Members are reminded that they must declare all relevant pecuniary and non-pecuniary interests relating to any items of business to be discussed at this meeting

BIRMINGHAM CITY COUNCIL

HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

TUESDAY, 26 APRIL 2016 AT 10:00 HOURS
IN COMMITTEE ROOMS 3 & 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1 **NOTICE OF RECORDING**

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

2 **APOLOGIES**

3 - 12

3 **MINUTES**

To confirm and sign the Minutes of the meeting held on 22 March 2016.

4 **DECLARATIONS OF INTERESTS**

13 - 20

5 **RESEARCH FINDINGS ON THE EFFECTS OF SHISHA SMOKING**

Dr Adrian Phillips (Director of Public Health) and Janet Bradley (Operations Manager Environmental Health and Public Health - Tobacco and Alcohol Control) will present the report which has been referred to this Committee by the Licensing and Public Protection Committee.

21 - 66

6 **WEST MIDLANDS AMBULANCE SERVICE NHS FOUNDATION TRUST**

Diane Scott (Deputy CEO), Nathan Hudson (General Manager Birmingham Division), Mark Docherty (Director of Nursing, Quality and Clinical Commissioning) and Andy Jeynes (Community Response Manager).

67 - 68

7 **TERMS OF REFERENCE - PREVENTION AND MANAGEMENT OF DIABETES IN BIRMINGHAM**

For discussion.

69 - 78

8 **WORK PROGRAMME 2015/16**

For discussion.

9 **REQUEST(S) FOR "CALL IN"/COUNCILLOR CALLS FOR ACTION/PETITIONS RECEIVED (IF ANY)**

To consider any request for "call in"/Councillor calls for action/petitions (if received).

10 **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.

11 **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'.

MINUTES OF A MEETING OF THE HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE HELD ON TUESDAY 22 MARCH 2016 AT 1000 HOURS IN COMMITTEE ROOM 6, COUNCIL HOUSE, BIRMINGHAM

PRESENT: - Councillor Majid Mahmood in the Chair; Councillors Mohammed Aikhlaq, Sue Anderson, Sir Albert Bore, Maureen Cornish, Andrew Hardie, Eva Phillips, Robert Pocock, Sharon Thompson and Margaret Waddington.

IN ATTENDANCE:-

Angie Wallace (Acting Chief Operating Officer), Marie Ward (Director - Specialist Services Division), Kate Cullotty (Service Lead - Unscheduled Care) and Mike Murphy (Consultant Oral Surgeon and Head of Service), Birmingham Community Healthcare NHS Trust

Karen Helliwell (Director of Primary Care and Integration) and Ravy Gabrria-Nivas (Senior Primary Care Quality Manager), Birmingham CrossCity Clinical Commissioning Group (CCG)

Dr Andrew Coward (Chair), Simon Doble (Senior Commissioning Manager) and Richard Mendelsohn (Clinical Head of Commissioning), Birmingham South Central CCG

Rose Kiely (Group Overview and Scrutiny Manager), Gail Sadler (Research and Policy Officer) and Paul Holden (Committee Manager), BCC

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NOTICE OF RECORDING

310 It was noted that the meeting was being webcast for live or subsequent broadcast via the Council's Internet site (www.birminghamnewsroom.com) and that members of the press/public may record and take photographs. The meeting would be filmed except where there were confidential or exempt items.

APOLOGIES

311 Apologies were submitted on behalf of Councillors Mohammed Idrees and Karen McCarthy for their inability to attend the meeting.

The Chair also welcomed Councillor Sir Albert Bore to his first meeting of the Committee.

MINUTES

312 The Minutes of the meeting held on 23 February, 2016 were, subject to the amendment of the third word of the second line on the fourth page to read "prostate", confirmed and signed by the Chairperson.

DECLARATIONS OF INTERESTS

313 Councillor Andrew Hardie declared that he worked as a GP at surgeries in Birmingham and Councillor Mohammed Aikhlaq that he was a governor on the board of the Heart of England NHS Foundation Trust.

BIRMINGHAM DENTAL HOSPITAL – UNSCHEDULED CARE

314 Angie Wallace (Acting Chief Operating Officer), Marie Ward (Director - Specialist Services Division), Kate Cullotty (Service Lead, Unscheduled Care) and Mike Murphy (Consultant Oral Surgeon and Head of Service), Birmingham Community Healthcare NHS Trust were in attendance.

The following PowerPoint slides were presented to the Committee:-

(See document No. 1)

During the discussion that ensued the following were amongst the issues raised and responses further to questions:-

a) The Service Lead, Unscheduled Care informed the meeting that virtually every if not all the patients booked in through NHS 111 had turned-up for their appointment.
b) Members were informed that on-site triage assistance was provided in circumstances where for example patients had a large facial swelling, bleeding or there was a child in pain. It was highlighted that there was a small leaflet listing the relevant conditions available to patients who turned-up at the Birmingham Dental Hospital.
c) The Service Lead, Unscheduled Care reported that a person presenting at the hospital with a neck swelling would definitely be seen. However, she would need to check how NHS 111 processed such cases.
d) A Member referred to the need for more detailed demographic data to be provided and the Acting Chief Operating Officer reported that it was recognised that a piece of work needed to take place in this regard.
e) The Chair pointed out that English was not the first language at home in respect of 73 per cent of the children who attended Hodge Hill Primary School (where he served as a school governor) and he enquired what work was taking place in terms of engaging with hard to reach groups. In highlighting that they were a commissioned service, the Service Lead, Unscheduled Care indicated that she considered that this was a matter that needed to be pursued jointly involving the community dental services across Birmingham and the Black Country.
f) A Member considered that the profile of people using services needed to be compared against the characteristics of the catchment area / profile of expected demand. The Consultant Oral Surgeon and Head of Service informed the Committee that this would be a matter for the Commissioners /

Public Health England to take on board and that the Birmingham Community Healthcare NHS Trust would be happy to work with them to increase take-up by hard to reach / vulnerable groups. At this juncture, the Chair also referred to involving Healthwatch Birmingham in respect of this issue and indicated that the Trust would be contacted in this regard.

g) The Service Lead, Unscheduled Care reported that they were connected to services for the homeless through the community dental services and that work was ongoing in this regard.

The Chair thanked the representatives for attending and informed them that they might be invited back to provide a further update in 12-18 months' time.

BIRMINGHAM CROSSCITY PRIMARY CARE STRATEGY 2016/20

The following paper was submitted:-

(See document No. 2)

Karen Helliwell (Director of Primary Care and Integration) and Ravy Gabrria-Nivas (Senior Primary Care Quality Manager), Birmingham CrossCity Clinical Commissioning Group (CCG) were in attendance. The paper was presented to the Committee.

During the discussion that ensued the following were amongst the issues raised and responses further to questions:-

a) In responding to concerns expressed regarding the poor quality accommodation used by many GP Practices, the Director of Primary Care and Integration informed Members that the CCG had an Estates Strategy that involved reviewing their existing buildings and which had to work hand in hand with the Primary Care Strategy. Furthermore, it was reported that an Estates Manager had been appointed and that work would start in April 2016 around prioritising and investing in premises using the National Transformation fund.

b) The Committee was informed that there were a number of ways in which GP Practices were supported including the following: Aspiring to Clinical Excellence (ACE) foundation level that sought to achieve a universal standard across all GP Practices and where there had been particular focus last year on people with learning disabilities; ACE Excellence that looked to improve the quality of services and where groups of GP Practices worked together to meet needs in their area; a GP Peer Support Programme that offered support in terms of sharing best practice; and Care Quality Commission (CQC) inspections of GP Practices (9 were currently in special measures and 3 required improvement). Furthermore, it was highlighted that a provider had been commissioned to work with the CCG on a General Practice Improvement Programme.

c) Members were advised that after 6 months if a poor performing GP Practice failed to improve there would be a follow-up CQC inspection and the Practice would be put into slow closure. A decision would also be taken on whether to re-allocate the patients to other GP Practices or re-tender the service. However, the approach being taken as part of the Strategy was to be proactive and intervene early so that the stage was not reached where a GP Practice had to be closed.

d) The Senior Primary Care Quality Manager informed the meeting that all the CCG's GP Practices were signed-up to the ACE scheme.
e) A Member voiced concern that the document did not address the important issues of identifying the areas where improvements needed to be made; what the CCG would do to make sure that there were improvements in those areas; and how it would be demonstrated that this had been achieved.
f) Further to e) above, the Director of Primary Care and Integration highlighted that she had wished to provide Members with a high-level overview and indicated that the detail would be available by May, 2016 when she could report further to the Committee.
g) A Member referred to the massive increase in the amount and intensity of work within General Practice and had real concerns for the health of people delivering the services.
h) The Director of Primary Care and Integration underlined that providing services for vulnerable groups and people with learning disabilities was a key theme of their Governing Body's work.
i) Further to g) above, the Director of Primary Care and Integration stressed that the CCG did not underestimate the challenge faced by GPs and recognised how important it was to support the workforce. It was highlighted that in addition to the General Practice Improvement Programme and the GP Peer Support Programme there was a Clinical Lead that supported the CCG on workforce issues. Furthermore, the Senior Primary Care Quality Manager referred to the importance of Information Technology (IT) (e.g. Skype, texts) as an enabler in terms of developing new ways of working.
j) The Director of Primary Care and Integration also cited working in different ways with pharmacists and across community services as a means to overcome challenges faced due to workforce capacity issues. In addition, mention was made of a workforce stream due to start in April 2016, as part of the General Practice Improvement Programme, where GP Practices would be reviewed on a bespoke basis to see how the workforce might be used differently and to identify any areas for change. The Senior Primary Care Quality Manager made reference to the resilience that came from GP Practices working together at scale.
k) Members were advised that a Health Federation had been established in the east of Birmingham and that details would be available in the CCG's Implementation Plan when the representatives next reported to the Committee.
l) The CCG had not yet undertaken any specific work associated with the new 'sugar tax' that was scheduled to come into effect. However, it did work closely with the Local Authority and Public Health on the prevention agenda which was a key theme of the organisation's work.
m) A Member referred to work the Sutton Coldfield District Committee was doing around falls prevention, dementia and child obesity and stressed the need to reduce the workload on GP Practices. He also voiced concern that owing to IT and data protection issues Healthchecks could only be carried out in GP Practices. The Director of Primary Care and Integration undertook to pursue this matter with the Member outside the meeting.
n) In responding to comments made by a Member, the Director of Primary Care and Integration undertook to follow-up the issue of the need for easy to read / picture leaflets to be available for people with learning disabilities and others who might have difficulty reading, such as individuals whom English was a second language.

o) A Member informed the representatives that the document now before Members was not a strategy but a vision statement / aspiration. The Committee therefore needed to receive information on what the position was at present in addition to the CCG's Operational Plan to assess how the CCG proposed to move from the current situation to the delivery of the vision statement. The Director of Primary Care and Integration undertook to take on board the comments made and respond in detail at a future meeting.
p) In response to a question from the Chair, the Director of Primary Care and Integration undertook to arrange for Members to be provided with details in respect of the take-up of personal health budgets.

The Chair proposed that the representatives report back to the Committee in July 2016 with the CCG's Strategy / information requested and this was agreed. He also thanked the representatives for attending the meeting.

315 **RESOLVED**:-

That the CCG's Strategy / information requested as referred to in o) above be reported to the Committee in July 2016.

DIABETES PREVENTION

316 Dr Andrew Coward, Chair of the Birmingham South Central Clinical Commissioning Group (CCG) introduced the item of business and also presented the following PowerPoint slides to the Committee:-

(See document No. 3)

Simon Doble (Senior Commissioning Manager) and Richard Mendelsohn (Clinical Head of Commissioning), Birmingham South Central CCG also attended the meeting during consideration of this agenda item.

