BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD

TUESDAY, 30 JULY 2019 AT 14:00 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 Chairman to advise/meeting to note that this meeting will be webcast for live or subsequent broadcast via the Council's Internet site (www.civico.net/birmingham) and that members of the press/public may record and take photographs except where there are confidential or exempt items.

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2 **APPOINTMENT OF HEALTH AND WELLBEING BOARD - FUNCTIONS, TERMS OF REFERENCE AND MEMBERSHIP**

To note the re-appointment of the Health and Wellbeing Board with the functions, terms of reference and membership as set out in the schedule.

3 **DECLARATIONS OF INTERESTS**

Members are reminded that they must declare all relevant pecuniary and non pecuniary interests arising from any business to be discussed at this meeting. If a disclosable pecuniary interest is declared a Member must not speak or take part in that agenda item. Any declarations will be recorded in the minutes of the meeting.

4 **APOLOGIES**

To receive any apologies.

5 **DATES OF MEETINGS**

To note the dates of the meetings of the Board for 2019/2020 as follows:
Tuesday 30 July 2019*
Tuesday 24 September 2019
Tuesday 26 November 2019
Tuesday 21 January 2020
Tuesday 17 March 2020

All meetings will commence at 1500 hours *(except for 30th July's meeting which will commence at 1400 hours) and will be held in Committee Rooms

3&4, Council House, Victoria Square, Birmingham B1 1BB.

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6 **MINUTES AND MATTERS ARISING - PUBLIC**

To confirm the public part of the Minutes of the meeting held on the 30 April 2019.

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7 **NOTES OF INFORMAL MEETING ON 18 JUNE 2019 (1410 - 1415)**

The Notes are attached for members information and members are requested to ratify the recommendations highlighted therein

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8 **ACTION LOG (1415 - 1425)**

To review the Actions arising from previous meetings.

9 **CHAIR'S UPDATE (1425-1430)**

To receive an oral update.

10 **PUBLIC QUESTIONS (1430-1440)**

Members of the Board to consider questions submitted by members of the public.
The deadline for receipt of public questions is 3:00pm on Thursday 25 July 2019. Questions should be sent to: HealthyBrum@Birmingham.gov.uk.
(No person may submit more than one question)
Questions will be addressed in correlation to the agenda items and within the timescales allocated. This will be included in the broadcast via the Council's Internet site (www.civico.net/birmingham). NB: The questions and answers will not be reproduced in the minutes.

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11 **DEVELOPMENT OF HEALTH & WELLBEING BOARD SUB-COMMITTEE STRUCTURE (1440 - 1455)**

Dr Justin Varney, Director of Public Health will present the item.

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12 **MAKING EVERY ADULT MATTER (1455 - 1510)**

Dr Justin Varney, Director of Public Health will present the item.

55 - 66

13 **MEETING THE NEEDS OF PEOPLE WITH COMPLEX AND SEVERE MENTAL ILL HEALTH IN BIRMINGHAM (1510 - 1525)**

Tom Howell, Head of Joint Commissioning for Mental Health and Personalisation will present the item.

67 - 142

14 **DRUG AND ALCOHOL - CHANGE GROW AND LIVE: PEER MENTOR (1525 - 1540)**

Max Vaughan, Public Health Commissioning, will present the item.

143 - 170

15 **BIRMINGHAM OLDER PEOPLE PROGRAMME: UPDATE ON THE AGEING WELL PROGRAMME (1540 - 1555)**

Andrew McKirgan and Andy Lumb will present the item on behalf of the Birmingham Older People Programme, Ageing well

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16 **HOMELESSNESS IN BIRMINGHAM SESSION (1555 - 1655)**

This session will be hosted by Councillor Sharon Thompson and Kalvinder Kohli, Birmingham City Council. This will be an interactive session which includes the screening of a short film.
https://vimeo.com/341360256/36383c9df4
Supporting information for this item has been provided by Birmingham and Solihull CCG, Sandwell and West Birmingham CCG, Birmingham Community Healthcare Trust and Birmingham and Solihull Mental Health Trust.

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17 **BIRMINGHAM HEALTH AND WELLBEING BOARD FORWARD PLAN (1655 - 1700)**

To agree a forward plan for the Board

18 **DATE, TIME AND VENUE OF NEXT BIRMINGHAM HEALTH AND WELLBEING BOARD MEETING**

To note that the next Birmingham Health and Wellbeing board meeting will be held on Tuesday 24 September 2019 at 1500 hours in Committee Rooms 3&4, Council house, Victoria Square, Birmingham B1 1BB.

19 **OTHER URGENT BUSINESS**

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

20 **EXCLUSION OF THE PUBLIC**

That in view of the nature of the business to be transacted which includes exempt information of the category indicated the public be now excluded from the meeting:-

Exempt Paragraph 2

P R I V A T E A G E N D A

21 **MINUTES - PRIVATE**

- Information which is likely to reveal the identify of an individual;

22 **OTHER URGENT BUSINESS (EXEMPT INFORMATION)**

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

APPOINTMENT OF BIRMINGHAM HEALTH AND WELLBEING BOARD

FUNCTIONS, TERMS OF REFERENCE AND MEMBERSHIP 2019/20

In accordance with paragraph 6.9 of Article 6 (The Executive) of the City Council Constitution, the board is constituted as a Committee under the chairmanship of the Cabinet Member for Health and Social Care in order to discharge the functions of the board as set out in the Health and Social Care Act 2012, including the appointment of board members as set out in the schedule of required board members in the Act.

Functions

To discharge the functions of a Health and Wellbeing Board as set out in the Health and Social Care Act 2012, including the appointment of Board Members as set out in the schedule of required Board Members in the Act.

The Health and Wellbeing Board will:

a) promote the reduction in Health Inequalities across the City through the commissioning decisions of member organisations

b) report on progress with reducing health inequalities to the Cabinet and the various Clinical Commissioning Group Boards

c) be the responsible body for delivering the Joint Strategic Needs Assessment for Birmingham (including the Pharmaceutical Needs Assessment)

d) deliver and implement the Joint Health and Wellbeing Strategy for Birmingham

e) participate in the annual assessment process to support Clinical Commissioning Group authorisation

f) identify opportunities for effective joint commissioning arrangements and pooled budget arrangements

g) provide a forum to promote greater service integration across health and social care.

Terms of Reference

Under the Health and Social Care Act 2012 the composition of Board must include:-

The Leader of the Council or their nominated representative to act as Chair of the Board
The Director - Adult Social Care Directorate (Director for Adult Services)
The Director – Education and Skills Directorate (Director for Children's Services)
Nominated Representatives of each Clinical Commissioning Group in Birmingham
The Director of Public Health
Nominated Representative of Healthwatch Birmingham

Each Local Authority may appoint additional Board Members as agreed by the Leader of the Council or their nominated representative. If additional appointments are made, these will be reported to Cabinet by the Chair of the Board.

For the Board to be quorate at least one third of Board Members and at least one Elected Member must be present

Members of the Board will be able to send substitutes with prior agreement of the Chair. Each member is to provide the name of an alternate/substitute member.

Membership 2019/20

City Council Appointments to the Health and Wellbeing Board

Cabinet Member for Health & Social Care as Chair: Cllr Paulette Hamilton (Lab)	Cllr Paulette Hamilton
Cabinet Member for Children's Wellbeing: Cllr Kate Booth	Cllr Kate Booth
Opposition Spokesperson on Health and Social Care – Cllr Matt Bennett (Con)	Cllr Matt Bennett
Vice Chair for 2019/2020 to be a Clinical Commissioning Group (CCG) representative (to be advised by the CCG) - to reinforce the Board as a joint body rather than a solely LA committee	Dr Peter Ingham
Director - Adult Social Care Directorate	Professor Graeme Betts
Director - Education and Skills Directorate	Dr Tim O'Neil (Sarah Sinclair as substitute)
Director of Public Health	Dr Justin Varney

External Appointments to the Health and Wellbeing Board

Representative of Healthwatch Birmingham	Andy Cave
2 Representatives of Birmingham and Solihull Clinical Commissioning Group	Dr Peter Ingham and Paul Jennings
Representative of Sandwell and West Birmingham Clinical Commissioning Group	Ian Sykes (from 1 August 2019) Professor Nick Harding
Representative of Third Sector Assembly	To be appointed
Representative of Birmingham and Solihull STP (One Care Partnership)	Paul Jennings

Chief Executive of Birmingham Children's Trust	Andy Couldrick
Chair of the Birmingham Community Safety Partnership/WM Police	Dawn Baxendale Chief Executive (Dr Justin Varney as substitute)/Chief Supt John Denley
Representative of the Department of Work and Pensions	Gaynor Smith
Member of the Birmingham Social Housing Partnership	Peter Richmond
Representative of Birmingham Community Healthcare NHS Foundation Trust	Richard Kirby
Representative from the Education Sector	Dr Robin Miller

Co-optees

Birmingham Voluntary Services Council	Stephen Raybould
Representative from the Business Sector	To be appointed
Representative from the Birmingham and Solihull Mental Health Trust	Charlotte Bailey
Representative from SIFA FIRESIDE	Carly Jones

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD TUESDAY, 30 APRIL 2019

MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON TUESDAY 30 APRIL 2019 AT 1500 HOURS IN COMMITTEE ROOMS 3 AND 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM B1 1BB

PRESENT: -

Councillor Paulette Hamilton, Cabinet Member for Health and Social Care in the Chair.
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Councillor Kate Booth, Cabinet Member for Children's Wellbeing
Andy Cave, Chief Executive, Healthwatch Birmingham
Andy Couldrick, Chief Executive, Birmingham Children's Trust
Professor Nick Harding, Chair of Sandwell and West Birmingham CCG
Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG
Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS Foundation Trust
Dr Robin Miller, Head of Department, Social Work and Social Care, Health Services Management Centre, University of Birmingham
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Antonina Robinson, Think Family Lead Birmingham, Department for Work and Pensions

ALSO PRESENT:-

Chris Baggott, Service Lead for Public Health Division
Maria Gavin, Assistant Director, Quality and Improvement, Adult Social Care
Elizabeth Griffiths, Acting Assistant Director of Public Health
Rebecca Hadley, SIFA FIRESIDE
Superintendent Sarah Tamblin, West Midlands Police
Dr Dennis Wilkes, Assistant Director of Public Health
Errol Wilson, Committee Services

The Chair invited the Board members who were present to introduce themselves.

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record and take photographs except where there are confidential or exempt items.

DECLARATIONS OF INTERESTS

369 Members were reminded that they must declare all relevant pecuniary interests and non-pecuniary interests relating to any items of business to be discussed at this meeting. If a pecuniary interest is declared a member must not speak or take part in that agenda item. Any declarations would be recorded in the minutes of the meeting.

APOLOGIES

370 Apologies for absence were submitted on behalf of Charlotte Bailey, Executive Director Strategic Partnerships, Birmingham and Solihull Mental Health Trust
Chief Superintendent John Denley, West Midlands Police (but Superintendent Sarah Tamblin as substitute)
Professor Graeme Betts, Director for Adult Social Care and Health Directorate (but Maria Gavin as substitute)
Dr Peter Ingham, Clinical Chair, NHS Birmingham and Solihull CCG
Carly Jones, Chief Executive, SIFA FIRESIDE (but Rebecca Hadley as substitute)
Peter Richmond, Chief Executive, Birmingham Social Housing Partnership
Sarah Sinclair, Interim Assistant Director, Children and Young People Directorate
Dr Justin Varney, Director of Public Health, Birmingham City Council (but Dr Dennis Wilkes as substitute)

MINUTES AND MATTERS ARISING

Minute No. 362 (k) was noted as an action for the Birmingham Health and Wellbeing Board Development Day scheduled for Wednesday 15 May 2019.

371 **RESOLVED: -**

That the Minutes of the meeting held on 19 March 2019, having been previously circulated, were confirmed and signed by the Chair.

ACTION LOG

372 The following Action Log was submitted:-

(See document No. 1)

Elizabeth Griffiths, Acting Assistant Director of Public Health introduced the item and updated the Board concerning the Action Log.

Log No. 362 refers – this was action related to the JSNA and that she was pleased to advise that they now have Deep Dives champions from the Board.
Death and Dying Deep Dive – Paul Jennings and Stephen Raybould volunteered.
Veterans Health – Dr Peter Ingham.
Health and Wellbeing Public Sector – Richard Kirby.
Diversity and inclusion will be discussed later in the main agenda.

Dr Wilkes gave a brief update on the IPS Mental Health there was no one as yet wishing to volunteer to help steer and keep to task the IPS, the scheme to support the development of supporting work. This was still an outstanding action. The Chair suggested that Charlotte Bailey be nominated to the IPS Mental Health. The Board agreed this nomination. Dr Wilkes undertook to contact Charlotte Bailey concerning the issue.

Log No. 346 refers – this will be picked up as part of the Board's Development Day scheduled for the 15 May 2019.
Log No. 351 refers – Mr Jennings advised that an update on the NHS long-term plan would be submitted at a future Board meeting.
Log No. 352 refers – this was around substance misuse and would come back to the Board at a later date.

HEALTH AND WELLBEING BOARD DRAFT FORWARD WORK PROGRAMME

373 The following draft Forward Plan was submitted:-

(See document No. 2)

Dr Dennis Wilkes, Assistant Director of Public Health introduced the item and advised that the Forward Plan (FP) was intended to plan the work to support the Board and for members to be able to prepare themselves for future discussions. There will be another private session for September's Board meeting and the Development Session will be held on the 15 May 2019 at Woodcock Street in the Auditorium. If members had issues which they want to put on the FP, they could contact Dr Varney.

CHAIR'S UPDATE

374 The Chair gave a brief update on the following: -

- Donor City Training
- NHS long-term plan and
- West Birmingham

(See document No. 3)

PUBLIC QUESTIONS

375 The Chair advised that there were no public questions submitted for this meeting, but following on from Councillor Matt Bennett, the question was asked

as to what they were doing to promote this issues. The Chair added that last month they had put a video on line and a strategy was currently being developed which would be available at the end of May 2019 to start promoting the *Public Questions* item widely. The Chair requested that they be given until September when it was hoped that people would start asking a lot of questions. She requested that the Board Members also publicises this to each of their particular areas.

BIRMINGHAM JOINT STRATEGIC NEEDS ASSESSMENT: DIVERSITY AND INCLUSION DEEP DIVE 2019/20

376 The following report was submitted:-

(See document No. 4)

Elizabeth Griffiths, Acting Assistant Director of Public Health introduced the item and assured the Board that work continues apace on the Joint Strategic Needs Assessment (JSNA). She advised that they had three programmes one on the core data set (JSNA) which they would be discussing later on the agenda. The deep dive reviews which she will speak to the Board about. They were working on the longer term plan to improve the JSNA up to an excellent standard through integrating data and also linking in with the population health management process that was going on.

Alongside the JSNA work within the Council and with partners, they were in the process of getting back the results from an internal audit that made recommendations on the basis of how people were currently using the JSNA within the local authority. They would ensure that these were fed into the development process. They had an officer who was seconded to Public Health England to look at better practice in JSNA which was also fed through and the Board will see some of the recommendations from that in the draft template in the report appendix.

Each year for the deep dive reviews, they had made a commitment to have four slots, three of which will be of general interest reviews and one will be for a diversity and inclusion topic. The Board was required to agree what this year's diversity and inclusion topic was and to get a Board Champion agreed or volunteered so they could move forward.

Ms Griffiths drew the Board's attention to Appendix 1 to the report and advised that they had an outline of what they were proposing the deep dive review should look like. This includes within the scoping to ensure they get both depth and breadth within their review. Each deep dive will need to identify and engage with stakeholders, define exactly what the population of interest was identify what the necessary data sources were, develop a communications plan that was unique to the deep dive area of interest they were looking at. They were also looking at what other products might be needed.

They had received positive feedback on the infographics that Public Health had already produced and they would like to ensure that for each of the deep dives reviews they have an infographic to explain what the key areas of interests and

needs were for the different populations. They would ensure that along with any other products that were identified were included.

Ms Griffiths drew the attention of the Board to the section in the appendix stating *what good would look like* in JSNA. This would include ensuring that they had a wide range of data, engaging with stakeholders and also in particular for deep dive reviews, that the review itself looked at not just where they had review data, but where there were no data, where there were gaps that they could make recommendations to improve data collections in the future, particularly when they were talking about marginalised groups within their diversity and inclusion topics. Ms Griffiths stated that feedback on the draft template from the Board would be welcomed.

Appendix 2 to the report detailed some deep dive diversity and inclusion topics which sets out where they had information from a national level of inequalities experienced by different groups that comes under diversity and inclusion category. What they would like to do through the deep dive process was to look at what they know in Birmingham and whether the national picture apply here and where were the specific gaps in intelligence that they had.

It was important to note that whatever deep dive category they chose and the diversity and inclusion, they would look at a wide range of issues. They would look at the population identified throughout the life course, but they would also look at any other inequalities experienced within other diversity and inclusion characteristics. Example, if sensory impairments were chosen, they would look at whether any particular inequalities were experienced by black and minority ethnic groups within sensory impairments within different characteristics. They would ensure that they look at the breadth and depth of the issue. Within the appendix a number of different options under the different diversity and inclusion characteristics were outlined – sensory impairments and looking at different levels within our population.

Ms Griffiths then referred to information from the World Health Organisation in relation to people with visual impairment who were more likely to experience poverty and disadvantage; people with learning disability or intellectual impairment where it was known that those with learning disability were ten times more likely to suffer sight loss and hearing loss occurred within 40% of the elderly population etc.

Action: Ms Griffiths advised that the outcome they would like was for the Board to choose a topic for review and identify a volunteer to be the champion for that review.

In response to questions and comments, Ms Griffiths made the following statements:-

1. Ms Griffiths noted Councillor Bennett's comments concerning the information in relation to faith and stated that this showed why a deep dive review was necessary as this was taken from a national dataset and an investigation which the Local Government Association (LGA) had undertaken.
2. What they wanted to do was to look in detail at what information they had available that breaks down communities and populations by their faith

and where not, what information do they have and what inferences could be made.

3. Within the deep dive review that would allow for them to make an assessment and discuss the information they had and what they could/could not take from it; where they were making assumptions and how robust those were and what were the degree of confidence in what they were saying was accurate in relation to faith and where it stand and to where the factors mentioned might be down to ethnicities.
4. They would want to drill down further during the course of the deep dive review.
5. Ms Griffiths noted Professor Harding's concerning in relation to choosing a topic for review and stated that all of the topics referred to in the appendix to the report were important and was a difficult decision to make.
6. That they would like to hit the ground running this year and have something they could be working with and then in future years they had a long list of review topics through the process of prioritisation they could look at what the Board felt were their priority area.
7. At this stage, it would be useful to have one topic and then they could perhaps have a further discussion and they could go back and look at some more information if that was what the Board needed to make that decision for the longer term.
8. One of the ways they were going to propose resolving the long list of the other deep dive topics from next year onwards was to do a Delphi process where the Board and the steering group members would be asked to rank each of the areas and then through a series of questionnaires and also a feedback as a way of developing a consensus between the group without getting polarised views.
9. That her proposal to make a decision for the Board easier was if they add this year's diversity and inclusion topic to the list within the Delphi process they could asked each member what it was that they felt were the most important ones.
10. If the Board consent to be part of that they would ensure that they were all included on the series of questionnaires. ACTION: She undertook to ask her team to provide further details on life expectancy etc. if the Board was happy for this to be done.
11. The deep dive reviews would be until March 2020 and they were looking at a four monthly process for each of them. If they get the Delphi process started in a few months they could identify the Forward Plan and then come back to the Board at the next meeting to get the champions identified. Alternatively they could email around once the topics gets decided. ACTION: Ms Griffiths undertook to circulate further information to the Board explaining the Delphi process.

The Chair commented that she was minded to go with the disabilities topic when the Delphi questionnaires have been circulated.

JOINT STRATEGIC NEEDS ASSESSMENT REPORT UPDATE

The following report was submitted:-

(See document No. 5)

Elizabeth Griffiths, Acting Assistant Director of Public Health introduced the item and advised that this was an update on the core JSNA dataset. One element they were looking at alongside the deep dive reviews was bringing the core dataset up to speed. They were aiming for a good dataset to inform the autumn commissioning around this year. They had ambition to move from good to better and then from better to excellent in the near future. As part of getting to excellent they had a long-term programme about integrating data where they could across different partners.

Within the Committee report was a template with the proposed dataset for the core data. This draws on other areas such as Southampton in terms of the depth that they look at their data and Solihull which helps with the CCG to look at the breadth of data that was available. They were proposing that the core dataset follows the life course but also looked at the wider determinants of health.

The aim was to highlight inequalities and variations in outcomes at the city level, but also where they had that information available within the different population groups such as the diversity and inclusion characteristics. They were keen to use infographics where they could and the proposal for each of the topic headings to have an infographic that explained the information that they had for those particular areas.

Ms Griffiths drew the attention of the Board to the outline information in the report and highlighted that on page 56 of the document there was a mock-up of one of the questions i.e. what was the demographic need and overview of the topic. What did the data tells us about the information and need and then looking at different categories within the childhood section – oral health, early years' education etc. The proposal was to publish a project plan for the core dataset that would give the Board a timeline. They were working towards getting this ready for the autumn round of commissioning, but would have exact details of the timeline to come back to the Board and could circulate it. The JSNA Steering Group had met and was developing the long list of topics and had proposed that Delphi process that was mentioned in the previous item.

Stephen Raybould commented that the JSNA and its profile within the city, was perhaps a major area where the Health and Wellbeing Board could exert leverage over other spaces. He added that it was notable in the steering group and amongst others that when you start having conversations about the JSNA they often enquired what this was, which, was unusual for a local authority area as it had a much stronger function than other areas. The Board's capacity to make decisions about its content was important in terms of driving the agenda to encourage people to support it.

The Chair commented that this was an excellent point and that as a local authority they were at fault because for about two years they did not produce a JSNA. It appeared that it was put on the back burner which meant that they were not doing the work through any strategic direction so they were not able to sell what they were doing and how they were doing it. Going forward, they were putting the building blocks in place over the next two years. As the Public Health consultation goes out, the partners should be talking about this at every meeting they attend as it should be part of every discussion that they have.

Professor Harding commented that they had several JSNAs in Birmingham and that they had shown roughly the same things which states that they have some health and inequality concerns that they needed to do something about. Whilst it was exiting to have a JSNA, there were two things that were needed. Firstly that it was produced in such a way that everyone could understand it so that people could decipher the main languages in terms of what it was trying to say not how it was written. Secondly, the actual plan associated with the JSNA as it was still a plan at the end of the day. It was making sure that they did something rather than having a great plan.

377 **RESOLVED: -**

The Health and Wellbeing Board noted the proposed outline of the core dataset for the JSNA to include health, social care, housing and economic data from the Council, health data from the NHS and crime data from the Police and Community Safety Partnership.

HEALTH PROTECTION FORUM REPORT

The following report was submitted:-

(See document No. 6)

Chris Baggott, Service Lead for Public Health Division, presented the item and drew the Board's attention to the information contained in the report. He advised that they were addressing the challenges identified in the report and would be developing action plans; identifying strategic leads for some of their particular concerns and will be developing action plans to improve and address the challenges identified in the report. These actions will be monitored over the coming months at the Health Protection Forum (HPF) and it was hoped that they would be in a position to report back to the Health and Wellbeing Board in 12 months' time to inform the Board what progress had been made.

The Chair commented that she was perturbed when she read the report. She highlighted the following: -

- Page 5 para 1.3 of the report the assurance statement; Page 7 Pulmonary TB cases starting treatment in four months; Page 8 of the report the improvement plan second sentence. The question was why this was not adopted and implemented and what the reason was for it being held up. Page 14 Performance summary.
- The Chair remarked that there was a lot of talking but not much action. She added that there needed to be some clear specific actions coming to the Board on a regular basis to show that something was happening in this area.

Councillor Bennett made the following statements: -

a. That that he endorsed the Chair's comments above and queried the MMR vaccinations as this was mentioned in the national press in the last couple of weeks.

b. It was accepted that the Public Health team was not responsible for delivering this, but the Secretary of State had not ruled out the possibility of giving admissions to schools for children that had not been vaccinated. This was something they all had to consider carefully.
c. The figures did not look good and the variations were worst. He voiced concerns that they were not able to get a grip on this, but that he realised that whilst there were some national issues which was out of our control he understood that there was information being spread around on a huge level, but combatting ignorance was a key part of it.
d. Of concern was that what was proposed was a group getting together to draw up an action plan and it was just being suggested that the Board would be given an update in 12 months' time.
e. In his opinion he did not think that this was good enough and that there needed to be a clear understanding of what was being done locally soon. Whether more needed to be done nationally or more powers be given as they needed to understand this quickly.
f. Everything he had been reading recently suggested that they were on the edge of a major public health crisis about the take up of vaccinations.
g. A lot of people were coming and going in the city and it was important to get to that point quickly, not just for the Commonwealth Games.

Councillor Booth commented that:-

i. She endorsed Councillor Bennett's statements. She voiced concerns that in the city there were pockets of areas where they did not have an equality of immunisation.
ii. There were some surgeries as mentioned earlier where there was 100% coverage, whilst there were others where this was not happening.
iii. These children were not making the decision themselves not to be vaccinated and was something that they must do as a city on their behalf.
iv. She did not want to see the resurgence of the situation where parents were not doing this as a result of what they were reading on social media.
v. It was creeping into the press again that people were not being vaccinated when there was no good reason for them not to have their children vaccinated.

Professor Harding stated that: -

- The last point made by Councillor Booth was important. The thing that made the biggest difference was having people that influenced people and got behind campaigns to vaccinate people. It was known that historically through many years.
- It was important that a strong stance was taken and what we think about immunisation with the public health department locally and nationally. There was an outbreak of measles within this city.
- We needed to think hard about the actions as one of the things that worry him about the actions was that they did not have the people with the power in the room to make the decisions and they did not have the providers.
- In terms of recommendation 3(a) he was confused how CCGs could be part of that … They needed to think hard about the commissioners and providers etc. to ensure that the actions were associated with the right people otherwise they will not get to where they needed to get to.

Mr Baggott advised that:-

1) The partners mentioned in the recommendations were the partners of the HWB.
2) That he was aware that many of the other key influencers – the commissioners and the providers – would need to be part of this.
3) The recommendations were for the Board and he wanted to highlight which Board members would be usefully engaged with the action plans on these working groups.
4) They were working with the commissioners on a daily basis. They have a Measles Elimination Working Group set up locally and will talk about measles outbreak in the second report on the agenda.
5) Following this they had convened a local sub-region list – the Measles Elimination Sub-Region Group which had been doing work deep dive updated to try and understand the variation in MMR uptake was.
6) The system was not set up easily, but this was completed by key partners locally.
7) The Measles Elimination Group locally was working on that.
8) The key part was understanding variation and where the challenges lay and ensuring that MMR vaccinations was the best tool for addressing and preventing measles as the best key for the local immunisation plan.
9) In relation to social media, there was no denying that social media was a particular challenge.
10) The statutory services communication responses which in the days of social media were relatively inflexible.
11) The public found it far easier to take on board information social media. They needed to do more about understanding who the key influences were.
12) In terms of HPV vaccination for aged 13 and 14 year old girls that will be expanding shortly to boys. This was low and was a challenge.
13) It was acknowledge that vaccine uptake was voluntary and that many people for whatever reason declined vaccine consent for their children.
14) It was important that they understood the reasons behind that as they have cultural groups within the city that held particularly challenging views.
15) It was also important that they understand the drivers for why people were choosing not to consent to vaccinations for their children.
16) The percentage of TB treatment starting in the city, were outperforming the West Midlands and the UK rates which was good news story. They had requested their people to be quicker on TB treatment locally and this was a good news story.
17) In relation to TB and housing, this was a complex situation because TB affects people who had chaotic and vulnerable lifestyles. This includes people who had no recourse to public funds.
18) The support that a local authority housing team within a local authority was able to provide to people with no recourse to public funds was limited and they were often not able to support people with that status.
19) It was important as a housing social care system that they work together to find different solutions to that challenge where the local authority could not provide the answer by itself.

Dr Wilkes commented that he believe that Dr Varney would be delighted at the strength of concerns parallel his own concerns about the state of preparedness

and protection. Having made these concerns more explicit within the system itself and other partners who were not around the table were suddenly taking further note and proposing to engage much more energetically and actively around these issues. The support of the Board gives him some cutting edge intervention and action. He added that Dr Varney was clear that action was what was needed. He would drive the task and finish group into much sharper focus and impact that had been seen in the past.

Mr Jennings referred to the point in relation to no recourse to public funds and commented that what often happened and could happen was that they end up in acute hospital whilst they were receiving their TB treatment some times for months. They had found a way through the NHS where they could commission appropriate service with support for those individuals and were in the process of setting that up for the West Midlands and this would be dealt with.

Councillor Bennett proposed that the Board be submitted with a report on the vaccination issue in three months to get a better understanding on what was happening.

Mr Kirby stated that he wanted to make a practical offer. He added that they provide the school age vaccination service so they were part of the process. They had a reasonably size team the infection control team that supporting the community team. This worked on whether there were gaps or no gaps in infection control outside of hospitals and would be keen to make more contributions.

Mr Baggott stated that identifying these recommendations and the task and finish groups did not meant that they were not addressing these issues already. It did not mean that they were starting from a blank sheet of paper. There were many groups and discussions and plans on-going, but as Dr Varney had identified they needed a step change in how well they were doing because we cannot keep doing the same thing, they needed to make significant differences particularly the screening uptake. Improving things by a few percent here and there would still leave us short of the target we would want to achieve.

ACTION: The Chair commented that it was important to get a quarterly report back to the Board on everything and specifically around immunisation. This could be done on a quarterly or bi-monthly basis.

378 **RESOLVED: -**

1. Members of the Health and Wellbeing Board accepted the report;
2. Members supported the assurance statement;
3. CCG, NHS England and Local Authority (Public Health, Environmental Health and Social Care) members of the Board (as appropriate) committed their organisations to engage with specific task and finish groups to address issues identified in the full report:

   a) To implement the TB/housing framework (CCGs and Local Authority already working collaboratively);

b) To identify and address gaps in community infection prevention and control provision (CCG and Local Authority Social Care);

c) To reduce variation in the uptake of screening and immunisation programmes, and reduce inequality (NHS England and CCGs); and

d) To address novel challenges to health protection that did not sit with any one organisation.

BIRMINGHAM OLDER PEOPLES PROGRAMME (BOPP) PROGRESS UPDATE

379 The following report was submitted:-

(See document No. 7)

The Chair advised that this item was for information.

SUSTAINABILITY TRANSFORMATIONAL PLAN (STP) UPDATE – LIVE HEALTHY LIVE HAPPY

380 The following report was submitted for information:-

(See document No. 8)

The Chair advised that this item was for information. She commented that this was an excellent report and requested that it be circulated to all Birmingham City Council councillors.

Mr Jennings emphasised that in relation to the stakeholder engagement element he was pleased with this piece of work since he had been involved with it which was for a year and a half in this leadership role since last August. They have been trying to enhance their engagement and their profile in terms of what they were there to do and how they were setting out to do it. The next phase was important as they were taking it to a broad set of communities with a roadshow. They were asking people to publicise this and to be involved and engaged if they would to hear about the priorities of the portfolio boards.

On the development of the outcomes framework, there was an excellent piece of work already in Solihull and West Birmingham around this and they had shamelessly plagiarised and joined them around that. They were trying to produce an outcomes framework rather than what they tend to do which was about transactional issues - an output framework which was coherent for Birmingham and Solihull including the West Birmingham and Sandwell part. This was focussed around trying to identify what they were trying to achieve in terms of making a difference to people's lives rather than just the transactional elements. Importantly for them, in that piece of work they would be co-producing it with the Health and Wellbeing Boards and others.

In relation to population health, Birmingham and Solihull were leading the pack at present. Regarding this piece of work they had some well advanced plans

around outputs in terms of understanding the information that they could gather and how they could put that in relation to the various needs they had for it and in particular how they could identify relevant information and deliver that to the Primary Care Networks.

The Primary Care Networks will be the engine of change for the system. The big providers would do things more effectively and efficiently and their focus on quality, but the change and sustainability would come from those Primary Care Networks in the system. It was crucial that they give them the information to make that happen. They were engaged with the other STPs in the West Midlands and were a well-supported piece of work to move that population and health management piece forward quickly.

Mr Cave stated that nationally local Healthwatch had being commissioned through Healthwatch England by NHS England to carryout engagement activity as part of the development of the local long-term plan. As such there was a national survey that was being promoted at the moment. To find the survey people will need to Google late Healthwatch and they were encouraging people to take part in that survey.

Locally they were focussed on carrying out focus groups on key population groups and they were asking the questions around self-care and what the barriers of self-care were as part of the prevention strategy locally. They had carried out five focus groups as part of that and they were with key population groups such as LGBT, people with sight loss, mental health and others. The report will be published by 20 June 2019 and will be shared with the STP as part of that.

Mr Jennings explained the connection in relation to population health management and the joint strategic needs assessment and how they interact in response to Dr Miller's enquiry. Ms Griffiths added that they had consistent membership in their steering group for JSNA and a member of the team was working on the PHM development so they were sharing that.

PRIMARY CARE NETWORKS

381 The following report was submitted:-

(See document No. 9)

The Chair advised that this item was for information.

UPDATE ON THE GREEN PAPER CONSULTATION

382 The following report was submitted:-

(See document No. 10)

The Chair advised that this item was for information.

PROPOSAL TO RELOCATE AND IMPROVE THE ADULT SEXUAL ASSAULT REFERRAL CENTRES WHICH SERVE BIRMINGHAM, SOLIHULL AND THE BLACK COUNTRY

383 The following report was submitted:-

(See document No. 11)

The Chair advised that this item was for information.

DATE OF NEXT BIRMINGHAM HEALTH AND WELLBEING BOARD MEETING

384 It was noted that the next Birmingham Health and Wellbeing Board meeting will be a Development Session which will be held on 15 May 2019 at 1500 hours, in the Auditorium, 10 Woodcock Street, Birmingham, B7 4BL.

EXCLUSION OF THE PUBLIC

385 That in view of the nature of the business to be transacted which includes exempt information of the category indicated the public be now excluded from the meeting:-

Exempt Paragraphs 1 and 2

Agenda Item: 7

Birmingham City Council

Birmingham Health and Wellbeing Board

Informal meeting 1500 hours on 18 June 2019, Committee Rooms 3&4

Present:

Councillor Paulette Hamilton (Chair)
Dr Justin Varney
Chief Superintendent John Denley
Roger Varley
Charlotte Bailey
Stephen Raybould
Dr Peter Ingham (Vice Chair)
Paul Jennings
Chris Atkins
Micky Griffith
Carly Jones

1. **Welcome**
   The Board members were welcomed to the informal meeting of the Birmingham Health and Wellbeing Board.

2. **Apologies**
   Apologies were received from Councillors Matt Bennett and Kate Booth, Professor Graeme Betts, Andy Cave, Andy Couldrick, Professor Nick Harding, Richard Kirby, Dr Robin Miller, Peter Richmond, Sarah Sinclair and Gaynor Smith.

3. **Declarations of interest**
   No declarations of interest were received.

4. **Minutes and matters arising.**
   The minutes were deferred to the next formal meeting of the Board on 30 July 2019.

5. **Chair's update**
   The Chair delivered a short verbal update to the Board.

6. **Public Questions**
   No public questions were received.

   ACTION: All Board members to promote submission of public questions to the Board.

7. **Better Care Fund Governance agreement report**
   This item was deferred to a future meeting of the Board.

8. **Air quality update report**
   Duncan Vernon, Acting Assistant Director of Public Health delivered on the work that is being undertaken across the city in relation to improving air quality.

   ACTION: Board members encouraged to participate in Clean Air Day 20 June.

9. **Active Travel update report**

Duncan Vernon, Acting Assistant Director of Public Health delivered on the work that is being undertaken across the city in relation to improving Active Travel.

ACTIONS:

- **Board to work with their partners to promote active travel away from main roads and along green spaces where possible**
- **Kyle Stott, Public Health, to bring mapping of active travel back to the Board**

10. **Developers Toolkit update report**

Kyle Stott, Public Health, delivered an update on the Developers Toolkit that has been developed in the City. Birmingham is a national leader in this area.

ACTION: Board members to encourage the use of the developer's toolkit in their organisation's capital build projects as well as retro-build and refurbishments but to include anything in the present

11. **Feedback on the Health and Wellbeing Board development session**

Feedback on the Board's development session was delivered by Kyle Stott, Public Health and Elizabeth Griffiths, Acting Assistant Director of Public Health.

ACTION: Board members to look at opportunities for LD/MH employment within their organisations

DECISION (TO BE RATIFIED AT THE FORMAL BOARD MEETING ON 30 JULY 2019): The Board agreed to adopt the recommended indicators for its Health Inequalities dashboard. (SEE BACKGROUND REPORT 7a)

12. **Changing Places report**

Maria Gavin, Assistant Director Quality and Improvement presented a report on the ambition to improve changing places in the city.

ACTION:

- **Maria Gavin to see whether changing places can be a specific requirement for Commonwealth Games new-builds**
- **Board Chair to write to WMCA around transport infrastructure hubs: where there is a full station refurbishment changing places to be included.**
- **Board Chair to write to the Neighbourhoods Directorate to support the implementation of changing places in parks.**

13. Live Healthy Live Happy STP update report

Paul Jenkins delivered an update on the Live Health Live Happy Sustainability and Transformation Partnership (STP) in Birmingham and Solihull.

ACTIONS:

- **Birmingham and Solihull STP to work with local elected members around awareness raising of ICS & PCNs – what they mean and the implications.**
- **The Board raised concern that changes to West Birmingham area could cause destabilisation for the system and the citizen experience Commissioners and providers agreed to meet outside of the meeting and report back to Board on how we get to an integrated system – particular reference to equity of provision for West Birmingham.**

14. Other urgent business

ACTION: The following items to be added to the Board's forward plan:

- **Thrive at school**
- **Ageing / Age friendly city including access to toilet facilities**

Birmingham Health and Wellbeing Board

	7a (Background Report)
Date:	**18 June 2018**
Title:	**BIRMINGHAM HEALTH AND WELLBEING BOARD: MAY 2019 DEVELOPMENT SESSION FEEDBACK**
Author:	**Elizabeth Griffiths - Acting AD Public Health**

Report Type:	**Information**

1. Headline messages

1.1 It is proposed that the Health and Wellbeing Board adopt a health inequalities dashboard that breaks down health inequality indicators in a three by three table according to physical health, mental health and wellbeing and at a city level (macro), ward/GP practice level (micro) and special focus level (i.e. community of interest such as those with free school meal status).

1.2 There should be consistency of measures; indicators should be shared across the health and wellbeing board, community safety partnership, education and skills and community cohesion wherever possible.

1.3 A further paper will come back to the board suggesting the current position against the selected indicators and the desired trajectory. This will be used to inform the Board's development of an action plan to reduce health inequalities in Birmingham.

2. Recommendations

2.1 It is RECOMMENDED that the Board adopt the health inequality measures outlined in Table 2 for its health inequalities dashboard.

3. Background

3.1 On 15 May 2019 the Birmingham Health and Wellbeing Board had a development session. The session comprised two workshops, one for each of the Board's strategic priorities – Health Inequalities and Childhood Obesity.

3.2 The aims of the health inequalities workshop were to: consider existing approaches to monitoring health inequalities; consider and prioritise health inequalities topics under macro, micro and special focus; and select specific measures for each topic to be included on a health inequalities dashboard.

3.3 The Board was shown existing city level health inequalities dashboards—such as the Marmot indicators for local authority areas—and were provided with a list of alternative measures, their strengths, weaknesses, methodology and frequency of reporting.

3.4 On tables, the Board discussed which indicators it should adopt for monitoring health inequalities on its health inequalities dashboard. Workshop groups fed back on the proposed indicators; each of the options was discussed in a plenary session.

4. Group Discussions

4.1 Table 1 outlines the indicators favoured by each workshop group. Please note macro level relates to city level data; micro level relates to small area data such as ward or constituency and special focus relates to specific groups such as those with free meal status.

4.2 Two of the groups proposed taking a life course approach to monitoring inequalities and suggested suitable proxy measures. One of the groups suggested a range of measures to cover wellbeing, physical health and mental health.

4.3 There was general support for breaking down health inequalities by physical health, mental health and wellbeing.

4.4 It was suggested that there should be consistency of measures and that indicators should be shared across the health and wellbeing board, community safety partnership, education and skills and community cohesion wherever possible.

4.5 The Public Health Division was asked to come back to the Board with a proposal for the Heath Inequalities dashboard based upon the suggestions below.

Table 1. Health inequalities workshop – group feedback on proposed health inequalities indicators

	Group 1	*Group 2*	*Group 3*
Suggested indicator(s)	School readiness (macro and micro levels)	Unemployment (macro, micro and special focus)	Wellbeing: unemployment; economic inactivity for health reason (macro level).
	Employment rates (macro and micro levels)	NEET (macro and micro levels)	Wellbeing: immunisation (micro level)
	Life expectancy (macro and micro levels)	School readiness	Physical Health: physical activity and inactivity (macro level)
		Health visitor data	Physical health: chronic disease diabetes/CVD (micro level)
		Life expectancy	Smoking in pregnancy (special focus)
		Healthy life expectancy	Mental Health: gap in employment for mental health and learning difficulties
		Employment data relating to health	Other measures relating to children and young people to be confirmed

5. Suggested health inequalities measures

5.1 It is suggested that the Board adopt the measures on Table 2 for the Health and Wellbeing Board's Health Inequalities dashboard; breaking down health inequalities by physical health, mental health and wellbeing.

5.2 The recommended indicators draw on the wider determinants of health – such as employment, education; health protection; chronic disease and lifestyles.

Table 2. Suggested health inequalities indicators

	Physical health	*Mental health*	*Wellbeing*
Micro level	Chronic disease: Type 2 Diabetes and CVD (recorded prevalence)	Chronic disease: Depression (gap between recorded and modelled prevalence)	Immunisation rates (various)
Macro level	Physical activity and inactivity	Healthy life expectancy	Unemployment: Economic inactivity for health reason.
Special interest	Smoking in pregnancy	Gap in employment rates for mental health and learning disabilities	Gap in school readiness for those with free school meal status

5.3 Further work will be required with the Board on the desired improvement needed on these indicators, for example the desired improvement for the Chronic disease: Depression would be to see a reduction in the gap of recorded prevalence and modelled prevalence of the disease as this would show that we are getting better at identifying, diagnosing and recording depression in Birmingham.

5.4 A paper setting out the current position against each of these measures, the desired trajectory and ambition will be presented to a future meeting of the Board; this will allow the Board to align actions to reduce health inequalities in the City.

Birmingham City Council

Action Log 2019

Birmingham Health and Wellbeing Board

Rag rating :
- Overdue
- In progress
- Complete

Index No	Date of entry	Agenda Item	Action or Event	Named owner	Target Date	Date Completed	Outcome/Output	Comments	RAG
346	19.02.2019	Childhood Obesity	DPH was asked to reflect on potential for social marketing high profile campaign - similar to the partnership approach to 'sugar free' month promoted by Sandwell Council and partner organisations and 'Fizz Free Feb' led by Southwark Council.	Justin Varney	Development day 14.05.2019				
351	19.02.2019	NHS Long Term Plan	It was agreed that, as the local 5-year plan was being drafted, consultation should take place with the Health and Wellbeing Board and engagement with key leaders in the City to enable them to give an input to the plan.	Paul Jennings	19.03.2019				
IAN6	18/05/2019	Public Questions	All Board members to promote submission of public questions to the Board	All Board members	24/09/2019				
IAN9a	18/05/2019	Active travel update	Board to work with their partners to promote active travel away from main roads and along green spaces where possible	All Board members	ongoing				
IAN9b	18/05/2019	Active travel update	Kyle Stott, Public Health, to bring mapping of active travel back to the Board	Kyle Stott	24/09/2019				
IAN10	18/05/2019	Developers Toolkit update	Board members to encourage the use of the developer's toolkit in their organisation's capital build projects as well as retro-build and refurbishments but to include anything in the present	All Board members	ongoing				
IAN11	18/05/2019	Feedback on the Health and Wellbeing Board development session	Board members to look at opportunities for LD/MH employment within their organisations	All Board members	ongoing				
IAN12a	18/05/2019	Changing places	Maria Gavin to see whether changing places can be a specific requirement for Commonwealth Games new-builds	Maria Gavin	24/09/2019				
IAN12b	18/05/2019	Changing places	Board Chair to write to WMCA around transport infrastructure hubs: where there is a full station refurbishment changing places to be included.	Chair/PH	24/09/2019				
IAN12c	18/05/2019	Changing places	Board Chair to write to the Neighbourhoods Directorate to support the implementation of changing places in parks.	Chair/PH	24/09/2019				
IAN13a	18/05/2019	Live Healthy Live Happy STP update report	Birmingham and Solihull STP to work with local elected members around awareness raising of ICS & PCNs – what they mean and the implications.						
IAN13b	18/05/2019	Live Healthy Live Happy STP update report	The Board raised concern that changes to West Birmingham area could cause destabilisation for the system and the citizen experience Commissioners and providers agreed to meet outside of the meeting and report back to Board on how we get to an integrated system – particular reference to equity of provision for West Birmingham.						

Birmingham Health and Wellbeing Board

	Agenda Item: 11
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30th July 2019**
TITLE:	**DEVELOPMENT OF HEALTH & WELLBEING BOARD SUB-COMMITTEE STRUCTURE**
Organisation	**Birmingham City Council**
Presenting Officer	**Dr Justin Varney, Director of Public Health**

Report Type:	**Decision**

1. Purpose:

1.1 This document sets out the proposed sub-committee structure of five forums to support the delivery of the shared ambitions of the Health and Wellbeing Board, including:

- Forum structures and governance
- Roles and responsibilities of different committees
- Draft TOR
- Draft initial membership & chairing arrangements

2. Implications:

BHWB Strategy Priorities	Health Inequalities	✓
	Childhood Obesity	✓
Joint Strategic Needs Assessment		
Joint Commissioning and Service Integration		✓
Maximising transfer of Public Health functions		✓
Financial		
Patient and Public Involvement		✓
Early Intervention		✓
Prevention		✓

3.	Recommendations
3.1	The Board is asked to:
3.1.1	Approve the development of the five Health & Wellbeing Board Forums to support the delivery of the Health and Wellbeing Board's objectives.
3.1.2	Agree to schedule Health & Wellbeing Board meetings on alternate months (5 a year) with the Forums meeting in the interim months.
3.1.3	Volunteer Board member organisations to support the secretariat of specific Forums.
3.1.4	Provide comments by email by the 10th August on the TOR and Membership for each Forum.

