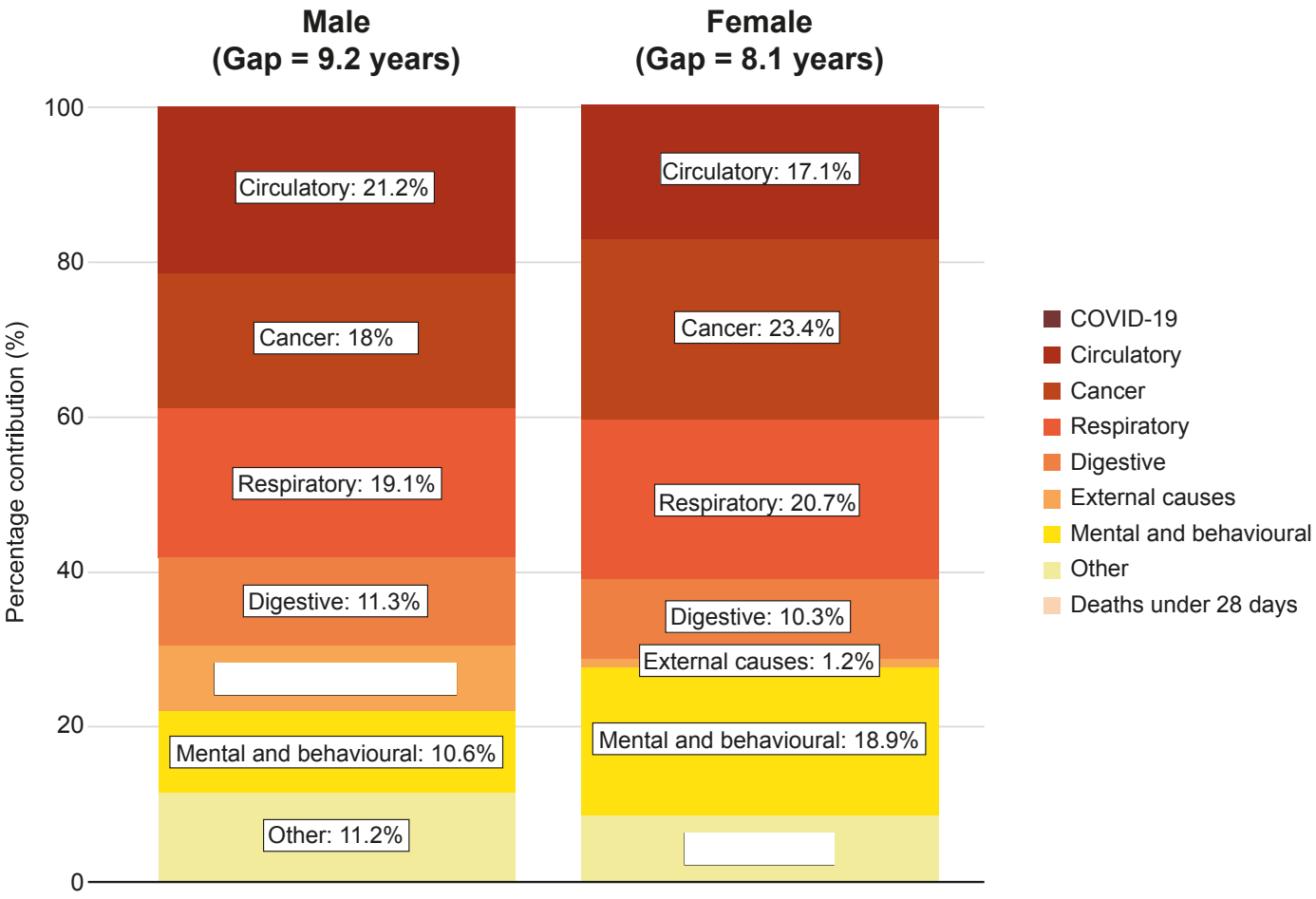
Scarf Chart showing the different types of disease causing the gap in life expectancy between Birmingham and England (2017-19)



Understanding the scale of our challenge

Figure 3:

Scarf Chart showing the different types of diseases causing the gap in life expectancy within Solihull (2017-19)



The pattern of drivers of the life expectancy gap are pretty consistent across years, however the pandemic did have an impact and the 2020-21 provisional charts reflect this (Figure 4 and 5). It is important to keep in mind that those most likely to die due to Covid-19 are the elderly, those with chronic diseases especially high blood pressure and diabetes, smokers and those carrying excess weight, many of the same groups with the highest risk of death from circulatory, cancer and respiratory disease as well.

Understanding the scale of our challenge

Figure 4:

Scarf Chart showing the different types of disease causing the gap in life expectancy within Birmingham (2020-21)

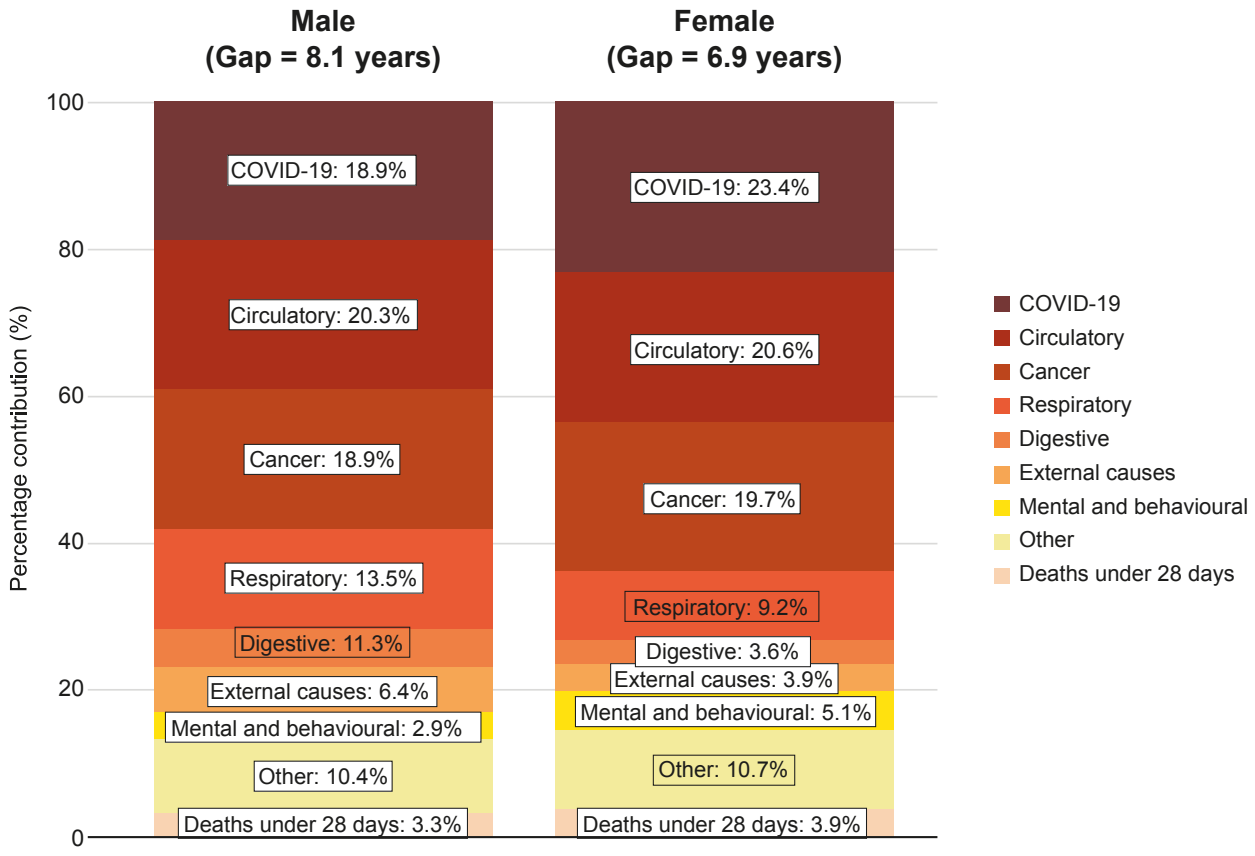
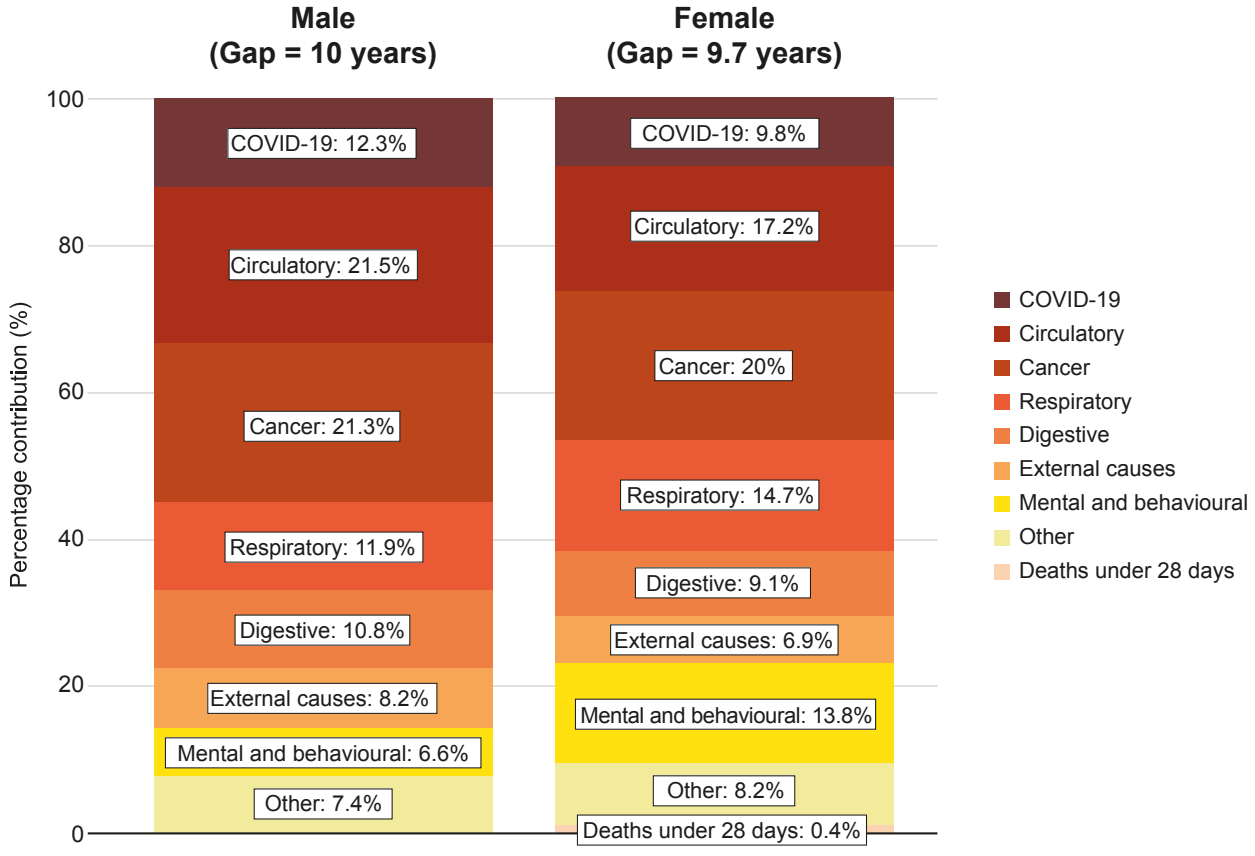


Figure 5:

Scarf Chart showing the different types of diseases causing the gap in life expectancy within Solihull (2020-21)



> *"The best community experience has to be our green spaces, which should be protected and cherished in this increasingly busy world. A walk in the park for me is the easiest way to relax and take in what little nature we have in our busy lifestyles. Keep them clean, tidy and safe as they are an oasis of calm for us."*
>
> Kingstanding resident

As well as how long people live for, as a system we want to work to make sure people live as long as possible in good health. Too many people live for too long in poor physical or mental health with significant impacts on their quality of life and ability to work.

This consolidates into five key clinical condition areas which, through sustained improvements in outcomes, will give us the best opportunity to achieve that aim: but this can only be done by transforming the planning and delivery of health and social care in Birmingham and Solihull and by working alongside our communities as an integral partner at the heart of the change we need to achieve.

The five clinical condition areas are:

- **Circulatory Disease**
- **Infant Mortality**
- **Respiratory Disease**
- **Cancer**
- **Mental Health**

As an ICS Partnership we want to see the system work together to maximise the impact of health and social care to reduce these potentially preventable deaths and diseases through clear and coherent action at pace and scale, including taking into account Core20PLUS5 for adults and children.

Research has demonstrated that about 20% of health is directly a result of access to care and treatment, 40% to behaviours such as smoking, alcohol, inactivity and diet, and 40% to the wider determinants of health such as employment, education and the built environment.

Bowel cancer: the perfect pathway

Meet 48-year-old Aisha from Washwood Heath.

Aisha is a busy working mum of three and also cares for her elderly parents at home.

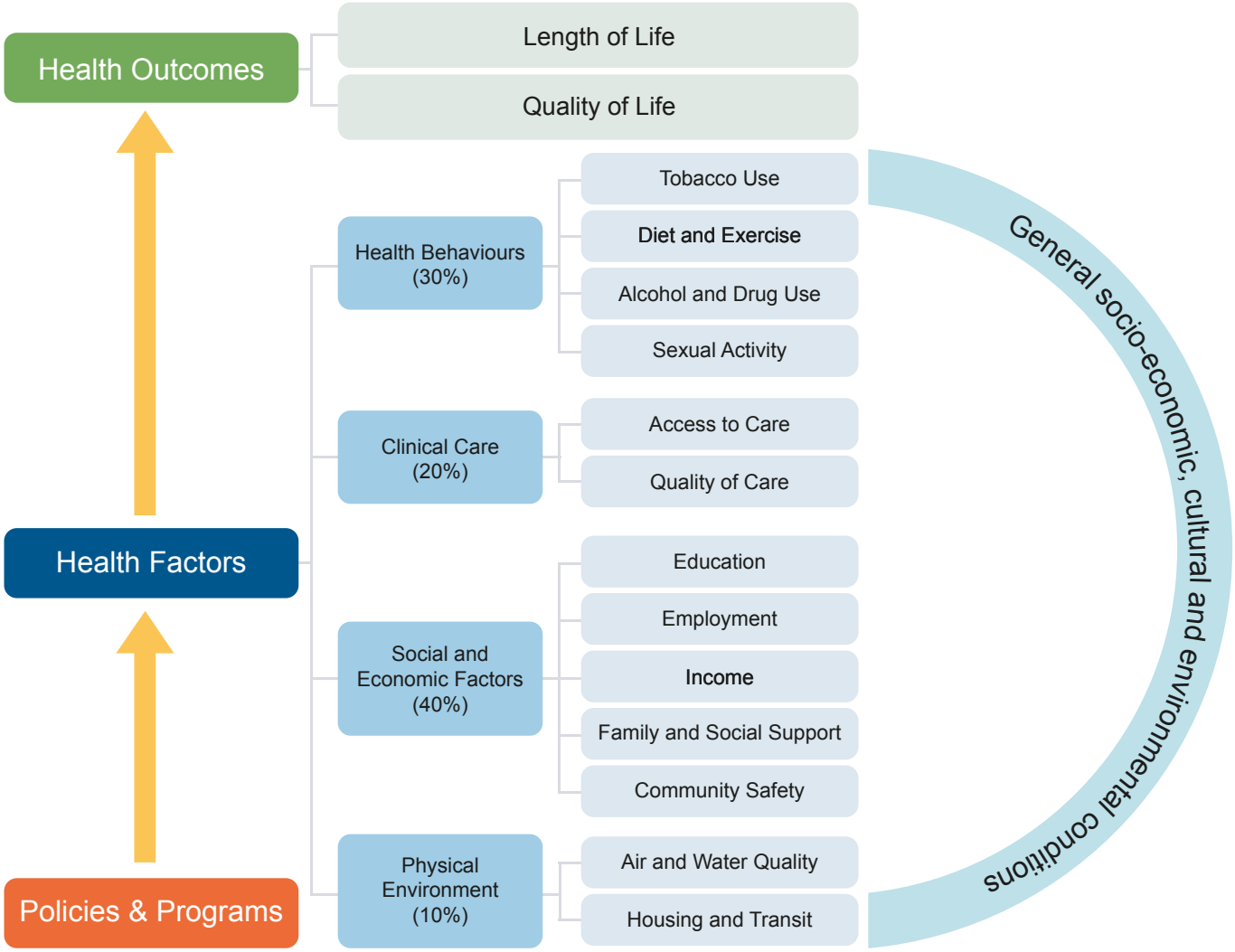
Aisha has recently been feeling more tired than normal and is struggling to manage the demands of work and home life. Over the last week she has noticed blood in her poo.

Read Aisha's perfect pathway here

Understanding the scale of our challenge

Figure 6:

What causes systematic differences in health outcomes?



Source: Adapted from the County Health Ranking Model. Note: % figures are estimates and averages, the relative controbution for an individual's life will be unique to them For illustrative purposes only.

Across the first 60% there is significant evidence and practice that can be brought to bear to reduce the inequalities in life expectancy through the work of health and social care organisations and professionals alongside others in the public and community sector. Whilst other key partners including local Health and Wellbeing Boards, the West Midlands Combined Authority and Police and Crime Commissioner – as well as national government – are key to helping us to address the 40% driven by the wider determinants of health, there are also important contributions the ICS partners can make as anchor organisations in this space as well.

> *"I don't have a great deal of faith in the (health and) care system because they failed my daughter miserably. We had so many problems leaving childhood (services) and going into adult services... it was horrendous because it seemed as thought they don't share details, they don't share information....we were saying the same thing over and over again."*
>
> Kiran Williams, parent of children with Learning Disabilities, Moseley Resident

Understanding the scale of our challenge

Our challenge is how we organise ourselves better in the future to ensure that everything we do in health and social care is taking into account – and having a measurable impact on – helping people to live longer and healthier lives.

We already have local Health and Wellbeing Boards in Birmingham and in Solihull which oversee Joint Strategic Needs Assessments - setting out the key challenges for each place, and using data 'deep dives' and locality profiles which identify more specific opportunities for action.

This strategy builds on the consultation and engagement that has co-created the Creating a Bolder Healthier City Strategy for Birmingham, the Tackling Health Inequalities: a blueprint for Solihull and Solihull's Health and Well-being Strategy 2019-22.

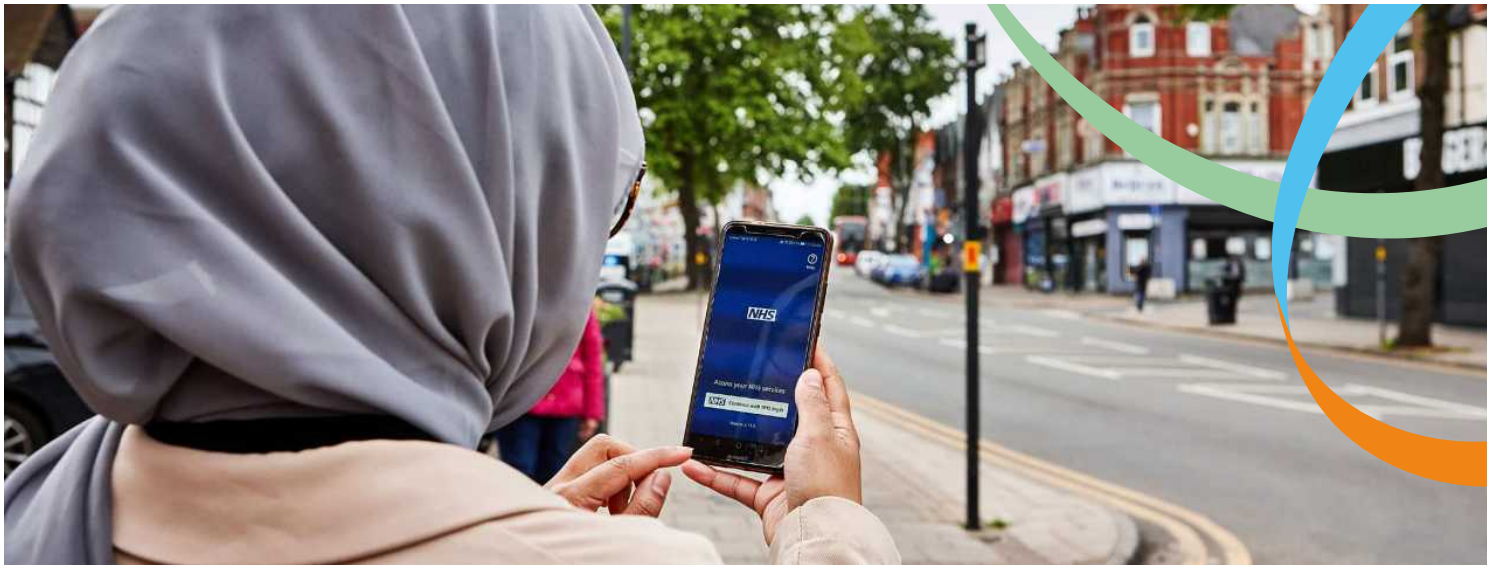
The summary of the two strategies clearly shows the overlapping priorities and these align with the ICS Inception Framework and the priorities and approaches set out in this document.

Understanding the scale of our challenge

Summary of Health and Wellbeing Board Strategy Priorities for Birmingham and Solihull and areas of shared priority

Level	Maternity & Early Years	School aged children & Youth	Working age adults	Older Adults	Diversity & Inclusion	Wider Determinants
Shared	Infant Mortality Childhood immunisation School readiness	Childhood immunisation	Suicide prevention Reduce depression and anxiety Physical activity	Ageing well approach Healthy life expectancy at 65yrs	Better data and analysis to increase understanding Carer support	Maximise benefits of green space & built environment Promote healthy housing Active transport
Common principles	Community collaboration, Integrated delivery, better use of data and analysis, safeguarding, anchor organisations					
Birmingham	Oral Health Healthy Start Vouchers	Childhood obesity Accident prevention	5-a-day/nutrition Health literacy	Dementia detection Falls prevention Excess winter deaths Musculoskeletal disease	LGBTQ+ mental health Ethnic inequalities in diabetes & CVD	
Solihull	Infant and parental mental health	Youth training, support and employment	Employment and support for people with LD and MH issues	Social connectedness and isolation	Learning disabilities and autism Mental health	Net Zero

Our vision and ambition



Our vision, as a partnership, is that the people of Birmingham and Solihull live longer, healthier and happier lives, whilst **our ambition** is that this is something to be realised for every community and every person, not just those who have social and economic advantages.

We want to ensure that everyone is supported from birth to their end of life in ways that are culturally safe and give them control, dignity, and choice.

Through the actions of our partnership, we should strive to ensure that those who are vulnerable, disadvantaged or disabled by society will be safeguarded, protected, enabled and empowered to achieve their full potential.

Case Study

Tackling obesity in people with a learning disability

Obesity contributes to many diseases including heart disease, cancer and mental health and rates of obesity are higher in people with a learning disability. 80% of people with a learning disability do less physical activity than recommended and they are also four times more likely to die from an avoidable medical cause than the general population.

In 2021, Birmingham City Council Public Health used a government grant to pilot new adult weight management programmes for people with a learning disability, sensory and mobility impairment.

Lifestyle company Beezee Bodies were commissioned to develop a bespoke 12-week programme that included one-to-one support and advice around diet, exercise and mental and physical health. The programme was co-created with people with learning disabilities, sensory and mobility impairment, as well as carers and healthcare professionals, and was delivered in both home and community settings.

149 of the 167 adults recruited to the programme completed it and 88% of all participants lost weight. There was a 44% increase in average mental wellbeing score from before and after the programme and all participants increased the number of days they did physical activity – going from 0.2 days at the beginning of the programme to an average 3 days at the end.

As the grant funding came to an end the Council looked at how to mainstream the funding for a sustainable future targeted programme.

Our vision and ambition

We should work with all our local communities to really understand what matters most to them and involve them in determining what will help to improve their wellbeing, health and care. This builds on the innovation of the Community Health Profiles and BLACHIR review and the empowering of communities and citizens thinking about place, identity and experience.

But it's not just our communities that matter: it's our staff. All the evidence shows that a happy and engaged workforce is more productive and will deliver better services and outcomes for the people they serve. All our partner organisations need to demonstrate how they support and respect they staff and how they engage them in delivering the ambitions set out in this strategy.

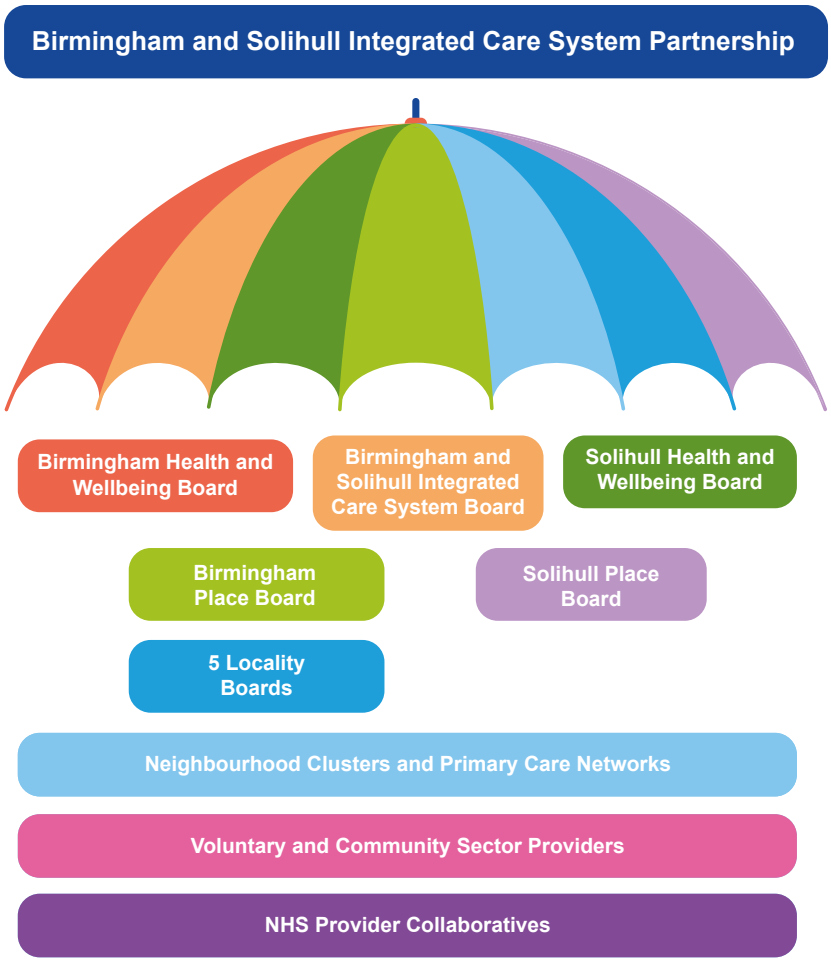
As a system, we play an active role in improving quality of life through our wider role as employers and anchor institutions.

We see this at different levels from neighbourhoods to the overall gaps between our ICS and the England average, different identity communities such as LGBT+, ethnic and disabled communities and different communities of experience such as veterans, carers and sex workers. We also recognise the intersectionality between these.

Subsidiarity is at the heart of our approach: doing things as locally as possible to deliver better outcomes for people and making the most of the partnerships, knowledge, assets and capability in different parts of our system.

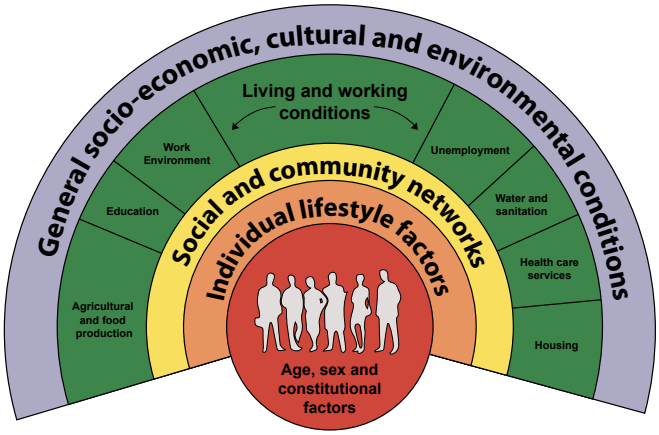
We want to ensure that the ambitions set out in this strategy don't just sit on a shelf – they drive and guide every aspect of policy and delivery in the ICS. This will require continued leadership to drive those ambitions, which will be delivered through the two Health and Wellbeing Board Strategies and specific ICS strategies such as the Learning Disabilities and Autism strategies. The ICS Partnership Strategy sits as an umbrella above these delivery strategies and frameworks to complement them and demonstrate the synergies in principles and practice.

However our ambition can only be achieved working in partnership across boundries, between organisations and with people. It is essential that all layers of the ICS understand this and model true partnership behaviours.



> *"You feel helpless in yourself and you need that help...but it's really a shame that you can't get joined up (services) to help you to do that, if you could, it would be a different situation altogether."*
>
> Jane Cousins, Fordbridge Resident, Solihull

Our partnerships



Source: Dahlgren and Whitehead, 1991

Organisational boundaries mean little to patients, carers and the public but we all want to experience high quality service delivered in ways that are culturally safe and intelligent by staff who are valued and care about them.

As a partnership we recognise the broad range of organisations who play a role in the delivery of health and social care in Birmingham and Solihull. We also recognise the importance of the ICS governance structures working with these organisations as equal partners rather than playing upon historical power dynamics based on headcounts or commissioning power.

In our integrated system, the voice of local community pharmacy should be as important to the governance decision making as that of the largest acute trust and it is important that the emerging governance structures value and listen differently from the past.

We want to see people at the centre of our approach and this means at every layer of the governance of the ICS system there should be clear and transparent approaches to inclusion of people's voices and consideration of representation and marginalisation.

Delivering our ambition for people to live healthier, happier and longer lives will require action across treatment and care, prevention and early intervention in every setting for short and medium term gain. It will also require upstream action as a partnership to fundamentally rewire the landscape of our places, both physical and social, to enable healthier futures in the long term. This is in line with the drivers of health which are well recognised by Dahlgren and Whitehead (1991) and subsequent reports including the Marmot reviews and set against – and will need to respond to – a challenging socio-economic backdrop.

Frailty: the perfect pathway

Meet Patrick from Solihull.

Patrick is an 82-year-old widower who lives alone. His daughter lives in Australia but his neighbours keep an eye on him.

After a fall at home he needs some extra support and is worried he might need to go into hospital – find out how a multidisciplinary team supports him to stay happy and healthy in his own home here

Read Patrick's perfect pathway here

Our shared objectives

Creating cohesion in how services are delivered locally can only happen if all organisations who contribute to health and care delivery are united around a set of clear objectives.

Throughout our consultation on the development of this strategy, six clear objectives emerged. They are:

Reduce inequalities

We will be intentional in acting to reduce inequalities in everything that we do as a system. We will consider inequalities in the context of place, identity and experience and work to close the gaps in our understanding, working with communities as well as with data and monitoring systems. We will use audit and needs assessments to check on progress and to demonstrate we are making real change and working towards closing the unacceptable gaps in care, treatment and outcomes for people. We will be a system that tackles variation in clinical practice and outcomes proactively and has visible quality improvement as a core priority for every partner. We will work with communities in closing the gaps we find.

Case Study

Empowering young women to make healthy life choices

Health Hacks is an initiative developed by NHS Ladywood and Perry Barr Locality Partnership (LPBLP) and Birmingham City Council Public Health in response to high levels of smoking in pregnancy and maternal obesity, poor maternal outcomes and high rates of infant mortality. The approach involves co-production with secondary school students to discuss what factors can lead to better health outcomes in pregnancies.

Events with students - girls in the first instance - focus on developing action to improve health behaviours and identifying and discussing early detection of problems. The main aim is empower young women to make healthy life choices that minimise infant mortality risk factors.

Presentations from health professionals provide up-to-date information about infant mortality, and information on the current scale and likely future trends in genetic problems caused by social and cultural factors in Birmingham. The events bring together a wide variety of partners and introduce students to a range of different health professions.

Through the sessions, the young people have become empowered around their own reproductive health and also become advocates within their families.

Our shared objectives

Deliver integration for people

We will work together as a system to deliver joined up integrated services and experiences of prevention, treatment and care. We will enable fluid and secure movement of data between partners to support people getting the best care and support and we will work with service users to continually improve our systems and delivery. We will deliver cost and delivery efficiencies that work for people and their needs through improved integration and performance management.

Protect people from harm

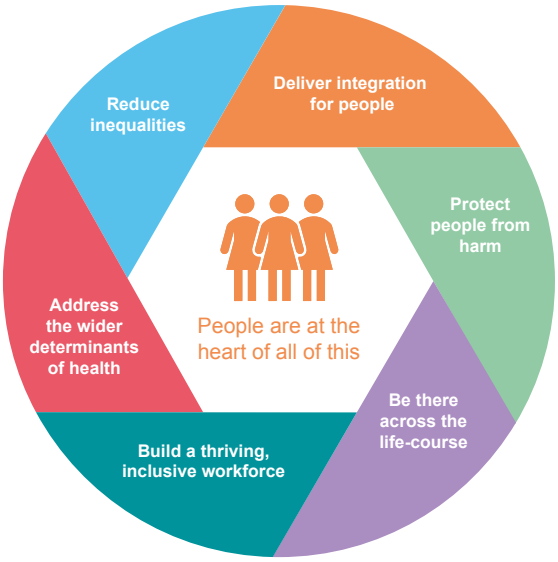
We will be a system that actively protects people from harm, from our robust clinical governance framework to our integrated approaches to infection control, immunisation and screening and the work we do together on early intervention and prevention. We will also be a system that is prepared for emergencies and acts quickly to protect our people from harm. We take seriously our commitment as corporate parents and guardians of the vulnerable and we want to see this visible at every level of the ICS system.

Be there across the life course

Whilst we recognise the importance of the early years and rightly invest in giving every child in Birmingham and Solihull the best start in life, our responsibility doesn't stop there. We are committed to being there for people as they grow, age and die. This spans our partnership work through the health and wellbeing board, addressing environmental change through the layers of primary prevention, early intervention and secondary and tertiary intervention, right up to the end of life.

Our role is to ensure that health does not become a barrier to achieving your potential whatever your impairments, and we want to be a system that enables everyone to participate fully.

> *"If I had a magic wand, I would like somebody who was there consistently..putting the needs of these vulnerable people first. I would like it to be more accessible, and not just via the Internet because not everyone has access to a computer or is computer literate."*
>
> Parent of children with learning disabilities, Birmingham



Special educational needs and disability (SEND): the perfect pathway

Meet The Jenkins Family from Hall Green.

Isla is 11 and lives at home with her Mum, Dad and younger brother Leo, who has Autism.

Isla has recently moved to her new secondary school and is struggling to cope with the increased demands and complexity of interacting with peers as well as with the size of the school environment which she finds difficult to navigate. She has been upset and distressed when she comes home despite appearing to cope in the school day.

Read Isla's perfect pathway here

Our shared objectives

Build, develop and retain a great, inclusive workforce

We want to be a system that at every layer is playing its role anchoring communities and providing great employment to a diverse local workforce that delivers great services. We want every ICS partner to be intentional in tackling workplace racism, homophobia, transphobia and discrimination and demonstrate active improvement in the experience of our staff at every level.

Contribute to the wider determinants of health

The ICS is a major employer and purchaser and is a significant physical presence in place and it will play a significant role in addressing the wider determinants of health such as employment, education and environmental sustainability through its intentional actions at every level.

As a collection of large anchor organisations, the ICS recognises its role in promoting wider regional economic growth.

Case Study

Boosting career prospects for North Solihull citizens

Solihull Recruitment and Training Centre is based in Chelmsley Wood Shopping Centre and provides an employment support service for local citizens as well as working with local businesses recruit to their vacancies. Citizens can access a range of training opportunities on site and can also get advice on health, financial, housing or travel services.

Amber left school with good passes in GCSEs and was interested in a career in the NHS. Amber was living in a workless, single-parent household, with a younger sibling. She had no work experience and no access to a computer so was referred to Solihull Council's employment and skills team as she wanted help to apply for a health and social care apprenticeship. She had put together a very basic CV, so the employment team worked with Amber to enhance it to better reflect her skills, knowledge and experience. They also found her three apprenticeships to apply for within easy travelling distance. Amber completed her applications in the Centre, with support and advice from her employment adviser. She was due to attend a healthcare careers fair to talk to prospective employers, but to her delight, found out that she had been offered an apprenticeship with a local NHS Trust. She remained in regular contact with her adviser to ensure that she is well prepared to start her new role.

Creating the conditions to enable greater focus prevention

> *"There is a disconnect between health bodies.. and other agencies and community stakeholders (like charities) doing the same thing but they do it in parallel universes. They're not doing it collectively, collaboratively so that we can .... get a better return on the investment we receive ...and ensure that people who are in need get access to that support."*
>
> Sparkbrook resident

The ICS is a partnership and to deliver the ambitions of this strategy will require all involved to completely reimagine how they work together in the future.

Achieving common goals across health will require closer working than ever before, greater inter-dependency, co-production and stronger trust between organisations as we adapt to this new way of working.

But joint working has to be more than just agreeing on a set of ambitions: it requires changing the way we commission and deliver services, from shared funding, collaborative commissioning and localised multi-disciplinary teams designed around people and their lives.

The ICS should work across the system to maximise cross-boundary working by putting a real focus on developing an integrator model which delivers against it's aim to create locally-based health and social care teams through the provision of Integrated Neighbourhood Teams.

Given the current pressures, in part created by Covid-19, on access to services, the ICS should look to use the development of service integrators not only to address the immediate issue of access but to create the time and space for teams to be able to give real focus to the prevention agenda in the future.

Joint working will be fundamental at a delivery level. We should expect to see integrated services that feel connected and seamless for those using them and whilst we recognise there is much to do to achieve this, it is a core aim of the ICS partnership.

Key to this will be **subsidiarity**, the principle that things should be done at the level of the system that is most relevant, effective and efficient, and that by doing this, these actions at every level work together to contribute to the overall ambition of the ICS.

Governance and oversight for Integrated Neighbourhood Teams should, over time, also be delivered as locally as possible through Place Committees. As Place Committees develop they will set the direction for Integrated Teams and have direct commissioning powers for elements of their work.

MSK: the perfect pathway

Meet The Wilson Family from Erdington.

Mike is 61. He's a gas engineer and watches more golf than he plays since his back pain started a few months ago. Mike lives with his wife Priya (56) who works in a school and they have a 19-year-old son Arjun, who is training to be an accountant.

Read Mike's perfect pathway here

> *"People say 'prevention is better than cure' so it's knowing what can be done at the very beginning before having to come to a GP practice...informing people where they can go to get the help that they need."*
>
> Adilla Jones,
> Health Inequalities Champion, Hall Green Primary Care Network

Case Study

Asthma Friendly Schools

To boost the support offered by primary care to families of children with asthma, Ladywood and Perry Barr Locality Partnership has been teaming up with education and community partners in West Birmingham to put more power in the hands of families and the people who support them.

Currently working with 10 schools and BLESST youth club in West Birmingham, they have developed a model for 'Asthma Friendly' schools and youth clubs, in which all children with asthma have an up-to-date personalised asthma plan, staff are asthma-trained, parents are empowered, fellow pupils are sensitive and supportive, and the school is working in partnership with the local authority to improve local air quality.

The initiative involves in-school events and promotional webinars, offering educational talks and clinics with pupils and/or parents on topics such as how to use inhalers, triggers for asthma and how to request a personalised asthma plan. The framework also encourages pupils to be asthma champions and to present their learning at assemblies, to help demystify the condition and raise awareness amongst their peers.

Anecdotal feedback from schools and families who have already benefitted has been wholly positive, with school heads sharing how asthma is now better understood by staff and students, and asthma is neither something to be afraid of, nor stigmatised.

We also know that building systems and pathways needs us to also work with people to empower and enable them to navigate them when they need help.

Across the ICS we will need every organisation to actively consider access, inclusion, cultural safety and health literacy. The ICS should consider and act upon the findings of the deep dive Needs Assessments and recommendations from these reports, including the Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR) and the various Healthwatch reports.

Innovation, evidence and research should be at the heart of our evolving approach to the challenges we face and the opportunities to deliver our ambition at scale and pace. We want to see the ICS be confident in its use of data and we expect the ICS to be brave in exploring in depth the inequalities in outcomes and the variation in practice across the system.

Overall, the biggest impact the ICS can have is to create the focus around the determinants of poor health, maximise the care and prevention in clinical pathways and provide leadership and vision around improving outcomes in our communities.

Therefore the ICS should prioritise creating an Outcomes Framework to drive this approach. This should be centrally developed initially, but responsibility and ownership of this Framework should shift to Place Committees over time as they mature in their role.

> *"I would make young person services more young person-centred...sometimes they just address the adult and don't speak to the young person the whole appointment, How are you supposed to reach these clinical outcomes when you're not even involving the young person in their own decisions and their own care?"*
>
> Beth Dennis, Chair, Young Person Advisory Group

Case Study

Detecting and treating cancer early

In 2022, as part of a national programme, a pilot launched in Birmingham to identify signs of lung cancer early, targeting those most at risk of the disease.

Early diagnosis is key to effective treatment, particularly for lung cancer. Yet currently around 75% of lung cancers are diagnosed at a late stage (stages 3 and 4).

If diagnosed earlier (stages 1 and 2), 70% of lung cancer patients will survive for at least a year, compared to around 14% for people diagnosed with the most advanced stage of the disease.

In Birmingham, the Targeted Lung Health Check (TLHC) programme launched in Washwood Heath, which is one of the most deprived areas of the country, and lung cancer is more prevalent in areas of high deprivation.

The TLHC programme is available to residents aged 55 to 74 who have a history of smoking or have other lung or heart conditions.

Eligible residents receive an invitation via post and initially they will have an appointment with a lung health nurse, either over the phone or face-to-face. People considered to have a higher risk of lung cancer will then be offered a low-dose CT scan in a mobile truck, conveniently located in their local area.

If a cancer is detected, the patient will be referred to secondary care, for further scans and treatment – the hope is that through earlier detection, there is a much greater chance of successful and less invasive treatment.

How will we know if we're having an impact?

There are **five big differences** we should expect to see in the way we work if we succeed in delivering the changes outlined in this strategy. They are:

1. Fully integrated health and social care that is based around the person in local communities

This would mean that people engaging with health and social care services will not have to repeat information because there will be connected data sharing between providers that respects confidentiality and prioritises individuals' needs.

> *"One of the biggest challenges and one of the things that can hold up improvements is not having that ease of information sharing. The voluntary sector, the NHS, the ICB and ICS partners need to have the agreements in place."*
>
> VCFSE Respondent, ICS Strategy Engagement Report

We would also see services designed to join up around patients through more 'one stop shop' clinics, so that people who need support can see multiple professionals in the same site on the same day, rather than having to juggle multiple appointments in different locations.

For some services, this may mean fully integrated teams with integrated management and terms and conditions, but it may also mean aligned or co-located services, and this will depend on the service.

2. Prevention is embedded in every step of every pathway to prevent disease and reduce the impact of ill health on lives

The full breadth of the health and social care system will be proactive in taking action on prevention at every stage of life and in every care pathway, this will be about preventing disease but also about supporting changes that reduce the risk of complications and improving health in those living with long term conditions.

We recognise that early help is more effective at supporting people to live happier, healthier lives than treatment to repair and recover, and as an ICS we will invest more proactively in early help, early intervention and prevention before people become clinically unwell or require social care support. In some cases this will only be able to defer need but in others it may prevent it completely and this will free up other resources and so is both the ethical and economic thing to do.

This means that people will be able to have conversations about what support they need in any setting across the system and the professionals talking with them will know how to connect them with support available.

> *"It's about relationships really, so to build a strong relationship across our locality is the way forward... I think there's a lot of scope for us to work together but for me, it's that local relationship building that's got to work."*
>
> VCFSE Sector respondent, ICS Strategy Engagement Report

Social prescribing, community navigators and cultivating and supporting trusted sources of information and advice are key to delivering this in an integrated way from welfare advice to wellbeing support.

We plan for this to be clearly set out in the commissioning and monitoring of services, as well as in how we train and educate our health and social care workforce so they are skilled to have enabling and empowering conversations. We will working in partnership with community organisations to support their knowledge and expertise alongside where we are commissioning service provision as a system.

Screening, vaccination and health checks are fundamental to prevention and we expect there to be rapid improvement so that the variation and inequalities in uptake and in clinical practice across our neighbourhoods and between communities of identity and experience disappear.

3. A diverse and successful workforce across health and social care that delivers high quality care and rewarding career opportunities for all

Birmingham and Solihull health and social care system will become employers of choice, offering careers and experiences that value and support inclusion and enables local employment that is rewarding and fulfilling.

Across the system we will be confident that the evidence-base of what works is being implemented routinely and when mistakes happen we can demonstrate rapid learning and implement changes to avoid future issues.

Fully implementing evidence-based care will lead to fewer patients developing complications and reduce the burden on health and social care services through better management. This is especially important to reduce inequalities and will also mean we have staff who are culturally intelligent in their practice and treat every person in a holistic way.

People using our services feel that they are receiving high quality care and the number of complaints sets a new, much lower baseline because people are confident in the care they receive and are involved in their care decisions individually and are involved in service decisions as local communities.

4. Achieve financial sufficiency through better use of skill mix, evidence-based practice and using research and insight at pace to improve outcomes

Every organisation has to balance the finances - the health and social care system is no different, and the ICS will achieve financial sufficiency through the changes we plan.

We will be a system that is much better at using skill mix, while recognising the paradox of delegation, creating more complex demands on higher skilled staff. Professionals will feel valued and supported to deliver care within their sphere of competency and with clear risk management and clinical governance.

We will also maximise the efficiency of our public sector estate, working across the health, local government, police, education and other public sectors to embed services in spaces that work for communities in joined up ways.

This means that people will be able to access care more easily from a diverse range of professionals and volunteers that provide care and support across the full week, in a range of community and health settings. It means that simple things can be done closer to home or work and only those health issues which need to go to our most specialist centres go there.

Through a strong and consistent approach to prevention and early intervention and better integrated services we will reduce financial waste across the system and improve the experience for service users.

5. Making a positive impact through every health and social care provider's actions on the wider determinants of health and reducing inequalities

Across health and social care we will use our role as anchor organisations in communities to employ locally, supporting local education pathways to successful careers, and buy locally to help the local economy.