In the course of the discussion that ensued the following were amongst the issues raised and responses further to questions:-

a) The Clinical Head of Commissioning indicated that he believed that there were both genetic and lifestyle elements to why people of South Asian origin had a higher incidence of diabetes than Caucasians with the genetic aspect being the greater of the two factors.
b) Members were advised that overall there had been an approximately one in five take-up from amongst the at risk patients who were contacted by mail and that importantly there had been a good retention rate in respect of both the appointed lifestyle intervention providers - Health Exchange and Gateway Family Services.
c) In relation to Gateway Family Services it was reported that around 400 at risk patients were on courses and that the retention rate was about 92 per cent. It was highlighted that the length of time someone had to wait for a course with a provider depended on how many people there were available to attend - if there was a good sized group at a GP Practice a course could be put on straightaway.

d) The Clinical Head of Commissioning highlighted that he had been advised that a 20 per cent response was good and also considered that the commissioners of the initiative had liked the mailshot approach the Birmingham South Central CCG had taken. The CCG considered that the fact that the letters had been sent to patients by GPs had made a difference in terms of eliciting a good response.

e) It was pointed out that the CCG was a first wave implementer in respect of the 2016/17 national roll out and that the footprint included the Birmingham, Sandwell and Solihull CCGs / Local Authorities.

f) Options were still being explored in terms of how best to follow-up on those people who had not responded to the mailshot. Reference was also made to discussions taking place with the South Asian Health Foundation concerning a bespoke promotion.

g) The Senior Commissioning Manager explained that the first wave implementer would be carried out through the Healthcheck (40+ years of age) route and should produce about 900 patients a year. However, the Birmingham South Central CCG was in discussions with NHS England and Public Health England concerning the GP-led case finding route given that it was considered that the method had merit and worked. Nonetheless, at present, this approach did not form part of the first wave implementer. It was pointed out that though there was greater risk of diabetes when 40+ years of age this threshold was lower amongst people of South Asian origin.

h) The Chair highlighted that a letter could be sent to Community Events asking that the representatives be included on the circulation list of events scheduled to take place in the City.

i) At this juncture, the Chair of the Trust also drew attention to work in the United States where it had been discovered that a number of women who'd dropped out of weight loss clinics had been sexually abused and he commented on the issue of how people's Adverse Childhood Experiences (ACEs) predicated their lifetime risk of both mental and physical problems. He also referred to evidence of a decline in the number of suspensions and exclusions of children from school as a result of routinely enquiring about ACEs.

j) Further to i) above, a Member suggested looking at holding a scrutiny inquiry on the issue of ACEs. The Chair proposed that Councillor Paulette Hamilton, Chair of the Health and Wellbeing Board, be invited to bring a discussion paper to the Committee on the issue in the near future and Members indicated that they supported this approach.

k) A Member referred to the common bond between the Local Authority and NHS in terms of having to find ways of dealing with reducing budgets which in respect of adult care and tackling diabetes was largely about prevention. He considered that it therefore needed to be conveyed to the public that the only way that the City Council and NHS was going to be able to provide services into the future was if success was made of preventative measures. In highlighting the need for cost / benefit data, he referred to the need to charge someone maybe initially through the Health and Wellbeing Board or Cabinet Member for Health and Social Care with bringing matters into the public domain in a way that generated publicity - and which would have the effect of driving more people into the Diabetes Prevention programme.

l) The Chair underlined that if an increase in the prevalence of diabetes was not prevented it would be a massive problem in years to come and highlighted that this was the reason why the Committee had agreed to look into the issue. Furthermore, in referring to the tendency nowadays of a number of people of South Asian origin to use takeaways a number of times

a week he considered that in the future the adverse impact on people's health would become apparent if nothing was done. He pointed out that at weddings he'd attended there had been individuals who'd had amputations because of diabetes. He considered that the risks of not making efforts to prevent diabetes developing should be publicised and conveyed to those patients who had not responded to the mailshot.

m) In referring to a Diabetes Prevention Board, the Clinical Head of Commissioning indicated that the member who led on promoting physical activity had concerns that people currently receiving support and reducing their risk of developing diabetes might not continue to maintain the lifestyle changes in a year's time for example. Nonetheless, the Clinical Head of Commissioning also highlighted that the CCG had been informed that activities arranged as part of the diabetes prevention work taking place needed to be a group activity. He referred to the greater likelihood of individuals continuing to exercise if they were part of a close network that involved other people in similar circumstances.

n) Further to k) above, the Senior Commissioning Manager reported that the School of Health and Research at Sheffield University had been appointed to provide a cost / benefits model covering what investment would deliver on a longer term basis - the idea being to provide a tool that Local Authorities and CCGs could use.

o) The Chair of the Trust indicated that he viewed increasing levels of obesity as a modern day crisis and considered that today's generation would be judged in the future on how they had tackled the issue and encouraged people to become more active and healthier. He highlighted the need for a similar level of skills, conviction and political courage etc. to that which had been evident in this country in the past when faced with different challenges.

p) A Member who suffered with Type 2 diabetes stressed the need to convey to individuals, especially those in the South Asian community, the risks of diabetes developing. In referring to the Healthcheck at 40+ years of age he highlighted for example that people could become borderline diabetic in their teenage years. The Member also cited a link between diabetes and cholesterol and considered that people needed to be made aware of this.

q) The Chair of the Trust advised Members that in respect of diabetes the three critical indicators to a good outcome were good control of your blood pressure, cholesterol and the diabetes itself. In relation to people of South Asian origin being more predisposed to develop diabetes especially at an earlier age he acknowledged the need for a more nuanced and sophisticated approach in terms of tackling the issue.

r) Further to p) above, the Clinical Head of Commissioning informed the Committee that a number of CCGs in the West Midlands had grouped together to do case-finding work around very high cholesterol within families. In relation to diabetes, he indicated that he would welcome local leadership from Councillors on the issue and highlighted that he and colleagues could come to meetings to talk to citizens about the programme.

s) The Chair considered that it would be helpful if people knew about individuals who already had diabetes so that they were aware of how prevalent the condition was and the risks that there were of the condition developing. At this juncture he also highlighted that, as raised at previous meetings, people were discouraged from walking / exercising in the City's parks due to a lack of toilet facilities. He pointed out that this issue would be looked at during the diabetes scrutiny inquiry.

t) A Member considered that there was a need to identify how best to motivate people to exercise and also referred to the need for work to take place with schools, vulnerable groups etc. He felt that the reason why people in the country had become obese was largely because of a reduction in levels of exercise, rather than a change in calorific intake. Therefore, although diet was important, exercise was really significant and there was a need to look at how it was promoted and progress made on the issue.

u) The Chair of the Trust concurred that exercise was vitally important and in highlighting that many British people worked some of the longest hours in Europe referred to the need to look at how exercise could be built into citizens' daily lives. Members were advised that the Department of Health recommended engaging in 30 minutes of exercise 5 times a week to raise your heart rate.

The Chair advised the meeting that the Council would be liaising with the representatives concerning the forthcoming diabetes scrutiny inquiry. In addition, further to the comments in j) above, he highlighted that Councillor Paulette Hamilton would be invited to report to a future Committee meeting on the issue of ACEs with a view to that matter also forming the subject of a scrutiny inquiry in due course.

ENHANCED ACCESS TO GPs

317 Dr Andrew Coward (Chair), Simon Doble (Senior Commissioning Manager) and Richard Mendelsohn (Clinical Head of Commissioning), Birmingham South Central CCG were in attendance.

The Chair of the CCG provided an initial introduction during which he referred to both the increased activity and insufficient investment that there'd been in the NHS, particularly General Practice, over many years and the lower share of the overall NHS budget going into GP services. The Clinical Head of Commissioning presented the following PowerPoint slides to the Committee:-

(See document No. 4)

In the course of the discussion that ensued the following were amongst the comments made and responses further to questions:-

a) The Chair of the CCG reported that Birmingham South Central had 55 GP Practices in total and therefore that just under 50 per cent (i.e. 23 GP Practices) were part of the MyHealthcare wave 2 pilot. He considered that the Government had envisaged there would be a reduction in avoidable hospital admissions but this had not been the experience across the country. He therefore was of the view that the Civil Servants' advice to Ministers was that for improved GP access and 7 day services to be provided, funds would need to be made available.

b) Members were advised that the CCG had been waiting for two months for an announcement on how the MyHealthcare arrangements currently in place would be funded going forward. Furthermore, the Chair of the CCG informed the meeting that they absolutely would wish to widen the initiative to cover all their GP Practices if recurrent funding was provided. He highlighted that potentially the arrangements could be put in place city-wide.

c) A Member indicated that his experience of the CCG's MyHealthcare arrangements was that they were fairly seamless and worked really well.
d) The Clinical Head of Commissioning highlighted that the Government might provide funding for the 23 GP Practices to continue with their current arrangements and indicated that he believed that those Practices within the CCG that had joined the pilot were glad that they had done so.
e) The Chair of the CCG considered that GP Practices working at scale was a reaction to an increasing demand for GP services and the financial challenges. In highlighting that the traditional model that had been in place for many years was under threat, he nevertheless considered that the MyHealthcare arrangements had the potential to provide the best of both worlds: continuity of care and working at scale - and that, by accepting compromises around the edges, there was scope to protect the heart of the service going forward.
f) Members were advised that appointments needed to be booked to access the general medical services provided under the MyHealthcare arrangements which were available from 8am to 8 pm seven days a week - though a more limited service operated on Sundays as there was less demand. The service did not compete against the urgent care system.
g) The initial language used in respect of the MyHealthcare initiative had been that of a pilot. However, the Clinical Head of Commissioning indicated that conversations were now more about a way of GPs working together at scale. In reinforcing earlier comments made, he reiterated that at the beginning it had been considered that the initiative should pay for itself through reduced Accident and Emergency / hospital admissions. However, this had not been the experience and furthermore a review of the first wave had shown an increase locally and nationally in service users presenting with primary care type health problems - reflecting perhaps previously suppressed demand. The discussions now therefore were more about the issue of there being extra cost if 7 day GP services were to be provided. Nonetheless, as also indicated earlier, MyHealthcare was viewed to be a model that worked and that the CCG would therefore like to roll out the arrangements to cover the other GP Practices in its area.
h) The Clinical Head of Commissioning advised Members that he had not interpreted that the provision of enhanced GP access / 7 day services meant that people would specifically be able to see their own GP. Furthermore, in indicating that there were alternative models to MyHealthcare, he nevertheless considered that the hub and spoke arrangements put in place by the CCG had proved their worth.

The Chair thanked the representatives for reporting and indicated that they would be invited back to a future meeting to provide an update if there was a further roll out of the CCG's MyHealthcare arrangements.

2015/16 WORK PROGRAMME

The following Work Programme was submitted:-

(See document No. 5)

Further to discussion earlier in the meeting, the Chair highlighted that the issue of Adverse Childhood Experiences / related health outcomes needed to be added to the Work Programme. He also referred to convening a scrutiny inquiry session on diabetes within the next few months and advised Members that they would be contacted in this regard.

318 **RESOLVED**:-

That the Work Programme be noted.

AUTHORITY TO CHAIR AND OFFICERS

319 **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 1252 hours.

……..…….
CHAIRPERSON

BIRMINGHAM CITY COUNCIL

REPORT OF THE ACTING DIRECTOR OF REGULATION AND ENFORCEMENT TO THE LICENSING AND PUBLIC PROTECTION COMMITTEE

17 FEBRUARY 2016
ALL WARDS

RESEARCH FINDINGS ON THE EFFECTS OF SHISHA SMOKING ON CARBON MONOXIDE AND $PM_{2.5}$ CONCENTRATIONS IN THE INDOOR AND OUTDOOR MICROENVIRONMENT OF SHISHA PREMISES

1 Summary

1.1 This report and the scientific paper attached advises committee of the research undertaken by your officers and Birmingham University to determine that there is the potential to cause harm to employees and customers who frequent and work within Shisha premises. The research was published within the journal Science of the Total Environment in January 2016.