4.	Background
4.1	Over 2018/19 the Health and Wellbeing Board has undergone a period of development and refresh and is now moving into a more shared action and delivery phase.
4.2	The Board has agreed two priorities for 2019/20: • **Obesity** • **Health Inequalities**
4.3	In addition, consultation on the public health priorities for the city has highlighted a need for a stronger upstream and public health focus on mental health and wellbeing.
4.4	The Director of Public Health (DPH) has set out an ambition to develop a Health Inequalities Framework for the city which will provide an overarching framework for the Health and Wellbeing Board's shared ambition to protect and improve the health and wellbeing of the citizens of Birmingham. The Framework approach will identify the actions led through a matrix of strategies and action plans across the Council and its partners to deliver change.
4.5	In order to support the objective of the Board to improve the health and wellbeing of citizens and reduce health inequalities in the City, the Board needs to establish a sub-committee structure to enable focused partnership delivery in areas where there are not currently strategic partnerships, strategies or action plans.

4.6 The Board has one existing sub-committee—the Health Protection Forum—which focuses on health protection issues such as vaccination, screening and infection control and is chaired by the Director of Public Health.

4.7 Therefore, following discussion with partners and Cabinet members, it is proposed that the Board establishes four new sub-committees (Forums) to oversee development and delivery of shared action to drive city-wide improvement. The proposed new structures are:

- Creating A Mentally Healthy City Forum
- Creating A Healthy Food City Forum
- Creating An Active City Forum
- Creating A City Without Inequality Forum

4.8 These Forums will strengthen the connection between the Board and other city and regional partnership bodies.

4.9 It is proposed that the Fora with be co-chaired by a Cabinet Member with an external partner and that the secretariat function will be shared with HWB members.

5. Discussion

5.1 The four new Forums have evolved through discussions with partners recognising some of the gaps in system leadership and activation and an ambition to engage a wider network of people in delivery beneath the strategic partnership of the Health & Wellbeing Board. The initial thinking on the focus of the Forums is:

5.1.1 Creating A Mentally Healthy City Forum

The Creating A Mentally Healthy City Forum will focus on developing a public health approach to mental health and wellbeing in the city, delivering the Public Mental Health Compact and evolving an evidence-based approach to mental wellbeing that supports every citizen to thrive.

5.1.2 Creating A Healthy Food City Forum

As part of addressing the ambition to take a strategic upstream approach to tackling obesity at all ages in the city the Creating A Healthy Food City Forum will lead partnership action to create a healthy food environment in the city. This aligns well with our international commitment to the Milan Food Pact and provide a focused partnership group to enable delivery of the Obesity Trailblazer programme. This also supports the NHS STP/CCG commitment to focus action on childhood obesity and leverage action that will create

sustainable change in the food environment of the city.

5.1.3 Creating An Active City Forum

As part of addressing the ambition to take a strategic upstream approach to tackling obesity at all ages in the city the Creating An Active City Forum will lead partnership action to create an active city and provide a strategic approach to physical activity that draws together active travel, leisure and recreation and the opportunities for the Commonwealth Games physical activity and health and wellbeing legacy.

5.1.4 Creating A City Without Inequality Forum

As part of addressing the specific priority of the Board to develop partnership action to close the health and wellbeing gaps in the city the Creating a City Without Inequality (CWI) Forum will bring together partners to focus on health inequalities and wider inequalities in the city.

5.2 We are planning to hold a series of workshops with stakeholders to refine the above and map the interconnection with other key partnerships. We plan to work with Cabinet members on the appointment of co-chairs building on the learning from these workshops.

6.	**Future development**
6.1	As part of the initial meetings the Fora will map their relationships with other external boards and establish clear engagement agreements and clarify respective lead areas to ensure there replication is avoided.

7.	**Compliance Issues**
7.1	***Strategy Implications***
	The Forums are designed to be focused on developing and delivering action plans and frameworks for their lead areas.
7.2	***Homelessness Implications***
	It is suggested that the Creating a City Without Inequality Forum will provide a space to connect across with the various Homelessness and Health related groups in the city and at a regional level.
7.3	***Governance & Delivery***
7.3.1	The Forums are accountable through their chairs to the Health and Wellbeing Board and each Forum will have at least one annual substantive update

	session at the Health and Wellbeing Board.
7.3.2	The Forums will also have a matrix relationship with other strategic boards and partnerships across the city, for example the Creating an Active City Forum will connect with the Brum Breathes Executive Group and Commonwealth Games Physical Activity & Wellbeing Legacy Group.
7.3.3	As part of the initial meetings the Forums will map their relationships with other external boards and establish clear engagement agreements and clarify respective lead areas to ensure there replication is avoided.
7.4	***Management Responsibility***
7.4.1	It is envisaged that each Forum will chaired by a cabinet member from the Council and will have a co-chair from an external agency. Membership of each Forum will include core representation from the NHS, Academia, Birmingham Community & Voluntary Sector and where appropriate Police, Fire and DWP.
7.4.2	We anticipate the secretariat function would be shared with specific members of the Health and Wellbeing Board and would welcome volunteers.
7.5	***Diversity & Inclusion***
	The Forums will help a more granular discussion of diversity and inclusion in the context of the specific topics.

Development of Health & Wellbeing Board Sub-Committee Structure

V0.1 - May 2019

Author: Dr Justin Varney, Director of Public Health

Partnerships, Insight and Prevention Directorate: Public Health Division

Version Control	Date	Amendments	Author
V0.1	12/05/19	Creation of draft document	Dr Justin Varney

1 Purpose

This document sets out the proposed sub-committee structure to support the delivery of the shared ambitions of the Health and Wellbeing Board, including

- Sub-committee structures and governance
- Roles and responsibilities of different committees
- Draft TOR
- Draft initial membership & chairing arrangements

2 Background

The Health and Wellbeing Board is a statutory partnership committee of Birmingham City Council.

Over 2018/19 the Health and Wellbeing Board has undergone a period of development and refresh and is now moving into a more shared action and delivery phase.

The Board has agreed two priorities for 2019/20:

- Obesity
- Health Inequalities

In addition consultation on the public health priorities for the city has highlighted a need for a stronger upstream and public health focus on mental health and wellbeing.

The DPH has set out an ambition to develop a Health Inequalities Framework for the city which will provide an overarching framework for the Health and Wellbeing Board's shared ambition to protect and improve the health and wellbeing of the citizens of Birmingham. The Framework approach will identify the actions led through a matrix of strategies and action plans across the Council and its partners to deliver change.

In order to support the objective of the Board to improve the health and wellbeing of citizens and reduce health inequalities in the City, the Board needs to establish a sub-committee structure to support focused partnership delivery in areas where there are not currently strategic partnerships, strategies or action plans.

The Board has one existing sub-committee – the Health Protection Forum, which focuses on health protection issues such as vaccination, screening and infection control and is chaired by the Director of Public Health.

Therefore, following discussion with partners and Cabinet members, it is proposed that the Board establishes four new sub-committees to oversee development and delivery of shared action to drive city-wide improvement. The proposed new structures are:

- Creating A Mentally Healthy City Forum
- Creating A Healthy Food City Forum
- Creating An Active City Forum
- Creating A City Without Inequality Forum

These sub-committees will strengthen the connection between the Board and other city and regional partnership bodies.

3 Roles and Responsibilities

Creating A Mentally Healthy City Forum

The Creating A Mentally Healthy City Forum will focus on developing a public health approach to mental health and wellbeing in the city, delivering the Public Mental Health Compact and evolving an evidence-based approach to mental wellbeing that supports every citizen to thrive.

The Creating A Mentally Healthy City Forum will be responsible for oversight of delivery of the Birmingham Suicide Prevention Strategy and Action plan.

The Creating A Mentally Healthy City Forum may support NHS led action on mental health services but this is not its primary focus, instead it will look to work in partnership to implement the evidence based approaches which create positive mental health and wellbeing, increase mental resilience and reduce the need for clinical interventions.

The Creating A Mentally Healthy City Forum will provide a link between the Health and Wellbeing Board and the NHS Mental Health Pathways Programme Board and NHS Mental Health Partnership stakeholder Board.

Creating A Healthy Food City Forum

As part of addressing the ambition to take a strategic upstream approach to tackling obesity at all ages in the city the Creating A Healthy Food City Forum will lead partnership action to create a healthy food environment in the city. This aligns well will our international commitment to the Milan Food Pact and provide a focused partnership group to enable delivery of the Obesity Trailblazer programme (if we are successful). This also supports the NHS STP/CCG commitment to focus action on childhood obesity and leverage action that will create sustainable change in the food environment of the city.

The Creating A Healthy Food City Forum will focus on developing a whole system approach to the food environment in the city, using existing evidence based approaches to planning, skills and education and public sector procurement to drive a step change in the food environment in Birmingham.

The Creating A Healthy Food City Forum will collaborate with the Active City Forum to jointly address the drivers of obesity and excess weight in the city. This work sits alongside the work led through the NHS STP and the Children's transformation programme on clinical weight management support downstream for citizens currently living with weight issues.

Creating An Active City Forum

As part of addressing the ambition to take a strategic upstream approach to tackling obesity at all ages in the city the Creating An Active City Forum will lead partnership action to create an active city and provide a strategic approach to physical activity that draws together active travel, leisure and recreation and the opportunities for the Commonwealth Games physical activity and health and wellbeing legacy.

The Creating An Active City Forum will focus on drawing together a strategic whole system approach to physical activity across the life course and maximise the potential synergies between the environmental transport approaches e.g. clean air strategy, the Commonwealth Games Legacy and the Health and Wellbeing agenda.

The Creating An Active City Forum will provide a link between the Health and Wellbeing Board and the Brum Breathes Executive Board and the Sport England funded Local Delivery Pilot and look to maximise the potential for a joined up approach to inclusive activity across the life course. This Forum will also support the Health and Wellbeing Board in ensuring the city delivery of the Physical Activity and Wellbeing Legacy of the Commonwealth Games.

Creating A City Without Inequality Forum

As part of addressing the specific priority of the Board to develop partnership action to close the health and wellbeing gaps in the city the CWI Forum will bring together partners to focus on health inequalities and wider inequalities in the city.

The CWI Forum will bridge between the Health and Wellbeing Board and the emerging thinking on the community cohesion, homelessness and inclusion health as well as linking to the child poverty forum. This Forum will also look to strengthen the link with the Community Safety Partnership, Safeguarding Boards for Children and Adults and the Inclusive Growth governance structures in the city.

4 Governance and Administration

4.1 Draft TOR

The Fora will have common core terms of reference which are attached at the end of this document and align with the Health Protection Forum TOR.

4.2 Initial Membership

The Fora are designed to be focused on developing and delivering action plans and frameworks for their lead areas.

It is envisaged that each Fora will chaired by a cabinet member or senior officer from the Council and a partner agency lead, and will include core representation from the NHS, Academia, Birmingham Community & Voluntary Sector, and where appropriate Police, Fire and DWP.

The initial thinking on membership is included alongside the draft core-TOR at the end of the document.

4.3 Secretariat

It is suggested that partners will share the secretariat support for the new sub-committees to ensure that this doesn't all fall to the Council.

The secretariat will be responsible for room booking, agenda and papers coordination and circulation and taking action point minutes.

Rooms for meetings will be provided by the Council where possible but we encourage partners to host meetings around the city footprint.

The proposed secretariat leads are:

- Creating a mentally healthy city – NHS
- Creating a healthy food city – BCC
- Creating an active city – BCC

- Creating a city without inequality – BCVS
- Health Protection Forum - BCC

4.4 Governance

The Fora are accountable through their chairs to the Health and Wellbeing Board and each Fora will have at least one annual substantive update session at the Health and Wellbeing Board.

The Fora will also have a matrix relationship with other strategic boards and partnerships across the city, for example the Creating an Active City Forum will connect with the Brum Breathes Executive Group and Commonwealth Games Physical Activity & Wellbeing Legacy Group.

As part of the initial meetings the Fora will map their relationships with other external boards and establish clear engagement agreements and clarify respective lead areas to ensure there replication is avoided.

Annex A: Core Draft Terms of Reference

Creating A XXX City Forum

Birmingham Health and Wellbeing Board Sub-Committee

Draft Core Terms of Reference

1. Purpose

1.1 The Birmingham Health and Wellbeing Creating A XXX City Forum is a sub-committee of the statutory Birmingham Health and Wellbeing Board.

1.2 The Forum has been established to enable local partners from Local Authority, NHS, third sector organisations and the wider Public Health sector to work as a collective to deliver a specific aspect of the Health Wellbeing priorities for Birmingham, namely XXXXX.

2. Objectives

The objectives of Health and Wellbeing Creating A XXX City Forum are to:

- Oversee and support the development and delivery of a strategic action plan/framework to deliver a measurable impact on citizens lives in Birmingham by 2020.
- Contribute to the development of the Joint Strategic Needs Assessment (JSNA)
- Progress and report to the Health and Wellbeing Board on an annual basis.
- Foster and develop partnership arrangements to deliver improvements in health and wellbeing for citizens of Birmingham.
- Other delegated responsibilities from the Health and Wellbeing Board.

3. Membership

3.1 The Fora will have a core group of organisations that will play a key role and will have the responsibility to improve the specific aspect/focus of the Forum in relation to the health and wellbeing for the population of Birmingham. Membership will be continuously reviewed and the Forum reserves the right to co-opt individuals for specific areas.

3.2 Each member of the group is accountable and has the responsibility to communicate through their respective organisation communication mechanisms the Forums business.

3.3 Each Lead officer has the responsibility for theme areas and items in the Forum action plan and to report on these to the Forum.

3.4 The core membership of the Forum will include:

	Name	Role/Organisation
Co-Chair		
Co-Chair		
Public Health Technical Advisor		
NHS Commissioner Representative		
NHS Provider Representative		
Academic Representative		
BCVS Representative		
Other		

3.5 If a member of the group misses 3 consecutive meeting without giving apologies, the organisation membership will be reviewed.

4. Frequency of meeting

4.1 Meetings will be scheduled to take place bi-monthly

4.2 However meetings may be called more frequently should commissioning decisions drive the agenda.

5. Working Arrangements

5.1 The Forum will be monitored and accountable to Health and Wellbeing Board through the agreed reporting arrangements.

5.2 The chairing arrangements will be agreed by the Chair of the Health and Wellbeing Board.

5.3 The Forum administrative support will be provided by XXXX and they will be responsible for arranging and minuting meetings, and disseminating supporting information to Forum Members.

5.4 Recommendations will be arrived at by consensus and recorded in the action minutes.

5.5 The Forum may establish task and finish groups as agreed by the Forum co-chairs.

5.6 A review of the Forum will take place on a yearly basis. The next review will be March 2020.

Annex B: Initial Membership for Forums

Creating a Mentally Healthy City Forum

	Name	**Role/Organisation**
Co-Chair		**NHS**
Co-Chair	**Cllr Paulette Hamilton**	**BCC Cabinet Member for Health & Social Care**
Public Health Technical Advisor	Dr Dennis Wilkes	Assistant Director of Public Health (Healthcare & Populations)
NHS Commissioner Representative		
NHS Provider Representative		
Academic Representative		
BCVS Representative		
Other		

Creating a Healthy Food City Forum

	Name	**Role/Organisation**
Co-Chair	**Cllr Paulette Hamilton**	**BCC Cabinet Member for Health & Social Care**
Co-Chair		
Public Health Technical Advisor	Dr Justin Varney	Director of Public Health
NHS Commissioner Representative		
NHS Provider Representative		
Academic Representative		
BCVS Representative		
Other		

Creating an Active City Forum

	Name	**Role/Organisation**
Co-Chair	**Cllr Waseem Zafar (tbc)**	**BCC Cabinet Member for Transport & Environment**
Co-Chair		
Public Health Technical Advisor	Duncan Vernon	Interim Assistant Director of Public Health (Wider Determinants)
NHS Commissioner Representative		
NHS Provider Representative		
Academic Representative		
BCVS Representative		
Other		

Creating a City Without Inequality Forum

	Name	**Role/Organisation**
Co-Chair	**Cllr John Cotton (tbc)**	**BCC Cabinet Member for Community Cohesion & Equalities**
Co-Chair	tbc	BCVS
Public Health Technical Advisor	Dr Justin Varney	Director of Public Health
NHS Commissioner Representative		
NHS Provider Representative		
Academic Representative		
BCVS Representative		
Other		

Birmingham Health and Wellbeing Board

	Agenda Item: 12
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30 July 2019**
TITLE:	**MAKING EVERY ADULT MATTER (MEAM) APPROACH**
Organisation	**Birmingham City Council**
Presenting Officer	**Dr Justin Varney**

Report Type:	**Discussion**

1. Purpose:	
1.1	The purpose of this report is to outline the benefits of the Making Every Adult Matter (MEAM) Approach and how it can enable a system change, strengthen the health and wellbeing partnership and help us develop a coordinated approach to tackling multiple disadvantage in Birmingham.
1.2	The Health and Wellbeing Board is requested to encourage this approach and support the partnership in its delivery.

2. Implications:		
BHWB Strategy Priorities	Health Inequalities	✓
	Childhood Obesity	
Joint Strategic Needs Assessment		✓
Joint Commissioning and Service Integration		✓
Maximising transfer of Public Health functions		
Financial		
Patient and Public Involvement		
Early Intervention		✓

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Prevention	✓
Homelessness	✓

3.	**Recommendations**
3.1	The Health and Wellbeing Board is requested to **encourage the MEAM Approach** and:
3.1.1	Consider Multiple Complex Needs (MCN) in partner work programme to develop a shared understanding and ownership of the problems with the current system and a clear vision and action for change;
3.1.2	Influence partner organisations and support the efforts to join up data and intelligence around those who have multiple complex needs;
3.1.3	Promote a better coordination of services for those with multiple complex needs and influence partner organisations to ensure their commitment;
3.1.4	Support a sustainable system and culture change that will enable a better coordination of services for those with multiple complex needs and create more opportunities for early intervention;
3.1.5	Agree that this is an area for focus for the emerging Board's Forum focused on Health Inequalities.

4.	**Background**
4.1	Despite the efforts to develop new and redesign existing services that provide support to individuals with complex needs and the homeless population, Birmingham remains one of the worst affected areas in the country with an unprecedented scale of homelessness. Throughout 2018 there were 91 rough sleepers and 928 of those registered with primary care service for the homeless and at risk of rough sleeping.
4.2	The prevalence data for Severe and Multiple Disadvantage from 2018 suggests that there are between 1,410 and 2,450 people in Birmingham in the homelessness, substance misuse and offending systems. The prevalence per 1,000 residents is significantly higher than the England average.

Severe Multiple Disadvantage Category	Rate per 1,000 Population		Estimated numbers of people	
	Birmingham	National average	Overall	With Mental Health problems
SMD1: Homeless only	5.3	1.9	3,640	480
SMD1: Offender only	5.8	3.4	3,950	960
SMD1: Substance Misuse only	6	5.4	4,070	2,350
SMD2: Offender + substance misuse	4.8	3	3,290	1,440
SMD2: Homeless + substance misuse	2.8	1.4	1,880	590
SMD2: Homeless + offender	1.4	0.8	960	340
SMD 3 (SP)	3.6	1.7	2,450	1,150
SMD 3 (OA)	2.1	1.4	1,410	750
SMD 1-3	29	17.4	19,720	7,110

4.3 Serious steps have already been taken to address these issues. A report on MCN which promoted the Changing Futures Programme that was considered by the Health and Wellbeing Board in February 2018 highlighted the need for the system change. Our Homelessness Prevention Strategy and Domestic Abuse Prevention Strategy were launched in 2018 and a number of partnership groups were established to take the delivery of these strategies forward. However, due to the complexity of the partnership landscape, overlap between groups, it has not been easy to make a significant progress towards taking a whole system person-centred coordinated approach that would secure sustainable outcomes.

5. Discussion

5.1 There is awareness that populations experiencing homelessness, substance misuse, poor mental health and offending behaviours overlap considerably. And yet in Birmingham and across the country, people facing multiple disadvantage are falling through the gaps between services and systems. As a partnership we fail to understand their needs fully and provide the right support at the right time in a coherent and coordinated manner.

5.2 The MEAM Approach is a framework used by local partnerships across England to develop a coordinated approach to tackling multiple disadvantage in their local area. It focuses on creating long-term sustainable change to the way that complex problems and systems are approached and understood. There are 7 key components of MEAM:

I. Partnership, coproduction and shared vision

II. Consistency in selecting a caseload (a consistent approach to caseload management)

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III. Coordination for clients and services (e.g. single point of contact & coordination, lean and easy customer journey)

IV. Flexible responses from services (trauma and strength-based approach, shared ownership and strong lean leadership, approach embedded in commissioning)

V. Service improvement and workforce development (based on evidence and understanding of gaps, new ways of integrated working)

VI. Measurement of success (impact on individuals and services and systems, client involvement in evaluation)

VII. Sustainability and systems change (partners' commitment to joint long term solutions).

5.3 The existing Big Lottery Fund's Changing Futures Together Programme, operating under the banner of the national initiative Fulfilling Lives is a serious attempt to take a MEAM Approach. We will be looking at this approach through the DPH report to consider how to draw on this learning to improve our support to citizens who face multiple and sustained challenges.

6. Future development

6.1 Through the Director of Public Health Annual report 2019 we will plan to develop the understanding of adults facing multiple complex needs and provide opportunities for future action to improve support and outcomes for these citizens. This will be underpinned by:

- Consolidation of relevant data and intelligence to be incorporated into the JSNA;

- Mapping of all initiatives that support the delivery of the MEAM Approach to explore best value for money and sustainable provision to address MCN effectively.

6.2 We recommend that the Health and Wellbeing Board supports this effort and the Board's emerging Forum on Inequalities takes a lead on this work.

7.	**Compliance Issues**
7.1	***Strategy Implications***
	Interdependencies with and contribution to the delivery of the following strategies and their delivery: - Public Health Priorities Green Paper - Homelessness Prevention Strategy - Domestic Abuse Prevention Strategy
7.2	***Homelessness Implications*:**
	The MEAM Approach is designed to develop a whole system coordinated response to tackling MCN, homelessness being one of them, therefore having a positive impact on the outcomes for those affected by homelessness.
7.3	***Governance & Delivery***
	See paragraph 6.2.
7.4	***Management Responsibility***
	TBC
7.5	***Diversity & Inclusion***
	The MEAM Approach considers methodologies for identifying individuals facing multiple disadvantage and selecting caseloads that reflect equality and diversity issues.

Birmingham Health and Wellbeing Board

	Agenda Item: 13
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30th July 2019**
TITLE:	**MEETING THE NEEDS OF PEOPLE WITH COMPLEX AND SEVERE MENTAL ILL HEALTH IN BIRMINGHAM TO REDUCE HEALTH INEQUALITIES**
Organisation	**BSOL CCG**
Presenting Officer	**Tom Howell**

Report Type:	**For information**

1. Purpose:	
1.1	The aim of the discussion is to explore how services currently providing homelessness, mental health and any additional care and support to every adult in Birmingham can work together to reduce the health inequalities faced by the adult population in our city.

2. Implications:		
BHWB Strategy Priorities	Health Inequalities	✓
	Childhood Obesity	
Joint Strategic Needs Assessment		
Joint Commissioning and Service Integration		✓
Maximising transfer of Public Health functions		✓
Financial		
Patient and Public Involvement		
Early Intervention		
Prevention		✓
Homelessness		✓

3.	Recommendations
3.1	The Board is asked to note the contents of this report.

4.	Background
4.1	The report was requested by the Birmingham Health and Wellbeing Board to support discussion around the theme of 'Making Every Adult Matter'.
4.2	Across the Birmingham and Solihull Commissioning footprint there are c14,000 adults recorded on the GP register as having a severe mental illness (SMI). The relationship between mental health and social disadvantage is complex. The paper describes a range of work intended to improve outcomes for people with complex and severe mental health needs. This is set in the context of BSOL STPs strategic approach to mental health.

5.	Discussion
5.1	The Report identifies current challenges and gaps in provision and the system of care and support. It goes on to set out a number of recommendations and next steps (see below) which have the potential to affect positive improvement in outcomes and value for money.

6.	Future development
6.1	The following are identified as areas for future development: • Develop Joint Commissioning Practice • Maximise potential funding streams through opportunities to apply for national schemes • Improve community pathways • Develop crisis alternatives • Transform mental health rehabilitation • Improve our ability to share information

7.	**Compliance Issues**
7.1	***Strategy Implications***
7.1.1	The report reinforces the need for commissioning across Health and Social Care to work collaboratively to realise best value and provide solutions to meeting complex need.
7.1.2	The approach set out in the report is consistent with the strategic approach adopted in 'Live Healthy, Live Happy'
7.2	***Homelessness Implications***
7.2.1	An accompanying report has been submitted by Birmingham and Solihull Mental Health Foundation Trust. The approaches and recommendations described in the paper seek to progress the homelessness prevention agenda in the following ways: - Provide support that acknowledges individuals' holistic needs - Seeks to develop and deliver services in an integrated manner to the individual - Seeks to prevent crisis and deterioration of health conditions that may place tenancies at risk - Supports economic wellbeing to better enable people to live with an appropriate level of independence within their local community.
7.3	***Governance & Delivery***
	Delivery of the commissioning programme will be monitored through the Integrated Commissioning Board as described in the Section 75 agreement between BSOL CCG and Birmingham City Council. Service level delivery is monitored via CCG contract review groups and Finance and Performance Committee where provision is commissioned by the CCG.
7.4	***Management Responsibility***
	The Senior Responsible Officer (SRO) for the CCG for Joint Commissioning is Jo Carney.

7.5	***Diversity & Inclusion***
	The programme of work seeks to address inequalities resulting from people's mental health needs. It is acknowledged that prevalence of complex mental health issues is higher within the homeless population. Where individuals have other protected characteristics in respect of gender, physical or learning disability ethnicity, religion and sexuality disadvantage can be amplified.

	Appendices
1.	Report of Birmingham and Solihull Mental Health Foundation Trust 'Meeting the Needs of People with Complex and Severe Mental Ill Health in Birmingham to Reduce Health Inequalities'

Birmingham and Solihull
Clinical Commissioning Group

Meeting the Needs of People with Complex and Severe Mental Ill Health in Birmingham to Reduce Health Inequalities

1. Purpose

The report was requested by the Birmingham Health and Wellbeing Board to support discussion around the theme of 'Making Every Adult Matter'. The aim of the discussion is to explore how services currently providing homelessness, mental health and any additional care and support to every adult in Birmingham can work together to reduce the health inequalities faced by the adult population in our city.

This paper focuses on provision to support people with complex and/or severe mental health conditions, including people with a diagnosis of personality disorder. The paper provides contextual information, a summary of existing provision and planned developments and indicates areas which present opportunities for further improvement with a particular focus on partnership and integration.

2. Population eligibility

Across the Birmingham and Solihull Commissioning footprint there are c14,000 adults recorded on the GP register as having a severe mental illness (SMI). The relationship between mental health and social disadvantage is complex.

There is a strong correlation between social injustice and the impact of poor Mental Health and Wellbeing. Research by the Mental Health Foundation (2007)[1] identified that there were notable differences of reported mental illness in relation to household income. The research identified that in the UK, 75% people living in the lowest income bracket reported having experienced a Mental Health problem, compared with 60% in the highest income bracket.

A recent study of the health needs of members of the homeless population in Birmingham found higher levels of mental illness and substance and alcohol dependency than in the general population. Further to this Public Health data shows that of people receiving a Care Programme Approach (CPA) to meet their mental health needs, those who have the highest level of need, only 55% were recorded as being in stable housing. Whilst this is similar to the national average it attests the significant interplay between mental health and social factors and presents a key area of focus for our strategic approach to the health and happiness of the population.

3. Strategic approach

Our vision is driven by a fundamental belief that mental ill health should not define the individual nor limit their potential to thrive physically, socially, educationally or economically.

We all want to prevent poor mental health and provide support for people who are suffering from mental health problems which actively promotes their recovery. We seek to increase independence, self-agency and hope, enabling people to live the life they want

[1] https://www.mentalhealth.org.uk/sites/default/files/fundamental_facts_2007.pdf

The approach looks to address the improved outcomes that we have all agreed to work to deliver across health, social care, local authority, police and criminal justice services.

There is a strong alignment between the principles of Making Every Adult Matter and the strategic priorities for the CCG which are to:

- Tackle and reduce health inequalities
- Rebalance investment in health care from crisis management to prevention and early action
- Achieve closer integration between health and social care

Our strategic aims for mental health are set out in the Birmingham Statement of Purpose for Improvement Mental Health.

The approach is intended to achieve the following strategic outcomes:

4. Service Provision and Current Accomplishments

The following section briefly describes a number current services and approaches intended to holistically support people with complex mental health needs. This is not intended as an exhaustive list of provision but rather highlights particular aspects of the pathway pertinent to this group. The

offers described form part of a full pathway of provision spanning primary, secondary and acute care:

4.1. System of Care for People with a Diagnosis of Personality Disorder

For a number of years there has been a recognition that people with this diagnosis often receive a comparably poor service when it comes to accessing health and social care support. In some cases people with this diagnosis may present challenges to services in terms of engagement and the development of trusting relationships. As such people have often been supported at the margins through A&E and at other points of crisis.

Evidence suggests that services sometimes lack the specialist skills to work with this group. The higher prevalence of substance misuse and alcohol dependency within the cohort, alongside challenges in sustaining housing and employment means that a skilled multi-disciplinary and trauma informed approach offers the best chance of supporting recovery.

This issue has been recognised in Birmingham. A system simulation exercise undertaken in 2017 found that admissions to psychiatric beds for this group were higher than in other areas operating more specialist services. In response commissioners have worked with providers of adult mental health services to develop a Personality Disorder Strategy which works with people in ways that are better suited to people's needs and patterns of engagement. A Personality Disorder Lead has been employed by Birmingham and Solihull Mental Health Foundation Trust to help ensure that the approach is not confined to a single service but informs support for people wherever they have contact with mental health services. Forward Thinking Birmingham, who provide mental health support for people aged 0-25 have developed their own service, ICON. In both cases admissions to inpatient beds have reduced and a number of people receiving are in hospitals outside the City have been brought back to their own community.

4.2. Assertive Outreach Teams (AOTs)

Assertive Outreach Teams have formed a key part of the mental health pathway for a number of years. They are based on a national model and carry small caseloads of mental health patients with complex needs. Very often this cohort of patients present challenges in terms of low levels of engagement and the interaction of a range of social factors including issues around housing, offending and broader issues of social exclusion.

AOTs are by design multi-disciplinary. In Birmingham investment via the Better Care Fund supports the inclusion of social workers in this service. Key facets of the Social Work input is to:

- Work as integrated member of the Assertive Outreach Team MDT
- Provide an AMHP service to this function
- Assess and plan around individuals care and support needs
- Promote service user and carer involvement
- Provider expertise in relation to Social Systems Support

Although AOTs continue to experience high levels of demand they remain highly effective in reducing risk to self and others; helping to prevent relapse and admission; maintaining people in a

stable housing environment; improving social functions and increasing stability in the lives of people's family and carers.

4.3. Crisis and Urgent Care

Where possible crisis should be prevented through collaborative treatment and management between the individual, the MDT supporting them and their family and support network. However, on occasions people's mental health will deteriorate to a point where a timely assessment of their needs is required. In some cases this may result in an admission to a psychiatric inpatient bed for further assessment and treatment. Currently, crisis support is provided through Crisis Resolution Home Treatment Teams and Psychiatric Liaison Services provided at general acute hospital sites with A&E units. Psychiatric Liaison is available 24 hours a day, 7 days a week.

In recent years the number of commissioned inpatient beds in Birmingham has increased. However, concurrently the demand for admissions has increased resulting in some patients being placed in units outside the local area. The CCG are working closely with providers and NHS England on a detailed plan to reduce to zero the number of such placements by march 2021.

4.4. Rehabilitation and Recovery Pathway

Discharge from an acute setting should be a catalyst for recovery and independence. The CCG commissions a range of rehabilitation support including 102 'Steps to Recovery' beds which are inpatient rehabilitation services provided by BSMHFT. In addition, individual packages of care are commissioned under Section 117 of the Mental Health Act. In many cases packages are commissioned jointly by the CCG and Local Authority where people's needs span health and social care.

Rookery Gardens is a rehabilitation unit located in North Birmingham which offers an innovative model of care for women with complex mental health needs. The workforce on the unit includes a majority of staff from Birmingham Mind who ensure a holistic recovery focused service is provided. The service is an example of the increasing recognition of the value of partnership and collaboration across statutory and non-statutory providers.

Locally the CCG has worked with providers to a scheme to deliver Personalised Care Plans in partnership with a voluntary sector organisation with resultant PHB's for community patients living isolated and impoverished lives. This approach is central to the above aim of stepping down rehabilitation patients giving them choice and co-production in the care plans to be delivered when back in the community, promoting security of tenure, citizenship and recovery.

4.5. Recovery and Employment

In 2018 Birmingham redesigned mental health day services and learning and work services. There are now 3 'Recovery Centres' offering a wide range of support for people with severe mental ill health. The services take a proactive approach to recovery encouraging individuals to set meaningful goals for themselves. Recovery is measured through the use of a validated client rated monitoring tool. Where a person wants to work, bespoke support is offered through an Individual Placement Support Service (IPS). IPS has a strong evidence base and provides both employee and employer with support for as long as is needed to achieve sustained employment. Workers are based in Community Mental Health Team and will be co-locating with Early Intervention Teams this year.

4.6. Supporting Carers

CCG commissioners worked in partnership with Birmingham City Council retender support for carers of people with mental illness. The service, which will continue to be provided by Home Group, will expand in remit to support carers of children with mental health issues. The service offers advice and information, one to one support and peer support for children and adult carers. The service offer is now aligned with the local authority commissioned offers for carers.

5. Challenges and Gaps

5.1. Demand

More people than ever are wanting to access mental health services. This is particularly the case amongst younger people where the evidence suggests that prevalence of poor mental health is growing.

5.2. Workforce

Nationally, mental health systems are challenged by under-supply of medics, nurses, allied health professionals and psychological therapists. Our local system is no exception to this and is grappling with both recruitment and retention of staff.

5.3. Balancing investment

A significant proportion of the money we spend on mental health funds hospital beds and specialist care. Shifting the balance so that more money is directed towards prevention and community-based services presents a challenge. Currently the system is spending in excess of £4m pa on Out of Area Admissions whilst support in primary care to assist GPs in managing patients with complex needs is limited.

5.4. Social Determinants

Increases in social causes of poor mental health, like homelessness and substance misuse, alongside reductions in local authority funding in these areas places additional demand on mental health services

5.5. Supporting Positive Risk Taking

Sometimes people with mental health problems pose a risk to themselves and occasionally to those around them. Striking the right balance between managing this risk whilst promoting recovery and independence will require a shift in culture.

5.6. Sharing Information

Putting in place information systems that talk to one another and enable staff to work more collaboratively across organisations.

5.7. Increasing use of Section 136

The use of s136 has doubled since 2017-18 increasing pressure for rapid assessment and short term admission

6. Recommendations and Next Steps

The following section sets out key recommendations for collaborative work across the system to ensure a more joined up and effective approach to supporting people with complex and severe mental health needs.

6.1. Develop Joint Commissioning Practice

Commissioners across Health, Social Care and LA Commissioning have begun working more closely together to align our work. Areas of focus include drug and alcohol services, vulnerable people support, homelessness and rough sleeping, personalisation, carer support and coproduction. A new Section 75 Agreement provides a framework for the ongoing development of our practice in this area.

6.2. Maximise potential funding streams

A number of funding opportunities have been made available to the local system to support ongoing transformation and improvement. CCG commissioners are working with Birmingham City Council submit a bid for c£500k from NHS England to improve our mental health offer to people who sleep rough. In addition, the CCG has submitted bids to enhance psychiatric liaison across our acute sites and develop a range of alternatives to admission for people in mental health crisis.

6.3. Improve Community Pathways

BSMHFT and FTB are both developing transformative plans to improve access and flow through their services. This will benefit those with the most acute needs by helping to ensure that capacity is freed up to work preventatively with people who have a greater risk of relapse.

6.4. Develop Crisis Alternatives

The CCG is working with mental health providers and local VCS organisations to develop alternatives to admission for people in acute need. These will include crisis cafes and crisis houses which offer people a place to go and, on occasion stay, when their mental health is compromised. These less-medicalised settings reduce the likelihood of admission, keep people closer to home and in closer contact with their family and local community.

6.5. Transform Rehabilitation

Person-centred planning should become the norm enabling people to shape the support they need to live the life they want. Personal Health Budgets (PHBs) offer a mechanism to hand more control to individuals and their families. Our aim is that everyone eligible for after-care under Section 117 should be enabled to have a PHB.

As post-acute support is increasingly provided in response to people's expressed preferences and goals a market will be shaped to meet these demands. Commissioners will work proactively in the space between the individual, statutory services and the market to facilitate the growth of provision that transforms the opportunities for recovery for people following hospitalisation. We want to expand the successes of approaches delivered by provision like Rookery Gardens empowering service users to move through recovery and rehabilitation pathways to independence.

Health and Local Authority commissioners, BSMHFT and FTB have committed to the principles of a rehabilitation, recovery and reablement system which will be characterised by:

- Support and treatment close to home
- Personalised support planning
- The goal of each person having their own front-door with the right support
- The opportunity for employment
- Support to be an active and engaged citizen

Our intention is to start by focusing on the needs of people in out of area rehabilitation settings with the aim of supporting them to achieve greater levels of independence in the local community.

We anticipate the establishment of Community Recovery Teams working with people with severe mental illness both pre and post admission. An approach of this type is being developed in Solihull. Teams will work closely with agencies providing care and support around a single recovery plan that pulls together housing, employment and social activity alongside care and treatment.

6.6. Improve our ability to share information

We know that all too often people are asked to tell their story on multiple occasions. This is unhelpful and potentially traumatic, not to mention inefficient. Commissioners and providers are exploring a range of approaches to use technology to enable staff to access key information about individuals and to empower citizens themselves to make decisions about who to share information with. As part of our Personalisation Programme we are trialling the use of a wiki system that gives children and their families the chance to tell their story once and then share it with professionals when the time is right. In addition, the CCG has worked with colleagues in Public Health to bid for funding via Public Health England to build on the tool developed through the Changing Futures Programme to enable professionals to view shared support plans of people with multiple complex needs.

Birmingham Health and Wellbeing Board

	Agenda Item: 14
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30th July 2019**
TITLE:	**CHANGE, GROW, LIVE (CGL) – OVERVIEW OF SERVICE**
Organisation	**Birmingham City Council**
Presenting Officer	**Max Vaughan & Karl Beese**

Report Type:	**Information**

1. Purpose:	
1.1	To provide the Board with a service overview of Change, Grow Live (CGL) focusing upon the service it provides for adults with complex needs.

2. Implications:		
BHWB Strategy Priorities	Health Inequalities	✓
	Childhood Obesity	
Joint Strategic Needs Assessment		
Joint Commissioning and Service Integration		✓
Maximising transfer of Public Health functions		✓
Financial		
Patient and Public Involvement		
Early Intervention		✓
Prevention		✓
Homelessness		✓

3.	**Recommendations**
3.1	Birmingham Public Health and BCC Commissioners to continue to work with CGL to ascertain how the service can be further developed to maximise health, social care and criminal justice outcomes for the benefit of the City. This will be consistent with the commissioning intentions for the two year extension period (March 2020 – February 2022) which have been developed through stakeholder consultation and working in partnership with the Council's Public Health commissioning team.

4.	**Background**
4.1	The provision of adult drug and alcohol treatment services is defined as one of the "grant conditions" as part of the Public Health Grant. Spending the grant a local authority has to *"have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services"*.
4.2	Drug and alcohol recovery and treatment provision in Birmingham is delivered by the third sector organisation 'Change Grow Live' (CGL).
4.3	The demand on the substance misuse service continues to increase with regards to the prevalence of misuse of Heroin, Cocaine, Novel Psychoactive Substances (NPS) and alcohol in the city. The complexity of service user presentations also continues to increase.

6.	**Future development**
6.1	CGL continue to work with key partners to maintain and further develop the current treatment and recovery pathways. The pathways will also be developed during the contract extension period (2020-2022).
6.2	CGL to continue providing their contribution to: - Homelessness and Health Steering Group - PHE Prisons Continuity of Care Group - Community Sentence Treatment Requirement (CSTR) Steering Group led by the West Midlands Combined Authority - West Midlands Alcohol Forum hosted by Public Health England - PHE Hepatitis C Testing working group - Drug and Alcohol Related Deaths Inquiry Group - The Birmingham Drug Alert System - BCC & CGL revisit and update the Social Value Plan.
6.3	The Substance Misuse Commissioning Group to be reconvened with the objective of developing the necessary commissioning approach for substance misuse prevention, treatment and recovery for the period after the current CGL contract extension ends in 2022. This may involve the development of a multiagency drug and alcohol harm reduction strategy for the City.

7.	Compliance Issues
7.1	***Strategy Implications***
	Health and Wellbeing Boards have overall responsibility to ensuring the integration of health and care functions within their localities.
7.2	***Homelessness Implications***
	Positive implications of the recommendations for homelessness in the City: - A Renewed Focus upon the Recovery agenda. - Responding to the changing patterns of drug and alcohol related harms with a specific focus on the harms caused by opiate, alcohol and Novel Psychoactive Substance misuse. - A refocus on Comorbidity: Mental Health and Substance Misuse
7.3	***Governance & Delivery***
	Governance arrangements include the Public Health Contracts Board, Adult Health Management Team, Partnerships, Insight and Prevention Management Board, Cabinet Members for Health and Social Care and Finance and Resources.
7.4	***Management Responsibility***
	Louise Collett, Assistant Director – Commissioning, Adult Social Care Justin Varney, Director – Birmingham Public Health

	Appendices:
	Information Briefing inclusive of following Sub-Appendices; - **1:** CGL Peer Mentor Stories **2:** Service User Involvement – It's Impact **3:** CGL Service User Representatives and Peer Mentors Prison Release Project Presentation. **4:** CGL Service User Representatives and Peer Mentors Homeless Project Presentation.

Information briefing

Report From: **Adult Public Health Commissioning Team**
Adult Social Care Directorate

Report To: **Birmingham Health & Wellbeing Board**

Date: **July 2019**

Title: **Change, Grow, Live (CGL) – Overview of Service**

1. Summary

A 'recovery' approach has been taken regarding the treatment for Birmingham citizens experiencing the harms associated with drug and alcohol misuse. This currently involves the treatment and care of approximately 7000 service users.

To support this, the Birmingham treatment and recovery single system is monitored and measured by the following key outcomes framework:

- Increased levels of employment
- Reduction in re-offending
- Improved housing
- Improved parenting
- Robust children's safeguarding
- Improvements in physical health
- Improvements in mental health
- Reduction in blood borne virus transmission
- Reduction in domestic violence
- Ensuring protection for vulnerable adults

2. Overview of the Service

2.1 The Service Delivery Model

To support the recovery focused delivery model CGL provide service users with the necessary advice and support delivered via a 5 tiered model which responds to differing levels of case complexity. The tiers include:

Tier 1: Advice & Information; including signposting to other services which include advocacy and mutual aid.
Tier 2: Non-dependent drug and alcohol use – Group / 1:1 work up to 12 weeks
Tier 3: Dependent alcohol use, opiate use, heavy crack cocaine/synthetic cannabinoids etc. – Group/1:1 work, longer term, structured support
Tier 4: In-patient specialist unit (Park House in Hockley) which delivers detoxification and stabilisation
Tier 5: Aftercare provision – Group/1:1 work

The provision of adult drug and alcohol treatment services is defined as one of the "grant conditions" as part of the Public Health Grant. Spending the grant, a local authority has to *"have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services"*.

Substance misuse treatment has been evaluated by researchers on a wide range of measures, including: drug use; abstinence from drug use; drug injecting; overdose rates; health and mortality; crime; social functioning, including employment; housing; family relations, and the perceptions of service users about their recovery status. The breadth of these measures reflects the broad range of benefits anticipated from providing effective substance misuse treatment.

The current drug and alcohol treatment and recovery provision in Birmingham is delivered by the third sector organisation 'Change Grow Live' (CGL). They were awarded a 5-year contract for the period 1st March 2015 – 28th February 2020 and BCC have recently exercised the option to extend the contract for a further two years from March 2020 to February 2022.

The demand on the substance misuse service continues to increase with regards to the prevalence of misuse of illicit drugs that include heroin, cocaine and novel psychoactive substances (NPS) and from alcohol. The complexity of service user presentations also continues to increase citywide.

2.2 CGL Locality Hubs

Since the contract award in February 2015, CGL have operated from Scala House in the city centre, however they are currently establishing four new locality recovery hubs across the City. The locations are in the North (Great Barr), Central & West (Newtown), East (Kitts Green) and South (Bournville). The Central & West and South Hubs are fully operational, and the North & East hubs will be operational in by mid-August 2019.

The four locality hubs provide increased accessibility for clients and welcoming spaces designed to develop the tackling substance misuse/prevention agenda within local communities. There are multi-disciplinary teams based at each of the four hubs, with a wide range of expertise that includes; Doctors, Nurses, Recovery Co-ordinators and Outreach Workers.

Each CGL hub is fully integrated with partner organisations who deliver health and social care services that link directly to delivering effective substance misuse treatment. This includes working with BCC and Third Sector Homeless services, the NHS, DWP and Criminal Justice services.

Following a joint funding bid made by Birmingham City Council and CGL, Birmingham has recently benefited from an award of £749,971 from a national £6m capital fund administered by Public Health England. This funding will enable CGL to increase access to alcohol treatments and recovery with a specific focus on helping vulnerable people who are parents and/or homeless/rough sleepers.

2.3 City Centre Service Provision including services for homeless people

CGL have a homeless team operating across the city working with complex needs homeless clients and working partnership with BCC Homeless Services as part of the Rough Sleepers Initiative. In Birmingham city centre CGL provide a mobile clinical prescriber and a team of support workers to deliver a rapid prescribing model, allowing interventions to be taken directly to clients who live in transient circumstances, i.e. either they live on the street or in temporary hostel accommodation. Two healthcare assistants support health and wellbeing signposting to partner organisations,

referral into substance misuse treatment and rapid prescription (opiate substitute) generation which enables a homeless person to be prescribed methadone within a matter of hours.

CGL offer effective city centre provision for homeless and criminal justice clients through a co-location arrangement with other partners who include: Shelter, the Salvation Army, the Probation Service, all Homeless Hostels and the Birmingham multi-agency resourced Street Intervention Team (SIT).

2.4 Delivery Partnerships

CGL working in partnership with four General Practitioners with Special Interest (GPSI's) deliver services from 70 GP surgeries citywide as part of the successful Shared Care treatment model (CGL worker based in the surgery, working closely with the service users own GP) and from other community locations such as Fire Stations and Community Centres.