We will be active with our existing partnerships such as health and wellbeing boards, supporting the leadership of both Councils, and others to work on the wider determinants such as housing, employment and education. The ICS will be visible in employing locally with a real Living Wage* and a strong approach to supporting training and development that helps reduce inequalities in employment as well as health outcomes. With the local community safety partnerships we will have played an active role in improving community safety and cohesion and where there are unique opportunities such as East Birmingham and North Solihull Investment Zone to drive change, we will be visible and active partners.

People from different communities will feel confident accessing services because they will know that health and social care professionals are culturally intelligent in the way they deliver care and understand the impact of experiences such as racism, homelessness and caring responsibilities on health and wellbeing.

> *"The NHS staff have to be anti-racist, not just less racist."*
>
> Birmingham community member, BLACHIR Report 2022

* Employing organisations should be accredited through the Living Wage Foundation.

Measuring success

It is essential that we have a clear metric dashboard for measuring the progress against this strategy. This will need to sit in synergy with the national ICS outcomes frameworks and local Health and Wellbeing Board Strategy dashboards. These metrics are hosted by Birmingham City Observatory

In setting out how we will measure success we are taking the subsidiarity model in our approach, so as the ICS Partnership we are defining the metrics against which we want to see progress and the anticipated direction of travel, but we expect the ICS Board and Place Boards to define the target outcomes and the trajectory to achieving significant change by 2033.

Also, in setting out our long and medium term metrics we recognise the challenges of the continually changing landscape of the public sector, the major impact of socio-economic factors and the changing demographics of our communities and we aim to revisit these every two years to ensure these remain relevant and appropriate to achieving our vision and ambition as a system.

We have included specific metrics focused on equality, diversity and inclusion which reflect our globally diverse population and the real inequalities between different communities of identity and experience as well as between geographical places.

> *"The main improvements I'd like to see are access to care in your local community without having to travel and the same comparable services, with comparable waiting times and access requirements across both Birmingham and Solihull. I would like services to be more joined up and to have that communication."*
>
> Heather Delaney, Chair and Director, Solihull Parent Carer Voice

ICS level long term metrics – ten year trajectory of change

- Life expectancy at birth and at 65yrs
- Disability-free life expectancy at birth and at 65yrs

- Inequalities in life expectancy within Place and between communities of identity
- Prevalence of excess weight in adults and children

Place and locality level medium term metrics – five year trajectory of change

- Uptake of antenatal screening
- Children achieving good level of development at the end of Reception & at 2-2.5yrs
- Increase the proportion of cancer cases diagnosed at stage 1 or 2
- Estimated dementia diagnosis rate in >65yrs olds
- Older adults still at home within 91 days from discharge to reablement

- Prevalence of cardiovascular disease
- Emergency admissions for cardiovascular disease, especially for stroke and heart attack
- Prevalence of diabetes
- Emergency admissions for chronic obstructive pulmonary disease (COPD)
- Infant mortality
- Hospital admissions caused by injuries and asthma in children
- Cancer mortality (all causes)
- Prevalence of smoking
- Suicide and self-harm rates
- Adults with a long term musculoskeletal health problem
- Emergency hospital admissions due to a fall in adults aged over 65yrs

Community inequality medium term metrics – five year or less trajectory of change

Communities of identity inequalities

We recognise the inequalities affecting communities of identity across Birmingham and Solihull and the need to drive specific action to address these through addressing structural discrimination as well as culturally intelligent commissioning and delivering cultural safety across all our services. There remain several communities of identity, such as faith, gender identity and sexual orientation, where routine data collection is limited and we are committed to closing these gaps in the first two years of the strategy and expanding this set of metrics to cover as a minimum the legally protected characteristics.

Ethnic inequalities

- Ensuring continuity of maternity care of women from ethnic communities and from the most deprived groups
- Uptake of cancer screening by ethnic communities
- Uptake of immunisation across the life course by ethnic communities

- Inactivity in people from ethnic communities compared to the national average
- Inequality gap in type 2 diabetes between different ethnic communities
- Ethnic pay gap in ICS organisations

Gender inequalities

- Uptake of long acting reversible contraception (LARC)

- Teenage conception rate in under 18yr olds
- Domestic violence and abuse related incidents and crime
- Physical inactivity rates in women and girls
- Gender pay gap in ICS organisations

Disability inequalities

- People with learning disabilities and those living with severe mental illness (SMI) receive annual health checks
- Carers receive an annual health check

- Inactivity in people with long term conditions and disabilities
- Smoking in adults with long term mental health conditions

LGBT+ inequalities

- Ensure LGBT+ people with common mental health issues receive timely and culturally sensitive support through IAPT and specialist services (IAPT dataset)

Community inequality medium term metrics – five year or less trajectory of change

Economic inequalities

We recognise the deep and entrenched inequalities between the most deprived and the most affluent populations and the need to maintain and accelerate our work to address these, both through increasing the money in people's pockets as well as considering the financial and social barriers to services and support.

- Uptake of healthy start vouchers
- Uptake of cancer screening in the most deprived communities
- Uptake of immunisation across the life course in the most deprived communities
- Proportion of ICS organisations, and contracted organisations, who are accredited Living Wage employers*

- Children living in relative low income families (under 16yrs)
- Fuel poverty
- Young people not in education, employment or training

Inclusion health populations inequalities

Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery. There are currently limited indicators that are routinely collected and we hope that the ICS will develop a fuller suite of metrics over the first five years of the strategy to build on these.

- Immunisation and vaccination coverage in inclusion health populations
- Early identification of blood borne viruses e.g. HIV, Hepatitis
- Children in care immunisations
- Supported adults with learning disabilities in paid employment

- Drug and alcohol admissions and related deaths
- Children on child protection plans
- Re-offending levels

* % of employers and contracted organisations accredited through the framework of the Living Wage Foundation. Living wage is also the core focus of the Health of the Region Task Group at the WMCA and this metric aligns with their trajectory.

Getting started

A focus on five key clinical indicators to help improve life expectancy

This strategy sets out an ambition to give the people of Birmingham and Solihull longer, happier and healthier lives so they can achieve their potential without health being a barrier.

But achieving this ambition is going to require early focus, leadership and a clear route map to support everyone in health and care to play an active part in contributing toward this.

While life expectancy is a long term indicator driven by many elements, there are five key areas where, if we can provide focus and accelerated change, we can make an early start to meeting our ambition. They are:

- **Circulatory Disease**
- **Infant Mortality**
- **Respiratory Disease**
- **Cancer**
- **Mental Health**

In each disease area there are multiple strands of action spanning prevention, treatment to end of life care. Addressing the disparities in life expectancy requires work at every stage from prevention of risk factors like smoking, through early identification using tools like screening and opportunistic testing and then reducing risk at every stage of the clinical pathway to give people the best quality of life and the best opportunity for a long and healthy life.

Figure 7:

An example of how we can prevent and reduce the risk of, and improve outcomes for, those living with cardiovascular disease

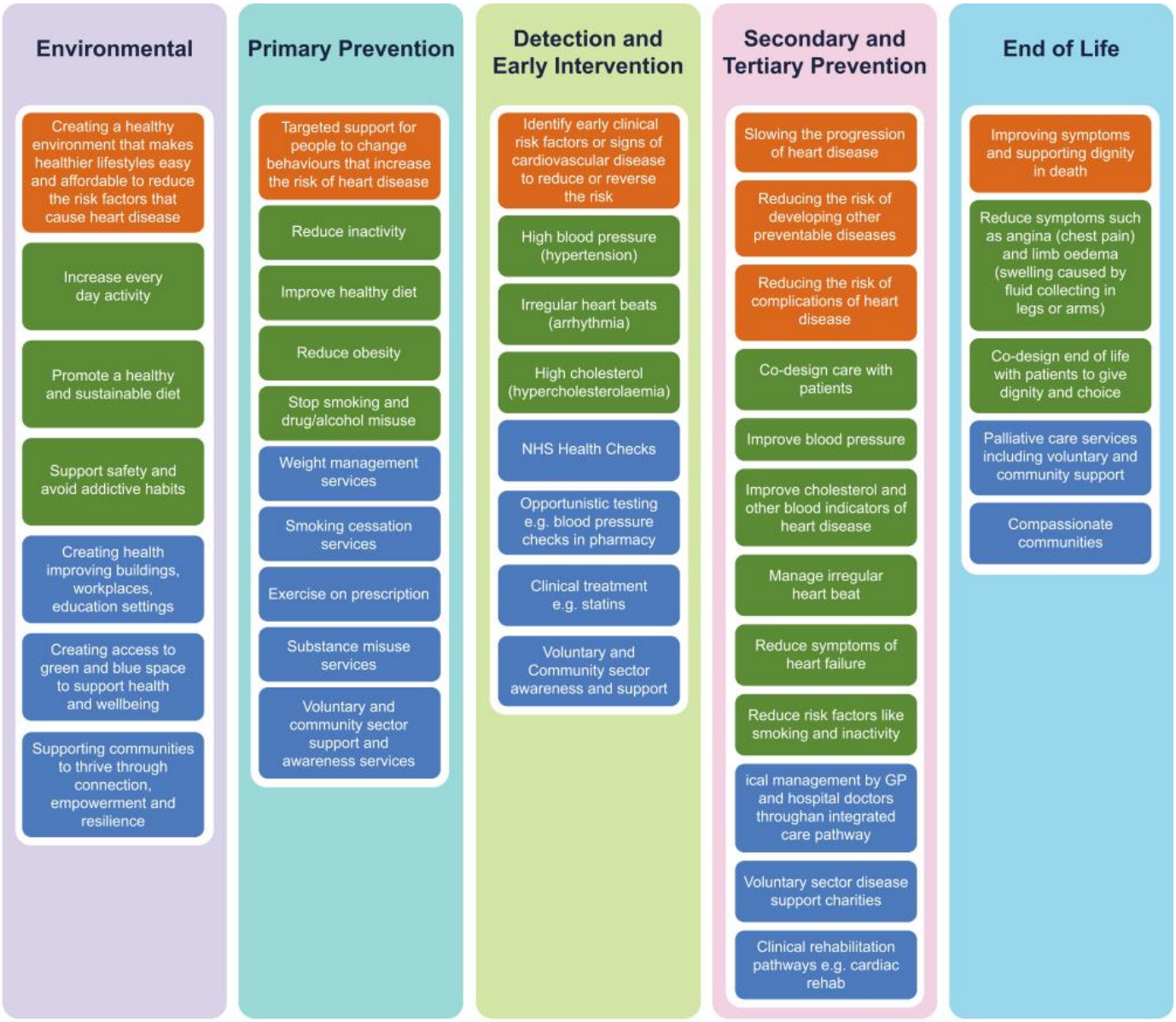


Figure 8:

An example of some of the existing metrics which can be used to monitor how our changes have an impact on cardiovascular disease outcomes

The indicators that have been identified to track progress for the ICB map into these domains although it is recognised that there are some areas where local indicators will need to be developed to improve the depth of understanding.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HELLO
THE HIGH STREET
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CREATIVITY IS JUST INTELLIGENCE HAVING FUN
forever young

Getting started

Addressing the improvements we need to see across each of these five requires action that will impact both long and short term and the ICS Partnership expects to see a relentless drive to address inequalities within each of these five areas.

In each area we are expecting to see action in 2023/24 under the following priorities to start this process of change:

1. UNDERSTANDING OUR COMMUNITIES

We expect to see explicit use of local data in each condition area to explore and understand racial inequalities and other identity and experience linked inequalities as well as geographic inequalities and this data driving service improvement and better outcomes.

2. MAKING EVERY CONTACT COUNT FOR PREVENTION

We expect to see all health and social care professionals completing basic e-learning for behaviour change and those in clinical contact roles completing additional training on brief advice for smoking cessation and physical activity in line with NICE guidelines. This will lay the foundation for organisations across the ICS to start to monitor and report on the use of primary prevention in pathways.

3. GET THE BASICS RIGHT

We expect to see each of the five clinical pathways complete and publish at least two audits based on NICE guidelines across the full footprint of the ICS i.e. integrated audit across primary, secondary and social care. Too often in the glare of new technology and the pressure of service reform the basics fall short and this will demonstrate a commitment to evidence based quality improvement.

4. LEARN FROM OUR MISTAKES

We expect the ICS to publish an annual report demonstrating the implementation of learning from the recommendations made through the statutory death panels e.g. Adult Safeguarding Reviews, Child Death Overview Panel, Domestic Homicide Panel, Deaths through Alcohol or Drugs Review and the LeDeR Programme (Learning from lives and deaths - People with a learning disability and autistic people).

Case Study

Helping people to make lasting lifestyle changes

A pilot programme which focussed on prevention has helped people in Solihull to live healthier lives and empowered them to make practical and effective lifestyle changes.

In a partnership between the five Primary Care Networks (PCNs), Gateway Family Services, Community Pharmacy, Public Health and Solihull Together Board, three Integrated hubs in Solihull were set up to focus on delivering lifestyle interventions, health checks and group consultation.

Through data held by GP practices, the pilot targeted people who would benefit most, such as those with a high blood pressure reading or a long-term condition.

Citizens were invited to a lifestyle check, provided by Gateway Family Services, which included weight and blood pressure checks. As required, Gateway could then refer people for tailored support around weight loss, healthy eating, reducing stress and smoking cessation. Following the intervention the patient was referred back to their GP for review.

This partnership approach ensured that patient care was managed through their GP practice, but with the benefit of a multidisciplinary team to carry out the checks and intervention.

The pilot successfully identified those at high risk - of the 135 people that took up the offer of the health check, 1 in 5 were identified as having a high blood pressure that required medical intervention or referral back to their GP and five individuals were identified as having atrial fibrillation (irregular heart rate).

Nearly half of all those who took part were referred on to other support services either provided through the partners involved or through an external service.

To expand this programme further it would benefit from being part of place based working for large scale vision and resource.

Our expectations as a partnership

The ICS Partnership expects that the ICS Board will respond to this strategy through the ICS Operating Framework and its underpinning strategies.

Through the monitoring of the dashboard of indicators, the ICS Partnership will assess impact of this operating framework on outcomes, alongside the ICS Board reporting on delivery of financial and performance improvements, in line with national and regional NHS expectations and the national NHS mandate.

The Partnership will be looking for explicit progress on integration and quality improvement within the first 24 months of the ICB activity, especially to address variation in clinical outcomes in both primary and secondary care, and be able to demonstrate progress in enabling and empowering people, patients and citizens to shape these improvements.

We recognise the workforce challenges and increasing burden of need and demand; this will require a radical change in the way we approach care.

The ICS research and innovation approach should reference the ICS Partnership strategy and have a clear focus on addressing some of the data insufficiencies, especially around granular data on ethnicity, sexual orientation and faith in performance data sets. This sits alongside a programme of deep dive explorations of inequalities in outcomes and service uptake in different communities.

We plan to refresh this strategy in 2025/26 once the ICS is more fully established and we have addressed some of the data and intelligence gaps to better understand need across our communities, however the Partnership will review the strategy each time a new Joint Strategic Needs Assessment is published by our partner local authorities.

As a Partnership we are committed to supporting the ICS through our leadership and oversight to ensure that the people of Birmingham and Solihull are supported to live healthy, happy and longer lives through our combined efforts as a system.

> *"We know that we're only going to be able to deliver the change we want to see, and that local residents want to see, by working together in partnership."*
>
> Ruth Tennant, Director of Public Health, Solihull MBC

Annex A: New legal duties strengthen our approach

There are a number of specific legal duties the ICS needs to be aware of in delivering its work, some of which will strengthen its ability to focus on tackling inequalities and improving outcomes.

Equality Act 2010

Public sector equality duty with three arms: i) prevent unlawful discrimination, ii) advance equality of opportunity, and iii) foster good relations between people who share a protected characteristic and those who do not

Specific equality duties on publishing equality information and setting and publishing equality objectives

Health and Care Act 2022

The Health and Care Act 2022 will introduce a range of obligations on NHS bodies in relation to health inequalities.

Tackling inequalities in outcomes, experience and access is one of the four key purposes of an ICS, supported by specific duties.

New ICB obligations on health inequalities

A new duty on health inequalities for ICBs: 'Each integrated care board must, in the exercise of its functions, have regard to the need to (a) reduce inequalities between persons with respect to their **ability to access health services**, and (b) reduce inequalities between patients with respect to the **outcomes achieved for them by the provision of health services.'**

A new **quality of service** duty on ICBs which includes addressing health inequalities.

A duty to **promote integration** where this would reduce inequalities in access to services or outcomes achieved.

Duties on ICBs in relation to several other areas which require consideration of health inequalities – in making wider decisions, **planning, performance reporting**, publishing certain reports and plans, **annual reports and forward planning.**

In addition, each ICB will be subject to an **annual assessment** of its performance by NHS England, which will assess how well the ICB has discharged its functions in relation to a range of matters including reducing health inequalities, improving quality of service, and public involvement and consultation.

Annex A

Committing to transparency: new requirements to publish inequalities data for ICBs, Trusts and Foundation Trusts

NHS England must publish a statement about use of information on inequalities in access and outcomes, setting out the powers available to bodies to collect, analyse and publish such information, and views about how the powers should be exercised.

NHS bodies should publish annual reports describing the extent to which NHS England steers on inequalities information have been addressed.

These new requirements sit alongside the existing duties on the NHS under the NHS Act 2006 and subsequent legislation as well as duties that require the NHS to actively contribute and participate in relation to:

- **Duties on equality and health inequalities under the Equality Act 2010 and the Health and Social Care Act 2012.**
- **Duties in relation to children in relation to the Children Act 1989 and 2004**
- **Duties on crime prevention and safeguarding including under the Domestic violence, Crime and Victims Act 2004 and as a Category 1 responder under the Civil Contingencies Act.**
- **Duties in relation to protecting staff under the Health and Safety at Work Act 1974 and training of staff under the Health Services and Public Health Act 1968**

Annex B: Full Glossary[1]

ICS – Integrated Care Systems

An ICS brings NHS providers, Clinical Commissioning Group (CCGs), local authorities and voluntary sector partners together to collaboratively plan and organise how health and care services are delivered in their area. There are currently 42 ICSs across England and each covers a population size of 1 to 3 million. The goal is that ICSs will remove barriers between organisations to deliver better, more joined-up care for local communities. Birmingham and Solihull ICS is our local ICS.

ICP - ICS Health and Care Partnership

The second part of the statutory ICS will be the ICS Health and Care Partnership. With a wider membership than the ICS NHS Body, the Partnership will bring together health, social care, public health and wider partners to develop a broader strategic health, public health and social care plan for the ICS. The ICS NHS Body will need to take this plan into account when making decisions about health care provision.

Provider collaborative

A provider collaborative is made up of several organisations coming together to make collective decisions about the design and delivery of health and care services. This collaboration can take place "horizontally" or "vertically". A horizontal collaborative may take place at ICS level or across several ICSs, between trusts delivering the same type of services such as non-specialist acute care. A vertical collaboration may happen at "place" level (see below) – for example between an acute trust and primary or community care. NHSE/I want every trust to be part of at least one or more provider collaborative, as they see collaboration as the best way to drive improvement.

Place

Most health and care services need to be planned, designed and delivered on a smaller geographic footprint and population size than the ICS. This means that within each ICS there are several smaller planning footprints – termed "places" – where health and care organisations come together to improve patient pathways and deliver more joined up care. In BSol ICS there are two Place Boards, one for Birmingham and one for Solihull, these align with the local authority boundaries.

Locality

In Birmingham, because of its large size, there are five locality partnerships, these focus on delivering change at a smaller geographic footprint than the Birmingham Place Board. Each locality covers two electoral footprints, e.g. North Locality includes Sutton Coldfield and Erdington. Each locality partnership is supported by a locality manager. The localities in Birmingham are East, West, Central, North and South.

Neighbourhood

Within each 'locality' and within Solihull's place governance structures, there are several neighbourhoods, which cover a smaller population size of roughly 30,000 to 50,000 people. They often focus on integrating primary, community and social care through multidisciplinary teams and joint working arrangements. Neighbourhoods are therefore key to the NHS's commitment to deliver more care as close to home as possible.

PCN– Primary Care Networks

A PCN brings together a group of local GP practices with other primary and community care organisations to join up health and care services at neighbourhood level. They were established in July 2020 to help stabilise general practice by using economies of scale, overcome barriers between primary and community services, and develop population health approaches. PCNs are still in development, but more mature networks are now able to deliver more joined up care for patients by developing multidisciplinary teams and recruiting additional roles to ease workload pressures.

Health inequalities

Health inequalities are defined as systematic, unfair and avoidable differences in health between different people within society.

Health disparities

Health disparities simply means health differences; whereas health inequalities points specifically to health disparities that are unfair and avoidable – that we can do something about.

Inclusion groups[2]

Inclusion health is a term used to describe people who are socially excluded and experience multiple risk factors for poor health such as poverty, violence and complex trauma. This can include people who experience homelessness, drug and alcohol dependence, Gypsy, Roma and Traveller communities, sex workers, victims of modern slavery, refugees, asylum-seekers and undocumented migrants. People belonging to inclusion health groups may experience stigma and discrimination and are not consistently included in electronic records such as healthcare databases. They frequently suffer from multiple ongoing health problems and face barriers to accessing healthcare. They may not be registered with a GP or have any information recorded about their health problems in health records. This leads to extremely poor health outcomes, often much worse than the general population, and contributes to increasing health inequalities.

[1] Adapted from https://nhsproviders.org/media/691164/system-working-glossary-for-governors.pdf

[2] Definition from Long read: winter vaccination for inclusion health groups - UK Health Security Agency (blog.gov.uk)

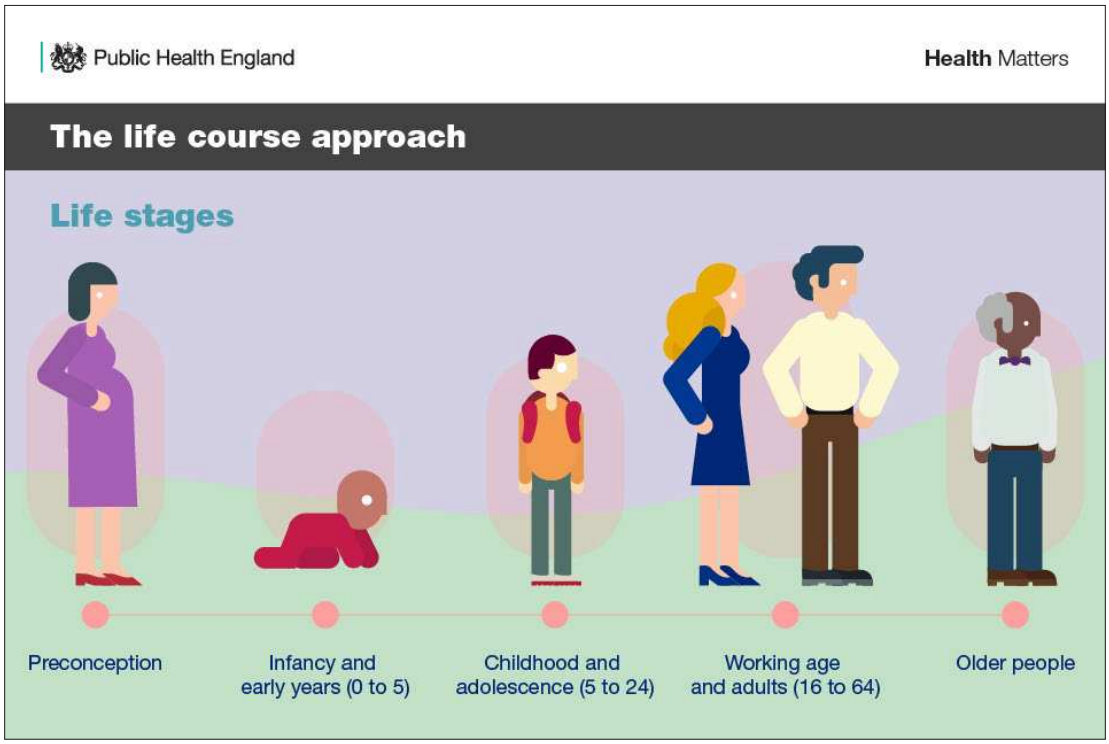
Annex B: Full Glossary[1]

Lifecourse[3]

A person's physical and mental health and wellbeing are influenced throughout life by the wider determinants of health. These are a diverse range of social, economic and environmental factors, alongside behavioural risk factors which often cluster in the population, reflecting real lives. All these factors can be categorised as protective factors or risk factors. Unlike a disease-oriented approach, which focuses on interventions for a single condition often at a single life stage, a life course approach considers the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing. A life course approach values the health and wellbeing of both current and future generations and recognises that protective and risk factors interplay over the lifespan and that maintaining good functional ability is best achieved through actions at every stage of life.

Figure 5:

The Life Course Approach (PHE 2020)



Health outcomes

Health outcomes are a change in the health status of an individual, group or population, which is attributable to an intervention.

Mortality

Mortality refers to the number of deaths that have occurred due to a specific illness or condition. Mortality is often expressed as a mortality rate, this is the number of deaths due an illness divided by the total population at that time of people who could get the illness.

Morbidity

Morbidity is a term that is used to describe the state of having a specific illness or condition, this can be acute or long term.

Co-morbidity describes when an individual has more than one conditions at the same time e.g. high blood pressure and diabetes.

Morbidity can be presented in two ways:

Incidence – the number of new cases of an illness or a condition within a population over a defined period of time, this can also be a rate or proportion of people within the population with the condition

Prevalence – this is the proportion of the population that has a condition or illness, it includes new and existing cases and can be calculated at a specific point in time or over time. It is usually presented as a percentage or a rate.

[3] Definition from Health matters: Prevention - a life course approach - GOV.UK (www.gov.uk)


Shirley Park

Birmingham City Council

Health and Social Care Overview and Scrutiny Committee

04.04.23

Subject:	Public Health – Immunisations (follow up from February paper)
Report of:	Mary Orhewere (Assistant Director, Public Health, Birmingham City Council)
Report author:	Mary Orhewere (Assistant Director, Public Health, Birmingham City Council) Helen Bissett (Senior Officer, Public Health, Birmingham City Council)

1 Purpose

1.1 The purpose of the paper is to provide follow-up information to the HOSC members about Public Health's role in the local immunisations system, following discussions and requests at the February HOSC meeting.

2 Recommendations

2.1 To note the contents of this report.

2.2 Any discussion and recommendations from HOSC committee members will be shared with all immunisation system partners to influence future work and planning.

3 Any Finance Implications

3.1 None.

4 Any Legal Implications

4.1 None.

5 Any Equalities Implications

5.1 There is high variation and inequality in vaccination uptake across Birmingham. This means that behind Birmingham's low uptake rate, there will be specific communities that have an even lower vaccination uptake rate. Improving uptake rate while reducing this inequality is essential to ensure all citizens in Birmingham are receiving an equitable vaccination offer.

6 Appendices

6.1 Public Health – Immunisations Roles and Responsibilities – 04.04.23

Public Health – Immunisations Roles and Responsibilities – 04.04.23

Background

In February 2023, a paper titled 'Strategic challenges with immunisation uptake in Birmingham' was presented to the Health & Social Care Overview and Scrutiny Committee. The paper was authored jointly by the Birmingham and Solihull Integrated Care Board (BSol ICB) and Birmingham City Council's Public Health Division. This joint paper included basic, preliminary data and information; ahead of two more detailed and separate papers, authored by the ICB and Public Health respectively.

The February paper presented the strategic challenges through 6 key themes:

1. Data – access to high quality data
2. Community links – establishing effective links with communities
3. Access to services – ensuring easy access to vaccination services
4. Vaccine hesitancy – vaccine hesitancy in the local population
5. Partnership working – partnership working outside of traditional health partners
6. Communications and marketing – tailored and effective communications and marketing

Comments, discussion, and questions from the councillors in the February HOSC meeting has informed the structure of the two April papers. Public Health were asked to bring back further details on the Division's roles and responsibilities within the local immunisation system.

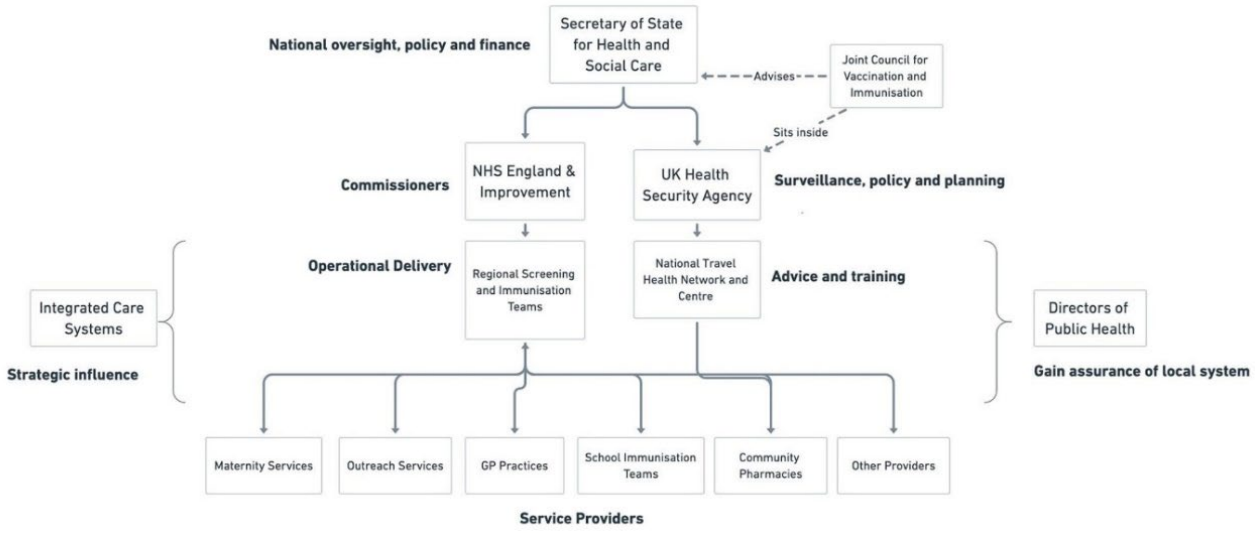
Purpose

The purpose of this report is to provide further details on Public Health's role in immunisations in Birmingham to the councillors (following discussion and requests at the February HOSC meeting). This paper also sets out ongoing immunisation work the Public Health Division are engaged with.

Statutory Roles and Responsibilities

Public Health have 3 key roles in the local immunisation system – to seek assurance, to support relevant immunisation activities and to challenge the existing plans.

Figure 1. Statutory Roles and Responsibilities within England's Immunisation System[1]



These roles are discussed in more detail below.

Assurance

Public Health sits outside of the commissioner-provider relationship yet influences both commissioning and delivery of immunisation via the role of the Director of Public Health to 'gain assurance of the local system'.

This key vehicle of the assurance function is the Health Protection Forum (HPF), a sub-forum of Birmingham's Health & Wellbeing Board (HWB) which meets monthly and reports quarterly to the HWB. Chaired by the Assistant Director of Public Health (Health Protection), members include senior leadership representing NHS England commissioners, the UK Health Security Agency, the NHS ICB Infection Control lead, and BCC Environmental Health. Each brings an update and issues for briefing, consideration and/or escalation. The Health Protection team will also bring assurance concerns to the HPF, ensuring a dynamic method to considering local immunisation plans.

This approach to assurance ensures that Public Health actively participates in the health protection of the local population. The process is made possible through the timely sharing of local data and plans from the NHS. This is fairly robust for the Covid-19 and seasonal flu programmes but less so for other immunisation programmes. There is scope for improvement which will help ensure that Birmingham residents are optimally protected from vaccine preventable disease.

Challenge

Public Health also have a role to act as a 'critical friend' and, where necessary, challenge arrangements for immunisations or vaccinations, particularly with regard to inequity within the city's residents. Plans need to be evidence based and able to address the needs of the local population at scale. This is an ongoing role that Public Health fulfil via the Health Protection Forum as well as in interactions across the wider system.

[1] Royal Society of Public Health. *Statutory Roles and Responsibilities within England's Immunisation System.* Available at: RSPH | Statutory Roles and Responsibilities within England's Immunisation System (Accessed 9 January 2023)

Support

Public Health, where appropriate, supports the NHS with uptake improvement activities, specifically in relation to identifying and reducing local inequalities and in the response to incidents. This continuing and effective support role is enhanced by the quality of effective partnership between Public Health and the ICB developed during the pandemic.

Public Health is a member of the ICS Immunisations and Vaccination Programme Board at all levels, providing support to ICB-led immunisation work where appropriate. However, work is needed from both Public Health and the ICB to ensure this supporting role works as effectively as possible.

The UK Health Security Agency (UKHSA) are the lead organisation when responding to infectious disease incidents. For serious and/or complex cases, UKHSA will convene a multi-agency Incident Management Team (IMT) to consider and agree response measures to be implemented. Public Health will be a member of IMT and are there to provide connection to other Council support if needed and seek assurance. Where there is a need for vaccination, to minimise illness, to reduce disease spread or both, the IMT will invite NHS England as commissioners to activate the appropriate vaccination response. In many situations, prophylactic vaccination (i.e. for prevention) is arranged through primary care. NHS England have contingency arrangements with Birmingham Community Healthcare Trust 9BCHC) if provision through primary care is not possible or when large numbers are needed. Public Health are currently working with UKHSA to establish a local health protection memorandum of understanding for infectious disease incidents and situations.

Public Health also supports the NHS through some of the mandated commissioned public health services where there are opportunities to promote vaccination such as childhood immunisation through the Healthy Child Programme and supporting Hepatitis B immunisation through Umbrella Community Sexual and Reproductive Health Services and CGL Substance Misuse services.

In Summary

Public Health has a statutory role around the assurance of the NHS approach to vaccination and immunisation which has three core elements: to seek assurance, to support relevant immunisation activities and to challenge the existing plans. The responsibility for commissioning and quality improvement in vaccination and immunisation sits with the NHS.

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Birmingham City Council

Health and Social Care Overview and Scrutiny Committee

04.04.23

Subject:	BSol ICB – Immunisations and Vaccinations (follow up from 22nd February paper)
Report of:	Kate Woolley (Director of Immunisations and Vaccinations BSol ICB)
Report author:	Matt Boazman SRO and Interim Chief Executive of Birmingham Women's and Children's NHS Foundation Trust Kate Woolley (Director of Immunisations and Vaccinations BSol ICB) Leon Mallet (Head of Service for Immunisations and Vaccinations BSol ICB)

1 Purpose

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2 Recommendations

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6 Appendices

6.1 Summary slide pack

6.2 Presentation pack with uptake data

Case Study

Birmingham & Solihull Vaccination Programme

The Bangladeshi Islamic Centre is a formally constituted, community led, independent charitable organisation, committed to the alleviation of disadvantage, inequality and deprivation through a targeted range of services to the communities with a particular focus upon the Bangladeshi community. The centre provides a wide range of services including information, advice and guidance to support the community. The centre bridges gaps between public sector partners and the communities they represent.

Birmingham & Solihull Vaccination Programme
Bangladeshi Islamic Centre
15/02/2023

Background:

The Bangladeshi Islamic Centre is a formally constituted, community led, independent charitable organisation, committed to the alleviation of disadvantage, inequality and deprivation through a targeted range of services to the communities with a particular focus upon the Bangladeshi community. The centre provides a wide range of services including information, advice and guidance to support the community. The centre bridges gaps between public sector partners and the communities they represent.

The key service areas the centre offers are:

- *Community centre management*
- *Sustainability & partnership development*
- *Advice, information & welfare*
- *Healthy living*
- *Women's development & empowerment*
- *Young people's social, educational & economic development*
- *Community centre development*

The vision of the Bangladeshi Islamic Centre is to be the most inclusive and successful community and voluntary sector organisation. Underpinning this high level aspirational vision is the total commitment to improving quality of life for all local residents and with a particular focus upon on Bangladeshi and other BAME groups living and working in the community. The centres mission is 'to promote health and wellbeing of the local community and support the achievement of lifelong learning for excellence.'

Partnerships:

Prior to attending the centre the Vaccination Inequalities team have been working in partnership and supporting the Flourish Project. Flourish is the West Birmingham Community Health Collaborative, an open group of third sector organisations working in partnership with the NHS and other care providers to reduce health inequalities across West Birmingham. Through Flourish our team was introduced to Approachable Parenting which is an organisation which was established in response to the needs of the Black, Asian and minority ethnic (BAME) communities. The organisation offers a variety of services and recognised parenting courses drawing from both Psychology and

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Last updated Shannon van Lier 16 Mar 2023

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communities. The organisation offers a variety of services and recognised parenting courses drawing from both Psychology and Faith Principles. Approachable Parenting works with people from all different backgrounds, cultures and faith communities, in a non-judgmental and supportive environment. Approachable Parenting have been working in partnership with Birmingham Community Healthcare (BCHC) and are undertaking some work with Post Covid Syndrome, whereby The Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations across Birmingham and Solihull have been provided with small grants to undertake community engagement on Long Covid. The organisations have been primarily focused in the most deprived areas of Birmingham and Solihull, engaging with communities that are often under-represented, seldom seen or seldom heard. The events are held in the communities and raise awareness of Long Covid, self-management of symptoms and how to access BCHC service if needed. Therefore, this was a great opportunity for our team to where possible join the events held in person and enable uptake of vaccine.

We were invited to support and attend the Bangladeshi Islamic Centre on Wednesday 15th February 2023 to support a women's only focus group with discussions around not only COVID vaccinations but also childhood immunisations. Data currently shows COVID-19 vaccination rates remain low within the Bangladeshi cohort and reaching and engaging into these communities have been difficult. The team consisted of Elizabeth Allcott (Operations Manager for Inequalities and Engagement) and Paula Skid (Senior Midwife). The flyer (below) was promoted through social media channels to promote the event.

Further Information

For further information please contact Elizabeth.Allcott@uhb.nhs.uk

Resources

Type	Name	Last Modified
Document	Birmingham and Solihull Bangladeshi Islamic Centre	17 Mar 2023

Case Study

COVID-19 mobile clinic at Newbigins Community Trust

Turn up, get jabbed, and receive a free meal and £5 cost of living grant to boot!

Covid-19 Mobile Clinic
At
Newbigins Community Trust
09/11/2022

Last updated Shannon van Lier 16 Mar 2023

Background

Is the COVID-19 virus still with us? The answer is unfortunately - Yes! But today (9/11/2022) saw a big drive, getting the local people of Winson Green vaccinated against the virus in time for the coming winter. And the local Lodge Road Church Centre became 'Vaccination Central' for the day. For those who turned up, got jabbed, received a free meal and £5 cost of living grant to boot!

COVID-19 is still here, with hospital admissions and deaths. You'd be forgiven for thinking the virus has passed, as the world is moving again. Shops, cinemas and bars are open again. And the news doesn't bang on daily about new infection rates and numbers who've died. But just because it's not on TV or in newspapers, doesn't mean the virus has gone away. It's out of the news, but still
ongoing!

It's thought there are around '400 Thousand' people across Birmingham, who have either not had any vaccinations or not received their full course of-first second and booster.The most significant variant been 'Omicron'. It's deemed less deadly, but more easily
infective.

Those unvaccinated tend to live in deprived areas, with low vaccination uptake for many factors. People on low incomes, can't or are unwilling to travel to other non-local areas for vaccination jabs due to cost or effort. They may mistrust authorities, or had bad experiences of GP's and hospitals. They fear hospitalisation, don't know there NHS number, or aren't even registered with a GP. There may be languages barriers, (meaning people missed important information).

Winson Green is one such area, with a low vaccination uptake. Meaning it's a risk of becoming a pocket for the proliferation and spread of the virus. Rev Angela Barker (Anji) explains, "In communities like ours, there tends to be a high density of people
with delicate, underlying and vulnerable health conditions".

Anji added, "Some people have a history of drug or alcohol misuse, or smoking related COPD. These only serve to weaken organs (making these people most at risk and susceptible to serious illness and hospitalisation), caused by the virus".

People, who aren't vaccinated, may also be excluded from places and events. Anji didn't want vulnerable people in Winson Green to miss out. As part of 'Flourish', (a West Birmingham NHS partnership), Anji met Sandra Fitzpatrick, a Registered Nurse, (with an MBE no less). Sandra's a 'Clinical Lead for Covid Programmes', and 'Inequalities Lead for Birmingham'.

Together with Anji, they launched the scheme to reach and vaccinate as many people in the community as possible, using the Newbigin Trust drop in Centres as Hubs. This was a more effective strategy to reach the people, (where local people feel more
comfortable and at ease). As pop up vaccination clinics, using a mobile van wasn't as effective,

as people would walk on by.

Sandra already had success setting up a vaccination scheme to reach pregnant women going through maternity. Called ‘The big push’, it’s been going for 9 months. A concern of expectant mothers, was the safety to the baby. But Sandra explains, “The vaccine produces antibodies to the virus in the mother, that crosses the placenta to protect the baby. And after birth, the protective antibodies are passed onto the baby through the mother’s milk”.

The visiting nursing team talked to people about the positives of having the vaccine jab. Sandra explains, “We talk about staying healthy during the winter period. Discussing chest infections, then flu jabs, and then talking about Covid. How receiving a jab gives protection from becoming really ill from Covid, and being less likely to need hospitalisation”. Sandra also talks to families about their childhood immunisations and the importance of contacting their GP/Health Visiting service to receive any outstanding immunisations.

Today was ‘Day 1’ of this NHS initiative in the Community Centre. Anji, herself received a COVID-19 vaccine booster jab, (setting a positive example for others). The vaccination day was so successful, that after just an hour, the team ran out of doses, ordering more to be rushed to the Centre, because of the bigger than expected uptake, (by 20 people in all). The nursing team expected to be at the centre from 10am – 2pm, (but stayed until 3pm due to the demand).

From a national standpoint, utilising Community Centres as ‘Vaccination Hubs’ is proving a good strategy to better reach people in deprived regions, particularly serving the vulnerable. So eliminating pockets for COVID-19 to linger and spread within communities.
Meaning people are less likely to need hospitalisation, which reduces winter pressures on NHS clinics and hospitals. This frees up hospital bed availability for those who need them for other conditions. This strategy is to be repeated across the region. Newbigin Trust have two more drop in sessions planned for this month.

Further information

For further information please contact sandra.fitzpatrick3@nhs.net

Resources

Type	Name	Last Modified
Document	Birmingham and Solihull Newbigins Community Mobile Clinic	17 Mar 2023

The **digital version of this document** is available on FutureNHS, the national sharing platform for the health and social care community. **https://future.nhs.uk**

Benson Community Hub
16/11/2022

Background:

Mothers attending the hub came from a mix of Pakistani, Bangladeshi and Black African backgrounds. A number of myth busting challenging conversations were held, five individuals converted to a vaccine with others saying they will think about it. Others said "no I am not interested," "thanks for the information I will think about it." There were around 20 mothers that were engaging in the activity put on by the hub, everyone was spoken to.

Impact:

The community knew we were at the hub a gentleman presented having had a fall. First aid was applied to his nose and forehead, conversation continued and his foot was cleaned and dressed, he was referred to a podiatrist for urgent treatment. Whilst having a conversation with a cup of coffee he was persuaded to have his vaccine.

We were approached by a concerned mother of three who was worried about the weight of her two youngest children. We went through both children's red books and identified that whilst weight and length were running along the same centiles, and advised to get a more up to date measurement. The mother was encouraged to attend her next health visiting clinic. Immunisations was also discussed and for this to be also updated at the health visiting clinic which was booked for w/c 28th November. Dietary suggestions were discussed at length including breast feeding, with advice documented in both red books.

It was identified that a nurse prescriber for even one session a week would have been very beneficial across both sites.

Number of people vaccinated:

In total seven booster vaccines were delivered. Five of which were their first booster and that was between 12 and 15 months.

Service User Engagement:

We had already been informed that this group were extremely vaccine hesitant. We therefore took part in the activity using this opportunity to softly engage in dialogue which eventually seven people were persuaded to have their vaccine.

One service user said "I'm now definitely going to go to the health visiting clinic and get my children measured properly, I feel so much better now that I understand. I can tell my family that you have to look at weight and length together and now I know that this is normal for my children."

Agreed Way Forward:

Staff have agreed to send key messages, post social media assets on all platforms appropriately, mothers with children they will highlight immunisations and key appointments.

Feedback from Chrissie (Hub Manager):

"It was great to have NHS workers at our Benson Hub last Wednesday to offer Covid19 Vaccinations and boosters. Not only did they make it extremely convenient for our community members by setting up on site, they also took the time to chat to our Wednesday morning attendees during our soap making workshop and answer some health questions, ranging from queries around vaccine concerns to regarding their children's developmental milestones.

I believe several people took advantage of the offer, which felt worth the call-out. This may have been more successful if the notice to school staff and parents was better circulated beforehand, and perhaps if we had had a sign on or fencing as a reminder or invitation. The NHS staff themselves were wonderfully warm, welcoming, friendly and respectful, which is all in line with our charity's ethos. Yes we would do this again."

Sandra Fitzpatrick MBE
RGN, BSc, Hons HV, MPH
&
Elizabeth Allcott
MPH & BSc Hons DR

For further information please contact sandra.fitzpatrick3@nhs.net

Supporting communities where the uptake of the COVID-19 vaccine is low in Birmingham and Solihull

Action card

Background
An estimated 400,000 people living in Birmingham are either unvaccinated against COVID-19 or have not received their full course, often living in areas of deprivation. There are many factors contributing to the lower uptake including historically lower trust of authorities, poor experiences of health services, financial restraints meaning they are unable or unwilling to travel to access the vaccine and language barriers (meaning important information is missed).

What we did
The COVID-19 vaccination team have developed a model to support the uptake of the COVID-19 vaccine in communities where uptake is low, by working closely with key stakeholders to identify the most effective approach. The model is evolving and under continual review and learning is used to inform the next initiative.

The initiatives the team have undertaken include holding myth-busting conversations and offering the COVID-19 vaccine at:

- A pop-up service at a church community hall where they offered a complementary food and cost of living support. More about this work can be found in a case study written by the team here.
- A session where they joined a soap making activity for mothers. More about this work can be found in a case study written by the team here.
- Joining an established Lottery Community Funded Project which supports a community in an area of specific deprivation. More about this work can be found in a case study written by the team here.
- A wider health-hub (e.g. services to support mental health, housing, registering with a GP, Hepatitis B and C vaccines) for asylum seekers residing in a local hotel.
- A drop-in service for people experiencing homelessness. The team also initiated 8 onward referrals to support health needs. More about this work can be found in a case study written by the team here.
- A focus group for women in Black, Asian and minority ethnic (BAME) communities about the COVID-19 and childhood immunisations. More about this work can be found in a case study written by the team here.
- A session at the local University to support pharmacy students.