1.2 The Local Authority has a duty to ensure workplaces are compliant with the Smoke free Regulations 2007 enacted under the Health Act 2006. These regulations aim to ensure employees and members of the public are not exposed to harmful environmental tobacco smoke within enclosed workplaces and other enclosed public places.

1.3 Within Birmingham and around the country, shisha premises have grown in popularity and number. The main service offered is the sale of shisha pipes to customers who smoke the flavoured tobacco. Shisha premises are required to comply with the smoke free regulations and, therefore, cannot operate in an enclosed space.

1.4 The results of the research indicates that smoking shisha increases considerably the concentrations of Carbon Monoxide (CO) and $PM_{2.5}$ (Particulate Matter less than 2.5 microns in size) inside shisha premises and that $PM_{2.5}$ leaks from within shisha premises to the external environment and may cause public health concerns to local communities.

2 Recommendations

2.1 The report is directed to the Chair of Health and Wellbeing Committee and Chair for the Planning Committee for consideration and discussion.

2.2 That committee endorses action by Environmental Health to work with partners to provide a harm reduction package for shisha users, employees in

shisha businesses and shisha business owners to effectively reduce the potential harm from the activity of smoking shisha or secondary smoking.

2.3 That a further update report detailing potential harm reduction strategies is brought to Committee by June 2016

Contact Officer: Janet Bradley, Operations Manager Environmental Health and Public Health (Tobacco and Alcohol Control)
Telephone: 0121 303 5435
E-mail: janet.bradley@birmingham.gov.uk

3. Background

3.1 The Local Authority has a duty to ensure workplaces are compliant with the Smoke free Regulations 2007 enacted under the Health Act 2006. These regulations ensure employees and members of the public are not exposed to harmful environmental tobacco smoke within enclosed workplaces and enclosed public places.

3.2 The legislation places a duty on all owners and employers where more than one person works or where the premises is open to members of the public, to be smoke free where the premises are enclosed and not allow smoking within enclosed premises. Enclosed means that 50% or more of the premises or room is not open to the natural air.

3.3 Carbon monoxide (CO) is a product of combustion and has an affinity for red blood cells that carry oxygen to our body. Therefore, if CO levels are high this will lead to oxygen depletion within the haemoglobin in blood. Symptoms of CO poisoning include dizziness, shortness of breath and confusion through to loss of consciousness and death at high levels. The fire authority is particularly interested in CO as it can impair the ability of persons to react in fire situations.

3.4 Fine Particulate Matter 2.5 ($PM_{2.5}$) is also a product of combustion and an air pollutant that adversely affects people's health when levels in the air are high. They are tiny particles in the air that may reduce visibility and cause the air to appear hazy when levels are significantly elevated. The particles are of particular significance because they are able to travel deep into the respiratory tract, reaching the lower parts of the lungs where gas exchange occurs. Short term exposure health effects can include; eye, nose, throat and lung irritation, coughing, sneezing, runny nose and shortness of breath. Longer term they affect lung function such as chronic bronchitis, reduced lung function and increased mortality from lung cancer and heart disease.

3.5 Indoor sources of $PM_{2.5}$ are tobacco smoke, cooking, burning candles, fuel-burning heaters and fireplaces, outdoor sources are mainly attributed to diesel engines and other sources of combustion.

4 Research Project

4.1 Photographic evidence using flash photography taken by Environmental Health within shisha premises, showed the air contained particulates, resulting in the photographs being grainy and hazy looking. In addition, officers used personal CO monitors during visits and these indicated the presence of CO. From this, officers formed the hypothesis that there were elevated levels of $PM_{2.5}$ and CO from environmental tobacco smoke from the shisha pipes, however, there was no previous evidence from specific shisha research to prove or disprove this theory.

4.2 Environmental Health works annually with the University of Birmingham's environmental health MSc course to assist with student dissertations. Your Officers hypothesis was put forward as the basis of a research project and accepted by the University. The students from the university and environmental health contacted a number of shisha businesses seeking their cooperation with the project.

4.3 Indoor concentrations of CO and $PM_{2.5}$ were simultaneously collected through sensors for 60 minutes. This was repeated within twelve shisha premises during busy periods during March and June 2014. Samples were also taken outside usually by the fire assembly areas as a representative open space. The number of customers present and shisha pipes alight was recorded during sampling.

4.4 For a control, the same exercise was repeated for both pollutants inside five pubs/restaurants with cooking facilities. It was assumed that particulate matter and CO would be present in similar concentrations to shisha premises as gas cookers were in operation. There were no smoking issues within the control premises.

4.5 Owners and managers of shisha premises were interviewed using a structured questionnaire to determine the levels of knowledge about tobacco smoke and its associated health risks.

4.6 Data analysis of the air sample concentrations collected was undertaken by the university to determine the statistical difference/relationships of the concentrations:

- inside and outside shisha premises;
- the inside of shisha premises and inside of pub/restaurant premises;
- inside shisha premises and urban monitoring background locations;
- the relationship between the inside concentrations and number of alight shisha pipes.

4.7 The uniqueness of this research compared to other research is:

- the finding that there is a strong suggestion that $PM_{2.5}$ leaks out into the immediate environment surrounding shisha premises; and
- this is the only research of its kind within the UK measuring $PM_{2.5}$ and CO concentrations.

5 Results of the Research

5.1 $PM_{2.5}$ and CO concentrations inside shisha premises:

On average concentrations are:

- 8 times greater for $PM_{2.5}$ and 11 times greater for CO inside shisha premises than outdoor (outdoor fire assembly points) background levels.
- 13 times greater for $PM_{2.5}$ and 9 times greater for CO inside shisha premises than inside control pub/restaurant.

5.2 The $PM_{2.5}$ concentrations inside and immediately outside strongly correlate suggesting that indoor air is leaking outdoors and contributing to enhanced $PM_{2.5}$ concentrations in nearby outdoor locations.

5.3 A comparison was made with the concentrations of $PM_{2.5}$ measured at urban traffic locations and background level monitoring sites in the UK. $PM_{2.5}$ concentrations were found to be considerably lower at the urban traffic and background level monitoring sites than those measured outside of the shisha premises during the same sample period.

5.4 Results showed a statistical significant difference between $PM_{2.5}$ and CO concentrations measured inside shisha premises compared to inside pubs/restaurants with a similar number of customers and cooking facilities being used (in that the concentrations within shisha premises were higher for both pollutants). This suggests a strong linkage for shisha smoke leading to poor indoor air quality inside shisha premises.

5.5 With regard to the association between indoor air quality with the number of active shisha pipes:

On average a shisha smoking session lasts around 60 minutes with 1 shisha pipe being shared between 3 to 4 customers. The highest number of active shisha pipes and customers found in premises also featured the highest $PM_{2.5}$ and CO concentrations. Analysis of this data suggests that the number of active shisha pipes is a strong predictor of the concentrations of $PM_{2.5}$ inside shisha premises. There was less of a correlation with CO with only 30% of the variability of the CO concentration could be attributed to shisha pipes.

5.6 Business owner's awareness of environmental tobacco smoke:

Out of 12 shisha premises owners, only 3 owners/managers knew about the effects of secondhand smoke and its associated health risks. The remainder did not recognize secondhand smoke from shisha smoking as a hazard and were not aware of the need for ventilation to prevent the buildup of toxic and hazardous gasses.

6. Conclusions

6.1 The results of the study have revealed elevated concentrations of CO and $PM_{2.5}$ inside shisha premises which are deemed to create a significant public health risk. This is consistent with results published around the world looking at indoor $PM_{2.5}$ levels within shisha premises.

6.2 The leaking of indoor air with raised levels of $PM_{2.5}$ from shisha premises to the outdoors could affect the health of local public causing potential harm to neighbourhood and environment. This in turn may raise environmental issues for local communities particularly where new developments are proposed near to residential or sensitive sites such as a school.

6.3 Smoking shisha inside shisha premises causes a detrimental impact to the indoor air quality. Shisha smoking is the main source emitting $PM_{2.5}$ and the more shisha pipes are active the higher the concentration. CO concentrations within shisha premises is likely to arise from burning charcoal (lighted briquettes are placed on top of the tobacco instead of being lit in a traditional cigarette), though shisha smoke cannot be ruled out. There was no clear reason found why CO was not at its highest where there was more pipes being used. This may be affected by other factors such as ventilation and the fact CO is heavier than air and, therefore, the gas will lie at low level and maybe agitated by feet, people moving or dead zones caused by furniture.

6.4 Customers (including non-smokers) and employees within shisha premises are exposed to consistently elevated concentrations of $PM_{2.5}$ and CO levels. These high levels pose a health risk for those working or socialising inside shisha premises and may increase the risk to employees and customers of serious illness and morbidity in later life.

6.5 The research concludes that even though this research was conducted in the UK, these results are likely to be representative of the situation experienced elsewhere due to the increased popularity of shisha smoking in countries around the world.

7. Legislation governing indoor air quality

7.1 There are currently no UK indoor air quality standards for $PM_{2.5}$. Only outdoor air quality standards are available within the UK for comparison. The range of concentrations of $PM_{2.5}$ found with in this study within shisha premises was between 37µg/m^3 and 3332µg/m^3 (average = 287µg/m^3 +/- 330µg/m^3 (1hr)). Tyburn roadside, an urban traffic reference site in Birmingham measured and average of 5.9µg/m^3 +/-1.9µg/m^3 (1hr) for the same time period. The national air quality objective and European directive limit and target values for the protection of human health in the outdoors is 25µg/m^3 $PM_{2.5}$ (average for the year) for the UK.

7.2 The average concentration of CO within shisha premises was found to be 7.3mg/m^3 (15mins). The workplace exposure limits set up by the Health and

Safety executive recommends 232mg/m^3 (15mins). Therefore, the level was found below the legislative limit.

8. Further use for the published evidence

8.1 Current interventions to reduce the harm from secondhand smoking within shisha premises are education and advice to shisha owners/managers and compliance interventions. Compliance with UK legislation only requires that 50% of the area in which smoking occurs is open to the air. The experience of your officers and from speaking to other local authorities, we have found that within some premises, interpretation of the 50% opening by designers and businesses owners has created smoking shelters that may technically adhere to the legislation but do not follow the spirit of the law in that they do not allow for the free movement of smoke out of the premises. Prosecution of the smoke free legislation for allowing smoking within enclosed premises has not found to have been effective in that some premises pay the fine and subsequently, continue to operate non-compliantly. Currently other avenues need to be investigated to ensure sustainable improvements are achieved.

8.2 Environmental Health continues to work with West Midlands Fire Service, the Black Country Tobacco Control Alliance, Birmingham City Council Public Health and Public Health England to consider a package of interventions to work towards reducing the potential harm from shisha smoking. This will include both smoking in shisha premises and within a domestic setting.

9. Awards

9.1 This research received the 2015 CIEH president's award from the Chartered Institute of Environmental Health in recognition for their services to the field of environmental Health which as presented to Birmingham City Council at the House of Commons on 14th July 2015.

9.2 In March 2015 Birmingham City Council and the MSc Environmental Health student won the Environmental Protection UK – 'best research project for indoor air quality'.

9.3. The MSc student who conducted this research was awarded the University of Birmingham Sir Oliver Lodge Student Prize 2014, which is awarded to high achieving students whose work has contributed to the field of environmental protection.