The CGL service offer is well known to a wide range of key partner organisations responsible for supporting vulnerable adults, including: Criminal Justice; Health and Social Care; the city's acute hospital sites; Birmingham and Solihull Mental Health Foundation Trust; GP's and Pharmacies; the Wellbeing Service; Mutual Aid Groups (Alcoholics Anonymous, Cocaine Anonymous & Narcotics Anonymous) and Community and Voluntary Sector organisations keen to deliver social prescribing opportunities for CGL clients who are in recovery.

3. CGL Accomplishments

A key national performance measure for substance misuse service is the number of individuals who successfully complete substance misuse treatment (free of drug/drugs of dependence and who do not then re-present to treatment services again within 6 months) demonstrate a significant improvement in health and well-being in terms of increased longevity, reduced blood-borne virus transmission, improved parenting skills and improved physical and psychological health.

CGL is in the top quartile nationally for the 4 service user cohorts (opiate, alcohol, non-opiate and alcohol and non-opiate) who receive and successfully complete treatment.

- For opiate clients successfully completing treatment Birmingham ranks 3rd highest of 8 Core Cities in 2017/18.
- For alcohol clients successfully completing treatment Birmingham ranks 2nd highest of 8 Core Cities in 2017/18.
- For non-opiate clients successfully completing treatment Birmingham ranks 2nd highest of 8 Core Cities in 2017/18.
- For alcohol clients successfully completing treatment Birmingham ranks 2nd highest of 8 Core Cities in 2017/18.

3.1 Increased levels of employment

In 2018/19 CGL had a target of 19.35% of opiate clients and 34% of non-opiate clients being in employment following their successful completion of treatment. CGL exceeded these targets by achieving 23.08% for opiate service users and 35.91% for non-opiate service users with 54 and 65 service users gaining employment respectively.
CGL during 2018/19 referred 809 service users to work programmes in order for them to achieve sustained employment.

3.2 Reduction in re-offending

This outcome is measured by service users successfully adhering to the treatment programme court mandated Drug Rehabilitation Requirement (DRR) or an Alcohol Treatment Requirement (ATR). In 2018/19 CGL had a target of ensuring that >55% of DRR's and ATR's were completed; this target was exceeded with figures of 83.5% of 173 issued DRR's completed and 98% of 42 issued ATR's completed.

3.3 Improved housing

Over 98% of CGL's service users had their housing status recorded during their initial assessment and of these 9.7% reported a housing problem.
In 2018/19 CGL referred 300 service users to Housing services.
In 2018/19 the CGL Homeless outreach team referred 137 homeless people into substance misuse treatment.
In 2018/19 635 service users received advice and support on housing related issues.

3.4 Improved Parenting

In 2018/19 a total of 3714 Service Users were receiving a structured Tier 3, 4 or 5 intervention from CGL. 1970 service users (53%) stated that a family member or someone in their social network had involvement in their recovery.
In 2018/19 10.4% of CGL clients had parental responsibility and completed a parenting needs assessment.

3.5 Robust Children's Safeguarding

All CGL clients have their parental status recorded at treatment commencement.
179 service users are living with a child.
22% of CGL clients have an active safeguarding case (the national average is approx. 12%).
In 2018/19 527 service users who are not parents were identified as having significant contact with children and received a risk assessment.

3.6 Improvements in Physical Health

The physical health of all service user's is measured and recorded when they enter treatment, during their treatment journey and when they leave treatment. Measurement is by a systematic and evidence based scoring scale which records the average increase in the physical health score of the service user.

3.7 Improvements in Mental Health

The mental health of all service user's is measured and recorded when they enter treatment, during their treatment journey and when they leave treatment. Measurement is by a systematic and evidence-based scoring scale which records the average increase in the mental health score of the service user.

In 2018/19 there were 596 dual diagnosis (mental health & substance misuse) clients in the recovery service and 295 dual diagnosis clients who successfully completed treatment during 2018/19.

3.8 Reduction in Blood Borne Virus (BBV) transmission

In 2018/19 338 CGL clients accepted Hepatitis B virus (HBV) treatment and completed a course of 3 HBV vaccinations.
In 2018/19 502 clients were tested for the Hepatitis C virus with 38 positive results.

3.9 Reduction in Domestic Violence

All CGL services users who report domestic violence and are referred to domestic violence services.
In 2018/19 3.6% of CGL clients reported to be victims of domestic violence.
In 2018/19 17 CGL service users were know known to be perpetrators of domestic abuse.

3.10 Ensuring protection for Vulnerable Adults

22% of CGL clients have an active safeguarding case (the national average is approx. 12%).
During 2018/19 CGL worked with 153 service users who were pregnant.

3.11 CGL Financial Performance

From a financial viewpoint the performance levels of CGL compare favourably nationally in terms of value for money as based on contract spend per head of population. Birmingham ranks as the 7th lowest spend out of 8 from a Core City perspective and ranks as the 11th lowest spend out of 15 local authorities from a Chartered Institute of Public Finance & Accountancy (CIPFA) perspective.

4. Peer Mentor's Review of Citizen's journey

Evidence shows that when service users are meaningfully involved in the planning, development and (when appropriate) delivery of services, service quality and user experiences improve. This leads to sustained recovery outcomes for large numbers of those engaging in services. Service user involvement also helps to foster positive relationships between staff and volunteers that can lead to opportunities for service users/ex-service users to give back to the treatment and recovery community in Birmingham.

CGL have developed an extensive peer mentoring and volunteering network utilising a group of 45 'experts by experience' to support other service users in their recovery journey, with several individuals obtaining employment in the support worker field.
CGL are committed to ensuring that Service User Involvement is a key focus within its services. Their Service User Involvement Policy, which all CGL employees and volunteers are expected to follow, is based on two main principles:

- Service Users will be central to improving the quality of our services and will have meaningful opportunities to contribute to the development of services;
- Because of this contribution, practices, policies and other products will have a greater focus and relevance to those most affected by them.

CGL Birmingham has a designated Service User Involvement Lead who is responsible for the coordination of structured activities across the service. The Service User Involvement Group meets quarterly and comprises of Commissioners, CGL and Service User Representatives and Peer Mentors.

CGL Peer Mentors provide advice and support to service users by using and sharing the knowledge and skills they have gained during their own recoveries. They evaluate a wide range of service delivery including:

- Meeting and greeting service users
- Supporting service users who are connected to specific teams e.g. women's team, homeless team, telephone triage, criminal justice etc.
- Co-facilitating groups within CGL venues and in the community
- Promoting and encouraging access to mutual aid networks

CGL Peer Mentors act as role models to all service users and are living proof that recovery is possible. Individuals who wish to become Peer Mentors must have a good level of recovery capital and need to be abstinent from problematic/illegal substances and behaviours. Peer Mentors are supervised monthly by CGL's Peer Mentor Co-ordinator.

CGL Service User Representatives and Peer Mentors have recently completed a project focusing upon Prison Release and the three key issues faced by those recently released which are substance misuse, homelessness and mental health.

A copy of the presentation is in *Appendix 3*; this has been presented at the West Midlands Continuity of Care from Prison Steering Group meeting at Public Health England (Birmingham) and has subsequently being shared with all 100 members of the Prison Continuity of Care Group and the PHE National team in order to for the presentation and service user findings to be taken into account for the development of national policy. The Prison Release Project has also been shared with the local Criminal Justice Board and the Reducing Reoffending Group.

CGL Service User Representatives and Peer Mentors also completed a Homelessness survey in August 2017 working in partnership with the Connect 2 Recover Service User Forum. The work undertaken has been shared with the Birmingham Homelessness Round Table and can be found in *Appendix 4.*

Appendix 1 details the stories of 2 CGL Service Users who now act as Peer Mentors.

Appendix 2 details of the Positive Impact of Service User Involvement.

CGL work in partnership with Forward Thinking Birmingham (FTB) and the Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) in order for the respective Peer Mentor Groups to jointly address issues relating to the dual diagnosis of substance misuse and mental health and to ensure that those in need of support receive fit for purpose responses from both CGL and the NHS.

5. Identifying the Gaps

Leading up to and during the contract extension period extensive work will take place with key partners (Criminal Justice, Mental Health, Homeless) and wider stakeholders to identify any gaps within the current substance misuse service. BCC commissioners, Public Health and CGL will assess the most practical and affordable ways to address any gap identified.

It could be said that the City needs a multiagency Drug and Alcohol Strategy so to effectively address the associated harms caused by substance misuse. Prevention, treatment and recovery elements could usefully be the key elements to any strategy. This approach would need to include the involvement of the treatment provider as well as other stakeholders including the Police, Health

partners, the Community Safety Partnership, Housing, the Police and Crime Commissioner and others.

The reducing trajectory of the Public Health budget which funds substance misuse services will be clearly communicated to all stakeholders so that greater collaborative and joint commissioning opportunities are developed when the service function enters its retender phase for post 2022.

6. Recommendations

Birmingham Public Health and BCC Commissioners will continue to work with CGL to ascertain how the service can be further developed to maximise health, social care and criminal justice outcomes for the benefit of the City. This will be consistent with the commissioning intentions for the two year extension period (March 2020 – February 2022) which have been developed through stakeholder consultation and working in partnership with the Council's Public Health commissioning team.

These intentions are:

- A Renewed Focus upon the Recovery agenda.
- Responding to the changing patterns of drug and alcohol related harms with a specific focus on the harms caused by opiate, alcohol and Novel Psychoactive Substance misuse.
- A refocus on Comorbidity: Mental Health and Substance Misuse
- A refreshed Locality Model of Delivery
- A refreshed Child Protection Focus
- Maintaining a Drug Alert System

7. Next Steps

CGL continue to work with key partners so to continue to maintain and further develop the current treatment and recovery pathways. The pathways will also be developed during the contract extension period (2020-2022) and involve the following organisations:

- Probation Service
- West Midlands Police
- Department of Work & Pensions
- Clinical Commissioning Groups (CCG's)
- Hospitals (Acute Sector)
- Mental Health services
- Homeless services
- Street Intervention Team (SIT)
- Community Safety Partnership
- Wellbeing Service
- GP's
- Pharmacies
- Homeless services

CGL to continue providing their contribution to:

- Homelessness and Health Steering Group
- PHE Prisons Continuity of Care Group

- Community Sentence Treatment Requirement (CSTR) Steering Group led by the West Midlands Combined Authority
- West Midlands Alcohol Forum hosted by Public Health England
- PHE Hepatitis C Testing working group
- Drug and Alcohol Related Deaths Inquiry Group
- Managing the Birmingham Drug Alert System

BCC & CGL revisit and update the Social Value Plan.

The Substance Misuse Commissioning Group to be reconvened with the objective of developing the necessary commissioning approach for substance misuse prevention, treatment and recovery for the period after the current CGL contract extension ends in 2022. This may involve the development of a multiagency drug and alcohol harm reduction strategy for the City.

Appendices

1: CGL Peer Mentor Stories
2: Service User Involvement – It's Impact
3: CGL Service User Representatives and Peer Mentors Prison Release Project Presentation
4: CGL Service User Representatives and Peer Mentors Homeless Project Presentation.

Appendix 1 – CGL Peer Mentor Personal Stories

Personal Stories

Hannah: Family Member

My Mom became dependant on alcohol and realised that she had a problem. She decided on her own that she needed help and wanted to change her life around. She realised the impact her drinking was having on herself mentally and health wise, but also what it was doing to our family.

Mom has been in recovery for 2 years now. The main thing that we have realised in the last 2 years is the lack of free rehab facilities. I understand that it's not easy to fund these projects but sometimes those who are most in need cannot afford the help. When mom was desperate we couldn't find a facility that cost less than £3000. As a family we don't have that sort of money and worried that we were going to have to go without. Then Summer Hill became available, and after her time there all of these opportunities have become available for my mom and for that I am thankful.

Mom has been volunteering [at CGL] for nearly one year. She attends meetings and discussions on various topics.

Personally I think mom enjoys the fact that she is giving something back after her time in rehab. She understands that rehab changed her life and wants to help others. She loves being a part of the CGL group. She is also embracing the new skills she learns each time she attends a group.

I feel that my mom gets so much fulfilment from volunteering with yourselves and it has really brought her out of her shell.

Thank you.

Tracey: Service User Representative

I've been in recovery for 2 years and 6 months. I started volunteering with CGL in July 2018.

I help with groups along with other Service User Representatives and Peer Mentors by giving my first-hand experience of alcohol abuse. This involves sharing my perspective and ideas.

I have received continual support from my supervisor, ongoing training on how to deal with certain situations and how to look after the welfare of both service users and myself e.g. 'the dos and don'ts on confidentiality and conduct'.

I enjoy the whole experience of volunteering for CGL. In particular I enjoy seeing that I can make a difference to others. I enjoy seeing positive changes/looks on service users' faces, even when they make only a little step forward.

CGL is a massively worthwhile organisation. It is a necessity for service users but also a huge part of my ongoing recovery.

It is imperative that the service continues but also grows to help more people in their time of need. I can certainly vouch for this from my own past experience and from where I am today.

A big thank you to all those who have helped me and I look forward to helping as many people as I can.

Appendix 2- Service User Involvement – It's Impact

Pregabalin and Gabapentin

Through his engagement with Service Users, a Service User Representative spotted a theme about Pregabalin & Gabapentin medications. He heard they were causing our Service Users significant problems and witnessed individuals approaching our service in desperate need of support. He spoke to staff and discovered that for clinical reasons, our service was not in a position to prescribe them.

He knew very little about Pregabalin and Gabapentin himself and wanted to do some research. As a Service User Representative he has access to our computer system and used this to investigate the issue online, as well as explore our internal policies and procedures. His research taught him that the medications were originally developed to treat epilepsy, however, are now commonly being used to treat conditions like neuropathic pain and anxiety. He also discovered that:

- it's possible to become physically dependent on them
- at the point of stopping the medications, if doses are not reduced gradually, the patient can experience significant withdrawal symptoms
- they carry an acute overdose risk, especially when used with opiates
- deaths related to these medications are rising year on year
- the British Medical Association were backing calls to make Pregabalin a "Class C" drug

He was really concerned about what he learned as it became clear that these medications pose a serious risk to our Service Users, especially those who use illicit or prescribed opiate based substances. His concern was further reinforced by the fact that he found no evidence of a formal CGL policy regarding Pregabalin and Gabapentin use.

He shared his new found knowledge with his fellow volunteers who became equally worried for our Service Users and as a team, decided to gauge the prevalence of Pregabalin and Gabapentin use amongst our Service Users via a targeted survey.

Within a few days, the team identified 42 Service Users who were using the medications. Worrying headliners from the survey result showed that of the participants:

- 50% were obtaining them illicitly (not prescribed)
- 47% were also using methadone and heroin
- 21% were also using methadone, heroin and alcohol

The Service User Representative was supported to turn his research into an evidenced based report which made some recommendations to CGL, which if undertaken, would improve the support available to our Service Users on a national scale. The recommendations include the development of a:

- training to upskill and educate staff
- clear harm reduction message for Service Users
- central CGL policy and procedure
- official communication to our partners e.g. GPs, Prisons etc. highlighting the risks of dependency, withdrawal and overdose
- detoxification prescribing option

The Service User Representative presented the report at a Midlands Regional Service User Council, a group who meet on a monthly basis to share learning and escalate Service User feedback. Walsall, Dudley and Nottinghamshire services were present and as well as showing their support for the

report's recommendations, they also shared accounts of how Service Users in their own towns and counties were being affected.

The Regional Council escalated the report to CGL's Medicines Management Board and as a result Prun Bijral, CGL's Medical Director, contacted the Service User Representative and his fellow volunteers. He advised them he had read the report and its recommendations and agreed that CGL could do more in relation to Service User safety and Pregabalin and Gabapentin use.

Since then a 'working group' has been created, which is led by our Service User Representatives and supported by Mohammed Fessal (CGL's Chief Pharmacist). Its main focus is to turn the report's recommendations into a reality which includes plans to conduct a clinical study on the issue, in partnership with the University of Manchester. Birmingham's Service User Representatives have developed a harm reduction leaflet that is aimed towards Service Users and will help people understand the risks of using Pregabalin and Gabapentin so they can make safer and more informed choices.

If the planned clinical study is a success, it would put CGL in a stronger position to conduct Pregabalin or Gabapentin detoxifications in the future. The working group are currently developing a 'prevalence study' that will assess the level of need that exists in Birmingham, plus three other West Midlands based CGL services and the Service User Involvement teams within each of those services, will be integral to this piece of work.

Service User Planning

Trevor Bedford who works within our Quality Improvement Team in Birmingham, approached our Service User Involvement Lead to ask if our team of Service User Representatives could review CGL's paper version of its Service User Plan, which workers and Service Users together in 1-2-1 appointments. The purpose of the plan is to help Service Users plan for their recovery by setting relevant and achievable goals.

Our Service User Representatives reviewed the document and came to the following observations:

- it was too overwhelming i.e. there were approximately 50 questions to answer within the plan, which they felt would be too much for Service Users to consider in one go
- the language that was used in the form was not 'service user friendly' i.e. it used 'service jargon' that Service Users may not understand
- the format of the form was not fit for purpose i.e. there was not enough room for the Service User to record information that was important in their recoveries
- the form looked like "just another form" and because of this they felt that it wouldn't feel important or helpful to Service Users, when setting their recovery goals

Our Service User Representatives made the following recommendations:

- they strongly felt that before the planning stage, the significance of the Service User Plan and how it will benefit them needed to be explained to the Service User – in very simple terms. And that within this discussion the service would need to convey/discuss how it's the Service User's plan and their responsibility i.e. they "own it"
- they felt it's important to acknowledge why they drink/use drugs but ultimately the main focus should be on what they "need" and want to "achieve" in their lives i.e. the plan cannot just be based around their drug/alcohol use, but also around their life goals/aims

- they felt individuals should have lots of "options" available to them – not just a prescription or a detox
- in order to cut down on the overwhelming amount of questions, they felt a simple scaling exercise would support the Service User to consider and choose their priorities
- they also felt like the plan needs space for them to record their successes – no matter how big or small, so Service Users can reflect on their achievements.

The group of Service User Representatives went on to design their own version of a Service User plan, ensuring that all of their recommendations and observations were incorporated within its design.

What's happened as a result of their feedback?
The Quality Team shared the feedback and the Service User Representative's version of the plan with Senior Management.

The Senior Management team endorsed the new plan and agreed that a set of 'service wide' workshops should take place, to share the new plan with all frontline staff and the reasons behind its design.

These workshops have since taken place and were attended by the Service User Representatives that designed the new plan.

Their work was well received by frontline staff who are now encouraged to use the new planning intervention with their Service Users, instead of the old version that was designed by the service.

Prison Release Project

Presented by:
Service User Involvement Team

Date: 16/05/2019

Our mission is to help people change the direction of their lives, grow as a person and live life to its full potential.

Snapshot - steps we've taken…

Research

- issues affecting people

Analysis

- 114 people - prison release clinic (Scala House)
- 4 week period - March 2019

Asked people to share their experiences

- experience (day 1 and 2)
- what did they need?
- did we (CGL) meet their needs?
- what could be done differently?

Research

Short sentences…

- 6 months or less (non-violent crimes)

Revolving Doors Agency

‘Short Sighted’ campaign

- ‘Freedom of Information’ legislation
- 3 in 5 report a drug or alcohol problem on arrival at prison
- 1 in 4 are released homeless
- 7 in 10 reoffend within a year of release

Research

Those 'caught up' in the 'revolving door'

- affected by 3 significant issues, simultaneously (60,000)
- offending, substance misuse, homelessness (men)
- women - domestic violence, sex work (to avoid sleeping rough/hostels)

Research

Revolving Door Agency 'Expert By Experience'

"I have done 19 short prison sentences in the last 20 years. A lot of the time I didn't get any interventions [to address] the problems that led me to being in custody – substance misuse, alcohol, drug addiction, homelessness.

These are the reasons I was breaking the law - to try and get myself somewhere to live for the night, to fund my addiction and just to survive really."

Analysis - CGL referrals from prison

Referrals by gender…

82%

18%

Analysis - CGL referrals from prison

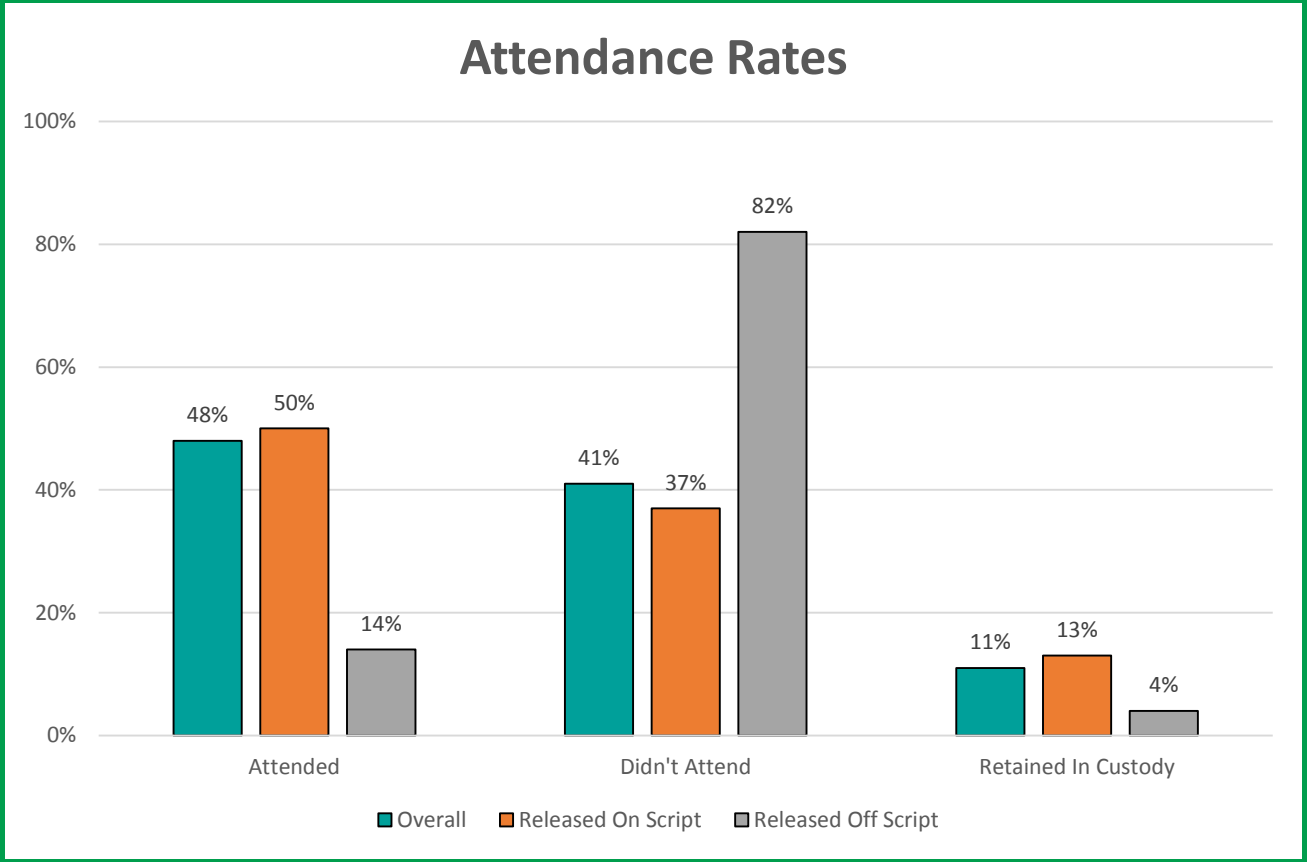
Referrals by medication status...

75%

25%

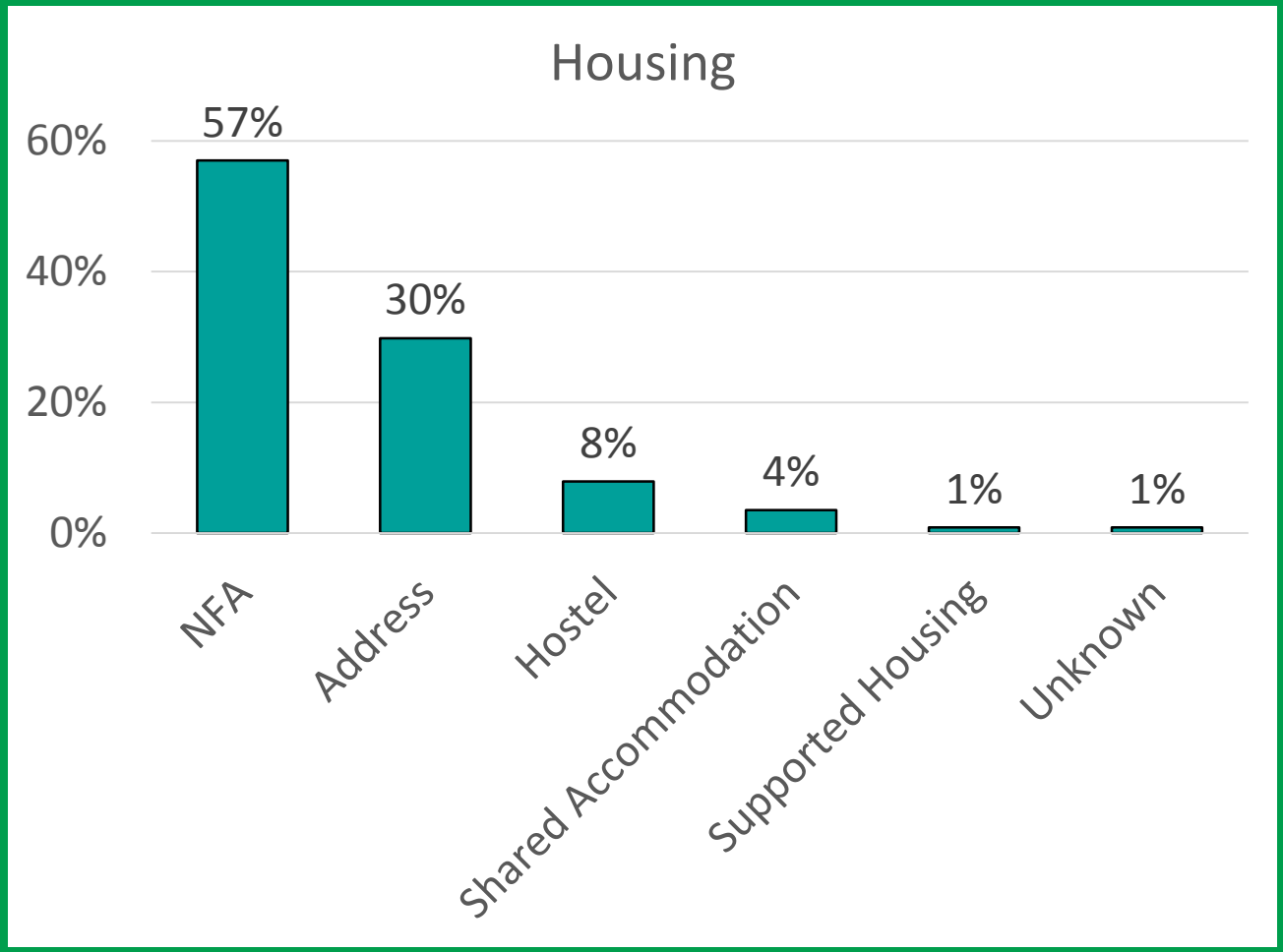
Analysis - CGL referrals from prison

Initial appointment attendance rates (overall)...



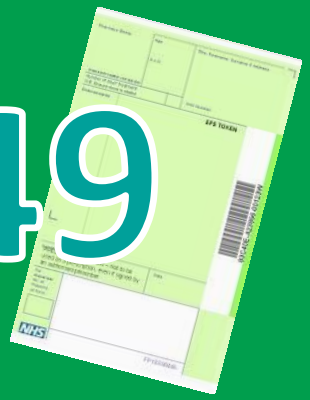
Analysis - CGL referrals from prison

Referrals by housing status...



Analysis - CGL referrals from prison

Of the 114 people who were booked into our prison release clinics in the month of March...



49

65%

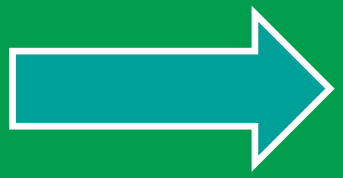
35%

Analysis - CGL referrals from prison

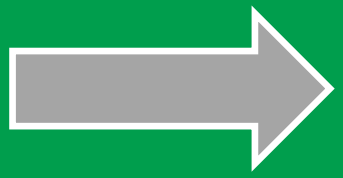
Optimal dosing…

Buprenorphine 12 - 16mg

Methadone >60mg



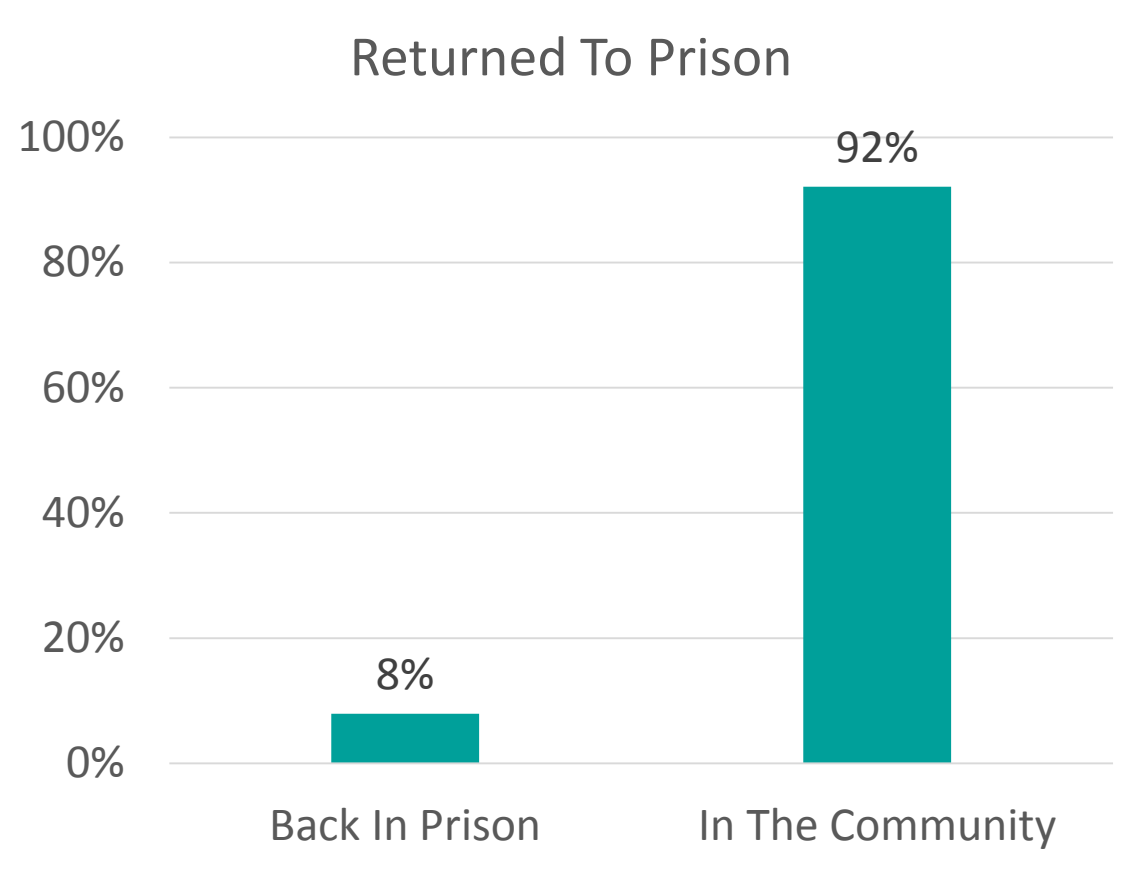
66%



34%

Analysis - CGL referrals from prison

Return to prison rates...after 4-8 weeks...



Analysis - CGL referrals from prison

Address status of those returning to prison...

78%

12%

Lived experiences - our approach

Questionnaire...two parts...

Wider picture

Age	.....	**Gender** (circle)	Male	Female	**I live in Birmingham** (circle)	Yes	No

When were you released from prison?	.....	**What type of sentence did you serve?** (circ	Short Medium

What is your housing situation? (circle)	Homeless	Hos
	Shared Housing	Supported

What do need support with now you are out of prison? (circle)	Housing	Mental
	Benefits	Employ
	Other	

Which of the above is the issue you feel is the most important you get support with and why?
.....
.....
.....

On the day

How would you rate the support you received from our service today?	Excellent Good Okay Not Good Poor
Please explain why you gave this answer	....

Have you got any other appointments with other services today? (circle)	Yes No	If yes, please list which services your appointments are with	1 ..... 2 ..... 3 .....

When CGL are supporting people who are released from prison, they can support them better by...	....

Lived experiences - emerging themes…

Scala House...

- flexibility - appreciated
- waiting times - mixed feedback
- treatment needs - mixed feedback
- overwhelming - amount of people

Bournville Newtown East North

Lived experiences - emerging themes…

Additional commitments...

- Probation - convenient location
- Housing - NFA
- Benefits - Job Centre

Lived experiences - emerging themes…

Housing…

↑ 2/3 - housing need

NFA Unsuitable

"it takes one bad egg to disrupt a whole house"

"I'm getting stung by a weekly service charge that's making it hard for me to get by"

"I want to work but I can't"

Lived experiences - emerging themes…

Benefits...

- **New claims - 6 plus weeks**
- **Emergency payments - repaid quickly**
- **Universal credit**
  - **- went in on ESA, out to UC claims**
  - **- technology**

Lived experiences - emerging themes…

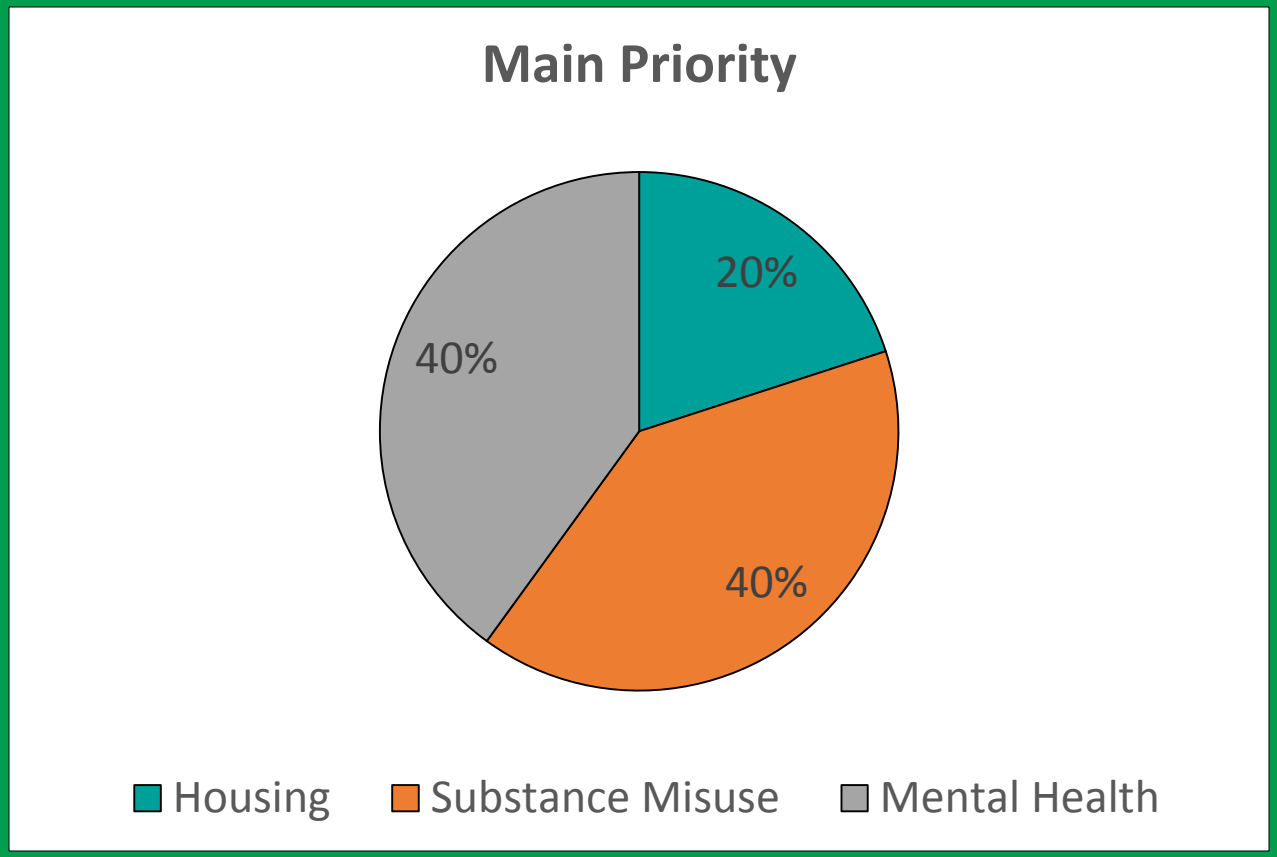
Mental Health…

↑ 2/3 - mental health

- hard to get support
- GP - not taken seriously
- GP - referral (no evidence)
- when you're abstinent, we'll look at your mental health

Lived experiences - emerging themes…

Most important outstanding need...



Recommendations…

Prisons…

- quality of referrals (minimal information)
- is a CGL referral really wanted/needed? If yes, what type of support is need? Self referral option?
- medication charts - sent routinely on the morning of release/court
- final dose - day of release
- maps - key appointments
- better communication - CGL/prison when people are retained in custody
- NFA - what area of Birmingham are they likely to reside in?
- mental health screening - GAD7, PHQ-9

Recommendations…

CGL…

- **increased choice treatment options…**
- **central point of contact - prisons**
- **GP summaries - less pressure (Probation?)**
- **new venues - clear directions/maps**
- **Espranor - better information including the reasons why**
- **prison in-reach - (video link)**
- **mutual aid information**

Recommendations…

Probation

- housing - better notice
- maps - key appointments
- family - change in approach
- person centred focus - goals

Staffordshire & West Midlands Community Rehabilitation Company

PROBATION

Overarching Recommendations…

mental health

staggered housing

appointments

~~Fridays~~ benefits

Homelessness Survey August 2017

Background…

- we wanted to make sure that the challenges that people have recently or are currently experiencing in hostels, would be captured and presented at today’s forum

Background…

- so we decided to coordinate a survey across the West Midlands in order to capture present-day views and opinions from those who are in a hostels

Who took part?

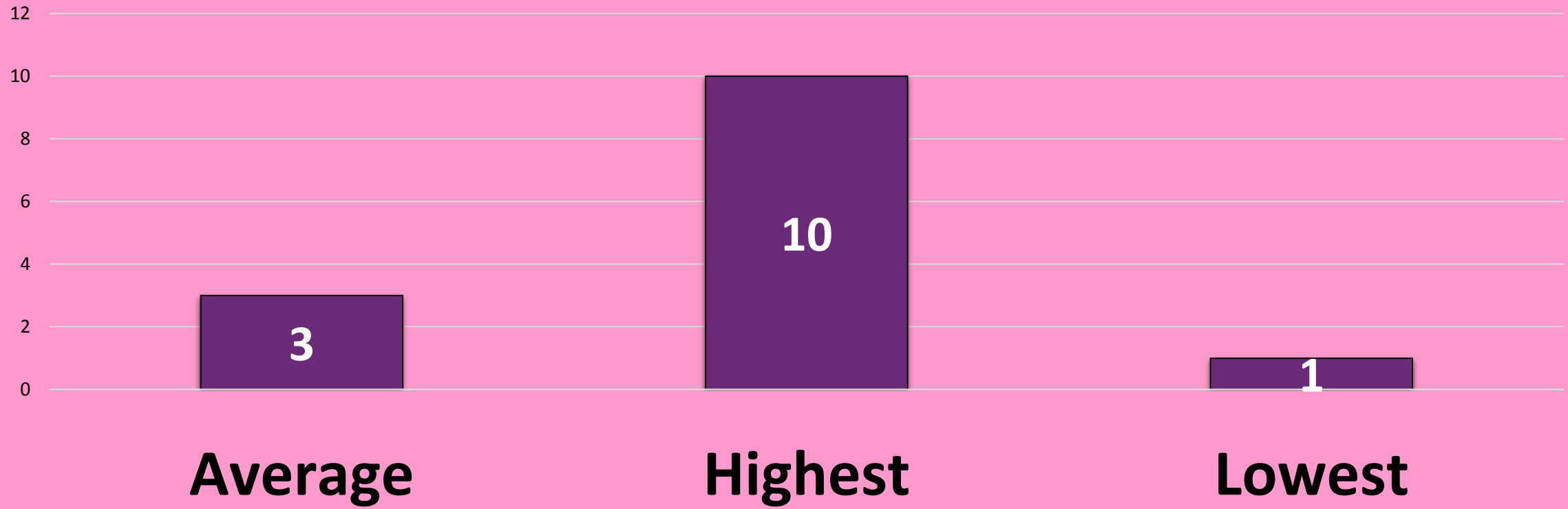
- members of the forum planning meeting committed to getting the surveys completed across the West Mids
- surveys included in the results were filled out by individuals based in Walsall, Coventry and Birmingham

The survey:

- the survey itself was created with the help of members of the homeless community

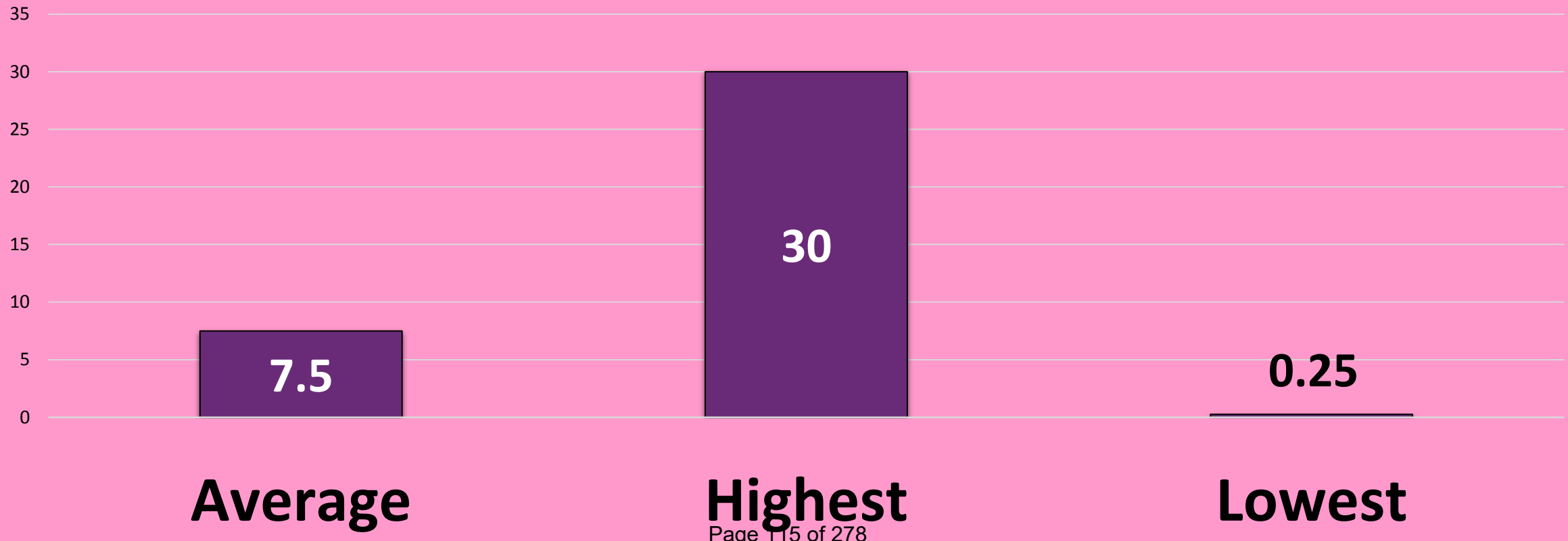
Hostel Residents:

How many hostels have you lived in, in your lifetime?