Supporting communities where the uptake of the COVID-19 vaccine is low in Birmingham and Solihull

Action card

The impact

- During our pop-up clinics, we have had many myth-busting conversations about the vaccine with members of the public, including those who had had their primary dose but did not feel they needed a booster, as well as those who are vaccine hesitant. Approximately 10% of these conversations resulted in people receiving their vaccine.
- Those who were fully vaccinated also welcomed the conversations about the importance of spreading the word to their friends and family of the benefits of being vaccinated.
- We held many wellbeing and general health conversations with people and were able to provide the information onsite or signpost them to relevant services. These conversations were our starting point in many instances and so were important as they often led to a discussion about the COVID-19 vaccine and sometimes a vaccine itself.

Key aspects to the success of the programme

- Engaging and planning with key people in local communities, such as local leaders, councillors, agencies supporting the communities.
- Having the right people who can understand, engage and communicate with the individual communities at the pop-ups.
- Thoroughly considering the location for the pop-up - members of the community might be more likely to attend if the vaccination is made available/being offered in a locally trusted place (such as a church hall) rather than a bus parked outside it.
- Dove-tailing the COVID-19 vaccination with other services that are relevant to the individual community, such as employment opportunities, registering with a GP, childhood vaccinations, etc. The opportunity to discuss additional health and lifestyle concerns has been found to increase footfall.
- Using an informal approach to maximise engagement. This could include taking part in an activity that is already scheduled or at a community event where practitioners are not in uniforms and opportunistic discussions about vaccinations and the benefits. People need to feel listened to and understood.

Supporting communities where the uptake of the COVID-19 vaccine is low in Birmingham and Solihull

Action card

Reflections from the Trust Inequalities Lead

"Decision making by communities where uptake is low has complex issues. However, working from a client centred approach and taking the vaccine into communities with community advocates has resulted in improved uptake. Understanding current health priorities such as, child health and childhood imms, Mental health, access to primary care, poor health in general has led to many of our community sites directly referring onto primary and secondary care. This has also supported trust in the NHS, in particularly communities that were negatively impacted by people's experiences of the pandemic."

Sandra Fitzpatrick MBE
RGN, BSc Hons HV, MPH

Covid-19 Mobile Clinic
At
Newbigins Community Trust
09/11/2022

Turn up, get jabbed, and receive a free meal and £5 cost of living grant to boot!

The vaccination team, Lead Nurse Sandra, Operations Manager Elizabeth, with their team

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16/11/2022

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Impact:

The community knew we were at the hub a gentleman presented having had a fall. First aid was applied to his nose and forehead, conversation continued and his foot was cleaned and dressed, he was referred to a podiatrist for urgent treatment. Whilst having a conversation with a cup of coffee he was persuaded to have his vaccine.

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It was identified that a nurse prescriber for even one session a week would have been very beneficial across both sites.

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Agreed Way Forward:

Staff have agreed to send key messages, post social media assets on all platforms appropriately, mothers with children they will highlight immunisations and key appointments.

Feedback from Chrissie (Hub Manager):

"It was great to have NHS workers at our Benson Hub last Wednesday to offer Covid19 Vaccinations and boosters. Not only did they make it extremely convenient for our community members by setting up on site, they also took the time to chat to our Wednesday morning attendees during our soap making workshop and answer some health questions, ranging from queries around vaccine concerns to regarding their children's developmental milestones.

I believe several people took advantage of the offer, which felt worth the call-out. This may have been more successful if the notice to school staff and parents was better circulated beforehand, and perhaps if we had had a sign on or fencing as a reminder or invitation. The NHS staff themselves were wonderfully warm, welcoming, friendly and respectful, which is all in line with our charity's ethos. Yes we would do this again."

Sandra Fitzpatrick MBE
RGN, BSc, Hons HV, MPH
&
Elizabeth Allcott
MPH & BSc Hons DR

For further information please contact sandra.fitzpatrick3@nhs.net

Nechells Pod
09/12/2022

Background:

Nechells has a significantly younger age profile than the city as a whole and has a higher BAME population share. Nechells is amongst the city's deprived wards and has the lowest average income out of the city's 69 wards. Resident employment rates in the ward are well below the city average and economically inactive residents account for nearly half of the working age residents.

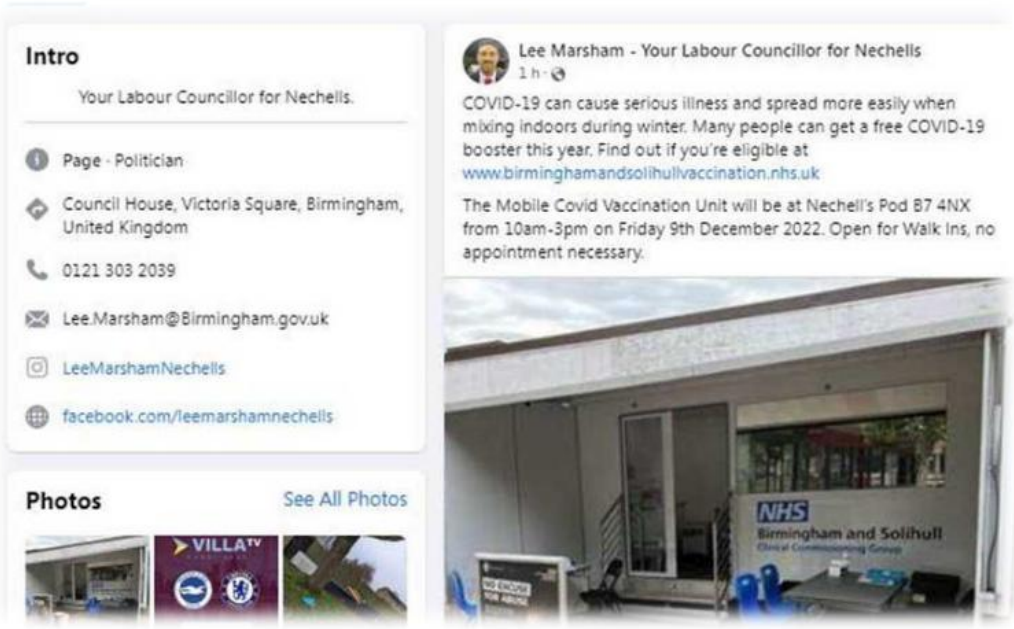
Nechells Pod works with and for the local community to enhance life chances for Nechells residents. The Pod also runs a successful 'All of Us Project' funded by the National Lottery Community Fund. The All of Us Project has three key priorities:

- ***Outcome 1*** *– Newly arrived families and isolated older people will engage in positive activities that improve community cohesion and reduce social isolation*
- ***Outcome 2*** *– Newly arrived adults will improve their communication skills and have access to training, volunteering and employment.*
- ***Outcome 3*** *– Physical and mental well-being of newly arrived families and isolated older people will be improved*

The vaccination team attended Nechells Pod on Friday 9th December 2022 as the pod was open as a food bank and a coffee morning for local residents on this particular day. Residents attending the pod came from a mixture of Pakistani and Black African backgrounds. This gave us the opportunity to engage with the local community and talk about staying healthy this winter including vaccinations.

Partnerships:

Prior to attending Nechells Pod we worked in partnership with local community organisations, local leaders and Cllr Lee Marsham who is the local Cllr for Nechells. This was to ensure information about the vaccination van being present was promoted and advertised. Information was also disseminated into the local community about the importance of Covid and Flu and the impact of the winter pressures. Beth Bailey who is the manager of Nechells Pod displayed posters at the pod and other community settings. The Local Cllr also supported by promoting the vaccination van through his social media (as seen on the image).



Cllr Lee Marsham post on Facebook

Posters displayed at Nechells Pod

Impact:

Around 32 residents attended the pod and engaging conversations were held with the offer of vaccination to everyone. A number of myth busting conversations were held, examples of the conversations were:

- ***"Covid only affects older and vulnerable people"***
- ***"The virus is becoming milder"***
- ***"Masks don't work"***
- ***"Vaccines don't reduce transmission"***
- ***"Covid vaccine is a trial and I do not wish to be a part of it"***
- ***"I have had a booster and do not need another one"***
- ***"My family say I don't need the vaccine"***
- ***"I have never had a vaccination and I have been fine, so I do not wish to have a Covid vaccine"***

Two individuals who had concerns around not needing another booster, after a conversation explaining the importance of needing an additional booster as antibodies gradually wane over time and a further booster is needed to help improve their protection. They both were persuaded to have and take the offer of an additional booster.

Around 10 individuals spoken to were already fully vaccinated but welcomed the advice and the importance of spreading the word to family and friends to get vaccinated.

Health & Wellbeing:

Several wellbeing conversations were held with residents at the pod. One resident had concerns around financial support, the individual was signposted and given details for the local council and who to contact to get support. Another resident had a housing concern, luckily on the day there was a local housing officer present at the Pod who was able to offer support with temporary to permanent accommodation. Another resident with a chest infection who mentioned coughing up blood and had not contacted his GP. Advice was given for him to contact his GP for an emergency appointment. The resident agreed to ring his local doctors whilst we were present and got an emergency appointment the same day.

Number of vaccines delivered:

In total five booster vaccines were delivered. All of the five boosters given it had been recognised it had been between 12 to 18 months since their last booster.

Agreed Way Forward:

Cllr Lee Marsham came down to Nechells Pod on the day to provide support and look at ways to help further with the local community. It was identified by the Cllr that more targeted work in the area was needed and the possibility of dropping leaflets through doors in the high rise flats within Nechells. Further conversations were held around looking at places the vaccination team had been previously and establishing possible venues and events to target.

The local community leaders and the Cllr have also agreed to continue to send key messages, post social media assets on all platforms appropriately. The key information will be then disseminated into the local communities with Nechells.

Feedback:

Established relationships within the communities with local leaders and people with trusted voices are important and paramount to the work we undertake. This helps us to set out clearly priorities and locally implement them effectively. The visit to Nechells Pod demonstrated prior, during and after the importance of partnerships and having leaders on board to continue to support the local community.

Elizabeth Allcott (Operations Manager) **Michele Owen** (Nurse in Charge) **Cllr Lee Marsham** (Nechells Cllr)

Elizabeth Allcott
MPH & BSc Hons DR

For further information please contact Elizabeth.Allcott@uhb.nhs.uk

Salvation Army
William Booth Centre
Birmingham & Solihull Covid Vaccination Programme

Background:

The Salvation Army operates over 80 supported accommodation services across the UK and the Republic of Ireland, these are known as 'Life Houses' because they are more than a place to stay. They are places where people can get support with their housing issues but also find support with other aspects of their lives such as employment, debt problems, training, spirituality, loneliness, addiction or mental health. The centre offers a safe, supportive environment for individuals, helping individuals to make positive choices about their current circumstances.

The William Booth Centre provides first stage accommodation and support for people currently experiencing homelessness. The service is intended for men and women aged 21 and above and each individual is allocated a key worker to help them work through their support issues. The centre runs services in a person-centred way by putting them in charge of the process. The aim is to look at things from the perspective of what they can do and are good at rather than what they can't do. By creating a calm, supportive environment the purpose is to make residents feel empowered and respected.

Solving someone's immediate need for housing is a vital first step and for some people that is enough. For other people they require more support, the ethos of the William Booth Centre is to recognise that everyone is an individual and people have different wants and needs. They also recognise that for some people the experiences that have led up to those becoming homeless may have been traumatic and they may require some specialist support.

Partnership:

Prior to the attending The Salvation Army Centre we worked in partnership with Will Neville who is the centres manager who also has lived experiences of being homelessness and drug addiction.

The vaccination team attended the centre on Tuesday 24th January 2023 from 9:30am to 2pm. The Hepatitis C and HIV clinic was also present on this day. This gave us the opportunity to work in partnership with the centre to help support the community with COVID vaccinations as well as engaging conversations around health and well-being and making referrals where appropriate.

Impact:

We spoke to twenty residents at the centre who were all offered the vaccination. Two health referrals were made and two health and well-being advice was given to residents at the centre.

Many tough and challenging myth busting conversations were held on the day with some residents who had strong anti-vaccination views. Several residents appeared not interested or not wishing to talk about vaccinations. Below are examples:

- **"You are killing everyone with them vaccines"**
- **"Is it compulsory for me to have a vaccine?"**
- **"Am I being forced to have a vaccine?"**
- **"I refuse to have anymore"**

- **"Why are you making different vaccines"**
- **"COVID is not real and it's about time you realised"**
- **"You are all doing a great job but I do not want any more vaccines"**
- **"What is the point in having the vaccine as I can still catch COVID and spread it?"**
- **"I am immune to COVID"**
- **"I got told by my mate the vaccine is there to kill you"**

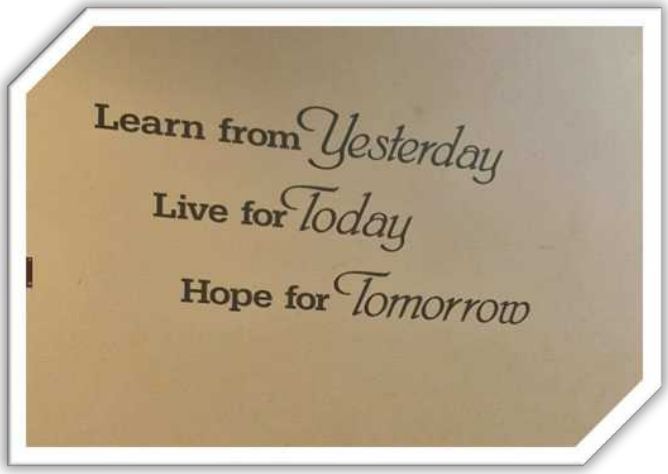
We spent a lot of time with some residents to understand their reasons and trying to break down the barriers of vaccine hesitancy. It was important to understand people's COVID-19 beliefs, their interactions with health misinformation and attitudes towards a COVID-19 vaccine. Residents spoke about a wide range of sensitive misinformation they had encountered which resulted in confusion, stress and mistrust. We found vaccine hesitancy was recognised by safety concerns, negative stories and personal knowledge. For many this didn't lead to a vaccination however, the intent was to assure residents with facts of the most relevant and up to date information in relation to COVID-19 in the hope they change their views which potentially might lead to a vaccination in the future.

Number of vaccines delivered:

We delivered one COVID booster to a resident where it had been over a year since their last vaccine.

Cases:

A resident presented with a clicking neck issue. It was understood they had already been to the Doctor who according to the resident suggested they needed vitamins. Michele our Nurse in Charge had a very general discussion about the neck and could see they was holding a very heavy bag on the shoulder. It was suggested changing sides for the day with the bag but also looking to try a back pack to try and distribute the weight more evenly. It was also recommended heat for the neck and painkillers if needed. This was more about taking time with the resident and showing them care.



Another resident presented with a sore ear. It was established they had ear surgery previously and had moved from another part of the country and did not have a GP in Birmingham. They described a sore

ear with discharge so it was advised to attend the walk in clinic that was open on the day downstairs in the Health Exchange to see if treatment was required.

Finally, we were asked to look at a resident's finger. This individual was an alcoholic on methadone and was in significant pain. On inspection the resident had an infected finger which had tracked up his arm and was showing early signs of a possible significant infection. We liaised with the individual's key worker to try and persuade him to attend hospital; sadly he was not compliant with this. Therefore, we utilised the centres well stocked First Aid bag. The resident's finger was cleansed and redressed with clean dressings. The resident's key worker was going to get the prescription made up to try and persuade him to at least take oral antibiotics. The resident was very grateful for our Nurses help and very upset he couldn't stop drinking. The centre agreed they would monitor and keep a close eye on the resident. We followed up with the centre on Thursday 26th January 2023. The resident's key worker said the anti-biotics were collected and the individual had started taking them. It was mentioned he had been downstairs to the Health Exchange to see the GP. However, the resident still refuses to go to hospital but he is doing okay at present.

Outcome:

When carrying out these particular visits we are increasing the scope of the service we are offering. It is important to give all the individuals we meet the time and care they need, especially when they do not have access to mainstream medical services or advice of when to seek intervention when required. Signposting is an essential part of our role along with making referrals where appropriate. We are lucky to have fantastic nurses attending the visits to offer their support to meet the resident needs. The visit highlights how our system goes above and beyond to reach our most vulnerable populations.

Nurses in Charge Lorna & Michele

Feedback:

Martin (Team Leader):
"The model of presenting ourselves as a health outreach primarily, with vaccination secondary, I felt helped pull down since of the initial resistance people had with talking to our team. We did one vaccination, but considering the low footfall today and the complex issues that the majority of the clients had, then this low number is not surprising."

Michele (Nurse in Charge):
"This has been my first session of this type and I have welcomed the opportunity to talk to people and try to engender trust in NHS staff where maybe they have not always trusted."

Lorna (Nurse in Charge)
"It felt as though when doing these visits, it would be good to increase the scope."

Reported by:
Elizabeth Allcott
Operations Manager (Inequalities & Engagement)

For further information please contact Elizabeth.Allcott@uhb.nhs.uk

Birmingham & Solihull Vaccination Programme

Bangladeshi Islamic Centre

15/02/2023

Background:

The Bangladeshi Islamic Centre is a formally constituted, community led, independent charitable organisation, committed to the alleviation of disadvantage, inequality and deprivation through a targeted range of services to the communities with a particular focus upon the Bangladeshi community. The centre provides a wide range of services including information, advice and guidance to support the community. The centre bridges gaps between public sector partners and the communities they represent.

The key service areas the centre offers are:

- *Community centre management*
- *Sustainability & partnership development*
- *Advice, information & welfare*
- *Healthy living*
- *Women's development & empowerment*
- *Young people's social, educational & economic development*
- *Community centre development*

The vision of the Bangladeshi Islamic Centre is to be the most inclusive and successful community and voluntary sector organisation. Underpinning this high level aspirational vision is the total commitment to improving quality of life for all local residents and with a particular focus upon on Bangladeshi and other BAME groups living and working in the community. The centres mission is 'to promote health and wellbeing of the local community and support the achievement of lifelong learning for excellence.'

Partnerships:

Prior to attending the centre the Vaccination Inequalities team have been working in partnership and supporting the Flourish Project. Flourish is the West Birmingham Community Health Collaborative, an open group of third sector organisations working in partnership with the NHS and other care providers to reduce health inequalities across West Birmingham. Through Flourish our team was introduced to Approachable Parenting which is an organisation which was established in response to the needs of the Black, Asian and minority ethnic (BAME) communities. The organisation offers a variety of services and recognised parenting courses drawing from both Psychology and

Faith Principles. Approachable Parenting works with people from all different backgrounds, cultures and faith communities, in a non-judgmental and supportive environment. Approachable Parenting have been working in partnership with Birmingham Community Healthcare (BCHC) and are undertaking some work with Post Covid Syndrome, whereby The Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations across Birmingham and Solihull have been provided with small grants to undertake community engagement on Long Covid. The organisations have been primarily focused in the most deprived areas of Birmingham and Solihull, engaging with communities that are often under-represented, seldom seen or seldom heard. The events are held in the communities and raise awareness of Long Covid, self-management of symptoms and how to access BCHC service if needed. Therefore, this was a great opportunity for our team to where possible join the events held in person and enable uptake of vaccine.

We were invited to support and attend the Bangladeshi Islamic Centre on Wednesday 15th February 2023 to support a women's only focus group with discussions around not only COVID vaccinations but also childhood immunisations. Data currently shows COVID-19 vaccination rates remain low within the Bangladeshi cohort and reaching and engaging into these communities have been difficult. The team consisted of Elizabeth Allcott (Operations Manager for Inequalities and Engagement) and Paula Skid (Senior Midwife). The flyer (below) was promoted through social media channels to promote the event.

For further information please contact Elizabeth.Allcott@uhb.nhs.uk

Impact:

In total twenty-two Bangladeshi women attended the discussion with all women spoken to about their vaccination status with additional discussions around childhood immunisations. We provided vaccination leaflets in multiple languages to support the discussions. The centre also provided translators to help with people where English was not their first language.

The aim was to understand the beliefs, barriers and hesitancy associated with the COVID-19 vaccine among Bangladeshi residents. It was important to connect with the community to

help build and improve confidence to gather key insights.

Communications:

Below are examples of the discussions around COVID-19 vaccines collected from the women who attended the discussion:

- ***"I am worried about the side effects* of the vaccine."**
- ***"What about the unknown future effects of the vaccine."***
- ***"I have doubt in vaccine safety as the vaccine was rolled out very quickly."***
- ***"Herd immunity will protect me if I don't have the vaccine."***
- ***"The impact of the virus has been greatly exaggerated."***
- ***"I have low confidence in the health system."***
- ***"My own GP told me I don't need the vaccine."***
- ***"Not enough information around the adverse reactions."***
- ***"My husband died and I am positive it was because of the vaccine."***
- ***"I have only had the vaccine as I need to travel."***
- ***"Five days after I had the AstraZeneca vaccine I developed a blood clot, I am too scared to have another vaccine."***
- ***"I have doubt in the effectiveness of the vaccine."***
- ***"It's not on the news anymore so is it that serious?"***
- ***"I have seen cardiovascular problems linked to the vaccine."***

Paula (Senior Midwife) also responded to questions around childhood immunisations in particular women who were pregnant which included; if the vaccination the child is receiving is a live vaccine, how long protection lasts for, if getting their child vaccinated is the right thing to do, being told by family members childhood diseases are not a large threat, therefore their child doesn't need any vaccinations. Paula explained in great detail the importance of childhood vaccinations and leaflets were also provided to support discussions for parents to make an informed decision.

Discussion:

Vaccine hesitancy is a key barrier within the Bangladeshi community. Women who had more knowledge regarding the COVID-19 vaccine seemed to have a higher level of acceptance and lower level of hesitancy concerning the COVID-19 vaccine. Over half of the group declared to be fully vaccinated but still had worries and concerns regarding the future effects of the vaccine. Many women also stated they had the vaccination for travelling reasons with others suggesting if it was mandated to travel they would take up the vaccine. Although the women understood the importance of the vaccine they still had hesitancy around the safety and potential side effects. Social media was also identified as another factor to misinformation and misleading news about COVID-19 vaccinations.

The discussion at the centre signified the importance on building trust in COVID-19 vaccines and disseminating trusted information. There needs to be more of a focus to resolve and clear misconceptions to try and stop people within the Bangladeshi communities losing trust. Misinformation and lack of knowledge is a key driver to vaccine hesitancy which was highlighted through many concerns around side effects. The discussion emphasised the importance of health information in disease prevention and vaccine acceptance.

Many women felt reassured about the information given in the discussion and emphasised they would consider having a COVID-19 vaccination. They also expressed having more accurate advice from healthcare professionals would reduce hesitation and build confidence around vaccination uptake.

Moving Forward:

Moving forward we plan to continue to work in partnership with BCHC and Approachable parenting to help support more discussions around COVID-19 vaccinations within our low uptake areas to assist with disseminating trusted information.

Supporting the Bangladeshi Islamic Centre has highlighted how our system can play a significant part in contributions to sharing trusted information and advice on staying protected. The visit also emphasised the importance of working in partnership with organisations which creates a better chance of creating services that meet people's needs, improving their outcome and experience. Working together can benefit from pooled expertise, resources and power sharing, with the goal to enhance the efficiency and quality of service provision.

Reported by:
Elizabeth Allcott (Operations Manager – Inequalities & Engagement)

Birmingham & Solihull COVID-19 Vaccination Programme

'Pakistani Women Focus Groups'

Background:

The vaccination inequalities programme continues to work in partnership with Flourish and Approachable Parenting to establish the needs of the Black, Asian and minority ethnic (BAME) communities. Approachable Parenting are working partnership with Birmingham Community Healthcare (BCHC) and are undertaking some work with Post Covid Syndrome, whereby The Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations across Birmingham and Solihull have been provided with small grants to undertake community engagement on Long Covid. The organisations have been primarily focused in the most deprived areas of Birmingham and Solihull, engaging with communities that are often under-represented, seldom seen or seldom heard. The events are held in the communities and raise awareness of Long Covid, self-management of symptoms and how to access BCHC service if needed. In partnership with Approachable Parenting we were invited to support a Pakistani women's only focus group being held at Masjid Al Faalah and The Abrahamic Foundation.

According to Birmingham City Council, data currently shows COVID-19 vaccination rates remain low within the Pakistani cohort and reaching and engaging with these communities has been difficult the COVID Vaccination Programme. Therefore, this was a great opportunity to support local discussions and encourage and enable vaccine uptake. Elizabeth Allcott (Operations Manager for Inequalities and Engagement) attended the sessions to engage with the community.

Visits:

On Friday 17th March 2023 Elizabeth Allcott supported Approachable Parenting by attending Masjid Al Falaah which is a Mosque within Birmingham that provides support services and activities for Birmingham's local community. According to the Office of National Statistics (ONS, 2021) Islam is the fastest growing religion in Birmingham and a large number of Muslims live in Birmingham. Mosques in Birmingham are the glorious example of the unity of Muslims who practice different faiths of Islam but stay together as a Muslim. The majority of Muslims

attend Masjid Al-Faalah in Birmingham where the Mosque is used for prayers, religious festivals such as Ramadan and community work.

On Monday 20th March 2023 Elizabeth Allcott attended The Abrahamic Foundation in partnership with Approachable Parenting. The Abrahamic Foundation was established in 2009 to serve the diverse needs of the Muslim community. It was founded by a group of scholars, teachers and other professional members of the community. The aim of the organisation is to create a centre that excels in providing high-quality education, youth work and training services. The Abrahamic Foundation is an inclusive organisation and endeavours on serving the community regardless of colour, race or ideological orientation.

Impact:

Even when vaccine supply is available and consistent, differences in rates of vaccination uptake are evident within specific populations including the Pakistani communities.

In total thirty-two Pakistani women attended the discussions over the two visits. The team provided leaflets including COVID-19 and childhood immunisations in multiple languages and translators were also available to support the discussions.

The aim of the visits was to understand experiences of coronavirus and COVID-19 vaccination whilst building confidence in the vaccine and highlight the safety and efficacy of the vaccine. The visit was also important to gather insights into the beliefs, barriers and hesitancy associated with the COVID-19 vaccine within the Pakistani community.

Communications:

Many Pakistani women didn't want to disclose their vaccination status with the majority revealing they were either unvaccinated or partially vaccinated with several being fully vaccianted.

Conversations collected from the women who attended the groups are found below:

- ***"I have had one vaccine and believe I am now immune."***
- ***"There has been so many stories on social media that has scared me."***
- ***"Since I had the vaccine me and my family have lost our identity."***
- ***"Since the vaccine I have never felt the same."***

- ***"The vaccine still allows you to catch COVID so I don't need it."***
- ***"I was very dizzy after the first vaccine so I did not return for another vaccine."***
- ***"I have not took any vaccines due to my diet being good and my body getting all the vitamins it needs."***
- ***"The vaccine has impacted me mentally."***
- ***"I work in a college and young people are not educated enough about the vaccine."***
- ***"There was not enough education within our communtity around the vaccaintions."***
- ***"Trust has been lost within the NHS since the pandemic."***
- ***"There has been too much scare in our community about the vaccination."***
- ***"The side effects of the vaccine has played a big part in the uptake within the community."***
- ***"Rumours spread very quickly in our community and our community is very close knitted."***
- ***"Misinformation around the vaccinations also came from healthcare professionals so we have lost trust."***
- ***"Many people in the community have had COVID and believe they are protected and don't require a vaccine."***
- ***"Too many women had problems with periods after the vaccine."***
- ***"Many people in our community especailly the elderly do not have access to technology and only listen to the rumours in the community which then scares them and they refuse to have the vaccine."***
- ***"I took the vaccine to protect my family."***
- ***"Im worried about the long term side effects of the vaccination."***
- ***"I was very sick after the vaccine so I didn't take another one."***
- ***"I was told by my midwife not to have the vaccine whilst I was pregnant."***
- ***"Many stories have spread about side effects of the vaccine within the community which has put many peiple off coming forward for a vaccine."***

Discussion:

The focus groups showed that the Pakistani community views ranged from those that clearly accept all vaccines to those who undoubtedly decline all. The groups indicated education level and previous infection played a significant role in vaccine acceptance, while not believing in vaccination was the primary reason for hesitancy. The women who stated that they were fully vaccinated were driven by securing their family's safety and protection.

The team held discussions around what would help motivate the community take the offer of the vaccination. Feedback from the women revealed that Pakistani men hold the power of decision making and if the men in the mosques were targeted and influenced to take the offer of the vaccination, this would be the key to convincing the community.

These expressed views highlighted that Pakistani women in the community still feel unable to make independent decisions about their own health.

The women's confidence in vaccine safety and efficacy was also another factor. The women suggested that in order to regain trust in the health system, more health literacy is required to share and better understand the purpose of not only the COVID-19 vaccination but all vaccinations within the Pakistani community. The Pakistani women were keen to have more and clearer information on COVID-19 vaccines and specifically; side effects, their contents and how they were developed and the differences between the COVID-19 vaccines.

The attendees suggested that increased knowledge and understanding of these factual issues may change their attitudes towards the vaccine.

The women also expressed confusion and concern about the different types of COVID-19 vaccines. The media coverage they were exposed to made it harder for individuals to understand whether they were all safe.

The discussion also emphasised the access to childhood immunisations. A Pakistani woman revealed not being able to have her child vaccinated due to the restricted clinic time. The lady stated the clinic only offered a 9am-11am clinic time to have her child vaccinated and wasn't able to accommodate any other times. The lady emphasised how this made it difficult for her as she can't afford to take time off work.

Moving Forward:

There are a lot of factors at play as to why individuals within the Pakistani community may have chosen not to be vaccinated or have delayed their vaccination.

Factual information, understanding more about the benefits and contents of the vaccine as well as overcoming family male influences are creating hesitancy.

Targeted interventions work such as here within the Pakistani community are vital as it helps the team to understand the preparations and provisions required to support and inform choice and therefore bridge the equity gap.

The partnerships that continue to be formed are significantly important to the work we carry out; using our listening and well-being approaches we work with community leaders because they are well respected and trusted individuals.

Approachable Parenting is very keen for our system to support more group discussions as this is an essential tool for women to make their voices heard and to gain equality and empowerment.

We continue to share these learning experiences with our partners to optimise how we respond to these concerns and fears.

Reported by:
Elizabeth Allcott
(Operations Manager – Inequalities & Engagement)

Birmingham and Solihull
Integrated Care System
Caring about healthier lives

Birmingham & Solihull Immunisations & Vaccinations Data Pack April 2023

Delivering a safe and effective service

Evergreen Performance by ICS and JCVI - 80% Highlight Threshold

Data Source: https://ppds.palantirfoundry.co.uk/workspace/contour-app/ri.contour.main.analysis.2d9dc97f-b2d9-43af-a93a-55dd3f7b1ca6/path/ri.contour.main.ref.71a90c5f-a83a-4462-88a8-07b6dae7aa0b/board?viewMode=edit

Data Correct as at 27/03/23

NHS England Midlands

Performance by JCVI – Current Uptake as at 27th March

JCVI	National	Midlands	BSOL	CW	HW	JUCD	LLR	LINCS	NHAMP	NOTTS	STW	SSOT	BC
1: Care Home Residents & Residential Care Workers	97.95%	97.90%	97.10%	98.45%	97.69%	98.19%	97.82%	98.39%	97.65%	98.55%	97.62%	98.51%	96.43%
2: Healthcare Workers	97.56%	97.22%	93.95%	97.78%	98.29%	98.36%	97.80%	98.66%	97.11%	97.76%	98.53%	98.36%	95.34%
3: Social Care Workers	99.60%	99.65%	99.50%	99.68%	99.80%	99.76%	99.71%	99.81%	99.41%	99.68%	99.66%	99.63%	99.48%
4: 80+	96.43%	96.85%	93.75%	96.68%	97.88%	97.88%	96.98%	97.71%	97.18%	97.46%	97.74%	97.77%	95.25%
5: 75-79	96.31%	96.91%	94.24%	97.01%	97.64%	97.54%	97.11%	97.56%	97.05%	97.15%	97.55%	97.66%	95.56%
6: 70-74	94.79%	95.63%	92.09%	95.29%	96.71%	96.60%	95.97%	96.55%	95.45%	95.97%	96.47%	96.79%	94.21%
7: 65-69	92.84%	93.75%	88.96%	93.09%	95.62%	95.16%	94.37%	95.12%	93.48%	94.01%	95.29%	95.36%	91.82%
8: At Risk	85.03%	86.12%	78.29%	85.13%	90.07%	89.55%	86.29%	89.69%	86.37%	85.32%	89.90%	90.32%	84.78%
9: 12-15 At Risk	51.01%	50.61%	37.92%	50.80%	56.32%	54.59%	54.28%	58.95%	53.57%	50.13%	60.77%	60.45%	42.35%
10: 12-17 Household contacts of immunosuppressed	56.26%	55.93%	41.21%	56.61%	59.78%	66.45%	56.81%	67.38%	58.90%	58.08%	58.00%	66.13%	45.91%
11: 5-11 At Risk	14.41%	14.02%	6.89%	14.67%	14.65%	16.74%	17.05%	20.01%	14.84%	14.69%	15.75%	19.48%	9.60%
12: 60-64	88.75%	89.75%	81.92%	88.93%	92.76%	92.31%	91.00%	91.48%	88.84%	89.81%	92.17%	92.63%	86.88%
13: 55-59	86.45%	87.56%	78.95%	87.19%	91.16%	90.21%	89.24%	89.24%	86.44%	87.77%	90.36%	90.48%	84.81%
14: 50-54	83.23%	84.46%	75.48%	83.52%	89.04%	87.55%	86.54%	86.23%	83.20%	84.59%	87.55%	87.97%	81.97%
15: 40-49	74.48%	75.31%	65.97%	74.32%	81.25%	80.27%	78.21%	76.83%	73.76%	75.16%	78.39%	79.75%	73.31%
16: 30-39	66.25%	65.98%	56.20%	65.50%	73.59%	73.51%	67.96%	68.16%	63.58%	63.95%	72.29%	71.55%	63.26%
17: 18-29	65.94%	65.65%	54.25%	62.89%	75.35%	74.26%	65.76%	71.93%	64.66%	66.66%	73.39%	73.15%	60.39%
18: 16-17	62.05%	62.16%	46.28%	63.51%	71.89%	70.27%	65.10%	70.18%	63.39%	61.99%	71.66%	70.29%	52.77%
19: 12-15	46.76%	46.44%	34.05%	47.16%	53.53%	53.11%	49.65%	53.63%	46.33%	46.94%	53.68%	54.02%	37.11%
20: 05-11	10.23%	9.78%	5.58%	11.46%	10.56%	11.48%	13.42%	11.83%	10.09%	9.92%	9.82%	12.07%	6.00%
All other	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%	0.01%	0.00%	0.00%	0.01%	0.01%	0.00%

Notes on Interpretation of Data:

Greater than or equal to National Uptake
Within the 80th Percentile of National Uptake
Below 80th Percentile of National Uptake

Evergreen Performance by ICS and Ethnicity

Data Correct as at 27/03/23

Ethnicity – Current Uptake as at 27th March

Ethnicity	National	Midlands	BSOL	CW	HW	JUCD	LLR	LINCS	NHAMP	NOTTS	STW	SSOT	BC
99: Not known	40.55%	39.75%	26.19%	35.74%	50.29%	46.20%	39.04%	39.17%	40.83%	45.81%	51.45%	49.62%	33.86%
A: White - British	67.27%	79.16%	75.57%	78.56%	80.81%	80.71%	79.72%	81.68%	78.68%	78.93%	80.41%	80.19%	75.38%
B: White - Irish	64.99%	78.39%	80.75%	81.14%	82.08%	79.50%	76.61%	80.75%	78.56%	74.97%	74.76%	75.68%	70.07%
C: White - Any other White background	49.81%	49.16%	45.38%	54.56%	59.81%	48.43%	50.55%	41.42%	40.50%	44.86%	56.94%	52.34%	51.07%
D: Mixed - White and Black Caribbean	35.33%	35.58%	33.22%	41.88%	47.07%	37.35%	37.08%	50.65%	39.68%	32.91%	42.71%	38.90%	31.83%
E: Mixed - White and Black African	32.57%	45.66%	42.50%	47.58%	49.39%	40.07%	40.40%	49.27%	44.63%	45.40%	47.39%	45.37%	52.20%
F: Mixed - White and Asian	44.32%	48.13%	41.87%	53.56%	63.74%	43.89%	48.07%	55.42%	51.02%	51.12%	49.34%	49.99%	41.61%
G: Mixed - Any other Mixed background	46.75%	48.76%	37.96%	48.63%	53.03%	44.65%	47.08%	73.64%	42.15%	43.92%	51.83%	50.15%	46.43%
H: Asian or Asian British - Indian	43.31%	67.65%	66.10%	64.70%	62.09%	67.61%	71.66%	61.90%	65.91%	59.09%	65.53%	63.11%	68.09%
J: Asian or Asian British - Pakistani	18.62%	54.86%	52.97%	58.61%	58.85%	57.55%	57.37%	58.14%	59.00%	57.87%	56.85%	57.86%	55.62%
K: Asian or Asian British - Bangladeshi	22.68%	60.59%	59.12%	64.05%	62.17%	64.75%	64.25%	61.98%	61.72%	64.27%	59.13%	62.21%	60.13%
L: Asian or Asian British - Any other Asian background	39.85%	59.85%	53.22%	61.09%	63.95%	63.67%	67.27%	66.42%	64.95%	56.04%	66.19%	62.65%	58.23%
M: Black or Black British - Caribbean	35.63%	47.07%	42.59%	57.92%	65.81%	60.98%	55.62%	65.37%	58.58%	49.96%	58.62%	57.57%	42.81%
N: Black or Black British - African	26.45%	45.71%	39.84%	48.63%	56.78%	45.69%	47.77%	44.87%	50.25%	48.24%	52.14%	51.24%	45.71%
P: Black or Black British - Any other Black background	29.08%	45.04%	38.85%	44.54%	57.06%	55.97%	50.40%	60.12%	53.61%	48.55%	51.10%	51.63%	40.88%
R: Other ethnic groups - Chinese	53.30%	50.03%	46.79%	52.62%	64.50%	63.67%	43.07%	65.53%	67.16%	41.95%	55.84%	60.22%	64.48%
S: Other ethnic groups - Any other ethnic group	38.52%	47.54%	41.74%	48.05%	51.38%	49.65%	53.89%	55.45%	48.56%	52.18%	47.72%	49.18%	40.96%

Ethnicity – Update Week beginning 20th March

Ethnicity	National	Midlands	BSOL	CW	HW	JUCD	LLR	LINCS	NHAMP	NOTTS	STW	SSOT	BC
99: Not known	113	8	-	2	-	-	1	-	1	-	-	1	3
A: White - British	1,330	252	11	24	17	28	31	7	20	35	19	39	21
B: White - Irish	-	-	-	-	-	-	-	-	-	-	-	-	-
C: White - Any other White background	130	19	5	1	-	1	1	2	1	1	1	4	2
D: Mixed - White and Black Caribbean	22	2	1	1	-	-	-	-	-	-	-	-	-
E: Mixed - White and Black African	26	6	-	1	-	-	3	-	1	1	-	-	-
F: Mixed - White and Asian	28	1	-	-	-	-	-	-	-	1	-	-	-
G: Mixed - Any other Mixed background	33	8	-	2	-	-	2	2	-	1	-	-	1
H: Asian or Asian British - Indian	175	32	3	3	2	2	6	1	-	7	-	1	7
J: Asian or Asian British - Pakistani	209	47	27	2	1	6	3	-	-	-	1	1	6
K: Asian or Asian British - Bangladeshi	73	10	6	-	-	-	2	-	-	1	-	-	1
L: Asian or Asian British - Any other Asian background	114	15	2	1	-	1	2	2	1	-	-	2	4
M: Black or Black British - Caribbean	44	8	5	1	-	-	-	-	-	1	-	-	1
N: Black or Black British - African	232	43	10	3	-	-	5	-	2	9	-	2	12
P: Black or Black British - Any other Black background	55	12	3	1	-	-	4	-	-	1	1	-	2
R: Other ethnic groups - Chinese	51	5	3	-	-	1	-	-	-	1	-	-	-
S: Other ethnic groups - Any other ethnic group	105	9	3	1	1	1	1	1	-	1	-	-	-
null	8	-	-	-	-	-	-	-	-	-	-	-	-
Total	**2,748**	**477**	**79**	**43**	**21**	**40**	**61**	**15**	**26**	**60**	**22**	**50**	**60**

NHS England Midlands

Notes on Interpretation of Data:

Greater than or equal to National Uptake
Within the 80th Percentile of National Uptake
Below 80th Percentile of National Uptake

Evergreen Performance by ICS and IMD

Data Correct as at 27/03/23

Data Source: https://ppds.palantirfoundry.co.uk/workspace/contour-app/ri.contour.main.analysis.2d131e27-b3c7-4311-a617-7289b87f444c/path/ri.contour.main.ref.9e111d7b-6604-4610-b3c6-7a889c9b5375/board?viewMode=edit

NHS England Midlands

IMD – Current Uptake as at 27th March

IMD	National	Midlands	BSOL	CW	HW	JUCD	LLR	LINCS	NHAMP	NOTTS	STW	SSOT	BC
1	58.18%	55.20%	50.31%	52.85%	62.40%	56.32%	58.29%	69.44%	56.08%	56.96%	60.22%	61.69%	56.68%
2	61.59%	61.60%	54.75%	58.77%	66.07%	67.31%	60.96%	72.78%	56.12%	62.81%	65.63%	65.76%	60.63%
3	64.12%	65.27%	61.65%	60.85%	69.17%	72.12%	61.33%	69.00%	60.40%	66.23%	70.15%	69.12%	65.44%
4	67.57%	69.83%	64.51%	62.40%	76.09%	75.14%	66.66%	73.04%	62.21%	70.75%	75.26%	73.95%	69.26%
5	70.82%	73.39%	67.90%	69.34%	77.55%	77.19%	69.06%	76.69%	67.75%	71.95%	78.44%	77.84%	73.45%
6	73.01%	75.30%	69.79%	71.22%	79.71%	78.31%	73.97%	77.90%	72.85%	73.46%	78.10%	78.57%	74.61%
7	75.31%	77.66%	71.28%	76.22%	79.52%	81.62%	75.71%	79.24%	75.88%	76.13%	79.26%	80.36%	78.26%
8	76.48%	78.89%	76.32%	75.76%	80.11%	81.54%	77.60%	79.99%	77.30%	79.68%	80.41%	80.51%	79.65%
9	77.94%	80.11%	76.99%	78.35%	80.79%	82.70%	78.91%	81.19%	78.06%	79.26%	81.66%	82.22%	80.39%
10	79.44%	80.75%	78.88%	79.57%	82.00%	82.28%	79.92%	82.79%	78.04%	81.28%	80.27%	82.38%	82.65%
99	59.36%	55.16%	49.94%	58.62%	73.47%	65.25%	54.48%	31.76%	32.65%	64.15%	76.12%	65.86%	53.97%
Total	70.10%	70.42%	59.85%	69.37%	76.73%	75.52%	71.35%	75.54%	69.05%	70.54%	75.99%	75.20%	65.96%

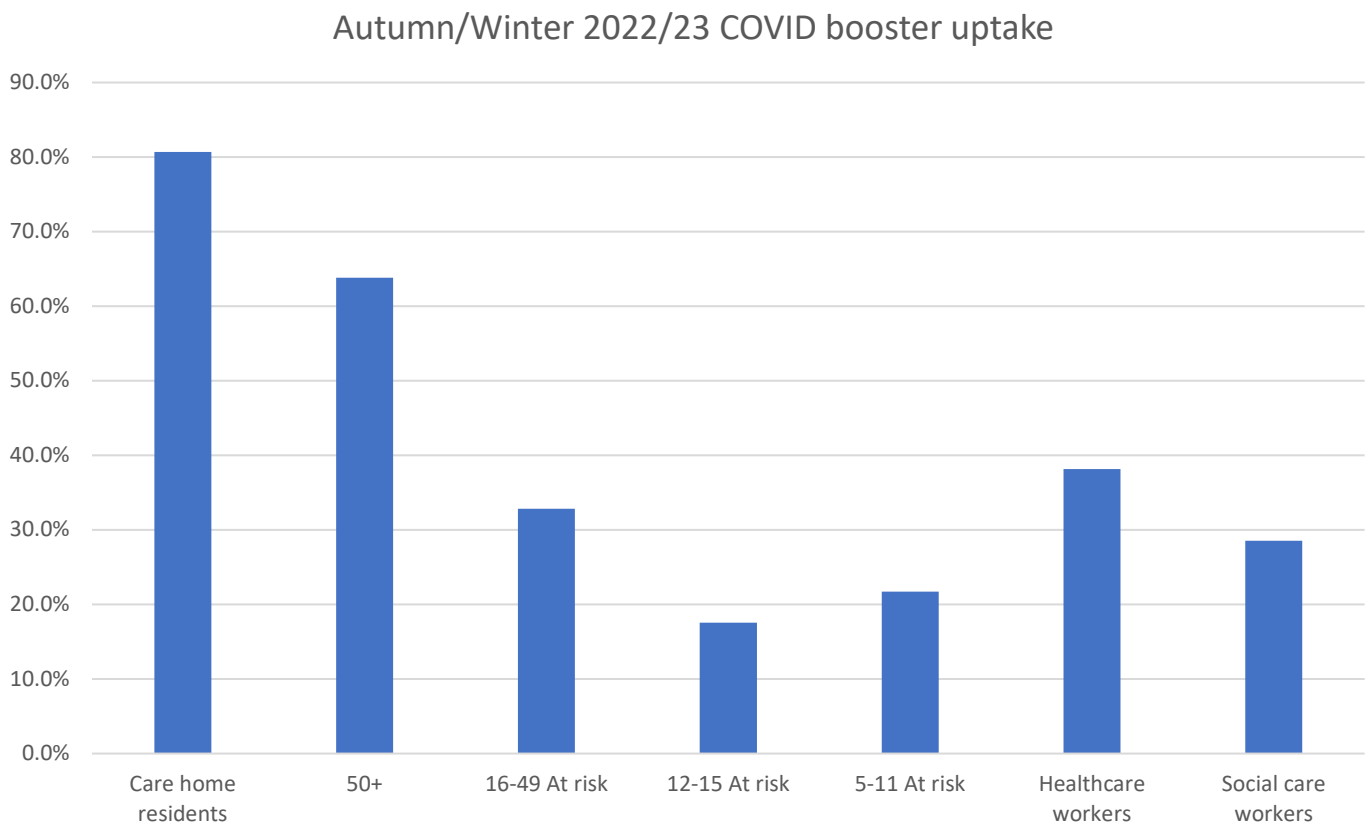
Notes on Interpretation of Data:

Greater than or equal to National Uptake
Within the 80th Percentile of National Uptake
Below 80th Percentile of National Uptake

IMD – Update Week beginning 20th March

IMD	National	Midlands	BSOL	CW	HW	JUCD	LLR	LINCS	NHAMP	NOTTS	STW	SSOT	BC
1	346	86	40	4	2	1	11	0	3	3	3	4	15
2	347	83	12	3	4	3	10	0	1	10	0	13	27
3	298	37	7	1	2	1	7	0	1	7	3	4	4
4	262	45	7	9	1	7	1	4	2	9	0	4	1
5	254	32	1	6	2	2	8	1	3	2	2	4	1
6	249	35	2	2	2	5	4	2	1	4	4	4	5
7	250	35	5	2	3	3	2	1	4	3	4	4	4
8	220	34	0	4	3	5	4	2	3	8	3	2	0
9	252	49	3	5	2	11	5	1	3	9	1	8	1
10	253	36	2	7	0	1	7	3	5	4	2	3	2
99	17	5	0	0	0	1	2	1	0	1	0	0	0
Total	**2,748**	**477**	**79**	**43**	**21**	**40**	**61**	**15**	**26**	**60**	**22**	**50**	**60**

COVID Vaccs – Autumn-Winter 2022/23

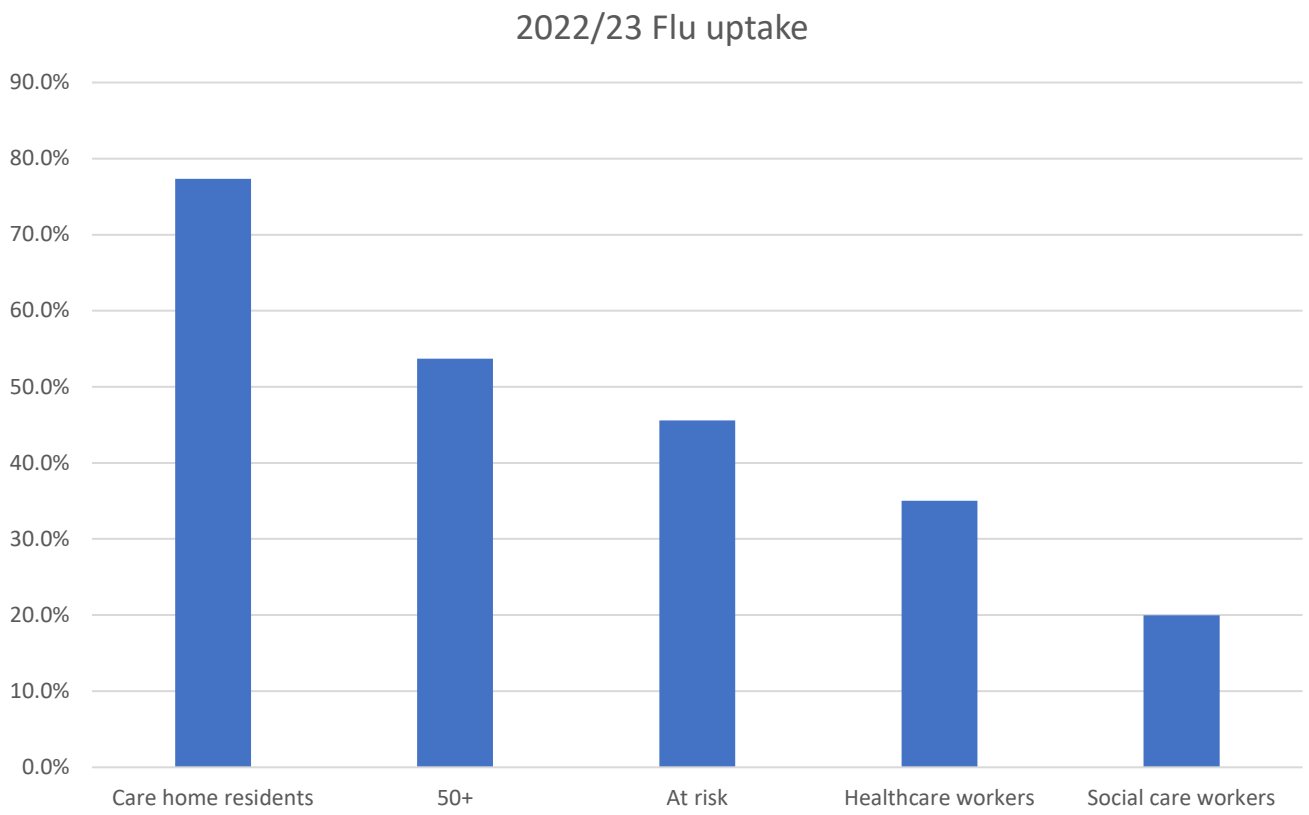


Age cohorts have been combined for ease.