10. Implications for Resources

10.1 The resources employed in carrying out the research detailed in this report were partly delivered by the University of Birmingham, whilst officer time will be contained within this Committee's budget.

10.2 Resources to undertaken the Regulation and Enforcements compliance measures of shisha premises are contained within this committees budget.

10.3 Future harm reduction measures will be borne through partnership working with Public Health England, Black Country Tobacco Control Alliance, Birmingham City University and West Midlands Fire Authority.

11 Implications for Policy Priorities

11.1 The work undertaken by Environmental Health also supports the Regulation and Enforcement Division's mission statement to provide 'fair regulation for all - achieving a safe, clean, green and fair trading city for residents, business and visitors'.

11.2 A link between poor outdoor air quality and social deprivation has been established with the more inner city wards suffering the greatest amount of pollution.

12. Public Sector Equality Duty

12.1 Air pollution has the potential to affect all members of society but can have specific impacts on pregnant women and the unborn child. The concerns about such are widely known and health advice is issued accordingly by relevant medical professionals.

12.2 The smoking of shisha in the UK within shisha premises is virtually universal. The approach taken to address air quality is such as to protect all members of society and does not discriminate against any group.

ACTING DIRECTOR OF REGULATION AND ENFORCEMENT

Background Papers:

~~Appendix 1 Gurung, G, Bradley, J, Delgado-Saborit, J.M, 2016. *Effects of shisha smoking on carbon monoxide and $PM_{2.5}$ concentrations in the indoor and outdoor microenvironment of shisha premises.* Science of the Total Environment 548-549, 340-346.~~

Health and Social Care Overview & Scrutiny Committee

26 April 2016

Agenda

- **General Trust Overview** - Diane Scott, Director of Corporate Services, Deputy CEO

- **5 Year Strategy and Initiatives** - Mark Docherty, Director of Nursing, Quality and Clinical Commissioning

- **Operational/Clinical Performance Update for 2014/15 (including winter)** - Nathan Hudson, General Manager

- **Demonstration of an Automated External Defibrillator** - Andy Jeynes, Community Response Manager

Trust Vision

Vision

Delivering the right patient care, in the right place, at the right time, through a skilled and committed workforce, in partnership with local health economies

Strategic Objectives

- **Achieve Quality and Excellence**
- **Accurately assess patient need and direct resources appropriately**
- **Establish market position as an Emergency Healthcare Provider**
- **Work in Partnership**

Values

- **World Class Service**
- **Patient Centred**
- **Dignity and Respect for All**
- **Skilled Workforce**
- **Teamwork**
- **Effective Communication**

Trust Governance Structure

Chief Executive Officer
Accounting Officer

Chair
(NED)

Council of Governors
- 5 Staff
- 15 public
- 6 Appointed

Members
(Public & Staff)

5 x Executive Directors (Voting)
- Director of Finance
- Director of Nursing, Quality and Clinical Commissioning
- Medical Director
- Director of Workforce & OD
- Director of Corporate Services

6 x Non-Executive Directors

3 x Associate Directors (Non-Voting)
- Communications Director
- Emergency Services Director
- Patient Transport & Commercial Services Director

Firmograhics

- Established in July 2006 merging with Staffordshire in October 2007
- 5.6 million population (Circa 10.5% of the English population)
- Over 5,000 square miles, 80% rural
- Approaching 3000 *999* calls per day
- Over 532,000 emergency journeys annually
- £250 million budget
- Fleet of over 850 vehicles
- 4,500 Staff and 1,000 Volunteers
- 5 x Helicopters
- 1 x Motorcycle

West Midlands Ambulance Service NHS FT

- **Emergency & Urgent Service (E&U)** = 85% of Trust's overall income
  Two Emergency Operations Centres – Stafford and Brierley Hill
  90 Community Ambulance Stations
  15 Hubs – Make Ready

- **Non Emergency Patient Transport Services (NEPTS)**
  Circa 800,000 Patient Journeys a Year
  One Control Room in Stafford

- **Logistics Service**
  Courier work e.g. clinical waste

- **Commercial Training**
  External First Aid courses
- **Audit Services**

Transformational Business Strategy

- **Retain the best elements of an operational Ambulance Service**
  - Emergency Planning
  - Major incident Response
  - Rapid Response to incidents
  - Flexible and Adaptable ways of working
- **Implement the benefits of an Integrated Healthcare Provider**
  - Community Paramedics
  - High volume of Healthcare Professionals
  - Higher volumes of referral to alternative pathways
  - Clinical Supervision and Mentoring
- **Delivery of a High Performing Ambulance Service**
  - Top Quartile in Response Times
  - Top Quartile in Clinical Outcomes
  - Cost effective delivery of service
  - Highly regarded by patients, public and Stakeholders

Three Transformational Objectives:

1. **Make Ready**
2. **NHS Pathways**
3. **Paramedic on every vehicle**

Key Outcomes from our Strategic Priorities

Business As Usual

Achievement of nationally and locally agreed performance standards

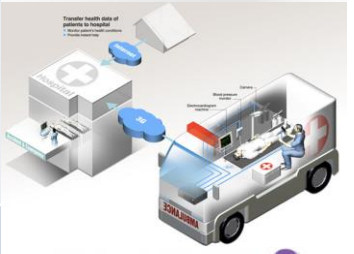
Efficient use of resources and technology

New Models of Care

Implementation of electronic patient record system

Development of telemedicine style service

Collaborative approach to design of new models of care



Business Opportunities

Non-Emergency Patient Transport Services

Courier Transport and Logistic Services

Commercial Call Handling

Commercial Training

Prevention

Making Every Contact Count

Community Responders

Education and Development

MAKING EVERY CONTACT COUNT

Recruitment

	2015/16	2016/17
Student paramedics	363	324
Graduate paramedics	32	45-50
Ambulance Fleet Assistants	10	As Required 3 adverts in process
Patient Transport Service apprentices	10	As Required 3 adverts in process
Business administration apprentices	11	As Required 2 adverts in process

Overall increase of frontline workforce establishment
from 2,372 WTE (2015/16) to 2,515 WTE (2016/17)

Total WMAS Workforce 4,558

Operational Performance 2014/15 and 2015/16 Out-turn Position

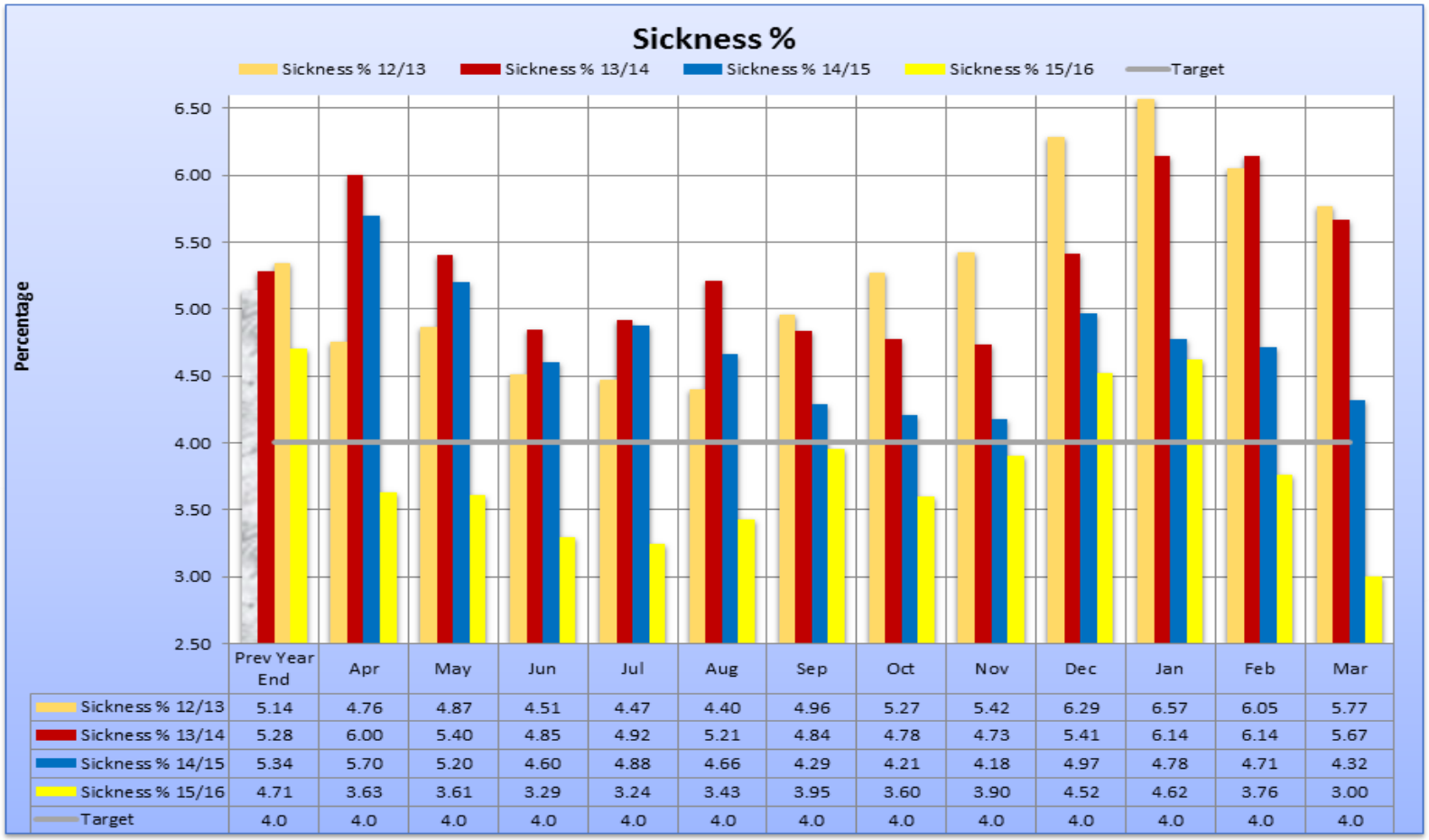
Category	Target	2014/2015	2015/16
Red 1	75%	77.5%	78.5%
Red 2	75%	74.3%	75.1%
Red 19	95%	96.8%	97.2%
Green 2	90%	88.3%	89.8%
Green 4	95% Triage in 60 min	99.4%	99.8%
Referral	90%	91.5%	88.5%
Call Answering	95%	96.7%	96.4%

Ambulance Quality Indicators

From April 2011 the Clinical Indicators changed to include the following:

- Outcome from Cardiac Arrest – Return of Spontaneous Circulation
- Outcome from acute ST Elevation Myocardial Infarction
- Outcome from Stroke for Ambulance Patients
- Outcome from Cardiac Arrest Survival to Discharge

Trust Sickness



	Prev Year End	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Sickness % 12/13	5.14	4.76	4.87	4.51	4.47	4.40	4.96	5.27	5.42	6.29	6.57	6.05	5.77
Sickness % 13/14	5.28	6.00	5.40	4.85	4.92	5.21	4.84	4.78	4.73	5.41	6.14	6.14	5.67
Sickness % 14/15	5.34	5.70	5.20	4.60	4.88	4.66	4.29	4.21	4.18	4.97	4.78	4.71	4.32
Sickness % 15/16	4.71	3.63	3.61	3.29	3.24	3.43	3.95	3.60	3.90	4.52	4.62	3.76	3.00
Target	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0

Complaints and Compliments

Complaints	Compliments
Reduced by 9%	Increase of 4%
358 in 2015-16 (393 previous year)	1,279 in 2015-16 (1,229 previous year)
1 in every 4,487 patients made a formal complaint	1 in every 1,256 patients Complimented the Trust

Foundation Trust

Authorised as an NHS Foundation Trust
1 January 2013

Licenced
1 April 2013

The Council of Governors

The Council of Governors consists of 26 Governors				
Staff - 5 Elected Governors				
Emergency and Urgent Operational staff (2)	Emergency Operations Centre Staff (1)	Non Emergency Operational Staff (1)	Support Staff (1)	
Public - 15 Elected Governors				
West Mercia (3)	Birmingham (3)	Black Country (3)	Staffordshire (3)	Coventry and Warwickshire (3)
6 Appointed Governors - 1 each of the following				
An NHS Acute provider	Community First Responder Regional Forum	An NHS Mental Health Provider		
Strategic Alliance for Health Education (representing Universities in the Region)	A Local Authority	An Emergency Service		

Foundation Trust Public Membership

Last year	This year
8,330	9,363




Future Developments

- Improving Paramedic skill mix
- Maximising front line staff = 2,515
- Urgent care system changes
- New Hub – Stoke On Trent
- Embedding Make Ready
- Ongoing Seasonal planning
- Continue to provide value for money
- Modern new fleet

Thank You

Any Questions?