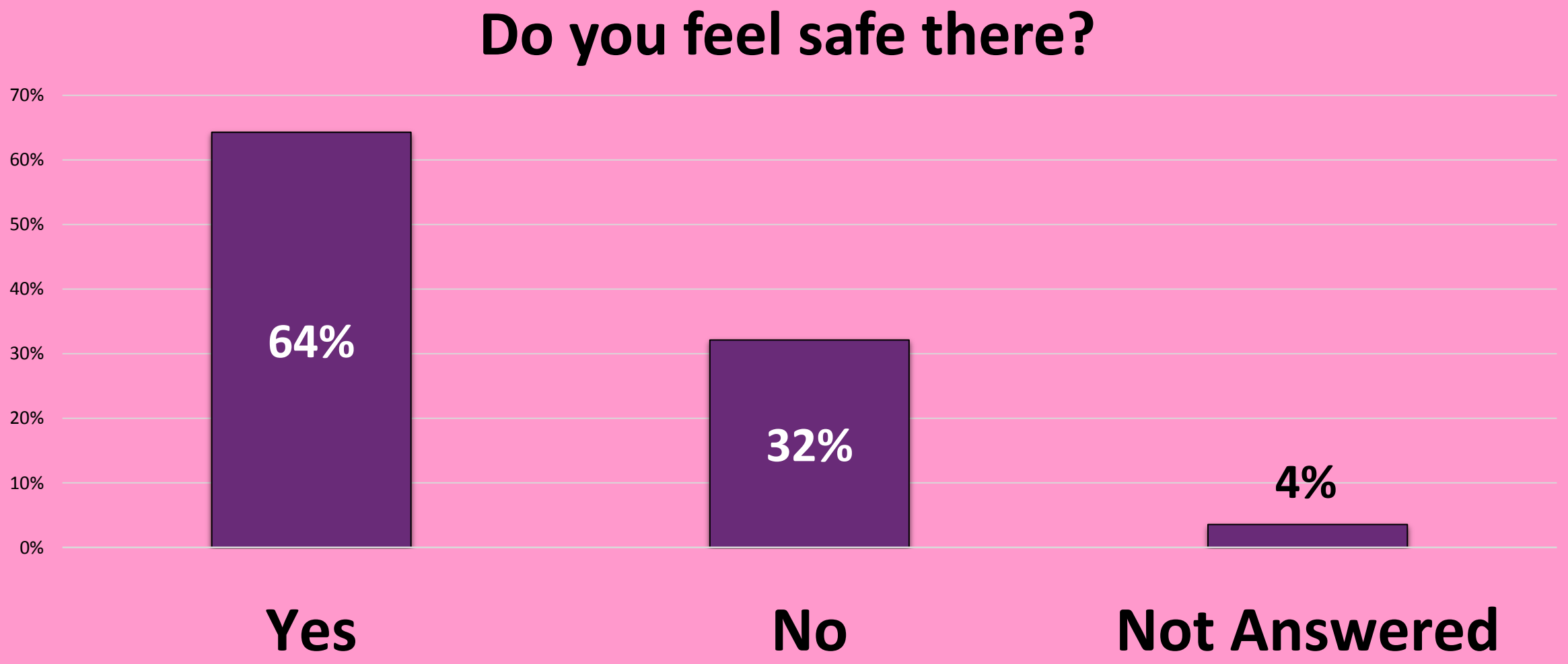


Hostel Residents:

How long have you lived in the hostel you're in now? (months)

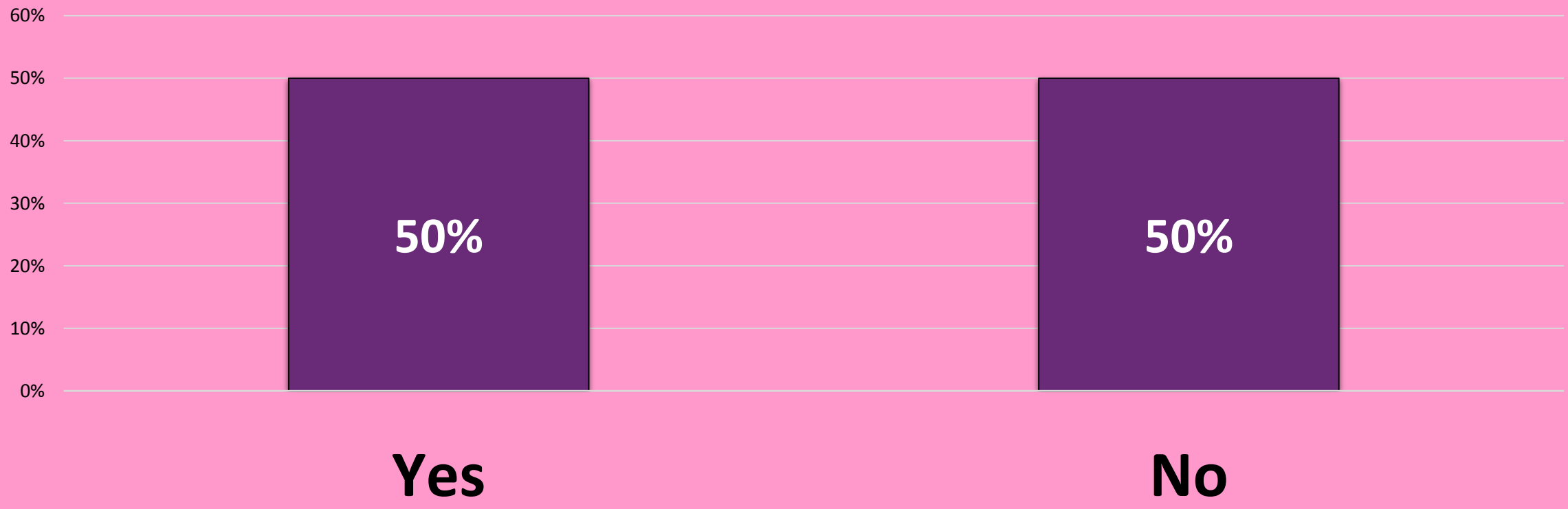


Hostel Residents:



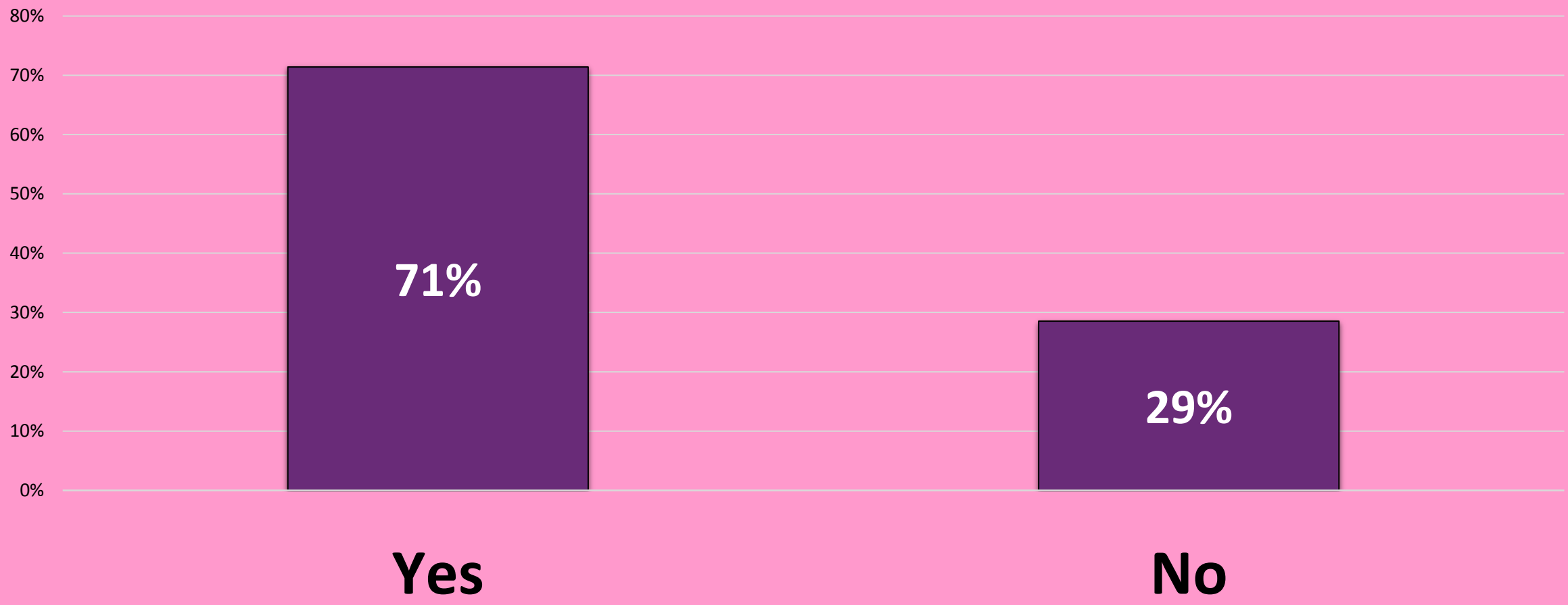
Hostel Residents:

Do you feel like your possessions are safe there?



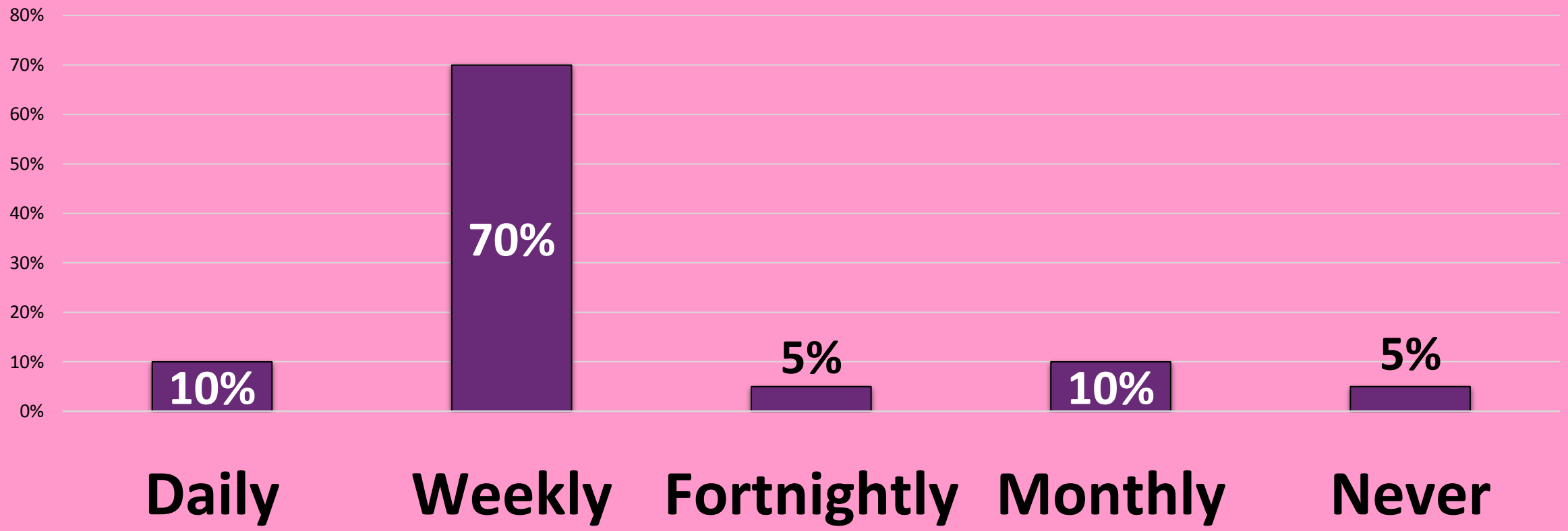
Hostel Residents:

Do you have a keyworker?



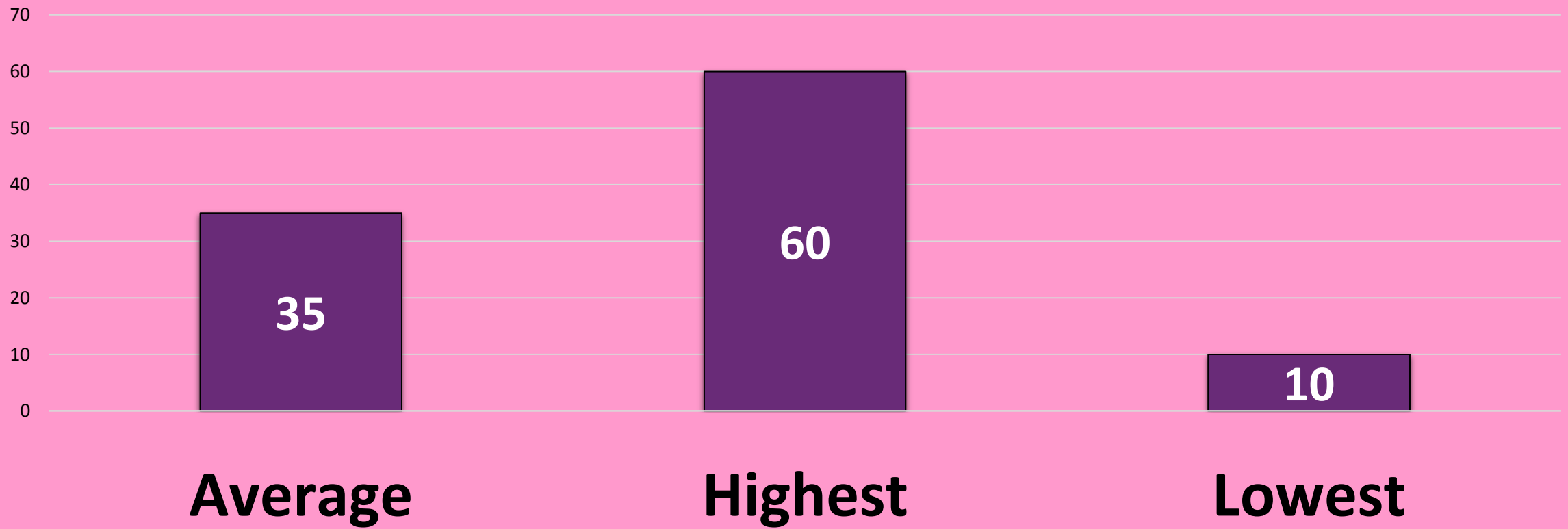
Hostel Residents:

How often do you have an appointment with your keyworker?



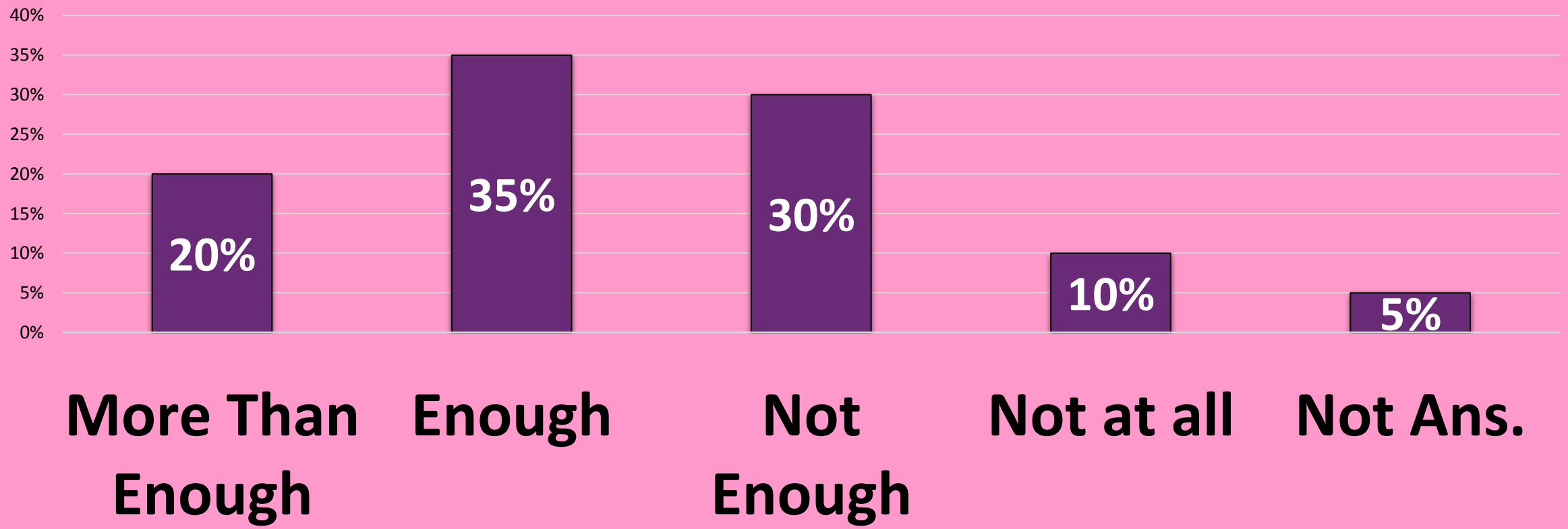
Hostel Residents:

How long do your appointments with your keyworker last for? (minutes)



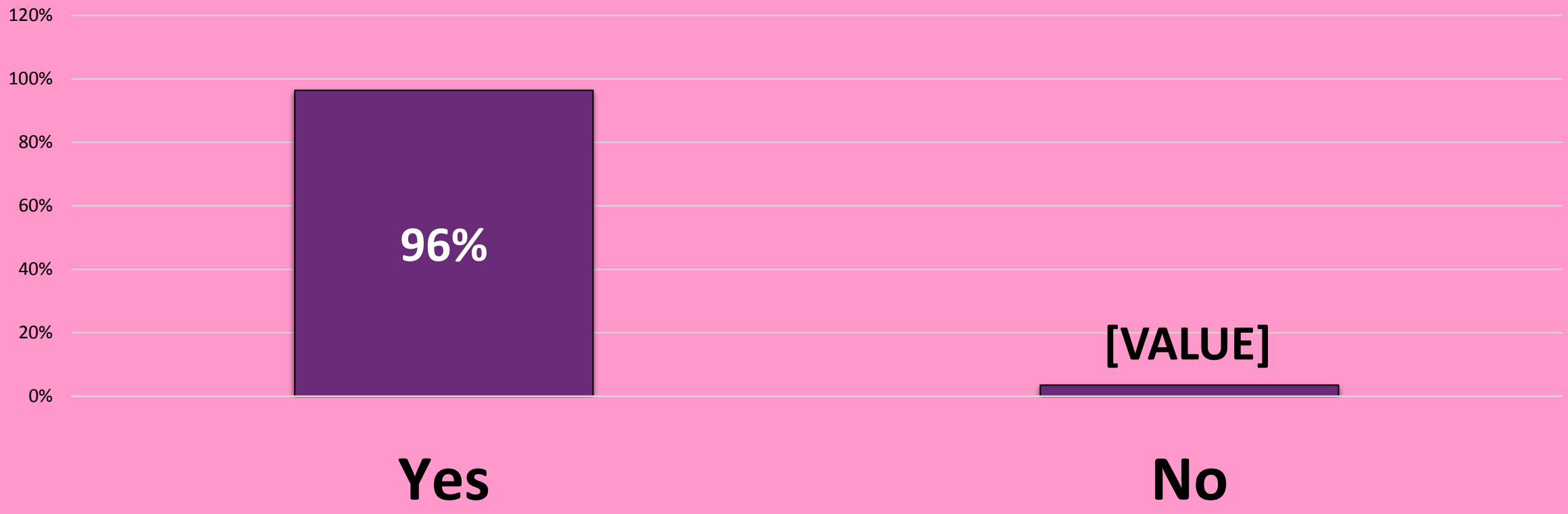
Hostel Residents:

How much support do you feel like you get from your keyworker?



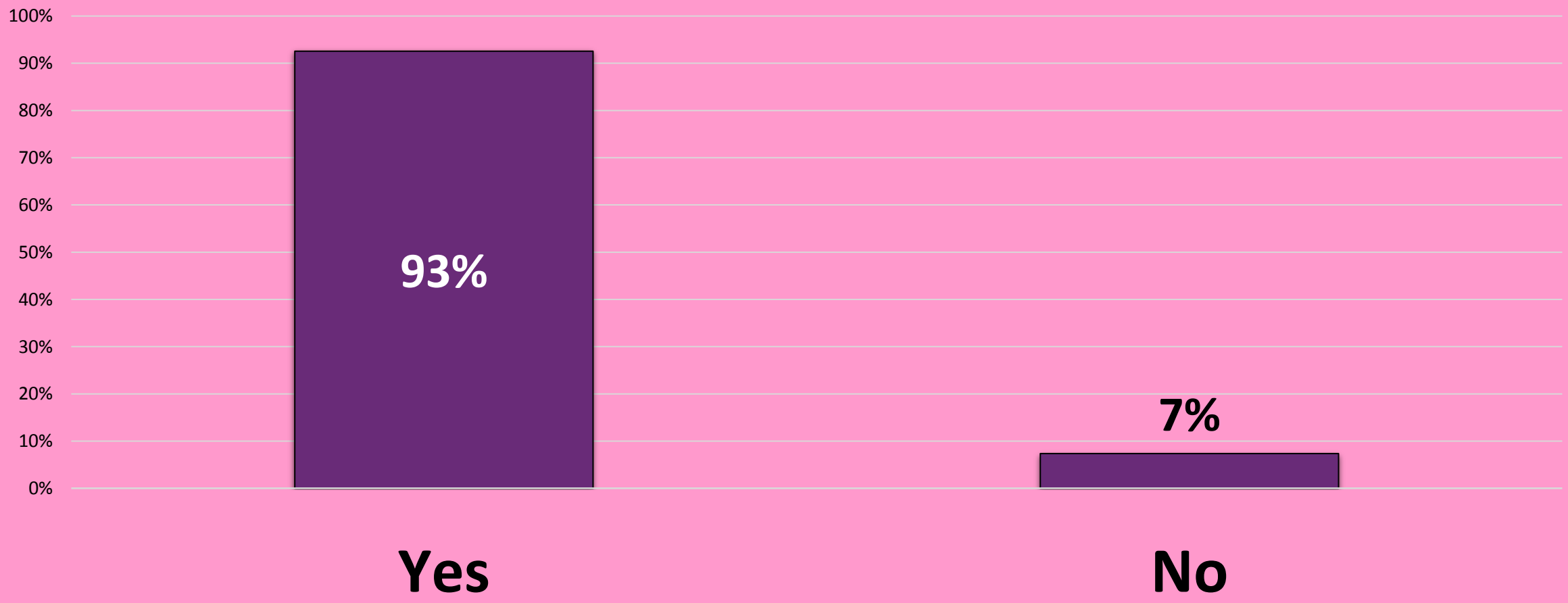
Hostel Residents:

Have you ever had a negative experience whilst living in a hostel?



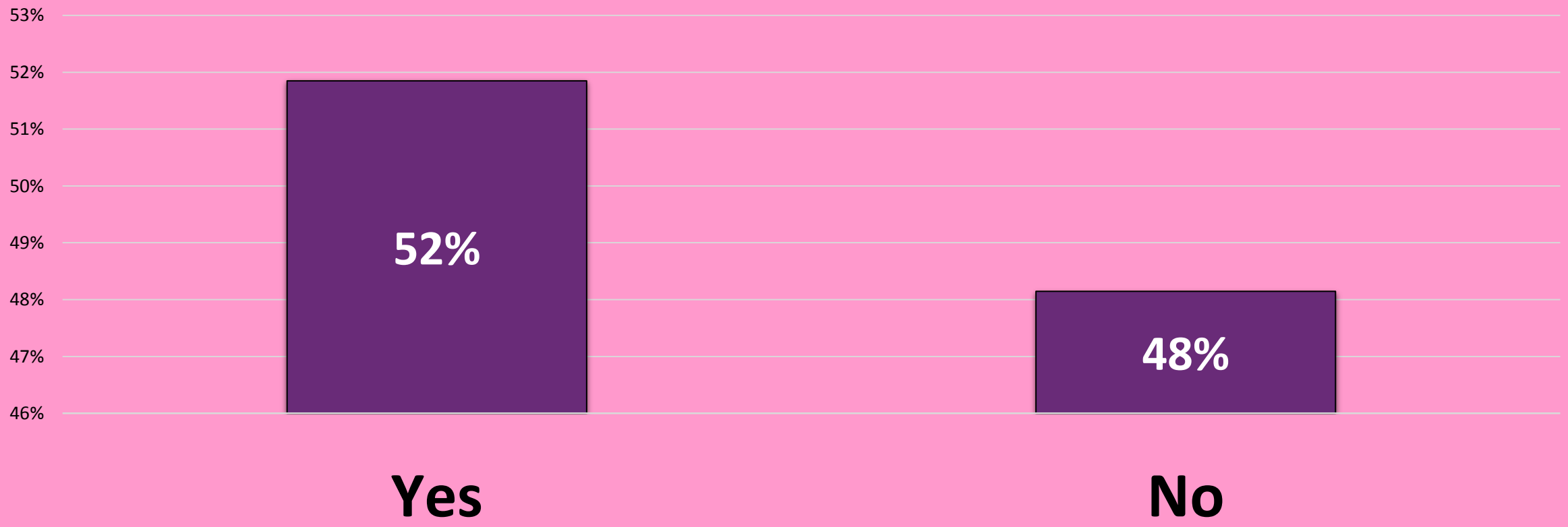
Negative Hostel Experiences:

Use Of Drugs/Alcohol By Other Residents



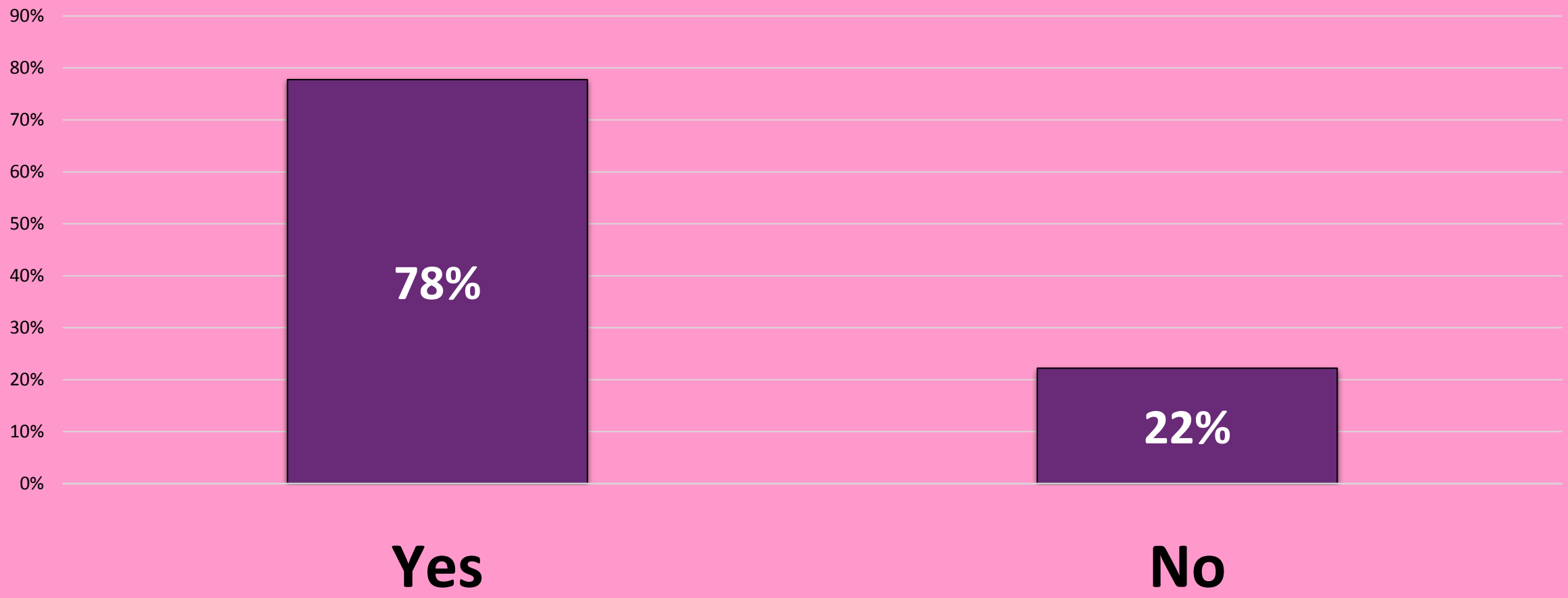
Negative Hostel Experiences:

Targeted By Drug Dealers Either In Or Outside The Hostel?



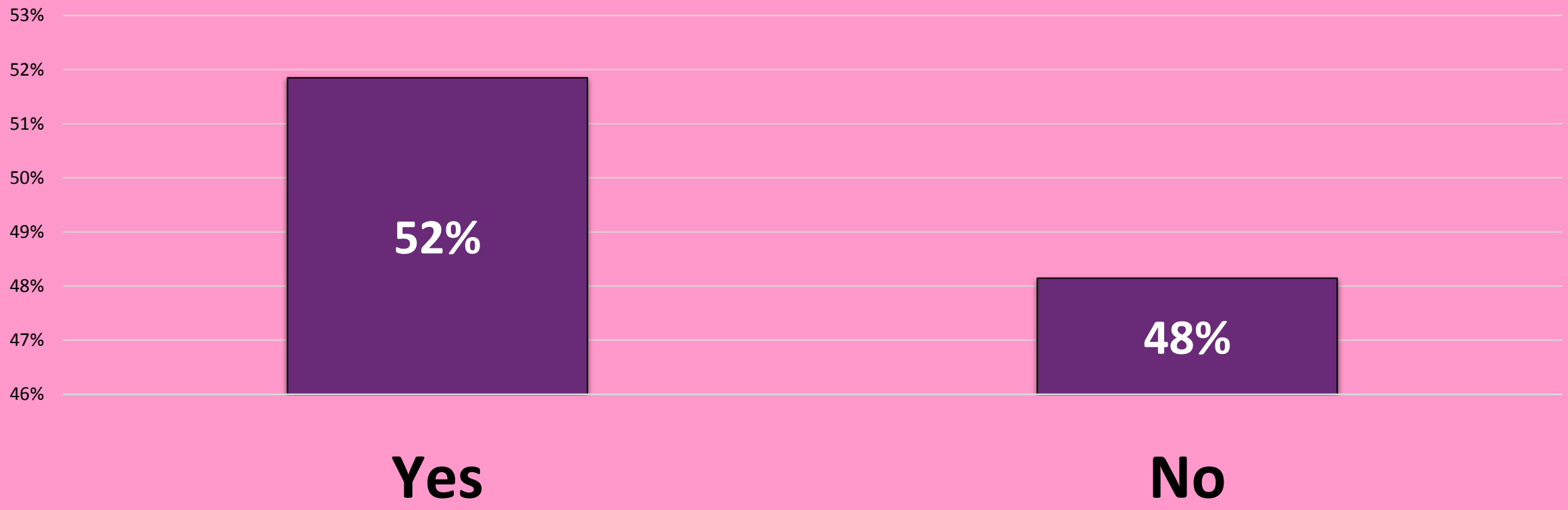
Negative Hostel Experiences:

Disrupted Sleep Caused By Other Residents



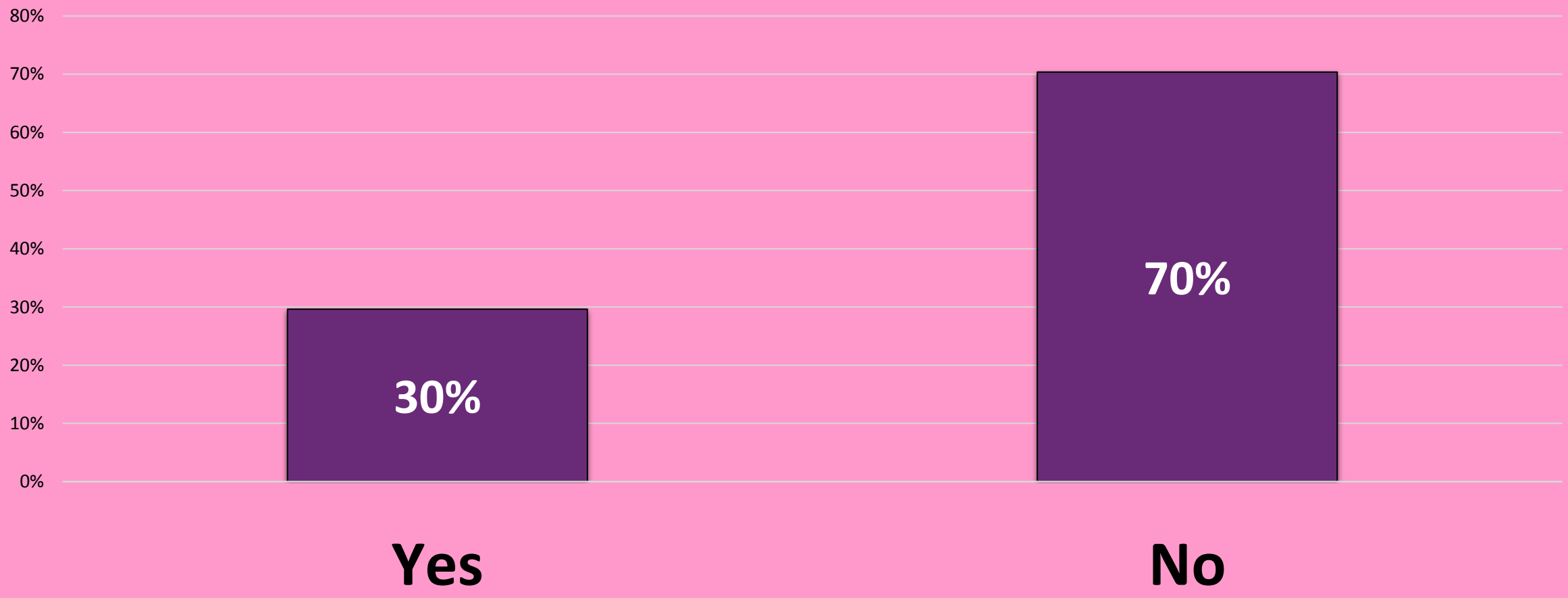
Negative Hostel Experiences:

Have Been Bullied Or Harrassed By Other Residents



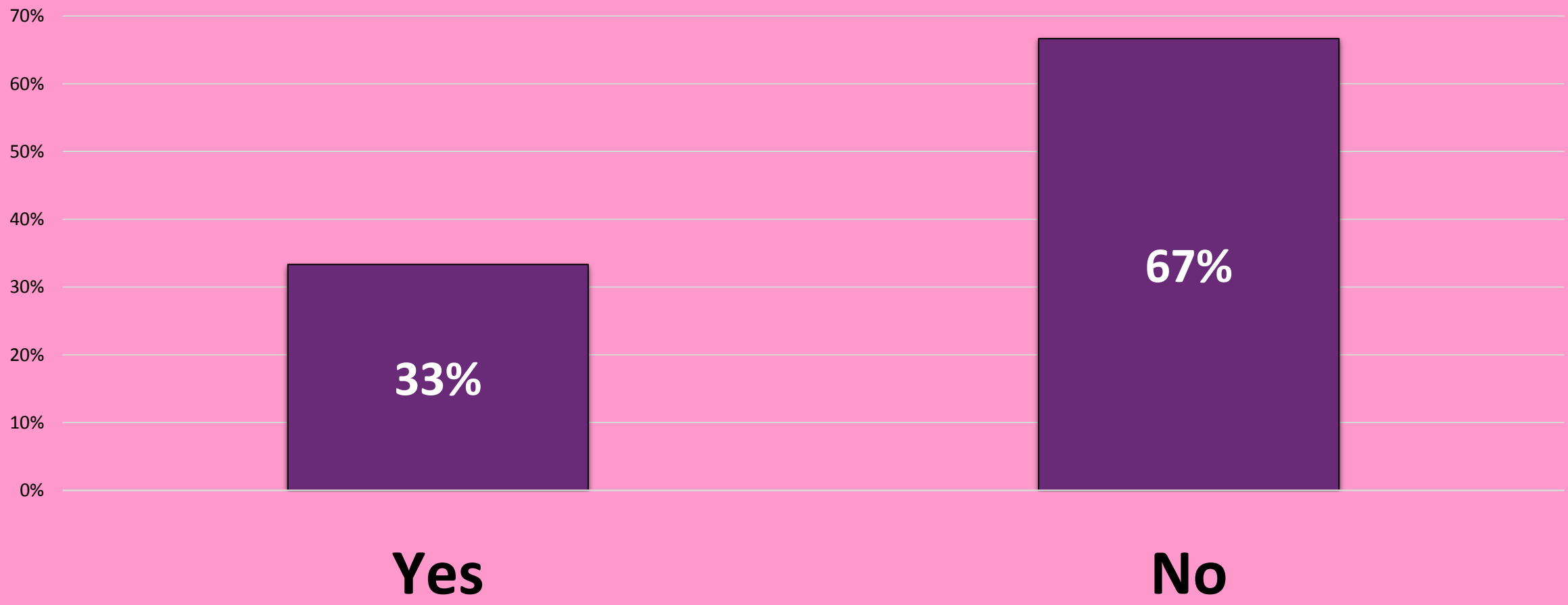
Negative Hostel Experiences:

Treated Poorly/Disrespectfully By Staff



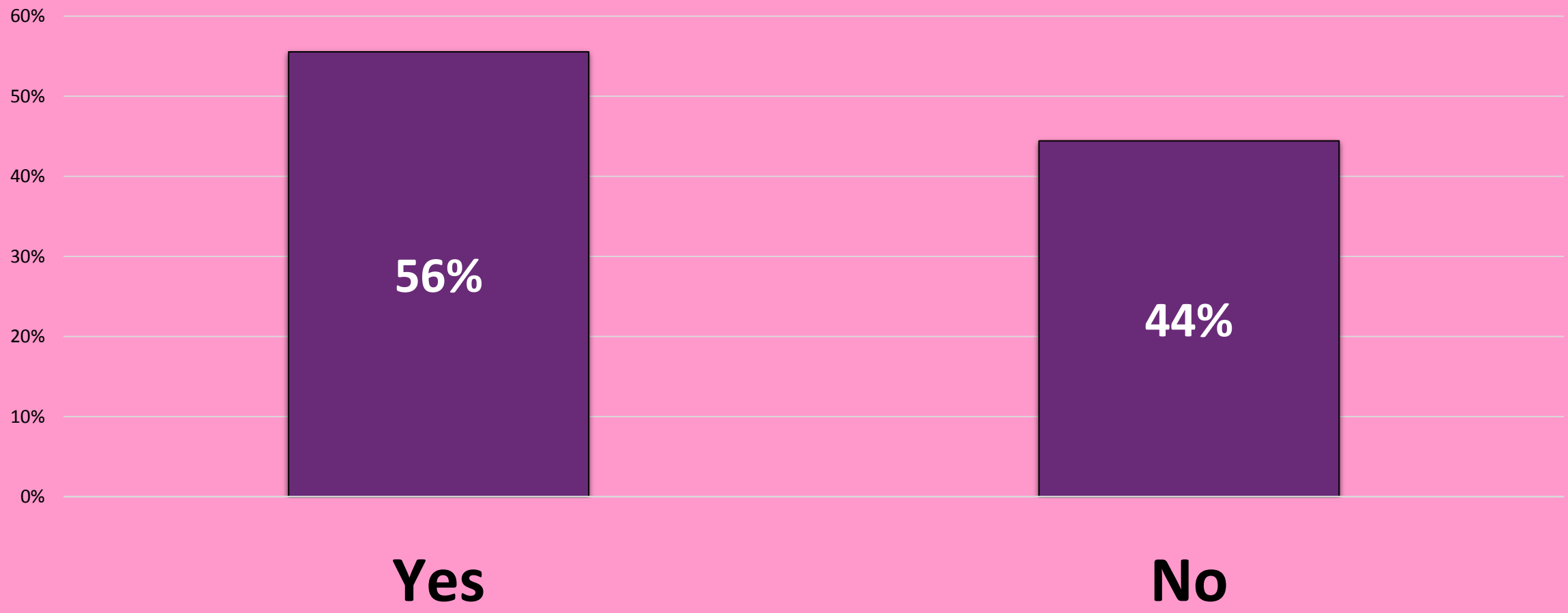
Negative Hostel Experiences:

Assaulted By A Fellow Resident



Negative Hostel Experiences:

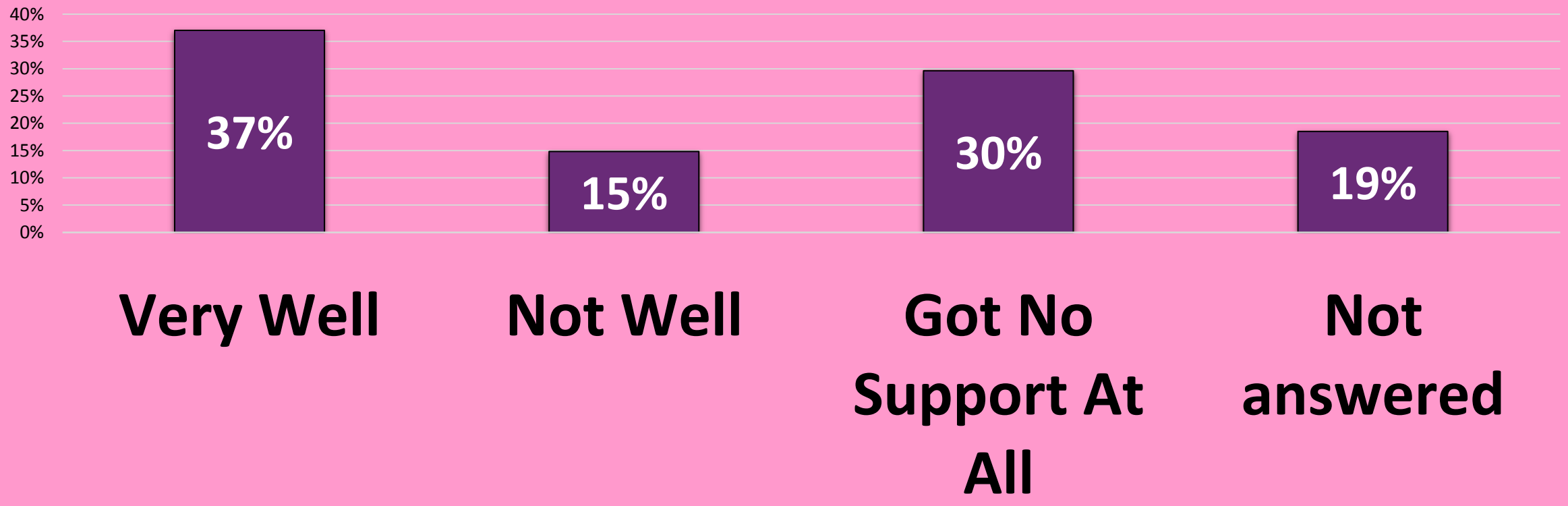
Had Personal Items/Money Stolen



Negative Hostel Experiences:

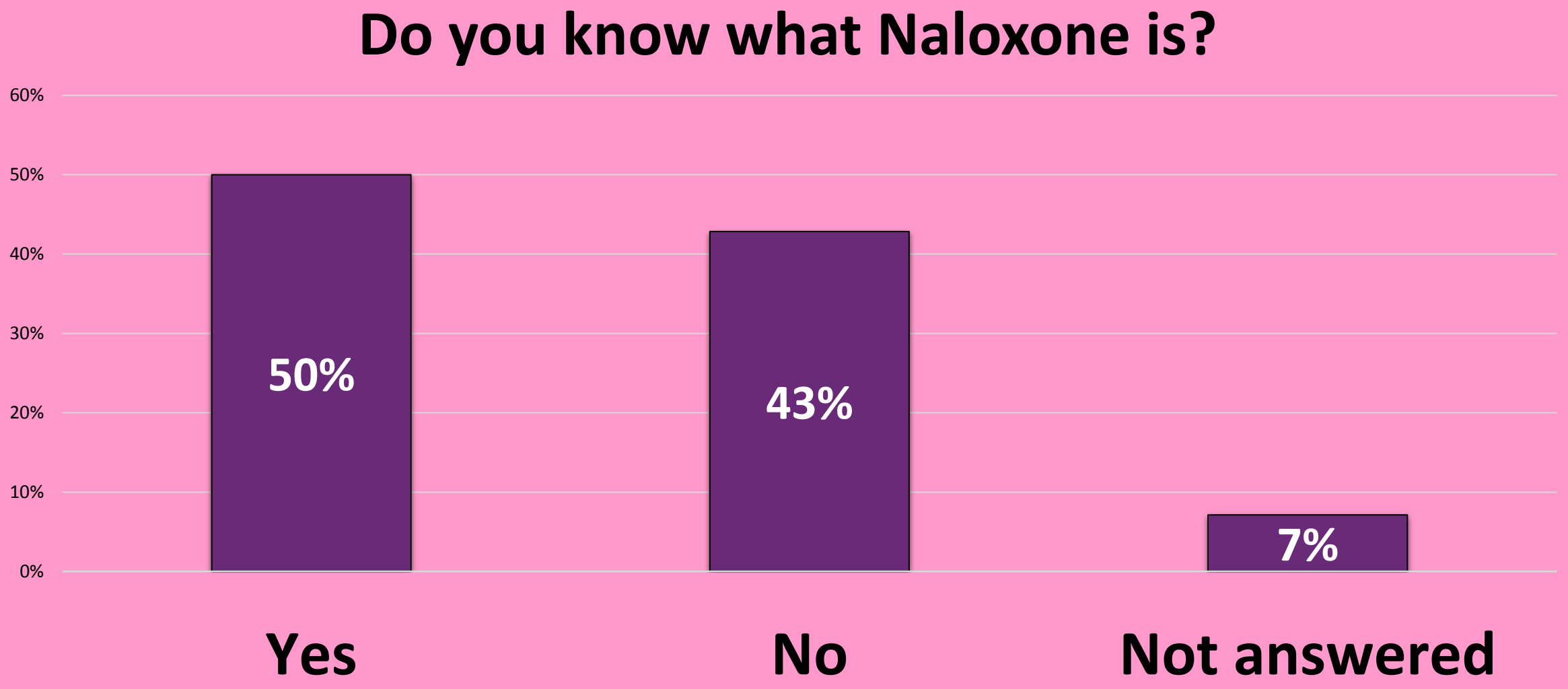
Hostel Staff Response:

If you've ever reported these issues to staff, how well do you feel they supported you?



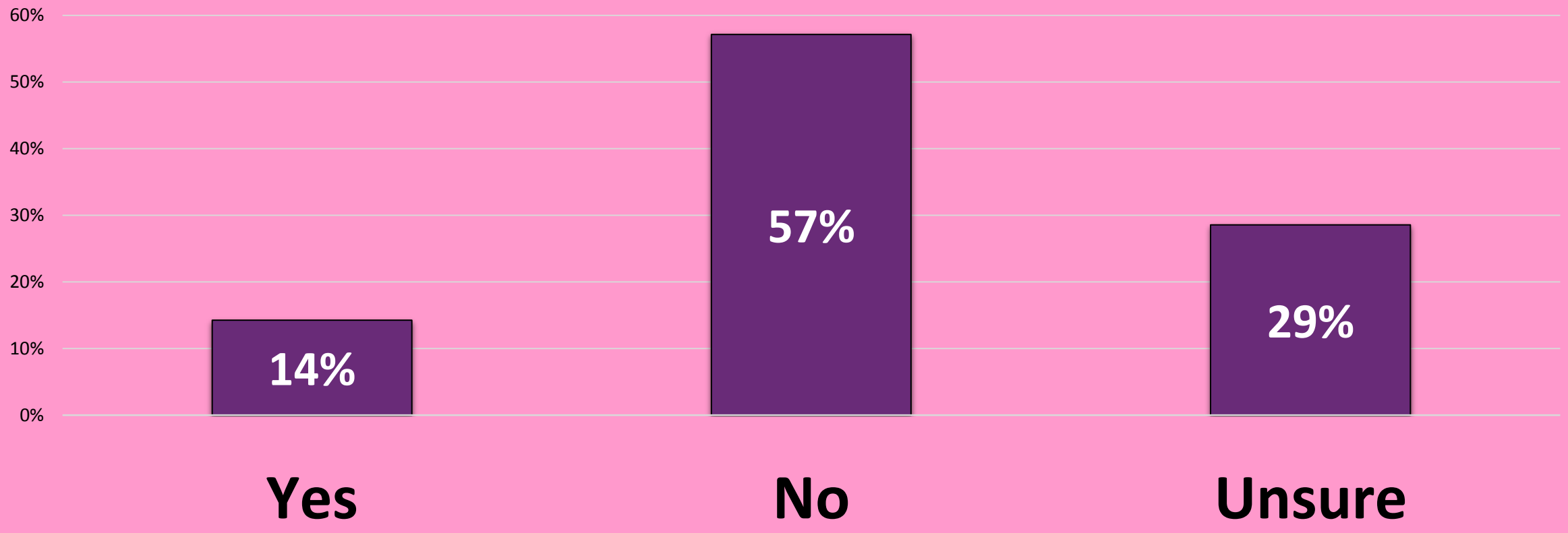

Batch:
Exp:
Man:
Contains: 1 x 2ml Prefilled Syringe and 2 Needles
Prenoxad™ injection
Naloxone Hydrochloride 1mg/ml solution for injection
OBTAIN MEDICAL ASSISTANCE AS SOON AS POSSIBLE.
Twist box to open

Naloxone:


Do you know what Naloxone is?
60%
50%
40%
30%
20%
10%
0%
50%
43%
7%
Yes
No
Not answered

Naloxone:

Do the staff at the hostel keep a supply of Naloxone on site?



