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

BIRMINGHAM CITY COUNCIL

HEALTH, WELLBEING AND THE ENVIRONMENT OVERVIEW AND SCRUTINY COMMITTEE

TUESDAY, 27 SEPTEMBER 2016 AT 10:00 HOURS
IN COMMITTEE ROOMS 3 & 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1 **NOTICE OF RECORDING/WEBCAST**

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

2 **APOLOGIES**

To receive any apologies.

3 **DECLARATIONS OF INTERESTS**

Members are 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 will be recorded in the minutes of the meeting.

3 - 6

4 **HEALTH, WELLBEING & ENVIRONMENT OSC ACTION NOTES 9TH AUGUST 2016**

To confirm the action notes of the meeting held on 9th August 2016.

7 - 40

5 **CABINET MEMBER FOR HEALTH AND SOCIAL CARE**

Councillor Paulette Hamilton, Cabinet Member for Health and Social Care, to give a progress update on the Birmingham & Solihull Sustainability & Transformation Plan

41 - 48

6 **PRIORITY REPORT OF THE CABINET MEMBER FOR CLEAN STREETS, RECYCLING AND ENVIRONMENT**

Councillor Lisa Trickett will be attending the meeting to give a report of her priorities.

49 - 116

7 **HEALTHWATCH BIRMINGHAM UPDATE**

Andy Cave, CEO Healthwatch Birmingham

117 - 122

8 **HEALTH, WELLBEING & ENVIRONMENT OSC WORK PROGRAMME 27TH SEPTEMBER 2016**

To consider the Work Programme for 2016/17.

The meeting is scheduled to adjourn for lunch at approximately 1230 hours.

LUNCH BREAK
The meeting will reconvene at **1400 hours in Committee Room 6** at the Council House.

123 - 132

9 **TRACKING OF THE 'TACKLING CHILDHOOD OBESITY IN BIRMINGHAM' INQUIRY**

Charlene Mulhern, Senior Officer Collaboration, Birmingham Public Health

133 - 140

10 **TRACKING OF THE 'LIVING LIFE TO THE FULL WITH DEMENTIA' INQUIRY**

Mary Latter, Joint Commissioning Manager Dementia

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

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

12 **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.

13 **AUTHORITY TO CHAIRMAN AND OFFICERS**

Chairman to move:-

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

BIRMINGHAM CITY COUNCIL

HEALTH, WELLBEING & THE ENVIRONMENT O&S COMMITTEE

1000 hours on 9th August 2016, Committee Room 2 – Actions

Present:

Councillor John Cotton (Chair)

Councillors Deirdre Alden, Sue Anderson, Mick Brown, Andrew Hardie, Simon Jevon, Carole Griffiths, Karen McCarthy and Robert Pocock

Also Present:

Karen Richards, Associate Director of Urgent Care, Birmingham CrossCity CCG
Carol Herity, Head of partnerships, Birmingham CrossCity CCG
Baseema Begum, Research & Policy Officer, Scrutiny Office
Rose Kiely, Overview & Scrutiny Manager, Scrutiny Office

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1. NOTICE OF RECORDING

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The whole of the meeting would be filmed except where there were confidential or exempt items.

2. APOLOGIES

Apologies were submitted on behalf of Councillors Uzma Ahmed and Kath Hartley

3. ACTION NOTES

It was noted that the Chair and Deputy Chair of the Committee have now written to the Leader in relation to the remit of the Committee and will report back to the members of the committee once a response has been received. The action notes of the meeting held on 19th July 2016 were otherwise noted.

4. DECLARATIONS OF INTEREST

Members were reminded that they must declare all relevant interests relating to any items of business to be discussed at the meeting. Councillor Andrew Hardie declared an interest as a registered GP working as a locum in Birmingham.

5. URGENT CARE IN BIRMINGHAM

The report was submitted.

The extensive pre-engagement work previously done during 2014/15 was referred to. It was noted that the new service needs to be transformational and needs to be simplified, providing 24/7 access where needed, and provide a consistent service across the city supporting patients. The Service needs to align to the national direction of change and to streamline and integrate services.

The existing walk-in/urgent care centre (UCC) contracts will be extended for 18 months while the broader urgent care strategy is being developed.

The recent re-procurement of the new NHS 111 service providing enhanced clinical assessment for patients within a clinical hub was referred to.

A service specification for the Urgent Care Service with a standardised offer and a minimum set of standards and services on offer is currently being developed. The aim is to have the minimum standards in place in our UCCs over the next 18 months/2 years and to develop the service from there. In terms of timescales a 12 week consultation should be ready to take place by the end of 2016 with the changes being in place for 2018.

In the course of the discussion Members emphasised the importance of:

- explaining and communicating the message to the public that the new service will be an improvement and the need to get the media message right with the public especially around what services are currently available and the current inconsistencies so that the service users understand the proposed changes.
- the necessity of making it easier for students to register with a GP since non-registration with a GP is a cause of many attendances at walk-in centres/UCCs.
- the fact that this is an opportunity to improve the way the service is delivered but that commissioners need to listen to patients.
- in particular account needs to be taken of travel scenarios and transport availability.
- the need to ensure that all parts of the city are covered by the new service in the way that UCCs are configured/located.
- doing the financial modelling around all the scenarios before they decide on the options to be included in the consultation.

In the course of the discussion the members requested that the following additional information be provided:

- A map showing where the current walk-in centres are with the postcode areas of users.
- The value of existing out of hospital contracts (excluding the tariff paid to A&E)

- The report of the feedback emerging from the 22nd July event.

6. HEALTH, WELLBEING & THE ENVIRONMENT OVERVIEW AND SCRUTINY COMMITTEE WORK PROGRAMME 2016-17

The work programme was submitted.

Members requested that the consultation plan including the financial implications of the options being consulted should be added to the agenda for the 25th October scrutiny committee meeting.

Members also requested that an item on the West Midlands Mental Health Commission should be added to the work programme, preferably also in October if possible.

RESOLVED:-

That the work programme be noted and updated in-line with comments made.

7. REQUEST(S) FOR CALL IN/COUNCILLOR CALL FOR ACTION/PETITIONS

None

8. OTHER URGENT BUSINESS

None

9. AUTHORITY TO CHAIRMAN AND OFFICERS

Agreed

The meeting ended at 1117 hours.

Birmingham City Council

Information Briefing

Report from:	STP Programme Office/Strategic Director for People	Date:	27th September 2016
Report to:	Birmingham Health Overview and Scrutiny Committee		

Progress Update – Birmingham and Solihull Sustainability and Transformation Plan (BSol STP)

1. Summary

This is a progress update on the development of the Birmingham and Solihull Sustainability and Transformation Plan (BSol STP). It sets out to provide some context to the STP process to date and an indication of next steps.

2. Background

On 22nd December 2015, NHS England (NHSE) published two key planning documents: the NHS Five Year Forward View 2016-2021, and the NHS Mandate, which covered commissioners and (for the first time) providers.
These set out the requirement for the NHS to provide a five year Sustainability and Transformation Plan (STP), which would be place based, and drive the Five Year Forward View covering October 2016 to March 2021. It was made clear that the STP was the only route to access additional sustainable transformation funding (STF) from government.

The guidance was clear that in addition to covering the NHS, the STP must cover "better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies"[1]

Local areas were asked to agree a transformation footprint for their STP by 29th January 2016. The footprints needed to be locally defined, based on natural communities, existing working relationships and patient flows, whilst also "taking into account the scale needed to deliver the service, transformation and public health programmes required, and how it best fits with other footprints"[2]. These footprints were then submitted to NHSE for approval. Where areas were unable to agree a footprint, the NHS made the decision.

[1] Delivering the Forward View: NHS Planning Guidance 2016/17-2020/21
[2] Delivering the Forward View: NHS Planning Guidance 2016/17-2020/21

In total, there are 44 STP footprints across England (Wales, Scotland and Northern Ireland do not have STPs). Within the WMCA geography, there are three STPs involving constituent members of WMCA – Birmingham and Solihull, the Black Country and Coventry and Warwickshire.

The appropriate footprint for Birmingham, Solihull and the Black Country was extensively discussed by NHS and local government leaders, and the current arrangement (ie Birmingham and Solihull STP, Black Country STP) was agreed as the best option. However, as part of East Birmingham falls within the Black Country STP due to NHS and local authority boundaries not being co-terminus, and there is significant cross-over patient flow within East Birmingham and Sandwell, both STPs have associate status within each other's governance arrangements. Birmingham and Solihull are fortunate to have a STP footprint that has considerable coherence both as geography and in how it works to meet the health needs of people within the area. All parties have worked hard to form a cohesive approach to the STP process sand there has been particularly strong collaboration and joint working between the two councils

Each footprint was also required to agree a system leader for their STP – individuals who command both the support of their local colleagues and the national leadership bodies of the NHS. Birmingham and Solihull's system leader is Mark Rogers, Chief Executive of Birmingham City Council. The Black Country STP is led by Andy Williams, Accountable Officer Sandwell and West Birmingham CCG.

Across the country, only four STPs have local government system leaders – Birmingham and Solihull, Norfolk and Waveney, Manchester and Nottinghamshire. The remainder are from the NHS.

The role of the system leader is to ensure the right conversations are taking place, help to mediate any internal frictions and prompt (sometimes forcefully) the necessary explorations of what needs to change. A system leader cannot adopt a top down 'command and control' approach to leadership, and they are not statutorily responsible for the delivery of the STP.

STPs are not statutory bodies but collaborations of organisations working together to join up health and care services for people across agreed areas. This is similar to the place-based approach that is more prevalent in local government planning. STPs are envisaged as umbrella plans for a locally agreed area. More specific organisational and/or service delivery plans will then align underneath them.

Scrutiny should also note that STPs are perceived nationally as an NHS-driven and NHS-owned plan. The role of local government is as a partner organisation round the table. The extent of engagement and involvement of local government within STP planning varies from place to place, and is largely dependent on the nature of the relationships within that place.

It should also be noted that the NHS has already signalled that the STP will replace further annual planning rounds, a move that would correct the previous deficit in local medium term planning. This also underlines the significance of the huge changes underpinned by the STP: moving to a collaborative place based planning system sounds reassuring and simple. The reality of replacing a system that has used competition and market shapes to define it requires significant organisational, cultural and behavioural change and work to date is only at the very early stages of making the shifts necessary to realise the full potential of the approaches offered by the STP.

Timescales to date

The NHS 2016/17 Planning Guidance issued in December 2015 originally outlined the following timescale:

Planning Guidance published	22 December 2015
Localities to submit proposals for STP footprints	29 January 2016
Submission of full STPs	End June 2016
Assessment and Review of STPs	End July 2016

The STP was asked to identify the scale of three gaps in the health and care system across the footprint – health and wellbeing, care and quality and the financial gap - up to 2021. It was then asked to outline how each footprint would propose to close those gaps, taking a system wide, transformational view.

It should be noted that NHS organisations were also required to write and agree their 2016/17 draft operational plans, approve their budgets and agree their contracting arrangements before the original June date for submission of the fully agreed and signed off STP.