Birmingham Area Performance

The Ambulance Response Model

National Overview

	RED1			RED2			A19		Call Pickup in 5 Secs		Proportion of Calls - Weekly						
WC_07/12/2015	Weekly Performance	YTD Performance	Cumulative Incidents YTD (With Response)	Weekly Performance	YTD Performance	Cumulative Incidents YTD (With Response)	Weekly Performance	YTD Performance	Weekly Performance	YTD Performance	Total Calls	% Of Red1	% Of Red2	% Of Green (Inc HCP)	Other	REAP Level	Comments
East of England	68.64 %	74.56 %	11,479	57.43 %	63.39 %	211,731	88.89 %	91.46 %	94.37 %	95.45 %	20745	1.85%	34.07 %	64.08 %	0.00%	4	
East Midlands	71.08 %	71.61 %	9,142	55.75 %	66.25 %	185,568	86.25 %	89.97 %	95.8%	93.6%	15641	1.87%	39.82 %	57.73 %	0.59%	3	
London	71.48 %	67.25 %	9,906	63.27 %	64.62 %	337,617	93.04 %	93.28 %	97.56 %	96.18 %	35372	0.99%	31.54 %	64.59 %	2.88%	4	
North East	55.70 %	70.80 %	7,893	56.30 %	71.60 %	122,127	84.77 %	92.72 %	95.7%	92.7%	12,542	2.28%	31.26 %	63.61 %	2.85%	3	
North West	75.62 %	76.90 %	19,734	66.67 %	73.98 %	299,737	91.54 %	94.23 %	94.24 %	96.26 %	26871	1.99%	35.14 %	51.58 %	11.28 %	4	
South Central	70.3%	72.1%	8,293	73.4%	73.8%	120,226	94.9%	94.6%	91.10 %	94.20 %	11,162	2.45%	33.58 %	63.98 %	0.0%	3	
South East Coast	75.9%	73.5%	9,632	67.7%	73.5%	185,347	95.9%	96.6%	89.82 %	86.75 %	18,203	1.85%	30.91 %	67.05 %	0.19%	4	
South West	74.67 %	75.17 %	11,999	63.63 %	67.12 %	207,412	89.95 %	91.35 %	87.99 %	91.85 %	18043	2.13%	36.20 %	61.66 %	0.00%	4	REAP level 3 to 4 from 9th December
West Midlands	74.5%	79.1%	16,160	75.1%	76.0%	280,093	96.9%	97.3%	96.2%	96.9%	21,153	2.17%	38.05 %	59.39 %	0.40%	3	ytd commences 1st April 2015.
Yorkshire	70.22 %	71.85 %	13,625	71.54 %	71.64 %	198,874	94.17 %	95.39 %	92.21 %	95.86 %	15386	2.72%	39.18 %	57.81 %	0.29%	3	
Combined Trusts YTD Cat A Performance (Calculated on current data entries)	**N/A**	**74.20 %**	**117863**	**N/A**	**69.90 %**	**2,148,732**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**		

Birmingham Performance 2014/15

Birmingham	Bulletin Board	Red 1		Red 2		Red 19min	
	2014/15	75% 8min		75% 8min		95% 19min	
Birmingham	Birmingham CrossCity	2076	85.80%	55537	78.20%	57613	98.80%
	Birmingham South & Central	571	82.80%	13543	73.80%	14114	99.10%
	Sandwell & West Birmingham	581	84.00%	16290	77.00%	16871	98.90%
	Solihull	505	74.90%	12209	68.30%	12714	95.80%
	County Total	**3733**	**83.60%**	**97579**	**76.10%**	**101312**	**98.50%**

Birmingham Performance 2015/16

Birmingham	Bulletin Board	Red 1		Red 2		Red 19min	
	2015/16	75% 8min		75% 8min		95% 19min	
	Birmingham CrossCity	3329	87.60%	57192	79.70%	60521	99.20%
	Birmingham South & Central	797	84.80%	14209	76.70%	15006	99.40%
	Sandwell & West Birmingham	900	86.70%	16441	79.20%	17341	99.10%
	Solihull	832	77.80%	12367	69.40%	13199	96.80%
	County Total	**5858**	**85.70%**	**100209**	**77.90%**	**106067**	**98.90%**

Operational Structure

Erdington

- Dean Jenkins -Area Manager
- Phil Calow - Assistant Area Manager
- Ray Earl
- Area Support Officer's
- James Williams
- Stuart Bastock
- Connel McHugh
- David Painting
- Graham Nash

Aston

- Tony Iommi - Assisant Area Manager

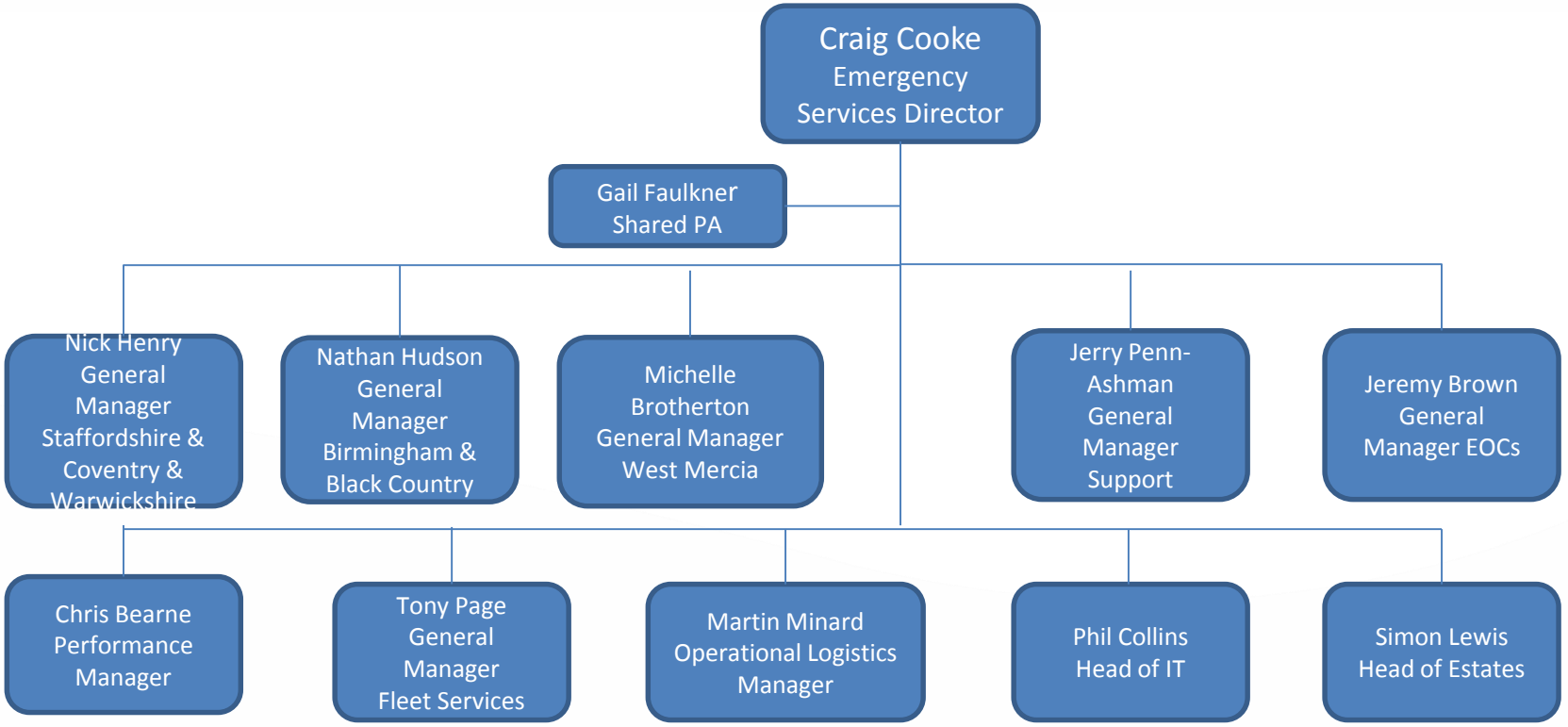
Hollymoor

- Nathan Hudson - General Manager
- Dax Morris - Area Manager
- Tim Hughes - Assistant Area Manager
- Area Support Officers
- Wes Jordan
- Greig Smith
- Chris Wood
- David Roberts
- Brian Fanthom