If you could change one thing about your hostel to make it better, what would it be?

- Stop “mamba heads”
- Other residents finding motivation to change their lives
- Make it a rule to not lend money or tobacco because it causes problems
- To let visitors stay overnight
- To be able to move out of here
- To get more CCTV in hostels

If you could change one thing about your hostel to make it better, what would it be?

- To be offered help into work
- Better trained staff
- For them to be cleaner
- More privacy
- More support options
- Have a cleaner
- Longer tenancy agreements
- More food
- Staff being more respectful
- Stop overcrowding hostels
- More support workers visiting hostels
- Less service charges
- Not being moved from room to room
- Better facilities

Summary:

- **a significant number of people had been living in their hostel for more than 12 months**
- **around one third of people didn’t feel safe in their hostel and half felt their belongings were not safe**

Summary:

- the majority of people have a keyworker at their hostel
- commonly, people are seen by their key worker at least once a week
- more than half of people felt they’re getting enough keyworker support

Summary:

- over a third of people had been assaulted by another resident
- three quarters of people had trouble sleeping because of other residents

Summary:

- **nearly everyone had experienced problems with other residents' drug/alcohol use; normally on a daily basis**
- **the majority of hostels don't appear to routinely keep Naloxone kits on site**

Summary:

- **There were mixed feelings about hostels in general…**
- **Somebody said: “I wouldn’t want to change my hostel, it’s the best I’ve been in” whereas another person said “they should be destroyed full stop”**

Birmingham Health and Wellbeing Board

	Agenda Item: 15
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30th July 2019**
TITLE:	**UPDATE ON BIRMINGHAM OLDER PEOPLE'S PARTNERSHIP PROGRAMME – EARLY INTERVENTION**
Organisation	**Birmingham Older People's Partnership**
Presenting Officer	**Andrew McKirgan**

Report Type:	**For HWBB Oversight**

1. Purpose:

1.1 The purpose of this paper is to update the Health and Wellbeing Board on the progress made within the Birmingham Older People's Partnership Programme.

1.2 For this quarter, the report concentrates on the Early Intervention work-stream as the testing phase draws to a conclusion and planning for roll out has begun.

1.3 Reporting to HWBB provides an opportunity for board members to provide challenge to the programme in terms of progress, impact and sustainability.

2. Implications:

BHWB Strategy Priorities	Health Inequalities	✓
	Childhood Obesity	
Joint Strategic Needs Assessment		
Joint Commissioning and Service Integration		✓
Maximising transfer of Public Health functions		
Financial		
Patient and Public Involvement		

Early Intervention	✓
Prevention	✓
Homelessness	

3.	**Recommendations**
3.1	The HWBB is requested to review the content of this report and the attached **Appendix 1** and to provide challenge as appropriate.

4.	**Background**
4.1	The HWBB has received reports on this programme previously which have outlined the partnership aims and objectives and the approach within each work-stream of the Birmingham Older People Programme. The HWBB has endorsed these plans and requested regular updates with further clarity sought about the engagement of citizens within the programme.
4.2	For this quarter a deep dive into the Early Intervention Programme is presented. This is attached as **Appendix 1** and summarised below.
4.3	The Early Intervention Programme is fundamentally a redesign of health and social care intermediate care services within the City to deliver a single integrated model. The programme is based on a previous diagnostic that identified significant opportunities to improve outcomes for citizens requiring this support and to deliver financial efficiency for the system.
4.4	The work stream is now in the phase of signing-off testing and developing plans for phased implementation. The development of components definitions, testing of components and how the components work together in localities has and is taking place. The sign-off of testing includes the scrutiny of metrics linked to system operational and financial performance via the Finance and Performance Delivery Group as well as redesigning operational systems and approaches with front line staff. Each of the five different components tested will have a 'manual' and sustainability matrices signed off via agreed governance routes.
4.5	The progress made in each test site is outlined in the deep dive document and have confirmed the opportunities identified in the diagnostic to both improve outcomes and deliver system efficiency.
4.6	The process of testing and subsequent discussions on planning for roll out have thrown up a number of sizeable challenges for the work stream and system partners. The most significant of these is in establishing the new

community team which requires resourcing by multiple system partners. The work required is complex, requiring long lead times and interdependent activities in order to secure the workforce including working with third parties.

4.7 In light of these requirements the current governance arrangements are being reviewed.

4.8 work-stream is pleased to note that Healthwatch have been engaged to support citizen and patient engagement working directly with individuals and their families receiving the component services and as a whole.

5. Discussion

5.1 The outputs of the testing phases have confirmed the opportunities in terms of both improved outcomes and financial efficiency for the system. However, they have also begun to identify the significant challenges for organisations that have to be overcome to deliver these opportunities. The approach to sharing of benefits and joint acceptance of risks is being worked through and these challenges for organisations within current individual governance requirements should not be underestimated.

5.2 The HWBB is asked to consider the support it can offer to organisations to enable these challenges to be overcome.

6. Future development

Testing of the new model has so far been confined to citizens from Edgbaston constituency who have accessed services at Queen Elizabeth Hospital. The next stages of the programme will see the implementation of the model on a phased basis across the city. This is scheduled to commence with an extension to include citizens from Northfield constituency. Throughout this process, learning will be applied to iterate the model as it is implemented in new locations and with new staff teams.

7. Compliance Issues

7.1 Strategy Implications

The report details progress against implementing the vision of the Birmingham Older People Programme.

7.2	***Homelessness Implications***
	Early intervention has highlighted current issues with the ability of the system to respond appropriately to some older people who experience housing issues, including homelessness. Typically, this is people who are medically ready to leave acute or sub-acute care but who are unable to return home for a variety of reasons. The programme has instigated work to develop better pathways for this cohort.
7.3	***Governance & Delivery***
	The Birmingham Older People Programme is governed through a multi-agency board comprising the health and social care partners who have committed to work together with the signing of a Memorandum of Understanding. The BOPP Board is accountable to both the Health and Well-being Board and the respective boards for Birmingham and Solihull and Sandwell and West Birmingham Sustainability Transformation Plans (STP).
7.4	***Management Responsibility***
	Graeme Betts, Director for Adult Social Care, is the Senior Responsible Officer for the Birmingham Older People's Programme.
7.5	***Diversity & Inclusion***
	The focus of the programme is older people within Birmingham. However, it is recognised that there is not a fixed age limit. Adults can experience frailty at any age and the new model will be responsive to condition rather than specific age.

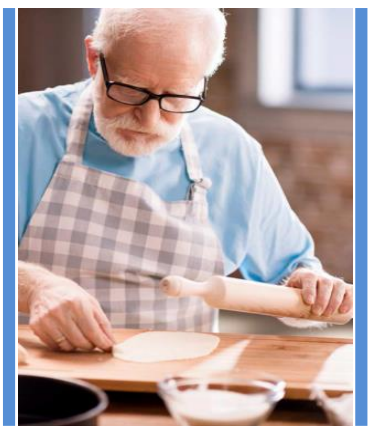
	Appendices
1.	'Making Birmingham a Great Place to Grow Old In' – Early Intervention Programme

Making Birmingham

a great place to grow old in.

The Early Intervention Programme.

Part of the Birmingham Older People's Programme.

Health & Wellbeing Board

Status as at 11 July 2019

Birmingham City Council

Live healthy Live happy Birmingham and Solihull

NHS

This is not about Health
and it's not about Social Care.

This is about people's lives.

Together with partners from across health and social care, we have committed to 'Making Birmingham a great place to grow old in'.

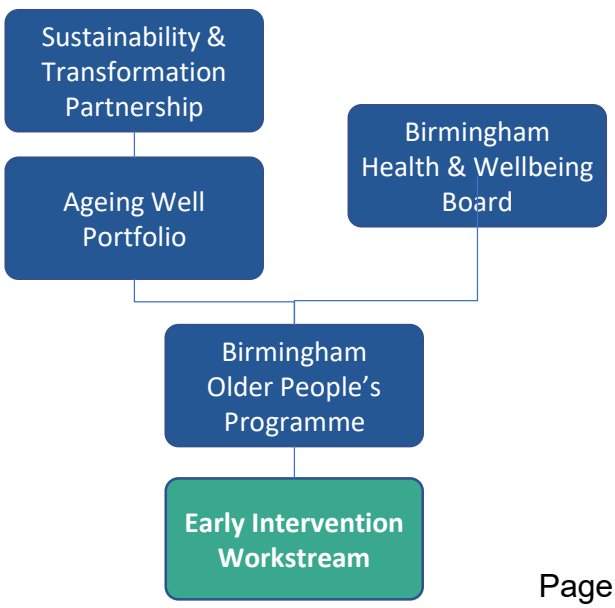
In doing so, we can help older people be happy and healthy, live self-sufficient, independent lives, with choice and control over what they do and what happens to them.

To deliver this we believe we need to design an integrated model of care that will deliver the right support, in the right place, at the right time. And once it's designed, make sure it delivers better outcomes for older people.

As part of this work, a team has been working on the delivery of a new early intervention model, that provides urgent assessment, treatment and care to older people; as well as a range of integrated services that promote recovery and independence.

This report provides an update on progress on how we designed the new integrated model of care, as well as how we tested the new model on the front-line and the results we achieved.

Andrew McKirgan
Senior Responsible Officer
Early Intervention Workstream
Birmingham Older People's Programme



You may be wondering how this work fits into other things that you might have heard of, like the Birmingham and Solihull Sustainability and Transformation Partnership (STP), and the Birmingham Health and Wellbeing board.

The Ageing Well Portfolio is one of the key priorities of the STP. Within the Ageing Well Portfolio, the Birmingham Older People's Programme is taking the lead in Birmingham.

The Birmingham Older People's Programme reports into both the STP and the Birmingham Health and Wellbeing Board.

Finally, the Early Intervention Workstream is one part of the Birmingham Older People's Programme.

MAKING BIRMINGHAM
A GREAT PLACE TO GROW OLD IN

You may have seen 'Phyllis', a production by the Women in Theatre group commissioned by the STP. The play focused on the experiences of Phyllis and her family when she was admitted to hospital. The production has been seen by hundreds of people across Birmingham and graphically underlined what needs to change to improve older people's experiences of health and social care. These are the issues we want to address.

We also knew in order to move forward we had to take on board the findings of the CQC system-wide report and an independent, detailed analysis of the root cause of our challenges completed by Newton.

Phyllis Photo credit: Stephen P. Burke

As a result of the findings, it became apparent that a **single system vision**, linked to the wider STP vision and strategy, was absent and we were letting down our older citizens like Phyllis. Both executive and operational leads agreed a joint vision was essential for all organisations to start moving forward together.

During 2018, we agreed an overarching vision for where we wanted to be in the future.

The vision of the Birmingham Older People's Programme is:

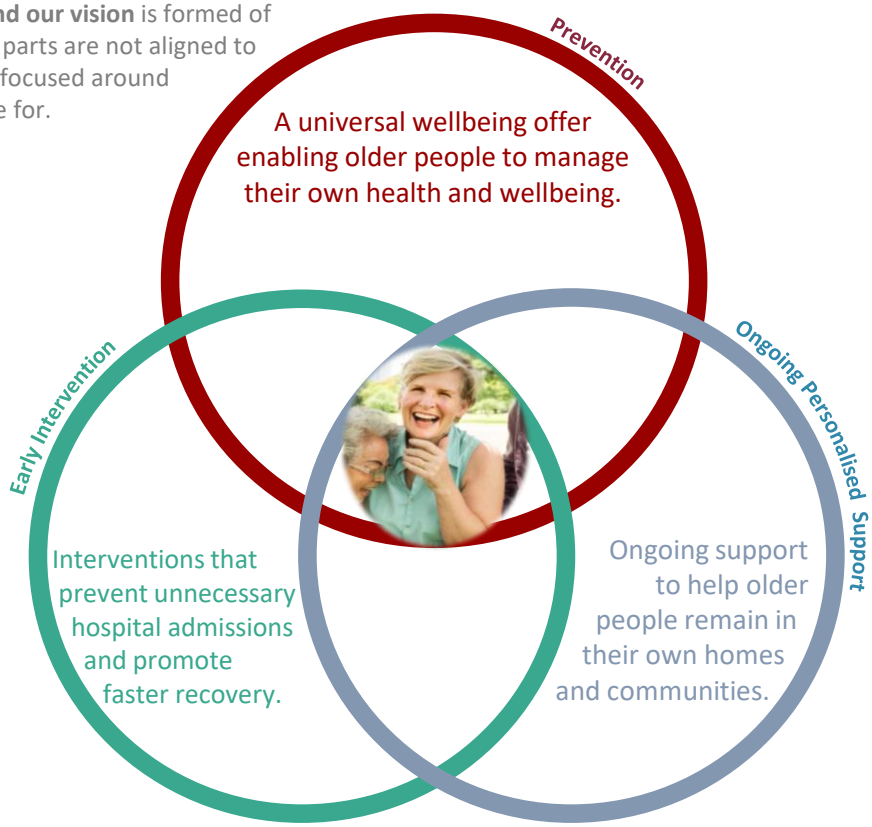
for older people to be as happy and healthy as possible, living self-sufficient, independent lives, able to have choice and control over what they do and what happens to them.

Getting to this point was itself an achievement given that historically we only ever worked inside our own organisations fixing things we could control, as opposed to working together across the system. It was clear that to achieve our ambitions would require us to think differently – **less about what our individual organisations do today that doesn't work and more about what older people need now and in the future.**

We have therefore committed to provide support that is **'joined-up'** across organisations so that older people do not experience duplication of services or delays in accessing support or fall between the gaps. We are open to new ways of doing things and we will make the most of the strengths of all our partner organisations from the public, private, voluntary and community sectors. There will be **no wrong door** throughout the system, avoiding people struggling and often failing to get the support, care and advice they need.

In order to give older people across Birmingham choice and control over what they do and what happens to them, we need to think of them as being at the **centre of everything we do**.

The strategy behind our vision is formed of three parts. These parts are not aligned to organisations, but focused around the people we care for.



PREVENTION	A universal wellbeing offer enabling older people to manage their own health and wellbeing, based in local communities and utilising local resources. It will address the issues that lead to older people entering into formal health and care systems, such as social isolation, falls and carer breakdown. Access to good quality information and advice will be the cornerstone of our wellbeing offer, enabling people to identify and access the support that they need in order to maintain living fulfilled lives.
EARLY INTERVENTION	A range of targeted interventions to promote faster recovery from illness or injury, prevent unnecessary hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living. We will respond quickly, minimise delays and not make decisions about long term care in a hospital setting.
PERSONALISED ONGOING SUPPORT	Some older people will need ongoing support to remain living in their own homes and communities. These services aim to maintain individual wellbeing and self-sufficiency, keep older people safe and enable them to be treated with dignity, stay connected to their communities and avoid unnecessary admissions to hospitals or care homes. We will change the way our services are commissioned and delivered to be more focused on achieving better outcomes for older people.

EARLY INTERVENTION **EXPLAINED**

Early Intervention is described in the green box on the previous page. The ultimate aim is to help people remain in their homes whenever possible. In most cases, this means older people are more comfortable and regain their independence more quickly if good quality therapeutic support is provided.

In 2017 Newton were commissioned to independently assess the health and social care services provided to older people before, during and following a crisis. Results highlighted areas going well and what could be done differently in order to:

- **Improve outcomes for those in need**
- **Improve the effectiveness of some services**
- **Improve the efficiency of service delivery**
- **Improve how organisations work together**
- **Deliver financial benefits**

In response, health and social care professionals worked together to identify a number of **principles**. These principles form a useful guide for understanding what it is and what it isn't:

- Our aim is to have one integrated model across our entire system.
- The person must be at the centre of everything we do (with family and carer input also valued).
- Our aim is to support their life not simply deliver a service.
- We need to make sure each person receives the right care, at the right time, in the right place, by the right professional, at the right cost.
- People should only have to tell their story as few times as possible.
- Staff across organisations work together to champion the 'home first' ethos.
- And the result of all these points - more people will live more independently in later life.

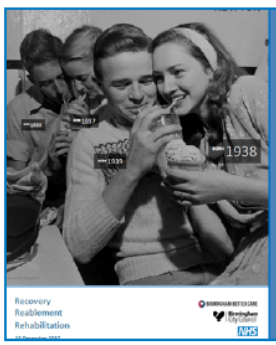
Working this way will mean:

- New relationships across the system.
- Removal of organisational boundaries.
- No wrong door for someone that needs help.
- Clearly defined roles to maximise skills and capacity.
- Efficient distribution of resources within a locality.
- Overall consistency accepting local variation where it makes sense.

The Early Intervention Programme will help us turn our vision into reality and ultimately achieve better outcomes for thousands of older people and at the same time deliver financial benefits for our system.

Early intervention will draw on the skills of a number of people working together. These are represented today in roles such as:

Consultant Geriatrician | CPN
Enablement Worker | Nurse
Occupational Therapist | Paramedic
Physiotherapist | Social Worker
GP | Specialist Nurse



The proportion of people we admit into hospital who could have been better looked after elsewhere. **23%**

The proportion of people in elderly care and longer stay wards who are medically fit but delayed, waiting to leave hospital. **51%**

The proportion of people who could benefit from a different pathway out of hospital, one better suited to their needs. **19%**

36% The proportion of people who could achieve greater independence, following a stay in a short-term bed, with our support.

37% The proportion of people currently with a long-term care package who could benefit from better enablement.

50% The proportion of people who's mental health reached crisis point (and went into hospital) that could have been avoided.

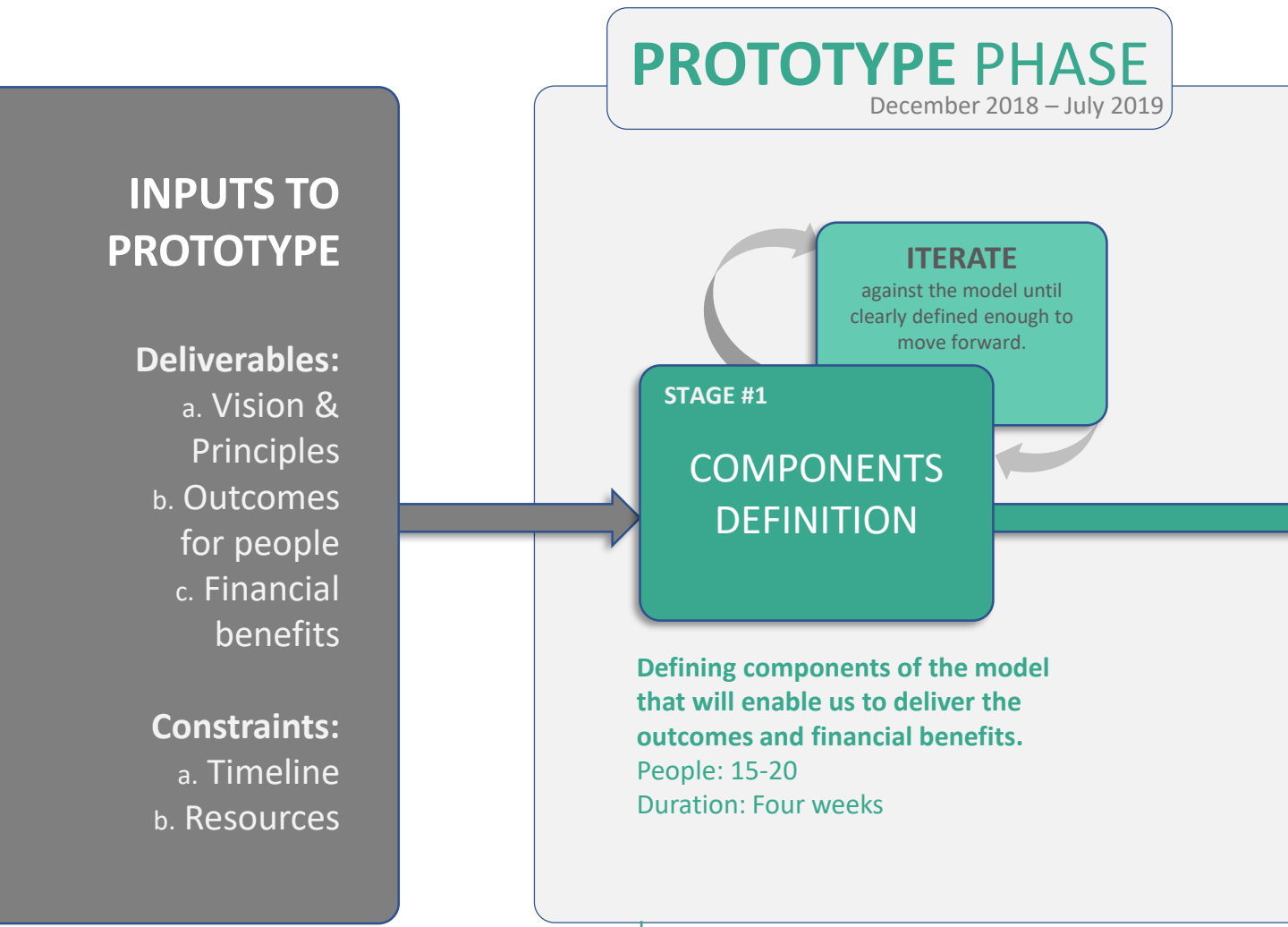
Six high-level headlines from the Newton work against which detailed analysis of root cause was provided.

HOW WE **GOT STARTED**

HOW DID WE **GET STARTED?**

During December 2018, 28 front-line staff and managers came together from all the organisations over three dates to work out the very first steps needed to move us closer to our ambition.

Working with Newton - specialists in large scale, front-line-led transformation - we started with a 'prototype' phase that splits our longer-term vision and ambition into more manageable chunks (or components – see stage 1 below), and in doing so allows us to thoroughly test and improve each bit separately (stage 2 below) before we then bring all the individual components together in one locality and test and improve how they work together until they are achieving everything we hoped they would. We knew if we could get this right it would make the roll-out of the changes much easier and more successful. We are currently at the very end of this prototype phase, with only a few weeks still to go.

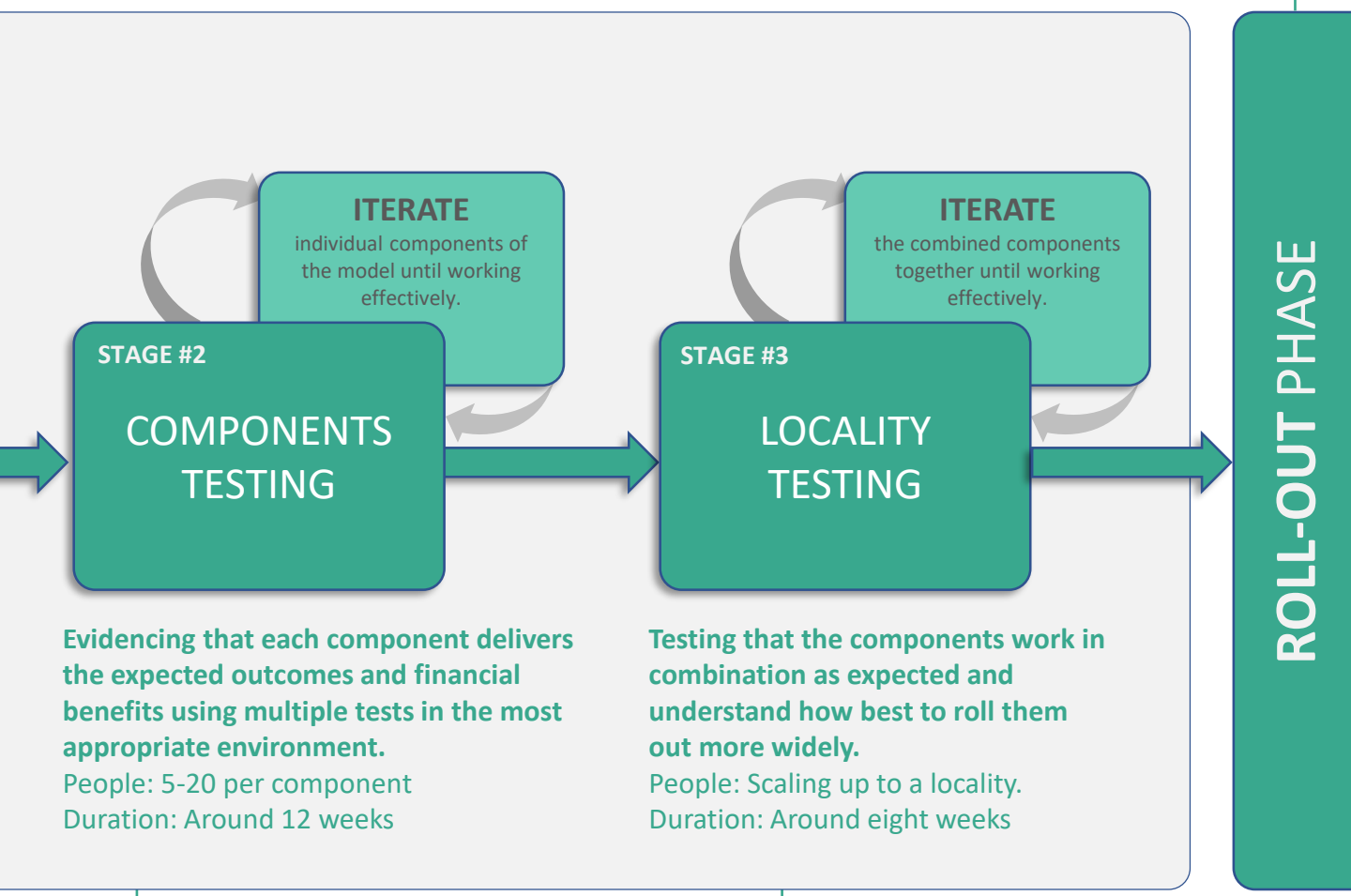


THE **COMPONENTS DEFINITION** STAGE

We've dropped into this document two outputs from this first stage. Firstly, a sample output from the group workshop agreeing what the experience needs to be like for the older person and the member of staff; and secondly, the output from the group discussion on which services should be included in the next stage – testing – along with who should participate and where each test site should be.

THE **ROLL-OUT** PHASE

This starts with planning a roll-out approach. What resources are required, what timelines are we working to, what is in and out of roll-out scope, and what does each organisation need to do separately, as well as collectively, to turn the results from the tests into results the whole city can benefit from.



Evidencing that each component delivers the expected outcomes and financial benefits using multiple tests in the most appropriate environment.
People: 5-20 per component
Duration: Around 12 weeks

Testing that the components work in combination as expected and understand how best to roll them out more widely.
People: Scaling up to a locality.
Duration: Around eight weeks

THE **COMPONENTS TESTING** STAGE

This stage helped us demonstrate exactly what operational changes impacted positively on outcomes, performance and cost for each component. By understanding this, we have been able to prioritise the ones with the biggest and best impact for citizens.

THE **LOCALITY TESTING** STAGE

Since May 2019 we have been testing how the separate components work together. For example: how OPAL or CDH can refer to the new community team; and how the intermediate beds are affected by different cohorts of older people moving through our system. **This is where we are today, with only a few weeks remaining before this work is completed.**

STAGE #1

COMPONENTS DEFINITION

This is a sample output from the group workshop agreeing what the experience needs to be like for the older person and the member of staff

How did teams from across Birmingham describe what services for older people should be like in the future?

The older **person in need** of some extra help should be able to say…

I'm in control and I feel safe.
I have my own plan, it's up-to-date, I know what's in it, it makes sense, I know what I need to do and how much I need to pay.
I can get the help I need - with things important to me - when I need it.
I feel listened to.
I know who to contact, they know me too - and we are honest with one another.
When I need some extra help, I am not overwhelmed by lots of different people coming and going.
The help I get fits around me - regardless of where I live - not the other way around.
It feels like my local community is there for me and there are things going on that can help me.
I am the one who's responsible for planning ahead for my own future.

The **member of staff** providing the help should be able to say…

There's one plan, it tells the person's story, it works for everyone and it's continuous.
I'm using my training and professional judgement, I'm capable and competent.
When I make decisions I feel confident and supported and I get feedback.
I know what options are available, they are relatively simple to follow and when new options become available I am effectively informed.
It's straightforward to join up with peers from different services when we need to and when I work with them we are honest with each other, we listen to each other, we trust one another.
The way I am measured is meaningful - aligned to outcomes.
I have access to forward-thinking services. The way we're set up means it's easy to work with local services.
I feel safe - through joint working or through feeling connected to the rest of my team.

STAGE #1

COMPONENTS DEFINITION

This is a summary of the output from the group, agreeing which services should be included in testing, along with who should participate and where each test site should be.

- Testing is a true partnership effort: team members, sponsors and practitioners have come together from across Birmingham

Team	Test Site	What's happening?	Who's involved?

Early Intervention Community Team	Edgbaston	A brand new team providing active health & therapy recovery services at home – supporting Older People to live independently and happily in their own homes.	• Multidisciplinary teams of practitioners from all agencies
			  • Therapy
			  • Nursing
			  • Social Work
			  • Operations
			  • Clinical
			• A new, specially trained team of cross-system improvement managers
			• Senior representatives from all partners in the Birmingham system
			• Operational and financial sponsors for each programme at director level
			• Finance managers
			• Informatics and data teams
			• Estates and services
			• Primary care engagement through three recently appointed GPs
			• Healthwatch for a public perspective

Acute Front Door	QEH – Older Person's Assessment & Liaison Team	An enhanced and expanded Older Person's clinical team at the Front Door of our hospitals, providing specialist care quickly, reducing hospital admissions, and ensuring we care for Older People in the most ideal setting for their recovery.	
Acute Back Door	QEH – Complex Discharge Hub for Edgbaston	A multidisciplinary team responsible for the appropriate and timely discharge of Older People with ongoing complex care needs. Ensuring we make the best decision for each person, prioritising active recovery and getting people home.	
Early Intervention Beds	Norman Power Care Centre	A therapy-led trial to standardise and simplify bed-based recovery for Older People across Birmingham. Bringing together a multidisciplinary team to promote more independent outcomes and minimise the time before an Older Person gets home.	
Acute Mental Health	Juniper Centre	Bringing together clinical, nursing, therapy and social work practitioners in our Acute Mental Health wards, to minimise every Older Person's stay and get them home.	

WHO'S **INVOLVED?**

Various groups of people have been carefully selected to get involved so that all organisations are represented, but the way we make progress is always together:

The **Chief Executives** of our organisations, who signed off the programme, are actively involved in helping to unblock some of the thorny challenges that make it difficult for us to work effectively across the system.

The **Citizen Representatives** who will be working throughout the programme to ensure service user experience is improved through co-production.

Three **GPs** applied to get involved in the programme and are provided support, challenge and feedback to the group.

The **Early Intervention Steering Group**, where we have executive leads for each organisation. The Early Intervention Steering Group are the ones who have been shaping the vision and setting up the programme so far:

- Birmingham City Council – Louise Collett, Pauline Mugridge, Mike Walsh
- Birmingham Community Healthcare NHS Foundation Trust- Chris Holt & Angie Wallace
- Birmingham & Solihull Mental Health Foundation Trust- Derek Tobin
- Birmingham & Solihull Clinical Commissioning Group - Karen Helliwell/Helen Kelly
- University Hospitals Birmingham NHS Foundation Trust - Andrew McKirgan
- University Hospitals Birmingham NHS Foundation Trust, Heartlands & Good Hope sites - Andrew Clements
- Programme lead - Judith Davis
- STP Special Adviser Older People - Professor Zoe Wyrko

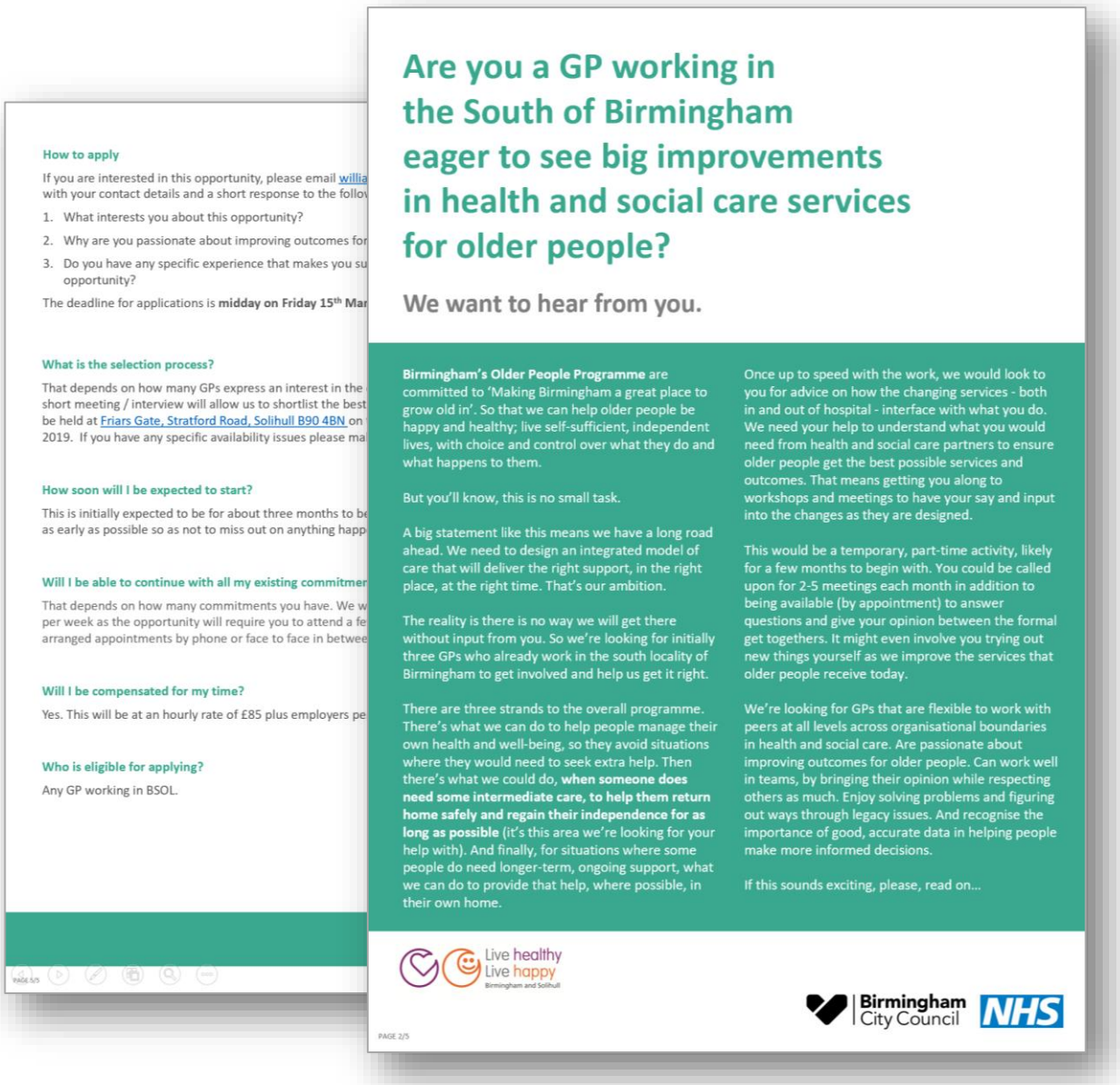
The **Finance Group**, who will help ensure the programme measures the right things and keeps on top of its performance and financial measures is chaired by Phil Johns, Deputy CEO, BSol CCG and has participants from every organisation.

The **Improvement Managers**
Eight dedicated 'Improvement Managers' have been recruited from across the system to support this programme. These eight individuals have been selected for their passion for improving outcomes for older people, their ability to work across the organisational boundaries, and their ability to solve problems and embrace change. They will be working full time as part of the Early Intervention team for the next year.

PROGRAMME SUPPORT FROM **PRIMARY CARE**

An invitation to participate in the programme was advertised and – following a selection process – three GP's were appointed to act in an advisory capacity to the programme:

Roger Gent – Coutts & Partners
Layla Eagles – Lordswood House Group Medical Practice
Rory Meade – Harborne Medical Practice



How to apply

If you are interested in this opportunity, please email willia
with your contact details and a short response to the follo

1. What interests you about this opportunity?
2. Why are you passionate about improving outcomes for
3. Do you have any specific experience that makes you su
opportunity?

The deadline for applications is **midday on Friday 15th Mar**

What is the selection process?

That depends on how many GPs express an interest in the
short meeting / interview will allow us to shortlist the best
be held at Friars Gate, Stratford Road, Solihull B90 4BN on
2019. If you have any specific availability issues please ma

How soon will I be expected to start?

This is initially expected to be for about three months to b
as early as possible so as not to miss out on anything happ

Will I be able to continue with all my existing commitmer

That depends on how many commitments you have. We w
per week as the opportunity will require you to attend a fe
arranged appointments by phone or face to face in betwee

Will I be compensated for my time?

Yes. This will be at an hourly rate of £85 plus employers pe

Who is eligible for applying?

Any GP working in BSOL.

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Are you a GP working in the South of Birmingham eager to see big improvements in health and social care services for older people?

We want to hear from you.

Birmingham's Older People Programme are committed to 'Making Birmingham a great place to grow old in'. So that we can help older people be happy and healthy; live self-sufficient, independent lives, with choice and control over what they do and what happens to them.

But you'll know, this is no small task.

A big statement like this means we have a long road ahead. We need to design an integrated model of care that will deliver the right support, in the right place, at the right time. That's our ambition.

The reality is there is no way we will get there without input from you. So we're looking for initially three GPs who already work in the south locality of Birmingham to get involved and help us get it right.

There are three strands to the overall programme. There's what we can do to help people manage their own health and well-being, so they avoid situations where they would need to seek extra help. Then there's what we could do, **when someone does need some intermediate care, to help them return home safely and regain their independence for as long as possible** (it's this area we're looking for your help with). And finally, for situations where some people do need longer-term, ongoing support, what we can do to provide that help, where possible, in their own home.

Once up to speed with the work, we would look to you for advice on how the changing services - both in and out of hospital - interface with what you do. We need your help to understand what you would need from health and social care partners to ensure older people get the best possible services and outcomes. That means getting you along to workshops and meetings to have your say and input into the changes as they are designed.

This would be a temporary, part-time activity, likely for a few months to begin with. You could be called upon for 2-5 meetings each month in addition to being available (by appointment) to answer questions and give your opinion between the formal get togethers. It might even involve you trying out new things yourself as we improve the services that older people receive today.

We're looking for GPs that are flexible to work with peers at all levels across organisational boundaries in health and social care. Are passionate about improving outcomes for older people. Can work well in teams, by bringing their opinion while respecting others as much. Enjoy solving problems and figuring out ways through legacy issues. And recognise the importance of good, accurate data in helping people make more informed decisions.

If this sounds exciting, please, read on...

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Birmingham and Solihull

Birmingham City Council NHS

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PROTOTYPE PHASE:

TESTING RESULTS

TEST AREA #1
HOSPITAL FRONT DOOR

All figures correct as at 9 July 2019

CONTEXT:
The work here is all about helping older people as they enter the hospital to get the support they need ideally back in their own home, thereby reducing the number of people that end up in a ward.

The Older Person's Assessment & Liaison service (OPAL) at the QE was chosen as the test site. Before changes were put in place, OPAL were already getting **6.6 people home every day**. That's around 2,400 a year.

RESULTS:
By changing the data captured; improving the quality and access to that new data; improving the actions that are taken by the team using the new data; optimising the mix of skills in the department; and giving the team access to the new community team (test area #3) – **OPAL now get 9.3 people home every day**. That's around 1,000 more people every year.

Right now, the single biggest blocker for OPAL not being able to get even more people straight home is related to IV – both antibiotics and fluids. Having improved access to these would allow OPAL to get an **extra two people home every day** – 730 a year.

However, more could be achieved. OPAL are not seeing everyone they could see right now because there aren't enough people in their team. A study at the QE front door revealed there are between **1,000 and 1,500 more older people** that could benefit from OPAL's input if they had the staff to see them – the shortages are broadly found in Nursing, Therapists and Geriatricians.

To support the case to invest in OPAL another study at QE was conducted to evaluate how 'effective' OPAL is at stopping people being admitted into hospital. The results were clear – as an older person, if you see OPAL **you have a 70% chance of going straight home.** If OPAL don't see you, you have a 52% chance of being admitted onto a ward.

COMING NEXT:
Meetings with teams at Good Hope and Heartlands hospitals are underway / being scheduled to first understand similarities / differences in operating models. Once established, it will be clear to what extent all the hospitals can benefit from the changes and successful results tested in QE.

Queen Elizabeth Hospital OPAL department was chosen as the test site.

TEST AREA #2
HOSPITAL BACK DOOR

All figures correct as at 9 July 2019

CONTEXT:
The work here is looking to speed up the time it takes to get older people out of the hospital. And, when we get them out, we get them to a place that is best suited to their situation because right now we often provide them with care in excess of their actual needs.

The QE 'Complex Discharge Hub' was chosen as the test site. Before changes were put in place, the average time it would take to get a person out of hospital once they were declared medically fit was **12 days**.

RESULTS:
By changing the data captured; improving the quality and access to the new data; improving the actions taken by the team using the new data; improving how the social workers and nurses work together; and giving the team access to the new community team (test area #3), the 12 days has reduced down to **nine days**.

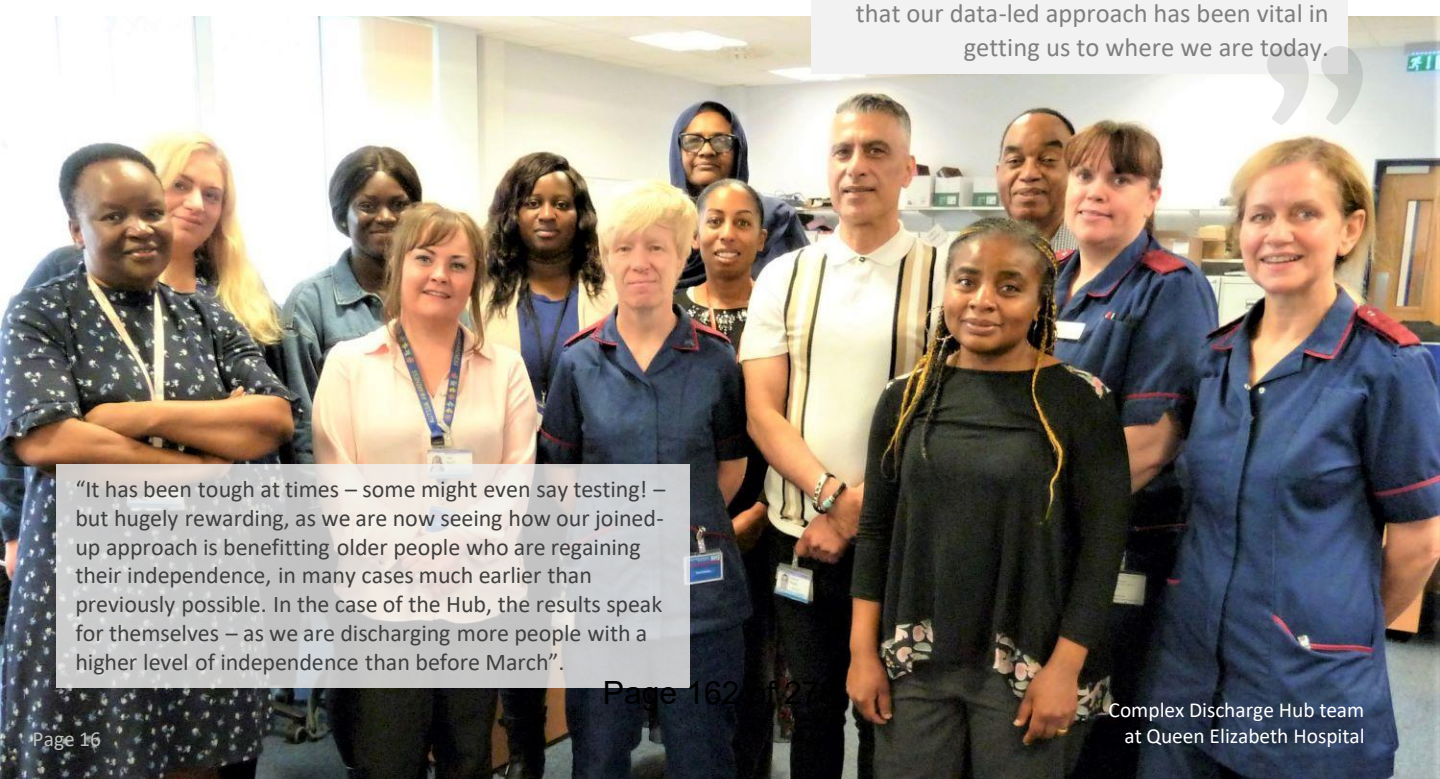
This reduction is benefitting the hospital, the equivalent of **6,500 bed days being freed up** per year that can be put to better use.

Within the Edgbaston constituency (test site area) every week we used to discharge two or three older people directly into long term care settings such as residential or nursing homes. Since the changes were made, **only one person has gone into long term care** in the last three months. That means in Edgbaston alone, the testing has shown that more than 130 people every year will end up back home as opposed to in a long term placement.

More broadly, people going from the hospital directly into **long term placements have reduced** significantly.

COMING NEXT:
Meetings with colleagues at Good Hope, Heartlands and City hospital are underway / being scheduled to first understand similarities / differences in operating models. Once established, it will be clear to what extent all the hospitals can benefit from the changes and successful results tested in QE.

> We have had to change the way we work since we began testing in March, as we shape services for the future. And I am convinced that our data-led approach has been vital in getting us to where we are today.



"It has been tough at times – some might even say testing! – but hugely rewarding, as we are now seeing how our joined-up approach is benefitting older people who are regaining their independence, in many cases much earlier than previously possible. In the case of the Hub, the results speak for themselves – as we are discharging more people with a higher level of independence than before March".

Complex Discharge Hub team at Queen Elizabeth Hospital

TEST AREA #3
NEW COMMUNITY TEAM

All figures correct as at 9 July 2019

CONTEXT:
The work here was to bring the expertise currently found in services such as BCHC's Rapid Response alongside other services that, together, would provide the right care in people's homes that helps them regain their independence and stay at home for longer.

The test team of around 15 staff pulled together from BCC, BCHC and UHB have now seen over 65 people since it started on 26 March 2019.

RESULTS:
Around half the people that have been referred to the new community team are now discharged from the service. **76% of the people that remained in their own homes are now enjoying full independence** with no reliance on either health or social care services.

There are people on the service that have not been able to remain in their own homes and have been admitted back into a hospital. This is currently **averaging out at 19%** of all referrals. This is being closely examined by the team to understand what can be done that is both inside and outside of their direct control to reduce this number.