1. In 50+, lowest uptake in youngest age brackets.
2. At risk – more to be done to close the gap, lowest uptake among 12-15s.
3. Health and social care workers low rates of uptake – likely that VCOD has impacted this.

Source: Foundry

Flu Vaccs – Autumn-Winter 2022/23



Age cohorts have been combined for ease.

1. At risk – lack of granularity for age bands as available for COVID uptake data.
2. Health and social care workers are reported with low uptake rates.
3. Social care significantly lower uptake than for COVID – this may be linked to reporting, and/or reflect a need for staff education

Source: Foundry

Healthcare staff uptake – COVID and Flu on 06/03/23

Trust	COVID eligible	COVID vaccinated	% uptake of eligible
Birmingham And Solihull Mental Health NHS Foundation Trust	4,916	1,575	**32.0%**
Birmingham Community Healthcare NHS Foundation Trust	4,907	2,094	**42.7%**
Birmingham Women's And Children's NHS Foundation Trust	5,948	2,827	**47.5%**
The Royal Orthopaedic Hospital NHS Foundation Trust	1,314	599	**45.6%**
University Hospitals Birmingham NHS Foundation Trust	26,666	11,723	**44.0%**
Total	**43,751**	**18,818**	**43.0%**

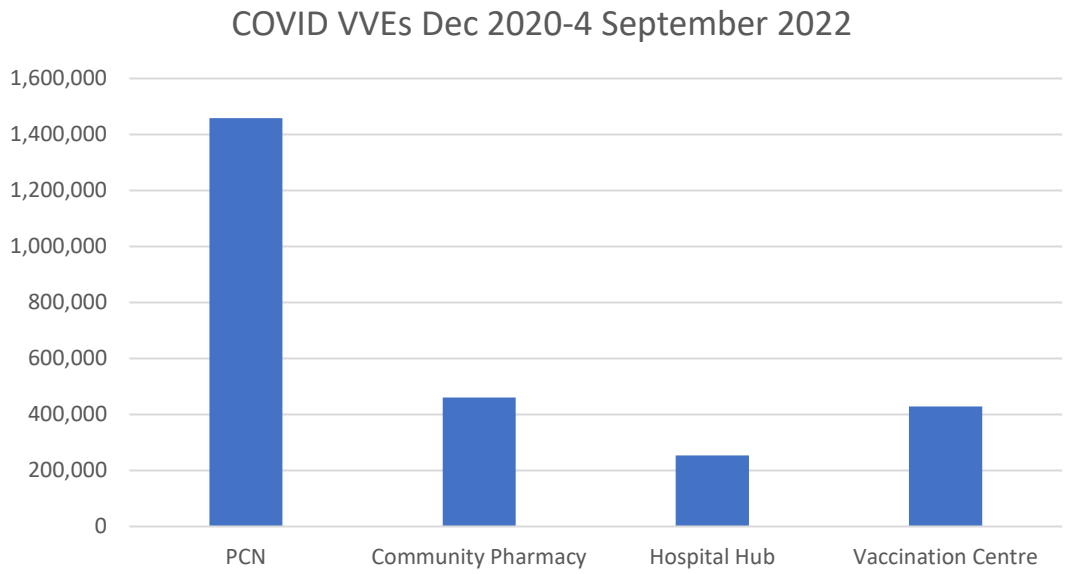
Trust	Flu eligible	Flu vaccinated	% uptake of eligible
Birmingham And Solihull Mental Health NHS Foundation Trust	5,726	1,992	**34.8%**
Birmingham Community Healthcare NHS Foundation Trust	5,637	2,605	**46.2%**
Birmingham Women's And Children's NHS Foundation Trust	6,695	3,369	**50.3%**
The Royal Orthopaedic Hospital NHS Foundation Trust	1,461	687	**47.0%**
University Hospitals Birmingham NHS Foundation Trust	31,241	12,894	**41.3%**
Total	**50,760**	**21,547**	**42.4%**

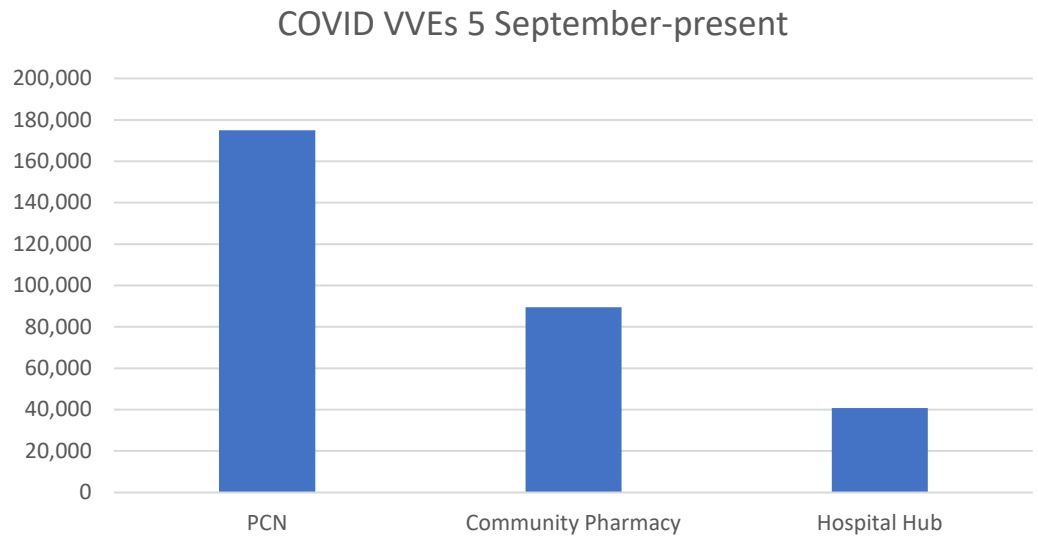
Note there are differences between what is reported via Foundry and what is shared with systems by NHS E in Performance Packs.

There are marked differences in percentage achievement for both flu and COVID.

Source: NHS E data reporting (Performance Pack)

COVID Uptake by Pillar – Launch to 4 Sep 2022, 5 Sep 2022 to present



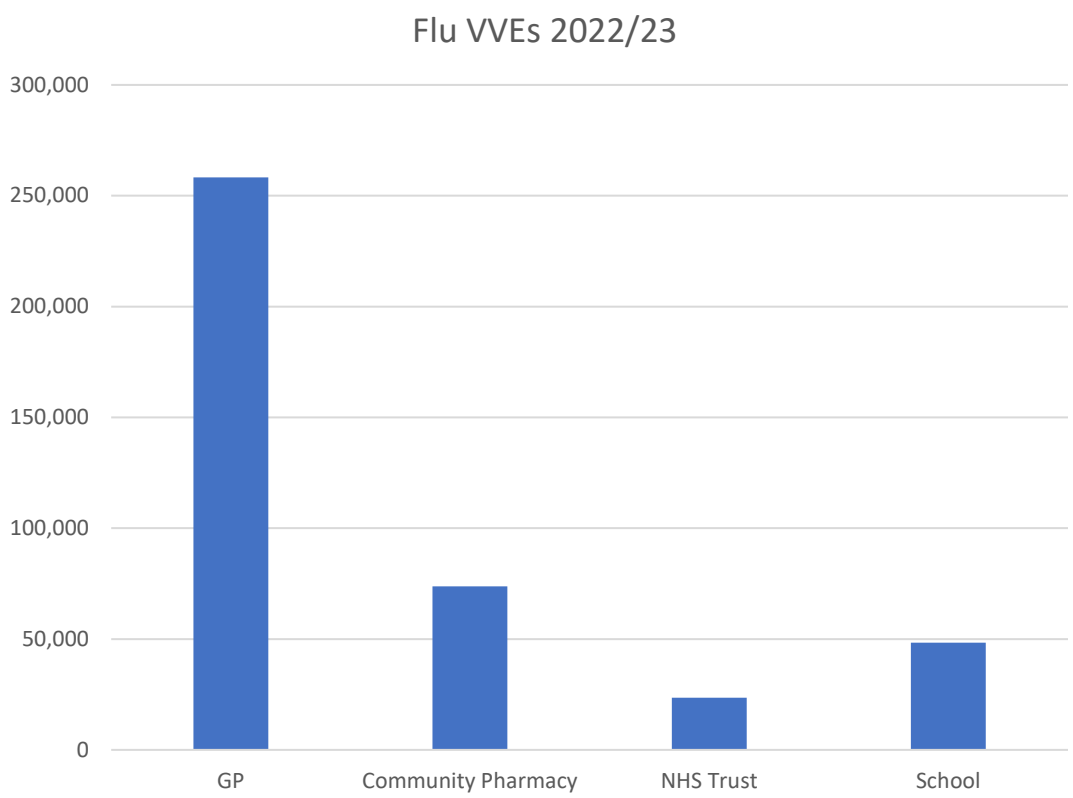


Vaccination Centres closed in 2022.

Notable proportionate increase of delivery via Community Pharmacies. The system team has worked to grow to CP delivery pillar to promote convenient access.

Source: Foundry

Flu Uptake by Pillar – Launch to 4 Sep 2022, 5 Sep 2022 to present



In 2022/23, 64% of activity via general practice.

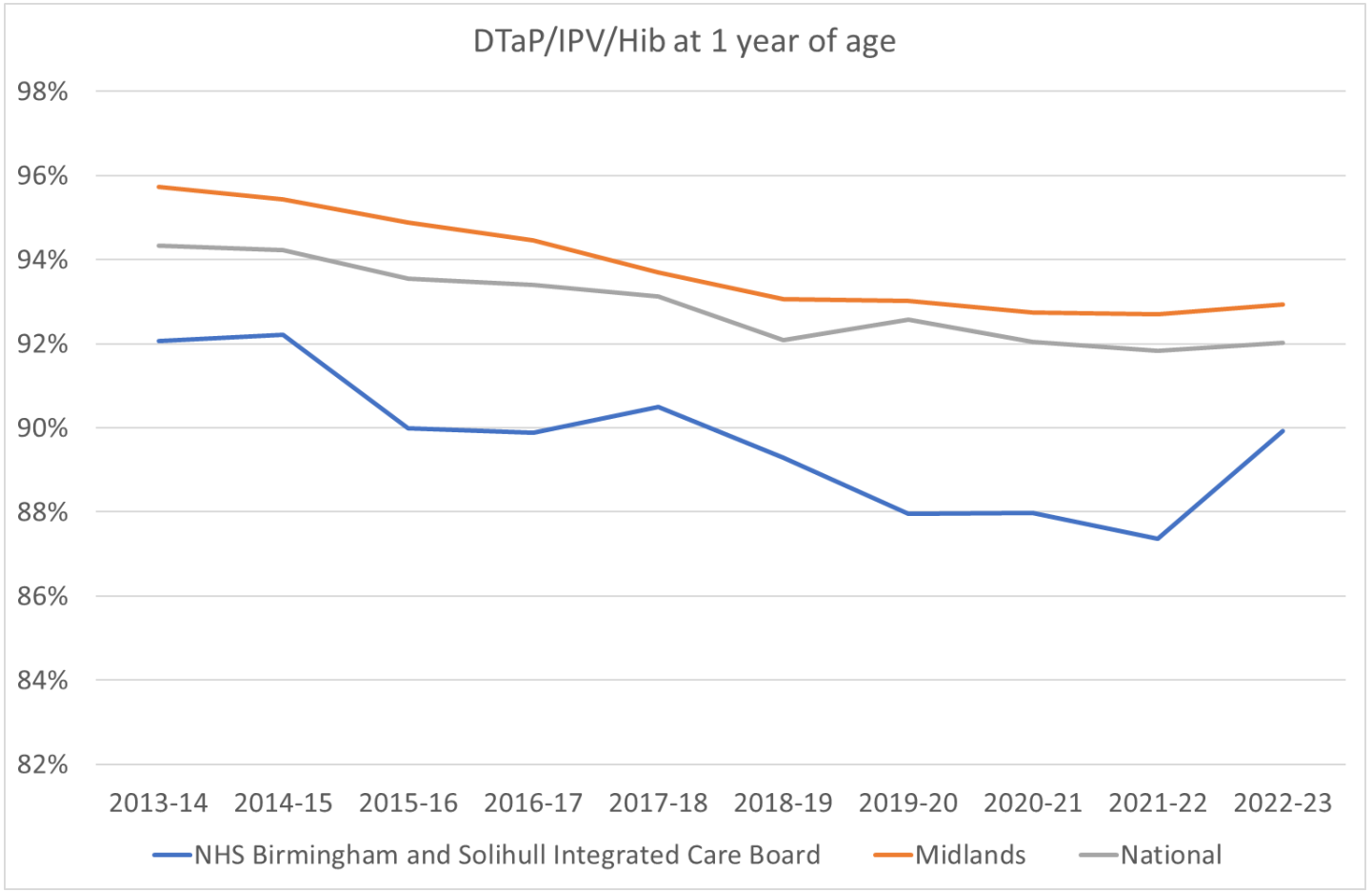
18% of activity through community pharmacy.

243 main and branch general practice sites.

316 community pharmacy sites.

Source: Foundry

DTaP/IPV/Hib/HepB (6-in-1) Vaccine at 1 year of Age



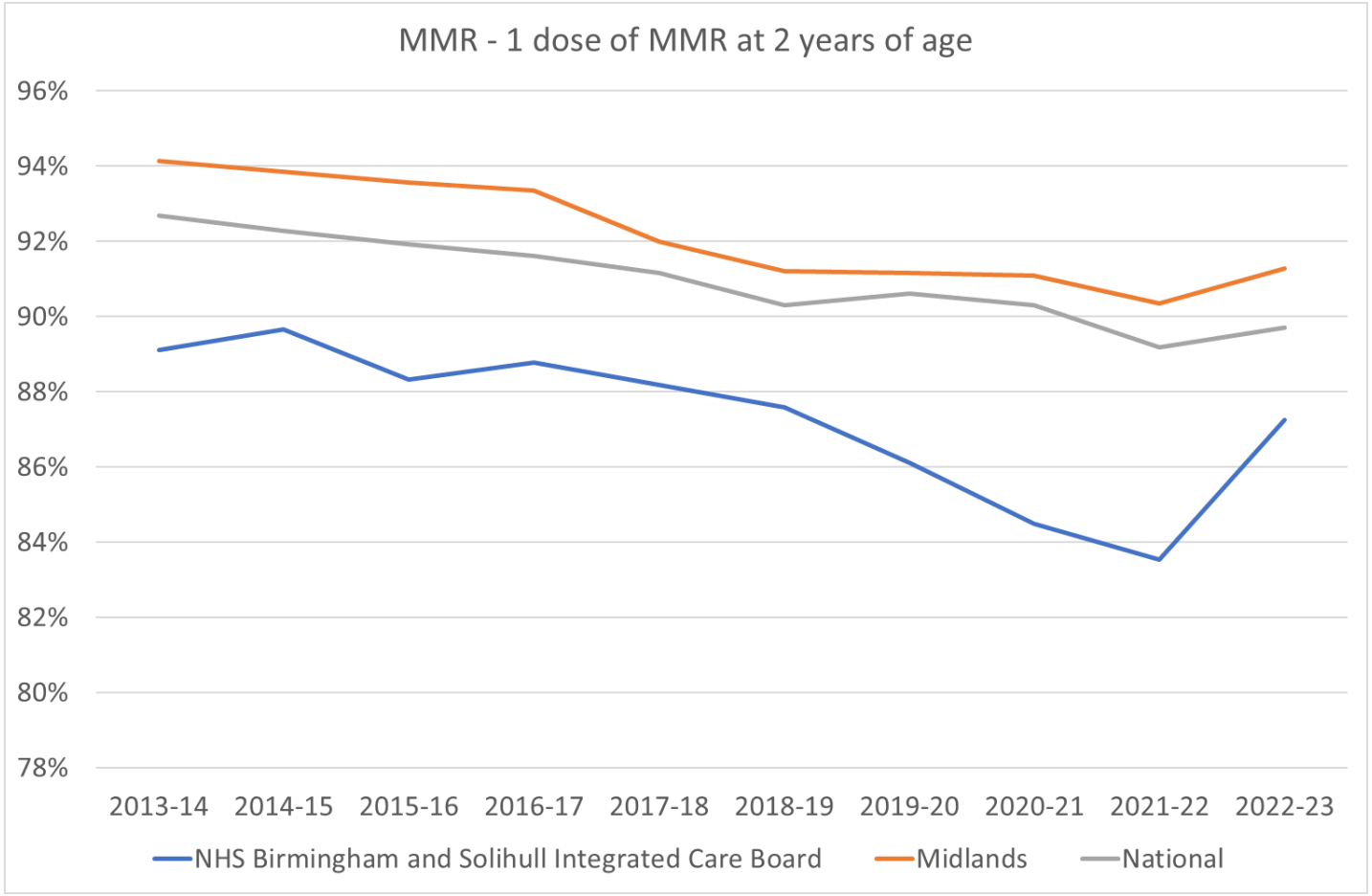
The graph shows decline for 6-in-1 uptake from 2013 to 2022, nationally, regionally and across Birmingham and Solihull.

What is notable is the sharper improvement in the BSol system in the past year (2022/23).

While there is still a gap to 95% attainment to be closed, there are positive signs of improvement shown in the data, returning to pre-COVID pandemic level of attainment (in 2017/18).

Source: NHS E data reporting

MMR - 1 dose of MMR at 2 years of age



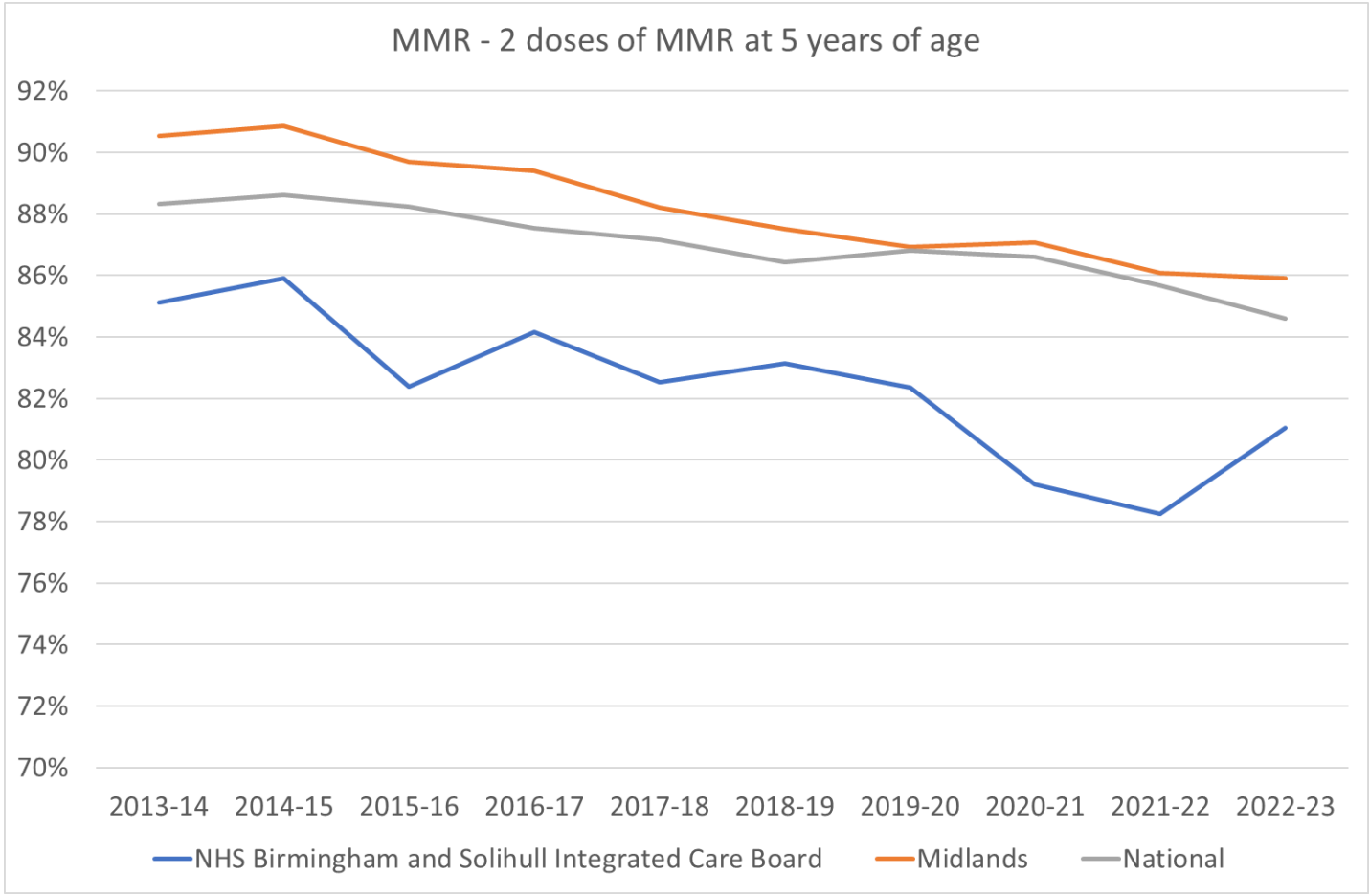
The graph shows overall decline nationally, regionally and across the BSol system to 2022, with all showing improvement in 2022/23.

BSol's rate of improvement is greater than nationally or regionally, but still some considerable distance from 95% attainment.

The attainment rate for 2022/23 approximates previous attainment in 2018/19.

Source: NHS E data reporting

MMR - 2 doses of MMR at 5 years of age



The graph below shows similar patterns of decline to the first dose.

However, while nationally and regionally decline has continued into 2023, across BSol there has been notable improvement in 2022/23.

This improvement does not yet match pre-pandemic attainment.

Source: NHS E data reporting

Queue Project Data Cleansing

	Practice 1	Practice 2	Practice 3	Practice 4	Practice 5
Waiting List	83	148	162	208	233
No longer registered	2	1	8	8	4
Already vaccinated	2	84	94	71	88
Already vaccinated as % of waiting list	*2.4%*	*56.8%*	*58.0%*	*34.1%*	*37.8%*
Declined	19	7	11	16	7

Data cleansing undertaken with engaged practices has frequently shown that many children in the queue have in fact been vaccinated, however there may not be a read-code in their record, with a free text entry instead – the CHIS extraction works from read-coding.

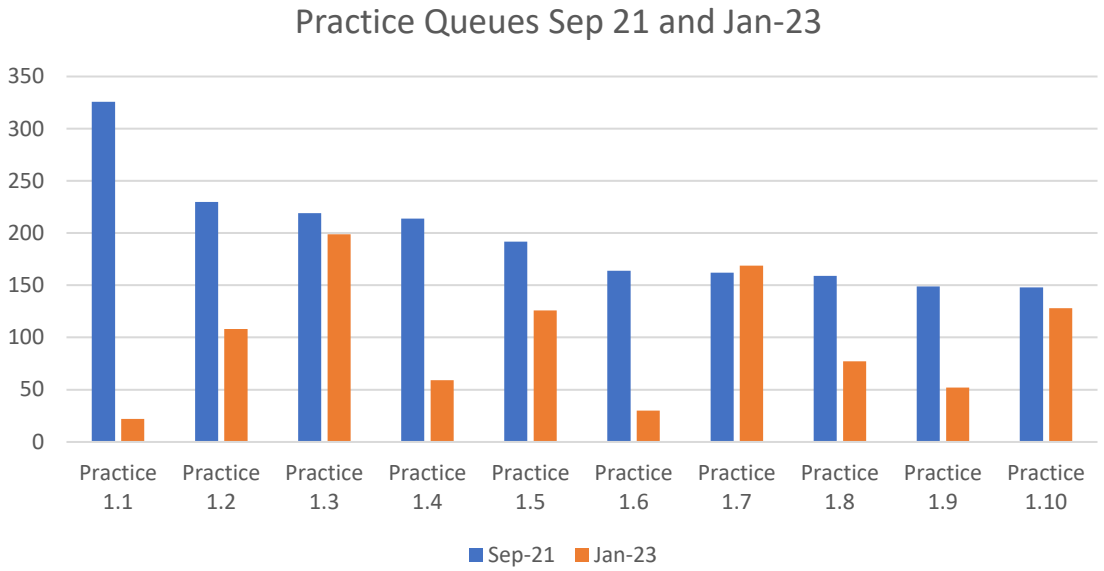
Since September 2021, the BSol Queue Project has approached practices with the largest queues, working with those which are responsive.

This work is led by members of the ICB's Peer Support team, and requires significant ICB staff time resource per practice for engagement.

Source: ICB Peer Support Team reporting

Practice Queues for Child Imms & Vaccs Appointments

Practice	September 2021	January 2023	Difference from Sep-21 to Jan-23
Practice 1.1	326	22	-304
Practice 1.2	230	108	-122
Practice 1.3	219	199	-20
Practice 1.4	214	59	-155
Practice 1.5	192	126	-66
Practice 1.6	164	30	-134
Practice 1.7	162	169	+7
Practice 1.8	159	77	-82
Practice 1.9	149	52	-97
Practice 1.10	148	128	-20
Total	1,963	970	-993



The table and graph show progress from the September 2021 data through to January 2023 data for the 10 general practices with the highest queues in September 2021. (Anonymised as practices 1.1 to 1.10).

For those 10 practices combined, there is a net reduction of their queues of 993 appointments from September 2021 to January 2023, albeit that 1 practice showed a small increase of queue.

Source: ICB Peer Support Team reporting

Birmingham and Solihull
Integrated Care System
Caring about healthier lives

Immunisations and Vaccinations

Birmingham Health Overview and Scrutiny Committee

18th April 2023

Delivering a safe and effective service

Birmingham and Solihull Integrated Care System
Caring about healthier lives

The Immunisation and Vaccination Landscape

Purpose

Following the receipt by HOSC on 22nd February 2023 of a joint strategic, co-authored ICB and Public Health teams overview paper provide a detailed briefing on the ICB provision and uptake of immunisations and vaccinations in Birmingham

Key Challenges

To highlight some of the key challenges that the system faces with increasing all immunisation and vaccination uptake and the opportunities for us to work collectively to address the health prevention agenda and the health protection deficit. A summary of what we are doing about the challenges

The ICB paper complements the Public Health paper seeking assurance and highlighting their contribution to these plans.

Roles and Responsibilities

Immunisation and vaccination services continue to be commissioned by NHS England. The primary responsibility for uptake improvement in the different immunisation programmes sits with NHS England's local screening and immunisation teams (SITs). NHSE are moving towards a delegation of their Section 7a responsibilities for a range of services. Immunisations and Vaccinations is not likely to be until 2025 or beyond.

BSol Integrated Care Board (ICB) has a system lead role in immunisation having an appointed Senior Responsible Officer (SRO). The service reports to the Chief Officer for Partnerships and Integration. For COVID the ICB has a memorandum of understanding with NHSE to assure delivery. Child and adolescent services vaccination services are directly contracted with NHSE and ICB oversight is not formally contracted.

NHSE providers have contracts directly with NHSE : In brief the following providers deliver to the all age immunisations agenda:

- Primary Care providers for those aged 0-5 years complemented by BCG provision through Birmingham Community Health Care NHS Trust and core provision of all age COVID and flu vaccinations , shingles and pneumococcal, including travel vaccinations
- Primary Care community pharmacies-for the provision of COVID and flu and other vaccines eg Shingles and Pneumococcal, including travel vaccinations
- Birmingham Community NHS Trust – BCG provision and Vaccinations for School Aged Children including the provision of outbreak responses e.g. recently for Hepatitis A
- Ante natal and Midwifery services – Flu COVID, pertussis
- University Hospitals Birmingham - System Vaccination Operations Centre Team – providing peripatetic, targeted mobile vaccinations for the public and NHS/Social Care frontline staff offer for COVID and Flu
- UHB - Allergy clinics providing support for those immune compromised for specific vaccine needs.
- UHB and BCHC provide an agile peripatetic response team for emerging risks eg Monkey Pox provision.

Birmingham and Solihull Integrated Care System
Caring about healthier lives

Governance and Resourcing

Governance

- Monthly all-age, all partner Immunisations and Vaccinations programme board with clinical input, with bi monthly Adults and Child and Adolescent Imms and Vaccs.
- Dedicated working groups on all aspects of the national immunisation programme. Partners are drawn from across the Integrated Care System (ICS) to contribute to these developments and strategic plans for these programmes are agreed at the board.
- ICB links into Birmingham's Health Protection Forum and Health and Well Being Board to assure the Director of Public Health that the plans we develop will protect the health of the local population.
- All providers complete a clinical assurance process before being approved to deliver vaccinations against national protocols and PDGs, which are routinely updated with every change in vaccine.
- Reports to an ICB Clinical Assurance and Quality Group monthly chaired by the CMO
- NHSE oversight meetings fortnightly on delivery for COVID and flu in autumn and winter

Resources and Funding

- COVID and flu funding is now transitioning to a business as usual approach. A standard Item of Service fee of **£10.06 per vaccination** is now applied for all routine, all age vaccinations and immunisations to cover all costs.
- GP practices are required to provide vaccinations and immunisations to all eligible patients or target groups. Pharmacies and other providers apply to become an accredited service provider with an NHSE contract. For COVID, PCN groupings co-ordinate and deliver the vaccinations through an identified lead practice on behalf of the grouping. Providers commissioned to deliver any of the routine vaccinations also receive the same item of service payment for each person vaccinated.
- A limited programme budget is allocated to support COVID delivery across the system. Savings and efficiencies have been made since March 2022 to support our most important outreach and community based offers.
- No flexible funding exists to support either our all age immunisations and vaccinations system oversight team or the providers beyond their item of service payments directly through their contracts with NHSE. The exception is the incentive payment to providers to reach Care Home residents in small and medium homes in the first two thirds of the phase (larger homes attract no premium) Those who are housebound also attract a payment premium.
- The development work that the system partners and its staff are supporting for all other immunisations and vaccinations are as an adjunct to their day job.

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Access to Data and Intelligence

Access to data and intelligence

- Performance packs for COVID and flu updates go through the I&V Board to members and partners. The use of Foundry as an information data capture tool enhanced the real time information on vaccination status for COVID and can illustrate information across a significant range of indicators.
- Data for shingles or pneumococcal vaccinations is recorded in primary care – in practices through GP systems or in Community pharmacies often through Pharmoutcomes. Ensuring all this data reaches the patient record in a timely way is critical.

Child and Adolescent Data

- Currently, BSol ICS does not have access to locally produced data for scheduled child vaccinations. The Cover of Vaccination Evaluated Rapidly programme **(COVER)** programme evaluates childhood immunisation in England, collating data for children aged 12 months, 24 months, and 5 years. with a lag of between 4 and 6 months.
- The Child Health Immunisations System (CHIS) system is an NHS-commissioned service that collates data from healthcare professionals for children aged 0-19 in a specified area, into a single child health record. The current CHIS system is being reprocured by NHSE and may be available from April 2024
- CHIS ensures that children receive appointments at the correct age for NHS immunisation and screening programmes, working with all providers to monitor and improve uptake of national childhood screening and immunisation programmes. CHIS notifies health visitors of all new births and of children who have moved into their area and ensures all babies have received their newborn screening. CHIS ensures children between 0-5 years receive appointments at the correct age for NHS routine childhood immunisations and monitors that school-aged children have had the immunisations they are due. The data recorded is gathered from a range of sources including midwives, health visitors, school nurses, and GPs.
- There is a need for more granular and timely data. In response to these needs the immunisations and vaccinations programme team is working with the BSol ICB digital team to establish a local data set that can fulfil our oversight needs on performance /uptake. We have piloted a local data extraction solution for patient level data extraction and is being finalised for local access.
- Low rates of childhood immunisations will affect primary care QOF achievements and payments and create additional pressure on practices serving communities where health inequalities are high and immunisation and vaccination uptake is lower. This leads to further under-resourcing to historically underserved communities as the funding gap widens.

The BSol Queue Project has approached practices with the largest queues for immunisations since September 2021 and it identified four main factors impacting on immunisation and vaccination queues and local vaccination rates. Updated NSE guidance will improve recording and uptake for the system.

- **Data cleansing** with engaged practices has frequently shown many children in the queue have in fact been vaccinated, however there may not be a read-code in their record, with a free text entry instead. The project afforded records to be corrected through appropriate read coding and thereby demonstrate the accurate uptake position.
- **Clinic slots** available for many practices are not sufficient to reduce the queue; this may be due to increasing numbers of child registrants at the practice or lack of recognition of the same.
- **Practices adding their own appointments outside the CHIS process** does not reduce the queue.
- **Parental factors**, including community-influenced attitudes to vaccination, as we have seen during the autumn and winter phase of the COVID and flu campaigns

Managing Performance and trends

Children and Adolescents

- Nationally and regionally the overall uptake for all age immunisations and vaccinations has seen a steady decline since 2013, with further impact of the COVID pandemic affecting childhood immunisation access, which is highlighted in the performance section.
- In the last 12 months BSol defies the national and regional trends with a sharp incline in performance. Whilst this does not return the system to the desired 95% herd immunity figure that we would aspire to it shows an encouraging improvement.
- The ability to manage vaccination performance and uptake effectively requires accurate and timely data. With the improvements to the nationally procured CHIS system and the ability to extract local data effectively from GP systems emerging we are confident of being able to improve our local reporting mechanism across the system in the near future enabling transparent and collectively agreed actions.
- We are now focusing a delivery group on 0-5 years uptake to ensure that the initial vaccination programme that children are offered is convenient for parents and close to home, accommodates catch up of missed vaccinations and that no child starts school without being fully immunised. Working with our Public Health, Education, Health Visitor and other NHS colleagues we will ensure that information is made consistently available to parents, on the importance of early immunisation.
- We are aiming to ensure that in all 0-5 year care settings there are opportunities to discuss fears and questions in advance and without judgement about this important health protection offer.

Adults

- COVID data still has gaps in data visibility. eg, identifying NHS staff who are flu or COVID vaccinated outside their own organisation relies on self declaration. Primary care staff and frontline staff in Local Authorities do not have the same data recording mechanisms as NHS Trusts and their uptake is not visible unless staff disclose their working status at a provider site.
- Through autumn and winter 2022, all systems experienced a significant behaviour change to COVID and flu vaccinations, where uptake for both avoidable illnesses resulted in around a **20%** reduction from 2021 mirrored nationally and regionally. BSol achieved a **49%** uptake for COVID and **42.3%** on average for flu. The expected and system target levels were **68%**.

Responding to Emerging Issues

- We have worked in partnership with BCC, Umbrella and Birmingham LGBGT to deliver a comprehensive programme of Monkey Pox first and second doses since August 2022
- BCHC have responded to two school outbreaks in the last 3 months involving Hepatitis A where children and staff were vaccinated at pace.
- We have supported UHB with a significant catch up programme on BCG unvaccinated babies
- We are keeping a watching brief on Avian flu.

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Improving Equity

Improving Equity

- In 12 months we have worked well as a system to focus on wards and communities where there are high levels of inequalities and a lower uptake of vaccinations. Particular attention has been to specific ethnic groups and those in the **IMD deciles 1-3** for all immunisations and vaccinations **(See Performance Pack slide 4)**
- We are working with the **Health Inequalities Board** and the **BLACHIR project and maintain regular and close contact with our public health colleagues through the Health Protection Board** to increase our at scale impact in year for those communities across all ages **(See performance pack)**

Children and Adolescents

- The age profiles that we need to significantly improve uptake within is for those who have not had a full course of routine childhood immunisations and in particular a focus on **MMR**
- Those who are at risk and not at risk between the **ages of 12 and 15 years,** and similarly for those **at risk 5-11.**
- Although we have seen recent improvement for covid and flu for these ages the increases are small.
- Particular focus through Spring will be on children in who have received bone marrow transplants where although numbers will be small, they need to receive another full programme of immunisations.

Adults

- The COVID evergreen offer and our health and well being engagement approach with vulnerable groups and low uptake communities shows improvements across Bangladeshi and Pakistani, African and Caribbean cultures but much remains to be achieved. The return of the West Birmingham locality /GP practices into the ICB on 1st July worsened our system position in terms of local uptake. The team have worked hard to address local needs with alternative engagement offers across specific wards. The Evergreen uptake shows significant improvement over the autumn winter 2022 campaign overall and our comparison with our nearest neighbour, the Black Country illustrates a reasonable re-alignment in performance, although there remains work to do.
- Work in Perry Barr and Ladywood have enabled us not only to succeed with vaccination offer but also make direct referrals for more urgent care needs and complete some direct nursing interventions on a range of sites for vulnerable people. This approach enables work with all ages and advice and guidance through our trained Health Visitor has supported mothers with questions and concerns about the health and well being of their children with active referral for catch up vaccinations. We aim to work consistently in communities and return visits to low uptake locations are already planned in for spring and summer. Local Councillors are supporting these visits and are routinely contacted as part of our plans,
- Particular emphasis in the autumn winter 2022 programme has been on those who are **homeless**, those with **a serious mental illness**, or who have a **learning disability**, those who are **carers** for a vulnerable person and those who are suffering from a **drug and or alcohol addiction**.

Birmingham and Solihull Integrated Care System
Caring about healthier lives

Improving Equity

What would support our campaign efforts for increasing uptake?

- To continue the ongoing shared commitment to promote and embed the benefits of immunisations and vaccinations for all ages across Council services and partnerships against a commonly agreed and consistent set of system messages
- Continued elected member support when we do community based vaccination offers as vocal advocates of the all age programme. We have agreed to provide PCN level Child and Adolescent uptake data to the Health Protection Board, although there will be a 4-6 month lag in reporting.
- Agree how we collectively target communities, with bespoke approaches especially ones with that lack vaccine confidence
- Use of media, local platforms, community links, to promote vaccination and/or dispel myths.
- Support an overall Council commitment challenge / scrutiny to encourage uptake in our 470,000 people who are unvaccinated eg for COVID and our 225k children living in poverty who will need the best start in life – immunisations being a key health protection issue that can support them be well.

Birmingham City Council

Health and Social Care Overview and Scrutiny Committee

Date Tuesday 18th April 2023

Subject:	Staying Independent at Home: Adaptation and Improvement Service
Report of:	Graeme Betts Strategic Director Adult Social Care
Report author:	Sarah Feeley Commissioning Manager – Adult Social Care

1 Purpose

1.1 The purpose of this report is to provide an update on the procurement of the Staying Independent at Home: Adaptation and Improvement Service.

2 Recommendations

2.1 That Health and Social Care Overview and Scrutiny Committee note the contents of the report and appendices for information.

3 Any Finance Implications

3.1 The Staying Independent at Home: Adaptation and Improvement Service will be funded through the Disabled Facilities Grant that is received by the Council each year. There is no Adult Social Care base funding required in order for this contract to be delivered.

3.2 The cost of the procurement will be funded from the Adult Social Care base budget.

4 Any Legal Implications

4.1 Section 14 of The Care Act 2014 states that the Council must provide minor works or equipment of a value of less than £1,000 free of charge to the citizen as detailed in The Act where these are necessary to meet a Care Act outcome.

4.2 The Housing Grants, Construction and Regeneration Act 1996 (HGCRA 1996) places a mandatory duty on the Local Authority to provide grants towards the costs of works required for the provision of facilities for people living with disabilities as defined in the Equality Act 2010. These are known as Disabled Facilities Grants (DFG).

5 Any Equalities Implications

5.1 The procurement of this service will ensure that citizens who are eligible for the assistance, receive a service that is reflective of their needs and has the ability to adapt to ensure that the citizen receives the best outcome possible.

6 Appendices

6.1 Staying Independent at Home: Adaptation and Improvement Service Specification

6.2 Staying Independent at Home: Adaptation and Improvement Service Procurement Strategy Report (March 2023)

6.3 Staying Independent at Home Policy – widening the use of the disabled facilities grant (March 2022)

Birmingham City Council

Service	Staying Independent at Home: Adaptation and Improvement Service
Period	1 January 2024 – 31 December 2029 (potential further 2-year extension subject to funding availability and performance)

The Council wishes to establish a Contract for the provision of Home Adaptation and Improvement Service for its citizens. The Service will be divided into two main delivery elements: Discretionary and Mandatory provision.

Mandatory Services will include delivery of Major Adaptations funded by the Disabled Facilities Grant (DFG) for all tenures with the exception of Council tenants.

Discretionary services will include works in excess of £30k (mandatory DFG limit), delivery of Key Safes, Minor Adaptations, some major adaptations costing under £10k and works to address affordable warmth, home hazards, safety and security within a citizen's property

1. National/Local Context

Birmingham Demographics

Birmingham is a growing city. Between the census years of 2001 and 2011 the city's population grew by 96,000 (9%) to 1,074,300. The most recent population estimate (2016) puts the city population at 1,124,569. The population increase over the last decade is associated with more births, fewer deaths and international migration. Birmingham has more citizens in the younger age groups, while England as a whole has a greater proportion of older citizens - 46% of Birmingham residents are under 30, compared with 37% for England (2016 estimates).

The largest ethnic group in Birmingham in 2011 was White British with 570,217 (53.1%). This proportion has decreased since 2001 (65.6%) and lower than the average in England (79.8%). Other large groups include Pakistani (144,627, 13.5%) and Indian (64,621, 6.0%) which have grown since 2001, while citizens defining themselves as Black Caribbean (47,641, 4.4%) have declined. More recent trends see citizens arriving from many different parts of the world, including Eastern Europe, Africa and the Middle East.

238,313 Birmingham residents were born outside the UK. Of these around 45% arrived during the last decade. 46.1% of residents said they were Christian, 21.8% Muslim and 19.3% no religion.

The 2011 Census included a measure around limiting long-term illness and in Birmingham 9.1% of citizens indicated that their activities were limited a lot due to health problems. 98,181 citizens in Birmingham identified that they had a long-term health problem or disability which affected their day-to-day activities a lot. This group was made up of 45% males and 55% females. Day-to-day activities were increasingly limited by age. In the age group 0-15, 1.97% stated that their activities were limited a lot, and this increased to 15.09% for those aged 65 and over.