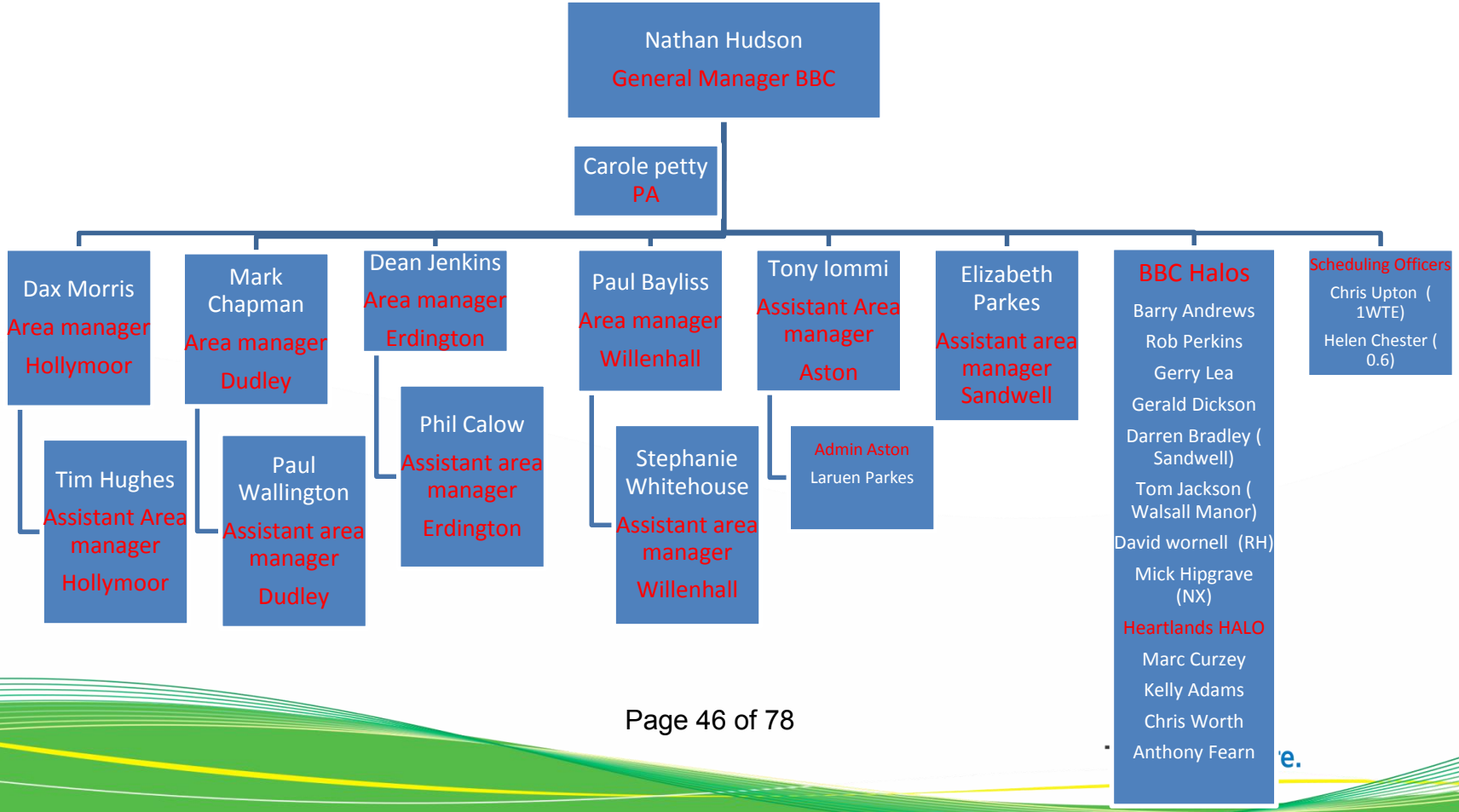
HALO's

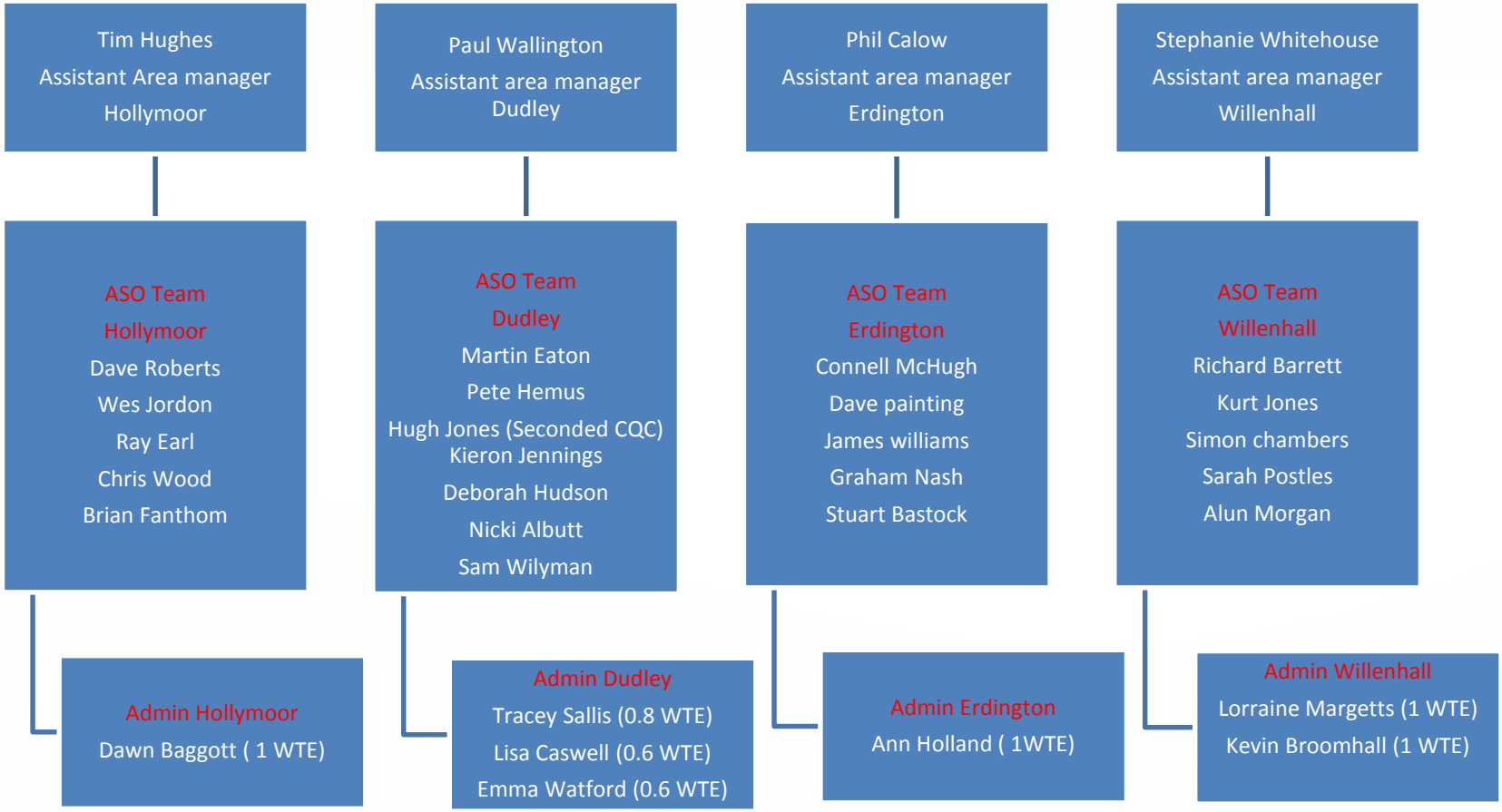
- Gerry Ley
- Gerald Dixon
- Rob Perkins
- Barry Andrews
- Marc Curzey
- Anthony Fern
- Chris Worth
- Kelly Adams

EMERGENCY SERVICES DIRECTORATE – MARCH 2016



Birmingham and Black Country Management Structure (NH April 2016)




Tim Hughes
Assistant Area manager
Hollymoor
Paul Wallington
Assistant area manager
Dudley
Phil Calow
Assistant area manager
Erdington
Stephanie Whitehouse
Assistant area manager
Willenhall
ASO Team
Hollymoor
Dave Roberts
Wes Jordon
Ray Earl
Chris Wood
Brian Fanthom
ASO Team
Dudley
Martin Eaton
Pete Hemus
Hugh Jones (Seconded CQC)
Kieron Jennings
Deborah Hudson
Nicki Albutt
Sam Wilyman
ASO Team
Erdington
Connell McHugh
Dave painting
James williams
Graham Nash
Stuart Bastock
ASO Team
Willenhall
Richard Barrett
Kurt Jones
Simon chambers
Sarah Postles
Alun Morgan
Admin Hollymoor
Dawn Baggott (1 WTE)
Admin Dudley
Tracey Sallis (0.8 WTE)
Lisa Caswell (0.6 WTE)
Emma Watford (0.6 WTE)
Admin Erdington
Ann Holland (1WTE)
Admin Willenhall
Lorraine Margetts (1 WTE)
Kevin Broomhall (1 WTE)

BBC HUB Parings

BBC North	BBC Central	BBC South
Erdington	Sandwell	Hollymoor
Willenhall	Aston	Dudley

Operational workforce

Position	In post	Skill mix
Emergency care assistants	22	3%
Paramedic (includes Adv, CTM, Mentors & FCP)	310	51%
Technician	161	46%
Tr Technician	90	
TOTAL FOR DIVISION FRONT LINE	583	

Estate & Resources

- 2 Hubs
- 15 community Ambulance Stations
- 89 Double crewed Ambulance resources
- 23 Rapid response vehicles.

Achieved

Sickness 2015-16 = 2.83% -
National target <4%

Mandatory training - 98% achieved

Personal development reviews -
100% completed

Acute Performance

Conveyance Volume (red > than f/cast)

	Last Week			MTD			QTD			YTD		
	F/cast	Actual	actual v f/cast % diff	F/cast	Actual	actual v f/cast % diff	F/cast	Actual	actual v f/cast % diff	F/cast	Actual	actual v f/cast % diff
Birmingham Childrens	175	**216**	**24%**	515	**590**	**15%**	1,807	**2,000**	**11%**	7,652	**8,148**	**6%**
Heartlands	835	**918**	**10%**	2,504	**2,640**	**5%**	9,416	**10,196**	**8%**	41,449	**43,123**	**4%**
Good Hope	535	**603**	**13%**	1,626	**1,741**	**7%**	6,337	**6,882**	**9%**	27,192	**28,076**	**3%**
Solihull	159	**161**	**2%**	484	**499**	**3%**	1,874	**2,005**	**7%**	7,760	7,627	-2%
New Queen Elizabeth Hosp	758	**827**	**9%**	2,282	**2,548**	**12%**	8,685	**9,827**	**13%**	37,518	**39,943**	**6%**
City (Birmingham)	571	**586**	**3%**	1,728	1,680	-3%	6,533	6,345	-3%	29,178	**29,269**	**0%**

Avg Handover Time (mins, green <= 15mins)

	Last Week	MTD	QTD	YTD
Birmingham Childrens	**12**	**12**	**11**	**11**
Heartlands	17	17	17	17
Good Hope	16	17	17	17
Solihull	**13**	**13**	**13**	**13**
New Queen Elizabeth Hosp	17	18	17	17
City (Birmingham)	**15**	**15**	**15**	**15**

Avg Turnaround Time (mins, red > 30mins)

	Last Week	MTD	QTD	YTD
Birmingham Childrens	27	26	26	26
Heartlands	**32**	**32**	**32**	**31**
Good Hope	30	**30**	**30**	30
Solihull	28	29	29	28
New Queen Elizabeth Hosp	**31**	**31**	**31**	**31**
City (Birmingham)	29	29	29	30

Compliments/Complaints

Patient Experience

Number of Complaints Received

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
Birmingham	3	0	4	4	3	8	4	3	2	1	6	5	43
Black Country	0	4	0	3	4	4	2	5	3	7	6	1	39
C&W	2	1	2	1	3	3	2	2	2	4	2	3	27
West Mercia	3	2	4	6	4	4	3	0	3	1	5	5	40
Staffs	2	4	4	7	2	3	6	3	3	5	5	3	47
PTS	1	5	4	5	4	3	5	2	6	4	10	11	60
EOC	6	7	7	7	4	9	8	6	10	10	10	12	96
Other	0	0	0	2	0	0	0	1	1	0	1	1	6
WMAS	**17**	**23**	**25**	**35**	**24**	**34**	**30**	**22**	**30**	**32**	**45**	**41**	**358**
Average Number of Days	**34**	**38**	**30**	**29**	**22**								**31**
Compliant with timescales													**0**
% Compliant													**0%**

Complaints

Number of PALS Contacts / Concerns

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
Birmingham	15	9	16	9	10	8	11	20	18	12	13	12	153
Black Country	7	10	7	6	7	8	16	13	11	13	9	9	116
C&W	10	7	5	4	7	8	11	4	9	6	9	11	91
West Mercia	2	8	9	11	12	9	16	9	7	13	12	10	118
Staffs	11	4	2	4	7	9	7	4	10	10	10	12	90
PTS	21	49	40	42	25	43	50	43	27	31	23	26	420
EOC	7	6	7	5	6	14	14	12	14	17	18	10	130
All	0	0	0	0	0	0	0	0	0	0	0	1	1
Other	1	2	0	5	5	1	1	1	1	3	1	3	24
WMAS	74	95	86	86	79	100	126	106	97	105	95	94	1143

Compliments

Number of Compliments received

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
Birmingham	11	19	15	19	30	17	18	24	18	25	10	23	229
Black Country	17	21	17	21	28	22	25	30	13	19	19	28	260
C&W	12	19	20	12	12	18	14	18	9	18	12	16	180
West Mercia	18	30	20	18	26	28	16	25	26	22	16	25	270
Staffs	13	9	13	20	15	15	9	10	16	16	14	15	165
PTS	4	1	3	8	2	2	4	0	1	5	2	4	36
EOC	3	10	7	5	6	7	1	6	7	12	7	7	78
MP/PPH	0	3	1	3	2	1	3	0	1	0	3	3	20
Trust HQ	0	0	0	0	4	1	0	3	1	1	1	1	12
CFR's	1	3	2	4	3	1	5	5	1	1	1	2	29
WMAS	**79**	**115**	**98**	**110**	**128**	**112**	**95**	**121**	**93**	**119**	**85**	**124**	**1279**

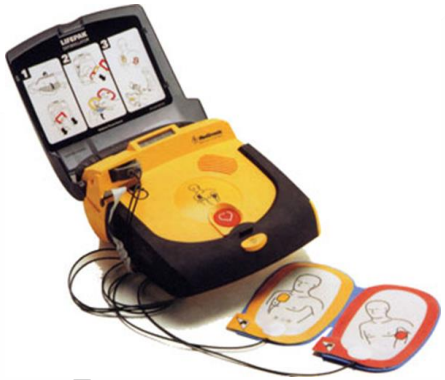
Summary

- Best performing city in the country
- Best attendance by staff in the country
- All staff have had a PDR
- All vehicles are clean and Made Ready
- 98 % of staff receive annual update training
- All mangers are Bronze commander trained
- Strong resilience for a Major incident.