The timescale has since been revised – an additional 'check-point' submission was added in April 2016 to see how plans were developing. As a result of this, the June submission became a further 'check-point', we have been asked to make a financial submission on Friday 16th September and the latest iteration of the full plan has been requested for October 21st 2016, when it will be assured nationally by a number of NHS bodies, including NHS Improvement and NHS England.

Over the past few months there has also been an increasing focus on the financial element of the STP from an NHS perspective – the size and scale of the gap and plans to close it over the next five years, which has formed the basis of the financial submission requested by NHSE and NHSI. At the time of writing, the financial submission does not make any specific mention of the social care financial gap from a local authority perspective.

Scrutiny may care to note that the timetable for this work to be completed, even with extensions, is extremely challenging, especially for those footprints with a more complex landscape who may be working together for the first time. This has also been a management process: trying to identify how to balance the health and care system is one of the most challenging issues of our time. At this stage all that has taken place is to develop a set of initial management options and a great deal of work needs to be done to develop the transformational aspects of the approach and to start the work that turns such plans into a reality.

National Progress

Comparative evidence for STPs is anecdotal at present, in part due to NHSE's instruction that draft plans were not to be shared publically (including with Health and Wellbeing Boards and Scrutiny Boards) in advance of submission of the 'full' STP – now October 21st. However, we do know that STPs are at varying stages of progress – in some areas programmes are more or less fully worked up with operational and financial agreements in place or close to agreement. Other areas still have a long way to go.

By looking at the success or otherwise of previous attempts at health and care integration through the BCF (Better Care Fund) nationally, broadly speaking it would seem that those areas where organisational boundaries are co-terminus, the provider and commissioner landscape is less complex and strong

relationships already exist have the best chances of success. There is also anecdotal evidence that those areas already under Success Regimes are making better progress with their STPs, as they have had a head start and a longer lead-in time to think about how they can address the complex issues that moving to a system-wide, transformational way of working present.

Engagement and Transparency

This has been a difficult area for STPs, as evidenced by recent commentary in the media resulting from a campaign by pressure group 38 Degrees. The guidance from NHSE up to point of writing has been very clear - STPs are not allowed to publically share their actual plans before 21st October, but can engage with stakeholders and the public about the kinds of issues and proposals that the plans may be covering. The degree to which footprints are able to do this will depend on how much progress has been made on drawing up potential proposals to the point that they can enable meaningful conversation.

Birmingham and Solihull STP are holding two workshop events on 27th September (Solihull) and 29th September (Birmingham) with key stakeholders from across the footprint, where some of the initial thinking will be shared and sense-checked. Our plans are not as advanced as in other areas - as this is the first time we have come together as a footprint to work in this way. It has taken time for us to make progress to the point that we have a sense of how we might begin to tackle the health and wellbeing, care and quality and financial gaps ahead. Once we have undertaken a sense-check on thinking so far, we will be in the position to plan out additional and more widespread engagement on the STP proposals with a much wider audience. It must be made absolutely clear that the planning document is a work in progress, it is a high level plan, no decisions have been made and no decisions will be made without proper consultation process being followed by the NHS and by the Local Authority.

See Appendix 1 (attached) for an overview of the gaps that the system currently faces with regard to:

- Health and Wellbeing;
- Care and Quality; and
- Finance and Efficiency.

On 28th September, the HOSC chairs of Birmingham and Solihull will receive a private briefing on the status of the STP plan. We cannot release the plan to Scrutiny in the normal way as this would in effect release it into the public domain, which we are currently being advised not to do until after 21st October.

There have also been issues for governing bodies with the tensions between tight timeframes for developing proposals and organisational governance requirements.

This whole issue has been one that is extremely challenging, particularly for how local government engages with the plans. Birmingham and Solihull Councils have therefore been clear to reach an agreement within the local Leaders and Chairs Group that the STP for this footprint is a work in progress and that we are all aware of the huge amount of work that is still needed, particularly to engage and develop proposals with the local population.

Understandably local government partners in STPs have stressed the importance of public engagement and confidence, and there is a major task ahead for leaders to move from discussions between themselves to leading local people through the choices entailed in creating a sustainable health and care economy. NHSE

published guidance on engagement on 16th September (attached as Appendix 2), and we will be looking locally to see a significantly increased profile of engagement from the 21st October.

Birmingham and Solihull STP – Role of the Local Authority

Birmingham and Solihull is in a different position to the majority of most STPs in having a local authority system leader, which has ensured that local authority engagement takes place at the highest level. As Mark Rogers is the BSOL system leader, the local authority position at Chief Executive level is led by Nick Page, Chief Executive at Solihull MBC, who works closely with Mark to ensure that both Birmingham and Solihull positions are represented.

At the political level, both the Leader, Cllr John Clancy and the Cabinet Member for Health and Social Care, Cllr Paulette Hamilton represent Birmingham City Council. Cllr Bob Sleigh (Leader) and Cllr Ken Meeson (Health and Wellbeing Board Chair) represent Solihull MBC.

NHS organisations are represented by their Chief Executives / Accountable Officers and the Chair of their Governing Bodies.

However, the key point that needs to be noted is that the local authority position is not as leader of the work. Both Birmingham and Solihull are players in a wider system. We are able to influence proposals, perhaps more widely than local authorities in other areas, but STPs remain, from a national perspective, an NHS plan. More recent discussions locally would suggest that local NHS colleagues recognise the role of local authorities within the local health and care system and are keen to create a system that works for Birmingham and Solihull. The Leaders and Chairs Group have therefore supported the inclusion of the care system within the overall picture.

For Birmingham City Council, the discussions about possible integration of services pre-date the arrival of STP guidance from the NHS. The Council's intention was to try and maximise the public pound in terms of the health and social care system, and to encourage, where possible and in the interests of the patient / citizen, the movement of adult social care services from acute settings to community settings. This intention is built into the budget of the City Council which has been clear that without a system wide approach, the reductions on local government funding would imperil the NHS. The STP is the best way for us to achieve this aim, working collectively with health colleagues across the Birmingham and Solihull footprint. It is also the only way we will achieve any additional government funding for transformation of services, be allowed to collectively control how we make any changes to our local system to ensure they are in the best interests of Birmingham and Solihull people, and the only way we can ultimately ensure that when decisions are made, they are made in a publically accountable way.

We have therefore as a Council adopted a clear approach to make a success of the STP and have supported it with considerable change investment funding alongside a huge commitment from the Chief Executive and other officers to work with the system. This reflects the changed approach by the City Council to model its future thinking on partnership approaches that mean sometimes working with the systems, rules and confines set by others and seeking to make a success of the work all the same. Ultimately our populations need answers as to how the NHS and care systems are going to work effectively to meet the challenges posed by rising demands and scarce resources.

Birmingham and Solihull Membership

Key partner organisations around the table at this point in time are: Birmingham CC, Solihull MBC, Solihull CCG, Birmingham Cross City CCG, Birmingham South Central CCG, University Hospital Birmingham Foundation Trust, Heart of England Foundation Trust, Birmingham Children's Hospital Foundation Trust, Birmingham Women's Hospital Foundation Trust, Birmingham Community Healthcare Foundation Trust, Birmingham and Solihull Mental Health Foundation Trust, Royal Orthopaedic Hospital Foundation Trust, Extracare Charitable Trust.

Sandwell and West Birmingham CCG and Sandwell and West Birmingham Hospital Foundation Trust are associate members.

NHS England and NHS Improvement also attend meetings

Contact Officer:	John Wilderspin, Strategic Programme Director BSOL STP Peter Hay, Strategic Director for People Cat Orchard, Senior Policy Officer to the Chief Executive
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SYSTEM GAPS

"We are asking local systems first to focus on creating an overall local vision, and the three overarching questions:

1. *How will you close the health and wellbeing gap?*
2. *How will you drive transformation to close the care and quality gap?*
3. *How will you close the finance and efficiency gap?"*

Delivering the Forward View: NHS planning guidance, Dec 2015

Demographic Context

Birmingham and Solihull have a total population of c1.3m people. Both have areas of affluence and areas of significant deprivation. Over 1.1 million people live in Birmingham and 205,000 in Solihull.

Summary of key demographics:

Birmingham is a young city (46% of the population are under 30)

Solihull has an ageing population (19% of the population are over 65, 13% in Birmingham)

Birmingham is a diverse city (42% of residents come from an ethnic group other than white)

Solihull has increasing diversity (11% of the population 15% of the under 15s)

Birmingham is a growing city linked in part to migration (9.9% increase since 2004, Solihull has increased by 3.6% since 2001)

Solihull has a prosperity gap reflected in the 10 year life expectancy gap between its wards

Other key facts:

75% of the Birmingham adult population owns a smart phone (highest coverage in Europe)

Solihull hosts significant economic hubs for the footprint – NEC, Land Rover, Birmingham Airport, and the future HS2 hub – currently drawing in 85,000 workers daily.

Birmingham hosts five universities.

HEALTH AND WELLBEING GAP

Scale of Gap
Vulnerable Groups & Communities 440,000 (~40% of the footprint population) live in the "bottom 10%" most deprived areas across the footprint. Within this population: - There is a life expectancy gap –Birmingham live 7.6 less years, men in Solihull 10.7, women in Birmingham 6.2, Women in Solihull 9.7 - 1 in 3 children live in poverty - 3x more likely to have a mental health condition, be admitted for ambulatory sensitive conditions, or die from conditions amenable to healthcare
Maternity & Early Years & Children & Young People - Birmingham is an outlier for A&E Attendances (0-4 years) - National outliner for infant mortality - Obesity: 38% of children aged 10-11 were classified overweight or obese in 2014/15, worst quartile (national average 34%) - Birmingham & Solihull are outliers in family homelessness
Employment & Health - 59,000 on Employment Support Allowance – (4.5% BSol population, compared to 3.7% national average)   - 49% with Mental Health problem, 14% musculoskeletal - Only 1% (Birmingham) and 3% (Solihull) of supported adults with LD in paid employment (national average 7%) - Only 6% of people with serious mental illness (on Care Programme Approach) recorded as employed
System factors - Outlier for hospital admissions for fall injuries: there were 2,363 injuries from falls in people aged 65 and over per 100,000 population in 2014/15, worst quartile (national average 2,000 per 100,000) - Deaths in hospital: 54% of deaths to place in hospital in Q1 of 15/16, worst quartile (National average 47%) - Primary care variation (See Care Quality gap)

CARE AND QUALITY GAP

Priority area	Areas requiring improvement	Planned activity
Primary care	• BSol is second lowest in country for GPs and nurses per thousand of the population • Nearly 1 in 4 of current GPs are over 55 • 27% Primary Medical Services in footprint Requiring Improvement or Inadequate (national average for footprints is 13%)	
HEFT	• Medical Care including older persons • Maternity and gynaecology • Outpatients and diagnostic imaging • Urgent and emergency care services • Children's and young people	Recovery plan in place and being implemented
Royal Orthopaedic Hospital	• Intensive / critical care • Outpatient and diagnostics	Recovery plan in place and being implemented
BCC Children's Service	• Long term ongoing issues with safeguarding	Recovery plan in place and being implemented
Adult social care provision	• Long term issues with quality requiring impovement	New dialogue with providers in Bham commenced

FINANCE GAP

2016/17

System faces **in year gap of c£18m in 2016/17**

This is driven by primarily by the pressures in Adult Social Care, the majority of which is as a result of BCC's situation, but there are emerging pressures in the commissioning and provider sides of the NHS

2020/21

Given no change in current spending trends, **the financial gap in 2020/1 will grow to c£713m**

Assuming we are able to deliver all currently planned savings right across the system, we would still have a residual gap of c £191m in 2020/1

Our Summary Story / key factors

Over 40% of the Birmingham and Solihull population (440,000 people) live within the lowest 10% deprivation decile; one in three children live in poverty.