The population of Birmingham aged 18-64 predicted to have a serious physical disability is estimated to be 14,934 by 2025. (From Projecting Adults Needs and Service Information).
The total population of Birmingham aged 65 and over predicted to have a limiting long-term illness whose day-to-day activities would be limited a lot is estimated to be 52,052 by 2025. (From Projecting Older People Population Information).

National Policy Context

Key to the development of this service is an understanding of both the legislative and policy context within which it is located. The council holds a number of key duties in relation to supporting citizens to remain independent within their own homes and the service will work alongside those core services already commissioned within the city.

The Care Act 2014
Section 14 of The Care Act states that the Local Authority must provide minor works or equipment of a value of less than £1,000 free of charge to the citizen as detailed in The Act where these are necessary to meet a Care Act outcome.

The Housing Grants, Construction and Regeneration Act 1996 (HGCRA 1996)
The Housing Grants, Construction and Regeneration Act 1996 (HGCRA 1996) places a duty on the Local Authority to provide grants towards the costs of works required for the provision of facilities for people living with disabilities as defined in the Equality Act 2010.

The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO 2002)
The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO 2002) enables the Local Authority to use discretionary powers to provide other forms of housing assistance in addition to the mandatory duties to provide DFG. In order to exercise discretion and flexibility in the form of assistance offered and crucially to enable flexibility in the use of the annual DFG funding allocation, the Local Authority must publish a policy setting out the assistance available.

Equality Act 2010
The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society. It replaced previous anti-discrimination laws with a single Act, making the law easier to understand and strengthening protection in some situations. It sets out the different ways in which it's unlawful to treat someone.
Additional Equality Act provisions came into force in April 2011:

a) Positive action - recruitment and promotion
b) Public Sector Equality Duty (see section below)

Public Sector Equality Duty
The Public Sector Equality Duty is made up of a general equality duty which is supported by specific duties. The general equality duty requires the Council to have due regard to the need to:

a) Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Equality Act;
b) Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it;
c) Foster good relations between people who share a relevant protected characteristic and those who do not share it

The Council is able to demonstrate understanding of the effect of its policies and practices on people with different protected characteristics by carrying out Equality Analyses on all aspects of the development of the new service offer.

Public Services (Social Value) Act 2012
The Public Services (Social Value) Act 2012 places a duty on Local Authorities at the pre-procurement phase of procuring services to consider how what is being procured might improve the economic, social and environmental wellbeing of an area and how the authority might secure that improvement in the procurement process itself. There is also a requirement that authorities consider whether to consult on these matters. In essence it is about factoring in 'social value'.

Housing (Homeless Persons) Act 1977
The Act requires the Local Authority to prevent as well as respond to homelessness and assist people under imminent threat of homelessness (and classes as 'in priority need') by taking reasonable steps to prevent them from losing their existing accommodation.

Local Policy Context

Birmingham City Council Vision and priorities 2018- 2022
The Birmingham City Council Plan and Budget 2018-2022, priorities will focus on:

a) Birmingham is an aspirational city to grow up in
b) Birmingham is a fulfilling city to age well in

Staying Independent at Home Policy (2022)
The Staying Independent at Home Policy aims to:

- Support disabled citizens to secure necessary adaptations which cost more than the maximum allowed under the Disabled Facilities Grant
- Secure prompt discharge from hospital of patients who might, due to accommodation difficulties, otherwise remain in hospital longer than necessary
- Address accommodation difficulties which, if not resolved, might lead to an avoidable admission to hospital, or residential care or to prevent an escalation

Creating a Bolder, Healthier City 2022 to 2030
Creating a Bolder, Healthier City contains five core themes alongside three life course themes. It is underpinned by the priority of Closing the Gap, which includes reducing health inequalities that have been highlighted and exacerbated by the Covid-19 pandemic.

Birmingham Better Care Fund Plan 2022-23
Each year a local plan is developed to recognise and support the integration of health and social care. This includes the delivery of the Staying Independent at Home agenda and ensuring that citizens are accessing support at the right time in the right place.

Everyone's Battle, Everyone's Business
Birmingham's bold strategy on tackling inequalities both across the city and within the Council was approved by Cabinet on the 6 September 2022. The Equality Action Plan for 2022/23 brings together a range of actions focused on protected characteristics.

Birmingham Business Charter for Social Responsibility
This Charter is a set of guiding principles to which Birmingham City Council will adhere to and to which it will invite its contracted suppliers, the wider business community, other public sector bodies, and third sector organisations (including grant recipients), to adopt.
Charter signatories will consider and describe how they can improve the economic, social and environmental well-being of Birmingham that result from their activities. This includes indirect outcomes through commissioning and procurement.
Charter signatories will commit to the principles below, either by fully adopting the Charter at the time of signature or alternatively making a commitment to full adoption within a clear timetable.

Future commissioning and contracting decisions will take account of the principles of this charter and it forms part of the terms of Birmingham City Council contracts. All the principles and policies of the Charter will be mandatory for organisations with individual contracts or grants over £200,000 per annum and for those that have aggregate annual contracts or grants above

£500,000. Contracts and grants below these thresholds have aspects of the Charter that are mandatory and aspects that are voluntary.
Charter Principles:

a) Local Employment
b) Buy Birmingham First
c) Partners in Communities
d) Good Employer
e) Green and Sustainable
f) Ethical Procurement

Living Wage Policy
Birmingham City Council has implemented the Living Wage, as part of the Business Charter for Social Responsibility, for Council employees and the promotion of this amongst Birmingham businesses.

The Living Wage Policy ensures that people working on behalf of the Council are paid the same minimum rate as if they worked directly for the Council. We also believe that since our procurement policies mean that more of them will be Birmingham residents, putting more money into those people's pockets will help local shops and businesses, creating a virtuous spiral that can treble its value to the local economy.

Birmingham Clean Air Zone
There is a Clean Air Zone within Birmingham that could impact on service delivery within certain areas of the city, this will need to be considered more fully by the Providers.

2. Outcomes

National and Local Outcomes
The Adult Social Care Outcomes Framework (ASCOF) identifies a number of outcomes for adult social care services which we expect the provider to contribute to and, therefore, to improve:

- Enhancing quality of life for citizens with care and support needs.
- Delaying and reducing the need for care and support.
- Ensuring that citizens have a positive experience of care and support.
- Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm
- Delayed transfers of care from hospital
- 1G: The proportion of adults with a learning disability who live in their own home or with their family
- 1H: The proportion of adults in contact with secondary mental health services living independently, with or without support
- 2B(1): The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
- 3D(1): The proportion of people who use services who find it easy to find information and support

Public Health Outcomes Framework (PHOF) sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is improved and protected. There are three homelessness indicators that are measured:

- Number of households in temporary accommodation (B15c)

Service Outcomes
This service will be expected to support and to deliver the following outcomes:

- Enable citizens to maximise their potential for independence and to sustain accommodation
- Contribute to the reduction of admissions and re-admissions into hospitals and residential care

- Support the reduction in the number of citizens having a delayed discharge from hospital due to their housing needs

Outcomes will normally be achieved by supporting citizens throughout the repair, adaptation or improvement of their home, so that they are able to remain there in a warm, safe and secure environment. This could include the direct provision of adaptation, repair and maintenance services, accident prevention or crisis avoidance measures.

3. Service Requirements

For the purpose of this Specification, Service means the Lead Provider or their representative sub-contractor. Ultimately the Lead Provider will be responsible for delivery, performance and standards.

Aims and objectives of the Service

The principle aim of the Staying Independent at Home Adaptation and Improvement Service (Service) is to enable those vulnerable citizens in need of support, to maintain their independence, health and well-being in their chosen home for the foreseeable future. This may include older people, people on low incomes, disabled people and other vulnerable groups determined by local circumstances.

The aim is to provide fair and equitable services to citizens of all tenures, although eligibility for actual services may vary.

Service Objectives

The Service has been developed to meet a minimum range of objectives; these include:

- To help increase the number of citizens successfully discharged from hospital to their own home.
- To help reduce the number of citizens entering residential/nursing care.
- To help reduce the number of emergencies amongst citizens living independently that might result in more intensive services being required.
- To increase the number of citizens that live with dignity in their chosen environment, which is made safe and secure.
- To extend the healthy life expectancy of citizens by improving the quality of homes in order to reduce fuel poverty, prevent ill health, falls and other accidents.
- To help tackle some of the causes of ill health associated with living in poorly insulated or poorly maintained homes.

Service Overview

The service will provide:

- Works based on the recommendations made by Occupational Therapists (or trusted assessors) or other professionals to enable the citizen to remain living within their home with minimum intervention and maximum outcome for the citizen.
- A design to build service based on the recommendations from the Occupational Therapists
- Works required under the discretionary assistance (as detailed in the Staying Independent at Home Policy) e.g., affordable warmth, safety and security etc.
- Provision of key safes and their installation
- A flexible and adaptive workforce that can meet the needs and demands of citizens across the city
- Coordination of the lead-provider and sub-contractor resource across the city to ensure that there is sufficient capacity to meet the demand, with the flexibility to move and adapt as these change
- Delivery of works within prescribed target timescales
- A flexible person-centred service ensuring that works are delivered in response to the citizens needs and allows them to improve their health and wellbeing outcomes

- Provide a fully qualified flexible workforce to meet the variety of works required as part of the service
- Have the ability to work with extremely vulnerable citizens with complex needs
- Have the ability to work with a wide range of diverse communities, including where English may not be their first language.
- Robust quality assurance processes including mechanisms to monitor and respond to customer satisfaction and feedback

Service Values
The following service values will underpin all activities undertaken by the service provider:

- Citizens should retain the greatest possible control over their lives.
- Citizens should be treated with courtesy, respect and dignity.
- Citizens should be personally involved in any decision-making process that impacts on their lives.
- Citizens views will be sought on the quality of the service provided.
- The diverse needs of citizens will be recognised and supported.

The following principles will be observed by the Service in delivering this service, when works are being considered, The Service will:

- Adopt a person-centred approach
- Will act on the instruction of the Occupational Therapist or relevant Birmingham City Council department on works
- Will seek permission from the citizen, their nominated representative and/or home owner/landlord (as appropriate) for authority to complete works
- Will supply sufficient information to enable the citizen to make informed choices available to them.

Service Elements
The Service will be divided into two main delivery elements: Discretionary and Mandatory provision.

Mandatory Services includes delivery of Major Adaptations funded by the Disabled Facilities Grant. It should be noted that for mandatory works this will be for all tenures with the exception of Council tenants.

Discretionary services include works in excess of £30k (mandatory DFG limit), delivery of Key Safes, Minor Adaptations, some major adaptations costing under £10k, works to address affordable warmth, home hazards, safety and security within a citizen's property.

Service Availability and Accessibility
The service will be expected to operate 7 days a week Monday – Friday 9am – 5pm, Saturday/Sunday 9am-12noon, including bank holidays. Consideration should be given on the Key Performance Indicators to ensure different elements of the service are available to achieve those timescales.

It should be noted that should there be an emergency caused by works completed by the Service, it is expected that the service will respond to that repair. Therefore, the service will be expected to have a 24/7 emergency hotline for citizens.

The service should:

- Have a physical location that can be fully accessed by disabled, older and vulnerable citizens to enable choice and support when considering works that have been offered. This should include space to demonstrate equipment such as stairlifts, through floor lifts and to see different choices in showers etc.
- Arrange for an interpreter where necessary to ensure those who do not speak English can access services.

- Ensure that their workforce/sub-contractors are culturally competent to provide a consistently high quality service to all citizens recognising the diversity of the city.

The service will be monitored to measure its success in reaching its target groups, as determined by eligibility for the service elements.

Service Responsibilities
The Service's attention is drawn to the fact that the property may be occupied when carrying out the works. The works must be completed within the timescales stated in the key performance indicators, unless alternative timescales have been agreed with Birmingham City Council and the citizen. Where work is required to rooms that citizens cannot readily make available then the works will be limited to one room at a time. Work shall then be completed so far as possible to each room before progressing to the next. It is essential that every care be taken when carrying out the works to minimise inconvenience and ensure the health, safety and welfare of the citizen whilst work is in progress. Importantly, the Service shall on completion of the works / at the end of each working day at the property leave all rooms / areas in the property where the Service has been working in a clean and tidy condition and maintain all necessary services for the owner / occupiers needs including any special requirements.

The Service will compass a number of service elements providing maximum opportunity for the delivery of positive outcomes for citizens. The Service must:

- Have a Health and Safety policy or procedure which is up to date and accords with current legislation. It should cover all potential risks.
- Ensure that there are regular health and safety inspections to identify risk, records of inspections, findings and the actions taken. It is essential that every care be taken when carrying out the works to minimise inconvenience and ensure the health, safety and welfare of the residents whilst work is in progress, regardless of disability or age.
- Take responsibility to identify the presence of asbestos and take safety measure to resolve the issue as and when appropriate.
- Ensures that the property remains suitable for occupation whilst the works are being carried out and where necessary, shall maintain the existing facilities or provide alternatives at all times for bathing, washing up, cooking, heating and sanitary accommodation, during the course of the works. The Service will be expected to raise any cases where the property would not be suitable for occupation during the works so that alternative plans can be agreed, on a case-by-case basis. Every effort should be made to ensure that the citizen can remain living within the property safely during the works.
- Ensure that all precautions must be taken to prevent damage to the existing structure and internal and external decorations. Temporary screens, weather proofing and dust sheets, must be provided and used where necessary to protect the existing structure, decoration, furniture and effects. Any damage that is caused by the service, or those they are responsible for, when not using this protection will be expected to be reinstated at their own expense. They will also be deemed responsible for meeting any claims arising from third parties for nuisance, negligence and/or damage as a result of the Works.
- Take all necessary measures to ensure that the whole of the existing structure, materials and plant shall be safeguarded from damage and / or theft and be responsible for providing such measures to prevent unauthorised persons from gaining access to the property. Any loss or damage to the property or contents resulting from the Service inadequacies / ineffectiveness shall be made good to the satisfaction of Birmingham City Council.
- Advise the occupiers, where necessary, of the need to move furniture and effects from an area to provide a suitable working space for the works to be completed. The Service may be asked to and will need to be able to assist with this operation.
- Shall inspect the property before work commences and complete a detailed schedule (dilapidation schedule) of the state and condition of the property that is signed and dated by all parties being the service, citizen or anyone authorised to act on their behalf should this be required.

- Lighting, Power and Water supply – the Service must not assume that they can use the existing supplies unless by prior arrangement and with a written agreement with the citizen. Importantly, this permission must be obtained 'prior to commencement' of any works and with an agreed and reasonable payment made to the citizen for its use if that forms part of that agreement, otherwise the Service must make their own arrangements that will be deemed to be included in their contracted costs. No extra costs will be paid through the contract to the Service for this provision.

The Service is not permitted to store materials in areas other than those areas agreed in advance with the citizen in line with health and safety protocol.

The Service is expected to supply and maintain vehicles as required in order to ensure that works can be completed within given timescales.

The Service staff will wear the company's corporate clothing including badges to enable citizens to recognise them as being from the Service.

The Service staff involved with installations will be competent, adequately trained and equipped with all the required tools and materials to carry out their role.

Service Staffing
The Service must provide adequate staffing and related support services to deliver the requirements of each of the service elements and to maintain effective business operations. This will include skills and expertise in project management, case management, planning, technical advice, Handyperson capability, and administrative support.

The Service will need a diverse workforce that can deliver support using a range of skills such as:

- Clear communication
- Listening skills
- Empathy
- Positive attitude
- Assertiveness
- Conflict resolution
- Situational awareness

The Service must comply with all statutory obligations relating to the recruitment, retention and employment of staff as outlined in the Contract General Terms and Conditions, including the safeguarding of vulnerable adults and children and the child protection, criminal record checks, health & safety at work, and a fair staff recruitment and selection policy.

As well as contributing towards the high-level outcomes described above, the Service will be expected to meet a number of targets relating to defined outputs. Key Performance Indicators are set out in each of the service elements.

The Service will be expected to use staff resources flexibly to respond to peaks and troughs in demand across the city.

Diversity and Inclusion
The Service will have a policy and procedure that covers equal opportunities, diversity, anti-discriminatory practice and harassment. The policies and procedures should be up to date and in line with current legislation.

The Service will ensure that the policy and procedures outline a planned approach to managing and responding to concerns or incidents and that the service understands and is sensitive to the diverse needs of the citizens.

Service Case Records

The Service will maintain comprehensive records of all enquiries and cases using the Council's preferred recording system, including contracts with, or made on behalf of, citizens. Copies of all correspondence and documents will be kept for a minimum of six years

The Service will keep detailed records of the process followed in each case, which can be made available upon request by the Council. The use of the Council's electronic management information system is required.

It is expected that the Service uses the preferred council IT solution to manage this contract as well as hold suitable IT software solutions which are compatible with Birmingham City Council electronic ordering and processing procedures and meet GDPR to work with sub-contractors. However, there must be a facility to receive orders by telephone, in exceptional circumstances if equipment is urgently required (for example to prevent a hospital admission), or if there is a breakdown of an IT system.

Payment to Service
All rates provided by the Service shall be fully inclusive of profits, overheads and insurances. Any additional work instructed during the course of work shall be carried out in accordance with the instructions provided at the time of the request for the additional works.

Discretionary Services
The Service will provide monthly invoices to the Council identifying individual property addresses where work has been ordered, date work was completed and VAT as a separate item.

Mandatory Services

The Service will submit invoices retrospectively to when work is completed linked to each individual property, interim invoices are acceptable.

The Council will pay all undisputed invoices submitted by the Service within 30 days of receipt.

Accessing Citizen's Property
The Service should assume the property will remain occupied whilst the mandatory or discretionary services work is being carried out. The access to the property shall be via existing access only.

The Service's working area will be confined to the boundary of any property. If access is required on to adjoining property, the Service must obtain that owner's permission and obtain a signed indemnity prior to entering the property. Any adjacent buildings must be afforded all necessary support, access, services and protection. Works to or in proximity to boundaries should be notified to any owners of adjacent land as detailed in The Party Wall etc. Act 1996.

The Service is deemed and expected to have visited the site prior to submitting the quotation and to have ascertained all local conditions and restrictions likely to affect the cost and duration of the execution of the works. Additional costs may be identified on the priced schedule, otherwise they are deemed to be included, and taken account of, in the contractor's quotation.

Service Standard of Workmanship and Materials
All work shall be carried out in accordance with the Building Regulations, as a minimum standard.

All materials and workmanship shall be in accordance with the latest edition of the relevant British Standard, British Code of Practice, or equivalent current at the contract date, hereafter collectively referred to "British Standard", except where the standard has been fully detailed in the specification and is of a higher standard than the British Standard. In the event of any dispute regarding acceptable tolerances, the permissible deviations details in the British Standard will be applied.

In the absence of a relevant British Standard, materials and products shall be certified by the British Board of Agreement and installed in accordance with the requirements of that certificate and manufacturers recommendations. If the manufacturer's instructions differ from the British Standard, the manufacturer's instructions must be followed – warranties / guarantees may otherwise be affected.
All materials and products used shall, wherever possible, reduce maintenance / be maintenance free and environmentally friendly.

Where and to the extent that materials, products and workmanship are not fully specified, they are to be suitable for the purpose of the works stated in, or reasonably to be inferred from, the contracts documents and in accordance with good practice.

The Service shall follow manufacturer's recommendations and instructions with regards material storage, fitting and fixing, and introducing materials and / or products into the works. The Contractor shall have regard for designer duties and responsibilities in respect of Health & Safety Regulations, CDM Regulations, and Lifetime Homes issues.

The Service shall ensure compliance with the Council's Birmingham Business Charter for Social Responsibility in respect of the purchase of materials / products.

Communication
The Service will employ methods of communication that are appropriate for use with vulnerable people, including people with physical and / or sensory impairments, older people, and where English is not a first language. It is essential to identify the preferred communication methods of individuals and to comply with the Accessible Information Standards.

The Service is responsible for arranging an appropriate interpreter, should this be required. No extra costs will be paid through the contract to the Service for this provision.

The Service is required to maintain a high standard of consideration, courtesy and will treat citizens with dignity and respect at all times.

The Service will contact citizens, prior to any surveys or installation of recommended works. The Service will ensure that citizens are informed of any delays or changes in a timely manner.

The Service will have a robust protocol in place for when they have been unable to contact a citizen to complete a survey and or recommended works.

Where the Service is unable to complete the requested recommended works due to feasibility or service being declined by the citizen, the contractor will contact the Staying Independent at Home Adaptation and Improvement team within 48 hours.

Defects and Anomalies
The Service shall notify Birmingham City Council immediately (and no later than 24 hours following identification) of any defects, anomalies or errors that may be discovered that are likely to delay the works or cause a subsequent delay if they are not attended to. If the Contractor knowingly conceals information / the works, he may be required to expose the area / item and if found defective or inadequate he shall make good at their own expense.

Rubbish and Debris
The Service shall remove all materials and debris from the site as it accumulates and is expected at the end of each working day to leave the site in a clean, safe and tidy condition. In the event damage is caused to the citizen's property due to poor cleaning methods, lack of removal of rubbish and debris the contractor will be responsible to remedy this at their own cost.

Protection from Inclement Weather
During the course of the works the Service shall take adequate measures to protect against inclement weather and keep the property and its contents secure and protected from the elements

at all times. Should the Contractor ignore this, then they can expect claims for damage and loss from the citizen, and any claims for extension of time to the works will be rejected as a result of their negligence / ineffectiveness.

Supervision of works
The Service shall at all reasonable times keep upon the works a competent person (Contract Manager) in charge to accept responsibility for programming, information, co-ordination and monitoring of works, statutory authorities and suppliers engaged for the works.

Safeguarding
The Service will have a policy and procedures in place for Safeguarding and protecting vulnerable adults and children. These should cover:

- A Code of Conduct for all employees which sets out the professional boundaries between citizens and staff.
- Procedures to prevent staff from personal benefit when working with vulnerable citizens.
- A clear procedure for reporting and recording any individual concerns from staff, citizens or from others, that ensure that prompt action is taken.
- Training for staff on how to recognise any safeguarding issues, how and who to report any actual or suspected incidents to.

The Service will ensure that they carry out recruitment checks including professional references and DBS checks for all staff that are involved in the delivery of the service including subcontracted staff. These should be renewed in line with national guidance.

The Service will ensure that staff receive appropriate training to understand their role in safeguarding vulnerable adults and children.

Civil Emergency, Business Continuity and Service Resilience
The Service will need to have a clear business continuity plan in plan on how the Service will be able to respond in times of civil emergency and how you will ensure the Service can still be delivered.

Sub-contracting
The Service will be expected to have a **minimum of 10** local contractors/organisations as part of their delivery mechanism. All sub-contractors must be local (local is defined as 30 miles from the Birmingham Boundary this is in line with the Birmingham Business Charter for Social Responsibility Charter). The Service must ensure that all due diligence is completed on the relevant proposed sub-contracted partners including, but not limited to:

- Staffing
- Financial standing
- Health and safety
- Insurances
- Training and competencies

The Lead Provider will be responsible for ensuring that all works completed by any sub-contracted partner is to the standard as detailed within this service specification and that required in the British Standard or relevant legislation at the time of the works.

There is an expectation that the Service **MUST** sub-contract a minimum of 50% of the works, this will be measured by the number of jobs allocated during each contractual year, information must be provided on a monthly basis. This will be measured as a Key Performance Indicator throughout the contract term.

The Lead Provider is expected to treat their sub-contractors equally and fairly with the same terms and conditions as is expected of the Lead Provider especially in consideration of rates of pay, timescales for payment and opportunities for staff development.

Service Development and Innovation
The Service is expected during the period of the contract to work together with the council to ensure the service is responsive to emerging and identified local needs. Any changes to services or how they are developed will be negotiated between the parties.

Technology has the potential to transform the way in which citizens receive care and support in the future. It is expected that, as technology advances and the city develops more resources for the utilisation of technology, the Service will need to adapt and flex the way in which works can be delivered throughout the contract term.

Exclusions to the Service
There are no grounds for exclusion and the provider will be expected to work proactively to reduce barriers to accessing the service.

Citizen Groups out of Scope for the Service
- Those who meet the threshold for residential care
- Those who have no care or support needs
- Major works to council properties

Service Record Keeping/Data Collection/Information Sharing
In line with contract the Service will ensure that robust systems are in place to meet the legal requirements of the General Data Protection Regulation (GDPR) to ensure the safety and security of any citizen data that the Service holds.

The Service will have agreed Data Sharing protocols with partner agencies to enable effective, holistic services to citizens.

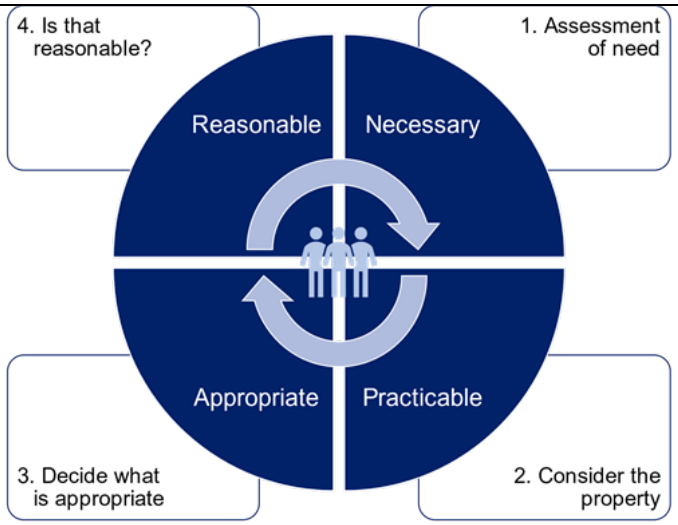
The Service will ensure that all staff have access to information sharing guidance including sharing information to safeguard or protect vulnerable adults, improve coordination and communication between services.

Referral Methodology
The Service must ensure that any referred or transfer of information is **not** sent by paper, post or fax. All information and communications will be stored and transmitted electronically. The provider and its partners must ensure that there is at all times a secure and safe method of electronic data recording and transfer/exchange of information.

The Service must be assured at all times that it has a robust security and back-up system to negate any risk to the loss of data or security breaches.

4. Mandatory Service Element

Eligibility
Support for major adaptations will be available to disabled individuals as defined by the Housing Grants, Construction and Regeneration Act 1996, who have been assessed by an Occupational Therapist and for whom a Statement of Need has been produced, and who need support to complete the adaptations. Priority will have been determined prior to the case having been referred to the lead provider. The Service will be responsible in collating the information and evidence to support Appropriate and Reasonable alongside the relevant Occupational Therapist or equivalent professional.



The provision of major adaptations to the home through the Disabled Facilities Grant (DFG), can be an overwhelming experience for vulnerable people who are often too ill, isolated, or distressed to cope with what remains a complex process.

The Service will be responsible to ensure that the most cost-effective scheme of works to meet the recommendation of need made by the Occupational Therapist is devised. This will include identifying any necessary repairs and improvements required in the property in line with the Staying Independent at Home policy, including comprehensive and competent technical support to supervise the project.

Some of the major tasks to be undertaken are to include:

- Select an appropriate workforce to meet the needs of the citizen and the requirements of the project; and agree with the citizen which contractor to engage and put in place the necessary contract arrangements.
- Identified contractor per citizen
- Arrange a visit to the citizen's property to devise the most cost-effective scheme, completing a financial evaluation of the required works using agreed unit rates to meet recommendations made by the OT; to include identification of any risks, hazards which would need to be mitigated in order to deliver the works e.g. asbestos testing.
- For discretionary works CAD drawing or equivalent of proposed works.
- For Mandatory works CAD drawing of proposed works.
- For all building works the lead provider will need to seek approval from the Council prior to sharing any drawings/scheme ideas with the citizen.
- Once permission from the Council to proceed with the scheme is received the lead provider is responsible to ensure the citizen/the property owner is in agreement with the proposed works as well as obtaining any necessary permissions prior to works on site commencing, including preparation and submission of any forms, plans, drawings, asbestos checks and other relevant documents on behalf of the citizen, e.g., planning, party wall agreements, Severn Trent etc

The Service will be required to support in identifying at the time of completing a financial evaluation of the works when alternative living arrangements are necessary for the Citizen when works are in progress. This should only be raised when necessary and agreement sort from the Council. On the whole citizens will remain in situ while works taking place.

Full detail of the technical aspects of the works are included in **Appendix 1 Technical Specification**.

The Service will ensure that:

- all works are undertaken in accordance with health and safety and other relevant construction industry legislation, guidance, national standards and technical specifications.
- Keep citizens informed of progress in line with key performance indicators and works being completed.
- Ensure that all work progresses in line with KPIs, and is completed, satisfactorily. This will involve carrying out site visits and inspection of works
- Ensure that adequate variation and defect procedures are in place to ensure the satisfactory conclusion of works
- Assist the resolution of any disputes that may occur between citizen and contractor
- Obtain any certificates and guarantees provided in association with the works (e.g., damp-proofing, timber treatment, gas, electrical or glazing installation) and provide to the Citizen and the Council copies of permissions, guarantees, etc, on conclusion of the project.
- Provide technical support to Occupational Therapists (OTs), when asked, regarding the feasibility of the proposed adaptation.

The Service must work closely with all those involved including the citizen, OTs, social care professionals, sub-contractors and others to ensure the most efficient and effective process for what, in the specific case of a major adaptation, will be a pre-determined outcome.

The Service will develop shared protocols and working arrangements and share monitoring information with other stakeholders as required.

Service Referral Arrangements
Referrals for this service will come directly from the Birmingham City Council, Staying Independent at Home Service.

Key Performance Indicators
Mandatory Provision

- Contact to be made with citizens within **48hours** of receipt of referral.
- Scoping of works including the submission of approval paperwork should be completed within **15 working days** of an initial visit, with the exception of larger works which include an extension a period of **30 working days** is allowed.
- From the Council approving a scheme this should be shared with the citizen and homeowner for agreement within **5 working days** and subsequent approvals need to be shared with the Council.
- From the point of a purchase order being raised the provider is required to complete internal works within **12 weeks** and external works within **24 weeks**.
- Completed works should be invoiced with supporting documents no later than **10 working days** from the works being completed.

Preferred Option

- Contact to be made with citizens within **48hours** of receipt of referral.
- Scoping of works this process should be completed within **15 working days** of an initial visit, with the exception of larger works which include an extension a period of **30 working days** is allowed.

5. Discretionary Service Element (including minor works and key safes)

Eligibility
Support for discretionary services is considered for supporting hospital discharge or to support a citizen to remain within their own home avoiding long term residential/nursing placements. This is the delivery of assistance and support detailed as part of the Staying Independent at Home Policy.

Examples of the types of works that could be delivered are:

- Key safe installation
- Grab rails

- Electrical works
- Heating and affordable warmth
- Safety and security

Full detail of the technical aspects of the works are included in **Appendix 1 Technical Specification**.

The Service is responsible for completing a scoping exercise to identify the most cost-effective works to meet the recommendations provided.

The Service is responsible for ensuring the appropriate owner permission is in place prior to providing the recommended works and should aim to complete the costing exercise and delivery of the works at the same visit. The only exception would be when the required discretionary works exceed the value of £5,000. For these cases escalation to the SIAH Team should be made within 48hours for Council approval to be given.

Once Council approval is received works should be completed in line with original priority time given on initial referral, which would commence from the day of approval being received.

Service Referral Arrangements
Referrals for this service will come directly from the Staying Independent at Home Team.

Key Performance Indicators
The Service is expected to respond in the following timescales:

Works under £1,000

- Hospital Discharge - hospital discharge referrals have to be prioritised and completed within **24 hours** after receiving the order (Exceptions would be for privately rented accommodations when permission is needed from landlords prior to starting the job)
- Urgent - urgent priority referrals should be completed within **48 hours** from receiving the order. Exceptions would be for privately rented accommodations when permission is needed from landlords prior to starting the job.
- None-priority – None-priority orders should be completed within **7 days**. Exceptions would be for privately rented accommodation when permission is needed from landlords prior to starting the job.

Works between £1,001 - £10,000*

- All requests for works are booked for scoping within **24 hours**.
- Hospital Discharge/Urgent - hospital discharge and urgent referrals have to be prioritised and completed within **7 days** after receiving the order (Exceptions would be for privately rented accommodation when permission is needed from landlords prior to starting the job)
- None-priority – None-priority orders should be completed within **28 days**. Exceptions would be for privately rented accommodations when permission is needed from landlords prior to starting the job.

*any works over £5,000 require approval from the Council prior to works commencing.

As detailed in Mandatory works the Service will be responsible for ensuring recommendations made by the Occupational Therapist or suitable professional are costed using the agreed unit rates.

6. Applicable Quality Requirements

Contract Quality and Performance Monitoring
The Service shall meet the service quality standards in the Contract. The Service will maintain systems for assuring quality based upon the principles of:

- Best value and continuous improvement, and,

- Self-assessment – ensuring that day to day responsibility for the quality of the service is managed primarily by the Lead Provider.

The Service will be expected to submit timely and accurate information, as requested by the Council and in line with agreed Key Performance Indicator's as detailed within this specification and the contract agreement.

The Service shall carry out a citizen satisfaction survey after each work allocation is completed with citizens, this information should be collated and submitted to the Council on a monthly basis as part of the performance monitoring for the contract. This survey will be developed with the Contract Manager after contract award**.** A return rate of at least 80% for feedback forms, and a 'very good' or 'excellent' satisfaction rating in at least 95% of cases will be required.

The Council will also carry out annual reviews of the Service to ensure that the service is meeting the purpose and objectives. This will include an evaluation of how the service is performing against the KPI's and will consider progress made as well as reviewing service delivery for the following year.

In addition to meeting quality standards, other monitoring arrangements will be required to cover not only routine matters such as the reporting of performance against targets, citizen satisfaction etc. but also more strategic issues such as service development and engagement with commissioners, citizens and their representatives etc.

Complaints

- The Service will have a clear written complaints procedure for dealing with any complaint relating to this service.
- The Service will keep a record in a form agreed by the Council of any complaints received about the service. This should detail the action taken by the Service as a consequence of the compliant.
- The Service must comply with the Councils procedure whenever a complaint has been made by a third party directly to the Council.

Appendix 1
Technical Specification

Birmingham Staying Independent at Home Adaptation & Improvement Service Technical Specification

Birmingham City Council

Technical Specification – Section 1 – General

All areas of Mandatory and discretionary works are to be provided in line with this document. Both Service Specification, Technical Specification and Unit rate documents are to be read in conjunction with other relevant documents and works provided according with current building regulations at the time of construction.

1.1 ACCESS TO AND USE OF BUILDINGS

1.1.0 RAMPS-General

The following considerations must be considered when designing ramps, and the requirements of the Building Regulations Part M, and BS8300 current at the time of the construction:

- Ramps/sloping surfaces should have a finish that reduces the risk of slipping. (Recommended: 600 x 600 x 50mm thick bar-faced pre-cast concrete paving slabs bedded solidly on a prepared subbase of 50mm sand / cement blinding on 100mm compacted good clean hardcore, including a weed inhibitive treatment).

- Have flights/landings whose surface widths are at least 1500mm, and with an unobstructed width of at least 1500mm or 1200mm is permissible, where space is limited. (Note: Contractors should be aware that ramps are individual and designed specific to the user's needs, and importantly the size of the user's wheelchair must be taken into consideration in every individual case – it should not be assumed that 'one design suits all).

- At changes of direction on the ramp a platform is to be constructed if space allows to a minimum plan size of 1500mm x 1500mm. When space is limited then a 1200mm x 1200mm platform is to be constructed with an added inside angle cut at 45° to assist the travel of the wheelchair.

- The ramp should not be steeper than 1 in 20 with a max rise of 500 mm when individual flights are 10 metres. Or no steeper than 1 in 15 with a max rise of 333mm when individual flights are between 5 and 10 metres. And 1 in 12 with a max rise of 166mm for flights between 2 metres and 5 metres. With no single flight being longer in length than 10m or greater in rise than 500mm

- When the total rise is greater than 2 metres, then an alternative means of access, such as a lift, should be considered for all wheelchair users.

- In each case additional consideration should be given to the following circumstances:

  a) Attendant Propelled Wheelchair:
  Ramp should preferably be at 1in 15, and for safety no steeper than 1 in 12.

  b) Self-Propelled Manual Wheelchair:
  Ramp should be no steeper than 1 in 15.

  c) Scooter or Motorised Wheelchair:
  Ramp should be on steeper than 1 in 12.

  d) For ambulant users:
  Only one handrail may be required at the side of the ramp; however, each case should be judged specifically on the individual user's needs.

- It should have top and bottom landings described above of at least 1200mm, and when

required, intermediate landings whose lengths are not less than 1.5 metres**.**

In all cases the ramp shall be clear of any door swing, or other obstructions such as window openings.

- It should have a raised kerb at least 100mm high on any open side of a flight, or landing area.

- When the length of the ramp exceeds 2 meters it shall have a continuous and suitable handrail on each side of flights and landings.

1.1.1 General Design Considerations

- There should be adequate visibility and manoeuvring space at the top and bottom of the ramp/s.

- *When deciding on the design and layout of the ramp consideration should be given to both the disabled user and their carer. The user's medical condition and the carers' capabilities are important issues that may dictate the design for that particular ramp.*

- *In all cases the medical condition must be taken into account.*

- The preferred minimum clear surface width of a ramp is 1500mm, and requires particular care and attention when deciding on the proposed route of the ramp so as to avoid potential hazards such as pipes, drains, window or door openings, projecting brickwork etc. Areas where a door opens onto the ramp or directly onto the platform area in the path of the wheelchair should be avoided.

- It is usual for ramps to bridge the horizontal dpc's of structures/dwellings. Whenever practical the ramp should be independent of the structure/dwelling, and a 100mm gap maintained between the ramp and the structure/dwelling. The gap should be filled with 50mm of clean pea gravel, the top of which shall finish a minimum of 150mm below the line of the dpc. When this is not possible, a vertical damp proof membrane of rigid material should be positioned against the structure and be continuous with the existing dpc. All measures should be taken to avoid bridging the dpc. Consideration should also be given in the design to the insertion of drainage pipe to remove the water if it is likely to be trapped between the ramp and the adjacent structure.

- A kerb must be provided to the exposed side or sides of any ramp, including platform areas, and have a minimum upstand of 100mm. Retaining walls adjacent to a ramped area shall also have a minimum upstand of 100mm.

- At the junction between the landing area and the door opening into the building a 'proprietary polymer concrete' or metal continuous 'U'-shaped cross section drainage channel (100mm deep and 100mm wide) fitted with a continuous metal open grid flush or just below the floor level (door threshold), to discharge into an existing drain or to a newly constructed/existing soak away.

1.2 THRESHOLDS

1.2.1. EXTERNAL

A nominally level safe area should be provided immediately in front of a door to enable easy operation of that door by the wheelchair user. Platforms/landings should be 1500mm x 1500mm and be clear of any door swing. They should be provided at the top and bottom of the ramp, and when necessary, at intermediate points.

Timber or raised thresholds should be avoided. If a situation arises when this is not possible, and there is no alternative then the height of the threshold should be a maximum of 15mm.

Proprietary brands of draught excluder, the type having a flexible centre to prevent draughts whilst allowing the passage of a wheelchair should be considered.

1.3 CONSTRUCTION OF RAMPS

1.3.1 RAMPS - not exceeding 300mm high

Sides can be constructed using a slab-on-edge detail. When used the slabs should be set in the ground at a minimum depth of 300mm and bedded in concrete surround (1:2:4 mix). The ramp is to be constructed with 600 x 600 x 50mm thick bar-faced pre-cast concrete paving slabs bedded on 50mm sand / cement blinding on a 100mm layer of clean, crushed and well compacted hard-core. The excavation to the proposed ramp area down to formation level shall be a minimum of 1500mm wide.

Handrails: pocket holes are to be excavated for the vertical members and at the appropriate centres as per specification the detail drawing/design, the poles when positioned in the pockets shall be surrounded/ backfilled with a lean mix concrete. Vertical poles are to be connected to the horizontal rails by means of a proprietary brand of mechanical fittings/fixings. Upon completion all disturbed surfaces are to be made good.

1.3.2 RAMPS - exceeding 300mm high

Retaining wall to side/s of ramp:
Foundation to be excavated to a minimum depth of 450mm.
Concrete (1:2:4) foundation to be laid 600mm wide x 150mm deep.
Wall to be constructed in 215mm semi engineering Class B brickwork,
Top of the wall to be finished with Class 'B' semi engineering brick-on-edge coping detail.

Ramp construction
600 x 600 x 50mm thick bar-faced pre-cast concrete paving slabs bedded on 50mm cement blinding on a 100mm layer of clean, crushed and well compacted hard-core.
The excavation to the ramp area down to formation level shall be a minimum of 1200mm wide.

1.3.3 HANDRAILS AND BALUSTRADES

Handrails must be a proprietary brand that includes all fitting including brackets and joints. When handrails are fixed to the house wall, the wall is to be drilled and plugged, and the brackets screw fixed with galvanised screws. Where the ramp forms an integral part of the yard area, slip resistant slabs can be used.

Handrails / Balustrade are to be to be formed from 45 - 50mm outside diameter galvanised mild steel, or aluminium tubing, adequately supported and with no sharp edges, from a proprietary brand that includes all fitting including brackets and joints, including a midrail.

A minimum of 50 – 75mm spacing is to be provided between the handrail and wall. Handrails are to be fitted to ramps at a height of 900 - 1000mm from the surface of the ramp (up to1100mm on landings), and on each side of open flights. And landings when the length of the ramp exceeds 2 metres.

Generally:

- Vertical members to support the handrail / balustrade to be at a maximum of 1.5metre centres with the excavated pockets backfilled with a lean mixed concrete.
- Handrails / balustrade should extend at least 300mm beyond the start and end of the ramp, or the top and bottom of a flight of steps and terminate with a closed end turned down for safety.
- The extended ends of the handrail / balustrade should not project into the route of travel.

- The handrail should not be positioned more than 100mm beyond the surface width of the ramp when fitted to an adjacent wall or supported on vertical posts.
- When fitted to a wall/structure there should be a minimum 50mm uninterrupted space between the wall/structure and the handrail.

1.4 STAIRS/STEPS

The following considerations must be taken into account when designing steps, and the requirements of the Building Regulations Part M, and BS 8300 current at the time of the construction:

1.4.1 General Guidance:

The needs of people with disabilities differ, and their individual needs should be catered for. Some ambulant disabled people find it as easy to negotiate a ramp as they do a stair. Therefore, other alternatives for means of access will be employed.

People with impaired sight are at risk of tripping or losing their balance when meeting sudden changes of level. People who wear callipers or who have stiffness in hip or knee joints are particularly at risk of tripping by catching their feet beneath the nosing or slipping on the tread. It is important that tread dimensions allow for both feet to be placed squarely upon it.

The design consideration for stairs must meet with the requirements of the Building Regulations. In addition, incorporating winders and splayed steps should be avoided. When this is not possible these should be incorporated at the bottom of the flight rather than at the top. A splayed nosing on the tread is preferable to square/protruding nosing, and the tread shall have a non-slip surface.

- Flights should have an unobstructed width and length of at least 1200mm.
- The rise of a flight between landings should have no more than 12 risers for a going of less than 350mm. And no more than 18 risers for a going greater than 350mm
- The flight of steps should have top and bottom landings, and when necessary intermediate landings, the lengths of which should be a minimum of 1200mm, and be clear of any door swing, opening window or other obstruction.
- The rise of each step shall be uniform and not exceed 170mm (150mm preferred)
- The going of each step should not be less than 280mm and no greater than 425mm. For tapered steps (winders) the 280mm going should be measured at a point 270mm from the inside of the stair.
- The risers should not be open. And both riser and going of each step should be consistent throughout the flight
- The projection of a step nosing over the tread below is to be avoided.
- There is to be a suitable and continuous handrail on each side of the flights of steps, and any landings, when the flight comprises of two or more risers.

1.4.2 EXTERNAL - Steps:

Construction:

Side walls: are to be constructed in 215mm thick semi engineering Class ‘B’ brickwork on 500 x 150mm (1:2:4) concrete foundation, at a minimum of 450mm below ground level.

Landing: be formed with 600 x 600mm non-slip paving slabs

Steps: to have a minimum of 50mm end bearing onto the side walls. The treads are to have a non-slip finish, and there is a continuous handrail on each side of the flight and landings if the rise of the stepped approach comprises of two or more risers.

External Half Steps:

Existing steps may require alteration in size and profile.

Two existing steps each of 250mm may need to be made into four steps of 125mm each.

Each step ideally being the size of a paving slab (600 x 600 x 50mm) positioned parallel to the door and having a non-slip finish.
The design of all steps must meet with the criteria for stairs.

Step Construction:
Side and front walls: to be constructed in 215mm Class 'B' semi engineering brickwork, built off a 500mm x 150mm (1:2:4) concrete foundation cast at minimum of 450mm below ground level. Steps: to be formed with 600 x 600 mm non-slip paving slabs with 2 courses of Class 'B' semi engineering bricks to form 150mm high risers. Nosing – all overhangs should be avoided.

1.5 DOORS

1.5.1 General Guidance:

Physically impaired people often experience difficulty with internal doors because they are unsatisfactorily positioned, not wide enough, or have unsuitable ironmongery fitted. Small rooms will be easier to use if the door is hinged to open outwards. Care must be taken so that door swings do not conflict.

When a door opening needs to be widened, consideration must be given to the positioning of the new door.

The preferred standard door size is a 900mm door set with at least a clear opening width of at least 800mm for straight on approach

Side hung doors that may be awkwardly sited for a wheelchair user may be replaced with

Sliding doors that can be pushed open in either direction. Glazed swing doors, when installed, should be safety glazed (to BS 1992) to minimise the hazard, limited to the top of the door and be in accordance with the Building Regulations current at the time of the construction.

Whenever possible side hung doors fitted with gentle rising butts should be used in preference to sliding doors. If the design needs a larger opening i.e., double doors, then one of the leaves is required to give a clear 800mm opening.

Internal sliding doors or external patio doors must give a clear 800mm clear opening leaf. When patio doors are used, careful detailing is required give a flush threshold detail i.e., raising the carpet or floor finish in such a way as to be flush internally with the top of the bottom member of the door frame section.

1.5.2 DOOR FURNITURE

- Door handles and pulls are to be carefully positioned, easy to grasp, readily distinguishable from the door, be robust and securely fixed (note: some users will use them for support as well as for the operation of the door).
- Lever handles with a return are preferable to knob sets for effective grip. Easily openable using one hand using a closed fist
- Closing pull handles should be considered for wheelchair users.
- Door handles/pulls/locks etc should be fitted at a height between 900 - 1100mm above floor level (1000mm is the preferred height and positioned to suit the user's particular requirements).
- Vertical pull handle bottom fixing height - 1040mm above floor level.
- Closing pulls (for a wheelchair user) are to be 300mm long positioned 1040mm from floor level, and 250mm away from furthest part of the handle.