Thank You

Any Questions?

Public Access Defibrillators



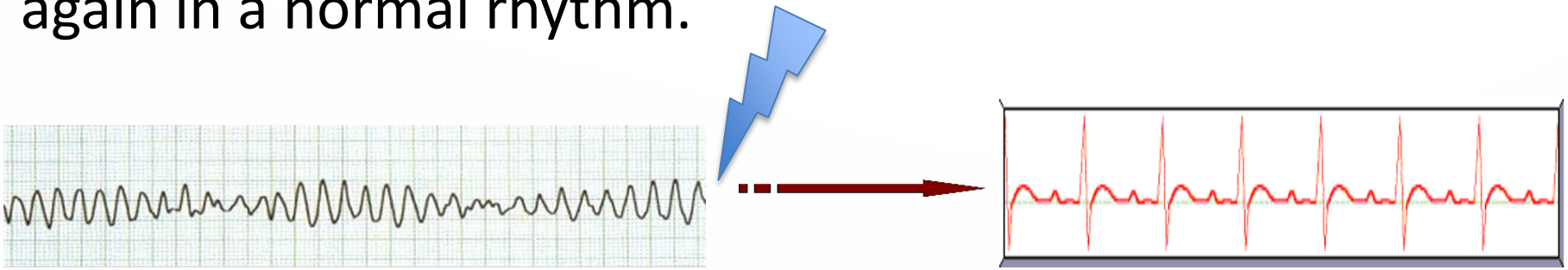
Where are they ?

Nearly 500 PAD sites across Birmingham. Located in swimming & leisure centres, Council house & offices, parks and nature centres, shops, business's, nursing / care homes, Railway stations, 21 in Birmingham Airport and 11 in the NEC Resort world footprint.

Map prepared by Birmingham Council

Defibrillation

The only effective way to treat Cardiac Arrest is with a defibrillator, a medical device that delivers an electrical current, or shock, through the chest to the heart. This shock interrupts the random electrical pulses of ventricular fibrillation and gives the heart a chance to start beating again in a normal rhythm.



Chain of Survival

Early Basic Life Support (BLS) ….

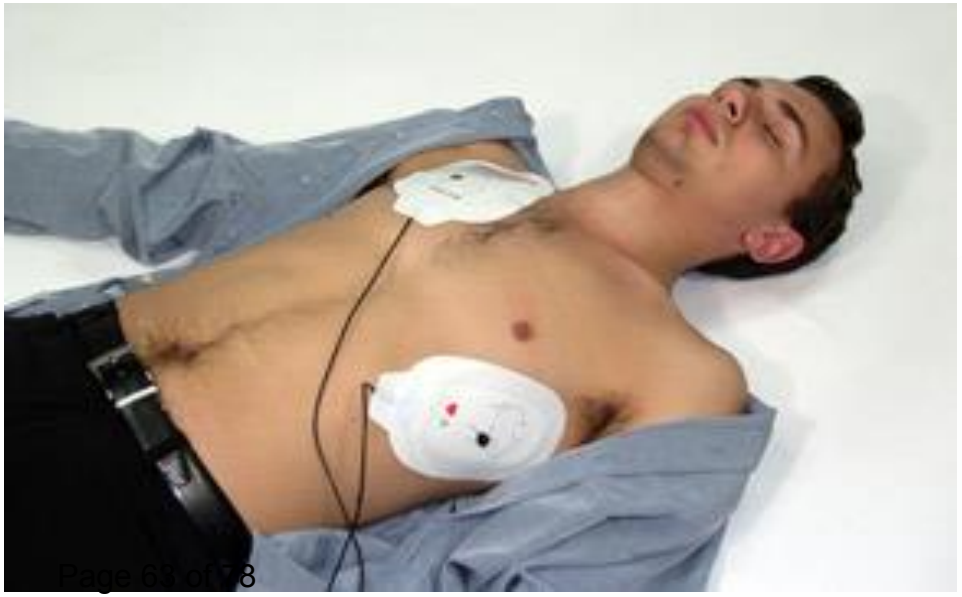
- Mimic the pumping action of the heart
- By squashing between the sternum and vertebrae
- To “pump” blood around the body

Why do CPR?

- **Reduces cerebral hypoxia**
- **Increase the duration of ventricular fibrillation**
- **Improve the chances of successful defibrillation**

Let the machine do the talking …..

- Confirm AED is “Rescue Ready” - **GREEN** Indicator - **OK**
- Open the lid (The unit will perform a self-check)
- Place PADS as directed – dry chest / move jewellery patches



… the machine will analyse the heart

- Once the PADS are placed it will say "*Analysing Rhythm*"
- Do **NOT** touch the Patient
- Be guided by the instructions
- The machine will decide if a SHOCK is required
- If **NO** – Commence CPR
- If **YES** *Think* **SAFETY**
- Press **RED** button to deliver the shock

Any Questions

Prevention and Management of Diabetes in Birmingham

Health & Social Care Overview & Scrutiny Committee

Lead Member:	Cllr Majid Mahmood
Inquiry Members:	Cllrs Mohammed Aikhlaq, Sue Anderson, Albert Bore, Maureen Cornish, Andrew Hardie, Mohammed Idrees, Karen McCarthy, Eva Phillips, Robert Pocock, Sharon Thompson, Margaret Waddington.
Officer Support:	Rose Kiely, Group Overview and Scrutiny Manager Gail Sadler, Research and Policy Officer

Key question:	How can the increasing prevalence of diabetes in Birmingham be managed and reduced?
Key lines of enquiry:	• How prevalent is diabetes in Birmingham and do rates vary in different parts of the city or between different communities? • How do these rates compare to the rest of the country? • What is the current trend in the number of people with diabetes in the city? • What is the difference between Type 1 and Type 2 diabetes? • What are the main risk factors for developing diabetes and how can these be reduced? • What are the potential long-term health implications? • What are the potential long-term financial implications? • What is being done in the city to identify those most at risk and prevent them developing diabetes where possible? • Is there evidence about what interventions work to prevent people developing diabetes and if so, what does the evidence show? • What is being done in the city in relation to diabetes management to reduce the risk of complications for those who already have diabetes? • What models of good practice exist in the city and elsewhere? • What are the potential barriers to these models being implemented widely in the city? • How could good practice examples be replicated or enhanced?

Anticipated outcomes:	• To develop a clear understanding of who is most at risk and what interventions work to prevent people from developing diabetes. • To produce recommendations that will support the widespread implementation of good practice in the city through prevention and good diabetes management.	
Key witnesses to include:	• NHS England – National NHS Diabetes Prevention Programme • Birmingham South Central Clinical Commissioning Group – Demonstrator Site for National Diabetes Prevention Programme (Simon Doble, Senior Commissioning Manager and Dr Richard Mendelsohn, Clinical Head of Commissioning.) • Health Exchange – Working with Birmingham South Central CCG and GP surgeries on diabetes prevention programme "Living Well, Taking Control" (Living well, Taking Control Programme Manager Leon Sewell) • Diabetes UK – (Re prevalence, risks, impact, care) • Be Active Plus – GP referral exercise programme for people with specific medical conditions including diabetes. • Birmingham Public Health Team? Lead Public Health Nurse Elaine George? • South Asian Health Foundation? • Diabetes Prevention Board – Euan Hamnett?	
Background information to include:	Latest Quality and Outcomes Framework Figures (2014/15?) The National Diabetes Audit 2012/13? Sheffield University Research?	
Inquiry Plan:	Feb 2016 April 2016 May 2016 June 2016 July 2016 Sept 2016	Inquiry agreed Terms of Reference to Health and Social Care OSC Evidence gathering Report drafting Report agreed by Committee Members Final Report submitted to City Council

Health and Social Care Overview & Scrutiny Committee
2015/16 Work Programme

Committee Members: Chair: Cllr Majid Mahmood

Cllr Mohammed Aikhlaq
Cllr Sue Anderson
Cllr Albert Bore
Cllr Maureen Cornish
Cllr Andrew Hardie
Cllr Mohammed Idrees
Cllr Karen McCarthy
Cllr Eva Phillips
Cllr Robert Pocock
Cllr Sharon Thompson
Cllr Margaret Waddington

Committee Support:

Scrutiny Team: Rose Kiely (303 1730) / Gail Sadler (303 1901)
Committee Manager: Paul Holden (464 4243)

Schedule of Work

Meeting Date	Committee Agenda Items	Officers
23 June 2015 10.00am	Part 1: Informal Meeting Part 2: Formal Meeting	Rose Kiely/Jayne Power, Scrutiny Office
21 July 2015 1.00pm	Petition – Budget cuts to Supporting People Mental Health and Disabilities Services Care Quality Commission – Quality Ratings Regime Healthwatch Annual Report	*Lead Petitioner, Lucy Beare, Student* Barbara Skinner/Donna Ahern, CQC Brian Carr, Acting Chair Candy Perry, Interim CEO
29 September 2015 10.00am	Primary Care and Community Mental Health Redesign Progress Report on the 'Falls Prevention' Inquiry Tracking of the 'Tackling Childhood Obesity in Birmingham' Inquiry Tracking of the 'Mental Health: Working in Partnership with Criminal Justice Agencies' Inquiry (DEFERRED)	Joanne Carney/ Dr Aqil Chaudary/ Ernestine Diedrick, Joint Commissioning Manager Dr Adrian Phillips, Director of Public Health Dr Adrian Phillips, Director of Public Health/Charlene Mulhern/Dr Andrew Coward, Chair, B'ham South Central CCG Michael Kay/Louise Collett/ Suman McCartney

20 October 2015 10.00am	Birmingham Substance Misuse Recovery System, CRI (Crime Reduction Initiative) – 6 months into new contract Tracking of the 'Homeless Health' Inquiry Tracking of the 'Mental Health: Working in Partnership with Criminal Justice Agencies' Inquiry	John Denley, AD People Directorate, Nic Adamson, Director CRI John Hardy, Policy & Development Officer / Jim Crawshaw, Integrated Service Head Homeless & Pre-Tenancy Services Michael Kay/Louise Collett/ Suman McCartney
24 November 2015 10.00am	Better Care Fund Update to include: • Links to independent living • Direct Payments 2014/15 Safeguarding Adults Annual Report Tracking of 'Living Life to the Full with Dementia' Inquiry Progress Report on the 'Adults with Autism and the Criminal Justice System' Inquiry Customer Care & Citizen Involvement Team Comments, Compliments and Complaints Annual Report 2014-15	Alan Lotinga, Service Director, Health and Wellbeing / Judith Davis, Project Manager Alan Lotinga, Service Director, Health and Wellbeing Mary Latter, Joint Commissioning Manager Dementia/ Cllr Paulette Hamilton/Suman McCartney, Cabinet Support Officer Maria Gavin, Assistant Director Commissioning Centre of Excellence / Louise Collett, Service Director – Policy & Commissioning / Martin Keating, West Midlands Police Charles Ashton-Gray, Strategic Performance & Engagement Manager /Melanie Gray, Performance Management Officer