When analysis of quality issues , specifically CQC ratings , are overlaid upon this picture of deprivation it is clear that the poorest people receive the poorest health and care offer resulting in increased hospital utilisation - a vicious circle. This is further compounded by the financial position of the Birmingham City Council (and less so Solihull Metropolitan Borough Council) and available resources for social care.

In addition we have multiple different cohorts who are of sufficient size to warrant specific attention and require engagement in different ways to be effective:

- **2,500 most vulnerable**
- **65,000 students**
- **Economic migrants and refugees**
- **Over 75s including those with dementia**

However we also have providers of world renown within the footprint and our collective challenge is to build upon this to drive overall improvements in health and social care provision and to use as the foundation for wider engagement on and contribution to economic development for the footprint and wider Combined Authority.

Engaging local people

A guide for local areas developing Sustainability and Transformation Plans

September 2016

Engaging local people

A guide for local areas developing Sustainability and Transformation Plans

Version number: 1

First published: September 2016

Prepared by: NHS England

This document is for: Teams developing Sustainability and Transformation Plans (STPs) in each of the 44 footprint areas, and the statutory organisations which form part of them

Publications Gateway Reference: 05761

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England*
- NHS Improvement*
- Health Education England (HEE)
- The National Institute for Health and Care Excellence (NICE)
- Public Health England (PHE)
- Care Quality Commission (CQC)

*The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.
*NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

Contents

1 Who is this document for?

This document, set out in the form of questions and answers, is for teams developing Sustainability and Transformation Plans (STPs) in each of the 44 footprint areas, and the statutory organisations which form part of them. Local statutory bodies are responsible for engaging and consulting on their proposals, and the relevant legal duties around engagement and consultation are set out in section 4 and Annex A.

It is intended to clarify the expectations on stakeholder involvement, in particular patient and public participation. It will be of particular interest to communication and engagement leads for STPs and footprint leaders. While the emphasis of this document is on patient and public participation, it is important that as part of their planning processes, those working to deliver STPs consider how they will engage with the governance structures of each of the constituent organisations across their footprint area.

2 Introduction

Local health and social care services have improved in recent years. People are living longer, waiting times are shorter, and treatments for cancer and heart disease - for example - are better than ever.

However, there are still improvements that need to be made to make sure that local health and care services are the best they can be – both now and in future years. We believe that health and care services, people, communities and stakeholders, need to work more closely together, and in new ways, to achieve three key aims in the next four years (by 2020/21), which collectively will help provide better services for the public. The aims are to:

- **improve the quality of care people receive;**
- **improve health and wellbeing; and**
- **ensure our services are efficient.**

It will only be possible to achieve these goals by working together. This means patients, the public, carers, clinicians, stakeholders and individual local health organisations (such as GPs, hospitals and local authorities) joining forces to agree a plan to improve local health and care services.

These local plans for better health and care are known as STPs. They will support the delivery of a national plan called the Five Year Forward View (5YFV). Published in 2014, it set out a vision of a better NHS, and the steps we should take to get us there by 2020/21.

To succeed, STPs will need to be developed with, and based upon, the needs of local patients and communities and engage clinicians and other care professionals,

staff and wider partners such as local government. And we cannot develop care coordinated and centred around the needs of patients and users without understanding what communities want and without our partners in local government. That is why we need robust local engagement plans as part of the STP process.

In our June STP submission guidance we set out expectations that STPs would include the following elements:

- Plan to engage more formally with NHS boards and those of their partners after the July conversations between STP leads and representatives from national bodies;
- How footprints have engaged organisations and other key stakeholders so far, and with whom they are still to engaged; and
- Evidence or plans to involve staff, clinicians and care professionals, patients and Health and Wellbeing Boards etc.

Local proposals for health and care transformation are not expected to have gone through formal local NHS or other organisations' board approval and/or formal public engagement or consultation at this early stage. It may be helpful to have early discussions which set out:

- a shared view from your team on the likely direction of travel for services in your area;
- existing or early insight about the needs and views of patients and the public; and
- your approach to engaging formally with boards, partners, patients and the public going forward with the STP process.

We expect that most areas will take a version of their STP to their organisation's public board meeting for discussion between late October and the end of the year.

We would also expect that most areas will publish their plans, for more formal engagement, during this period - building on the engagement they have already done to shape thinking.

Every area will be working to a different timeframe, based on its own circumstances and how well-progressed its plan is.

In this document, we primarily talk about involving patients and the public. Other terms are often used, such as engagement, consultation, participation and patient or public voice – these are all phrases used to describe different ways in which the public can be involved and are not mutually exclusive. Consultation is just one of the many possible types of public involvement that can be carried out by health and social care providers and commissioners to meet their legal duties relating to public involvement (see Annex A for information about the relevant duties).

This guidance is intended to support the STP process but does not replace each organisation's own legal responsibilities to involve the public. STP footprints are not statutory bodies – but discussion fora – so individual organisations within each remain accountable for ensuring their legal duties are met during the STP design, delivery and implementation process.

3 Why is the involvement of people, communities and stakeholders important in developing STPs?

Involving people, communities and stakeholders in developing plans is the right thing to do to ensure that the plans and their implementation are robust and meet the needs of people and communities. Building on the six principles for engaging people and communities, STP partners should work with the knowledge, skills and experience of people in their communities, working in co-production to improve access and outcomes.

Involving people, communities and stakeholders meaningfully is essential to effective service improvement and system transformation, from collectively identifying problems and designing solutions to influencing delivery and review. Effective communication and involvement throughout the process will help to build ownership and support for proposals to transform health and care and will also help identify potential areas of concern.

In addition, public bodies with responsibility for STPs have a variety of legal duties including to involve the public in the exercise of their statutory functions. Not doing so effectively is likely to cause legal challenge and lengthy delay. A well thought through and documented engagement approach, that involves local stakeholders on an ongoing basis and identifies those experiencing the greatest health inequalities, will lead to:

- the development of better quality STPs;
- STPs that draw on a range of insight and expertise, including from patients and the public; and
- reduced risk of legal challenge.

4 Whose legal duty is it to involve the public or consult?

Clinical Commissioning Groups (CCGs), local authorities, NHS trusts, NHS foundation trusts and NHS England all have separate, but similar, obligations to consult or otherwise involve the public.[1] Joint public involvement exercises are encouraged as they reduce the burden on patients and the public. They are likely to have wider reach into communities, help ensure a joined up approach across the STP footprint, and save time and money. Where joint exercises are developed, local partners will need to:

- ensure clarity about roles and responsibilities between the different organisations involved;

[1] For example, CCGs (section 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012), NHS England (section 13Q of the NHS Act 2006, as amended by the Health and Social Care Act 2012). Commissioners must also consult the local authority on substantial developments or variation in health services S244 (NHS Act 2006).

- ensure they understand and have taken account of the governance and assurance requirements for their constituent organisations of the STP, and have reflected these requirements in their timetable;
- consider how the constituent organisations should discharge their involvement duties with regard to the changes that are being consulted on; and
- ensure consistent messages about the case for change and the options for change that are being proposed.

See Annex A for more detail on the relevant statutory duties.

5 Who should we be talking to as we develop our plans?

It is essential that the STP partners in every area have an ongoing dialogue with patients, volunteers, carers, clinicians and other staff, citizens, the local voluntary and community sector, local government officers and local politicians, including those representing health and wellbeing boards and scrutiny committees and MPs. And local areas may wish to consider how to engage people who live outside the footprint area but access health and care services within it and may therefore be affected by footprint proposals.

Working with existing networks will help to maximise efficiency and effectiveness. Such networks will include CCG Lay Members, voluntary, community and social enterprise (VCSE) networks, Trust non-executive directors and governors, community networks and neighbourhood fora, Healthwatch, Health and Wellbeing Boards, Strategic Clinical Networks and Senates and Academic Health Science Networks). Local councillors can also provide a wide reach and depth of engagement with local populations, as well as working relationships with local neighbourhood or special interest groups.

As proposals take shape, there are a number of bespoke activities that STP partners could develop at the most appropriate level/s to strengthen participation, such as establishing citizen summits or panels, participatory events, or strengthening the roles of lay peers and champions.[2]

Health Overview and Scrutiny Committees and Health and Wellbeing Boards provide established channels to consult the public and involve local politicians. We advise that you discuss with your local government partners the most appropriate route to engage local politicians. Under the 2006 NHS Act and supporting regulations, scrutiny committees have the power to scrutinise the planning, provision or operation of health services in their area.

Where STP footprints cross local government boundaries, some local authorities are considering establishing joint boards or committees.

[2] The Participation Toolkit (Scottish Health Council, 2014) has a comprehensive and up-to-date list of different participation methods.

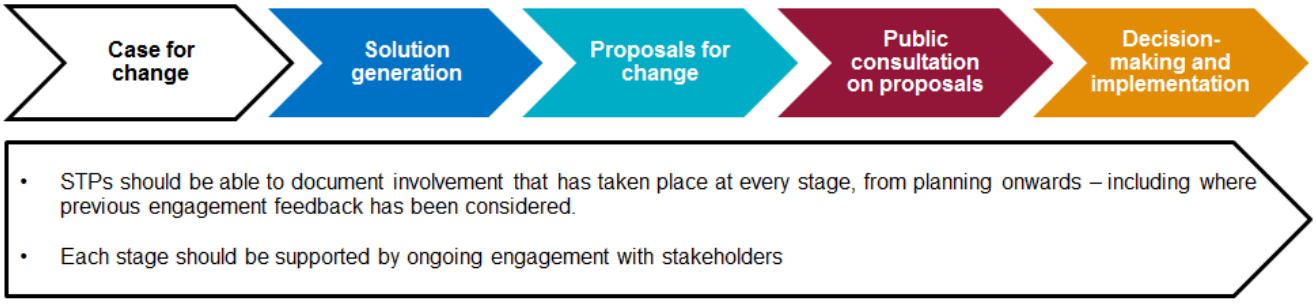
VCSE organisations can help to reach those who experience the greatest health inequalities, including those who work with people with protected characteristics. Particular emphasis should be given to engagement with people who are less frequently heard and who experience the greatest inequalities in health outcomes. This will help to ensure that informed and conscious consideration is given to assessing needs in respect of the equality and inequality duties. Locally, the best source of support for linking with the voluntary sector is frequently the council for voluntary services (CVS), sometimes called a local development and support agency.

Consider using community-centred and asset based approaches[3] that recognise the range of approaches to transforming services, reducing health inequalities and closing the three 'gaps' highlighted in the 5YFV. These approaches will help to ensure that people from all sections of the community are able to participate.