Everyone that is discharged from the service is offered a feedback card –**100% of family or carers said they would be happy to recommend** the service.

The KPIs are reporting positive results already, with the combined team achieving an average **reduction of two care calls per day per person** – performance beyond early expectations. Work is underway in the team to continue to achieve these results in less time – currently the average time for a person being with the service is **30 days** and ideally we would like to see this reduced to around 18 days.

These results are also producing some **inspiring stories from citizens** which obviously help to remind the team why we're doing this and one of the few things that we can all definitely agree on.

A story of difference: Sara

After suffering a fall, Sara was referred to the new community team by OPAL to improve her transfer and mobility outside, which was affecting her social life.

Initially Sara received daily personal care visits. After nine days she needed two weekly visits only, to help with her wash.

Now, in addition to the decreased care needed, Sara can independently get the ring-and-ride bus to attend day centres.

A story of difference: Paul

Paul was fully independent before his lengthy hospital stay due to pneumonia. When he was referred from the Complex Discharge Hub, he was anxious, had poor mobility, poor balance and reduced stamina.

Paul started the service on two calls a day, but through hard work we were able to facilitate his complete independence. Now Paul is much more confident, requires no walking aids in his home and is able to walk to the shops to buy his daily newspaper – with one walking stick – and has resumed his previous social life.

Patient names have been changed.

Colleagues from UHB, BCHC and BCC come together to form a new 'community team'.

HOW THE NEW COMMUNITY TEAM IS MAKING A POSITIVE IMPACT ON **PEOPLE'S LIVES**

Initial fall and admission	After suffering **multiple falls** due to a weakness, David was admitted into the QE hospital. After a stay in hospital he was referred into the new community team from the Complex Discharge Hub.
Came out of hospital requiring physio	David already had a pre-existing, private package of care in place, but needed help to regain his confidence and ability mobilising after his most recent fall and hospital admission.
Early Intervention Community Team	David was seen by a physiotherapist from the new community team **four times in nine days**, following a plan of action designed to get him back to his old self.
Increased independence and confidence	David now has **increased independence mobilising**, and has **regained confidence,** returning to his level of independence prior to admission.
Return to pre-admission needs	Even better, this care will help to break David's pattern of falls and is important to enable him to safely complete his weekly trip to dialysis.

Patient names have been changed.

TEST AREA #4
INTERMEDIATE BEDS

All figures correct as at 9 July 2019

CONTEXT:
The work here was to increase the number of discharges from the beds to settings more aligned with the needs of the person. And at the same time, decrease the length of time people stay in an intermediate bed.

The test site chosen to participate in the trials was Norman Power where there are 32 beds. Before any changes were tested the team at Norman Power were managing to get 28% of people home, whilst the average length of stay for a person was 36 days.

RESULTS:
Changes have been made in a number of areas: introducing specific, measurable and timely 'therapy goal setting'; a regular team meeting attended by an MDT aimed at tracking and progressing towards the ideal outcome for everyone; ensuring the person and their carer / family, have a say in what's happening and their expectations are managed.

These changes have brought about an increase in the number of **people going home from 28% up to 45%,** against a target of 38%.

During the testing period, the complexity levels of people entering Norman Power has increased which on the one hand makes the increase in people going home all the more significant, however it also means that the length of stay for people in Norman Power has not gone down – it has actually gone **up from 36 days to 49 days**. On the plus side, these are people who would have previously gone into long term care settings such as residential / nursing homes.

COMING NEXT:
Work is underway to further reduce the length of stay. Areas of opportunity include social worker assessments.

The existing team also carry out duties that are not related to completing the assessments – such as 'community reviews' (which it was agreed needed to remain with them); liaising with other colleagues to chase brokerage, housing, care homes; and general administration.

The group is therefore looking into what can be done to address these points and potentially free the social workers up to focus on their critical tasks.

And finally, the group is looking at whether some people need a social work assessment in the first place.

Evidence from this investigation is showing that people who are taken through a 'therapy led' route out of their bed and into the new community team (test area #3) versus a social care assessment and onto a package of care at home route, spend on average **23 fewer days in Norman Power.**

The team in Norman Power looking after 32 intermediate care beds for older people.

TEST AREA #5
ACUTE MENTAL HEALTH

All figures correct for the period March to June 2019.

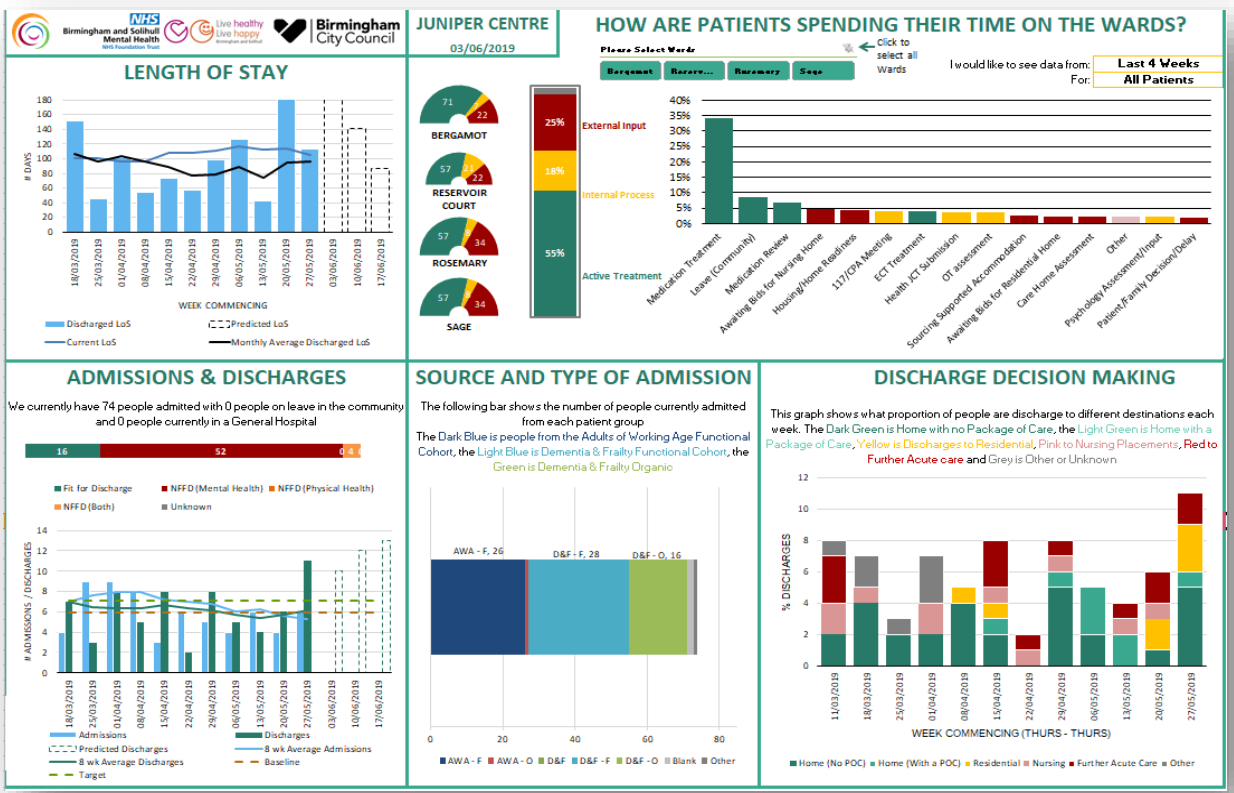
CONTEXT:
The work here was to reduce the amount of time people were staying in the hospital as a result of unnecessary delays to getting them healthier or getting them home. To do this, the team were looking to increase the number of people discharged every day which, before the changes were introduced, averaged at six people per day.

The test team were in the Juniper Centre, Moseley Hall Hospital.

RESULTS:
Changes were introduced including: a new social worker process which reduced the number of people delayed, waiting for social worker input, **from 14% to just 2%**; new data, tracking and reporting on referrals, allocations, timescales and activities – with a focus on having a clear next step for every person on the wards (increasing the proportion of people waiting for 'active treatment' **from 30% up to 58%**); and capacity of the team increased by 0.8 FTE.

These changes combined to increase the number of people being discharged every day **from six up to six point five.** The equivalent to **every person spending nine fewer days in hospital**. These performance figures are above what was anticipated.

COMING NEXT:
The team at Juniper remain above target and continue to work together to keep the new ways of working and reporting in place and running effectively.



A screengrab of the new data, reporting, tracking tool at Juniper that was instrumental in driving up active treatment and daily discharges.

PERFORMANCE MEASURES
& BENEFITS

PROGRAMME PERFORMANCE & BENEFITS

Figures correct as at 17.May.2019

The programme aims to make significant, measurable improvements to the care older people receive. To achieve this our system needs to make changes to existing services as well as set up new services, such that:

Approximately 5,000 more older people receive a more 'ideal service' than hospital admission per year (such as care in the community).

The 5,500 older people discharged per year in Birmingham with complex needs receive a measurably more independent package of ongoing care.

By improving discharge pathways and focusing on reducing delays, these complex patients also stay in hospital for, on average, ~four fewer days.

By ensuring more independent outcomes and reducing delays in transfer of care, the need for non-acute bed-based care in Birmingham is reduced by ~25%.

The length of stay for our Mental Health patients is reduced by ~10%.

We create a city-wide, joint health and social community service capable of seeing ~6,000 people per year and supporting them towards independence. We develop this joint health and social care service such that it has measurably improved outcomes relative to existing services.

Birmingham City Council, partner NHS organisations and Newton – supported by the Finance and Performance Delivery Group (FPDG) have calculated that by making the above improvements, financial benefits of between **£27.5m - £37.5m** per year are achievable – as a result of improved and more independent outcomes for thousands of older people across Birmingham every year.

The FPDG, chaired by Phil Johns, Deputy CEO at BSol CGG with carefully selected representatives from all partner agencies are responsible for helping guide system partners through challenging financial decisions on the programme as well as ultimately how the system benefits are calculated and released.

Enhancing the future of health and social care services for older people in Birmingham.

For more information:
Contact the EI Steering Group Lead for your organisation.
Visit the STP website: https://www.livehealthylivehappy.org.uk/
Look for Early Intervention newsletters and information in your organisation's communications channels.

Let's get you **healthier**.
Let's get you **home**.

Version: HWB Final

Early Intervention Workstream, part of the Birmingham Older People's Programme.

Birmingham City Council

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Birmingham and Solihull

NHS

Birmingham Health and Wellbeing Board

	Agenda Item: 16
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30th July 2019**
TITLE:	**HOMELESSNESS AND HEALTH DELIVERY PLANS**
Organisation	**Birmingham City Council and Partners**
Presenting Officer	**Councillor Thompson and Kalvinder Kohli**

Report Type:	**For information and Decision**

1. Purpose:	
1.1	To provide the Board with an update on the Homelessness Prevention Strategy 2017 and progress one year on.
1.2	To hear from key partners in terms of their contributions to this agenda.
1.3	To advise the Board of a key area of focus for year two priorities which include a focus upon Homelessness and Health.

2. Implications:		
BHWB Strategy Priorities	Health Inequalities	✓
	Childhood Obesity	
Joint Strategic Needs Assessment		
Joint Commissioning and Service Integration		✓
Maximising transfer of Public Health functions		✓
Financial		
Patient and Public Involvement		
Early Intervention		✓
Prevention		✓
Homelessness		✓

3.	Recommendations
3.1	The Board is asked to:
3.1.1	Note the year one progress of the delivery of the Homelessness Prevention Strategy 2017+ (HPS).
3.1.2	Agree to retain specific oversight of the implementation of the homelessness and health action plan and provide a critical friend role to understand what difference this is making to the lives of people affected by homelessness.
3.1.3	Agree to provide their organisational leadership and commitment to support the successful delivery of both the overall strategy and the proposed Homelessness and Health Delivery Plans.

4. Background

4.1 The impacts of homelessness are complex and intertwined which means that no one agency can respond to this issue alone. Agencies see homelessness through different lenses which means that a systemic approach is essential to:

- Prevent people from becoming homeless in the first place
- Assist people quickly if and when they do become homeless
- Ensure recovery is resilience based in order to avoid repeat homelessness

4.2 Homelessness Prevention Strategy 2017+ One Year one

4.2.1 The current Homelessness Prevention Strategy (HPS) was launched June 2018 (**Appendix 1)** Local authorities have a statutory duty to undertake a homelessness needs assessment of their local area and prepare Homelessness Prevention Strategies in order to address need in their area. In August 2018 government launched its National Rough Sleeper Strategy setting out its ambition for 2027 where no one has to sleep rough. A further requirement is placed upon local authorities to repurpose their HPS to include specific plans to tackle rough sleeping.

4.2.2 The HPS is a partner strategy, the delivery of which is overseen and supported by the Homelessness Partnership Board. The Board is facilitated by BCC Adult Social Care Commissioning in order to ensure governance reporting via the Health and Wellbeing Board and the Community Safety

Partnership.

4.2.3 Year one progress is attached as a background document (**Appendix 2**). The focus of the first year of the strategy was to develop an excellence model for the pathway. The aim of which, is to shape future commissioning activity and service delivery of organisations to operate individually and collectively to deliver the systems change required. Parallel to this work was specific areas of focused activity relating to a commitment to collaborate which moves agencies beyond the minimum duty to refer under the Homelessness Reduction Act 2017, into a space of more up-stream preventative activity for a boarder range of partners.

4.2.4 The proposed Year two priorities are currently being worked up into delivery plans and due to be agreed by the Homelessness Partnership Board in the Autumn. These priorities include:

- A continuation of the commitment to collaborate
- Specific delivery plans for key cohorts of population at risk of homelessness; young people leaving care, people leaving prisons, rough sleeper.
- Quality assurance for the exempt accommodation sector
- Homelessness and health.

4.2.5 Year two will also include encouraging cultural change in order to support the ambitions set out in the sister strategy to the HPS, the Domestic Abuse Prevention strategy 2018+ to change attitudes.

4.3 Health Inequalities

4.3.1 There is an increasing recognition that nationally the focus on homelessness has been overly housing focused with an emphasis for accessing suitable housing and maintaining financial sustainable tenancies and not enough focus on addressing the underlying causes of people's experiences which include the complexity of health needs including adverse childhood experiences **(Appendix 3 Public Health Presentation)**.

4.3.2 These health inequalities span beyond the very visible signs of street homelessness. The Birmingham Homelessness Prevention Strategy identified circa 20,000 households annually that fall into the broad definitions of homelessness to including those in precarious housing circumstances and temporary accommodations.

4.3.3 There are key cohorts of population that are at greater risk of becoming homeless. These include people leaving institutional settings, victims of

domestic or sexual abuse and households on low incomes. These vulnerabilities may be further exacerbated by multiple health conditions and use of substances.

4.3.4 Unsuitable or unaffordable housing can also affect health and wellbeing, for example properties in a state of disrepair including damp and mould or households affected by fuel poverty leading to respiratory problems and exacerbation of other health conditions.

4.3.5 National rough sleeping data identifies people with no recourse to public funds as 50% of the rough sleeping population.

4.4 National Responses

- The NHS Long Term Plan (2018) positively references the need to address the health needs of the homelessness populations.
- Public Health England (PHE) have produced a Homelessness and Health Toolkit for Practitioners.
- There is a focus from the Local Government Association and Association of Directors for Adult Social Services (ADSS) to explore the impacts of homelessness, safeguarding and Safeguarding Adult Reviews.
- Central Government Departments have also appointed Homelessness and Health Advisors which include a specific focus on young people leaving care.
- Central Government funding for Rough Sleeper Initiatives, Rapid Rehousing and Housing First include funding for health and social care interventions.
- Dedicated longer term funds are in the process of being agreed by NHS England (NHSE) for five local authority areas which related to homelessness and Mental Health.
- Public Health England have recently put out a funding call for homelessness and mental health.

4.5 A Local Response

The infra structure to provide a key focus on the homelessness and agenda is starting to evolve. Areas of recent activity within the City are set out below:

- The Birmingham and Solihull Sustainability and Transformation Partnership (STP) Population Health Management data project will

focus upon homelessness and health. A project team consisting of BCC, BSOL CCG and external partner agencies is being brought together. This is a 12 week project, which will include a focus on how we embed a sustainable systems change.

- As part of the governments National Rough Sleeper Strategy (2018) delivery Birmingham has been the recipient of targeted funds relating to Housing First and the Rough Sleeper Initiatives which has provided much needed additional support and accommodation into the city. This include small levels of funding for prescribing nurses, mental health outreach substance misuse support and an Adult Social Care Social Worker post. Whilst this is welcomed additional funds for the City, these are short term funds and therefore limited in terms of their sustainable impacts.

- Homelessness and health action plans for primary care and mental health have been produced by health colleagues following two round table discussions facilitated by Cllr Hamilton and Cllr Thompson **(Appendices 4 and 5**).

- The local authority's Adult Social Care Directorate are creating a vulnerable adult's team which will include dedicated support for people that are either at risk of homelessness or rough sleeping.

- Adult Social Care Commissioning is currently under way, commissioning using the positive pathway approach set out within the Homelessness Prevention Strategy. This includes a range of housing and wellbeing support services focused upon universal and targeted prevention, crisis support and recovery.

- Funding has been secured for a strategic post and project management support to work across health, social care and housing.

- Birmingham is being represented at the annual conferences and events for ADASS and LGA which this year includes a focus upon homelessness, health and safeguarding.

- The West Midlands Combined Authority is leading Homelessness and Health round tables for the region. This will include an opportunity for Birmingham to present at the WMCA Inclusive Growth annual conference in September.

- Birmingham City Council Adult Social Care has been invited to form part of a national expert reference group on safeguarding and homelessness

deaths.

- MHCLG have provided expert advisors to work with Birmingham specifically on this agenda. A key role for the advisors would be to provide some critical friend challenge to our proposed homelessness and health actions and also some observation and recommendations to re-modelling reviews planned for existing services.

- BSOL CCG is awaiting confirmation of additional funds to address health and mental health NHSE. The NHSE resources would be over period of 5 years.

- Some Rough Sleeper Initiatives funds will be used to support some cultural change activity for community and faith groups to raise awareness of self - neglect and promoting charitable aims in a preventative way.

5.	**Discussion**

A range of information items from NHSE have been included as information items to inform discussion and commitments moving forward.

- Homelessness and Health Draft Delivery Plan Primary care **(Appendix 4)**

- Homelessness and Health Draft Delivery Plan Birmingham and Solihull Clinical Commissioning Group and Sandwell and West Birmingham CCG **(Appendix 5)**

- Homeless Health Exchange **(Appendix 6)**

7.	**Compliance Issues**
7.1	***Strategy Implications***
7.2	***Homelessness Implications***

HWBB support to ensure the effective implementation of the strategy and homelessness and health action plan is critical to addressing the health Inequalities of people experiencing homelessness.

7.3	***Governance & Delivery***
	HWBB has governance oversight of the delivery of the Homelessness Prevention Strategy.
7.4	***Management Responsibility***
	Management responsibility for the homelessness and health action plan will sit with the key lead health partners and adult social care.
7.5	***Diversity & Inclusion***
	The actions in this report aim to address the health inequalities for citizens that are vulnerable due to their homelessness circumstances.

	Appendices
1.	Homelessness Prevention Strategy 2017+
2.	Birmingham Homelessness Prevention Strategy: One Year On
3.	Presentation: Homelessness and Health: Data and Evidence
4.	Homelessness and Health Draft Delivery Plan Primary Care
5.	Homelessness and Health Draft Delivery Plan Birmingham and Solihull Clinical Commissioning Group and Sandwell and West Birmingham CCG
6.	Homeless Health Exchange
7.	Support Provided for People who are Homeless – Birmingham Community Healthcare NHS Foundation Trust

BIRMINGHAM

Homelessness Prevention Strategy 2017+

Working together to end homelessness

Making a positive difference everyday to people's lives

Birmingham City Council

Contents

Foreword

Welcome to Birmingham's fourth Homelessness Strategy. We would like to thank partners from across the Health, Criminal Justice, Housing, Voluntary and Third Sectors, who have contributed to its development and are committed to its success.

Responding to the social and economic causes associated with homelessness, requires a Council-wide effort that supports citizens to be more resilient to its impacts. To make this a reality, alignment of investment in housing, jobs, skills and safer communities is a fundamental part of our longer term response to the issue.

This strategy recognises homelessness is a cross cutting issue which cannot be tackled by one agency alone. The negative impact that homelessness has upon the health and wellbeing of our citizens is well understood. For these reasons, it remains as a key priority for the Birmingham Health and Wellbeing Board, as well the Council.

Birmingham has a strong history of working together in partnership to tackle homelessness. Despite this the scale and extent of homelessness has remained persistent - too many families who are homeless and / or living in temporary accommodation. Collectively we also face challenges such as pressure on budgets in all sectors and changes to the welfare system. A radically different approach that drives whole system change is now necessary.

Our new strategy focuses on preventing people from becoming homeless in the first place and supporting those who are homeless to build a more positive future in good health, sustainable accommodation and long lasting employment.

In collaboration with local authorities across the West Midlands Combined Authority, the West Midlands Mayoral Taskforce, and our key partners, we will work together to eradicate homelessness from our city. The task ahead will be challenging as we respond to the diversity of presenting needs of homeless people in the city. This includes implementing the Homelessness Reduction Act 2017, which brings with it new opportunities to work together to design out homelessness.

We are confident that together with our experienced and innovative partners, in collaboration with people who have lived experience of homelessness, we can make a significant impact on homelessness. We look forward to working together to drive the systemic change required to deliver this strategy and achieve our collective vision for Birmingham.

Councillor Ian Ward	Leader
Councillor Brigid Jones	Deputy Leader
Councillor Peter Griffiths	Cabinet Member for Housing & Homes
Councillor Paulette Hamilton	Cabinet Member, Health & Social Care and Chair of Birmingham Health and Wellbeing Board
Councillor Carl Rice	Cabinet Member, Children, Families and Schools
Councillor Brett O'Reilly	Cabinet Member, Jobs & Skills
Councillor Tristan Chatfield	Cabinet Member Community Safety & Equalities
Councillor Majid Mahmood	Cabinet Member, Commercialism, Commissioning & Contract Management
Councillor Lisa Trickett	Cabinet Member, Clean Streets, Recycling & Environment
Councillor Stewart Stacey	Cabinet Member Transport & Roads

Our Commitment

Cllr Sharon Thompson
Birmingham Homelessness Ambassador

The impacts of homelessness are complex and intertwined. The growing number of people living on the street makes visible what may otherwise be unrecognisable to the majority of people in our city. Yet street homeless remains a relatively small proportion of the overall issue and we must not forget those living in precarious housing circumstances, temporary accommodation, hostels and supported accommodation - or indeed those who are taking positive steps to recover from homelessness.

Homelessness can lead individuals and families into a cycle that can have a profound effect on all aspects of life. It is not just a lack of accommodation; homelessness can affect our physical and mental health and wellbeing, educational achievement, ability to gain and sustain employment, and puts pressure on our personal and family relationships. These effects, especially on children, can be life long and can cause repeated homelessness of a generational nature.

No single organisation can prevent homelessness alone; together we must be proactive in working together to intervene earlier and prevent homelessness wherever possible.

Matt Green
Director, Crisis Skylight Birmingham on behalf of the Homelessness Partnership Board

This new homelessness strategy has the vision and ambition to make a profound effect on the lives of people who are homeless and those who face the uncertainty and risk of becoming homeless.

As organisations and individuals working in the city, we will continue to work with Birmingham City Council by jointly owning this strategy and working in partnership to deliver life-changing services so that the vision of eradicating homelessness in Birmingham becomes a reality.

The impact of homelessness devastates lives and it is often a long, hard, painful journey to leave homelessness behind for good. The implementation of the Homelessness Reduction Act 2017, alongside the delivery of this Homelessness Prevention Strategy through a Positive Pathway model, will be the opportunity to trigger a fundamental change in the way we create systems and design services to take a human rights approach to ending homelessness in Birmingham.

Introduction

Homelessness is caused by a complex interaction between a person or family's individual circumstances and a number of social and structural factors often outside of their own control.

Unless these other factors are addressed, the ability of an individual or family to become resilient and improve their chance of a positive future is greatly reduced, and places them at risk of becoming trapped in a cycle of homelessness.

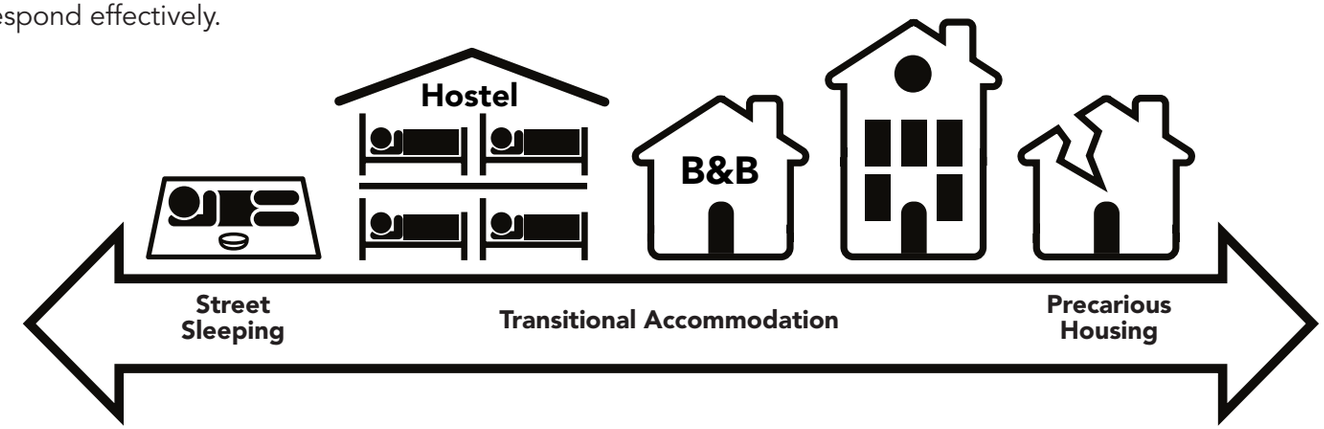
Tackling all of these issues at the point of crisis is complex and very expensive. Therefore, we must do more to intervene as early as possible, to limit the impact of homelessness, help people to recover from homelessness, and prevent it from happening in the future.

The journey into and through homelessness is different for everyone. People enter at different stages, at different times in their lives, and with varying levels and types of support needs. In recognition of this it is important that our approach is flexible to respond effectively.

Scope

The scope of this strategy recognises all types of homelessness needs:

- Those who are considering their housing options
- Those who are at risk of homelessness
- Those who are deemed statutory homeless
- Those who are deemed non – statutory homeless
- Those who are street homeless
- Children who experience homelessness
- Those who are moving on from homelessness
- The wider population (for the purposes of prevention more broadly).



Our Vision

Birmingham is a city where we all work together to eradicate homelessness

Aims

1. Ensure people are well informed about their housing options
2. Prevent people from becoming homeless
3. Assist people as soon as possible if they do become homeless so that their homelessness can be relieved by securing sufficient accommodation and support
4. Support people to recover from their experience and stay out of homelessness
5. Enable people to secure homes that they can afford and maintain.

Defining Homelessness

Statutory Homelessness

The **Ministry of Housing, Communities and Local Government** (MHCLG) defines statutory homelessness as:

"A household is legally homeless if, either, they do not have accommodation that they are entitled to occupy, which is accessible and physically available to them or, they have accommodation but it is not reasonable for them to continue to occupy this accommodation"

Households in priority housing need include families, pregnant women and single people who are particularly vulnerable.

Non-Statutory Homelessness

Non-statutory homeless people are typically single people/childless couples who are not assessed as being in 'priority need' and are only entitled to advice and assistance if homeless.

Some non-priority homeless people are offered access to Local Authority-commissioned housing support services.

Street Homelessness

MHCLG define street homelessness as:

"People sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments). People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or "bashes" (makeshift shelters))."

Legal duties

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

The **Homelessness Act 2002** places a specific requirement on Local Authorities to devise and implement a Homelessness Strategy.

The **Homelessness Reduction Act 2017** places a duty on Local Authorities to provide anyone threatened with or at risk of being homeless (within a 56 day period) with advice and support to prevent them becoming homeless.

Impact of Homelessness

The impact of homelessness begins at birth; children are more likely to be born at a low birth weight and miss their immunisations, and are less likely to be registered with a GP.

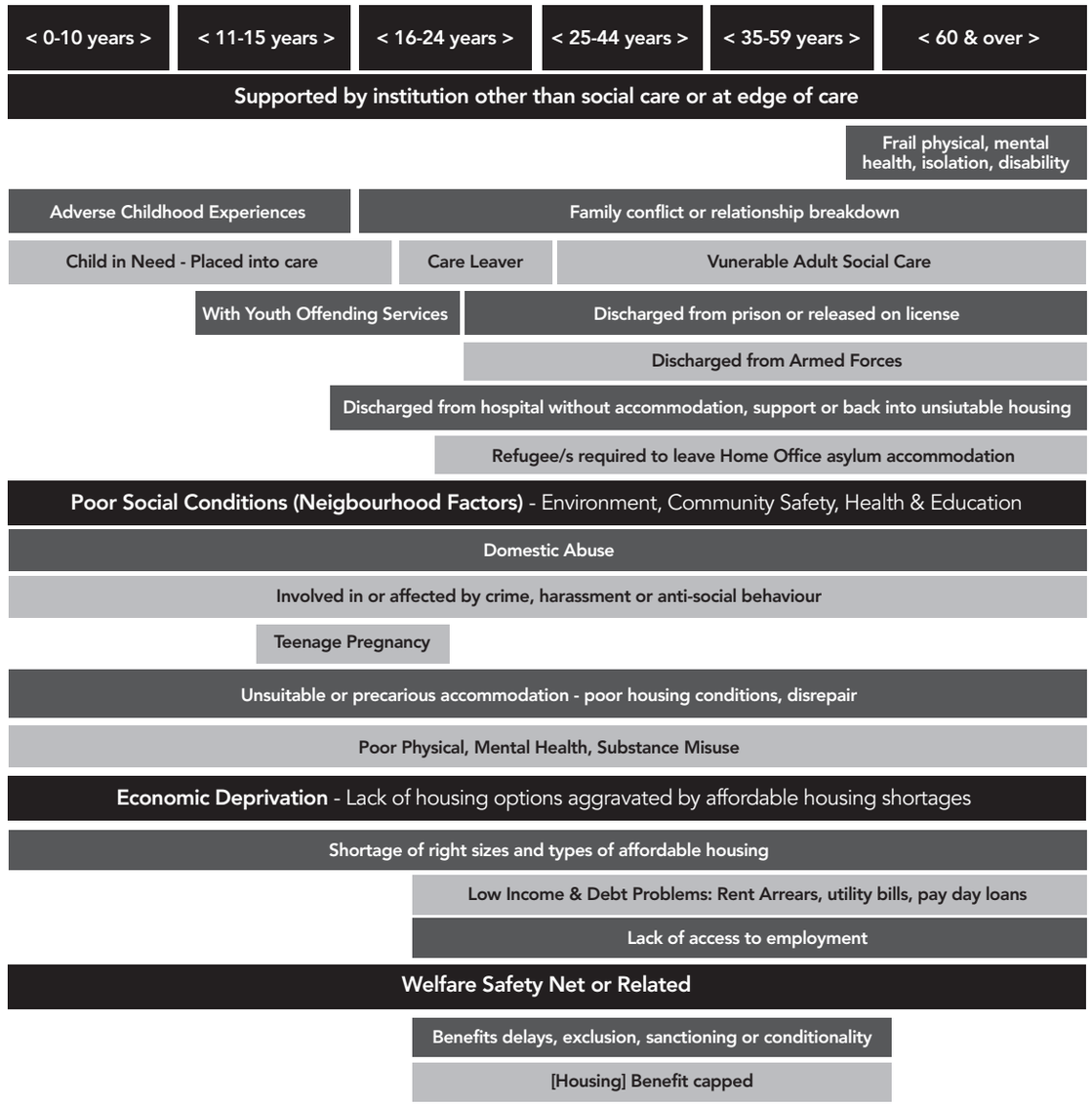
Homeless children are three times more likely to experience poor mental health; the impact of which is long lasting. Even after they have a new home, children who experience homelessness remain vulnerable to family breakdown, domestic abuse, mental ill health, and learning and development difficulties.

As a result of their preoccupation with addressing their unstable and unsafe living conditions, a parent's capacity to effectively parent is much reduced.

For many people, homelessness is not just a housing issue. It is closely linked with complex and chaotic life experiences. Mental health problems, drug and alcohol dependencies, and experiences in prison or with the care system are often closely linked to more entrenched experiences of homelessness. Traumatic childhood experiences are part of most street homeless people's life histories.

Homeless households experience severe health inequalities, poorer health and wellbeing, and a lower life expectancy than the general population. It is vital that we can identify and address the impact of homelessness for people at every stage of life.

Homelessness across the life course: Triggers, Causes & Risk Factors



A Priority for Birmingham

Homelessness continues to be a high priority for Birmingham. Despite our progress, the number of people experiencing homelessness is growing.

The cross cutting nature of homelessness is clear and highlighted by its inclusion as a key contributing factor to the success of the following strategic priorities:

- **Birmingham Housing Strategy Statement (2017)** - Enabling citizens to find, access and sustain housing that meets their needs is a key priority.
- **Birmingham Health and Wellbeing Strategy (2017)** - Tackling homelessness is key to children living in permanent housing, increasing employment or meaningful activity, stable accommodation for those with mental health problems, and improving the wellbeing of people with complex needs.
- **Birmingham Financial Inclusion Strategy (2017)** - Financial exclusion exacerbates poverty and can lead to serious debt problems, homelessness, mental health issues and involvement with crime.
- **Birmingham Domestic Abuse Prevention Strategy (2017)** - Domestic abuse is the second highest presenting reason for homelessness households in priority housing need.
- **Birmingham Early Help Strategy (2015-2017)** - Reducing the number of families experiencing homelessness and overcrowding is key to 'a good childhood for the best start in life'.
- The **agreed purpose for Improved Mental Health in Birmingham** (2016) - Supporting people to recover from poor mental health in order to reduce adult and youth homelessness.

Homelessness is an issue for the West Midlands as well as the city. We are very aware of the regional aspects of homelessness which include the impact of issues such as standards in the private rented sector, affordability and lack of supply. These structural causes influence levels of homelessness.

We will continue to explore regional opportunities to influence and contribute to the homelessness agenda across the West Midlands Combined Authority. We will also support activity and services that can afford us better value for money and improved outcomes for our Citizens through models such as Housing First and the combined efforts towards hospital discharge and prison release.

Birmingham is also keen to share its approach to tackling and preventing homelessness with the West Midland's Mayoral Taskforce on Homelessness, collaborating with our Local Authority neighbours to ensure we are making the greatest impact to achieve our vision.

Our Challenge

Nationally the Government recognises that the housing system is 'broken'. Locally, this market failure is particularly apparent as:

- There is a lack of affordable housing options for many larger households – Birmingham has higher than average household sizes but a limited supply of 4 bed and larger homes. This is especially difficult for larger households affected by the 'benefit cap',
- Increasing difficulties experienced by people under-35 to secure affordable, independent accommodation – particularly for low-income and unemployed young people. Whilst there is a relatively good supply of accommodation of this type, it is often not affordable for this group. People who are subject to benefit restrictions face additional difficulties.
  This contributes to a need for additional larger homes as young people are living with their family for longer representing a new and growing housing need in the city, as well as an affordable housing offer for young people, including young workers.
- Birmingham has a growing population, which is putting increasing pressure on the existing housing stock. Locally there are more than three times the rate of priority homeless households than the national average and double the rate of Core City neighbours. These high rates can also be seen as a direct consequence of a fractured housing system.
  The statutory homeless system can seem to offer a clear pathway into permanent accommodation, which contrasts with the difficulties that people experience in finding suitable and affordable accommodation.

Increasingly, people are presenting as statutory homeless because an assured shorthold tenancy has ended. Domestic abuse and parental exclusion are also significant reasons for why people become homeless in Birmingham; over 40% of homeless applications from outside of the city are associated with homelessness resulting from domestic abuse.

Deprivation and associated poverty / low incomes are key barriers for accessing suitable housing and maintaining stable and financially sustainable tenancies. Access to employment is a key mechanism for preventing homelessness. The average household income in Birmingham is relatively low. Combined with relatively high rates of unemployment – this is a driver of housing exclusion. Poor financial management and a failure to maximise household income also limit people's ability to access and sustain housing.

Our approach to recovery has been overly housing focussed, with an emphasis on securing accommodation and not enough attention given to prevent future homelessness by addressing the underlying cause of peoples' experience. We need to do more to recognise the impact that the trauma of homelessness can have on both adult and children's physical and mental health and wellbeing. Homelessness is an adverse childhood experience that can have a long-term negative impact on children's development.

Birmingham has a very high level of families who are homeless and/or in temporary accommodation. It affects social bonding, school performance as well as being linked to disadvantage in future generations. More than three quarters of applicants accepted as homeless and in priority need have children – either with a lone parent, or as dependants of a couple.

Young people are the most disadvantaged in the housing market because they are likely to have a low income and are viewed by Landlords as potentially high risk. As Birmingham is a young city, this is a particular local challenge. There are 4,118 young people facing homelessness in Birmingham, most of whom have been made homeless from their family home (42%). It is common for there to be other underlying factors that could contribute to or increase the risk of a young person becoming homeless, including lack of tenancy experience and mental health issues.

The difficulties that people experience trying to find and secure suitable housing has a direct impact on their health and wellbeing. This places increased pressure on health services, particularly family doctors and mental health services, as people struggle to navigate the housing system in the city. With more than 20,000 (est.) households in Birmingham each year either homeless, at risk of becoming homeless or transitioning out of homelessness – the overall health and wellbeing of the city is under threat.

Birmingham is at crisis point with street sleepers at the most visible tip of the homelessness iceberg. The number of street homeless people has increased by 53% in the last year, and by 588% since 2012.

The complexity of multiple needs, circumstances and increasing inter-relationship of triggers and reasons leading people to sleep rough makes it increasingly more difficult for a single provider or partner to address. At the same time, it is increasingly hard to engage with this group suggesting that our traditional approach is no longer as effective as it used to be.

The Housing Birmingham Partnership's strategy, "Birmingham: A Great Place to Live", sets out the challenge we face in terms of ensuring a sufficient supply of sustainable housing options for all citizens. Ensuring that households who have experienced homelessness are able to sustain accommodation in the long-term requires both the availability of suitable housing, and also the household having the capacity and resilience to maintain occupation of their home.

Our Approach – The Positive Pathway

The Positive Pathway is a whole system approach built on collaboration, best practice and service integration. Successful implementation of our approach will ensure an excellent response to homelessness in the city.

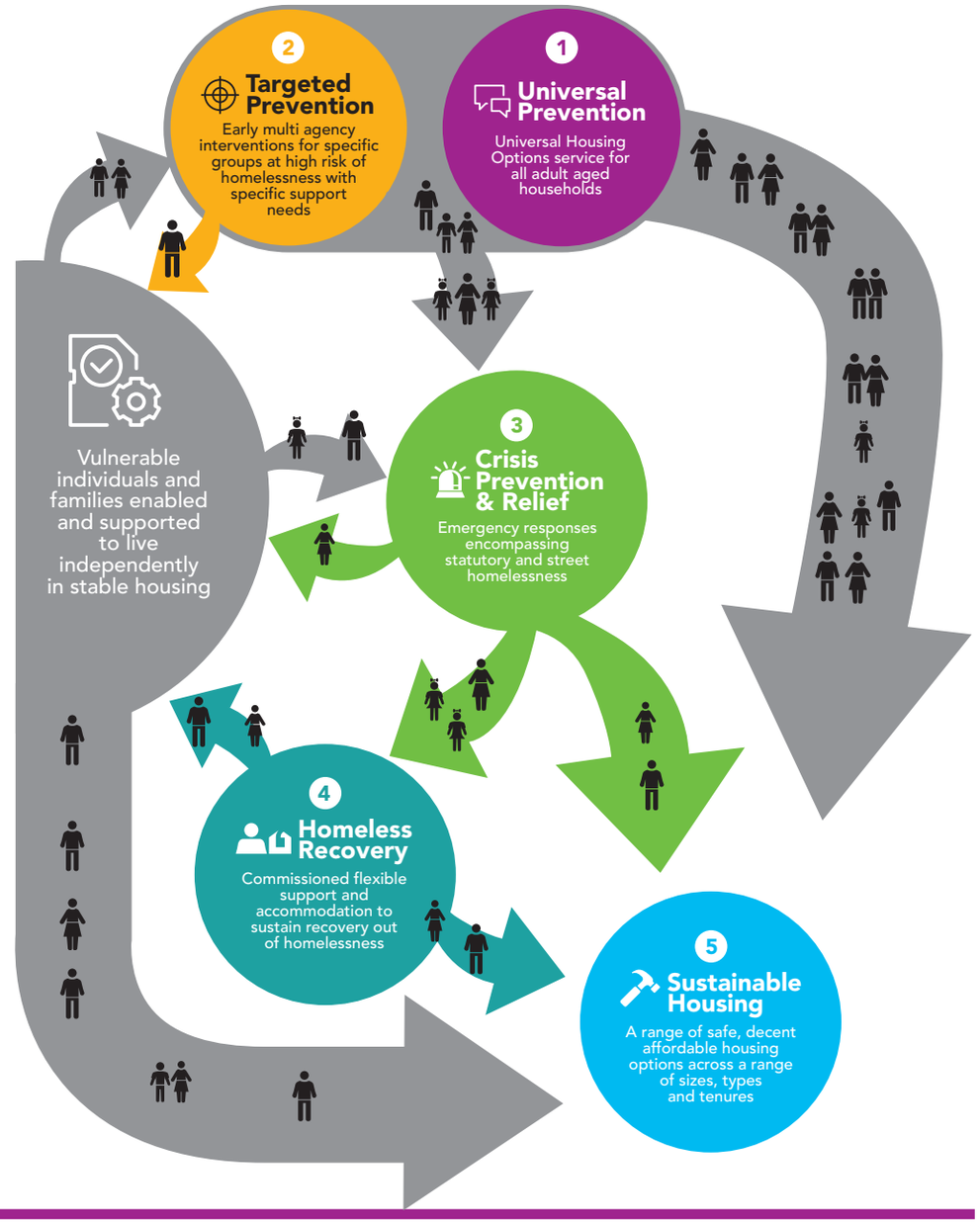
First developed by St Basils and implemented locally with young people at risk of or experiencing homelessness, the Positive Pathway has seen much success. By embedding the approach at the heart of this strategy, Birmingham will create a comprehensive and consistent approach to homelessness across the life course.

Our approach sets out five key areas that can be used flexibly to ensure that no matter what stage people enter the pathway, they will be supported as early and as effectively as possible.

The five key areas are:

1. **Universal Prevention**
2. **Targeted Prevention**
3. **Crisis Prevention and Relief**
4. **Homeless Recovery**
5. **Sustainable Housing**

The Positive Pathway radically changes the way we respond to homelessness in Birmingham; shifting the balance from a reactive crisis response to proactively addressing homelessness in all of its forms throughout a person's or family's journey.



Universal Prevention

Our Aim

To ensure people are well informed about their housing options.

Our Approach

Universal prevention sets out a bold vision of creating structural step change across the city to ensure people are equipped to navigate the housing system, and create a city that is sufficiently robust to deliver change at system, organisational and community levels.

It is intended to empower people and communities to successfully live resilient, independent lives without support from specialist services, and ensure they know where to go to seek help if required.

This domain includes the adoption of social prescribing which recognises that people's health is determined primarily by a range of social, economic and environmental factors.

The impact of inadequate or inappropriate housing may manifest on health and health services in a number of ways for example, repeat visits to the family doctor or Accident and Emergency department, or delays in discharge from hospital due a lack of safe, warm accommodation to return to.

This means that family doctors, nurses and other professionals will be aware of and be able to refer people to a range of local, non-clinical services relating to their housing needs.

This domain also includes a wide range of timely, accurate information and advice about housing options, financial issues and support services available to everyone to prevent issues with housing and housing related risks, occurring in the first place, and to ensure people understand the links between housing choice and their financial and employment circumstances.

Strategically, this approach links closely to the work of the Birmingham Health and Wellbeing Strategy, the Birmingham Financial Inclusion Strategy and the Child Poverty Commission to support reductions in inequality across the city.

Targeted Prevention

Our Aim

To prevent people from becoming homeless

Our Approach

Anyone can become homeless. However, it is possible to identify people who are most likely to become homeless. Groups at risk of homelessness include:

- Vulnerable children and young people
- Young people leaving the care of the Local Authority
- People leaving prison
- People experiencing domestic abuse
- People leaving the Armed Forces
- People with a mental health issue
- People with addictions e.g. drug, alcohol
- People experiencing family breakdown
- People with multiple and complex needs
- People on low incomes and those who are in debt
- People with learning disabilities
- Refugees and people with no recourse to public funds.

There is a strong overlap between homelessness and deep social exclusion.

This approach introduces early intervention through trauma informed practice – understanding trauma and how it may lead to homelessness either now or in the future.

Linked to the Birmingham Early Help Strategy, this domain focuses on early intervention targeted for people who are most likely, or identified, to be at risk of homelessness. People receive appropriate and relevant support as early as possible, to remain in their home or are supported to make planned moves before the risk of homelessness manifests. In a significant number of cases early, effective intervention can prevent homelessness occurring.

To be successful, we must strengthen our collective approach to ensure the right structures, partners, and services are in place to deliver a person centred approach. The development of appropriate and proportionate information sharing protocols with relevant agencies is vital to ensure a holistic response to the prevention of homelessness with people most at risk.

This will also ensure we can improve our understanding of the scale and nature of homelessness in the city, as well as the evidence base of 'what works' to predict and prevent homelessness, understand household strengths and assets, and achieve other related outcomes relevant to people in Birmingham.

Crisis Prevention and Relief

Our Aim

To assist people as soon as possible if they do become homeless so that their homelessness can be relieved by securing sufficient accommodation and support

Our Approach

Whilst we seek to shift the balance to a more proactive, preventative approach, we must ensure there is still an effective response for those who present as homeless in an emergency or crisis situation. Groups that are recognised as predominantly affected in this area are private rented sector tenants, families with dependent children, people experiencing domestic abuse, young people experiencing parental exclusion, under 35 year olds, people with multiple and complex needs, people with drug and /or alcohol addiction, and street homeless people.

Crisis prevention and relief is defined as a range of responses that support prevention and relief of homeless crisis.

This domain aims to respond at the point of crisis, where the threat of homelessness is imminent or has occurred. It includes interventions that result in someone making a homeless application in order to help them secure accommodation.

It also encompasses interventions that seek to resolve the threat of homelessness such as mediation resulting in someone being able to remain in the current home or alternative accommodation and therefore removing the imminent threat of being homeless.