15 December 2015 10.00am	Cabinet Member – Health and Social Care Local Performance Account 2014-15 (Adult Social Care Services) including an update on the West Midlands Peer Review Action Plan.	Cllr Paulette Hamilton/ Suman McCartney, Cabinet Support Officer Alan Lotinga, Service Director, Health and Wellbeing David Waller, AD
19 January 2016 10.00am	Healthwatch Birmingham Update (Including implementation of new strategic approach and HWE Quality Standards) People with Learning Disabilities: Support with Employment and Housing Smoking Cessation including e-cigarettes Infant Mortality in Birmingham - Intelligence Update	Brian Carr, Acting Chair Healthwatch Birmingham Kalvinder Kohli, Service Lead Prevention & Complex, Commissioning Centre of Excellence Dr Adrian Phillips, Director of Public Health Dr Adrian Phillips, Director of Public Health
23 February 2016 10.00am	Prostate Cancer and Health Inequalities – Information Briefing CrossCity CCG Draft Operational Plan 2016/17 Transforming Care for People with Learning Disabilities (Adults and Children) Update on the Sexual Health Services in Birmingham and Solihull – Umbrella - 6 months into the new contract	Mr. Richard Viney Consultant Urological Surgeon and Senior Lecturer in Urology, UHB Les Williams, Director of Performance & Delivery, CrossCity CCG Maria Gavin, Assistant Director Commissioning Centre of Excellence Max Vaughan, Head of Service, Universal and Prevention
22 March 2016 10.00am	CrossCity CCG Primary Care Strategy 2016/20	Karen Helliwell, Director of Primary Care & Integration, Carol Herity, Associate Director of Partnerships, B'Ham CrossCity CCG

	Birmingham Community Healthcare NHS Trust - Update on new telephone triage system to access unscheduled dental care appointments at Birmingham Dental Hospital. Diabetes Prevention Enhanced Access to GPs	Angie Wallace, Acting Chief Operating Officer, Marie Ward, Director – Specialist Services Division, Kate Cullotty, Service Lead – Unscheduled Care, Mike Murphy, Consultant Oral Surgeon and Head of Service, Birmingham Community Healthcare NHS Trust Dr Andrew Coward, Chair, Simon Doble, Senior Commissioning Manager, Richard Mendelsohn, Clinical Head of Commissioning, South and Central CCG.
26 April 2016 10.00am	West Midlands Ambulance Service NHS Foundation Trust • General Trust Overview • Operational/Clinical Performance Update for 2014/15 (including winter) • WMAS 5 Year Strategy and Initiatives • Demonstration of an Automated External Defibrillator Research Findings on the Effects of Shisha Smoking Terms of Reference – Prevention and Management of Diabetes in Birmingham	Diane Scott, Deputy CEO Nathan Hudson, General Manager Birmingham Division Mark Docherty, Director of Nursing, Quality and Clinical Commissioning, Andy Jeynes, Community Response Manager Dr Adrian Phillips, Director of Public Health, Janet Bradley, Alcohol & Tobacco Control
17th May 2016 Full Day	Inquiry into 'Prevention and Management of Diabetes in Birmingham' – Evidence gathering.	

June 2016	Tracking of the 'Tackling Childhood Obesity in Birmingham' Inquiry Tracking of the 'Mental Health: Working in Partnership with Criminal Justice Agencies' Inquiry	Dr Adrian Phillips, Director of Public Health/Charlene Mulhern/Dr Andrew Coward, Chair, B'ham South Central CCG Louise Collett/ Suman McCartney
July 2016	Tracking of the 'Living Life to the Full with Dementia' Inquiry Tracking of the 'Homeless Health' Inquiry Healthwatch: Update CrossCity CCG Primary Care Strategy 2016/20 – To look at the Operational Plan against: a) Statement of current position b) What we are going to do c) How we get there.	Mary Latter, Joint Commissioning Manager Dementia/ Cllr Paulette Hamilton/Suman McCartney, Cabinet Support Officer John Hardy, Policy & Development Officer / Jim Crawshaw, Integrated Service Head Homeless & Pre-Tenancy Services Candy Perry, CEO, Healthwatch Birmingham Karen Helliwell (Director of Primary Care and Integration), Ravy Gabrria-Nivas (Senior Primary Care Quality Manager)
September 2016		
October 2016	Forward Thinking Birmingham – Mental Health Care for 0-25s (Update 6 months into the new contract)	Denise McLellan, Managing Director
November 2016	Update on Umbrella - the Sexual Health Services in Birmingham and Solihull contract	Max Vaughan, Head of Service, Universal and Prevention
December 2016	15/16 Local Performance Account Report West Midlands Challenge of Birmingham Adult Care	Alan Lotinga, Service Director Health & Wellbeing Alan Lotinga, Service Director Health & Wellbeing

January 2017		
February 2017		
March 2017		
April 2017		

Items to be scheduled in Work Programme
• Urgent Care Strategy (To be confirmed)
• Mental Health Strategy (To be confirmed)
• Congenital Heart Disease Review – outcome from consultation on standards and service specification and next steps
• Tuberculosis Update
• Move of Health Visitors to Local Authority
• Birmingham Dental Hospital – Unscheduled Care – Further update report on data collection/analysis
• Discussion paper on 'Adverse Childhood Experiences'
• Enhanced Access to GPs

Suggested items	**Link to Council Priority**

Joint Birmingham & Sandwell Health Scrutiny Committee Work		
Members	Cllrs Majid Mahmood, Mohammed Aikhlaq, Sharon Thompson, Andrew Hardie, Sue Anderson	
Meeting Date	**Key Topics**	**Contacts**
1 July 2015 2.00pm in Birmingham	• Urgent Care • Cardiology and Acute Services • End of Life Care	Jayne Salter-Scott, Andy Williams
22 September 2015 2.00pm in Sandwell	• Urgent Care • End of Life Care • Primary Care Listening Exercise	Jayne Salter-Scott, Head of Engagement, Sandwell & West Birmingham CCG
15 December 2015 2.00pm in Birmingham	• Urgent and Emergency Care Programme Update • End of Life Care	Dr Manir Aslam, Urgent Care Clinical Lead, SWBCCG, Nighat Hussain, Sandwell Programme Director Jon Dicken, Chief Operating Officer – Operations, SWBCCG, Sally Sandel, Senior Commissioning Officer
11 February 2016 2.00pm in Sandwell	• End of Life Care • Oncology Services, Sandwell & West Birmingham Hospitals NHS Trust	Jon Dicken, Chief Operating Officer – Operations, SWBCCG, Sally Sandel, Senior Commissioning Officer Dr Roger Stedman, Medical Director, Sandwell & West Birmingham Hospitals NHS Trust
June 2016 TBC in Birmingham	• End of Life Care	Jon Dicken, Chief Operating Officer – Operations, SWBCCG, Sally Sandel, Senior Commissioning Officer

Joint Birmingham & Solihull Health Scrutiny Committee Work		
Members	Cllrs Majid Mahmood, Mohammed Idrees, Sir Albert Bore, Robert Pocock, Andrew Hardie, Margaret Waddington, Sue Anderson	
Meeting Date	**Key Topics**	**Contacts**
21 July 2015 5.30pm in Birmingham	• Non-Emergency Patient Transport • HoEFT CQC Inspection Report	Carol Herity, CrossCity CCG Sam Foster, Chief Nurse, NoEFT
6 October 2015 4.30pm tea 5.00pm start in Solihull	• Non-Emergency Patient Transport – results of consultation and proposed model • HoEFT Surgery Reconfiguration Update – Site Plans for all 3 Trust Hospitals and update on CQC inspection issues. • CCGs on Surgery Reconfiguration public consultation	Carol Herity, CrossCity CCG Ruth Paulin, Lisa Thompson, Richard Steyn
10 February 2016 5.00pm in Birmingham	• HoEFT – o Report on the outcome of the Monitor financial investigation. • Non-Emergency Patient Transport (NEPT) Consultation o Further information around the feasibility of a fee paying service in the new contract	Dame Julie Moore, Interim Chief Executive, HoEFT, Rt Hon Jacqui Smith, Chair, HoEFT Carol Herity, Associate Director of Partnerships, Mark Lane, Head of Planning & Delivery, Gemma Coldicott, Senior Communications & Engagement Manager, CrossCity CCG
24 March 2016 5.30pm tea 6.00pm start in Solihull	• NHS Procedures of Lower Clinical Value – Solihull and Birmingham CCGs Public Engagement Process • Mental health for young people across Birmingham and Solihull	Dave Rowson, NHS Midlands and Lancashire CSU
TBC Birmingham	• NHS Procedures of Lower Clinical Value – Solihull and Birmingham	Dave Rowson, NHS Midlands and Lancashire CSU

West Midlands Regional Health Scrutiny Chairs Network		
1 July 2015	• NHS England – West Midlands Neonatal Service Review • Integrating Health and Social Care • CQC – Update on Primary Medical Services	
7 October 2015 9.30am	• NHS 111 Contract – Dr Anthony Marsh, CEO WMAS, Mr Jon Dicken, Chief Officer SWBCCG (Lead Commissioners for NHS 111) • NHS England – Updates on Specialised Commissioning and Neonatal Review • Update on developments within the Centre for Public Scrutiny	Dr Anthony Marsh, CEO of WMAS, Jon Dicken, Chief Officer SWBCCG Christine Richardson, AD Dr Geraldine Linehan, Regional Clinical Director Brenda Cook, CfPS Regional Advocate & Expert Adviser
3 February 2016 10.00am	Session facilitated by the Centre for Public Scrutiny	Brenda Cook, Regional Advocate, CfPS
15 June 2016 10.00am	Mental Health (Changes taking place with primary and secondary care)	

CHAIR & COMMITTEE VISITS		
Date	**Organisation**	**Contact**
18 January 2016	HEFT Reconfiguration of Surgery Services – Visit to new centres at:- • Solihull (Dermatology) • Heartlands (Minor Injuries Unit alongside A&E) • Good Hope (Medical Assessment Unit)	Professor Matthew Cooke, Deputy Medical Director, Strategy and Transformation
To be advised	West Midlands Ambulance Service – Visit to an Ambulance Hub.	Diane Scott, Deputy CEO
To be advised	Birmingham Substance Misuse Recovery System:- Visit to CRI premises, Scala House, Birmingham.	John Denley, AD Commissioning Centre of Excellence / Nic Adamson, Director CRI
To be advised	Visit to The Bromford – a Supported Living Scheme in East Birmingham	Kalvinder Kohli, Head of Service, Prevention and Complex, Commissioning Centre of Excellence

INQUIRY:	
Key Question:	
Lead Member:	
Lead Officer:	
Inquiry Members:	
Evidence Gathering:	
Drafting of report	
Report to Council:	

Councillor Call for Action requests

Cabinet Forward Plan - Items in the Cabinet Forward Plan that may be of interest to the Committee			
Item no.	**Item Name**	**Portfolio**	**Proposed date**
000298/2015	Public Health Grant Reduction	Health & Social Care	16 February 2016
000355/2015	Public Report - Purchase of a Home Support Visit Monitoring System Full Business Case and Contract Award	Health & Social Care	28 June 2016
001551/2916	Approval to Consult – Personal Budget Allocation System	Health & Social Care	22 March 2016