It is essential that STP partners engage staff from constituent organisations, working through the internal communication channels available (including with unions). In particular, clinicians should be engaged in the case for change, based on the best available evidence. Clinicians are powerful advocates and play an important role in communicating the need for change and potential solutions to a wider community.

6 When should we be involving people in the STP process?

Stages for STP engagement[4]



All footprints should be engaging with local people via Healthwatch and other patient and public groups, to discuss and shape their proposals. This will help them to understand what matters to local people and how services might be improved. These early stages require that key stakeholders have been identified and discussion is taking place based on the emerging and draft content of the STPs. Although this type of involvement does not require full plans to be published at this early stage

[3] An example of an asset-based approach is co-production, where services are designed with service users and carers. The Six principles for engaging people and communities (5YFV People and Communities Board, June 2016) contains further information.
[4] These stages may apply to both the overall STP and/or different components (such as a service change proposal that forms part of the STP).

while they are still in development, sufficient information should be provided to identify stakeholders to enable them to be involved in a meaningful way.

Moving forward in the STP process, footprints must start to identify which proposed changes will have an impact upon the delivery of services to patients or the range of services available. They should develop their engagement plan, including the resources needed and the timeline for involving the public. Exact timelines will depend on the scale of the changes proposed and the amount of engagement that has already taken place. STP footprints and the relevant organisations within them may wish to take advice on their specific proposals from a legal perspective and test their approach with local stakeholders, including health overview and scrutiny committee(s). As per the STP guidance issued in May, STP submissions should include engagement plans for both ongoing dialogue with stakeholders and for any formal public consultations required for major service changes.

As part of the ongoing involvement that underpins STPs, stakeholders will want to know that footprint areas and organisations within them are taking account of existing insight about patient experience and about the service needs and expectations of patients and the public. This could include insight from previous involvement, such as:

- insight from previous consultations on service change in the footprint geography;
- consultation during the development of commissioning plans by Clinical Commissioning Groups (CCGs);
- intelligence from local organisations such as the voluntary sector or local Healthwatch; and
- Health and Wellbeing Strategies and Joint Strategic Needs Assessments.

They will also want to know key milestones for publication of plans and decision-making. Clear written documentation, within a robust engagement plan, of how previous insight and involvement has contributed to initial plans will help you to identify what further involvement is required in relation to proposals for change.

When planning for engagement, it is important to co-ordinate activity in a meaningful way, for example working together across service areas or organisations to develop joint approaches where possible.

7 Which methods should we use to involve patients and the public or to consult?

Lay representatives and establishing reference or advisory groups can help. STP partners can make use of existing lay involvement in governance to support this, for example, working with Patient and Public Involvement Lay Members on CCG Governing Bodies or trust non-executive directors.

Additional involvement or consultation will depend on the changes proposed. There is always a legal duty for NHS commissioners and providers to involve the public in

planning, and in proposals for change and operational decisions that have an impact on services.

There are also specific legal duties on local government in regard to changes in their service provision locally. For example, local authorities have general duties to consult on significant changes to services, as well as specific duties around: specific groups, such as under equality legislation; activities, such as on fees and charges; or on local priorities, such as specific community groups.

To ensure that you reach a wide range of people, a variety of involvement approaches including face-to-face events, focus groups, digital involvement, dedicated events with communities of interest may be appropriate. This helps to ensure that those experiencing the greatest health inequalities are reached.

The method you use should be appropriate to the nature of the engagement exercise and the appropriate audience. Online methods can often be useful, but are unlikely to be accessible for all audiences, for example older people from more disadvantaged socio-economic groups.

As a general rule, the greater the extent of changes and number of people affected, the greater the level of activity that is likely to be necessary to achieve an appropriate and proportionate level of public involvement. However, the nature and extent of public involvement, including the length of consultation required will always depend on local circumstances.

Whichever methods of involvement are used, it is essential that the approach is documented and agreed through governance structures, and that there is an audit trail of the activity that has taken place, including questions raised and the response to them. This will strengthen proposals, highlight likely areas of concern, and provide evidence in the event of subsequent challenge.

8 How do we know if a formal public consultation is needed?

A formal public consultation is not needed for every service change. However, it is likely to be needed should substantial changes to the configuration of health services in a local area be proposed, such as hospital closure, or significant service change. It is therefore necessary to include consideration of the need for public consultation, and how this can be undertaken if required, in the overall STP.

This will also trigger the requirement to consult the local authority on substantial developments or variation in health services.[5] Where a proposal for change covers more than one local authority area, STP partners will need to talk to local authorities about joint arrangements, for example a Joint Overview and Scrutiny Panel. It is also important that proposed consultation processes and options are tested with local stakeholders such as local authority scrutiny colleagues. Local voluntary sector

[5] Section 244 NHS Act 2006 (as amended).

organisations and local Healthwatch may also be willing to review proposed engagement plans.

Where service change is substantial and significant, the relevant organisations within the STP footprint should ensure that they understand their legal duties and plan the time and resource to deliver the consultation effectively. Not planning effectively in this way could mean that proposed changes may be delayed or not carried through.

When undertaking consultation on proposed service changes, proposing bodies need to have:

- an outline of how previous engagement has contributed to developing the content of the consultation;
- clear information on the range of options being proposed, including if appropriate an explanation of why one option is preferred;
- a detailed plan for reaching all those who will be affected by proposed changes, including staff; people who use services, their families and carers; voluntary sector; equalities protected groups – using a range of engagement channels; and
- an effective approach to informing the media.

9 Are there any basic consultation principles we can build on?

The guiding principles are fairness and proportionality, taking into account the extent of the change and the number of people affected. The Gunning Principles[6] provide a helpful overview of what constitutes a fair consultation process:

i. **Consultation must take place when the proposal is still at a formative stage** – consultation cannot take place on a decision that has already been made. Decision makers can consult on a 'preferred option' (of which those being consulted should be informed) and even a 'decision in principle' as long as they are genuinely open to influence.
ii. **Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response** – those being consulted should be made aware of the basis on which a proposal for consultation has been considered and will be considered thereafter, including any criteria to be applied or factors to be considered.
iii. **Adequate time must be given for consideration and response** – there is no automatically required time frame within which the consultation must take place unless statutory time requirements are prescribed. A rationale must be set out for any departure from that expected timeframe.
iv. **The product of consultation must be conscientiously taken into account –** decision makers must properly consider the material produced by the consultation.

[6] Case law has resulted in a set of principles known as the *Gunning Principles* that set out the legal expectations of what is appropriate consultation. The emphasis is on 'fairness'; the process must be *substantively fair* and have *the appearance of fairness*.

Additionally, the Cabinet Office published revised Consultation Principles in February 2016.

10 Making the plans clear

Using jargon free and accessible language that is appropriate to the audience will be essential to ensuring that people can participate meaningfully. So STPs are “local plans for health and care services”. Local organisations such as those in the voluntary sector or local Healthwatch may be able to provide information about whether engagement materials will be accessible for local people.

11 Should we consult for 12 weeks?

The principles are that the consultation approach must be fair and proportionate (see section 9). The nature and extent of public involvement, including the length of consultation required, will always depend on the specific circumstances of an individual service change process and the population concerned. There is no legal requirement that consultation must last 12 weeks. If you consult for less than 12 weeks, you will need to be able to justify your reasons for doing this, and discuss with the relevant overview and scrutiny committees.

12 Do we need to consult if we only think there is one clear proposal for service change?

The legal requirement to involve patients and the public in planning and proposals for change still stands if there is only one proposal, or a preferred option. Service change must be evidence-based, and this evidence should be publicly available during the consultation and decision-making stages. It is important that the consultation is approached in a way that is genuinely open to influence.

It will only be reasonable to justify carrying out a limited or no public involvement exercise on grounds of urgency when the lack of time was genuinely caused by an urgent development or where there is a genuine risk to the health, safety or welfare of patients or staff. In such cases, local organisations must balance legal duties to involve and consult with maintaining continuity of care and protecting patients or staff.

13 What if we identify that there is a lack of capacity to carry out the required engagement and consultation?

Skills and experience to carry out the required engagement are likely to be found in the communication, engagement and patient experience teams of STP partners in the NHS, local government and beyond.

Formal public consultations may require additional communications and engagement capacity, and you may wish to consider including this within programme and resource planning. The skills and experience can also be commissioned from the voluntary sector, local Healthwatch and via Commissioning Support Unit (CSU) frameworks.[7] It is important that there is an 'intelligent customer' in the STP communications and engagement team who has skills and experience in public involvement and the associated legal duties. This will enable STP partners to manage any external resource effectively and ensure aligned approaches across the different organisations involved, and ensure that legal requirements are met. Local government communications colleagues also have significant expertise and experience in developing and managing communications around change.

Many STP footprints will find that ongoing engagement can be supported through the existing engagement infrastructure of STP partners.

Although specialist communications and engagement resource is often seen as an additional capacity need, failure to appropriately involve patients and the public in plans may lead to judicial review and criticism, regardless of any resource constraints. More importantly, it could lead to proposals that do not adequately meet the needs of the local community. Investment in a team of specialist staff may help to mitigate this risk and lead to improved engagement with stakeholders.

[7] For advice on securing engagement support from the local voluntary sector, talk to the relevant local councils or umbrella bodies for voluntary services. For advice on securing engagement support from CSUs, talk to the NHS England regional communication team.

Annex A – Relevant Statutory Duties

This Annex sets out a summary of the main statutory duties that apply to the organisations involved in the STP process and may give rise to a legal requirement to involve patients, the public and other stakeholders.

This is not a definitive list of every such duty and organisations must have regard to their own legal duties and existing arrangements for consulting with or otherwise involving the public. The statutory duties set out below should be considered in conjunction with the guidance on public involvement and principles of lawful consultation, as set out in the body of this guidance and elsewhere.

Organisations should also be mindful that in some circumstances it may be incumbent upon a public body to involve the public as part of its general duty to act fairly, even if this is not required by statute. For example, where consultations have been promised to the public or a well-established and consistent past practice of consulting the public exists, the duty to act fairly may require that such commitments and expectations are met.

References to legislation are to such legislation as amended, in particular by the Health and Social Care Act 2012.

Public involvement and consultation by NHS England, CCGs, NHS foundation trusts and NHS trusts

National Health Service Act 2006: section 13Q (NHS England), 14Z2 (CCGs) and 242 (NHS foundation trusts and NHS trusts).

NHS England, CCGs, NHS foundation trusts and NHS trusts are all under a duty to make arrangements to involve patients in:

- the planning of commissioning arrangements (NHS England & CCGs) or provision of services (NHS foundation trusts and NHS trusts);
- the development and consideration of proposals for changes in the way those services are commissioned/provided which would have an impact upon the range of services available or the manner of their delivery; and
- decisions affecting the operation of those commissioning arrangements/services which would have such an impact.

CCGs are required to set out in their constitutions:

- A description of their arrangements to meet the above duty; and
- A statement of the principles which they will follow in implementing those arrangements.

CCGs are also required to have regard to relevant guidance published by NHS England, that is, Transforming Participation in Health and Care.