The scope of the Crisis Prevention and Relief offer is broad and includes:

- Outreach services that make contact with the street homeless population
- Support and intervention for adults and children affected by domestic abuse
- Specialist accommodation such as refuges
- Statutory and non-statutory homeless prevention services
- Immediate and direct hostel provision
- Bed and breakfast and temporary accommodation
- Housing options and advice
- Rapid re-housing via initiatives such as Housing First.

As a result, homelessness is prevented through intervention at point of crisis; emergency accommodation is secured for those without other housing options; and there is co-ordinated action to prevent street homelessness and move people into accommodation.

This domain is underpinned by a comprehensive, multi-agency holistic assessment of need and is a key data collection point to inform ongoing development of the pathway.

Homeless Recovery

Our Aim

To support people to recover from their experience and stay out of homelessness

Homeless Recovery means key agencies work together to support people to ensure they have access to a range of support that will improve their physical and mental health and wellbeing, access education or training, enter and/ or maintain employment, stabilise the family income, and strengthen social networks.

This type of preventative action will need to be sensitive, timely, appropriate and right first time. Done effectively, this approach supports people to regain their independence, enabling them to avoid the crises that may trigger homelessness in the future. It is recognised that recovery from homelessness can be a difficult journey, however, and as such this approach works to instil the resilience, skills and confidence people need to effectively manage crisis should it occur again.

Our Approach

People who have experienced homelessness are more likely to have additional needs around their mental, physical and emotional health and may need extra support to make a sustained recovery into stable housing and onward to a positive and healthy future. This is particularly true for children, young people and more vulnerable adults. Providing this extra support is critical to limiting the impact of homelessness as well as preventing homelessness recurring.

Experiencing homelessness can have a serious, adverse and long lasting impact, particularly in childhood. By understanding that being homeless can be traumatic, this approach involves working with people to reduce the risk of secondary trauma or re-traumatisation by encompassing psychologically informed environments.

This means taking into account emotional and psychological needs alongside continued support to stabilise their accommodation, and focusing on improving the overall wellbeing of all adults and children in the household.

Sustainable Housing Options

Our Aim

To enable people to secure homes that they can afford and maintain

Our Approach

There is no doubt that homelessness in Birmingham is exacerbated by the lack of supply and access to suitable, settled accommodation.

Recognising the impact of a growing population and increasing pressure on our current housing stock, sustainable housing options are a key part of resolving structural influences on homelessness.

To maintain the momentum of supporting people into independence when they are ready, we must have access to a truly affordable supply of accommodation for people to move into.

Without it, the current situation will remain inevitable: people that are ready for independence are trapped in supported accommodation, potentially blocking others in the system from moving on and getting the help they need.

At the same time, poverty and low incomes prevent people from accessing positive housing options and make others hard to sustain.

This approach requires the provision of a range of safe, decent, affordable housing options, both shared and self-contained, in the private, social and third sectors. Supply, affordability and support are key enablers of tenancy sustainment.

This domain concerns longer-term strategic actions such as improving the supply of suitably affordable housing to make a difference to homelessness. Alongside increasing sub-market level housing supply across all tenures, improving the standards and quality of tenure in the private rented sector can also contribute to tackling homelessness in the city. This is vital as poor housing conditions affect health and may have long-term implications for income and employment.

Likewise, both housing and employment are cornerstones of economic security. The stress of meeting housing costs may be compounded by unemployment or insecure work.

Creating an environment that includes improved standards, quality and supply of suitably affordable accommodation along with training and support that people may need to find good quality, long lasting jobs, will ensure people are economically active and have suitable homes that they can afford and build their future from.

Delivering our Vision

Oversight

The Housing Birmingham Partnership is responsible for, and committed to, ensuring that Birmingham's vision to eradicate homelessness becomes reality.

Assurance

The Birmingham Health and Wellbeing Board will seek assurance from the Homelessness Partnership Board on the effectiveness of partnership working in the development and implementation of the Strategy Implementation Plan.

Accountability

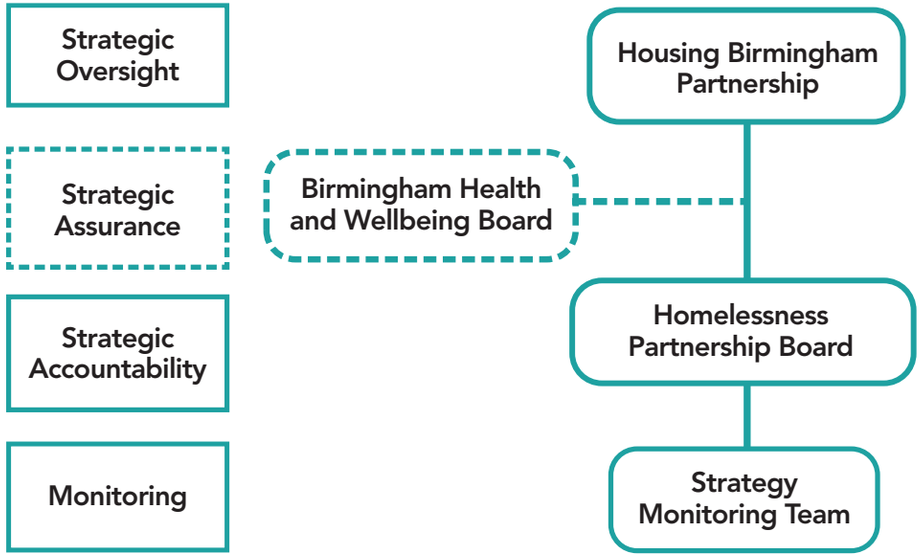
The multi-agency and cross sector Homelessness Partnership Board will be responsible for the successful delivery of the Strategy Implementation Plan.

Monitoring

The Strategy Monitoring Team will report progress against the Strategy Implementation Plan to the Homelessness Partnership Board. The Homelessness Partnership Board will undertake a review of progress against the Strategy Implementation Plan on an annual basis up to and including 2021.

Governance Structure

The strategy will be monitored through the following governance structure:



Equality Duty

The Public Sector Equality Duty (Equality Act 2010) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people when carrying out their activities.

As such, our approach has and will continue to be informed by the latest available intelligence when determining key actions associated with the delivery of our strategy vision.

Joint Action Plan

The Homelessness Partnership Board has agreed that the fundamental action is to develop an excellent pathway and secure its adoption by key partners in the city and to ensure that is appropriately resourced in terms of implementation. This requires significant system change, both in terms of how we work together as partners and what we jointly deliver. This action plan sets the direction for the next five years. The vision for the strategy is ambitious and there are a lot of things that need to be done. The following actions have been split into whole system and domain specific actions; the detail of which will continue to develop over a period of time.

Key System Actions:
Develop an excellent positive pathway across all five domains.
Embed a human-rights approach to homelessness in the city.
Establish a trauma based approach to responding to homelessness in the city.
Drive culture, organisational and decision making change to design out homelessness both within and between organisations.
System–wide, consistent communications and messaging to citizens in terms of options and offers available.
Develop specific responses for cohorts most at risk of becoming homeless.
Take pragmatic action in the best interest of individuals.
Review existing commissioned services to design in more flexibility and remove unintended barriers.
Contribute to the preparation work in readiness for the pending Supported Housing Finance reforms (April 2020).
Strengthen intelligence gathering and sharing to inform policy, practice and priorities for action.
Strategic leads across the city work together to collaboratively shape and drive key priorities and actions across related strategy areas including Housing, Health and Wellbeing, Domestic Abuse, and Financial Inclusion.
Complete a health impact assessment concerning the strategy delivery to better inform the responses to meet the health needs of homeless households.

Domain	Aim	Key Action
Universal Prevention	Ensure people are well informed about their housing options	Adopt a duty to collaborate between all partner agencies to support people to navigate their housing options.
		Develop a universal offer to enable access to high quality, appropriate advice and information on housing options and maintaining wellbeing.
		Communicate the universal offer consistently across the range of partnership agencies, making sure that messages and media are appropriate and relevant to all cohorts of people.
Targeted Prevention	Prevent people from becoming homeless	Develop the capacity and capability of organisations and workforces to competently respond to individuals and families at risk.
		Strong protocols for multi-agency working to support and appropriately refer individuals and families at risk.
		Design and implement early and targeted interventions for groups identified as higher risk of homelessness.
Crisis Prevention and Relief	Assist people as soon as possible if they do become homeless so that their homelessness can be relieved by securing sufficient accommodation and support	Redesign of systems and services to fully implement the Homelessness Reduction Act.
		Strengthen the response of the Street Intervention Team and Outreach service to tackle entrenched street sleeping.
		Reinforce commitments to minimise the use of bed and breakfast provision particularly for families with children and maintain zero usage for 16-17 year olds.
		Establish and enforce standards for the safety and quality of temporary accommodation.

Domain	Aim	Key Action
Homeless Recovery	Support people to recover from their experience and stay out of homelessness	Establish a minimum training standard for specialist support staff to work with therapeutic models such as Psychologically Informed Environments, in a person centred way to aid recovery and build resilience.
		Develop and implement a Homelessness Recovery Charter that is understood and accepted by all relevant agencies.
Sustainable Housing Options	Enable people to secure homes that they can afford and maintain	Ensure that updated policies in relation to housing continue to reflect housing needs in the city.
		Take innovative best practice models and mainstream them e.g. Housing First, modular housing, community led housing organisations, Employment First, and empty homes initiatives.
		Develop robust standards for existing housing provision designated for vulnerable people with care and / or support needs (in time for the April 2020 Supported Housing Financial Reform).
		Progress Selective Licensing options for the city as a means of improving standards in the Private Rented Sector.
		Take steps to support private rented sector landlords to build confidence in providing affordable accommodation for vulnerable groups.
		Take steps to better align Local Housing Allowance rates to the 30th percentile of market rents to increase affordability in the private rented sector.

Birmingham City Council

birmingham.gov.uk

Birmingham Homelessness Prevention Strategy: One Year On

Homelessness Week

17th - 23rd June 2019

Kalvinder Kohli, Head of Service, Adult Social Care, Birmingham City Council
Chair of the Homelessness Partnership Board

Challenges: national level (excluding reductions to council budgets)

- **Housing Supply -** Shortage of housing of all sizes, types and tenures in the city with greatest difficulty for those on low incomes requiring affordable housing. Most acute in the private rented sector (PRS) where support for housing costs for people aged under 35 years of age (LHA Shared Accommodation Rate) means less than 7% of available PRS housing can be accessed on housing benefit

- **Demand** - All forms of homelessness has increased since 2010. BCC housing register which is circa 12,500. Lettings in the social rented sector (council and housing association) are exceeded by demand. Increasing numbers of households in Temporary Accommodation both locally and nationally. Increase in Rough Sleeping across the Country

- **Welfare Reform associated hardship** - 2016 Benefit Cap affected 4500 households, Bedroom Tax/SSSC, Disability related benefits & further cuts to continue - By 2021, £37bn less will be spent on working-age social security compared with 2010, despite rising prices and living costs

- **Vulnerable Adults (high needs but below care threshold) -** Substance misuse and mental heath, physical health. Increasing vulnerability and complexity of need in the rough sleeper cohort. This is within the backdrop of reductions to health provision nationally.
- **Short term nature of central government funding**

Birmingham Homelessness Prevention Strategy 2017+

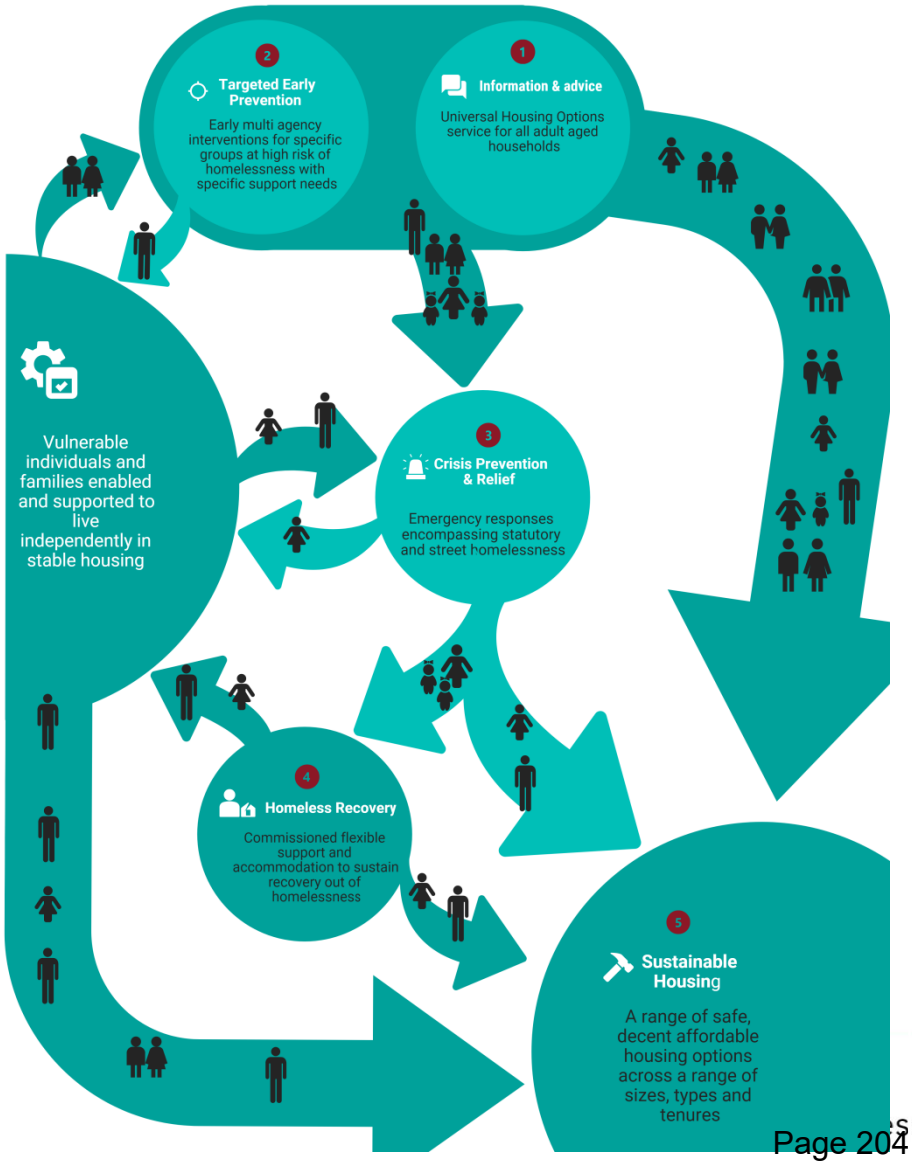
- Partners Strategy – No one single agency can resolve the homelessness crisis
- Developed by partners and people with lived experience of homelessness
- Delivery is overseen by the Homelessness Partnership Board

The Homelessness Act 2002 places a legal requirement upon local authorities to carry out a 'review' of all forms of homelessness in their district and publish a homelessness strategy.

- Broadest definitions of homelessness
- To be re - purposed to include an addendum Action Plan for Rough Sleeping.

Homelessness Prevention Strategy 2017+

BIRMINGHAM
Homelessness Prevention Strategy 2017+
Working together to end homelessness
Making a positive difference everyday to people's lives
Birmingham City Council



Targeted Early Prevention

Activity to provide a time critical response to those that do become vulnerable due to precarious housing and personal circumstances including leaving institutional settings, family circumstances, care-leavers, and people experiencing domestic abuse.

Crisis Prevention & Relief

Provision of emergency supported accommodation for vulnerable adults who find themselves in crisis for a short period of time in order to provide a range of support interventions.

Homeless Recovery

Using strength based approaches which promote wider health and wellbeing and outcomes relating to addressing loneliness and isolation, financial inclusion and connections into local community assets in order to regain or maintain independence.

Year One Progress: Action on Rough Sleeping

Enhanced capacity for emergency and severe weather shelter

- Included BCC, housing, voluntary and faith sector into emergency provision that is put in place for extreme and cold weather periods and events.

October 2018 Mobilised Rough Sleeping Initiative - MHCLG £500k

- 52 additional emergency beds for singles, couples (without dependents) including provision for pets
- Physical and mental health, substance misuse support for clients with multiple needs
- Young persons outreach and support service
- Plus dedicated funding for care leavers at risk of rough sleeping to the Children's Trust

December 2018 Mobilised Housing First – MHCLG £ 9.6m regionally

Year One Progress: Voluntary Commitment to Collaborate

Collaborative actions developed to prevent and relieve homelessness in housing, health, social and health sectors:-

- Pathway action plan across the Birmingham Social Housing Partnership to tackle homelessness in Birmingham's housing association sector including eviction prevention panels, resettlement support, advice information and guidance
- Focus on young people under 25s in tenancies by Trident Reach
- Repurposing Barry Jackson Tower, support delivery by Shelter

Improving referral systems across the health and social care system:-

- including access to health support for rough sleepers (mobile prescribing)
- social and care systems – vulnerable adults team, young people
- working with criminal justice services to offenders housing pathway
- health and homelessness action joint action plan developed by the CCG

Year One Progress: Promoting quality, prevention and partnership

Bending mainstream services to support homelessness prevention:-

- Birmingham DWP local advice and support services aligned to support vulnerable homeless groups – with advice teams serving rough sleeping, homeless families and domestic abuse client groups.

Integrating approaches to tackling and responding to homelessness:-

- Developing a set of quality standards for commissioning and delivery of homeless services across the city
- Joint BCC action plan developed for tackling Exempt Accommodation

Working with other local authorities and the West Midlands Combined Authority Homelessness Taskforce to:-

- Regional Task Group on Rough Sleeping
- Help deliver and promote Change into Action – regional public information and alternative giving fundraising campaign for responding to rough sleeping

Year One Progress: Adult Social Care Investment 2019-2022

£13M PER YEAR

Housing & Wellbeing Hubs – targeted at 7,500 households

Information, advice and guidance on accessing prevention services to complement housing options service. 4 Hubs to be established targeted at groups at risk with support needs (young people, adults singles & couples, domestic abuse, offenders)

Lead worker service for vulnerable homeless support needs groups – approximate capacity for total caseload of 4000 clients

Domestic Abuse, Young People, Adult Singles & Couples, Homeless Families in Temp Accommodation, Offenders

Crisis support and accommodation services

Rough Sleeping Outreach, Refuge, Emergency Accommodation

Recovery and resettlement

Complex Needs Support – Rough Sleeping, Domestic Abuse, Offenders

Year One Progress: Partnerships, Governance and reporting

One of the central aims of the strategy is to promote collective ownership on tackling and preventing homelessness. This is reflected in the governance and oversight arrangements on the delivery of the strategy and the multi-partner approach taken which includes a multi agency & sector Homelessness Partnership Board

Governance and oversight of the strategy undertaken by:-

- Homelessness Partnership Board (monthly)
- Cabinet Member Briefings (monthly)
- Birmingham Health and Wellbeing Board (quarterly)
- Housing Birmingham Partnership (quarterly)

Engagement also takes place with over forums including:-

- City Housing Liaison Board
- City Board
- Birmingham Community Safety Partnership
- Violence Against Women and Children's Board
- Birmingham Homelessness Forum

Influencing national agendas- working with Crisis, MHCLG, ADASS, Social Housing Regulator, LGA, CIH, PHE, DWP, WMCA and other LAs & Regions

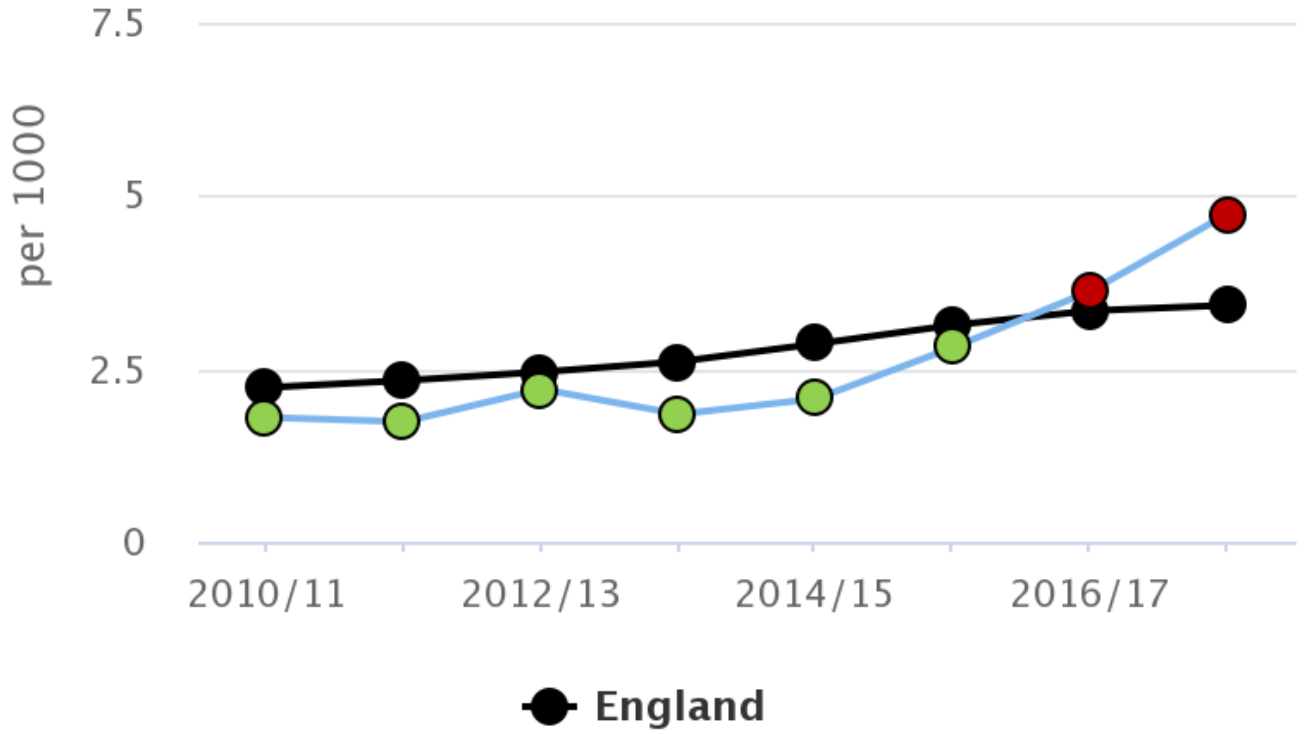
Homelessness and health: data and evidence

Duncan Vernon
Acting Assistant Director of Public Health

Contents

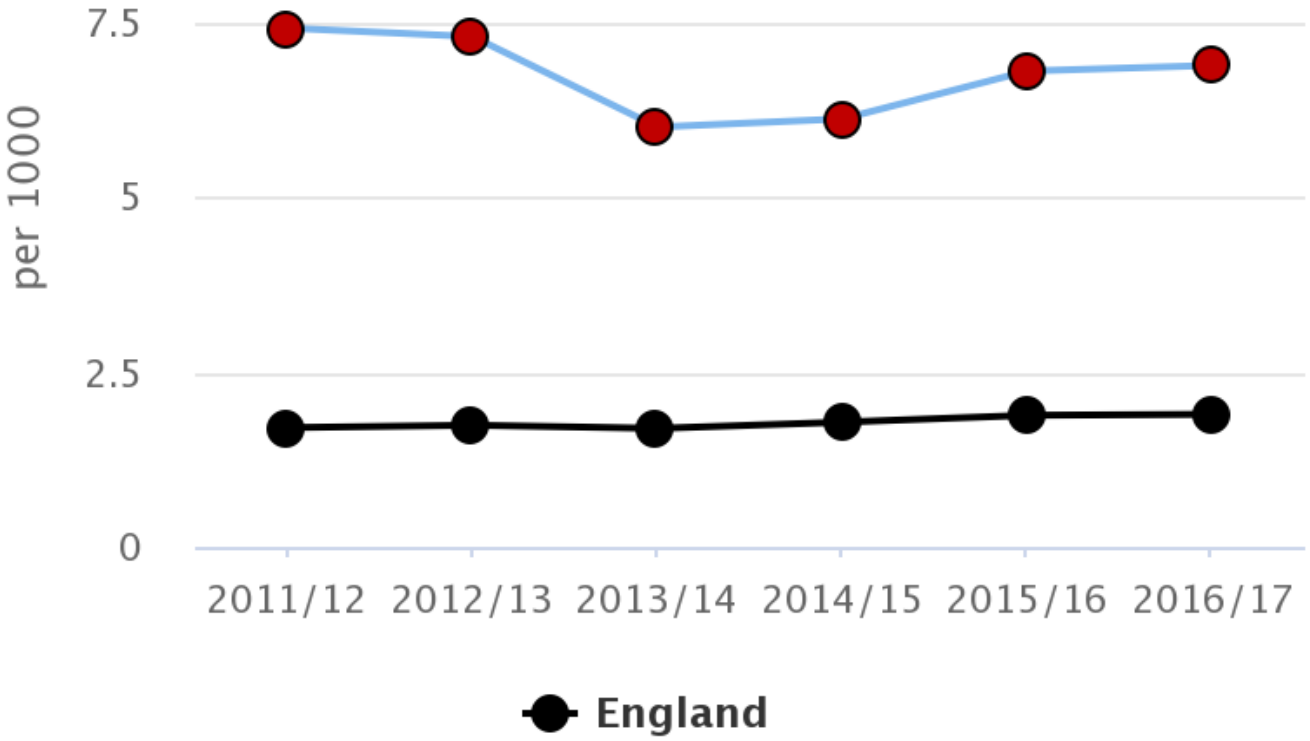
Households in temporary accomodation

Rate has doubled in recent years – there are around 2,000 households in temporary accommodation



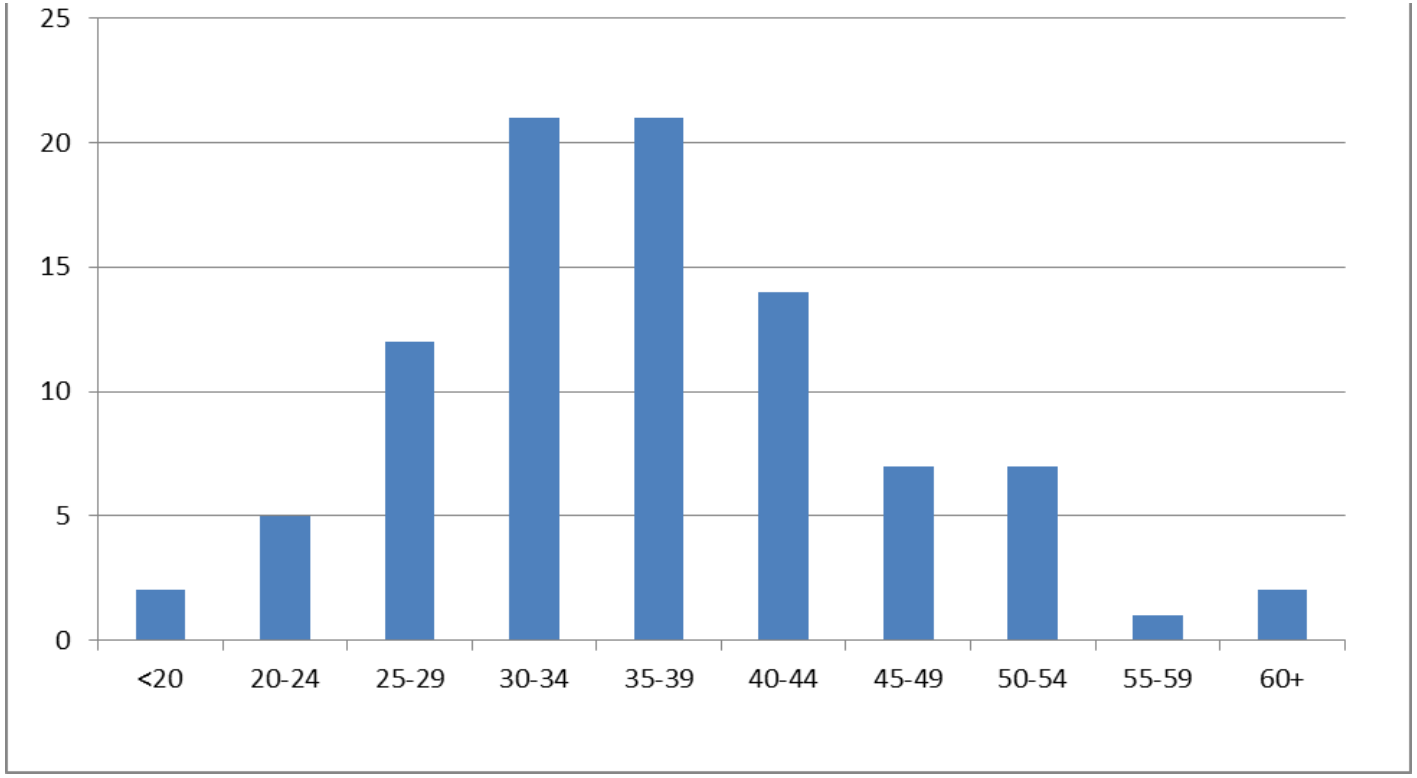
Family homelessness

Number of applications above England average



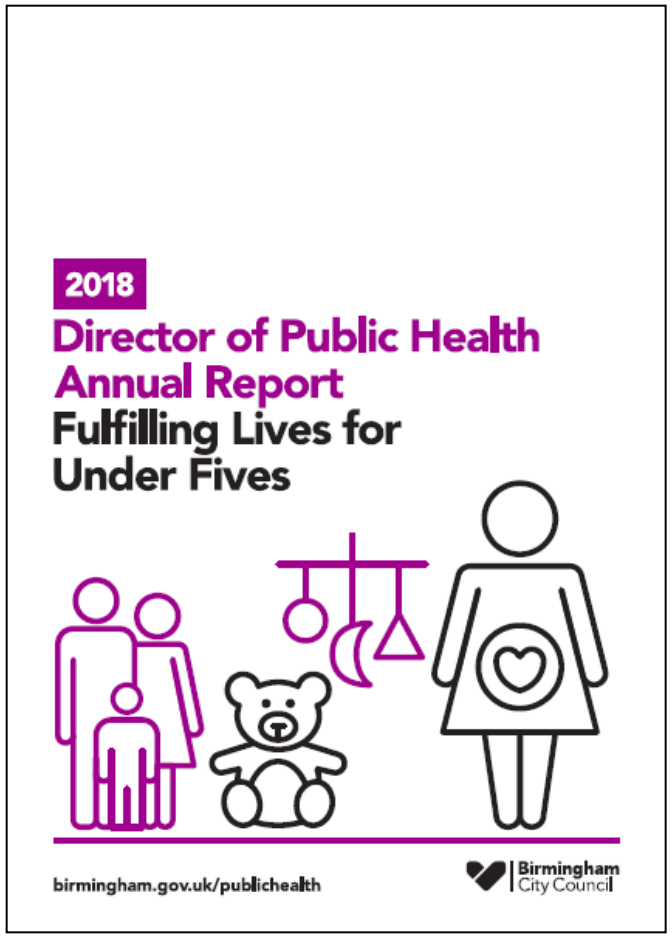
Rough sleeping

- 2018 rough sleeper count: 91 individuals, predominantly male



Causes of Poor Health

Family and child health



Adverse childhood experiences include:

- Child abuse – physical, verbal or sexual
- 'Dysfuntional' household – substance misuse, domestic violence or criminal behaviour

They can have long term negative impacts on health.

Some known unknowns:

- Missed routine contact with health services or vaccinations.
- Educational impacts and school attendance. Take up of free early years education and other welfare.

Poor mental health and it's role in causing homelessness:

An in depth study looking at mental health and homelessness in Nottingham helps our understanding (link)

- A clear linear trajectory could sometimes be traced, for example from trauma, to mental ill health, to drug or alcohol abuse, to homelessness, but it was usually more complex.
- With few exceptions, respondents had some form of mental health issue prior to their first episode of homelessness.
- Only a small number of times where mental health issues were clearly the primary and immediate trigger for homelessness

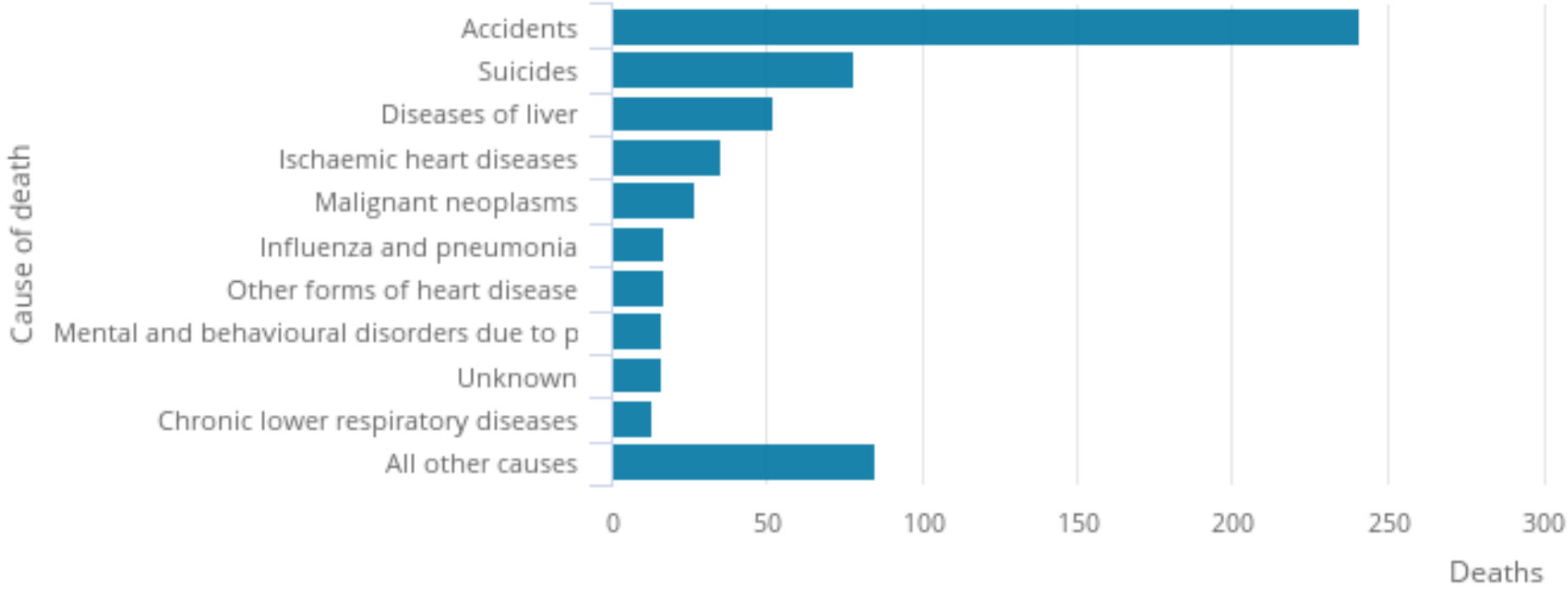
Deaths of homeless people in England and Wales

ONS calculated some ‘best estimates’ between 2013 and 2017 – homelessness isn’t recorded at time of death and covers a wide definition.

- Just under 600 deaths a year across England and Wales
- This has increased from 500 a year as recently as 2015.
- 84% male, average age of death was 44 years old – compared to 76 for the male population as a whole.
- No seasonal pattern to deaths
- 34 deaths in the WMCA area in 2017

Deaths of homeless people in England and Wales

Accidental death (including drug misuse) is the largest cause of death



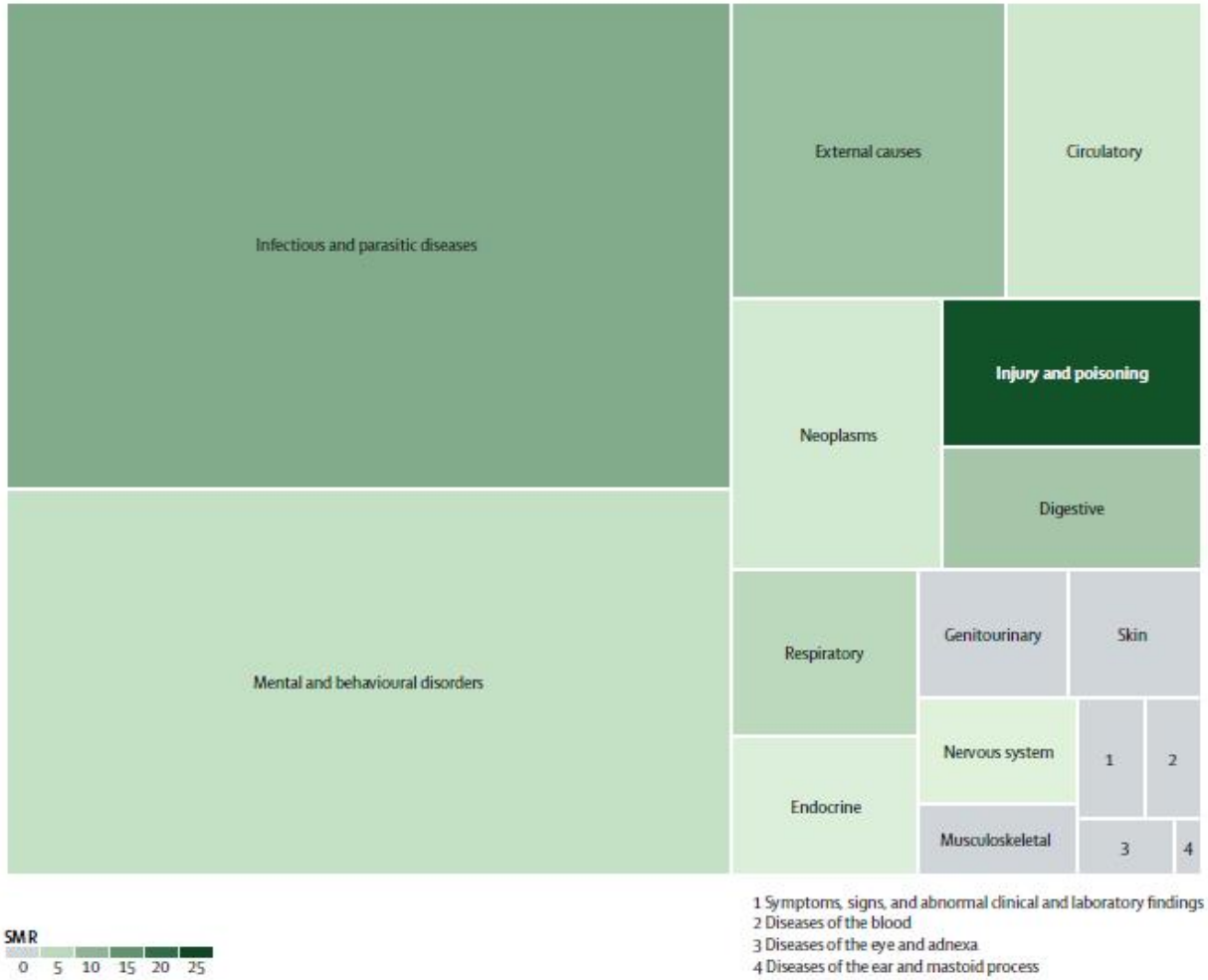
Deaths of homeless people in Birmingham

Table 1: The five local authorities with the most deaths of homeless people
England and Wales, 2013 to 2017

	2013		2014		2015		2016		2017	
1	Camden	21	Birmingham	18	Birmingham	20	Camden	23	Manchester	21
2	Birmingham	16	Lambeth	14	Westminster	19	Birmingham	18	Birmingham	18
3	Lambeth	16	Bristol, City of	13	Camden	19	Liverpool	17	Lambeth	17
4	Tower Hamlets	12	Manchester	12	Tower Hamlets	12	Brighton and Hove	13	Liverpool	17
5	Bournemouth	12	Newcastle upon Tyne	12	Leeds	12	Southampton	12	Bristol, City of	17

Source: Office for National Statistics

Matches the results of a very large review of evidence



Healthcare issues amongst Birmingham's homeless

University of Birmingham analysis of 928 patients registered at the Health Exchange (link)

- Mental health – highest prevalence was 21.3% alcohol dependent, next highest was substance dependence at 13.5%.
- Infectious disease – Hepatitis C had a prevalence of 6.3%. This is lower than other studies in Glasgow, Leicester and Dublin. 9.4% had STIs.
- Physical health – 4.2% on the register for hypertension.
- High levels of multi-morbidity.

Studies in London have found increased risks of Tuberculosis amongst people who are homeless, problem drug users and prisoners.

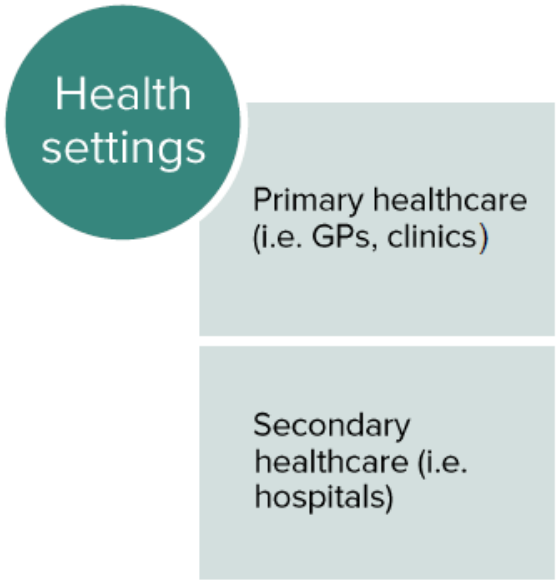
What works

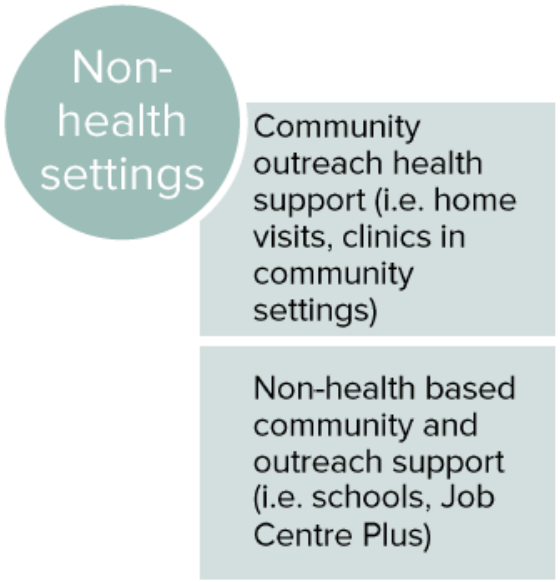
Adverse Childhood Experiences – DPH report recommendations

- Preventing long term negative impacts: Opportunities should be developed with **adult Mental Health clients** (including personality disorder, complex family presentations), **children's social care** (Child Protection and Child In Need) and **Primary Care**.
- Identifying children suffering an Adverse Childhood Experience: Opportunities should be developed into an Early Emotional Help system framework for Primary schools. This should be a **partnership of schools, the voluntary sector and NHS**, which responds to children with difficult and concerning behaviour.
- Preventing Adverse Childhood Experiences: Sharing the understanding of impacts of adverse experiences with parents during the antenatal period by the Local Maternity System and Forward Thinking Birmingham.

Preventing homelessness to improve health and wellbeing

- Rapid review to understand effective interventions – there were broken down by primary, secondary and tertiary prevention.





Preventing homelessness to improve health and wellbeing

- **Welfare Rights and consumer advice, includes housing advice.** Existing evidence shows advice helps prevent homelessness and provides financial gains; can include improvements to mental health and wellbeing.
- **Holistic in-tenancy support.** Existing evaluations largely positive about benefits including reduced A&E use; gaining employment and improved mental health.
- **Targeted support and advocacy to people leaving institutions.** Strong evidence base to build on. Existing evidence shows that effective discharge planning from health settings can improve health outcomes and prevent repeat homelessness.
- **Critical time intervention (CTI)** targeted at groups in the community. Evidence points to positive impact on both reducing repeat homelessness and providing a cost effective solution.

What works in inclusion health

- **Pharmocological interventions.** Directly observed therapy for HIV/TB. Vouchers or material incentives for adherence. Opioid replacement therapy is highly effective for individuals with substance use disorders.
- **Psycosocial interventions.** Combined motivational interviewing, cognitive behavioural therapy, and contingency management have been shown to be effective for prevention of reincarceration.
- **Case management.** Multidisciplinary team with low caseloads, community based services, and 24 h coverage reduced homelessness, with a greater improvement in psychiatric symptoms.
- **Harm reduction.** Targeted screening for TB and Hepatitis C. Hepatitis B vaccinations and needle exchanges are both very effective.