Sliding doors, should be avoided, but if necessary are to be fitted with auxiliary 'D' handles on

both sides to 915mm wide door sets and should give 800mm wide clear door opening. Using a recessed door handle on the inner face can increase the door opening by a further 100mm, but this may cause problems for users with poor grip and/or wheelchair users. If this is not achievable, then a wider door set should be fitted.

Locks or bolts provided to bathrooms and WCs' doors are to be of a type that can be opened from outside in case of emergency. When a door to a bathroom/WC opens inwards and it is considered that the user could be trapped inside if they fell against the door, the door should then also be fitted with 'lift-off' type hinges, and locks or bolts that can be operated from the outside. Alternatively, and when practical to do so, the door should be re-hung to open outwards.

1.5.3 KICKING PLATES

To protect the bottom of doors from damage from wheelchair, and some walking aids, plastic laminate kicking plates 400mm in height x width of the door should be fitted.
Note: Metal kicking plates are easily scratched and can damage the metal parts of some wheelchairs, but if specified then the edges should be bevelled, and corners rounded.

1.6 WINDOWS

1.6.1 General Guidance:

Windows should be designed so they can be operated with a clenched fist and may not require simultaneous use of both hands.

- The window opening device should be between 800 – 1000mm above the finished floor level.
- The window cill height shall be a maximum of 800mm above the finished floor level.
- The wall area directly beneath the window should be kept clear of any obstructions that might prevent easy operation of that window.

1.7 CIRCULATION SPACES

1.7.1 **General:**

Standard wheelchairs for independent use or pushed by an attendant, require a minimum clear width for movement in a straight line of 800mm, and 850mm for the larger wheelchairs. Self-propelled standard wheelchairs require a minimum clearance of 900mm.

1.7.2 **TURNING SPACES (ASSESSMENT TO CONFIRM TURNING CIRCLES)**

The passage width needed to turn a wheelchair through a door opening is usually governed by the width of the door opening. The allowance for comfortable turning through a door, given an opening width of 800mm, the passage should be a minimum of1500mm wide. And for 1200m wide passageways the opening width of a door should be a minimum of 825mm

Note: for ambulant disabled people i.e., people with walking aids, the above passage widths are acceptable.

Note: the space required to turn a self-propelling wheelchair is dependent on the size of chair, the capabilities of the user, and the position of the main wheels. For standard wheelchairs the preferred turning circle area is 1.5metre diameter (It is more economical on space to carry out a 3-point turn). In areas where doors will be opening off the ramp the passage widths will need to be at least 1200mm.

1.8 EXTERNAL SURFACES

1.8.1 **GARDEN PATHS**

Garden paths should be at least 1200mm wide with a non-slip surface. Slabbed paths should be flush pointed and treated to prevent weed growth.

1.8.2 **DROPPED KERBS**

Ramped kerbs should be installed for wheelchair users. Kerbs should be dropped to a maximum height of 30mm above the adjacent highway, with a pavement surface gradient not exceeding 1:10. The surface of the ramped area should have a textured pattern, or coarse aggregate finish to prevent slipping (unsealed aggregate surfaces must be avoided) and have a width between 1200-1800mm.

Note: The Contractor may be expected to apply for the required Planning Permission for a dropped kerb to be installed over a public footpath.

1.8.3 GENERAL - SURFACES

For independent wheelchair users, pavements, paving, paths etc, should have a gradient not exceeding 1:20, and be constructed using paving slabs, bitumen macadam, tarmac, or asphalt. **Unsealed gravel surfaces must be avoided**.

When pre-cast paving slabs or comparable block materials are used, they shall have a ribbed/non-slip surface, and laid evenly with joints flush pointed.

1.9 BATHROOMS/LEVEL ACCESS SHOWERS – Flooring

A slip resistant floor finish should be provided to floor areas for all users. Both when dry and when wet. With a minimum slip resistance value of R10.

1.10 WASH HAND BASIN

The option of a wall mounted wash hand basin, fixed on heavy-duty brackets, should be provided that allows knee space underneath if required.

The height of the wash hand basin must be decided with the customer on site. (The suitable average height range for wheelchair and ambulant people is 600-740mm from finished floor level to top of basin)

A clear space of 380mm should be allowed to the side of the wash hand basin for fitting of rails.

Lever taps, when specified, should have clear ‘hot’ and ‘cold’ markings and the user should be given a choice of lever lengths. And be capable of being operated by using a closed fist.

A double row of 150mm x 150mm (or equivalent area) tiled splash back should provided

1.11 WATER CLOSET’S

A minimum distance of 450mm should be maintained from the center line of the WC and the adjacent wall, 500mm is preferred. Radiators should be kept clear of this area. A low level, wash down suite (not close coupled), with a lever type flushing mechanism fitted on the outside of the WC cistern should be used. The preferred height of the WC should be 480mm from finished floor level.

1.12 BATHS

Baths: shall normally be a rectangular pattern min. 8mm thick, size 1700 x 700 x 400mm, and include a grab handle, waste, chain and plug, overflow, 2no. 22mm indexed chromium plated brass - easy clean pillar taps, plastic overflow and waste trap. (Please note that any standard bath installation should only be included when identified as part of a formal Occupational Therapists assessed recommendation)

1.13 SHOWER ROOMS

Shower trays should have a min wet area of 1200mm x 1200mm (or equivalent) wherever possible. But not less than 800mm in any direction. To have a fall of 1:60 to the floor of the tray.

Should be installed in accordance with the manufacturer's installation guidelines and should be a minimum of 800mm wide. With a preferred size of 1200mm x 1200mm.

1.14 LEVEL ACCESS SHOWERS

The floor should be laid to fall away from the door accessing the room in which the level access shower is located. And be provided with the maximum drainage outlet to minimize/prevent standing water. The floor should drain towards an approved trapped floor gully, fitted with a top/grating that can be easily removed for cleaning.

All flooring materials to all the floor area of shower rooms should be impervious to water and a have slip resistant finish (min R10) suitable for wet areas, and be laid in accordance with manufacturers specification, and have similar material used for coved skirtings/upstands.

A non-slip sheet vinyl can used on both timber or concrete floors fitted to an appropriate underlay or marine ply base.

Abrasive vinyl sheet flooring to be an approved safety flooring, hot welded and laid in accordance with manufacturer's instructions and with their recommended adhesive and sealants. Floor coverings are to be laid by manufacturers approved installers.

Pre-formed shower trays should preferably be square in layout with a 1200mm x 1200mm base size. Have easy access and be dependent upon the surrounding environment. A minimum dimension of 800mm in any single direction may be considered, where necessary.

1.15 SHOWER UNITS

The shower unit must be thermostatically controlled. And incorporate an appropriate anti-scold device.

The shower unit should normally be positioned to suit seated user – between 750mm and 1000mm above floor level.

In the case where the shower is to be used by both seated and standing people. And depending on installed shower tray layout. It may be necessary to make adjacent adjustments to both the height/location of the control box and the height/location of the riser bar. Extended rails and hoses should be used when necessary to suit the user's particular needs. Recommended range for detachable shower head, to be between 1000mm and 1400mm. All exposed pipe work shall be 15mm dia. and chromed. No pipe runs will be allowed in shower areas at low level.

The Service is to arrange for a 5-year guarantee to be provided to the citizen

1.16 SUPPORT RAILS

1.16.1 Vertical and horizontal support rails to be positioned within the shower area for support and/or to pull the user up to a standing position, all as instructed on site. To have a non-slip easy-grip contoured surface and made of either nylon-coated steel or plastic.

1.16.2 Drop down rail should be of nylon coated steel, with a non-slip easy grip contoured surface and securely fixed to the wall or floor surface.

1.17 SHOWER CURTAINS

Corner 'L' or 'U' shaped rails should extend sufficiently to cover the minimum wet area of the preformed shower tray layout and have a corner ceiling support. The rail height, and/or the double hooks should be adjusted so that the curtain finishes 10mm or less above the finished floor level – the curtain height should be a minimum of 1800mm in height with a weighted bottom and must not hang in standing water. Fixed shower screens are at the discretion of the

Occupation Therapist and will only be permitted where an assessed need has been established.

1.18 WALL TILES

Wall tiles to shower area shall be full floor to ceiling wall height and to a minimum area of 8m2. Fixed with waterproof adhesive and grouted. All in accordance with manufacturer recommendations. Plastic nosing strips to be used in ‘all cases’ where edges of tiles are exposed.

An appropriate aqua based wall tile backing board should be used in all exposed wet areas

1.19 SHOWER ROOM EXTENSIONS

Minimum preferred internal measurements shall be 2300 x 2300mm – (see Standard Drawing for preferred internal layout) All design and build criteria to comply with regulations current at the time of construction. A set of full architect prepared layout drawings to show both existing and proposed layouts are to be submitted by the Service, as part of the quotation pack for Birmingham City Council’s consideration, prior to formal scheme approval.

1.20 BATHROOM EXTENSIONS

Minimum preferred internal measurements shall be 2300 x 2300mm – (see Standard Drawing for preferred internal layout) All design and build criteria to comply with regulations current at the time of construction. A set of full architect prepared layout drawings to show both existing and proposed layouts are to be submitted by the Service, as part of the quotation pack for Birmingham City Council’s consideration, prior to formal scheme approval.

1.21 WC EXTENSIONS

Minimum preferred internal dimensions shall be 1500mm x 2000mm – see Standard Drawing for preferred internal layout. And should comply to the same specification standards as new build shower room extensions

1.22 LOBBY SPACE

A ventilated lobby space is to be provided for external access only. Where there is no other alternative to provide a suitably located external access point. Then the minimum preferred internal dimensions of the ventilated lobby space should be at least 1200mm wide, preferably 1500mm, to allow for wheelchair turning space.

Technical Specification – Section 2 – Level access showers and kitchens

2.1 LEVEL ACCESS SHOWER ROOM / KITCHEN EXTENSIONS

2.1.1 GENERALLY

All external walls are to have the outer skin built in fair-faced brickwork to match the existing including the third return wall to the neighbouring property. The citizen shall be given a choice of six colours of bathroom fittings, kitchen units, tiles, and flooring from a manufacturers standard range, and have a choice available of optional extras e.g., lever taps, mixer taps, for sanitary fittings and sink units and pelmets and cornices for kitchen cupboards etc. They shall be of a good quality and able to stand the rigours of normal use considering the application. The layout shall be discussed and agreed in writing with the citizen, with a plan drawn up if required before the contractor orders any materials or puts any work in hand.

2.1.2 HEATING

All bathroom extensions are to include for a heating appliance that provides a reasonable level of background heating for the purpose (criteria being 18°C non-habitable rooms and 21°C in habitable rooms). Electric convector fan heaters, or oiled filled radiators, are not an acceptable means of providing background heating to satisfy the above. This type of heating can only be used when there is no other alternative, and only then with Birmingham City Council Service delivery team approval

2.2 SANITARY FITTINGS

2.2.1 GENERALLY

The customer shall have a choice of at least six different colours/styles within a range of fitting, and have a choice available of optional extras e.g. mixer taps etc. All fittings shall be of best quality, fit for purpose, free from cracks, grazing, chips or undue distortion and be capable of heavy domestic use. All taps, valves, and fittings shall satisfy the requirements of the local water authority. All fittings are to be securely fixed to the structure all in accordance with the manufacturer's instruction/recommendations, with chromium plated dome head screws.

2.2.2 BATH - WC – PEDESTAL BASIN

Wash Hand Basin (Pedestal Type): Basins and pedestals are to be 560 x 405mm vitreous china with raised edges and combined overflow, 36mm chromium, plated brass waste, chain, stay and plug, 1no. pair of 15mm indexed chromium plated brass easy clean pillar taps (lever type unless specified), concealed fixing brackets and plastic trap.

All suites are to be supplied in matching sets and colours, and be co-ordinated to the satisfaction of the service delivery team

PLANNING and LAYOUT: the layout of the units should be well planned and must be agreed by Birmingham City Council service delivery team. Plumbing and other services should be installed and planned to be compatible with the general layout. Making good to any affected areas should also be completed and allowance made for any proposed wall tiling, especially on return or part affected walls. Sound fixing points should be considered and anticipated in advance.

2.2.3 INSTALLATION

Fitting: All fittings shall be level, plumb and square and should function properly. All plumbing shall be in accordance with the regulations current at the time of installation.

Fixing: Fittings are to be fixed in accordance with manufacturers recommendations/instructions using the full number of fixings screw and in the positions provided.

Protection: All fittings shall be adequately protected throughout the installation and whilst other works are in progress. Fittings that are damaged, marked or scratched in any way, will not be accepted and shall be replaced by the contractor entirely at his expense.

Completion: On completion/handover all protective coverings shall be removed, all surfaces thoroughly cleaned, all fittings checked for correct operation and adjusted accordingly, all in accordance with manufacturers recommendations.

1.23 BEDROOMS

1.23.1 Care should be taken when planning size of the bedroom and consultation with the user is essential in determining the most suitable size and layout for their particular needs.

Guidance for wheelchair users: (OT to confirm)
Single bedroom minimum internal measurements - 3000mm x 2700mm
Double bedroom minimum internal measurements - 3900mm x 3600mm
Maximum turning circles should always be maintained and a minimum clearance for carers of 500mm on the one side of the bed and a minimum of 1200mm on the other sides for wheelchair transfer.

1.23.2 Floors are to be covered in an approved slip resistant floor covering (to a minimum of R10 or equivalent) unless other coverings have been specified.

1.23.3 Wall and ceiling plaster finishes, together with all woodwork, are to be decorated on completion.

1.23.4 Provide two-way switching for light fitting including a pull cord over the bed, and 2no. double Socket outlets positioned to suit users' requirements.

1.23.5 All window and external door openings should comply with current regulations and associated legal building standards. With due consideration being given to natural light and ventilation. Together with means of escape in the event of fire. Lockable opening lights are at the discretion of the user.

1.23.6 Background gas or electric heating is to be provided as standard. By way of extending the existing gas central heating system, where possible. Or provision of an appropriate wall mounted heating source. Which complies with current electrical installation or gas safe legislation

1.24 SMOKE DETECTOR

Supply and fit hard wired detector circuits complete with smoke detectors to suit the new layout and comply with minimum legislation requirements.

1.25 KITCHENS (for wheelchair users)

Kitchen layouts are to be designed using the Occupational Therapist's recommendation taking into consideration the needs of other household members. Units and accessories are to be fitted in accordance with manufacturer's recommendations. And are subject to the submission of detailed design and layout drawings from an approved specialist manufacturer.

An unobstructed floor space or turning circle of 1500mm x 1500mm is preferred between opposite facing floor units or an opposite facing wall.

1.26 WORK SURFACES –confirmed by assessment

Height range will typically be between 760mm to 800mm to top of surface from the finished floor level, and wherever possible they shall be continuous. A smooth transition between work surface, hob and drainer is essential. An 'l' or 'U' shape is preferred rather than parallel

or galley type layouts. They shall be 600mm deep and have knee recesses to allow access for the preparation of food. Consideration should also be given for pull out boards below the work surface, being especially useful when located adjacent to the oven.

Ergonomically the layout should be designed so that travel is minimized between the sink, hob, oven, fridge, and other task areas.

When space is limited - consideration should be given to providing floor mounted cupboards with banks and draws, and corner carousel units. Another option could be to provide a moveable trolley.

A single row of tiled splash back (or equivalent area) should be provided to all work surfaces/base units and behind the sink unit.

1.27 SOCKETS OUTLETS

To be fixed no higher than 100mm above the work surface, or 1000mm from finished floor level.
When reach is limited, and sockets are to be positioned at the front of work surfaces. Full domestic electrical installation regulation compliance, regarding positioning at a reasonable distance away from sinks and hob areas, should be adhered to.

1.28 CUPBOARDS/SHELVING

Shelving is to be positioned to a maximum height of 1150mm from the finished floor level.
Cupboard units and draw handles should be of a design that is easy to grip.
Cupboard unit doors should swing open through 180 degrees.
Wall mounted cupboards to be 300mm deep.

1.29 SINK

The sink unit is to be located near to the hob and oven.
The sink should be shallow - 150mm deep sink is preferable.
All exposed hot pipes and waste pipe on the underside of the sink should be insulated.
The recess is to be to be a minimum width of the sink to allow wheelchair access.
The sink top is to be fitted with swivel neck mixer lever taps with clear hot and cold markings - a ¼ turn operation to full flow is preferred. And be capable of being operated by using a closed fist.

1.30 HOB

The hob is to be located near to the oven and sink and insulated underneath. Heat resistant surfaces are to be provided at each side of the hob and be at least 300mm wide.

Controls are to be positioned at the front and on either side of the hob, or mounted in a deep fascia running across the front easily identified and easy to operate.
Cooking rings at the rear of the hob are to be no more than 400mm from the front edge of the work surface.

Gas rings are to be self-igniting.

Design of the hob - the projection of the hot plates shall be as shallow as possible with minimal projection above the surface of the hob.

Electric hobs – Importantly it is essential that there is clear and obvious indication that when in use the user can see that the rings are hot and danger is present.

1.31 OVEN UNITS

The handle of the door is to be agreed to hang on the left or right hand side.
Ovens with pull out shelves or a pull out board directly beneath the oven strong enough to

support heavy cooking items should be considered in the design when accessing the users particular needs.
When specified it should be located so that the drop down drawer or pull out shelf is 760mm above the finished floor level, or 850mm above the finished floor level for ambulant people with back problems.
Controls should be no higher than 1050mm and no lower than 700mm and be clearly marked.

1.33 GENERALLY

1.33.1 A minimum of 4 number double electrical socket outlets should be provided as standard. Together with a minimum of 2 gang/2 way light switches at all entrance/exit points. Fitted to comply with current domestic electrical installation safety regulations

1.33.2 The height and positions of the light switches and socket outlets should be dependent on the needs of the user and positioned where they are most useful to them.
Wherever possible socket outlets should be 750mm – 1000mm above floor level, if however there is a danger of hazard due to trailing flex, lower fixing heights should be considered i.e. 400mm (minimum) above floor level, or other options considered to eliminate the hazard.
All switches and outlets are to be a minimum of 350mm from the corner of room.
Light switches should be fixed no higher than 1400mm above finished floor level; the preferred height however of light switches will generally be between 1000mm – 1200mm above floor level.

Note: All references to Building Regulations and British Standards etc. in Section 1 are to be those current at the time of the works/contract.

2.4 KITCHEN UNITS - Generally

2.4.1 Where a new kitchen is required and has been approved the citizen shall have a choice of at least six different colors/styles of kitchen units and worktops within a 'range' of units. Should changes to the existing kitchen be required, all attempts should be made to match in with the existing units, in the event this is not possible escalation to Birmingham City Council will be required. Accessories such as cornices, pelmets, shelving units, oven housings, tower units etc, are to be made available as optional extras.

A minimum kitchen unit package should include the following. Unless otherwise recommended by the service delivery team.

- 1 x double base unit (1000mm)
- 1x double wall unit (1000mm)
- Up to 3m of work top (600mm deep)
- 1 x single drainer sink unit (left or right hand)
- Single row of splash back tiles above all worktops and base units. With appropriate mould resistant mastic seal
- Cooker control point (both gas and electric)
- 1 x washing machine outlet point with below work top single socket outlet
- 4 x double socket outlet points

2.4.2 **CONSTRUCTION**

The rigid carcass: shall be built from 20mm wood chipboard or laminated and faced in white melamine or wood grain veneer having a minimum paper weight of 80 g/sq. m. All components shall be securely jointed together with all vulnerable and exposed face edges lipped, with either 0.40mm PVC or 0.35mm melamine, or wood grain veneer. All lipping's shall be machine bonded with hot applied adhesive. All units shall be of rigid construction capable of heavy domestic use, and be factory assembled before delivery to site.

The style of units and colours: shall be agreed with the customer being offered a choice of at least six different styles/coloured doors, drawer fronts and worktops. Floor units shall be supplied complete with legs permitting air circulation under the units, and capable of giving –5mm or +15mm adjustment to allow for variations in floor levels. Floor units shall also be fitted with back panels which shall be recessed a minimum of 50mm to allow for pipe runs and waste outlets.

Doors and drawer fronts: shall be made from at least the same quality chipboard or laminate used for the carcass but have a minimum melamine facing of 110 grammes per square metre. All four exposed edges shall be lipped as before described and shall be fitted with blank plastic clips.

Door hinges: shall be 170 degrees opening, concealed, self-closing, and fully adjustable.

Drawer boxes: may be manufactured from either laminate, or formed from extruded plastic, have a white melamine lacquered hardboard or laminate bottom, and be fitted with metal drawer runners incorporating a safety pull-out stop. The drawer runners shall be securely screwed to the carcass.

Shelves: shall be manufactured from at least the same quality chipboard or laminate used for the carcass and have at least the same quality melamine facing or veneer. All edges shall be lipped as before described. Shelves shall be adequately supported and where situated in units over 600mm wide, they shall have central supports.

Plinths: shall be manufactured from at least the same quality chipboard or laminate used for the carcass and have at least the same quality melamine facing or veneer. All edges shall be lipped as before described. Plinths shall be front fixed to allow access underneath for cleaning

etc and when secured should be slightly raised from the floor to allow for air circulation
Underneath the units: the manufactured range of units must be capable of being supplied with individual and continuous plinths as necessary.

Worktops: shall be 40mm thick (nominally) and be constructed of wood chipboard type C1A. The worktop shall be post-formed along the front edge and faced in a decorate laminate of nominal thickness of 0.6mm. All return edges shall be lipped in matching laminate and the rear edge lipped in white melamine all machine bonded with hot applied adhesive. The underside shall be treated with a laminate or coating designed to prevent moisture ingress.

The suppliers of worktops shall offer a choice of at least six different coloured, and patterned surfaces complimentary to door and drawer fronts.

The wearing characteristics of the worktop shall satisfy the performance standards of the appropriate British Standard for severe use.

Fascia's shall be manufactured from at least the same quality chipboard or laminate used for the carcass and have at least the same quality melamine facing or veneer. All edges shall be lipped as before described, and fixings concealed.

2.5 KITCHEN UNITS – Installation

2.5.1 PLANNING AND LAYOUT

The layout of the units should be well designed and planned and agreed with the Birmingham City Council and the citizen. Plumbing and other services should be installed and planned to be compatible with the general layout and designed to be concealed as much as the layout will allow. Plastering should be completed before the units are fitted, with allowances being made for proposed tiling, with special regard to return walls. Sound fixing points to the structure should be considered and anticipated in advance.

2.5.2 FITTING

All units shall be fitted level, plumb, square, and free from distortion so that doors and drawers' function properly. Floor and wall irregularities should be accommodated using suitable wedges and packing pieces. Packing pieces etc should be capable of withstanding anticipated loads, not be affected by moisture, and able to resist splitting when penetrated by fixings.

If site modifications are required, the structural integrity of the unit must be maintained. When it is necessary to alter unit panels all raw edges shall be sealed with an approved waterproof sealant to prevent ingress of moisture. When doubt exists, the contractor should seek advice from the manufacturer of the units.

2.5.3 FIXING

Units shall be fixed strictly in accordance with manufacturer's instructions and directions using the full number of fixings screws, and in the fixing positions provided. Adjacent units shall be fastened together using proprietary fittings wherever possible, ensuring that front edges and panels are properly aligned.

2.5.4 WORKTOPS

Uneven wall surfaces should be made good and true, or the worktop scribed to the wall profile ensuring a good close fit. Worktops shall be fitted level and properly secured in accordance with manufacturer's instructions. Worktops spanning across gaps of more than 500mm shall have additional supports. Timber battens when used shall be planed softwood, 50mm x 25mm securely screwed to the wall at a minimum of 300mm centres (minimum of two fixings).

End panels shall be constructed from at least the same quality chipboard, melamine facing, or veneer used for the carcass. The panels shall be secured to both the underside of worktop and the floor by means of zinc plated table stretcher plates and non-ferrous screws.

On all new works joints between adjacent worktops shall be level and have flush mitre joints. When butting up new to existing work surfaces the butt joint should be sealed with a flexible waterproof sealant and joined together with an anodised aluminium/bronze jointing-strip (to match worktops). Joints between worktops and sink tops shall be sealed with a flexible waterproof sealant.

Where a post formed worktop edge abutts a square-ended sink top, an anodised aluminium/bronze coloured jointing strip (to match worktops) should be used to cover the joint.

All cut or raw edges, including butted or mitred joints and cut outs for in-set sink tops, should all be sealed with an approved waterproof sealant.

2.5.5 PROTECTION

All units, sink tops and worktops should be adequately protected during installation and whilst other work in the vicinity is in progress. Units that have been damaged, marked, or scratched will not be accepted. The contractor is expected to replace them at no extra cost to the contract.

2.5.6 COMPLETION

On completion/handover all protective coverings shall be removed, units and surfaces thoroughly cleaned inside, outside and under the units. All doors and drawers checked for correct operation and hinges adjusted as necessary, all-in accordance with manufacturers recommendations. Any defective, marked, or scratched materials shall be replaced at the Contractors expense before being offered to the citizen for acceptance at handover stage.

Note: All references to British Standards etc. are to be those current at the time of the works/contract.

Technical Specification – Section 3 – Stair Lifts

STAIR LIFT SPECIFICATIONS FOR SUPPLY AND INSTALLATION

3.1 STAIRLIFT (Standard)

The complete installation shall be in accordance with BS EN 81-40:2020 Safety rules for the construction and installation of lifts or the most current British Standard at the time of installation - special lifts for the transport of persons and goods. Stairlifts and inclined lifting platforms intended for persons with impaired mobility

3.1.1 The lift shall have a speed of travel not exceeding 0.15m/sec. The lift shall be designed for a rated load of 115kg. The lift shall swivel through 90° and shall be lockable at a minimum of three positions 0°, 45° and 90° with a hand release interlocked to the lift control. The seat shall have a height range of 400mm to 525mm.

3.1.2 The lift seat controls shall be constant pressure toggle or button type with separated controls at top and bottom of the stairs.

3.1.3 The lift shall be fitted with sensitive edges/surfaces interlocked with the lift controls to prevent shearing, crushing, trapping, or abrading hazards.

3.1.4 The lift shall be fitted with a retractable safety belt to restrain the passenger during travel.

3.1.5 The lift shall also be complete with a digital counter connected to the control or motor contractor circuit: the counter shall be a non-zeroing type.

3.1.6 Where a powered swivel is required, it shall automatically return to its **ride** position when you call the stair lift.

3.1.7 The footrest shall either be linked to the arms or the seat of the chair to enable the footrest to be folded up flat when not in use, so that the user does not have to bend down to fold up the footrest. The footrest shall finish **flush** with the top landing.

3.1.8 The arms shall fold back individually.

3.1.9 The chair shall be fitted with functionality to be immobilised, to prevent injury to other parties.

3.1.10 The chair shall have a **soft start - stop** and travel smoothly up and down the track without any vibration or noise being transmitted through the chair to the user.

3.1.11 Minimum depth of seat to be 350mm.

3.1.12 Chair and carriage shall not project into the stairway by more than 420mm for a straight track and adhere as near as possible to this dimension with a curved track.

3.1.13 The chair and track shall have all concealed wiring and terminals etc, which are child proof.

3.2 SITE SURVEY

The contractor shall allow for a site survey of each dwelling before information is submitted to the council for approval. The Contractor shall inform the Council of any additional works required, all with associated costs in order to complete the installation to the required specification.

3.2.1 *Bulkheads* To be raised if necessary to give a minimum height of 2m above the pitch line. This also applies where the lift may have to pass through existing doorways etc.

3.2.2 *Width of stairs* Stair lifts shall not be fitted where tread width is less than 0.75m.

3.2.3 *Handrails/balustrades* to be reinstalled where existing has been removed.

3.2.4 *Handrails* To be fitted on opposite side of staircase from the lift.

3.2.5 *Window ledges to* be cut back if necessary to accommodate lift.

3.2.6 *Gas/electric fires/radiators* to be moved if causing an obstruction to the lift and re-fixed elsewhere to suit customer. Moving the aforementioned fixtures to be carried out by qualified personnel.

3.2.7 *Lift track* Shall not project into/across doorways/passageways. A hinge track may solve this problem in certain circumstances. Hinge track shall be interlocked with lift controls.

3.2.8 *Top quarter landing* It may be possible to infill part of this landing to create an additional riser, but the new landing shall not be less than 500mm long, and a figure 7 shaped grab rail may need to be fixed to the top newel post to prevent tripping by able bodied occupants.

3.2.9 *Bottom quarter landing* May need to be removed and an additional riser created to assist transfer to and from the lift. This work to be carried out if required.

3.2.10 ***Hinged bridging platforms***- The hinged bridging platform shall be capable of being folded away without an obstruction and leaving the stairs free from obstruction for other users.

3.2.11 Shall be designed to carry a load of 375kg/m² and shall be retained in position by a device that is capable of being released by the remote controls or automatically in the case of automatic control.

3.2.12 If the platform is power operated it shall be fitted with safety devices to prevent injury to persons by trapping, and means shall be provided to prevent overloading.

3.2.13 Warning labels shall be fitted and positioned so that it can be seen at all times. The lettering used shall comply with BS EN 81-40:2020

3.2.14 Where hinged bridging platforms are being installed, the back wall to be strengthened using 20mm plywood, planed and chamfered on exposed edges, and shall be painted to blend in with surrounding decorations.

3.3 METER CUPBOARDS GROUND FLOOR TOILETS ETC.

a) All the above may need to be altered to accommodate the parking of the lift and assist transfer to and from the chair at the bottom of the stairs.
b) The allocated lift companies to be responsible for this operation.
c) In the event of alterations to internal meter cupboards, then all subsequent fire regulations to be adhered to, i.e., cladded partitions, fire check doors etc. **NB existing fire barrier within the cupboard must be reinstated if altered or damaged.**

3.3.1 Moving meters

All work shall be carried out by either the local supply company if appropriate, or by qualified personal registered with GAS Safe for gas installations and NICEIC or ECA for electrical.

3.4 ELECTRIC'S GENERAL INSPECTION

3.4.1 Mains earth to be upgraded to current edition of BS 7671 (18th edition) Requirements for Electrical Installations if existing not up to standard.

3.4.2 All bonding, earthing to mains shall be installed before the installation of the lift.

3.4.3 Clamped earth is **not** acceptable, where this is found to be in place it shall be changed by the electric supply company to a sweated joint.

3.4.4 If the above is not possible due to local circumstances, an earth leakage breaker of the residual current type to be fitted, rated at 30mA or less, plus a separate earth electrode to comply with the BS 7671 (18th edition) Requirements for Electrical Installations.

3.4.5 **Not** acceptable to run earth cables externally, except in galvanised conduit.

3.4.6 Pre-payment meters

a) Prepayment meters are **not** allowed and shall be replaced prior to the lift installation.
b) Lift company **must not** install the lift whilst these meters are in place. Letters of recommendation are not acceptable.
c) The occupier of the property being the person responsible for the changes through the local supply company.

3.5 ELECTRICAL SUPPLIES

All electrical work shall be carried out by a competent electrical engineer in accordance with the current edition of BS 7671(18th edition) Requirements for Electrical Installations

The supply shall be dedicated to the lift and shall originate at the household consumer unit in all situations.

3.5.1 Temporary supplies

Temporary supplies **not** acceptable under any circumstances. It is the responsibility of the contractor to ensure that installation of the electric's is carried out before the lift installation.

3.5.2 Wiring system

The wiring system for electrical services associated with the chair lift shall be PVC double insulated cable with CSA 2.5mm². The wiring shall be installed in a system of PVCu high impact mini trunking, white in colour.

Trunking shall be secured to all surfaces via steel wood screws, **under no circumstances** shall self-adhesive mini trunking be accepted.

The bends, elbows, adapters etc shall be of purpose manufacture and from the trunking manufacturers product range.

3.6 MAIN ELECTRICAL SUPPLY (240V POWERED)

For the purpose of this installation the incoming electrical supply shall be deemed to be the main incoming distribution board of the premises.

3.6.1 Directly below the existing distribution board a single switch unit with an RCD shall be supplied and installed. The incoming supply to the RCD shall be wired via a spare way within the distribution board.

3.6.2 Should there be no spare ways available, an independent supply can be obtained by applying to the local electric supply company for a Henley block to be fitted.

3.6.3 The lift company to leave 25mm² tails from new consumer unit, which the local supply company will connect to their new Henley block. The RCD shall be fed via a 20amp MCB/BS 3036 device installed within the distribution board.

3.7. MAIN ELECTRICAL SUPPLY (BATTERY LIFT)

For the purpose of this installation the incoming electrical supply shall be deemed to be the main incoming distribution board of the premises.

3.7.1 Directly below the existing distribution board a single switch unit with an RCD shall be supplied and installed. The incoming supply to the RCD shall be wired via a spare way within the distribution board. Should there be no spare ways available, then an independent supply can be obtained by applying to the local electric supply company for a Henley block to be fitted.

3.7.2 The lift company to leave 25mm² tails from new consumer unit, which the local supply company will connect to their new Henley block. The RCD shall be fed via a 10amp MCB/BS 3036 device installed within the distribution board.

3.8. MEANS OF ISOLATION

3.8.1 At the circuit termination adjacent to the lift equipment a **"means of isolation"** shall be installed.

3.8.2 This shall be a double pole switch with indicator lamp.

3.9. PERIODICAL LABELLING

All circuits shall be identified.

3.9.1 All equipment and accessories shall be suitably labelled (including circuits, earthing etc).

3.10. SMOKE DETECTORS

Two smoke detectors to be fitted in all situations where stair lifts are being installed, except where existing (if any), and comply with this specification.

a) Smoke detectors to be hardwired to the downstairs lighting circuit and linked together.
b) Smoke detectors to be ionisation type with 10-year battery backup.
c) One at each level.

3.12. MAINTENANCE

The cost shall include for ten years' Service and maintenance after handover for each lift.

3.12.1 Periodic servicing

a) The stair lift shall be thoroughly serviced by a competent person within six months of commissioning, and thereafter at intervals not exceeding twelve months.
b) At every service, any serious defect should be rectified to conform to this standard, and particular attention should be given to those features listed in BS EN 81-40:2020
c) The contractor shall produce a servicing schedule, and times allowed for each visit.
d) Upon completion of each service visit, the company shall produce a completed and signed service report for each and every installation.

3.13. ADEQUATE MEANS OF ESCAPE

a) Stair lifts shall not obstruct doors, or any access into or out of the property.
b) The stair lift must not, as is reasonably possible, obstruct access ways/passage ways.

3.14. ASSOCIATED WORKS

3.14.1 Where decorations have been damaged or disturbed, the areas are to be reinstated as near as possible to the existing finishes. This includes wallpaper, Artex finishes or similar.

3.14.2 Radiators and window boards etc may need to be moved/cut back to accommodate stair lift.

3.14.3 In certain circumstances existing hall may need to be extended, to enable the front door to be repositioned, then external door openings to have low line threshold strips. **(Not cills).**

3.14.4 Where glazed screens or entrance frames fall within proximity of the stair lift, the existing glass shall be upgraded to comply with current regulations.

3.14.5 Hallway may need to be extended, where the existing hallway is of insufficient size to accommodate the stair lift, when the front door is opening inwards onto the lift. **(NB) The door shall open to 90° without hindrance. Any hallway extensions to accommodate the installation of a stairlift shall be constructed in accordance with current building regulations and comply with minimum insulation values.**

3.14.6 The reversing of doors to open out should be avoided.

3.14.7 It is the responsibility of the contractor to obtain building control approval (if appropriate) for any building work or alterations and produce plans where required.

3.15. SPECIFICATION FOR BUILDING WORKS

It is the responsibility of the contractor to be versed on the requirements of the specifications.

3.16. CLEARING AWAY RUBBISH

Rubbish and redundant materials to be removed from site by the lift contractor at the end of each working day.

3.17. SAFETY HEALTH AND WELFARE

To include Health and Safety Executive Regulations.

3.18. DISCOVERY OF ASBESTOS

If, during the performance of the Contract, the Contractor discovers within the area of the Works, asbestos whose presence has not been foreseen in the Specification/Schedule of Works then the Contractor shall immediately comply with the Safety clauses in this Contract.

Technical Specification – Section 4 – Powered Lifting Platform / Step Lifts

POWERED LIFTING PLATFORM/STEP LIFTS - SPECIFICATION FOR SUPPLY AND INSTALLATION

4.1. PREFACE (POWERED LIFTING PLATFORMS/STEP LIFTS)

Installation of powered lifting platforms/step lifts are to be installed in various locations outside and inside domestic Properties in Birmingham. The Service shall comply with BS EN 81-70.

4.2 POWERED LIFTING PLATFORMS/STEP LIFTS

The Servicer shall provide and install powered domestic lifts to fixed landing levels inside and outside Properties, for use by a passenger in a wheelchair. The complete installation shall be carried out by the Contractor all in accordance with BS 6440: 2011. The lift shall have a maximum rated speed of 0.15m/s with a load of 225kg. Together with a lift car minimum dimension of 1100mm wide and 1400mm deep.

Car controls should be set at between 900mm - 1200mm from the car floor (1100mm preferred) and at least 400mm from any return wall.

Landing call controls should be set at between 900mm - 1100mm from the landing floor, and at least 500mm from any return wall.

4.3. DESIGN

The design of doors, gates and movable barriers should consider the special needs of disabled persons elaborated in BS 8300:2001 and be designed to be moved by the application of low manual effort. All doors, gates, safety barriers or sensitive edge switches should be of the mechanically operated type, whose contacts are mechanically broken to overcome the possibility of a welded contact failing to operate to the break position.

4.4. CONTROL SYSTEM

There are several methods by which lifting platforms may be controlled either by electrical, mechanical, pneumatic, or hydraulic means. Whichever method is adapted, the control system should be designed to be fail safe.

4.5. HARMFUL OR HAZARDOUS EXTERNAL INFLUENCES TO BE CONSIDERERED

Mechanical and electrical components of the lifting platform should be protected from the harmful or hazardous effects of external influences. These influences would include the ingress of water, solid bodies, effects of humidity, temperature, corrosion, atmospheric pollution, solar radiation and the action of flora and fauna. Additional precautions may also have to be incorporated to resist the efforts of vandals. Guidance on the construction of equipment, selection of enclosures, choices, and treatment of materials, sealing techniques, etc, may be obtained by reference to BS EN 60034-5, BS EN 60947-1, BS EN 60529 and PD 6484.

4.6. FIRST VISIT

It is expected that the first visit to the property must be with the appropriate company contracted to do the work.

4.7. SITE SURVEY

The Service shall allow for a site survey of each Property before information is submitted for approval by the Council. The Service shall inform the Council representative of any additional works required, all with associated costs to complete the installation to the specification.

4.8. LOCATION

The lift shall be installed in a location where:

It will not obstruct access to and from the dwelling, and if the lift is internal, not obstruct access through the building. Means of escape **must not** be obstructed in any way.

Check that when the lift is installed there will be adequate room to manoeuvre a wheelchair entering or leaving the platform.

4.9. RETAINING WALLS

After the survey has been carried out, and the heights of any raised platforms and retaining walls that may be required have been established, drawings for same must be submitted with quotation.

4.10. HANDRAIL RAILS/GUARD RAILS

Handrails/guard rails will need to be provided if any landing/platform is more than 600mm above finished floor level/finished ground level.

Handrails shall be 45/50mm ø and shall be galvanised (including all fittings and fixings), all cut edges to be primed and painted.

4.11. ELECTRICAL SERVICES

All electrical work must be carried out by a competent electrical engineer in accordance with the current edition of BS 7671(18th edition as amended) Requirements for Electrical Installations.

The control circuit voltage should not exceed 55v and should be derived from the secondary winding of a double-wound transformer that complies with BS EN 61558-1 (2019). It is essential that the transformer secondary winding, fuse, switching contact, relay operating coil, and earth shall be connected in the positions shown in BS 5900 (as amended)

4.11.1 Wiring system

a) The supply shall be dedicated to the lift, and shall originate at the household consumer unit, and terminate at a double pole fused spur conforming to relevant British Standards and regulations.
b) The wiring system for electrical services associated with the lifting platform shall be PVC double insulated cable with CSA 2.5mm². The wiring system shall be installed in a system of PVCu high impact mini trunking, white in colour.
c) The trunking shall be secured to all surfaces via steel wood screws, **under no circumstances** shall self-adhesive mini trunking be accepted.
d) The bends, elbows, adapters, etc, shall be of purpose manufacture, and from the trunking manufacturers product range.

4.11.2 Main Electrical Supply (240V Powered)

For the purpose of this installation, the incoming electrical supply shall be deemed to be the main incoming distribution board of the premises.

a) Directly below the existing distribution board, a single switch unit with an RCD shall be supplied and installed. The incoming supply to the RCD shall be wired via a spare way within the distribution board.
b) Should there be no spare ways available, then an independent supply can be obtained by applying to the Local Electric Supply Company for a Henley block to be fitted.
c) The lift company to leave 25mm ø tails from new consumer unit, which the local supply company will connect to their new Henley block. The lift shall be fed via a 20-amp MCB/BS3036 device installed within the distribution board.

4.11.3 Main Electrical Supply (Battery Lift)

For the purpose of this installation, the incoming electrical supply shall be deemed to be the main incoming distribution board of the premises.

a) Directly below the existing distribution board, a single switch unit with an RCD shall be supplied and installed. The incoming supply to the RCD shall be wired via a spare way within the distribution board.
b) Should there be no spare ways available, then an independent supply can be obtained by applying to the Local Electric Supply Company for a Henley block to be fitted.
c) The lift company to leave 25mm ø tails from new consumer unit, which the local supply company will connect to their new Henley block. The RCD shall be fed via a 10-amp MCB/BS 3036 device installed within the distribution board.

4.11.4 Temporary Supplies

Under no circumstances must equipment be installed on a temporary supply. It is the Services responsibility to ensure that the electrical supply for the lift is installed prior to lift installation.

4.11.5 Means of isolation

At the circuit termination adjacent to the lift equipment, a "means of isolation" shall be installed.

This shall be a double pole switch with indicator lamp.

4.11.6 Labelling

All equipment and accessories shall be suitably labelled, circuits, earth wires etc.

4.11.7 General Electrical Inspection

a) The Contractor shall make a general inspection of the incoming electrical supply.
b) Mains earthing to be upgraded to **current edition of BS 7671 (18th edition) Requirements for Electrical Installations** if existing not up to standard**.**
c) All bonding, earthing to mains must be installed before the installation of the platform.
d) Clamped earth is **not acceptable**, where this is found to be in place it must be changed by the Electric Supply Company to a sweated joint.
e) If the above is not possible due to local circumstances, an earth leakage breaker of the Residual Current Type to be fitted, rated at 30mA or less, plus a separate Earth Electrode, in order to comply with current edition of the BS 7671(18th edition) Requirements for Electrical Installations.
f) **It is not acceptable** to run earth cables externally, **except** in galvanised conduit.

4.11.8 Pre-payment meters

a) Prepayment meters are **not allowed,** and should be replaced prior to the lift installation.
b) Lift company **must not** install the lift whilst these meters are in place. Letters of recommendation are **not acceptable.**
c) The owner/tenant/occupier of the property being the person responsible for the changes through the local electricity supply company.

4.11.9 Moving of existing meters

a) Meters both gas and electric may need to be moved, if causing an obstruction where alterations need to be implemented.
b) The allocated lift company to be responsible for this operation.
c) In the event of alterations to internal meter cupboards, then all subsequent fire regulations to be adhered to, i.e., cladded partitions, fire check doors etc.

d) Doors and walls of internal meter cupboards must have a **minimum ½ hour fire resistance**. The existing fire barrier in the meter cupboard between gas and electric meters must be reinstated to give a **minimum ½ hour fire resistance,** if damaged during alterations to the existing meter cupboard.
e) Any work carried out in relation to meters must be by qualified personal, and registered with GAS SAFE for gas, NICEIC or ECA for electrical.
f) Smoke detectors to be hardwired to the downstairs lighting circuit and linked together.

4.12. TESTING

The complete installation shall be tested in accordance with BS 6440 (11th edition) and test results shall be provided at handover.

4.13. MAINTAINANCE

The Contractor shall allow for the service and maintenance of the complete installation for ten years after handover.

4.13.1 The lift company shall be required to produce a servicing manual, and the times allowed for each service.

4.13.2 The lifting platform should be thoroughly examined by a technically qualified competent person within 6 months of commission, or completion of a major modification, and at subsequent intervals not exceeding 6 months.

4.13.3 A test report shall be prepared of features tested. If defects are reported, the recommended repair, and period within which the repair should be carried out, should be stated in the report.

4.13.4 A copy of the test report should be provided to the purchaser, or purchaser's representative, and a copy retained by the examiner.

4.13.5 If any defect affecting safety is reported, and immediate repairs are required, the user should be advised, and the lifting platform removed from service.

4.14. ASSOCIATED WORKS

It is the responsibility of the Contractor to comply with local planning regulations, building regulations, and submit application plans where required.

4.14.1 All building works/groundworks to comply with current Council specifications, good building practice. Together with all relevant legal and/or building regulations current at the time of installation

4.14.2 It is the responsibility of the Contractor to locate any underground services, and if found to be causing an obstruction, apply to the local supply companies to have the services relocated.

4.14.3 All disturbed area's to be made good and reinstated to match existing.

4.15. BUILDING WORKS SPECIFICATION

It is the responsibility of the Service to be versed on the requirements of this specification.

4.16. CLEARING AWAY RUBBISH

Rubbish and redundant materials to be removed from site by the Service at the end of each working day.

4.17. SAFETY HEALTH AND WELFARE

The Service shall comply with all safety requirements.

Technical Specification – Section 5 – Hoist

HOIST SPECIFICATIONS FOR SUPPLY AND INSTALLATION

POWERED LIFTING PLATFORM/STEP LIFTS - SPECIFICATION FOR SUPPLY AND INSTALLATION

5.1. HOISTS

The hoists, including ceiling track and gantry, shall comply with current relevant regulations at the time of installation (electrical), **Lifting Operations and Lifting Equipment Regulations 1998 (LOLER 98)**, and **BS EN ISO 10535 2006.**

The installation shall be carried out by a competent person,and be in accordance with the relevant requirements of Local Building Regulations, and the Health and Safety at Work Act 1974, and associated regulations.

The complete installation shall be **tested to 150%** of the safe working load, and a properly completed test certificate issued on completion.