NHS foundation trusts and NHS trusts are required to have regard to relevant guidance published by the Secretary of State, that is, Real involvement: working with people to improve services, and Involving people and communities: a brief guide to the NHS duties to involve and report on consultation (please note that this guidance has not been updated to reflect the abolition of primary care trusts and strategic health authorities, but still applies to NHS foundation trusts and NHS trusts).

Review and scrutiny by local authorities

National Health Service Act 2006: Part 12, Chapter 3.
Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013: Part 4.

Local authorities have a role in reviewing and scrutinising matters relating to the planning, provision and operation of health services in their local area. This role is usually carried out by an overview and scrutiny committee of the local authority for its local area or a joint overview scrutiny committee appointed by two or more local authorities to cover a larger area.

Commissioners and providers of NHS services (including NHS England, CCGs, NHS trusts, NHS foundation trusts and private providers) must consult the local authority where they are considering any proposal for a substantial development or variation of the health service in the area. Ordinarily, where the services in question are commissioned by NHS England or CCGs (as the case may be), the commissioners carry out this exercise on behalf of providers. Providers of public health services commissioned by the local authority are also required to consult the local authority in the same way as commissioners and providers of NHS services.

The local authority may scrutinise such proposals and make reports and recommendations to NHS England and the Secretary of State for Health. Legislation provides for exemptions from the duty to consult in certain circumstances, for example where the decision must be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff. As part of the overview and scrutiny process, the local authority will invite comment from interested parties and take into account relevant information available, including that from Local Healthwatch.

Local Healthwatch may also choose to refer a matter relating to social care services to the local authority, in which case the local authority must decide whether its review and scrutiny powers can and should be exercised in relation to the matter in question.

Public sector equality duty

Equality Act 2010: section 149

The Equality Act 2010 prohibits unlawful discrimination in the provision of services on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. These are known as protected characteristics. As well as these

prohibitions against unlawful discrimination, the Act requires public authorities to have due regard to the need to:

- eliminate discrimination that is unlawful under the Act;
- advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it; and
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

This is known as the public sector equality duty. To effectively discharge the public sector equality duty it is often necessary to carry out equality impact assessments and consult and engage with individuals with protected characteristics.

Health and Wellbeing Boards

Local Government and Public Involvement in Health Act 2007: sections 116 and 116A
Health and Social Care Act 2012: Part 5, Chapter 2

Health and Wellbeing Boards (HWBs) are established by local authorities and include a number of members from organisations with a stake in health and wellbeing in the area, including NHS England, CCGs, the local authority and Local Healthwatch. HWBs are under a duty to encourage integrated working in their local area.

The primary roles of HWBs are to work with local CCGs to:

- carry out assessments of needs in the local area (joint strategic needs assessments); and
- prepare a strategy for meeting such needs (joint health and wellbeing strategies).

In preparing such strategies, HWBs and CCGs must consider whether needs could be more effectively met through integrated arrangements between the NHS and local government, involve Local Healthwatch and involve people who live or work in the area.

HWBs may require information from their members, who must comply with such requests.

Commissioning plans

CCGs are required to prepare commissioning plans. These must set out how CCGs propose to exercise their functions (including how the CCGs propose to discharge their duty to involve the public).

CCGs are required to consult the public when preparing or amending their commissioning plans.

A HWB may give NHS England its opinion on whether a CCG's commissioning plan takes proper account of the joint health and wellbeing strategy.

Healthwatch

Local Government and Public Involvement in Health Act 2007: Part 14.
Health and Social Care Act 2008: Part 1, Chapter 3
NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012: Part 6.

Healthwatch was created with the purpose of understanding the needs, experiences and concerns of service users and to speak out on their behalf. Established through the Health and Social Care Act 2012, this created a model that operates both locally (Local Healthwatch) and nationally (Healthwatch England).

Local Healthwatch organisations carry out a range of activities in their local area, including:

- promoting and supporting the involvement of local people in the commissioning, provision and scrutiny of health and social care services;
- enabling local people to monitor and review the commissioning and provision of health and social care services;
- obtaining the views of local people about their needs for, and their experiences of, health and social care services;
- making such views known and making recommendations about how or whether health and social care services could or ought to be improved to those responsible for commissioning, providing, managing or scrutinising health and social care services and to Healthwatch England;
- providing advice and information about choice and access to health and social care services; and
- reaching views on the standard of health and social care service and whether, and how such services could or ought to be improved, and making those views known to Healthwatch England.

Bodies that are responsible for commissioning, providing, managing or scrutinising local care services must have regard to the views, reports or recommendations received from Local Healthwatch. They are also required to acknowledge and respond to such reports or recommendations. Such bodies would primarily include NHS England, CCGs, NHS foundation trusts, NHS trusts and local authorities in the area, as well as private providers of health and social care.

Healthwatch England provides general advice and assistance to Local Healthwatch organisations. It also has statutory powers to provide the Secretary of State, NHS England, NHS Improvement and local authorities with information and advice on:

- the views of people who use health or social care services and of other members of the public on their needs for and experiences of health and social care services; and

- the views of Local Healthwatch organisations and of individuals on the standard of health and social care services and whether or how it could or should be improved.

The bodies listed above are legally required to respond in writing to such advice from Healthwatch England.

Other governance arrangements and requirements

All organisations should be conscious of and adhere to their own governance arrangements and the need to consult and/or seek approval from others in order to take decisions in relation to STPs. For example:

- some decisions may have been reserved or delegated, depending on the organisation's scheme of delegation, standing financial instructions and constitutions (as applicable) (for example, where a CCG has reserved certain types of decisions to its membership);
- some commissioning decisions may have been delegated to and exercised by a joint committee (for example, where NHS England has delegated decisions related to primary care to a CCG under "co-commissioning" or where CCGs have established a joint committee to jointly exercise their commissioning functions);
- some decisions by NHS foundation trusts need approval by their council of governors (for example, "significant transactions", where and as defined within the constitution);
- the legal requirement to hold meetings in public, except where it is permissible to exclude the public, for example:
    - for NHS England and NHS trusts, where publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, as provided for by the Public Bodies (Admission to Meetings) Act 1960;
    - for CCGs, where it would not be in the public interest for the public to attend, as provided for in their constitution;
    - for NHS foundation trusts, where special reasons apply as provided for in their constitution.

Annex B – Resources and support on involvement and consultation

- Centre for Public Scrutiny, Smart Guide to Engagement: Working with Local Authority Scrutiny. This provides a succinct and practical guide to working with local authority Scrutiny.

- Department of Health, Real involvement: working with people to improve services (2008). Despite being published before the changes made by the 2012 legislation, this sets out a helpful guide to what 'involvement' really means and why effective involvement is so important, including patients, staff, local authorities and voluntary sector partners.

- Department of Health, Advice to local authorities on scrutinising health services (2014). This explains the health scrutiny regulations and provides local authorities with advice about how to implement them to ensure that existing health services are providing effectively for local communities.

- Five Year Forward View People and Communities Board, Six principles for engaging people and communities: definitions, evaluation and measurement (June 2016). This helps to better understand and measure the impact of engaging with local people and communities.

- Independent Reconfiguration Panel, IRP: Learning from reviews (November 2014). This sets out practical advice based on referrals to the IRP.

- Local Government Association, Integrating Community Engagement and Service Delivery - pointers to good practice (September 2010). This guide aims to help local authorities ensure that the results of community engagement processes are built into their service plans and the ways that they deliver services.

- Local Government Association, Association of Directors of Adult Social Services, Society of Local Authority Chief Executives, Centre for Public Scrutiny, Association of Directors of Public Health, Shared principles for redesigning the local health and care landscape (October 2015). This provides system leaders with key principles for ensuring that service change proposals are focused on improving services and improving outcomes.

- Local Government Association, Centre for Public Scrutiny, Piecing it Together: Effective Scrutiny of Health and Social Care Integration (May 2015). This provides a summary of key lessons and messages from scrutiny inquiry days held in three areas to assess the current role of scrutiny in the development of local plans for integration and how this can be improved in the future.

- NHS Confederation, NHS Clinical Commissioners, NHS Providers and the Local Government Association, New Care Models and Staff Engagement: All Aboard (June 2016). This contains four case studies that examine the ongoing work of NHS and local government organisations that are ensuring staff are at the heart of all decisions about new models of care in local areas.

- NHS England, Transforming Participation in Health and Care (2013). For general advice on involvement principles and approaches and helps CCGs and other commissioners of health and care services to involve: patients and carers in decisions relating to care and treatment; and the public in commissioning processes and decisions.

- NHS England, Planning, assuring and delivering service change for patients (November 2015). This is a good practice guide for commissioners on the NHS England assurance process for major service changes and reconfigurations.

- NHS England, Statement of Arrangements and Guidance on Patient and Public Participation in Commissioning (November 2015). This provides a helpful guide to NHS England's own public involvement legal duty which may also be of interest to others (including the ways in which the public can be involved and the guiding principles about fair and proportionate involvement).

- NHS Improvement, Communications and engagement toolkit: for teams in service change programmes (June 2016). This is a step-by-step guide to the different phases of a potential service change programme and the role of communications and engagement.

- National Institute of Health and Care Excellence, Community Engagement: improving health and wellbeing and reducing health inequalities, NICE Guidelines NG44 (March 2016). This covers community engagement approaches to reduce health inequalities, ensure health and wellbeing initiatives are effective and help local authorities and health bodies meet their statutory obligations.

- New Care Models, New Care Models: empowering patients and communities (December 2015). This sets out a directory of what support is available from the 5YFV partners and voluntary sector strategic partner organisations to fully engage with people and communities.

- Scottish Health Council, The Participation Toolkit (2014). This was compiled to support NHS staff to involve patients, carers and members of the public in their own care and in the design and delivery of local services, and is particularly useful on different involvement approaches.

Please contact your regional Head of Communications within NHS England for further support or advice.

Health, Wellbeing & the Environment O&S Committee - 27 September 2016

Priority Report of the Cabinet Member for Clean Streets, Recycling and Environment

Councillor Lisa Trickett

1. Purpose of report

This report sets out the Cabinet Member's portfolio priorities for 2016/17.

The report will only focus on those areas of the portfolio that are relevant to the remit of this committee and therefore will not include operational waste management (incorporating street cleaning, litter prevention, fly tipping, graffiti and placarding) as this falls under the remit of the Housing and Homes Overview and Scrutiny Committee.

2. Accountability and Responsibilities

In accordance with the City Council Constitution the Cabinet Member for Clean Streets, Recycling and Environment has accountability for positioning Birmingham as a 'Green City' ready for the challenges of the future, and with a sustainable infrastructure that supports these objectives through initiatives that are delivered by the city council and also by partner agencies, private and third sector organisations.

And has responsibility for the following:

Green City

Strategic leadership of the city's sustainability agenda, advising all Cabinet Members of initiatives that need to be taken and particularly in respect of employment, highways, transport, waste recycling and disposal matters, health and housing.

Climate Change

Strategic lead on policy and its implementation to address issues including climate change, carbon reduction, flood management, clean air zones, energy security, reduction of fuel poverty, food security and to maximise the contribution to be made by parks and green spaces.