What works in inclusion health

Wider determinants – housing and employment

- Housing first. Significantly improved stable housing status and quality of life, and reduced contacts with the criminal justice system. Evidence more mixed for improving mental health, substance use, and community functioning outcomes.
- The Individual Placement Scheme model of supported employment in ordinary workplaces beneficial for people with severe and enduring mental health problems.
- Respite care (ie, short-term recuperative care for homeless individuals after hospital discharge) can reduce the number of future hospital admissions and use of emergency departments in homeless populations

Transition points and care protocols

Transfer points between healthcare and related settings and the community have an agreed protocol in place and are used to enable continuity of care and prevent crisis for the population. Eg:

- Urgent and emergency care
- Hospital discharge – physical health
- Hospital discharge – mental health
- Substance misuse treatment
- Prison release
- Police custody
- Transition from adolescence to adulthood
- Transition from other institutional care

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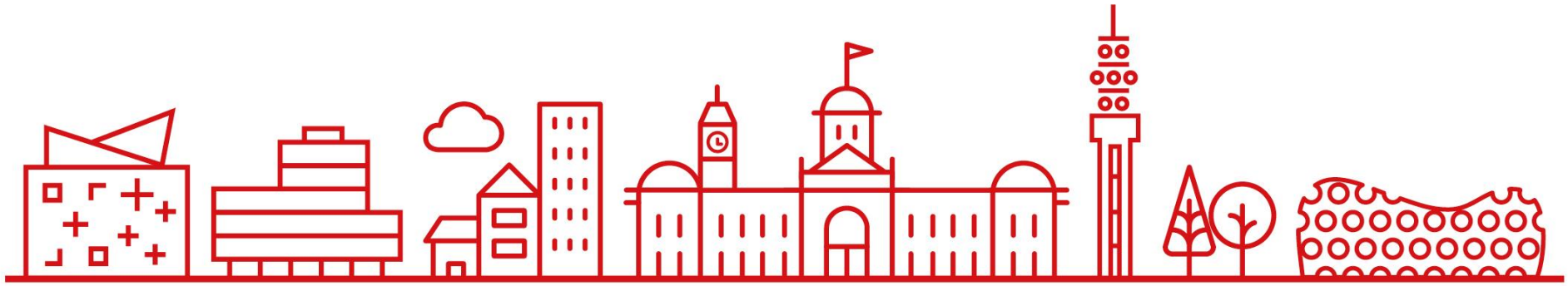

Universal Prevention	Targeted Prevention	Crisis Prevention and Relief	Recovery	Move on Support	Settled Home
All citizens will have access to health care services – registration at GP; access at the point of need regardless of their housing situation. ***Primary Care Services (commissioner)*** **Current provision** – everyone does have a right to access healthcare. GPs cannot refuse to register someone because they are homeless or have no proof of address. GP can only refuse if; they have a closed list or the person lives outside the practice boundary. **Future** – CCG working to educate and empower patients to challenge practices. On-going CCG will work with colleagues in the city to create an escalation process and feedback system for when	*Health practitioners will work with the Local Authority and homelessness services to provide bespoke access for those who have barriers to health as a result of their housing situation:* ***Primary Care Services (commissioner)*** **Current provision** – Health Xchange provide bespoke services for the homeless. **Future** – The CCG will ensure that the redesign of the homeless primary care services will reduce barriers. The CCG are committed to working with the emerging Primary Care Networks to identify opportunities to reduce barriers in accessing primary care – Initial service by October 2019	*Homelessness Health services will provide accessible, safe, responsive access for those in crisis.*	*Health practitioners will work in collaboration with housing and support services to ensure the individual has the best possible chance of recovery*	*Health practitioners will work with Housing and support providers during transition and move on*	*Health practitioners will provide ongoing necessary support to sustain settled home*

patients have experienced barriers. April 2020					
General assessment and triage will take account of the individual's current living situation and their ability to attend in considering any intervention required ***Primary Care Services (commissioner)*** **Current provision** – There is a duty to refer ***Mental Health Services (commissioner)*** FTB/BSMHFT are commissioned to provide a comprehensive assessment of mental health needs, which would include having an understanding of social needs including housing.	*Health practitioners will consider co-location or multi-agency working with homelessness services where this is in the best interests of those at risk.* ***Primary Care Services (commissioner)*** **Current provision** – Health Xchange co-located at local charities. **Future** – work with providers to seek opportunities for appropriate co-location. Redesign and re-procurement of the homeless primary care services will ensure appropriate co-location is secured.	*Health services e.g. Nurse practitioners will work within immediate access homelessness services or Hubs.* ***Primary Care Services (commissioner)*** **Current provision** – Health Xchange employ nurse practitioners who work from Health Xchange and offer out-reach services. **Future –** Redesign and re-procurement of the homeless primary care services will ensure that nurse practitioners are included as part of the service offer. December 2019	*Integrated care and support assessments and plans will be put in place for those in recovery*	*Health practitioners will ensure planned handover when locality changes take place*	

If homelessness or housing need appears to be a contributing factor to the person's health and well-being, the health provider will have information to make appropriate referrals including duty to refer ***Primary Care Services (commissioner)*** **Current provision** – There is a duty to refer. **Future** – Patients who are at risk of becoming homeless can be 'read coded' on the system. This will trigger a referral process to local support services. April 2020	*Homelessness services will have fast track access to primary care and mental health support for homeless or at risk clients.* ***Primary Care Services (commissioner)*** **Future –** Further national guidance to be released on the national commitment to invest up to £30 million extra on meeting the needs of rough sleepers. The funding will be used to ensure that the parts of England most affected by rough sleeping will have better access to specialist homelessness NHS mental health support, integrated with existing outreach services. (NHS Long Term Plan) The CCG will work with local providers to establish how this money is best spent if Birmingham is awarded funding.	*Health services will contribute to and adhere to referral protocols for hospital discharge.* ***Primary Care Services (commissioner)*** **Current provision** – Hospitals should be adhering to discharge policies. **Future** – CCG will advertise the escalation routes and disseminate this to local partners. Internal escalation through to secondary care contracts team who will challenge the appropriate hospital. April 2020			

Health services will not discriminate against individuals because they are homeless or in insecure housing. ***Primary Care Services (commissioner)*** **Current provision** – health services do not and should not discriminate against any individual. **Future** – CCG will advertise the escalation routes and disseminate this to local partners. April 2020	*There will be confirmed escalation processes when general access is not working.* ***Primary Care Services (commissioner)*** **Current provision** – the CCG are the escalation point. **Future** – CCG will advertise the escalation routes and disseminate this to local partners. April 2020				
Health practitioners will ensure that they listen to the experience of their patients and take action on feedback which helps to prevent and relieve homelessness	*Primary care services will have fast-track referral routes to Homelessness Services* ***Primary Care Services (commissioner)*** **Future** – CCG are committed to work with partners to develop these referral routes. April 2020				

Mental health services and drug and alcohol services are commissioned to take account of the close link to homelessness and ensure the person's housing situation is considered in holistic assessments and planned intervention. ***Primary Care Services (commissioner)*** **Current provision** – There is a duty to refer.	*Primary care services will provide access to information on where to seek help if you are homeless or at risk within their public areas.* ***Primary Care Services (commissioner)*** **Current provision** – There is a duty to refer. **Future** – Patients who are at risk of becoming homeless can be 'read coded' on the system. This will trigger a referral process to local support services. April 2020				
Health services in the City will commit to a voluntary commitment to collaborate to prevent and relieve homelessness and publish visibly what this means. ***Primary Care Services (commissioner)*** **Current and Future –** The CCG are committed to collaboration through the actions outlined in this document					

Commitment to collaborate to prevent and relieve Homelessness - Health 'asks'

Homelessness and Mental Health (BSOL CCG Joint Commissioning Team [JCT])

- The table below sets out the expectations that commissioners have of our providers in relation to the support of people with housing needs
- In addition, it briefly describes future activity to progress this agenda
- The Mental Health Joint Commissioning Team (JCT) is now based at Woodcock Street – the team is committed to progressing Joint Commissioning and is meeting on a regular basis with commissioning colleagues within BCC. The actions below reflect the output of discussions to date
- The JCT is keen to support the work of the Homelessness Partnership Board and better utilise this group to identify issues and develop shared solutions
- The JCT is working closely with BCC commissioners to develop applications for funds via Public Health England and NHS England to target mental health support to the rough sleeper population. Submissions are due to be made in July 2019
- The JCT is working with colleagues in Adult Social Care to transform the mental health rehabilitation pathway. The new approach will seek to support people in their own home wherever possible enabling people to live the life they want to live.

Universal Prevention	Targeted Prevention	Crisis Prevention and Relief	Recovery	Move on Support	Settled Home
All citizens will have access to health care services – registration at GP; access at the point of need regardless of their housing situation. ***Mental Health Services (commissioner)*** **Future** - As part of the transformation of mental health services existing community caseloads will be reviewed. Commissioners will	*Health practitioners will work with the Local Authority and homelessness services to provide bespoke access for those who have barriers to health as a result of their housing situation:* ***Mental Health Services (commissioner)*** Forward Thinking Birmingham (FTB) are commissioned to provide specialist support to vulnerable group of children and young people. They do	*Homelessness Health services will provide accessible, safe, responsive access for those in crisis.* ***Mental Health Services (commissioner)*** Forward Thinking Birmingham (FTB) are commissioned to provide specialist support to vulnerable group of children and young people. They do this by working collaboratively across the city.	*Health practitioners will work in collaboration with housing and support services to ensure the individual has the best possible chance of recovery* ***Mental Health Services (commissioner)*** Forward Thinking Birmingham (FTB) are commissioned to provide specialist support to vulnerable group of children and young people. They do	*Health practitioners will work with Housing and support providers during transition and move on* ***Mental Health Services (commissioner)*** Forward Thinking Birmingham (FTB) are commissioned to provide specialist support to vulnerable group of children and young people. They do this by working collaboratively across the city.	*Health practitioners will provide ongoing necessary support to sustain settled home* ***Mental Health Services (commissioner)*** Forward Thinking Birmingham (FTB) are commissioned to provide specialist support to vulnerable group of children and young people. They do this by working collaboratively across the city.

encourage providers to identify individuals who are not registered to a GP and provide advice to facilitate this. December 2019	this by working collaboratively with the LA and St Basils. Birmingham and Solihull Mental Health Foundation Trust (BSWMHFT) are commissioned to provide specialist support to vulnerable adults. They do this by working collaboratively with the LA and VCS partners. **Future -** The CCG is working alongside BCC and Mental Health Providers to develop and submit applications to PHE and NHSE to attract additional funding to target provision to this population Submissions July 2019 A workforce of Link Workers will be employed in new Primary Care Networks. We will work with BCC to ensure that this workforce understand the Homelessness Prevention agenda and can provide appropriate advice and information to citizens presenting in Primary Care	Birmingham and Solihull Mental Health Foundation Trust (BSWMHFT) are commissioned to provide specialist support to vulnerable adults. They do this by working collaboratively across the city. **Future –** The CCG is working alongside BCC and Mental Health Providers to develop and submit applications to PHE and NHSE to attract additional funding to target provision to this population Submissions July 2019	this by working collaboratively across the city. Birmingham and Solihull Mental Health Foundation Trust (BSWMHFT) are commissioned to provide specialist support to vulnerable adults. They do this by working collaboratively across the city. **Future –** The CCG would like to work with the Homelessness Partnership Board to identify good practice locally and better understand areas in which collaboration is not working effectively October 2019	Birmingham and Solihull Mental Health Foundation Trust (BSWMHFT) are commissioned to provide specialist support to vulnerable adults. They do this by working collaboratively across the city. **Future –** The CCG would like to work with the Homelessness Partnership Board to identify good practice locally and better understand areas in which collaboration is not working effectively October 2019	Birmingham and Solihull Mental Health Foundation Trust (BSWMHFT) are commissioned to provide specialist support to vulnerable adults. They do this by working collaboratively across the city.

	September 2019				
General assessment and triage will take account of the individual's current living situation and their ability to attend in considering any intervention required ***Mental Health Services (commissioner)*** FTB/BSMHFT are commissioned to provide a comprehensive assessment of mental health needs, which would include having an understanding of social needs including housing.	*Health practitioners will consider co-location or multi-agency working with homelessness services where this is in the best interests of those at risk.* ***Mental Health Services (commissioner)*** FTB/BSMHFT are commissioned to work collaboratively and to led and take part in Multi-Disciplinary Approach with external agencies when appropriate. **Future –** The CCG would like to work with the Homelessness Partnership Board to identify opportunities to better align and integrated provision October 2019	*Health services e.g. Nurse practitioners will work within immediate access homelessness services or Hubs.* ***Mental Health Services (commissioner)*** Forward Thinking Birmingham (FTB) are commissioned to provide specialist support to vulnerable group of children and young people. They do this by working collaboratively with the LA and St Basils. **Future –** The CCG is working alongside BCC and Mental Health Providers to develop and submit applications to PHE and NHSE to attract additional funding to target provision to this population Submissions July 2019	*Integrated care and support assessments and plans will be put in place for those in recovery* ***Mental Health Services (commissioner)*** FTB/BSMHFT are commissioned to work collaboratively to support assessments and plans will be put in place for those in recovery **Future –** The CCG is keen to work with the Homelessness Partnership Board to explore approaches to developing single shared plans for individual citizens such as the ICAT tool developed as part of the Changing Futures Model Timescale to be agreed with Homelessness Partnership Board	*Health practitioners will ensure planned handover when locality changes take place* ***Mental Health Services (commissioner)*** FTB/BSMHFT are commissioned to ensure planned handover when locality changes take place **Future –** The CCG is keen to work with the Homelessness Partnership Board to explore approaches to developing single shared plans for individual citizens such as the ICAT tool developed as part of the Changing Futures Model Timescale to be agreed with Homelessness Partnership Board	

Commitment to collaborate to prevent and relieve Homelessness - Health 'asks'

If homelessness or housing need appears to be a contributing factor to the person's health and well-being, the health provider will have information to make appropriate referrals including duty to refer ***Mental Health Services (commissioner)*** FTB/BSMHFT are commissioned to provide a comprehensive assessment of mental health needs, which would include having an understanding of social needs including housing **Future -** Agree key messages around homelessness prevention via Homelessness Partnership Board tailored to health professionals which can be disseminated via CCG communication channels. September 2019	*Homelessness services will have fast track access to primary care and mental health support for homeless or at risk clients.* ***Mental Health Services (commissioner)*** FTB/BSMHFT are commissioned to provide a model of care that considers risk factors including homelessness and at risk of homelessness **Future –** Commissioners are working with NHS providers and the VCS to broaden the options available to people in mental health crisis. This will include better access to 'Crisis Café's and 'Crisis Houses'. The CCG is working with partners to develop an application for Transformation Funding to support crisis alternatives. Submission July 2019 Crisis alternatives operational March 2020	*Health services will contribute to and adhere to referral protocols for hospital discharge.* ***Mental Health Services (commissioner)*** FTB/BSMHFT are commissioned to work collaboratively with hospitals to support discharge planning and community support.	*Health services will not discriminate against individuals because they are homeless or in insecure housing.*	*There will be confirmed escalation processes when general access is not working.*	*Health practitioners will ensure that they listen to the experience of their patients and take action on feedback which helps to prevent and relieve homelessness* ***Mental Health Services (commissioner)*** FTB/BSMHFT have been commissioned to ensure that they listen to the experience of their patients and take action on feedback. **Future -** Patients who are at risk of becoming homeless can be 'read coded' on the system. This will trigger a referral process to local support services.

Mental health services and drug and alcohol services are commissioned to take account of the close link to homelessness and ensure the person's housing situation is considered in holistic assessments and planned intervention. ***Mental Health Services (commissioner)*** Housing needs form a key part of an individual's initial and ongoing assessment. Workers will seek to work in partnership with other agencies to ensure that housing needs are met recognising this as a key protective factor in an individual's mental health. **Future –** The CCG is keen to work with BCC around the recommissioning of Vulnerable Adults Housing Support and Wellbeing Services for people with Mental	*Health services in the City will commit to a voluntary commitment to collaborate to prevent and relieve homelessness and publish visibly what this means.* ***Mental Health Services (commissioner)*** The CCG will work with mental health providers to develop a shared statement which sets out how it will seeks to prevent and relieve homelessness through the delivery of its services. Timeframe Oct 2019 This will be developed as part of the wider transformation of the mental health pathway being progressed locally.				

Health Needs to ensure alignment of provision 2021					
					Tom Howell June 2019

NHS
Sandwell and
West Birmingham
Clinical Commissioning Group

Health and Homelessness

- SWB CCG is committed to addressing the barriers that prevent people who are homeless from having equitable access to health services and health outcomes.
- SWB CCG will collaborate with partners to influence the wider determinants of health which prevent people who are homeless from living healthy, happy and fulfilling lives.
- SWB CCG has joint commissioning arrangements in place with BSOL CCG for Mental Health, Learning disability, Children and Homeless services. Further information will be available from BSOL CCG.
- SWBCCG is lead commissioner for health services to asylum seekers in Home Office initial accommodation (IA) in Birmingham and is committed to collaborating with partners to minimise the risk of homelessness and destitution across the asylum pathway.

1. Current Programmes 2019/20 :

Intervention	Programme	Outcomes	Lead & Scope	Timescales
Targeted: Patients that are Homeless will have access to bespoke services to meet their needs	Birmingham Homeless Primary care Health Service	As per BSOL information provided	SWB CCG Jointly commission with BSOL CCG identified as lead commissioner Birmingham City	As per BSOL information provided.
Targeted: Asylum Seekers at risk of homelessness will receive bespoke support into appropriate pathways.	LASLO	**Health outcomes:** Asylum seekers are supported to register with GP practices and to access appropriate health services including maternity and mental health services.	Birmingham City council. *(SWBCCG have been key partners to the development + implementation of LASLO's)* Birmingham City.	TBC
Universal: access to GP services and registration for people with insecure	The Safer Surgeries Initiative	GP primary care services will provide equitable access.	SWB CCG commissioned service. Lady Wood and Perry Barr	To 31st March 2020

housing or unstable immigration status		Healthcare professionals and staff will promote inclusive practice and be responsive to the needs of this patient group. GP practices will have access to on-line advice and guidance to create a safe environment.	localities of West Birmingham.	

2 Development to inform future commissioning priorities (19/20):

Intervention	Programme	Outcomes	Scope	Timescales
Wider Determinants	Review and redesign of pathways from IA health services to into dispersed accommodation and wider integration into communities.	Mapping of pathways Identification of gaps and opportunities. Identification of commissioning priorities.	SWB CCG (Multi agency partnership group) Ladywood and Perry Barr localities.	By April 2020
Mental Health	Test community based models for people with co-occurring mental health and alcohol conditions who are homeless or rough sleeping	Support local developments to test out the impact of community based models across the footprint.	Birmingham City wide	tbc
	WMCA Thrive into Work	Primary care networks register to join the pilot. Patients that fit the criteria are	WMCA Ladywood and Perry Barr localities	October 2019

Intervention	Programme	Outcomes	Scope	Timescales
		referred into the programme. Learning from the pilots informs future commissioning priorities.		
Health Screening for LTBI and Treatment for TB	Review screening and treatment pathways for people that are homeless or with NRPF.	Mapping of pathways Identification of gaps and opportunities. Identification of commissioning priorities.	SWB CCG	By April 2020

Birmingham Health and Wellbeing Board

	Agenda Item:16 Appendix 6
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30th July 2019**
TITLE:	**HOMELESS HEALTH EXCHANGE - A HOMELESS PRIMARY CARE SERVICE**
Organisation	**Birmingham & Solihull Mental Health NHS Foundation Trust (BSMHFT)**
Presenting Officer	**Charlotte Bailey, Executive Director Strategic Partnerships**

Report Type:	**For information as requested by the HWBB**

1. Purpose:
To update and assure the Birmingham Health & Wellbeing Board on the provision offered to the homeless population centred around Birmingham city centre. The Homeless Health Exchange provides a fully functioning Primary Care General Practice Medical Service to a targeted population living in and around the practice area, specifically servicing those people identified who are rough sleeping, in temporary accommodation via direct access hostels or those at risk of becoming homeless, who require access to a GP Practice, who can support their often complex needs.

2. Implications:		
BHWB Strategy Priorities	Health Inequalities	✓
	Childhood Obesity	
Joint Strategic Needs Assessment		
Joint Commissioning and Service Integration		✓
Maximising transfer of Public Health functions		✓
Financial		
Patient and Public Involvement		

Early Intervention	✓
Prevention	✓
Homelessness	✓

3. Recommendations
To note for information.

4. Background
The Homeless Heath Exchange Service was transferred to Birmingham and Solihull Mental Health Foundation Trust from Heart of Birmingham PCT in April 2008, following the cessation of the PCT. The service was transferred with **564** patients registered and a budget of circa **£620k** and was made up of the following staff groups: General Practitioners Service Manager Practice Nurses Specialist Substance Misuse Nurses Community Psychiatric Nurse Primary Care Mental Health Worker Support Worker Administration staff Today the practice has **1032** patients registered, a direct budget of **£615k**, slightly reduced from the original budget of which 90% relates directly to staff pay costs. The Homeless Health Exchange support two specific homeless projects within Birmingham, that link up to the Homeless Prevention Strategy: **Local Authority Street Intervention Team (SIT) -** the service provides a Specialist Nurse Prescriber from the Homeless Health Exchange 4 hours each day to work alongside the SIT, to identify those rough sleepers who need physical and/or mental health support by immediate examination and prescribing, also encouraging new homeless rough sleepers to register at the Homeless Health Exchange and often by supporting the person in need to attend A&E, where indicated and acting as an advocate the ensure the correct care is given. **Stone Road Asylum seekers project –** funded via S&WB CCG, a Psychiatric Nurse from the Homeless Health Exchange supports mental health assessments for asylum seekers who are temporarily placed at Stone Road, whilst their 'right to stay' is reviewed by the Home Office. Our nurse supports this vulnerable patient group by assessment of mental health needs, providing a support package and

linking the group into appropriate care pathways or advocating on their behalf with the Home Office in relation to their ongoing mental health needs, if remaining within Birmingham our nurse will ensure appropriate and ongoing mental health follow up and offer registration at the Homeless Health Exchange, as required.

5. Discussion

What are the health needs of the homeless population within Birmingham. The Homeless Health Exchange have been instrumental in a recent study, published in July 2019 – "Healthcare issues amongst the homeless in Birmingham" in conjunction with West Midlands Combined Authority, Public Health England (West Midlands), University of Birmingham and Robert Green University, Aberdeen.

The study looked specifically at the registered patients of the Homeless Health Exchange, to understand the needs of the Birmingham homeless population, some of the key areas noted are as follows:

- Based on **928** patients at the time of the study, 831 (89.5%) were male with 97 (10.5%) female, between the ages of 17 and 81 years.
- Average age of males 39 and females 34, the majority White British
- 33% of Health Exchange registered patients attended A&E at least once within 12 months
- 21.3% of Health Exchange registered patients were alcohol dependent at a harmful level
- 13.5% of Health Exchange registered patients were drug dependent
- 6.5% of Health Exchange registered patients had treatment for leg ulcers, national average less than 1%
- 52.3% of Health Exchange registered patients were smokers
- Lower levels of mental health issues at Health Exchange against other specialist homeless practices
- Substance misuse issues at Health Exchange at lower levels against other specialist homeless practices
- Low cancer rates levels at the Health Exchange than expected
- High prevalence of multi-morbidity e.g. mental health, substance use and infectious diseases with the Health Exchange population.

The mean age of the general population experiencing these types of illnesses between 60-69 years the mean age of those registered at the Homeless Health Exchange experiencing these illnesses 38 years old.

6. Future development

The service focus for the next twelve month's is as follows:

- to agree joint pathway plans, with the wider homeless stakeholder group, including other healthcare provision, to incorporate not only current rough sleepers, but also those at risk of rough sleeping via links with criminal justice, diversion and liaison services
- to work alongside BSMHFT services within HMP Birmingham to identify those released without accommodation and GP registration, back to Birmingham.
- To support 'housing first' initiative.

7. Compliance Issues

7.1 Strategy Implications

BSMHFT is a member of the Birmingham Homeless Board and has contributed to the development and planning for the city. It has provided data and statistics to help understand the matters related to homelessness and have supported piloting new initiatives.

The service has worked hard to link with other services as described in section 7.3

The service will be looking at how it continues to support the prevention strategy and specifically housing first, when issues of mental health, homelessness and drug and alcohol support is required.

7.2 Homelessness Implications: -

There is a growing number of homeless people within the city; not just those who are in the street but the 'hidden homeless'. The numbers supported by the services have nearly doubled in the last ten years. The service has had a budget reduction despite providing for more people whom are homeless.

There is a growing number of projects for the service to interface with and opportunities for the service to work with others including drug and alcohol services.

7.3 Governance & Delivery

The Homeless Health Exchange, delivers a Monday to Friday service, currently between 9am and 5pm with both booked and drop-in appointments with GP's and Practice Nurses on a daily basis for both those already registered at the practice

and those who self-refer for new registration or those referred by other homeless providers, the service provides outreach provision to all local direct access homeless hostels and 'on street' support.

The Homeless Health Exchange provides a range of primary care services for homeless patients with some enhanced services to meet the specialist requirements of the homeless population, which includes:

GP Services

General Practitioners (GP's) work from the service, providing 8 sessions per week from Monday to Friday. The Practice closes each day between 12.30 and 13.00

Phlebotomy

A full range of physical health conditions are tested for using staff trained in phlebotomy. In addition a significant number of homeless substance misusers will have a history of previous intravenous drug use or will be currently injecting. It is widely accepted that injecting drug use is common amongst the homeless population and that up to 50% of intravenous drug users have Hepatitis C virus infection. Hepatitis B infection is also common amongst this group. The service provides:

- Testing for presence of blood borne viruses and immunity status
- Immunisation check and catch up
- Screening for Hepatitis A, B and C
- Vaccination against Hepatitis A and B viruses as required
- Health education and harm reduction advice
- Referral to and close liaison with hepatology services and the Liver unit as appropriate
- Support to attend hepatology appointments.

Nursing in-reach and out-reach clinics

A Practice Nurse provides drop-in clinics at Sifa Fireside each week.

The clinics cover:

- Minor Illnesses and Injury to include prescribing
- Chronic Disease Management/Support
- Cervical Screening
- Smoking Cessation
- Wound Care/Management

Clinics with the Health Exchange cover specific nurse appointments are available for:

- New Patient Health Checks
- Chronic Disease Management
- Wound Management

- Specialist Nurse Prescribing.
    - Signposting, co-ordination and facilitating of referrals to appropriate statutory/non-statutory/secondary care agencies e.g. Specialist Mental Health, Diabetes Clinics, Drug and Alcohol Agency referrals
    - Referral to secondary care outpatient clinics e.g. Epilepsy, Neurology, Cardiac and ENT outpatients.
    - Medication Reviews

The following specific women's services are available through the Homeless Primary Care Service:

- Pregnancy Testing
- Advice about Contraception
- Provision of Contraception (including implants)
- Cervical Cytology

Substance Use

The Homeless Health Exchange has two specialist primary care substance use nurses who work with homeless individuals to reduce the physical health harm incurred through individuals' substance use and homelessness to provide access to treatment of alcohol and substance problems with related physical health concerns, through the delivery of high quality evidence based services. These staff do not provide substitute prescribing in relation to substance use, but support those requiring this into local substance use services, whilst ensuring the physical health concerns are addressed.

The service will offer an appointment or domiciliary contact immediately prioritising those individuals with urgent health needs and rough sleepers who may have little or chaotic contact with local substance use services and who may be 'lost to follow-up' if there has been delays by local substance use provision offering an appointment.

The nurses work in an outreach capacity with the entrenched street sleepers to deliver street based health interventions and engagement of individuals to access primary care in order to address their physical and mental health issues. They offer clinic based appointment and assessments and domiciliary visits to hostels and other venues across the city, such as:

- Salvation Army
- Washington Court
- St Ann's Hostel
- Trinity Hostel
- Waterside House
- Holiday Road, MNU
- Lancaster Street, MNU
- Helen Dixon House
- Zambezi
- South Road Hostel
- Long Street Hostel

The nurses' work closely with the local substance use treatment provider to facilitate individual's access to their services and jointly work with keyworkers to manage the complex physical health care needs of chaotic homeless substance misusers.

Primary Mental Health Care

The Homeless Primary Care Service strives to provide access to a primary mental health care service to all patients who meet the referral criteria. The service work in partnership with BSMHFT Homeless Mental Health Outreach team to provide:

- Support for homeless people registered to the Practice to access secondary mental health services as required, in both a routine way and for those in a psychiatric emergency via the Trust's Single Point of Access service.
- Manage people within the Primary Care Service who no longer need secondary mental health support for primary mental health issues.
- Case management, care planning and relapse prevention planning for those patients who regularly move between primary and secondary mental health provision.

The Homeless Health Exchange psychiatric staff are responsible for:

- Assessment of primary mental health problems
- Assessment and management of primary care psychological and social needs
- Monitoring of patients in the community
- Medication management in liaison with the GP and where necessary in relation to joint case management the Psychiatrist from BSMHFT
- Relapse prevention and patient education
- Effective two way communication between primary care and other agencies involved in the patients care (A&E, GP's, CMHT and non-statutory agencies)
- Psychological Assessment
- Short term psychological intervention

The team see clients within 2 weeks of referral from within the Primary Care Service (16 weeks before national target requirements), the team also have a drop-in clinic weekly for patient registered patients to refer themselves to which enables easier opportunistic access for patients.

Health Promotion

Health Promotion is generally provided on an individual opportunistic basis and may include:

- Sexual health
- Diet & Nutrition
- Smoking Cessation
- Winter wellness support (Flu vaccination)

Wound Care

Numerous risk factors predispose homeless people to develop acute and chronic wounds of the skin and subcutaneous tissue. Many of the same conditions that give rise to such wounds also impede healing, the service provides:

- Regular wound care and dressing as part of the open access or specialist clinic.
- Prescribing of specialist dressings.
- Support to other homeless service providers on wound care.

The nurses based with the Homeless Primary Care Service have up to date knowledge about tissue viability and ongoing access to the CCG Tissue Viability Team.

Podiatry

Foot problems are one of the greatest sources of infection amongst the homeless, who are almost constantly on their feet, often wear inappropriate footwear and rarely have the opportunity to wash or care for their feet. These conditions range from skin disorders and wounds to trench foot and ulcers which can become infected and lead to gangrene, amputation and even death.

A Podiatry Service is available weekly, each via Birmingham Community Health Trust each Thursday, between 13.00 and 13.30.

Referral into Dental and Oral Care

Many factors contribute to poor dental and oral health amongst homeless people and ensure that they remain a high-risk group for oral and dental disease. The chaotic nature of a homeless person's lifestyle can prevent them from developing routines of eating and personal hygiene.

On top of this, many homeless people suffer from mental health or substance use problems. This can seriously undermine oral and dental health due to a lower interest in oral hygiene or the effects of drugs or tobacco and increased risk of oral cancer. The service is able to refer patients to a Dental and Oral Care Service available at Attwood Green Health Centre.

Service Model

The Homeless Primary Care Service adopts an assertive engagement approach in its work with individuals. The 'assertive outreach' mode of working originates from within the mental health field. It is an approach that is employed when the relationship between services and an individual is complex and chaotic. The flexibility of this approach enables the service to be provided to those who may not otherwise access it. The overall aim in working within this approach is to develop trusting relationships with individuals in a needs-focused way, employing flexibility and creativity, so enabling the delivery of a care package that is specific to client need. The service aims to stay in contact with individuals, making repeated assertive

attempts to make contact with people if they miss appointments. this is a service especially focussed on this patient group, many of who would not attend a standard general practice.
7.4 Management Responsibility
The practice's service delivery and governance arrangements are monitored via formal CQC registration, with direct reporting into BSMHFT and BSol CCG governance structures, with the service is linked into the wider homeless stakeholder group, through its membership of the multi-agency and sector Homeless Partnership Board.
7.5 Diversity & Inclusion
Section 5 outlines the profile of those whose use the service, as determined by a recent study.

Signatures	
Chair of Health & Wellbeing Board (Councillor Paulette Hamilton)	
Date:	

Birmingham Health and Wellbeing Board

	Appendix 7
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30th July 2019**
TITLE:	**SUPPORT PROVIDED FOR PEOPLE WHO ARE HOMELESS**
Organisation	**BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST**
Presenting Officer	

Report Type:	**For Information**

1. Purpose:
To provide information regarding the services that are available to support people who are homeless, following a request from the Health and Wellbeing Board

2. Implications:		
BHWB Strategy Priorities	Health Inequalities	✓
	Childhood Obesity	
Joint Strategic Needs Assessment		
Joint Commissioning and Service Integration		✓
Maximising transfer of Public Health functions		✓
Financial		
Patient and Public Involvement		
Early Intervention		✓
Prevention		✓
Homelessness		

3.	Recommendations
	No recommendations are being made as this item is for information only

4.	Background
4.1	Birmingham Community Healthcare NHS Foundation Trust (BCHC) is a large specialist provider of community health care. Our 4,500 colleagues provide services to people across Birmingham and the West Midlands, including many of the most vulnerable in our communities, including children in care and children and adults with learning disabilities and autism spectrum disorders.
4.2	We operate from over 300 sites across the Birmingham & Solihull and Black Country & West Birmingham Sustainability and Transformation Partnership (STP) footprint, providing care for people of all ages, throughout their lives. Our services are diverse; from health education and promotion activities to support people to live well to the most complex healthcare for those with highly specialist needs. We provide care in people's homes, in clinics and inpatient units.

5.	Discussion
5.1	In terms of the Birmingham City Council homelessness prevention strategy, BCHC will be involved in supporting local citizens in two of key areas set out in the Positive Pathway approach; targeted prevention and homeless recovery.
5.2	Our services support local people in 3 of the high risk groups identified in the homelessness prevention strategy:- • Vulnerable children and young people; • Young people leaving the care of the Local Authority, and; • People with learning disabilities <u>Vulnerable Children and Young People</u> The Birmingham Forward Steps service, which is a partnership between BCHC, Spurgeons, Barnado's, The Springfield Project and St Paul's Community Development Trust, provides a range of services for all children

aged 0-5 and their families. This will include children and families who are at risk of becoming homeless or who are homeless with Health Visiting input to hostels and asylum refuges. The service identifies issues such as domestic violence, parental drug and alcohol misuse and parental mental illness that increase the risk of homelessness.

https://bhamforwardsteps.co.uk/wp-_content/uploads/2018/10/BFS-Glossary-of-Services-FINAL-V3.pdf

We also provide the school nursing service for Birmingham, a range of therapy services as well as a community paediatric service. These services support children whose parents may be homeless. This contact is particularly about safeguarding children thorough child in need and child protection plan processes.

Young People leaving the care of the Local Authority

BCHC provides a health assessment service to children in care with medical assessments of 'new to care' children and nurses providing review health assessments. The Clinical Commissioning Group has invested in the nursing team so that by the start of 2020 there will be one nurse for every 100 children in care.

The roles of the expanded team are developing but should be an important service to young people at the point of leaving care and this is a group at high risk of homelessness.

People with Learning Disabilities

The route into our services for people with learning disabilities who arrive from outside Birmingham and who are homeless, is usually via a GP referral, referral by Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) or referral from an acute Trust following attendance at A&E.

Other Services

Community Dental Services within BCHC offer a drop-in service on a Thursday afternoon at Attwood Green Health Centre, on Bath Row. One of our Dental Nurses from this service spends time visiting local hostels, of which there are a number in the area, and needle exchange centres in the city centre to promote the service, identify people who may require this service and encourages them to attend.

6.	Future development
	We will continue to work closely with BSMHFT and acute providers to ensure that vulnerable people who are homeless and are not known to our services are able to rapidly access care

7.	Compliance Issues
7.1	***Strategy Implications***
	None identified
7.2	***Homelessness Implications***
	No negative implications have been identified. Bringing together different service providers to tackle these problems is a positive step forward
7.3	***Governance & Delivery***
	All services provided by BCHC are governed by the Board of Directors
7.4	***Management Responsibility***
7.5	***Diversity & Inclusion***
	These services are available to everyone who needs them

Birmingham Health and Wellbeing Board

Draft Forward Work Programme

2019-20 to 2020-21

Board Members:

Councillor Paulette Hamilton (Board Chair)	Cabinet member for Adult Social Care and Health	Birmingham City Council
Dr Peter Ingham (Vice Chair)	Clinical Chair	NHS Birmingham and Solihull CCG
Councillor Kate Booth	Cabinet Member for Children's Wellbeing	Birmingham City Council
Councillor Matt Bennett	Opposition Spokesperson on Health and Social Care	Birmingham City Council
Dr Justin Varney	Director of Public Health	Birmingham City Council
Professor Graeme Betts	Corporate Director for Adult Social Care and Health Directorate	Birmingham City Council
Sarah Sinclair	Interim Assistant Director for Children and Young People Directorate	Birmingham City Council
Paul Jennings	Chief Executive	NHS Birmingham and Solihull Clinical Commissioning Group
Ian Sykes	Chair, Sandwell and West Birmingham CCG.	Sandwell and West Birmingham CCG.
Andy Cave	Chief Executive of Healthwatch	Healthwatch Birmingham
Andy Couldrick	Chief Executive of Birmingham Children's Trust	Children's Trust
Dr Robin Miller	Head of Department, Social Work & Social Care Co-Director, Centre for Health & Social Care Leadership	University of Birmingham Education Sector

Gaynor Smith	Senior and Employer Partnership Leader	Department for Work and Pensions
Peter Richmond	Chief Executive of Birmingham Housing Trust.	Birmingham Social Housing Partnership
Richard Kirby	Birmingham Community Healthcare NHS Foundation Trust	Birmingham Community Healthcare NHS Foundation Trust
Sarah Sinclair	Interim Assistant Director for Children and Young People Directorate	Birmingham City Council
Co – optees		
Carly Jones	Chief Executive of SIFA FIRESIDE.	SIFA FIRESIDE
Charlotte Bailey	Executive Director Strategic Partnership.	Birmingham and Solihull Mental Health Trust
Stephen Raybould	Programmes Director (Ageing Better)	Birmingham Voluntary Services Council

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Schedule of Work: April 2019-March 2020

Board Meeting Date	Deadlines	Scheduled Agenda Items	Presenting Officers
Formal Meeting 30th April 2019 Venue : Committee Rooms 3 & 4, Council House, 3pm -5pm	Draft Report Deadline for Pre- agenda : 4th April Final Report Deadline: 18th April Agenda and Reports Dispatch Date: 20th April	Presentation Items Health Protection Report Update **PRIVATE ITEM** Health Protection Incident Report Update Birmingham joint strategic needs assessment: diversity and inclusion deep dive 2019/20 Joint strategic needs assessment update Information Items Feedback on Public Health Green Paper Consultation **(verbal)** Care Quality Commission Quarterly Update – Combined with Birmingham Older People Programme(BOPP) Sustainable Transformational Plan (STP) Bi – Monthly Update Proposal to relocate and improve the Adult Sexual Assault Referral Centres which serve Birmingham, Solihull and the Black Country. Primary Care Network	 Chris Baggott Chris Baggott Elizabeth Griffiths Elizabeth Griffiths Elizabeth Griffiths
Board Development Day 14th May 2019, Venue: 10 Woodcock Street , Aston Birmingham	Time : 1pm - 5pm	Workshop Group Discussion Items Health Inequalities Childhood Obesity	 Elizabeth Griffiths Kyle Stott

Informal Meeting 18th June 2019 Venue : Committee Rooms 3 & 4, Council House, 3pm – 5pm	Draft Report Deadline for Pre- agenda : TBC Final Report Deadline: tbc June 2019 Agenda and Reports Dispatch Date: tbc June 2019	**Themed : Place** **Discussion Items** Air Quality Update Report Active Travel Update Report Developers Toolkit Update Report Feedback on the Health and Wellbeing Board Development Session Changes Places Live Healthy , Healthy Happy STP Update Report	 Duncan Vernon Duncan Vernon Kyle Stott Kyle Stott and Elizabeth Griffiths Maria Gavin Paul Jennings
Formal Meeting 30th July 2019 Venue : Committee Rooms 3 & 4, Council House, 2pm – 5pm	Draft Report Deadline draft reports : 3TH July 2019 Pre – agenda meeting – 8th July 2019 Final Report Deadline: 19th July 2019 Agenda and Reports Dispatch Date: 22nd July 2019	**Discussion Items** Development of Health & Wellbeing Board Sub-Committee structure Making every adult matter overview Complex severe mental health : Dual diagnosis /personal disorder Drug and alcohol – Change , Grow and Live : Peer mentor Birmingham older people programme : Update on the ageing well programme Homelessness overview Birmingham Health & Wellbeing Board Forward Plan	 Justin Varney Justin Varney Tom Howell Max Vaughan Andrew McKirgan, Andy Lumb Cllr Sharon Thompson and Kalvinder Kohli

Formal Meeting 24th September 2019 Venue: Committee Room 3&4, Council House, 3pm – 5pm	Draft Report Deadline for Pre- agenda : 28th August 2019 Pre –agenda meeting : 2nd September 2019 Final Report Deadline: 13th September 2019 Agenda and Reports Dispatch Date: 14th September 2019	**Presentation Items** Public Health Budget Suicide Prevention Strategy NHS Long Term Plan Health and Wellbeing Board Priorities Update: Health Inequalities, what good looks like **Information Items** Public Health Priorities Green Paper Response Health and Wellbeing Board Priorities Update: *Childhood Obesity* Delayed Transfer of Care Care Quality Commission Update – Combined with Birmingham Older People Programme(BOPP) Sustainability and Transformation Plan Update Better Care Fund Governance Agreement Report	 Justin Varney Mo Phillips / Justin Varney TBC TBC

Formal Meeting 26th November 2019 Venue: TBC	Draft Report Deadline for Pre- agenda : 6th November 2019 Pre – agenda meeting : 11th November 2019 Final Report Deadline: 14th November 2019 Agenda and Reports Dispatch Date: 15th November 2019	**Presentation Items** Creating a Healthy Food City Forum Update Health and Wellbeing Board Priorities Update: *Childhood Obesity* JSNA Core Data Set JSNA Deep Dive – H&WB of Armed Forces Veterans in Birmingham Health Inequalities Focus on Employment: Gap in employment rates for mental health and learning disabilities Health Inequalities Focus on Employment: Economic inactivity for health reason **Information Items** Health and Wellbeing Board Fora information updates Health and Wellbeing Board Priorities Update: *Health Inequalities Indicators* Sustainability and Transformation Plan Update	Kyle Stott TBC Ralph Smith Susan Lowe TBC TBC

Formal Meeting 21th January 2020 Venue: Rooms 3 & 4, Council House, 3pm -5pm	Draft Report Deadline for Pre- agenda : 2nd January 2019 Pre – agenda meeting : 6th January 2020 Final Report Deadline: 10th January 2020 Agenda and Reports Dispatch Date: 13th January 2020	**Presentation Items** Creating a Mentally Healthy City Forum Update JSNA Deep Dive – Death and Dying in Birmingham Health Inequalities Focus on Children: Gap in school readiness for those with free school meal status Health Inequalities Focus on Children: Smoking in Pregnancy Health Inequalities Focus on Children: Life Expectancy at Birth Childhood Obesity Focus on topics TBC (potentially multiple presentations) Thrive at School **Information Items** Health and Wellbeing Board Fora updates Health and Wellbeing Board Priorities Update: *Childhood Obesity Indicators* Care Quality Commission Update – Combined with Birmingham Older People Programme(BOPP) Sustainability and Transformation Plan Update	 Mo Phillips Susan Lowe TBC TBC TBC TBC TBC

Formal Meeting 17th March 2020 Venue : Rooms 3 & 4, Council House – 3pm -5pm	Draft Report Deadline for Pre- agenda : 19th February 2020 Pre – agenda meeting : 24th February 2020 Final Report Deadline: 5th March 2020 Agenda and Reports Dispatch Date: 6th March 2020	**Presentation Items** Creating an Active City Forum Update JSNA Deep Dive – H&WB of Public Sector Workforce in Birmingham Health Inequalities Focus on Chronic Disease: Type 2 Diabetes and CVD Health Inequalities Focus on Chronic Disease: Depression Childhood Obesity Focus on topics TBC (potentially multiple presentations) Health and Wellbeing Board Priorities Update: Health Inequalities and Childhood Obesity Indicators Ageing / Age friendly city including access to toilet facilities **Information Items** Sustainability and Transformation Plan Update Health and Wellbeing Board Fora updates	 Kyle Stott Susan Lowe TBC TBC TBC TBC TBC

Development Day 28th April 2020 Venue: TBC	Draft Report Deadline for Pre- agenda : 1st April 2020 Pre – agenda meeting : 6th April 2020 Final Report Deadline: 16th March 2020 Agenda and Reports Dispatch Date: 17th March 2020	TBC	TBC

Formal Meeting July 2020		**Presentation Items** Appointment and Terms of Reference Health Protection Forum Update JSNA Deep Dive – Diversity and Inclusion (TBC) Health Inequalities Focus on Physical activity and inactivity Childhood Obesity Focus on topics TBC (potentially multiple presentations) **Information Items** Health and Wellbeing Board Priorities Update: *Childhood Obesity Indicators* Care Quality Commission Update – Combined with Birmingham Older People Programme(BOPP) Sustainability and Transformation Plan Update Health and Wellbeing Board Fora updates	 TBC Chris Baggott Susan Lowe TBC TBC

Formal Meeting September 2020		**Presentation Items** Creating a City without Inequality Forum update JSNA Core Data Set JSNA Deep Dive – topic TBC Health Inequalities Focus on Immunisation Rates Childhood Obesity Focus on topics TBC (potentially multiple presentations) **Information Items** Health and Wellbeing Board Priorities Update: *Health Inequalities Indicators* Sustainability and Transformation Plan Update Health and Wellbeing Board Fora updates	 Monika Rozanski Ralph Smith Susan Lowe TBC TBC

Formal Meeting November 2020		**Presentation Items** JSNA Deep Dive – topic TBC Health Inequalities Focus on Employment: Gap in employment rates for mental health and learning disabilities Health Inequalities Focus on Employment: Economic inactivity for health reason Childhood Obesity Focus on topics TBC (potentially multiple presentations) **Information Items** Health and Wellbeing Board Priorities Update: *Childhood Obesity Indicators* Sustainability and Transformation Plan Update Health and Wellbeing Board Fora updates	 Susan Lowe TBC TBC TBC

Formal Meeting January 2021		**Presentation Items** JSNA Deep Dive – topic TBC Health Inequalities Focus on Children: Gap in school readiness for those with free school meal status Health Inequalities Focus on Children: Smoking in Pregnancy Health Inequalities Focus on Children: Life Expectancy at Birth Childhood Obesity Focus on topics TBC (potentially multiple presentations) **Information Items** Health and Wellbeing Board Priorities Update: *Health Inequalities Indicators* Care Quality Commission Update – Combined with Birmingham Older People Programme(BOPP) Sustainability and Transformation Plan Update Health and Wellbeing Board Fora updates	 Susan Lowe TBC TBC TBC TBC

Formal Meeting March 2021		**Presentation Items** JSNA Deep Dive – topic TBC Health Inequalities Focus on Chronic Disease: Type 2 Diabetes and CVD Health Inequalities Focus on Chronic Disease: Depression Childhood Obesity Focus on topics TBC (potentially multiple presentations) Health and Wellbeing Board Priorities Update: Health Inequalities and Childhood Obesity Indicators **Information Items** Sustainability and Transformation Plan Update Health and Wellbeing Board Fora updates	 Susan Lowe TBC TBC TBC TBC
Development Day April 2021		Health and Wellbeing Board Priorities – Review and Refresh	TBC

Standard Agenda

1. Notice of Recording
2. Notice of Potential for Public Exclusions
3. Declaration of Interests
4. Apologies
5. Minutes and Matters Arising
6. Action Log
7. Chair's Update
8. Public Questions
9. Presentation Items (see detail above)
10. Information Items (see detail above)
11. Forward Plan Review
12. Finalise Agenda for next Meeting
13. Date, Time and Venue of next Meeting
14. Notice of Recording Ceased
15. Private Items (see detail above)

Notes

Any agenda change request must form part of prior HWBB information item with as much lead in as possible but no later than the HWBB immediately prior to the agenda change request, including requests from sub-groups (see below).

Health Inequality Focus and Childhood Obesity Focus agenda presentations can be several items if appropriate but all must include decision(s) and / or action(s) for the Board.

Health and Wellbeing Board Fora will provide a written update to each Board meeting; each will have an annual formal presentation to the Board on a rotational basis.

Any decisions and actions shall be subject to providing an update to the Board on the substantive outcomes, either via presentation or information item as deemed appropriate by the Board, at a future date to be agreed as part of said decision or action.

Supporting Documents Requiring Development

Agenda change request form
Report draft template
Report final template
Action / Decision request form
Action / Decision update report template