Electrical operated hoists shall have a **soft start - stop.**

5.2. REQUIREMENTS FOR RATE VEOLCITY OF LIFTING AND LOWERING

The requirements for rate velocity etc are detailed below:

- The rate of raising or lowering shall not exceed 0.15 milliseconds when loaded.
- The rate of raising or lowering shall not exceed 0.25 milliseconds when unloaded.
- Powered horizontal movement, linear velocity shall not exceed 0.15 milliseconds.

Electrically operated hoists shall be provided with an emergency device which is readily accessible, and is wired to isolate the supply, and to stop any electrically produced mechanical movement which could cause a safety hazard.
On all battery powered hoists, to ensure that a full range lifting cycle with maximum load can be completed once started, a warning device shall be provided.

On all battery powered hoists, a warning device(s) shall be provided that will indicate when the battery(ies) require charging.

When this device operates, there shall be sufficient power available to complete one full lifting cycle with full maximum load.

Hoists shall be provided with a safety device that shall ensure that the lifted person does not fall in the event of a single fault condition of the lifting machinery.

Electrically operated hoists shall confirm to EN 60601-1-2.

Every hoist shall be capable of lifting a lifted person of 120kg mass, excluding the mass of any body support unit.

All load bearing fasteners shall be either self locking, or fitted with a locking device to prevent detachment.

All hoists shall be fitted with an emergency lowering device.

5.3. SITE SURVEY

First visit the first visit to the property shall be completed by the provider contracted to do the work this must take place prior to submitting a quotation and any additional works which should be detailed including all associated costs in order to complete the in specification.

5.3.1 Suitability of the building Seek expert advice regarding the construction of the building:

- New building with roof trusses.
- System built.
- Reinforced concrete floors.
- Hollow floor beams.
- Floors supported by steel beams.
- Wimpy no fines etc.

This information will be required before a decision can be made regarding which type of support for the hoist will be suitable.

5.3.2 Ceiling tracks Method of fixing ceiling tracks shall be required before work proceeds

5.3.3 *First floor* Where a ceiling track would be required to pass through an existing doorway, or a new doorway would need to be formed, a new full height door frame and full height double doors would be required, or existing door could be used with 2 small doors over to accommodate passage of hoist and track.

5.3.4 None of this work to be carried out until a proper survey of roof space has been completed, to determine the structural stability of the building the outcome of the survey should be included with the quotation in order for approval to be obtained from Birmingham City Council.

5.3.5 Full height door frame to be supplied and fixed in position after ceiling track has been fixed. The track centre line should pass through the doorway centre line and should have at least 450mm clearance on both sides.

5.3.6 Double doors to be formed from a **door blank** and all 4 edges of each door to have 100mm wide solid styles.

5.3.7 Each door to be notched at the top to accommodate the ceiling track. Doors to be hung with standard 1½ pair 100mm butts to open 1 way only.

5.3.8 Each door to have a door pull handle on 1 side with a push plate on the opposite side.

5.3.9 Each door to have a spring-loaded bull catch fitted to the head of door.

5.3.10 Where existing door could be used with 2 half width doors over, the 2 half doors to be hung using 2-way spring hinges, and notched at the top to accommodate the ceiling track. Pull handles, push plate or spring-loaded ball catch **not required.**

5.3.11 *Ground floor* when a proper survey has been carried out and it has been established that it would not affect the stability of the building to continue, similar procedures to be followed as for 1st floor.

5.3.12 All disturbed work and decorations to be made good.

5.3. ELECTRICAL SUPPLY

All electrical work must be carried out by a competent electrical engineer, in accordance with the current edition of BS 7671:2008 Requirements for Electrical Installations.
The supply shall be dedicated to the hoist, and shall originate at the household consumer unit, and terminate at a double fused spur conforming to current regulations and British Standards.

5.3.1 Wiring system

The wiring system for electrical services associated with hoists shall be PVC double insulated cable with CSA 2.5mm². The wiring shall be installed in a system of PVCu high impact mini trunking, white in colour.
Trunking shall be secured to all surfaces via steel wood screws, **under no circumstances** shall self-adhesive mini trunking be accepted.

The bends, elbows, adapters, etc, shall to of purpose manufacture and from the trunking manufacturer's product range.

5.4. MAIN ELECTRICAL SUPPLY (240V POWERED)

For the purpose of this installation, the incoming electrical supply shall be deemed to be the main incoming distribution board of the premises.

Directly below the existing distribution board, a single switch unit with an RCD shall be supplied and installed. The incoming supply to the RCD shall be wired via a spare way within the distribution board.

Should there be no spare ways available; an independent supply can be obtained by applying to the local electric supply company for a Henley block to be fitted.

The hoist company to leave 25mm² tails from new consumer unit, which the local supply company will connect to their new Henley block. The hoist shall be fed via a 20amp MCB/BS 3036 device installed within the distribution board.

5.5. MAIN ELECTRICAL SUPPLY (BATTERY LIFT)

For the purpose of this installation, the incoming electrical supply shall be deemed to be the main incoming distribution board of the premises.

Directly below the existing board, a single switch unit with an RCD shall be supplied and installed. The incoming supply to the RCD shall be supplied and installed. The incoming supply to the RCD shall be wired via a spare way within the distribution board.

Should there be no spare ways available, then an independent supply can be obtained by applying to the local electric supply company for a Henley block to be fitted.
The hoist company to leave 25mm² tails from new consumer unit, which the local supply company will connect to their new Henley block. The RCD shall be fed via a 10amp MCB/BS 3036 device installed within the distribution board.

5.6. MEANS OF ISOLATION

At the circuit termination adjacent to the lift equipment, a **"means of isolation"** shall be installed.

This shall be a double pole switch with indicator lamp.

Chargers, transformers, etc, shall be positioned outside a bath/shower room, in a position to enable them to be seen, and to enable checks and maintenance to be carried out.

5.7. LABELLING

All equipment and accessories shall be suitably labelled (including earth terminals, circuits, etc).

5.8. GENERAL ELECTRICAL INSPECTION

5.8.1 The contractor shall make a general inspection of the incoming electrical supply.

5.8.2 Mains earthing to be upgraded to **the current edition** BS 7671:2008 Requirements for Electrical Installations if existing not up to standard.

5.8.3 All bonding, earthing, to mains must be installed before the installation of the hoist.

5.8.4 Clamped earth **is not** acceptable, where this is found to be in place it shall be changed by the Electrical Supply Company to a sweated joint.

5.8.5 If the above is not possible due to local circumstances, an earth leakage breaker of the residual current type to be fitted, rated at 30mA or less, plus a separate earth electrode, in order to comply with current edition of the BS 7671:2008 Requirements for Electrical Installations.

5.8.6 **Not acceptable** to run earth cables externally, except in galvanised conduit.

5.8.7 Temporary supplies **- under no circumstances** shall equipment be installed on a temporary supply.

5.9. PRE PAYMENT METERS

Prepayment meters **are not allowed** and should be replaced prior to the hoist installation.
Hoist company **must not** install the hoist whilst these meters are in place. Letters of recommendation **not acceptable**.
The owner/tenant/occupier of the property being the person responsible for the changes through the local electricity supply company.

5.10. TESTING

5.10.1 The complete installation shall be tested in accordance with the **Lifting Operations and Lifting Equipment Regulations 1998 (LOLER 98)**, and **BS EN ISO 10535 1998,** and the current edition of BS 7671:2008 Requirements for Electrical Installations.

5.10.2 All hoists shall be proof load **tested to 150%** of its maximum load along the entire track length, to ensure that the installation/hoist is safe for normal use.

5.10.3 If the hoist completes the test successfully, a hoist and load test certificate shall be issued, with invoice and electrical certificate to BS 7671:2008 Requirements for Electrical Installations.

5.10.4 Testing to take place after 2 weeks and not longer than 4 weeks. Termination of warranty period to be taken from date of witnessed testing, acceptance and certification.

5.11. MAINTENANCE

5.11.1 The contractor shall allow for the guarantee/maintenance of the complete installation for ten years after handover.

5.11.2 The hoist company shall be required to produce a servicing manual, and the times allowed for each service.

5.11.3 The installation shall be checked at 6 month intervals, and a complete service at minimum 12 months, or at intervals specified by the product manufacturers. Load tests to be carried out every 12 months, labels stating time and date of checks and servicing, shall be posted on the equipment.

5.11.4 Upon completion of each maintenance/service visit, the company is required to submit a completed and signed report for **each and every installation**.

5.12. CLEARNING AWAY RUBBISH

Rubbish and redundant materials to be removed from site by the contractor at the end of each working day.

5.13. DISCOVERY OF ASBESTOS

If, during the performance of the Contract, the Contractor discovers within the area of the Works, asbestos whose presence has not been foreseen in the Specification/Schedule of Works then the Contractor shall comply with the Safety clauses in the Contract.

Technical Specification – Section 6 – Key Safes

A key safe is a small stand alone, strong, heavy-duty vault with a locking mechanism opened by a confidential code using push buttons on the front which will store keys safely. The safe will have a cover and will be fixed securely on an outside wall away from the public view. Only people who know the code are able to open the safe and access the keys.

6.1 Key safe requirements:

Requirement	Min requirement	Description
Security approval	Secured By Design (SBD) approved	Secured by Design: National Police Projects focusing on the design and security for new and refurbished homes, commercial premises and car parks as well as the acknowledgement of quality security products and crime prevention projects.
Security tested	LPS standard	A test devised by security experts including the Association of British Insurers and the Association of Insurance Surveyors. Testing conducted by leading experts in manual forced entry techniques, to ensure the key safes deliver the required performance to their very demanding LPS1175 standard; and regular production audits to ensure the product's continue conformity.
Insurance	Acknowledged	Clients are advised to inform their home insurance company.
Weatherproof	Protects from ice, snow, water and dust.	Protects from ice, snow, water and dust and keeps device out of sight.
Dimensions	(H)152mm x(W)101mm x(D)50mm approx	Suitable for up to 5-6 Yale or 2-3 Chubb keys. Ideally with a hook for easier storing
Weather Cover	Required	To hide buttons from view
Fixing Kit to be included	Minimum 4 fixings	Suitable for brick and masonry
Construction	Solid Metal	Containing zinc for durability in low temperatures helping against resistance to freeze spray attack and making it non-corrosive
Hinged	Attached to vault	In order to ensure it can be opened with one hand and not allow lid to fall on fall and get damaged or taken into property
Locking mechanism	Secure	Cannot be left unlocked. Won't open if wrong code entered Cannot be forced open

Recycle	Can be removed and reused	Extra fixings available to re-fit. Minimum 1 year guarantee
Guarantees and Warranties for new units	2 years	Minimum 2-year guarantee
Codes	Optional length	Codes of between 5-7 numbers in length with optional letters that can be used in the code.
Instructions	Required	Comprehensive instructions and user guide

Example of suitable key safe meeting the required specification include: C500 and Burton Keyguard XL.

It is the responsibility of the service to ensure:

- The key safe is fitted covertly where possible
- Provision of concrete posts, when they are unable to fit a key safe to the actual building i.e. cladding walls. The provider needs to include the cost of concrete post to the invoice.
- Always use the correct fixings specified and supplied by the manufacturer
- Install the key safe into brickwork never into timber or plasterboards
- Ensure that installation is placed no higher than head/eye level or too near the floor, requiring the user to reach high or bend over to obtain the key as this is a health and safety risk. Take into account wheelchair users and their needs.

6.2. INFORMATION ON KEYSAFE

The Service needs to ensure that they have good information leaflets (or supplied by manufacturer) and that these are explained to the service users, especially in relation to the following: Choosing a code, Changing a code and general maintenance.

6.3. STANDARD OF WORKMANSHIP AND MATERIALS

All work shall be carried out in accordance with the Building Regulations, as a minimum standard. However, compliance with the requirements of the Building Regulations may not necessarily achieve a sufficient standard to comply with the requirements of this Specification.

All materials and workmanship shall be in accordance with the latest edition of the relevant European Standard, British Standard, British Code of Practice, or equivalent current at the contract date, hereafter collectively referred to “British Standard”, except where the standard has been fully detailed in this Specification and is of a higher standard than the British Standard.

In the absence of a relevant British Standard, materials and products shall be certified by the British Board of Agreement and installed in accordance with the requirements of that certificate and manufacturers recommendations. If the manufacturers instructions differ from the British Standard, the manufacturer’s instructions must be followed – warranties/guarantees may otherwise be affected. All materials and products used shall, wherever possible, reduce maintenance/be maintenance free and environmentally friendly. Where and to the extent that materials, products and workmanship are not fully specified, they are to be suitable for the purpose of the works stated in, or reasonably to be inferred from, the contracts documents and in accordance with good building practice.

The standard of workmanship unless otherwise specified shall be carried out in accordance with British Standards latest release. In the event of any dispute regarding acceptable tolerances, the permissible deviations details in the British Standard will be applied.

The Service shall follow manufacturer's recommendations and instructions with regards material storage, fitting and fixing, and introducing materials and/or products into the works. The contractor shall have regard for designer duties and responsibilities in respect of Health & Safety Regulations, CDM Regulations, and Lifetime Homes issues. He shall ensure compliance with the Council's "Sustainability Procurement Policy Statement" in respect of the purchase of materials/products.

Birmingham City Council

Report to Cabinet Member(s) Health & Social Care and Finance & Resources

16 March 2023

Subject:	**STAYING INDEPENDENT AT HOME ADAPTATION AND IMPROVEMENT SERVICE PROCUREMENT STRATEGY**
Report of:	**Professor Graeme Betts CBE Executive Director for Adult Social Care**
Relevant Cabinet Member:	**Cllr Mariam Khan - Health and Social Care Cllr Yvonne Mosquito - Finance and Resources**
Relevant O &S Chair(s):	**Cllr Mick Brown - Health and Social Care Cllr Akhlaq Ahmed - Resources**
Report author:	**Sarah Feeley Commissioning Manager – Adult Social Care Email: Sarah.Feeley@birmingham.gov.uk Timsey Deb Multi-Disciplinary Team Manager – Adult Social Care Email: Timsey.Deb@birmingham.gov.uk**

Are specific wards affected? If yes, name(s) of ward(s):	☐ Yes	☒ No – All wards affected
Is this a key decision? If relevant, add Forward Plan Reference:	☐ Yes	☒ No
Is the decision eligible for call-in?	☒ Yes	☐ No
Does the report contain confidential or exempt information?	☐ Yes	☒ No
If relevant, state which appendix is exempt, and provide exempt information paragraph number or reason if confidential:		

1 Executive Summary

1.1 This report is to obtain approval to the strategy and seek authority to proceed with the procurement of the Staying Independent at Home Adaptation and Improvement Service to deliver the assistance detailed within the Staying Independent at Home Policy. The contract agreement will be for a period of 5 years commencing on the 1st July 2023, with an option to extend for a further period of 2 years, subject to satisfactory performance and budget availability. The estimated value of the contract based on forecast data is £84m (£12m per year) funded from the Disabled Facilities Grant.

2 Recommendations

2.1 That the Cabinet Members for Health and Social Care, and Finance and Resources:

2.1.1 Approve the contents of this report in order to implement the strategy and the commencement of procurement activity for Staying Independent at Home Adaptation and Improvement Service in accordance with the requirement and approach set out in paragraph 3.9.

2.1.2 Note that the outcome of the procurement process will be reported to Cabinet together with a recommendation for approval of contract award.

3 Background

3.1 In March 2022 Cabinet approved the Staying Independent at Home (SIAH) Policy and the widening of the assistance that would be available to citizens. Approval of the Commissioning and Procurement Strategy was delegated to the Cabinet Members for Health and Social Care and Finance and Resources.

3.2 The SIAH Policy sets out the assistance that the Council will provide in response to duties and powers arising from three key pieces of legislation: The Care Act 2014, The Housing Grants, Construction and Regeneration Act 1996 and the Regulatory Reform Order (RRO) 2002.

3.3 As well as the mandatory Disabled Facilities Grants the exercise of discretionary powers through the RRO, the policy commits to achieving the following objectives:

3.3.1 Supporting disabled citizens to secure necessary adaptations which cost more than the maximum (£30k) allowed under the Disabled Facilities Grant. These will be known as Top Up Grants.

3.3.2 Securing prompt discharge from hospital of citizens who might, due to accommodation difficulties, otherwise remain in hospital longer than necessary. This will be known as Discharge Assistance

3.3.3 Addressing accommodation difficulties which, if not resolved, might lead to an avoidable admission to hospital, or residential care or which impact upon the ability of a citizen to live safely and independently at home. This will be known as Independent and Safe Assistance

3.4 In order to meet the demands of the citizens a different approach is required to ensure that services can be delivered to meet both mandatory and discretionary assistance.

3.5 There are currently a range of services being provided that are due to expire on the 30th June 2023, these are related to the future service model and these are:

- Minor Adaptations
- Major Adaptations – Lots 1 (lifting equipment) and 2 (bathrooms and kitchens)
- Key Safes

3.6 Outcomes Expected

3.6.1 The following outcomes are anticipated as a result of the proposed procurement process to be carried out:

- Increase in the number of citizens that can receive support through the widening of the assistance available
- Reduction in the length of time for certain works with improved access to assistance
- Reduction in the number of citizens who are stuck in hospital as a result of their home not being accessible or meeting their needs

3.7 Market Analysis

3.7.1 A market engagement event took place on the 17th November to provide a summary of potential changes as well as providing the opportunity for networking and connecting smaller local organisations who may be interested in partnering or collaborating for this service.

3.7.2 There is already an established number of providers within this field and the potential market for a lead provider is developing further with new providers coming forward as interested parties in the development of a new integrated service model.

3.8 Strategic Procurement Approach

3.8.1 The following options were considered:

- Decommission the service – the council has a statutory requirement to provide these services, therefore this is not a viable option.
- Extending the current contract – there is no scope to extend the current contract and a different service model is required to implement the changes resulting from the Staying Independent at Home Policy.
- Delivering in house – there is no current capacity to deliver this service and no internal model currently exists.
- Use of existing frameworks – there are no current frameworks in existence that would be able to provide the services required.

Four options have been given further consideration and the following details illustrates the options and a view on the associated advantages and disadvantages.

The recommended option is Option 2 for the Contract to deliver the service through a lead provider model, as this will best meet the need of the council.

Option 1 **Framework agreement to deliver all elements (unit rate) – Multiple providers**	
Advantages	**Disadvantages**
• Cost certainty with agreed unit rates in place • Consistent city-wide coverage in order to meet changing demand • Direct relationship with each provider, positive working relationships	• Restrictive to bringing in new providers should this be required • Time required to understand capacity across the providers • Contract management of a large contract required • The ability to understand the specialism of the technical aspects of the service provision
Option 2 **Contract to deliver the service through a lead provider model**	
Advantages	**Disadvantages**
• Easier contract management as the contract would sit with one provider as the lead • Consistency in standards across service delivery • Ability to flex and move capacity and resources to meet the demand • Increased partnership working with the third sector	• Adding in an additional layer into the communication and allocation of works which could potentially cause a delay
Option 3 **Contract to deliver a provider collaborative model**	
Advantages	**Disadvantages**
• Encourages joint working among local smaller providers • Opportunity to increase the availability for smaller providers to bid for larger contracts and sharing of expertise	• Provider market not yet established to deliver this kind of model • Market competitiveness and resulting in the breakdown of working relationships if collaboratives could not be established
Option 4	

Contract/Framework with lots (broken down into work areas)	
Advantages	**Disadvantages**
• Ensures that there are providers delivering all areas of specialism • Consistency of works across the City • Opportunity for smaller organisations to bid on a variety of works	• Could limit the number of providers if only able to bid for one or two lots, providers might want to be considered for a variety of lots • Joint working across more than one area could lead to additional delays • Contract management of a large number of providers will be resource intensive

3.9 Procurement Approach

Duration and Advertising Route

The contract will be awarded for a period of 5 years with the option to extend for a further 2 years and advertised in the Contracts Finder and www.finditinbirmingham.com. The contract term is recommended on the basis that this provides stability and consistency of delivery for the most vulnerable citizens in Birmingham. Any future service needs time to embedded and the widening of support and assistance available through the contract are also new areas of support for the council. The term allows for all of the new areas to develop along with a revised service model, the longer term is essential for delivering the approach of the policy.

3.9.2 Sourcing Strategy

The contract will be awarded to 1 supplier with specified sub-contracting provision.

3.9.3 Procurement Route

The contract will be tendered following the 'Open' Procedure that will enable the specification to be considered by the wider market.

3.9.4 Scope and Specification

The Council seeks to establish a contract for an integrated Adaptation and Improvement Service aligned with the priorities within the SIAH Policy to be delivered via a Lead Provider model. Details of the services will be set out in the service specification.

3.9.4 Tender Structure (Including Evaluation and Selection Criteria)

3.9.4.1 Evaluation and Selection Criteria

The evaluation of tenders will be assessed as detailed below:

The assessment will be divided into the following stages:

Stage 1 – Selection Stage
Stage 2 – Invitation to Tender

Stage 1 – Company Information

Criteria	Evaluation
STAGE ONE - Selection Stage	
Company Information	Pass / Fail
Financial Information (including Insurance)	Pass / Fail
Health and Safety	Pass / Fail
Compliance with Equalities	Pass / Fail
Quality Management	Pass / Fail
Grounds for Mandatory Exclusion	Pass / Fail
Grounds for Discretionary Exclusion	Pass / Fail
Modern Slavery Act 2015	Pass / Fail
Living Wage	Pass / Fail
Technical and Professional Ability	Pass / Fail
Sub-contracting	Pass / Fail
Data Processing/Protection	Pass / Fail
Declaration	Pass / Fail

Tenderers will be required to pass Stage 1 in order to progress to Stage 2.

Stage 2 – Invitation to Tender Stage

Evaluation and Selection Criteria

Tenders will be evaluated using the quality / social value / price in accordance with a pre-determined evaluation model. The quality element will account for 50%, social value 20% and price 30%. This quality / social value / price balance has been established having due regard to the corporate document 'Evaluating Tenders' which considers the complexity of the services to be provided and the degree of detail contained within the contract specification.

Tenders will be evaluated against the specification in accordance with the pre-determined evaluation model described below:

Quality (50% Weighting)

	Criteria	Overall Weighting	Sub-weighting
Written Proposal	Service Delivery	40%	35%
	Organisation and Resources		15%
	Customer Care		25%
	Outcomes		15%

	Mobilisation and Implementation		10%
Presentation	Case Study	10%	100%
Overall Quality	**Total**	**50%**	

The council reserves the right to exclude tenderers who score less than 50% of the quality threshold i.e., a score of 50 out of a maximum quality score of 100 (50 marks out of 100).

Social Value (20%)

	Sub-Weighting	**Sub-Criteria**	**Theme Sub-Weighting**
Qualitative	**60%**	Buy Local	10%
		Good Employer	40%
		Partners in Communities	30%
		Green and Sustainable	20%
			TOTAL 100%
Quantitative	**40%**	BBC4SR Action plan	Total of financial proxies (£) score
			TOTAL 100%
Overall Social Value	**20%**		

Tenderers who score less than 50% of the social value threshold will not proceed to the next stage of the evaluation.

Price (30%):

Tenderers will be expected to submit a price on the basis of service delivery and mobilisation.

The price of the service includes:

- Costing Scenarios
- Birmingham unit rates for delivery
- Equipment prices

The tenderer with the lowest acceptable price for all elements is given the maximum possible weighted score. The other tenderers' weighted price scores will be calculated on a pro rata basis.

Criteria	Overall Weighting	Sub-weighting
Scenario 1 – costing level access shower	100%	30%
Scenario 2 – extension bathroom/bedroom		20%
Unit Rates – Discretionary		20%
Equipment		30%
Overall - Price Value	**30%**	

Overall Evaluation

The evaluation process will result in comparative quality, social value and price scores for each tenderer. The maximum quality score will be awarded to the bid that demonstrates the highest quality. The maximum social value score will be awarded to the bid that demonstrates the highest social value. The lowest price will be given the maximum score. Other tenderers will be scored in proportion to the maximum scores in order to ensure value for money and the proposed contract will be awarded to the first ranked tenderer.

3.9.5 Evaluation Team

The evaluation of tenders will be undertaken by officers from Adult Social Care, supported by the Corporate Procurement Services.

3.9.6 Indicative Implementation Plan

Procurement Strategy Approval	March 2023
ITT Issued	March 2023
ITT Return	June 2023
Evaluation Period	July 2023
Cabinet Approval (Award)	September 2023
Contract Award	September 2023
Mobilisation period	September-December2023
Contract Start	1st January 2024

3.9.6 Service Delivery Management

3.9.6.1 Contract Management

The contract will be managed operationally by the Multi-Disciplinary Team Manager, Adult Social Care Directorate with support from the Commissioning Team as required.

There will be a formal review at 6- and 12-months post contract start to ensure that the service is delivering the required outcomes for citizens. This will be in addition to the required contract management with regular reporting and contract review meetings.

3.9.6.2 Performance Management

The contract will include a range of performance measures which will be monitored on a quarterly basis through the Contract Management process. This will include a range of outcome and quality measures. The main outcomes expected to be achieved are:

Mandatory Provision

- Contact to be made with citizens within **48hours** of receipt of referral.
- Scoping of works this process should be completed within **15 working days** of an initial visit, with the exception of larger works which include an extension a period of **30 working days** is allowed.
- From the Council approving a scheme this should be shared with the citizen and homeowner for agreement within **5 working days** and subsequent approvals need to be shared with the Council.
- From the point of a purchase order being raised the provider is required to complete internal works within **12 weeks** and external works within **24 weeks**.
- Completed works should be invoiced with supporting documents no later than **10 working days** from the works being completed.
- Citizen contacted within 48hours of receipt of referral

Discretionary Provision

Works under £1,000

- Hospital Discharge - hospital discharge referrals have to be prioritised and completed within **24 hours** after receiving the order (Exceptions would be for privately rented accommodations when permission is needed from landlords prior to starting the job)
- Urgent - urgent priority referrals should be completed within **48 hours** from receiving the order. Exceptions would be for privately rented accommodations when permission is needed from landlords prior to starting the job.
- None-priority – None-priority orders should be completed within **7 days**. Exceptions would be for privately rented accommodations when permission is needed from landlords prior to starting the job.

Works between £1,001 - £10,000*

- All requests for works are booked for scoping within **24 hours**.
- Hospital Discharge/Urgent - hospital discharge and urgent referrals have to be prioritised and completed within **7 days** after receiving the order (Exceptions would be for privately rented accommodations when permission is needed from landlords prior to starting the job)
- None-priority – None-priority orders should be completed within **28 days**. Exceptions would be for privately rented accommodations when permission is needed from landlords prior to starting the job.

4 Options considered and Recommended Proposal

4.1 Alternative procurement options are shown in paragraph 3.8.

5 Consultation

5.1 The development of a Staying Independent at Home Procurement Strategy was included in the Cabinet report on the 22 March 2022 which was approved.

5.2 The contents of this report were discussed at the Adult Social Care Commissioning Management Team on the 5th August 2022. and they Management Team were supportive of the recommendations within this report.

5.3 The contents of this report were discussed at the Staying Independent at Home Programme Board on the 9th August 2022. The Board were supportive of the recommendations within this report.

5.4 The contents of this report were discussed at the Adult Social Care Management Team on the 17th August 2022 and the Management Team were supportive of the recommendations made within this report.

5.5 The contents of this report were discussed at the Better Care Fund Commissioning Executive on the 7th September 2022. The Board were supportive of the recommendations within this report.

5.6 Officers from City Finance, Corporate Procurement and Legal and Governance have been involved in the preparation of this report.

6 Risk Management

6.1 The CPS approach is to follow the Council Risk Management Methodology and the Procurement Team is responsible for local risk management. CPS maintains a risk management register and documentation relevant for each contract. The risk register for the service has been jointly produced and owned by the Adult Social Care Directorate and CPS with arrangements being put in place to ensure operational risks are appropriately mitigated.

7 Compliance Issues:

7.1 How are the recommended decisions consistent with the City Council's priorities, plans and strategies?

7.1.1 The proposals contribute to the delivery of the Council's core vision and priorities in the Council's Vision and Forward Plan 2018 - 2022 of:

- Birmingham is an aspirational city to grow up in – through the policy implementation this will give greater choice to citizens of all ages to be able to make a more informed decision about living at home with support to ensure home is a safe environment. This widens the options available to citizens to have greater choice when addressing their social care need.
- Birmingham is a fulfilling city to age well in – by implementing the Staying Independent at Home Policy the Council will be able to support citizens to remain living as independently as possible within their own homes.

7.1.2 Birmingham Business Charter for Social Responsibility (BBC4SR)

Compliance with the BBC4SR is a mandatory requirement that will form part of the conditions of these contracts. Tenderers will be required to submit an action plan with their tender that will be evaluated in accordance with the procurement strategy set out in paragraph 3.9.4 and the action plan of the successful tenderers will be implemented and monitored during the contract period.

7.2 Legal Implications

7.2.1 Section 14 of The Care Act 2014 states that the Council must provide minor works or equipment of a value of less than £1,000 free of charge to the citizen as detailed in The Act where these are necessary to meet a Care Act outcome.

7.2.2 The Housing Grants, Construction and Regeneration Act 1996 (HGCRA 1996) places a mandatory duty on the Local Authority to provide grants towards the costs of works required for the provision of facilities for people living with disabilities as defined in the Equality Act 2010. These are known as Disabled Facilities Grants (DFG).

7.2.3 The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO 2002), enables the Local Authority to use discretionary powers to provide other forms of housing assistance in addition to the mandatory duties to provide DFG. In order to exercise discretion and flexibility in the form of assistance offered and crucially to enable flexibility in the use of the annual DFG funding allocation, the Local Authority must publish a policy setting out the assistance available.

7.2.4 Under Section 111 of the Local Government Act 1972, a local authority has the power to take action, which is calculated to facilitate, or is conducive or incidental to, the discharge of any of its functions and therefore has a general power to enter into contracts for the discharge of its functions. Section 93 of the Local Government Act 2000 gives the Secretary of State power to award grants to local authorities for expenditure incurred by them in the provision of welfare services determined by the Secretary of State.

7.2.5 Pre-Procurement Duty under the Public Service (Social Value) Act 2012

The Social Value outcomes to be supported by this contract have been determined and are included in the specification, as well as incorporation of the associated Themes from the BBC4SR that are included in the tender evaluation, therefore no additional stakeholder consultation is required.

7.3 Financial Implications

7.3.1 Funding arrangements for the provision:

- This is a procurement process for a contract for a 5-year period with the potential for a further 2-year extension, in order to ensure citizens are able to remain living at home for as long as possible.
- The contract will be funded through the Disabled Facilities Grant which is a grant received by the Council from the Government on a yearly basis.
- The costs of undertaking this procurement exercise will be met through the Adult Social Care budget.

7.4 Procurement Implications

7.4.1 This report concerns the procurement strategy for the Staying Independent at Home Adaptation and Improvement Service and the implications are detailed through the report.

7.4.2 The Lead Provider model appears to be the most suitable option for the proposed Service, but it is not without its complications particularly around the subcontracting arrangements. CPS is working closely with Commissioners to ensure that the criteria around subcontracting, supply chain due diligence is clearly developed and set out in tender documentation.

7.4.3 Sub-contracting levels will be specified as part of the tender documentation to ensure that there is the opportunity for smaller local businesses to be able to be part of a bid submission.

7.4.4 Sub-contracting provisions will also be stipulated within the contract and approval will have to be given for any removal or addition.

7.4.5 Consideration is being given to the inclusion of scheduled tender clarification meetings to provide clarification around the service delivery model and subcontracting arrangements

7.4.6 The tender opportunity will be open for a minimum of 40 days to give the market more time to put together their proposal around the model.

7.5 Human Resources Implications (if required)

7.5.1 The procurement activity and the subsequent contract management will be undertaken by Council staff.

7.6 Public Sector Equality Duty

7.6.1 A relevance test to decide whether the planned procurement for the Staying Independent at Home Adaptation and Improvement Service has any relevance to the equality duty contained in Section 149 of the Equality Act 2010 of eliminating unfair/unlawful discrimination and to promoting equality and human rights was conducted on 7th November 2022, reference EQUA1009. The screening identified that there was no requirement to assess this further and completion of an Equality Assessment form was not required.

8 Appendices

8.1 None

9 Background Documents

9.1 Staying Independent at Home Policy Cabinet Report – March 2022

9.2 Staying Independent at Home Policy

Birmingham City Council
Report to Cabinet
22nd March 2022

Subject:	**STAYING INDEPENDENT AT HOME POLICY – WIDENING THE USE OF THE DISABLED FACILITIES GRANT**
Report of:	**Professor Graeme Betts CBE Director for Adult Social Care**
Relevant Cabinet Member:	**Cllr Paulette Hamilton - Health and Social Cllr Shabrana Hussain - Homes and Neighbourhoods Cllr Tristan Chatfield - Finance and Resources Cllr Sharon Thompson - Vulnerable Children and Families**
Relevant O &S Chair(s):	**Cllr Mick Brown - Health and Social Care Cllr Akhlaq Ahmed - Resources Cllr Narinder Kaur Kooner - Education and Children's Social Care**
Report author:	**Sarah Feeley, Commissioning Manager Email: sarah.feeley@birmingham.gov.uk**

Are specific wards affected? If yes, name(s) of ward(s):	☐ Yes	☒ No – All wards affected
Is this a key decision? If relevant, add Forward Plan Reference: 009964/2022	☒ Yes	☐ No
Is the decision eligible for call-in?	☒ Yes	☐ No
Does the report contain confidential or exempt information?	☒ Yes	☐ No
If relevant, state which appendix is exempt, and provide exempt information paragraph number or reason if confidential: Exempt Appendix 1 – Paragraph 3. Information relating to the financial or business affairs of any particular person (including the authority holding that information).		

1 Executive Summary

1.1 The report is seeking approval to adopt a new policy to provide support to citizens to remain living independently in their homes and the extensions required to ensure services are able to deliver as outlined in the policy for an interim period.

2 Recommendations

2.1 That Cabinet; -

2.1.1 Approves the Staying Independent at Home (SIAH) Policy and the associated implementation measures.

2.1.2 Notes the implementation dates of the assistance

2.1.2.1. Top Up Grant implemented from the 11th April 2022.

2.1.2.2. Other forms of assistance implemented by the 3rd October 2022.

2.1.3 Approves a 16-month extension for current contracts for the provision of Key Safes and Major Adaptations as detailed in 7.4.6 - 7.4.9 for the maximum value of £14.362m.

2.1.4 Delegates the approval of the Commissioning and Procurement Strategy to the Cabinet Members for Health and Social Care and Finance and Resources.

2.2 Authorises the City Solicitor (or their delegate) to conclude and enter into all legal documents to give effect to the above

3 Background

3.1 The Housing Grants, Construction and Regeneration Act 1996 (HGCRA 1996) places a mandatory duty on the Local Authority to provide grants towards the costs of works required for the provision of facilities for people living with disabilities as defined in the Equality Act 2010. These are known as Disabled Facilities Grants (DFG). Funding is allocated annually from central government via the Better Care Fund to support local authorities to discharge this duty.

3.2 The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO 2002), enables the Local Authority to use discretionary powers to provide other forms of housing assistance in addition to the mandatory duties to provide DFG. In order to exercise discretion and flexibility in the form of assistance offered and crucially to enable flexibility in the use of the annual DFG funding allocation, the Local Authority must publish a policy setting out the assistance available.

3.3 Currently, Birmingham does not have a published policy under the Regulatory Reform Order (RRO) 2002. This means that the Council is unable to make use of the discretionary powers. By having a policy in place, the Council will be able to exercise greater flexibility to support citizens to remain living independently at home. This provides benefits to both the Council – in terms of less bureaucratic processes – and to citizens – in terms of more responsive and personalised assistance.

3.4 The SIAH Policy sets out the assistance that the Council will provide in response to duties and powers arising from three key pieces of legislation: The Care Act 2014, The Housing Grants, Construction and Regeneration Act 1996 and the Regulatory Reform Order 2002. Bringing these together into a single policy is intended to provide a clearer framework for assistance.

3.5 The SIAH Policy has been developed through co-production with citizens. The project team would like to formally acknowledge the dedication and hard work of those citizens in supporting the development of the policy and providing a better understanding of how this could support citizens to stay independent at home. There were 6 key themes identified by citizens as important. These underpinned the policy development and are:

3.5 In respect of the exercise of discretionary powers through the RRO, the policy has been developed to meet the following objectives:

- Supporting disabled citizens to secure necessary adaptations which cost more than the maximum (£30k) allowed under the Disabled Facilities Grant. These will be known as **Top Up Grants.**

- Securing prompt discharge from hospital of citizens who might, due to accommodation difficulties, otherwise remain in hospital longer than necessary. This will be known as **Discharge Assistance**

- Addressing accommodation difficulties which, if not resolved, might lead to an avoidable admission to hospital, or residential care or which impact upon the ability of a citizen to live safely and independently at home. This will be known as **Independent and Safe Assistance**

3.6 This will enable the Council to provide support and services to citizens with a greater focus on prevention and providing assistance in a way that meets the needs of the citizen, keeping them independent at home.

3.7 In order to ensure that the services are able to develop and be mobilised there is a phased approach planned for the implementation of the policy that will see the Top

Up Grants implemented from the 11th April 2022 and the other forms of assistance by the 3rd October 2022.

4 Options considered and Recommended Proposal

4.1 Do Nothing – do not publish a policy and continue only providing the mandatory requirements. This is not recommended as this limits the support and assistance that the Council is able to provide to citizens, which could prevent them needing further intervention.

4.2 Limited development – only increasing the support available through the mandatory grant such as top ups. This is not recommended as this limits the assistance the Council could provide to support citizens to remain at home.

4.3 Implement the policy – approve the implementation of the policy, which enables the Council to widen the use of discretion to be able to provide additional support and assistance to citizens enabling them to remain living as independently as possible at home. This is the recommended proposal.

5 Consultation

5.1 The contents of this report were discussed at the Staying Independent at Home Programme Board on the 18th January 2022. The Board were supportive of the recommendations within this report.

5.2 The contents of this report were discussed at the Better Care Fund Programme Board on the 25th January 2022 and the Board were supportive of the recommendation to implement the policy.

5.3 The contents of this report were discussed at the Adult Social Care Management Team on the 26th January 2022 and they were supportive of the recommendations within this report.

6 Risk Management

6.1 The policy has been developed through a robust project management programme that includes the management and identification of risks that are tracked as part of the project delivery. There are no identified risks in the adoption of the policy, but this will continue to be monitored as the policy implementation is completed and through service delivery.

7 Compliance Issues:

7.1 How are the recommended decisions consistent with the City Council's priorities, plans and strategies?

7.1.1 Birmingham is an aspirational city to grow up in – through the policy implementation this will give greater choice to citizens of all ages to be able to make a more informed decision about living at home with support to ensure

home is a safe environment. This widens the options available to citizens to have greater choice when addressing their social care need.

7.1.2 Birmingham is a fulfilling city to age well in – by implementing the Staying Independent at Home Policy the Council will be able to support citizens to remain living as independently as possible within their own homes.

7.2 Legal Implications

7.2.1 Section 14 of The Care Act 2014 states that the Council must provide minor works or equipment of a value of less than £1,000 free of charge to the citizen as detailed in The Act where these are necessary to meet a Care Act outcome.

7.2.2 The Housing Grants, Construction and Regeneration Act 1996 (HGCRA 1996) places a mandatory duty on the Local Authority to provide grants towards the costs of works required for the provision of facilities for people living with disabilities as defined in the Equality Act 2010.

7.2.3 The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO 2002), enables the Local Authority to use discretionary powers to provide other forms of housing assistance in addition to the mandatory duties to provide DFG. In order to exercise discretion and flexibility in the form of assistance offered and crucially to enable flexibility in the use of the annual DFG funding allocation, the Local Authority must publish a policy setting out the assistance available.

7.3 Financial Implications

7.3.1 The implementation of the policy will be funded through the Disabled Facilities Grant received into the Council, Adult Social Care base budget and also the Housing Revenue Account (council tenants).

7.3.2 Revenue spend will replace funds already spent on achieving care outcomes, so will not put a pressure on general fund. Capital spend will be funded from either the HRA or the annual Disabled Facilities Grant (currently £12.7m per annum, which cannot be used for other purposes other than statutory adaptations grants or discretionary spend as per a published policy) depending on the tenure of the citizen.

7.3.3 The cost of the proposed contract extensions detailed in 7.4.6 - 7.4.9 will cost a maximum of £14.362m for 16 months and will be funded through the annual Disabled Facilities Grant that is received by the Council. There is no additional funding required from the Council to support the extensions of the contracts.

7.3.4 The policy includes a prioritisation of approvals of grant requests according to need and statutory requirement. Although there is currently no expectation of applications exceeding the total grant income and existing reserves for the short to medium term, this prioritisation ensures that the introduction of discretionary assistance creates no risk of overcommitment of funds.

7.3.5 The Social Care White Paper – "People at the Heart of Care" - has also indicated that additional funding will be given to Local Authorities to support people to remain living independently. This policy reflects the ambitions of the white paper and will enable the Council to deploy any additional funding within an agreed policy.

7.4 Procurement Implications

7.4.1 Integrated Service Model – in developing the policy officers have been mindful of the need to develop new delivery arrangements to support implementation. Therefore, work has commenced on the commissioning strategy for an Integrated Service that will be able to deliver and respond to the needs of Birmingham Citizens and more suited to the capability of the market. The aim of the Integrated Service will be to bring all of the services including Key Safes, Minor Adaptations and Major Adaptations together as well as bringing in additional new areas of delivery, refocusing the provision on the areas outlined in the policy. Over the coming months market engagement will develop the future model and specification.

7.4.2 The indicative implementation plan for the commissioning and procurement is:

Activity	**Proposed Dates**
Commissioning strategy development	March – July 2022
Specification and ITT developed	July – August 2022
Procurement Strategy Report	September 2022
ITT Issued	September 2022
ITT Return	November 2022
Evaluation Period	November – December 2022
Contract Award	December 2022
Mobilisation period	January – April 2023
Contract Start	July 2023

7.4.3 The proposal for the procurement is via the Open tender route to market. The proposed split for price, quality and social value is based on ensuring that the quality and provision provided would be able to meet the needs of our most vulnerable citizens whilst still maintaining value for money, therefore the split of 50% Quality, 30% Price and 20% Social Value.

7.4.4 It is proposed that the approval of the Procurement Strategy be delegated to the Cabinet Members for Adult Social Care/Finance and Resources and the Director Adult Social Care to enable the procurement of a new integrated model to be achieved within the advised timeline above.

7.4.5 In order to be able to deliver assistance under the policy there will be a requirement to extend the current service arrangements to stabilise services

for the interim period while the commissioning and procurement detailed above is completed. As part of the policy development it was clear that services would need to be delivered differently in the future to meet the need, widened scope and potential additional demand. It was identified that it would not be in the best interests of the Council or providers to undertake multiple procurement processes in quick succession.

7.4.6 The services that require an extension are:

Key Safes

This service is currently provided by Black Country Housing Group with a contract value of £600k, the original contract was for a 2 plus 2 which expired on the 31st March 2020, a procurement process was followed but this was unsuccessful in securing an award due lack of quality responses from the market. Therefore, as there is a statutory duty under Section 2 of the Care Act to provide this service, the contract was extended until 4th December 2021. The provider has continued delivering the service since this date at risk, therefore this additional proposed extension would formalise the contract. The proposal is to extend the current service until the 30th June 2023 (16 months) with a maximum value of £250k. There are no performance issues with this provider.

Major Adaptations

This service is currently broken down into 2 lots as detailed below:

7.4.7 Lot 1 (lifting equipment) extension would be for a maximum value of £2.8m with Able Access UK Ltd and Dolphin Lifts Midlands Ltd, the original contract awarded was for a 3 plus 1 which have already been utilised this expired on 31st August 2021. The providers have continued to deliver the service at risk, therefore this would be an additional extension to formalise the contract. There are no performance issues with the current providers.

7.4.8 Lot 2 (bathrooms and kitchens) extension would be for a maximum value of £11.312m, the original contract awarded was for a 3 plus 1 which is due to expire on the 31st April 2022, therefore this would be an additional extension, there are no performance issues with the current providers. The extensions would be with; -

- 3MS Gold Services Ltd
- Able Access UK Ltd
- Bickford Construction
- Eden Adaptations
- Fortem Solutions Ltd
- Goodwells Ltd
- Hardyman Group Ltd

- John Gillespie Contractors Ltd
- Laker BMS Ltd
- S Kitaure Construction
- Wates Construction Ltd

7.4.9 The original combined contract value for these Lot 1 and Lot 2 services for four years was £17.6m. This was a reflection of the amount of DFG grant allocated to the Council from government in 2017/18. This grant allocation has increased substantially over the years to a position where grant allocation for 2021/22 is £12.7m. Demand has steadily increased for these services and while the long-term effects of Covid and its impact on demand is yet to be determined, it is likely that demand for this enabling service will continue to increase.

7.4.10 In light of the details outlined in 7.4.6 – 7.4.8 the Council seeks to amend the contracts in accordance with the Public Contract Regulations (PCR 2015). Clause 72 of the Public Contract Regulations (72.1.bii) permits contract modifications "*for additional works, services or supplies by the original contractor that have become necessary and were not included in the initial procurement, where a change of contractor—*

(ii) would cause significant inconvenience or substantial duplication of costs for the contracting authority, provided that any increase in price does not exceed 50% of the value of the original contract;"

7.4.11 Due to the increase in grant funding, the value of the extension is in excess of 50% of the contract value, and therefore there could be a risk of challenge from other providers, however the value of the extension is required to ensure that the Council is able to spend its annual grant allocation.

7.4.12 Given that this arrangement is time-limited and that the recommendations of this report will commence a commissioning and procurement process, the risk of challenge from other potential providers is considered to be minimal and outweighed by the risk of not having a continuation of service in place.

7.4.13 In order to further mitigate the risk, a Voluntary Ex Ante Transparency (VEAT) notice will be published notifying the market of our intension to extend these contracts.

7.4.14 The value of the extension for Key Safes is contained within the 50% allowance.

7.4.15 The contract for Minor works which is the delivery of works less than £1,000 is currently out for procurement and due to be completed shortly.

7.4.16 The Contracts will be managed by the Multi-Disciplinary Team Manager within the Adult Social Care Directorate, supported by the Commissioning Manager as required.

7.5 Human Resources Implications

7.5.1 None

7.6 Public Sector Equality Duty

7.6.1 Through the adoption of the Staying Independent at Home Policy the support and assistance available to citizens will be widened. Citizens who are eligible for assistance as detailed within the policy will be able to seek assistance and support from the Council.