Waste Strategy and Services

Development of a financially and environmentally sustainable waste strategy for the city, the collection and sustainable disposal of waste from residential and other properties within the city, street cleansing on operational matters and the promotion of recycling.

Local Parks and Allotments

Provision, maintenance and usage of local facilities

Cleaner Neighbourhoods

Street Cleaning, litter prevention, fly tipping, graffiti, placarding.

Pest Control

Provision of the Pest Control Service

3. Priorities – 2016/17

Working towards the shared vision of a fair, prosperous and democratic city and aligned to the priority outcomes of the City Council, and in particular a city with 'A Strong Economy' the Cabinet Member's portfolio priorities are:

- To develop a spatial framework for Birmingham that identifies geographical areas of 'sustainability' need and identify and implement the necessary interventions to address those needs.
- To ensure that 'sustainability' is at the core of neighbourhood and city centre development and transport planning.
- To develop a new waste strategy for Birmingham focused on reducing waste produced wherever possible, maximising recycling and reuse and where we cannot prevent, reuse or recycle we will maximise recovery through generating energy.
- To maximise the contribution that our parks, open spaces and allotments can make as 'Natural Assets' to the Future City agenda through the development of a 25 year Natural Capital Plan; echoing the Government's own policy. To respond to the Department of Communities and Local Government Select Committee on the 'Future of Parks'.
- To consult with partners and stakeholders on the provision of a new vision for grounds maintenance and parks services contract for 2019.
- To seek to increase the level of volunteering in Birmingham parks whilst maintaining a sustainable balance between empowering communities and our landlords duty of care.
- To raise parks profile and continue to achieve accolades such as Gold medal at Chelsea 2017, Britain in Bloom etc. and to continue to work with sponsors to increase floral opportunities, encouraging businesses to the city and maximising economic growth.
- To develop a consolidated Flood Risk Management Strategy for Birmingham building on the Surface Water Management Plan and the Strategic Flood Risk Assessment.
- To improve air quality in the city through the development of a clean air zone and other initiatives to reduce the impact of vehicle emissions. Alongside vehicle emissions, which account for the majority of poor air quality, we will also refresh our air quality action plan drawing together all areas in which the City Council can influence improvements.
- To establish an energy company that will, as a minimum, provide cheaper energy to our citizens in fuel poverty.
- To ensure that the delivery of the Birmingham Development Plan supports the growth of sustainable communities in a social, environmental and economic way.
- To maximise the opportunities that come from our infrastructure in terms of

decentralised energy, for example, maximising the potential of the city centre district energy scheme; ensuring options around cleaner, greener and leaner energy provision are a core part of our new developments.

- To ensure that we take an integrated approach to sustainability and that the energy, transport and waste systems complement each other to maximise value for the city.

4. **Progress/Achievements** (info awaited from service area leads)

- Members of this Scrutiny Committee will be aware of the progress being made on the development of a new waste strategy for Birmingham having been engaged in the first two of four workshops. In summary:
  - The aim of the new strategy will be to set out a long term vision of how the Council, its partners and the waste industry will work in collaboration with local residents and businesses to ensure that waste is reduced wherever possible, and only waste that cannot be reused or recycled is treated and managed in a way that maximises its financial, environmental and social benefit.
  - The principles of the 'circular economy' feature prominently in how the strategy will deliver this ambitious aim and the strategy should act as a platform for the city to act as place for innovation, both in terms of technical developments in how waste is best managed but also in the range of delivery models needed to make the circular economy a reality locally.
  - The work programme is on target to bring forward the final strategy for formal endorsement by Cabinet in [December 2016]. A series of officer / member workshops are currently underway in which the options for how we collect, treat and dispose of each type of waste (i.e. residual, garden, food, and recyclables) are being evaluated against criteria established in the first workshop. This process will provide transparency in terms of how a range of potential service options perform against the financial, environmental and social value priorities.
  - Work is underway to cost up to 7 different service configurations and compare this against the how the current service performs in terms of cost, recycling performance, carbon reduction, etc.
  - Public consultation on the key aims, objectives and targets of the draft strategy has now completed and a detailed analysis of the findings will be used to test how well each of the short listed options help meet public expectations. This is likely to be available at the end of September for consideration.
  - A key part of the waste strategy will focus on waste prevention and include a range of measures and projects to prioritise reduce and reuse ahead of recycling to help mitigate the effects of household growth over the period to 2030. The new corporate campaign aimed at promoting cleaner, greener streets launched on 12 September and the first 'mini-campaign' is promoting how members of the public, local businesses and other partners can take practical steps to change their behaviour. This campaign is expected to run for up to 3 years.
- In partnership with the University of Birmingham, the City together with additional external partners including the Royal Town Planning Institute and the Royal Chartered Institute of Surveyors; has secured Research Council funding to undertake

a 2 year national trial (2016-2018) of the Natural Capital Planning Tool, developed and being tested in Birmingham.

- The Parks service is working in partnership with national organisations including Historic England, the Forestry Commission and the National Trust on initiatives such as woodland management (in Sutton Park) and the Green Academies Project (GAP) to deliver habitat management courses for 16-21 years old and Urban Rangers for 11-16 year olds. Community use of parks continues to be supported and through the summer attracted over 300,000 visitors whilst also providing Ranger led events and Ranger led school visits.
- An options appraisal is being undertaken to explore the potential for a city energy company; this will be reporting back on 20 September in the first instance before proceeding with a full business case of the preferred option.
- We are working with the European Investment Bank to understand the potential of using European Local ENergy Assistance (ELENA) funding to develop the city's potential for heat networks and large scale rollout of solar PV.
- We are now 33% of our way to achieving our carbon reduction target of 60% by 2027; we will be re-signing up to the Covenant of Mayors (soon to become the Global Covenant of Mayors) to support us on our way to meeting this target.
- Funding has been secured from Climate KIC to support the cities work in relation to sustainability; this includes grants to SMEs who have innovative ideas to assist us in meeting some of our energy-related challenges.
- Working with the Heat Network Delivery Unit in the Department for Business, Energy and Industrial Strategy (BEIS) the Sustainability Team is seeking to develop opportunities for heat networks across Birmingham. Over the past two years the team has secured £350,000 to develop the pre-investment evidence bases that are required to develop networks, working with various major energy consumers and neighbouring local authorities from across the GBS LEP to create a project pipeline for investment.
- The Sustainability Team has worked with ENGIE to continue to develop the Birmingham District Energy Scheme that supplies low carbon and low cost heat to major energy consumers across the city centre. A major interconnection between the Broad Street and Aston University schemes is being finalised and will allow further expansion and more connections to be realised on the scheme. To date there has been £15m worth of investment, 12km of pipework installed and a saving of 18,000 tonnes of carbon per year.
- The Flood Risk Management Strategy for Birmingham has been completed to draft status and is currently being updated to take account of consultation responses.
- The Cabinet Member, with responsibility for Flood Risk Management, has consolidated political oversight of flooding by now Chairing the Strategic Flood Risk Management Board (SFRMB) partnership meeting as well as attending the Regional Flood and Coastal Committee.
- Flooding investigations for the June 2016 flood events are being undertaken. This has entailed 2000+ surveys covering 122 Roads; 422 reported flooded properties

from 712 responses. Partnership approach through SFRMB is being adopted.

- The phase one of the River Tame flood alleviation works for Perry Barr and Witton are nearing completion.
- Air Quality Steering and Management Groups with shared ownership of Air Quality as a Public Health Issue have been set up to oversee, coordinate and deliver and the Clean Air Action Plan. The programme of intervention actions being developed through this Action Plan which will ensure that Birmingham achieves its obligations and ambitions with respect to improving air quality and sustainably reduce the levels of key air pollutants (primarily nitrogen dioxide and particulate matter).
- Several actions and initiatives are taking place in respect of the Clean Air Zone and some of these include:
  - Hydrogen Buses and re-fuelling – UK and EU funding sourced to deploy 22 Hydrogen Fuel Cell Buses on Birmingham's roads. This will be delivered along with hydrogen refuelling infrastructure.
  - Electric Buses and Charging – OLEV funding sourced through TFWM and National Express to procure electric buses to be deployed between Birmingham and Walsall. This will be accompanied with charging infrastructure for bus usage.
  - OLEV funding has been sourced to carry out Euro 6 approved LPG retrofit taxi programme and has retrofitted 20 Hackney Carriages and is set to deliver 63 taxi retrofits by December 2016. OLEV funding has also been sourced to implement electric charge points in 4 City Council buildings with 6 electric vehicles in operation as result.
  - Tyseley Energy Park planning application was submitted in August as a key location to include low/zero emission re-fuelling infrastructure as the first location to be developed in a network to support fleet transition to Electric, Hydrogen, CNG & LNG (compressed natural gas & liquid natural gas), bio-diesel, and LPG (liquefied petroleum gas). The site will also include a Hydrogen production facility. This also supports green growth through Hydrogen as part of the GBSLEP low carbon & environmental sector growth strategy.
  - We are in the process of determining the public availability of EV charging on Council owned land across the city at city and local centre locations, places of destination, and other key strategic locations linked to the road network.

5. Key Budget Issues

I am responsible as the Cabinet Member for significant financial resources in the delivery of my portfolio service as summarised in the table below:

Service	**Expenditure £m**	**Income £m**	**Net Budget £m**
Waste Management Services	73.7	(20.6)	53.1
Park Services (including internal recharges)	36.8	(22.6)	14.2
Total Revenue Budget	**110.5**	**(43.2)**	**67.3**

In addition, a total of £8.7m will be spent over the next 3 years to improve our Waste Management Services Depots and a further £3.2m will be spent over the same period on continuing to improve our Strategic and Local Parks. This expenditure will be funded primarily from City Council resources including historic Section 106 reserves and self-funded prudential borrowing.

Waste Management Services

The resources are utilised to deliver an extensive range of services including domestic waste collections, recycling services, street cleaning, trade waste, green waste and the disposal of waste.

The main components of the expenditure include £24m on employees, £32m on waste disposal costs and the remainder is spent on transport and capital finance costs. The majority of the income (estimated at 60%) is received from our trade waste services and the remainder is generated from green waste and paper income. The net expenditure on the service of £53.1m is equivalent to £1 per week for each citizen of Birmingham.

A Service Improvement Plan has been developed and implemented to stabilise and improve the service following the completion of the Wheeled Bin Programme in November 2015 (the latter was completed within budget and to the planned timescale). The key projects that are being implemented include performance management frameworks, optimising the route planning, reducing missed collections, waste prevention & enforcement and re-balancing the work force to minimise agency and overtime expenditure. These actions may result in some mitigation of the financial pressures and overspend that is projected for the service in 2016/17 (the latter is estimated at £8m but needs to be considered in the context of total expenditure and income of £94.3m).

The financial challenges on the service will continue in the medium term to 2019/20 – additional efficiencies and savings are planned to provide a major contribution to the budget shortfall that is facing the City Council due to the ongoing national public expenditure restraints. The new Waste Strategy that is being developed to support the commissioning/procurement of the Waste Disposal Service in 2019 has the potential to make a significant contribution to improve our environment and to continue to reduce the cost of the service.