7.6.2 See **Appendix 3** Equality Impact Assessment (EQUA849)

7.6.3 The requirements of Standing Order No. 9 in respect of the Council's Equal Opportunities Policy are incorporated in the Contract for those services proposed to be extended.

7.6.4 The requirements of the Equality Act 2010 are specifically included in the Contract to comply with, the Act.

8 Appendices

8.1 **Appendix 1** - Exempt Information

8.2 **Appendix 2** - Staying Independent at Home Policy

8.3 **Appendix 3** - Equality Impact Assessment (EQUA849)

Birmingham City Council

Birmingham Staying Independent at Home Policy

Contents

Birmingham City Council

Staying Independent at Home Policy

1. Introduction

1.1 This document is the Council's policy on the provision of support and assistance that can be provided to enable citizens to staying independent within their own homes, this includes support under the:

- The Housing Grants, Construction and Regeneration Act 1996
- Care Act 2014
- Regulatory Reform Order 2002

1.2 It is widely acknowledged that home is best for most citizens, their families and carers, it is where they are happiest and thrive with the right support. We know that poor quality housing is thought to cost the NHS an estimated 1.4 billion pounds per year, over half of which is attributed to poor housing among older adults.

1.3 As housing is a key determinant of health this policy will set out how Birmingham City Council will reduce the health inequality brought about by poor living standards, by providing support in form of grants, loans or services to improve housing conditions. Ensuring that homes are decent, accessible, safe and secure is not only important for the health and wellbeing of the citizen, but it is also vital for the sustainability of communities. This policy sets out the Council's response to this and the range of assistance available to assist citizens in better maintaining their home.

1.5 The policy sets out both the assistance that the Council has a duty to provide (mandatory) and assistance that will be provided through the use of discretionary powers. The amount of discretionary assistance to be given each year will be determined by the Council and will be dependent upon the level of resources available.

2. Legal Context

2.1 The Housing Grants, Construction and Regeneration Act 1996 provides for Disabled Facilities Grants, of up to £30,000. These are grants to help with the cost of adapting a property to meet the needs of a disabled occupant.

2.2 The Care Act 2014 provides that, in certain circumstances, the Council must meet the costs of minor works or providing equipment, costing up to £1,000.

2.3 The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 ('the Order') provides the Council with a power to give assistance to enable individuals to acquire living accommodation, or to adapt, improve or repair their living accommodation. This is the basis for the "discretionary assistance" detailed in Section 5 of this policy.

2.4 The Better Care Policy Framework 2021-22[1] issued by the Department of Health & Social Care, Ministry of Housing, Communities & Local Government and Department for Levelling Up, Housing & Communities sets out plans to continue to help prevent the need for long-term services and to keep people out of hospital and independent in their own homes for as long as possible.

2.5 The Housing Act 2004; Local Authorities have a duty to keep housing conditions under review, including having regard to particular hazards that might be dangerous or prejudicial to health for certain vulnerable groups.

3. Rationale for Assistance

3.1 Improving housing conditions across the city will lead to improvements in the health and wellbeing of our citizens and additionally will have a positive impact on local neighbourhoods, particularly for those citizens who are vulnerable and may not be able to carry out necessary repairs, or for those who cannot access their homes due to disability.

3.2 As described in the legal context above, the Council has statutory duties in respect of the provision of Disabled Facilities Grants and minor works and/or providing equipment to discharge Care Act obligations.

3.3 The funding available to be provided for discretionary assistance, under the Order, is not unlimited. The Council must focus the provision of assistance where it can have the most positive benefit for citizens, and the City. The Council has identified three priority areas for the deployment of assistance and use of powers, under the Order:

- Supporting disabled citizens to secure necessary adaptations which cost more than the maximum allowed under the Disabled Facilities Grant;
- Securing prompt discharge from hospital of citizens who might, due to accommodation difficulties, otherwise remain in hospital longer than necessary; and
- Addressing accommodation difficulties which, if not resolved, might lead to an avoidable admission to hospital, or residential care or which impact upon the ability of a citizen to live safely and independently at home

4. What our citizens told us

4.1 Through engagement with our citizens on how we can help them to live independently at home, the following six themes emerged

[1] https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/better-care-fund/

5. Forms of Discretionary Assistance

5.1 Supporting disabled citizens to secure necessary adaptations which cost more than the maximum allowed under the Disabled Facilities Grant.

5.1.1 Disabled Facilities Grants play an important role in supporting disabled citizens to secure necessary adaptations for their homes. However, there is a statutory maximum on the sum payable. Currently, the maximum is £30,000. It is sometimes the case that necessary adaptations cost more than the statutory limit.

5.1.2 The power to provide discretionary assistance over the statutory maximum value is, therefore, an important mechanism to avoid disabled citizens going without necessary adaptations when this has been assessed and agreed as being the best course of action.

5.1.3 For those citizens assessed as eligible for a Disabled Facilities Grant, the Council will consider applications to top-up the Disabled Facilities Grant above the statutory maximum value, to secure the adaptations identified as necessary during the Disabled Facilities Grant application process.

5.2 Securing prompt discharge from hospital of citizens who might, due to accommodation difficulties, otherwise remain in hospital longer than necessary – Discharge Assistance

5.2.1 Delayed discharge of citizens from hospitals and short-term care beds has significant adverse consequences. These citizens often experience reduced positive outcomes. Delays also impact on the wider health and social care system. Hospital and short-term care beds, needed for other citizens, are occupied unnecessarily, which is wasteful, and impacts care pathways for many other citizens.

5.2.2 Where citizens will require care after discharge from hospital, problems with accommodation can frequently be a reason for delayed discharge from hospital. The citizen's accommodation might not be a suitable environment for the provision of the care which the person now requires. Therefore, providing assistance to support prompt discharge of citizens, who are in need of care, is an area where the Council will provide assistance under this Policy.

5.2.3 The Council will consider providing assistance under the Order to citizens who:

- Are in hospital or a short-term care bed (Pathway 2 Bed);
- Have (or appear, to the Council, to have) needs for care at home; and
- Are likely to be unable to receive the care they require at home, due to the condition of their home, such that their discharge from hospital may be delayed.

5.2.4 Forms of assistance, can include but not limited to:

- Heating system repairs/replacement
- Access to facilities including gas, electric and water
- Addressing hoarding and deep cleans
- Stair lifts
- Level access showers
- Ramps
- Ceiling track hoists
- Minor hazard repairs
- Technology Enabled Care

5.3 Addressing accommodation difficulties which, if not resolved, might lead to an avoidable admission to hospital, or residential care or which impact upon the ability of a citizen to live safely and independently at home – Safe and Independent Assistance

5.3.1 Problems with accommodation can inhibit the provision of effective care at home, meaning that individuals are more likely to face a crisis situation, requiring admission to hospital or admission to residential care. Both scenarios are likely to involve reduced positive outcomes for the individuals, and place undue pressures on the health and social care system across the City. Therefore, providing assistance to address barriers to care provision in the home is an area where the Council will provide assistance under the Order.

5.3.2 The Council will consider providing assistance under the Order to citizens who:

- Have (or appear, to the Council, to have) needs for care at home; and
- Are likely to be unable to receive the care they require at home, due to the condition of their home. And/or
- Would benefit from assistance related to their living environment that enables them to meet one of the Care Act outcomes – most likely. And/or
- Being able to make use of the home safely. And/or
- Maintaining a habitable home environment.

5.3.3 Forms of assistance, can include but not limited to:

- Heating system repairs/replacement
- Access to facilities including gas, electric and water
- Addressing hoarding and deep cleans

- Minor hazard repairs
- Stair lifts
- Level access showers
- Ramps
- Ceiling track hoists
- Technology Enabled Care

6. Extent of Assistance

6.1 The Council will consider the extent of funding required in each case. Decisions as to the funding to be offered, under the Order, will be taken having regard to factors including: the extent to which the proposed works further the aims identified in this Policy; the likely effectiveness of the proposed works; and the availability of other options to address the presenting problem (e.g. other sources of funding, or other steps the individual could take). The Council will also have to have regard to the need to support other citizens, and the extent of the Council's resources to provide assistance under the Order.

6.2 Support under the Order for the Disabled Facilities Grant top-up in each case will be uncapped subject to the relevant Occupational Therapy assessment for the required necessary adaptations.

6.3 Support under the Order for Discharge Assistance and Safe and Independent Assistance; the Council expects that in each case, it will provide not more than £10,000 in funding. In very many cases, the necessary assistance under this Policy, will probably cost much less. In each case, the value of the assistance provided will be that which the Council considers is reasonably required to meet the objectives of this Policy, having regard to the circumstances of the particular citizen.

7. Cases which fall outside of the policy

7.1 When dealing with requests we will endeavour to apply conditions of assistance flexibly and sensitively in order to support those in need of help.

7.2 Those cases which fall outside this policy but have been assessed as exceptional circumstances may be submitted to Birmingham City Council for consideration with formal approval required from the Corporate Director – Adult Social Care, or their nominated representatives.

8. Appeals or Review

8.1 The Council will set out in writing for eligible households the terms and conditions under which the assistance will be given. Where citizens are dissatisfied with a decision made by the Council relating to assistance provided under this policy, they should in the first instance submit their concerns via email to CSAdultsSocialCare@birmingham.gov.uk or in writing to the following address:

OT – DFG
PO Box 16606
Birmingham
B2 2FD

8.2 Where a citizen continues to be dissatisfied, they may submit a formal complaint to the Council. Details of the Council's Complaints Policy and how to make a compliant are provided on the Council's website[2].

9. Resources

9.1 Birmingham City Council reserves the right to use its discretion under this policy to pay for staff and alternative requirements to support the delivery of this policy.

10. Monitoring and Review of the Policy

10.1 Feedback from the citizen will be sought following completion of work and subject to the type of assistance provided if appropriate follow-up assessment will take place to ensure the works meet the needs of the citizen.

10.2 The contents of the policy will also be reviewed from time to time to ensure the assistance provided remains relevant and keeps abreast of any national legislative changes or best practice.

10.3 A full review of the policy should be undertaken no longer than one year following adoption.

2 https://www.birmingham.gov.uk/info/20018/adult_social_care/116/statutory_adults_social_care_complaints_comments_and_compliments

Appendix 1 – Summary of Assistance

Assistance	Eligibility
Disabled Facilities Grant (DFG)	Based on an assessment (compliant with the Housing and Regeneration Act 1996) by the Adult Social Care Occupational Therapy Team
Disabled Facilities Top-Up Grant	Restricted to those eligible for a DFG as above, Based on an assessment by the Adult Social Care Occupational Therapy Team
Minor Works – works or equipment costing less than £1000	Based on an assessment of social care needs compliant with the Care Act 2014
Discharge Assistance	The Council will consider providing assistance under to citizens who: • Are in hospital; • Have (or appear, to the Council, to have) needs for care at home; and • Are likely to be unable to receive the care they require at home, due to the condition of their home, such that their discharge from hospital may be delayed.
Independent and Safe Assistance	The Council will consider providing assistance to citizens who: • Have (or appear, to the Council, to have) needs for care at home; and • Are likely to be unable to receive the care they require at home, due to the condition of their home. And/or • Would benefit from assistance related to their living environment that enables them to meet one of the Care Act outcomes – most likely: • Being able to make use of the home safely • Maintaining a habitable home environment

Appendix 2

Disabled Facilities Grant

1. What are Disabled Facilities Grants (DFG)?

1.1 The Disabled Facilities Grant is a means-tested grant to install adaptations such as showers, stairlifts, ramps or other changes to the home that enable disabled children, disabled adults and older adults to live safely, independently and with dignity in their community.

A citizen is deemed disabled if:

- Their sight, hearing or speech is substantially impaired
- They have a mental disorder or impairment of any kind
- They are physically substantially disabled by illness, injury, impairment present since birth, or otherwise.

It can be a crucial step to avoid the need to move into a care facility and can be key to enabling citizens to be discharged from hospital without delay.

All applications for DFG must meet the relevant requirements as set out within the legislation. This means that works being requested must be deemed as being 'necessary and appropriate' and 'reasonable and practicable'.

2. Who is eligible for the Disabled Facilities Grant?

2.1 Disabled or elderly citizens who live in Birmingham may be entitled to apply for this grant.

2.2 Homeowners who receive a grant would be expected to be likely to remain in their home for at least 10 years following the work being carried out. In this instance a limited land registry charge is made against the property to recoup some of the costs of work costing between £5,000-£10,000 if the property is sold before this time.

3. Works eligible for DFG assistance

3.1 General

3.1.1 The adaptation works eligible for assistance will be those listed under section 23 (1) of the Housing Grants, Construction and Regeneration Act 1996, as follows.

3.2 Access to the dwelling

3.2.1 Works eligible for assistance may include:

- Ramped access to main entrance door for wheelchair use; widened or shallower steps to main entrance door or a step lift;
- Widened entrance door for wheelchair use;
- Resurfaced or re-graded path to entrance door;
- Alterations to secondary entrance door/patio window to provide access to rear garden/yard where access cannot easily be gained via the adapted main entrance and drive/side path;
- Structural alterations required to allow installation of stair lift through floor lift or step lift equipment.

3.3 Making the Dwelling Safe

3.3.1 Works eligible for assistance may include:

- Works to provide a means of escape from fire (usually to flats).
- Provision of guards to prevent persons with behavioural problems harming themselves.
- Specialised glazing or shades to windows to protect occupants with a medical condition which make them sensitive to sunlight.
- Repairing defective stairs or floors etc which are hazardous.

3.4 Access to Principal Family Room

3.4.1 Works eligible for assistance may include:

- Widened doorway for wheelchair access.
- Provision and installation of stair lift/through-floor lift equipment and structural alterations required to allow installation, if the principal living room is on an upper floor.
- Widened doorway in entrance hall to access principal family room for wheelchair use.

3.5 Access to Sleeping Room

3.5.1 Works eligible for assistance may include:

- Provision and installation of stair lift/through-floor lift equipment and structural alterations required to allow the installation, where access is required to a bedroom or room suitable for sleeping which is above ground floor level.
- Conversion of a ground floor room into a bedroom, widened doorway for wheelchair access to sleeping room.
- Construction of bedroom extension (see notes on extensions).
- Strengthened ceiling and/or preparation works for ceiling track hoist, where hoist is to be provided by Lift provider.

3.6 Access to Water Closet (WC)

3.6.1 Works eligible for assistance may include:

- Provision and installation of stair lift/through-floor lift equipment and structural alterations required to allow the installation, where access is required to a WC above ground floor level;
- Strengthened ceiling and/or preparation works for ceiling track hoist, where hoist is to be provided by Lift provider.
- Repositioning WC to facilitate access by wheelchair user.
- Raised/lowered WC pan.
- Provision of grab rails.
- Provision of ground floor WC where upper floor cannot be accessed.
- Widened doorway for wheelchair access.

3.7 Access to Bathing Facilities

3.7.1 Works which may be eligible for assistance include:

- Provision and installation of stair lift/through-floor lift equipment and structural alterations required to allow the installation, where access is required to an existing bathroom above ground floor level.
- Provision of shower (thermostatically controlled) over a bath, including necessary curtain, tiles and grab rail.
- Replacement of bath with shower facility.
- Replacement of shower with a bath.
- Provision of bath and shower where there are 2 or more disabled occupants with differing needs.
- Provision of bathroom extension (see notes on extensions).
- Relocation of bath/shower to facilitate use by wheelchair user.
- Strengthened ceiling and/or preparation works for ceiling track hoist, where hoist is to be provided by Lift provider.
- Widened doorway for wheelchair access.
- Provision of fixed seat/grab rails.
- Non-slip/sloping floor to create shower facility.

3.8 Access to Wash Basin

3.8.1 A wash-hand basin will normally be provided in the same room as the WC.

Works to provide access may include:

- Relocation of wash-hand basin to facilitate use by wheelchair user.
- Replacement of wash-hand basin with more suitable type e.g. replace vanity unit with wall fixed wash-hand basin.
- Replacement of taps with lever taps in association with above.

3.9 Access to Kitchen Facilities

3.9.1 The extent of adaptation work in a kitchen should be related to the extent of cooking and food preparation normally undertaken by the disabled person.

3.9.2 Works which may be eligible for assistance include:

- Rearrangement of kitchen fittings/appliances to facilitate their use.
- Enlargement of the kitchen if it is too small to allow its safe use by wheelchair user.
- Adapted work-top/storage unit for wheelchair user.
- Adapted doorway for wheelchair user.
- Widened doorway for wheelchair user.

3.10 Access to Power, Light and Heat

3.10.1 Works which may be eligible for assistance include:

- Relocating power points to make them accessible.
- Adaptation of heating/lighting controls to make them accessible.

- Replacement of solid fuel fire with other heating appliance in living/sleeping rooms normally used by a disabled occupant.
- Improvement of inadequate heating in living/sleeping rooms normally used by disabled occupant.
- Provision of central heating.

3.11 Access to Permit Care of Other Persons

3.11.1 Where the disabled occupant cares for other persons e.g. spouse, young children or elderly relatives who are normally resident in the dwelling, works may be provided to other rooms in the dwelling to allow the client access to care for those persons, including:

- Provision and installation of stair lift/through-floor lift equipment and structural alterations required to allow the installation, where the client lives on the ground floor but needs access to bedrooms.
- Widened doorways to bedrooms of those being cared for by client, wheelchair user.

3.12 Access to the Garden

3.12.1 In deciding the extent of providing access to the rear garden, the following will be considered.

- Grant assistance will not be given where there is already access to the garden but grant assistance may be given to improve an existing access to make it safe for the client to use. It does not include extending an existing access e.g. creating a side access so a client can also go around the side of a house.
- Generally, the most modest solution for providing access to both the house and the garden will be considered and this can mean that one access may be sufficient to access both the house and the garden.
- Where homes have communal gardens, e.g. blocks of flats served by a single access, grants will not normally be provided for an individual access to the garden unless it can be demonstrated that because of the clients condition the travel distance to the garden would be excessive and unreasonable.

4. How do I access the DFG Grant?

There are a few simple steps required for you to start the application process to the access the grant. The steps are (or refer to the flowchart on page 15):

Step 1 - Contact or email
The first step in accessing the grant is to call or email and request an OT assessment as you think you may require some adaptations; anyone can make this call as long as they have your consent to do so. During the call you will asked a range of questions to help us decide the best support we can offer you.

Step 2 - Occupational Therapy (OT) Assessment

In order to make sure that we can meet your needs we need to work with you to understand what these are. An OT will discuss with you your concerns/issues and look at the most cost-effective solution is to meet those assessed needs. This may mean we can meet your needs in other ways, should all options have been considered as not suitable, then a recommendation for an adaptation is required.

Step 3 - Priority Needs Assessment (PNA)
If it has been deemed that the adaptations are necessary, a Priority Needs Assessment is then completed. The PNA:

- Confirms the necessary and appropriate adaptations
- Determines the relevant priority

Prioritisation Panel Process
For citizens where it is proposed that adaptations are necessary and appropriate the Occupational Therapy Service will present the case to the Prioritisation Panel for approval.

The Prioritisation Panel is made up of Occupational Therapist Senior Practitioners.

If approved a Priority Needs Assessment is completed and includes:

- What the need for the citizen is
- What alternatives have been considered
- The recommendation (proposed solution)
- Level of priority

Each recommendation will be assigned a level of priority:

Level 2	you have a medium level of priority
Level 3	you have a high level of priority

Birmingham City Council would aim for all recommendations to be completed within the timescales set out in the legislation. The priority levels detailed above will be used in order to complete and deliver the recommendations with priority given to completing Level 3.

If a citizen's health deteriorates from the initial assessment there will be the opportunity for their case to be reprioritised, subject to advice and information from Health or Social Care.

Step 4 - Application for DFG funding
The PNA is submitted for consideration for a mandatory grant, you will be contacted to progress your application, including a means test if applicable.

As part of the process this could include a survey to confirm that your property is suitable for the proposed works (reasonable and practicable), if your property is deemed as not suitable, this will be discussed with you.

If a property doesn't meet the Housing Health and Safety Rating System Standard (free from Category 1 hazards), Birmingham City Council reserves the right to use its discretion to undertake required works to resolve identified hazards in order to enable the adaptations to proceed.

Step 5 - Grant decision

A decision on your application for a DFG grant is then made, this considers:

- Proposed adaptation meets the needs identified
- If the proposed recommendations exceed the DFG maximum grant allocation (if funding does exceed the Council may use its discretion based on the individuals assessed need)
- If a contribution is required

Step 6 - Decision notification

You will be notified of the outcome of the grant application:

- Application approved - if approval is given your contractor will contact you to arrange a start date for works.
- Application declined - Should the works required not be feasible you will be contacted to discuss alternative options but the initial request for funding would be declined.

Step 7 - Works Completed

5. Timescales

5.1 By law Birmingham City Council must consider applications for DFG and make determinations on those applications within 6 months of receipt. The Council considers that an application for a DFG has been submitted at the point of a satisfactorily completed application form, along with quotations for the work, landlord certificates and any relevant permissions that are required. Where a grant is to be means tested, evidence of financial income and savings and signed certificates of future occupation. Birmingham City Council shall provide support to applicants to assist them with this process.

5.2 Whilst applications must be determined within 6 months of receipt. Once an application for a DFG is approved the Council must ensure that the DFG is completed within 12 months.

6. Means Tested Contributions

6.1 During the DFG application process a test of resources may be undertaken to determine whether a citizen has the means to make a financial contribution towards the cost of works undertaken.

7. Repayment of Disabled Facilities Grant

7.1 Where the cost of an extension exceeds £10,000 Birmingham City Council will apply a land charge to the homeowner's property in line with current valuations for a maximum of 10 year.

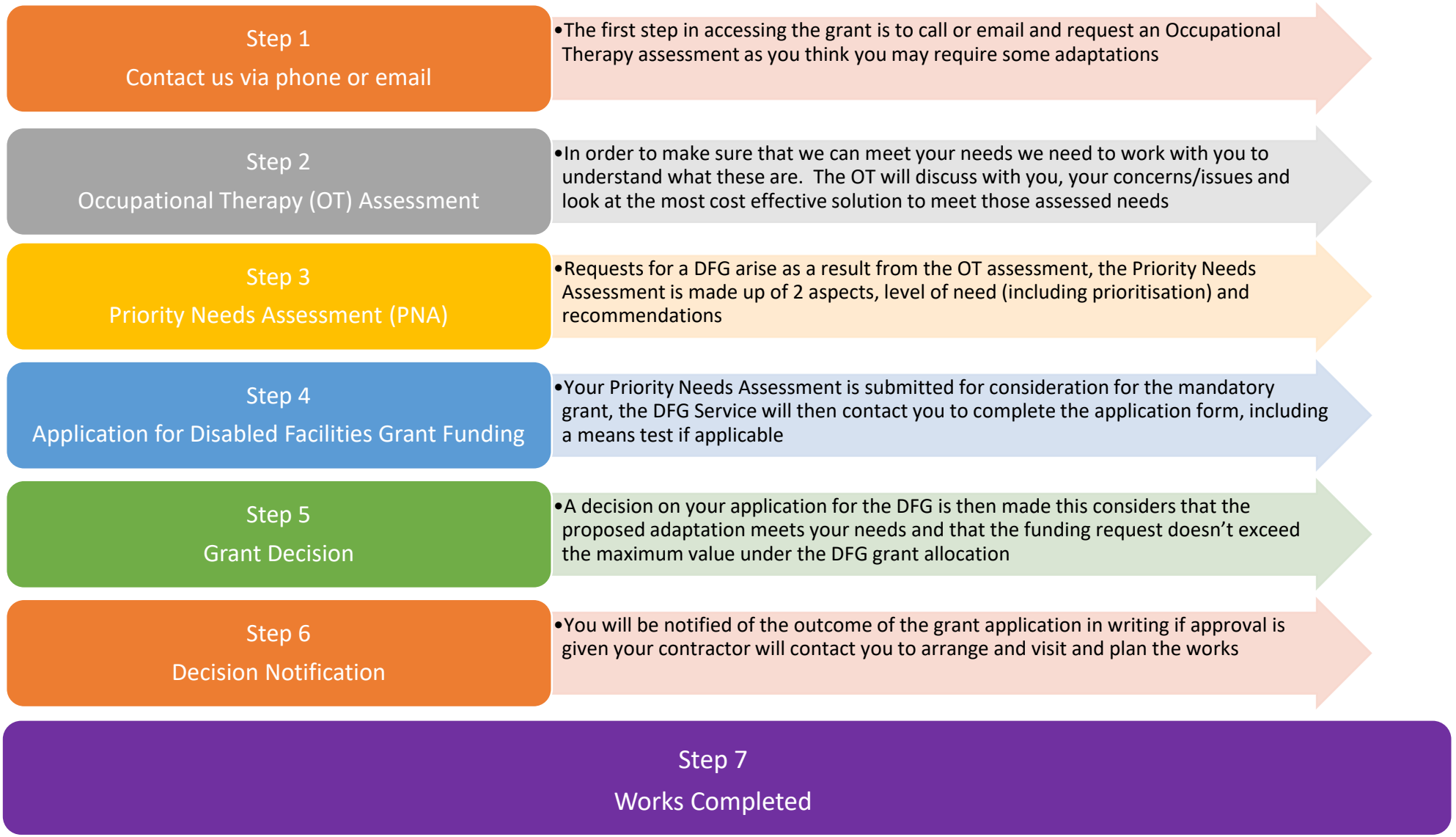
7.2 Homeowners who have previously had DFG funded adaptations carried out in their property who subsequently move to another home within the Birmingham City Council boundary and require further grant aid to install similar adaptations, these works will be subject to land charge if the cost exceeds £5,000.

7.3 In those cases that charges have been levied, Birmingham City Council must be satisfied that it is reasonable for this repayment to be made and will consider this in line with current DFG legislation.

8. Delivery of Adaptations

8.1 Birmingham City Council has an agreed list of contractors to undertake adaptation works.

8.2 Homeowners not wishing to use Birmingham City Council's framework or use an alternative contractor, can still apply for a DFG should they choose to. In these circumstances the applicant shall be solely responsible for making the application, sourcing contractors and overseeing any works undertaken. Works undertaken in these circumstances must be completed to the satisfaction of Birmingham City Council prior to the release of any grant funding.


Step 1
Contact us via phone or email
•The first step in accessing the grant is to call or email and request an Occupational Therapy assessment as you think you may require some adaptations
Step 2
Occupational Therapy (OT) Assessment
•In order to make sure that we can meet your needs we need to work with you to understand what these are. The OT will discuss with you, your concerns/issues and look at the most cost effective solution to meet those assessed needs
Step 3
Priority Needs Assessment (PNA)
•Requests for a DFG arise as a result from the OT assessment, the Priority Needs Assessment is made up of 2 aspects, level of need (including prioritisation) and recommendations
Step 4
Application for Disabled Facilities Grant Funding
•Your Priority Needs Assessment is submitted for consideration for the mandatory grant, the DFG Service will then contact you to complete the application form, including a means test if applicable
Step 5
Grant Decision
•A decision on your application for the DFG is then made this considers that the proposed adaptation meets your needs and that the funding request doesn't exceed the maximum value under the DFG grant allocation
Step 6
Decision Notification
•You will be notified of the outcome of the grant application in writing if approval is given your contractor will contact you to arrange and visit and plan the works
Step 7
Works Completed

Health and Social Care O&S Committee: Work Programme 2022/23

Chair:	Cllr Mick Brown
Deputy Chair:	Cllr Rob Pocock
Committee Members:	Cllrs: Kath Hartley, Jane Jones, Kirsten Kurt-Elli, Gareth Moore, Julian Pritchard and Paul Tilsley.
Officer Support:	Senior Overview and Scrutiny Manager: Fiona Bottrill (07395 884487) Interim Scrutiny Officer: Adewale Fashade Committee Manager: Sofia Mirza (675 0216)

1 Introduction

1.1 The Health and Social Care Overview and Scrutiny Committee's remit is to fulfil the functions of an Overview and Scrutiny Committee as they relate to any policies, services and activities concerning adult safeguarding, social care and public health; and to discharge the relevant overview and scrutiny role set out in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012, including: The appointment of Joint Overview and Scrutiny Committees with neighbouring authorities; and the exercise of the power to make referrals of contested service reconfigurations to the Secretary of State as previously delegated to the Health and Social Care Overview and Scrutiny Committee by the Council.

1.2 This report provides details of the scrutiny work programme for 2022/23.

2 Recommendation

2.1 That the Committee considers the review of its work programme for 2022/23 attached at Appendix 1, and agree on any item to take forward.

3 Background

3.1 "Scrutiny is based on the principle that someone who makes a decision…should not be the only one to review or challenge it. Overview is founded on the belief that an open, inclusive, member-led approach to policy review…results in better policies in the long run." (Jessica Crowe, former Executive Director, Centre for Governance and Scrutiny).

3.2 Developing an effective work programme is the bedrock of an effective scrutiny function. Done well, it can help lay the foundations for targeted, inclusive and timely work on issues of local

importance, where scrutiny can add value. Done poorly, scrutiny can end up wasting time and resources on issues where the impact of any scrutiny work done is likely to be minimal.

3.3 As a result, the careful selection and prioritisation of work is essential if the scrutiny function is to be successful, add value and retain credibility.

4 Work Programme

4.1 Appendix 1 sets out this work programme for this Committee. This provides information on the aims and objectives, together with lead officers and witnesses, for each item. The attached work programme also includes items reported on at meetings this year and any outstanding items including the tracking of previous recommendations.

5 Joint Working Across Committee Work Programmes 2022/23

5.1 As the work programmes for the Committees have developed a number of cross cutting issues were identified. To avoid duplication Members will be invited to attend different Overview and Scrutiny Committee meetings for relevant reports as set out below:-

Lead Committee	**Meeting and Agenda Item**	**Members to be invited and reason**
Education and Children's Social Care O&SC	17th May 2023 Report from Birmingham Safeguarding Children's Partnership (BSCP)	Members of the CYP Mental Health Inquiry from the Health and Adult Care O&SC Information from the BSCP will inform the CYP mental health inquiry.
Commonwealth Games, Culture and Physical Activity O&SC	Meeting: TBC Report on employment and skills Legacy of the Commonwealth Games	Members of the Economy and Skills OSC At the meeting on the 8th July 2022 Co-ordinating O&SC decided that this issue falls within the remit of the CWG, Culture and Physical Activity OSC, and as it has been identified during the work planning for the Economy and Skills. O&SC as an issue of interest Members of this Committee would be invited to the relevant meeting.

6 Inquiry

6.1 Evidence gathering meetings for the inquiry on children and young people's mental health were arranged during March 2023.

7 Other Meetings

7.1 The Birmingham Health Scrutiny Committee will meet on Tuesday 18th April 2023 at 10.30am Committee Rooms 3 and 4, Council House, Victoria Square, Birmingham. The date for the next Joint Health Scrutiny Meetings is TBA.

Call in Meetings:

None scheduled

Petitions

None scheduled

Councillor Call for Action requests

None scheduled

The Committee approved Tuesday at 10.00am as a suitable day and time each week for any additional meetings required to consider 'requests for call in' which may be lodged in respect of Executive decisions

8 Forward Plan for Cabinet Decisions

8.1 Since the implementation of the Local Government Act and the introduction of the Forward Plan, scrutiny members have found the Plan to be a useful tool in identifying potential agenda items.

8.2 The following decisions, extracted from the CMIS Forward Plan of Decisions, are likely to be relevant to the Health and Social Care O&S Committee's remit. The Panel may wish to consider whether any of these issues require further investigation or monitoring via scrutiny. The Forward Plan can be viewed in full via Forward Plans (cmis.uk.com).

9 Legal Implications

9.1 There are no immediate legal implications arising from this report.

10 Financial Implications

10.1 There are no financial implications arising from the recommendations set out in this report.

11 Public Sector Equality Duty

11.1 The Council has a Public Sector Equality Duty under the Equality Act (2010) to have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

11.2 The Committee should ensure that it addresses these duties by considering them during work programme development, the scoping of work, evidence gathering and making recommendations. This should include considering: How policy issues impact on different groups within the community, particularly those that share a relevant protected characteristic; Whether the impact on particular groups is fair and proportionate; Whether there is equality of access to services and fair representation of all groups within Birmingham; Whether any positive opportunities to advance equality of opportunity and/or good relations between people are being realised.

11.3 The Committee should ensure that equalities comments, and any recommendations, are based on evidence. This should include demographic and service level data and evidence of residents/service-users views gathered through consultation.

12 Use of Appendices

12.1 Appendix 1 – Work Programme for 2022/2023

APPENDIX 1

HEALTH & SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE 2022-23 WORK PROGRAMME

Date of Meeting: 19th July 2022

Item/ Topic	Type of Scrutiny	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information (Including joint working / links with other O&S Committees)
Q4 Adult Social Care Performance Monitoring	*Agenda item*	*Report on red rated performance indicators; 5 performance indicators chosen by HOSC for in-depth examination and the complete set of Adult Social Care performance indicators.*	*Maria Gavin*	*N/A*	*None identified*	*Maria to include any performance information on Delayed Transfers of Care.*
Healthwatch Birmingham Annual Report 2021/22	*Agenda item*	*Reporting on investigations completed in the previous year.*	*Andy Cave, CEO, Healthwatch Birmingham*	*N/A*	*None identified*	• *Access to NHS Dentistry* • *Investigation about people's experiences of Day Services* • *Access to GP Services*

Final Deadline: Thursday 7th July 2022

Publication: Monday 11th July 2022

Date of Meeting: **Tuesday 20th September 2022**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Election of Deputy Chair	*Agenda item*	*To elect a Deputy Chair. Deferred from 19th July informal meeting.*				
Action Notes/ Matters Arising	*Agenda item*	*To approve the action notes of the meeting held on 29th March 2022.* *To note the action notes of the informal meeting held on 19th July 2022.*				
Report of the Cabinet Member for Health and Social Care	*Agenda Item*	*To set out the Cabinet Member's priorities for the coming year.*	*Ceri Saunders*	*N/A*	*None identified*	*Councillor Mariam Khan*
Period Poverty and Raising Period Awareness	*Tracking Recommendations*	*To track progress against implementation of recommendations.*	*Monika Rozanski* *Rokneddin Shariat*	*N/A*	*None identified*	

Final Deadline: Thursday 8th September 2022

Publication: Monday 12th September 2022

Date of Meeting: **Tuesday 18th October 2022**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Forward Thinking Birmingham	*Agenda item*	*To present the annual report.*	*Fiona Reynolds Chief Medical Officer Birmingham Women's and Children's NHS Foundation Trust (FTB)*	*N/A*	*None identified*	It was agreed at Co-ordinating OSC on the 8 July 2022 that the Health and Social Care O&SC undertakes scrutiny of children's mental health (under the overview and scrutiny role set out in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012) and members of the Education and Children's Social Care Committee will be invited to attend as mental health is included within the Committee's terms of reference.
Infant Mortality – Tracking Report	*Tracking Recommendations*	*To track progress against implementation of recommendations.*	*Dr Marion Gibbon*	*N/A*	*None identified*	

Q1 Adult Social Care Performance Monitoring	*Agenda item*	*Report on red rated performance indicators; 5 performance indicators chosen by HOSC for in-depth examination and the complete set of Adult Social Care performance indicators.(Deferred to 20 December 2022)*	*Maria Gavin John Williams Merryn Tate*	*N/A*	*None identified*	*The Q1 Performance data had been deferred to the meeting on 20 December. An update will be provided to the October meeting on the future arrangements for Adult Social Care Performance Monitoring data.*
Children and Young People's Mental Health Inquiry	*Agenda item*	*Terms of Reference*	*Fiona Bottrill*	*N/A*	*None identified*	

Final Deadline: Thursday 6th October 2022

Publication: Monday 10th October 2022

Date of Meeting: **Tuesday 22nd November 2022**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Birmingham Substance Misuse Recovery System (CGL)	*Agenda item*	*Annual report on performance against public health contract.*	*Karl Beese*	*N/A*	*None identified*	
Birmingham and Solihull Integrated Care System Ten-Year Strategy	*Agenda item*	*Report setting out the plan for health and care services for Birmingham and Solihull*	*David Melbourne Chief Executive, Birmingham and Solihull ICS*	*N/A*	*None identified*	

Final Deadline: Thursday 10th November 2022

Publication: Monday 14th November 2022

Date of Meeting: **Tuesday 20th December 2022**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Birmingham Safeguarding Adults Board Annual Report	*Agenda item*	*Reporting on outcomes against priorities in the previous year.*	*Asif Manzoor Dr Carolyn Kus, Independent Chair*	*N/A*	*None identified*	
Birmingham and Lewisham African Health Inequalities Review (BLACHIR)	*Agenda item*	*Reporting on progress against actions in the report*	*Monika Rozanski; Jo Tonkin; Modupe Omonijo; Marcia Wynter; Ceri Saunders*	*N/A*	*None identified*	*Councillor Mariam Khan, Cabinet Member for Health and Social Care.*
Q2 Adult Social Care Performance Monitoring	*Agenda item*	*Report on red rated performance indicators; 5 performance indicators chosen by HOSC for in-depth examination and the complete set of Adult Social Care performance indicators.*	*Maria Gavin*	*N/A*	*None identified*	*Reporting Q1 and Q2.*

Final Deadline: Thursday 8th December 2022

Publication: Monday 12th December 2022

Date of Meeting: **Tuesday 24th January 2023**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Adult Social Care Reforms	*Agenda item*	*To inform the committee on reforms to Adult Social Care.*	*John Williams*	*N/A*	*None identified*	
Approved Mental Health Professional	*Agenda item*	*Evidence gathering for the Children and Young People's Mental Health Inquiry*	*John Williams / Joanne Lowe*	*N/A*	*None identified*	

Final Deadline: Thursday 12th January 2023

Publication: Monday 16th January 2023

Date of Meeting: **Tuesday 21st February 2023**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Birmingham Sexual Health Services – Umbrella (UHB)	*Agenda item*	*Annual report on performance against public health contract.*	*Karl Beese*	*N/A*	*None identified*	
Strategic Overview of Immunisations in Birmingham	*Agenda item*	*Report to set out the strategic oversight.*	*Mary Orhewere / Paul Sherriff / Leon Mallett*	*N/A*	*None identified*	

Final Deadline: Thursday 9th February 2023

Publication: Monday 13th February 2023

Date of Meeting: **Tuesday 14th March 2023**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Cabinet Member Update Report	*Agenda item*	*Cabinet Member to report progress against portfolio priorities*	*Ceri Saunders*	*N/A*	*None identified*	*Councillor Mariam Khan, Cabinet Member for Health and Social Care.*
Day Opportunities Co-Production Review	*Agenda item*	*Feedback of the implementation of the independent co-produced review of day opportunity services*	*Dr Temitope Ademosu / John Williams / Saba Rai / John Freeman*	*N/A*	*None identified*	*Also attending are representatives from the Empowering Peoples Team.*
Q3 Adult Social Care Performance Monitoring	*Agenda item*	*Report on red rated performance indicators; 5 performance indicators chosen by HOSC for in-depth examination and the complete set of Adult Social Care performance indicators.*	*Maria Gavin*	*N/A*	*None identified*	

Final Deadline: Thursday 2nd March 2023

Publication: Monday 6th March 2023

Date of Meeting: **Tuesday 18th April 2022**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
ICB Update	*Agenda item*		*Paul Sherriff and Karen Kelly*	*N/A*	*N/A*	
Immunisation	*Agenda item*	*Report to set out the challenges with the take up of immunisations.*	*Mary Orhewere / Kate Woolley, Director of Immunisation and Vaccinations*	*N/A*	*None identified*	*Report to be presented as a scoping paper for a possible future inquiry based on previous scoping paper for Infant Mortality.*

Final Deadline: Tuesday 4th April 2023

Publication: Thursday 6th April 2023 (Brought forward due to Easter Bank holiday)

INFORMAL BRIEFINGS (TO BE ARRANGED)
Engaging with third sector providers of Adult Social Care (Louise Collett)
City Observatory Data (Richard Brooks)

TO BE SCHEDULED:

1. Public Health Horizon Scanning / JSNA
2. Primary Care Networks
3. Mental Health and Wellbeing Post-COVID
4. Visit to UHB NHS Foundation Trust Hospital sites (Contact Gemma Rauer)
5. Visit to Early Intervention Community Team, Norman Power Centre (Contact Andrew Marsh)

BIRMINGHAM/SANDWELL JOINT HEALTH SCRUTINY COMMITTEE

Date of Meeting: **29th November @ 2.00pm**

Venue: **Birmingham**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Committee Terms of Reference	*Agenda item*	*To update the committee terms of reference*	*Fiona Bottrill*	*N/A*	*None identified*	
Acute Care Model	*Agenda item*	*To report on the model for acute care.*	*Liam Kennedy, Midland Metropolitan Hospital Delivery Director*	*N/A*	*None identified*	
Feedback on proposed changes to Day Case Surgery	*Agenda item*	*To report on feedback regarding proposed changed to Day Case Surgery.*	*Liam Kennedy, Midland Metropolitan Hospital Delivery Director*	*N/A*	*None identified*	

Final Deadline: 17th November 2022

Publication: 21st November 2022

BIRMINGHAM/SOLIHULL JOINT HEALTH SCRUTINY COMMITTEE

Date of Meeting: **13th October – 1800-2000 hrs – Solihull Civic Suite**

Venue: **Solihull**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Draft BSoL Strategic Vision for Autism and the Draft BSoL Strategic Vision for Learning Difficulties and Disabilities	*Agenda item*		*TBC*	*N/A*	*None identified*	
Birmingham and Solihull ICS Financial Planning Update	*Agenda item*	*To report on the financial plan for the ICS.*	*Paul Athey, ICS Finance Lead*	*N/A*	*None identified*	
Update on the recovery and proposed configuration of surgical services across University Hospitals Birmingham – ICB and UHB and Preparation for Winter Pressures	*Agenda item*	*To report on the current status of services and waiting lists.*	*Jonathan Brotherton, Chief Operating Officer, UHB*	*N/A*	*None identified*	

Final Deadline:

Publication: **5th October 2022**

BIRMINGHAM/SOLIHULL JOINT HEALTH SCRUTINY COMMITTEE

Date of Meeting: **19th January 2023 at 2.00pm, Committee Room 3&4, Council House**

Venue: **Birmingham**

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Committee Terms of Reference	*Agenda item*	*To update the committee terms of reference*	*Fiona Bottrill*	*N/A*	*None identified*	
Healthwatch Ground Rules for Reviews announced by NHS Birmingham and Solihull	*Agenda item*	*To seek endorsement from the committee on the ground rules*	*Fiona Bottrill / Andy Cave, Healthwatch Birmingham*	*N/A*	*None identified*	
ICS/UHB Update	*Agenda item*	*To respond to concerns raised by the BBC Newsnight investigations.*	*Jonathan Brotherton, UHB; David Melbourne, BSol ICS*	*N/A*	*None identified*	
West Midlands Ambulance Service Update	*Agenda item*	*To respond to concerns raised by the BBC Newsnight investigations*	*Vivek Khashu and Mark Docherty, WMAS; David Melbourne, BSol, ICS*	*N/A*	*None identified*	
BSol ICS update on performance against finance and recovery plans	*Agenda item*	*To update on the current status regarding finance and recovery plans*	*Paul Athey, ICS Finance Lead*	*N/A*	*None identified*	

Final Deadline: 10th January 2023

Publication: **11th January 2023**

BIRMINGHAM/SOLIHULL JOINT HEALTH SCRUTINY COMMITTEE

Date of Meeting: **15th February 2023 at 6.00pm, Civic Suite**

Venue: **Solihull**

Dementia Strategy	*Agenda item*	*Following consultation seeking approval for the strategy*	*Revinder Johal, Commissioning Manager – Strategy and Integration, ASC* *Anna Walker, Commissioning Manager for Strategy and Planning, Solihull MBC*	*N/A*	*None identified*	
Primary Care Enabling Strategy	*Agenda item*		*Paul Sherriff*	*N/A*	*None identified*	
ICS/UHB Update	*Agenda item*	*To receive an update on the 3 reviews being undertaken at UHB.*	*TBC*	*N/A*	*None identified*	
Proposed configuration of services across UHB – engagement outcomes	*Agenda item*		*TBC*	*N/A*	*None identified*	

Final Deadline: 6th February 2023

Publication: **7th February 2023**

BIRMINGHAM/SOLIHULL JOINT HEALTH SCRUTINY COMMITTEE

Date of Meeting: **13th March 2023 at 2.00pm, Committee Rooms 3 and 4, Council House**

Venue: **Birmingham**

ICS/UHB Update	*Agenda item*	*Update on the 3 reviews being undertaken at UHB. Findings of the 1st review.*	*Jonathan Brotherton, UHB; David Melbourne, BSol ICS**	*N/A*	*None identified*	*Representatives for UHB and BSol ICS TBC.*
West Midlands Ambulance Service Update	*Agenda item*	*Update on actions taken to respond to concerns raised at the January meeting.*	*Vivek Khashu and Mark Docherty, WMAS; David Melbourne, BSol, ICS*	*N/A*	*None identified*	
BSol ICS update on performance against finance and recovery plans	*Agenda item*	*To update on the current status regarding finance and recovery plans*	*Paul Athey, ICS Finance Lead**	*N/A*	*None identified*	*Representative for Paul Athey TBC.*

* Representatives from BSol ICS and UHB to be advised.

Final Deadline: 2nd March 2023

Publication: **3rd March 2023**

TO BE SCHEDULED

Item/ Topic	Type	Aims and Objectives	Lead Officer	Witnesses	Visits	Additional Information
Integrated Care System and the Role of Scrutiny	*Agenda item*	*To determine future arrangements and reporting*	*David Melbourne, BSol ICS*	*N/A*	*None identified*	
ICS Joint Forward Plan	*Agenda item*	*Report on health planning for the system including commissioning intentions.*	*Carol Herity to confirm Lead Officer*	*N/A*	*None identified*	*To be scheduled early in the new municipal year*
ICS Quality Assurance Update	*Agenda item*	*Update on Quality Assurance to every JHOSC*	*Carol Herity to confirm Lead Officer*	*N/A*	*None identified*	*To be scheduled early in the new municipal year*
Update on Post-COVID Syndrome ('Long COVID') Rehabilitation	*Agenda item*	*Update on previous report presented to JHOSC on 29th September 2021*	*Ben Richards, Chief Operating Officer, Birmingham Community Healthcare NHS Foundation Trust*	*N/A*	*None identified*	*Report to include Long COVID implications on health and long-term employment.*
Phase 2, Musculoskeletal Redesign Programme	*Agenda item*	*To report on the current status of the programme*	*Marie Peplow, Chief Operating Officer, The ROH*	*N/A*	*None identified*	