Parks Services

The resources are utilised to deliver an extensive range of services including the maintenance of all our strategic and local parks, protecting our woodlands, providing allotment services and our park ranger services. Our services continue to receive national recognition for innovation and excellence.

The main components of the expenditure include £8m on employees and the remainder effectively relates to our commissioned grounds maintenance services (this includes services provided to other parts of the Council e.g. our housing estates).

The finances of the service are being managed effectively although a modest overspend of £0.8m is currently projected – this relates to some specific components of our savings programme for the generation of extra income from the Cofton Nursery and the

consideration of land re-designation to support the growth of the City and the development of new housing.

The current approved savings of £1m in 2016/17 for the service are only expected to increase marginally by £0.8m over the next 4 years to 2019/20 (primarily the land disposal programme of 8 acres per year compared to our estimated 8,000 acres of open public spaces and parks).

Strong financial management of the resources will continue and we will work closely with our partners and citizens to ensure that value for money continues to be provided to our service users.

Andy Cave – Chief Executive Officer

How we work - Our strategy

Healthwatch Birmingham aims to hold commissioners and providers of Health and Social Care services to account for ensuring patients, public, service users and carers are at the heart of all changes and decisions made in the name of service improvement.

Our strategic objectives are to reduce health inequity by:

1. Listening to patient, public, service user and carer experiences to identify specific aspects of inequity which matter most to them. We raise these issues and hold commissioners and providers to account, ensuring they take action which will result in service improvement.
2. Improving the quality and use of patient and public insight, experience and involvement in Health and Social Care in Birmingham.

How we work - Delivering our Statutory Functions

Statutory Function	Service Area
1) Gathering the views and understanding the experiences of patients and the public	Listening: Feedback Centre and Widget, Information and Signposting Line, Community Engagement. Investigations
2) Making people's views known	Investigation Reports Right to Respond (Feedback Centre) Feeding back and reporting direct to providers and through meetings
3) Promoting and supporting the involvement of people in the commissioning and provision of local Health and Social Care services and how these are scrutinised.	Quality Standard Key Challenge Questions Lay Member Project
4) Recommending investigation or special review of services via Healthwatch England or Care Quality Commission (CQC)	National Database – CRM System Red Flag Reporting (National Issues) Referral – Safeguarding and CQC
5) Providing information and signposting about services and supporting informed choice.	Information and Signposting Line Website Community Engagement
6) Making the views of people known to Healthwatch England	National Database – CRM System Regional and National Healthwatch Network meetings Investigation Reports

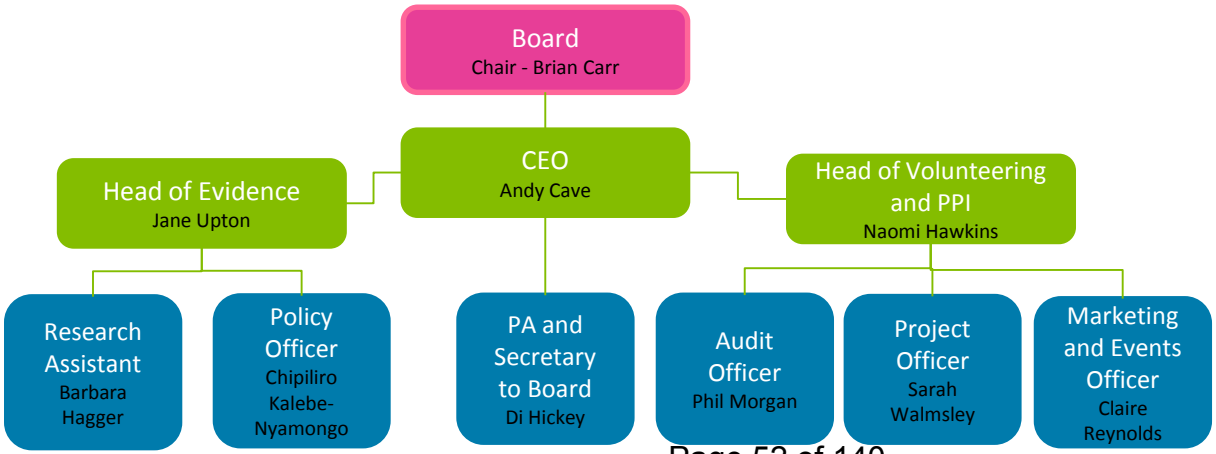
Governance and Staff

Healthwatch Birmingham Board

- Our Board has 6 Non-Executive Directors (NEDs)
- Full governance review completed in June 2016
- NED recruitment planned for Quarter 3 16/17

Healthwatch Birmingham Staff Team

- Full staff team from June 2016
- Clearly defined specialist staff roles; all experts in their field



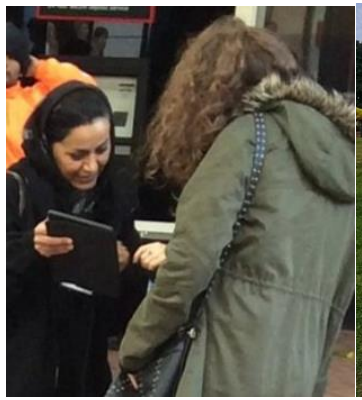
Volunteers

- Volunteers are central to our strategy and a crucial part of our growth as an organisation
- 29 active volunteers
- Quality assurance and volunteer development systems are in place – right volunteer at the right time with the right skills.
- Volunteer activity is aligned to our objectives around listening to people's experience
- Continually recruiting volunteers through:
  - BVSC
  - Do-it volunteer recruitment website
  - Local universities and colleges
  - Directly with third sector organisations
  - NHS Jobs

How we listen

Public, patient, service user and carer and experience is at the heart of everything we do.
We listen more and more by using our:

- Website
- Feedback Centre
- Feedback Centre Widget
- Social Media
- Information and Signposting Line
- Community Engagement



How we listen - Engagement

Proportionate Universalism

To ensure we hear from everyone, and in particular the groups most likely to experience health inequities, we monitor and identify gaps and target our engagement work accordingly.

In particular we are interested in:

- Diversity groups (seldom heard)
- Geographical spread (every district)
- Areas of deprivation

Districts Covered:
Voices heard from all 10 Districts
Community Engagement activity in 7/10 districts

Focused collection through identified groups:
Young people
Mental Health
Asian Women
Parents (Children under 5)

Areas of Deprivation:
Top 5 most deprived districts covered

How we listen - Engagement

Community Engagement

- Between May – August 2016 there have been 11 Community Engagement Sessions across 7 districts of the city.
- Engaging a total of 685 individuals

Website

- On average we recieve around 5500 page views per month on our website.

Social Media

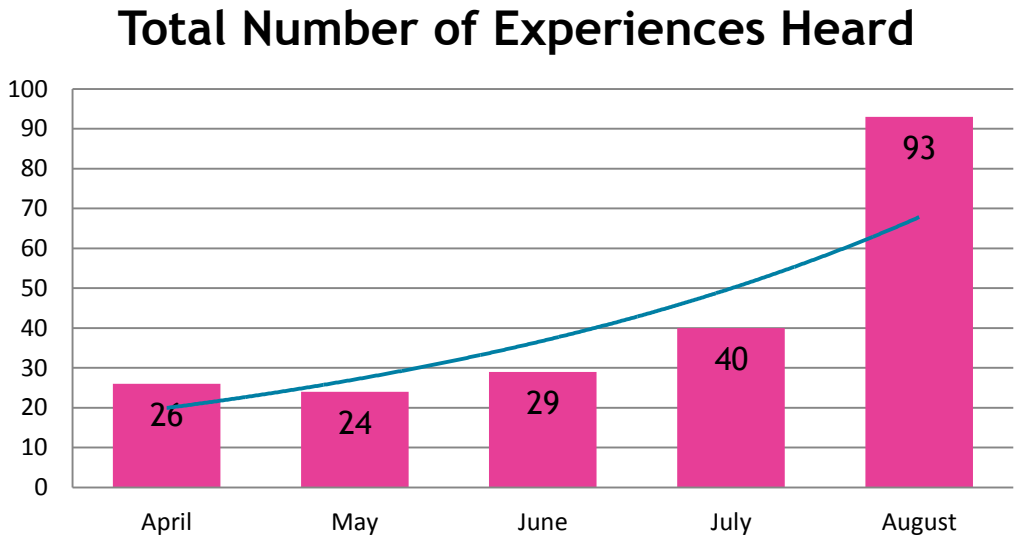
- We have a total of 3367 followers on Twitter

E-Bulletin

- Our stakeholder mailouts go out on average to 250 readers from across the Health and Social Care Sector.

Listening more and more

From April – August 2016 we have seen a continuous growth in the number of people leaving feedback.



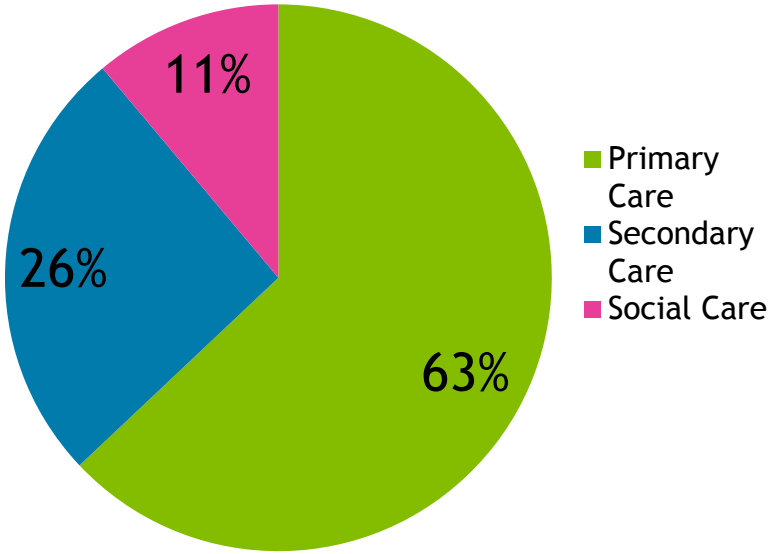
#FeedbackonFriday

In August we launched our #FeedbackonFriday campaign to encourage people to take 5 minutes to feedback about the services they have accessed.

In September we launch our advertisment campaign on Birmingham buses.

What we have heard

We listen to experience to identify shortcomings in care that could be a cause of inequity.



What we are hearing about services via our Information and Signposting Line:

- Quality of Treatment – 35%
- Complaints Process – 28%
- Staff Attitude – 19%
- Access to Services – 17%
- Diagnosis – 16%
- Service Co-ordination – 11%

Your experiences of health and social care

August 2016

What have people been telling us about their experiences, through our Feedback Centre?

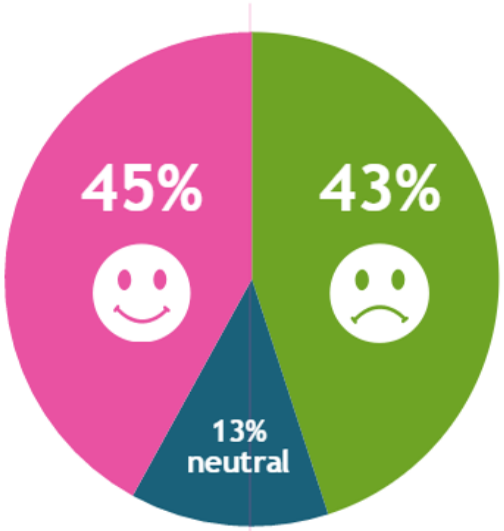
Treatment & Care
58% positive reviews

Staff
53% negative reviews

Appointment availablity
81% negative reviews

Waiting times
71% negative reviews

Overall sentiment



Average rating for services

Service type reviewed

We received the most feedback about GPs due to our latest investigation and community engagement activity.

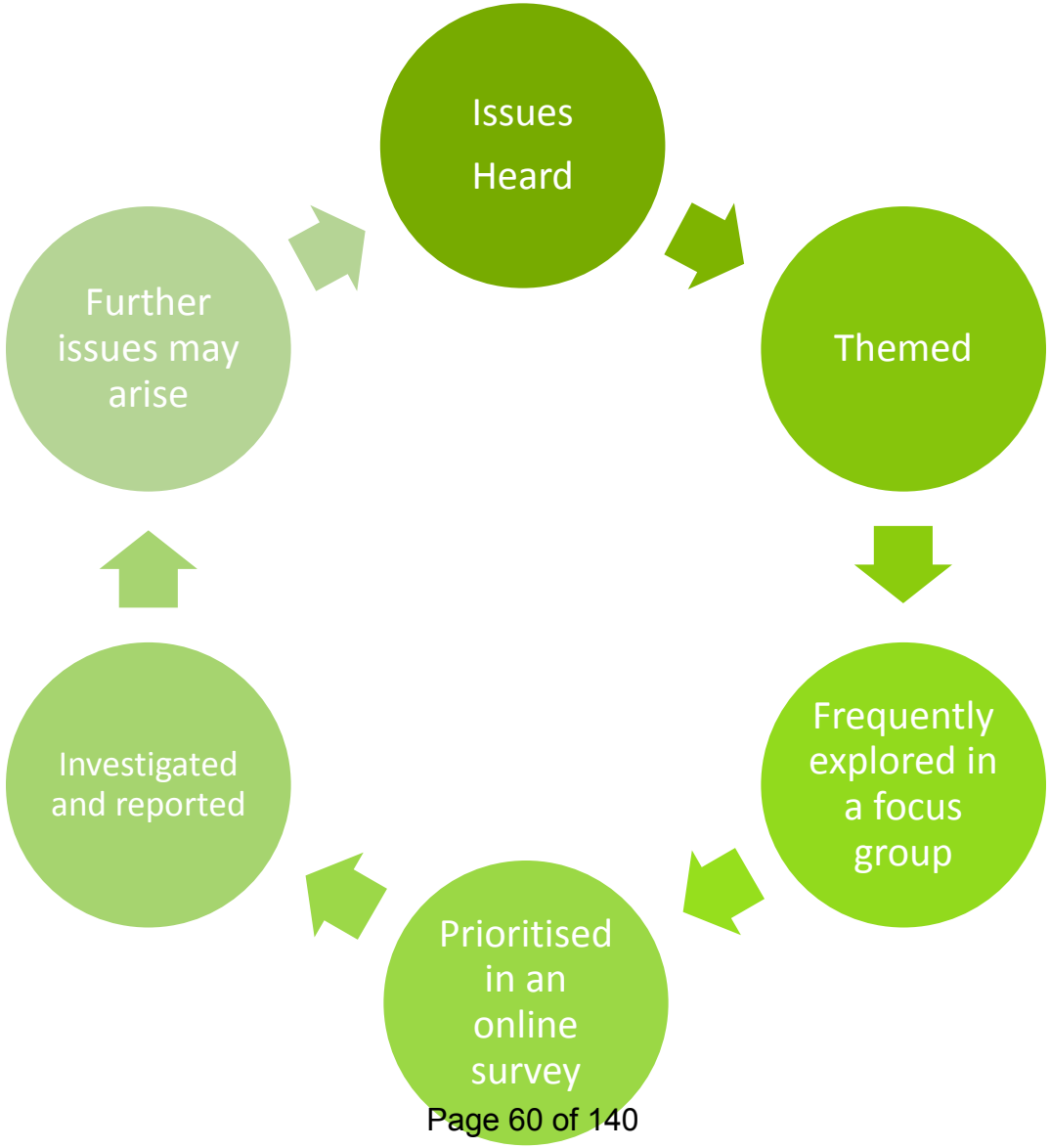
healthwatch Birmingham

www.healthwatchbirmingham.co.uk | 0800 652 5278

Direct reporting of data to:

Commissioners and Providers
Right to Respond – Feedback Centre
Healthwatch England
CQC
Numerous boards and Meetings
Consultations

How topics are prioritised by the public?



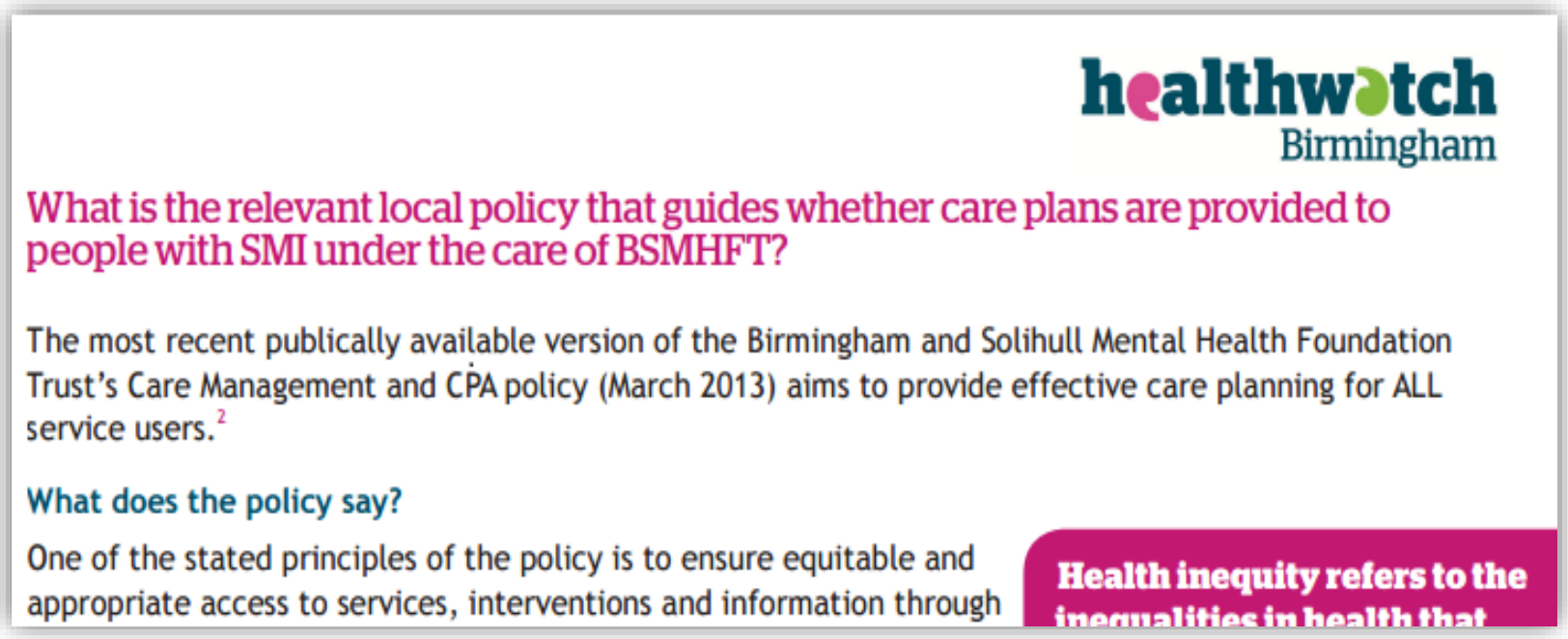
Healthwatch Birmingham Survey - what would you like us to investigate in Autumn 2016?

* 1 Please select **THREE** topics that you feel need to be improved in the health and social care system in Birmingham.

- [ ] The quality of communication between General Practitioners (your family doctor) and hospitals regarding patient's medical records
- [ ] The quality of after care in audiology (hearing) departments
- [ ] The ease of complaining to the Clinical Commissioning Groups (CCG) in Birmingham about health services they commission
- [ ] The ease of complaining to Birmingham City Council about social care providers they commission
- [ ] The level of respect that some staff show people with learning disabilities who use the services provided by the Birmingham Community Healthcare Trust
- [ ] The quality of involvement of patients and the public in consultations about proposed changes to chiropody and physiotherapy services
- [ ] The quality of specialist treatment provided by district nurses to patients in the community
- [ ] The quality of discharge following medical and surgical procedures received by patients in hospitals
- [ ] The quality of care and attitude towards patients by dentists
- [ ] Delays in MRI scans in hospitals
- [ ] Patients rights to access and challenge what is written in their hospital medical records
- [ ] Poor integration of care between service providers, patients, and family post-discharge, which may leave patients without support

How do we explore variation in quality of Health and Social Care services that may lead to health inequity?

We identify the relevant local policy. For example the following is a section from one of our recent reports



healthwatch Birmingham

What is the relevant local policy that guides whether care plans are provided to people with SMI under the care of BSMHFT?

The most recent publically available version of the Birmingham and Solihull Mental Health Foundation Trust's Care Management and CPA policy (March 2013) aims to provide effective care planning for ALL service users.[2]

What does the policy say?

One of the stated principles of the policy is to ensure equitable and appropriate access to services, interventions and information through

Health inequity refers to the inequalities in health that

How do we explore variation in quality of Health and Social Care services that may lead to health inequity?

We collect robust evidence

Young people & patient centred care in General Practices

- 304 young people interviewed about patient centred care

Care plan provision for people with serious mental illness

- Chief Executive of the local Mental Health NHS Trust interviewed & data obtained
- Commissioner at CCG interviewed & data obtained

GP emergency appointments

- 66 patients told us their experiences of trying to make an emergency appointment
- 56 GPs completed an online questionnaire

We report our findings

3. We highlight where the local policy has been implemented in such a way to lead to variation in services that may lead to health inequities. Examples:

Young people & patient centred care in General Practices

- e.g. The level of patient centred care is not consistent or good enough. 1:5 young people rate the level of patient centred care as either 'poor' or 'fair'.

Care plan provision for people with serious mental illness study

- e.g. Although all patients with a SMI and registered on the 'Care Plan Approach' at BSMHFT should have a care plan, 20% do not.

GP emergency appointments

- A draft report is currently being sent out to stakeholders. We therefore can not share the findings in this slide set as we take a 'no surprises' approach. The data describe variability in service provision and focus on particular population groups. that may be particularly affected by this issue.

We report our findings and hold to account

1. We send a draft report to key stakeholders

2. We revise the report to include the actions providers and/or commissioners have said they will take as a result of the report.

3. The report is sent out widely: relevant Boards, Third Sector organisations, volunteers and stakeholders, and is available on our website.

4. If appropriate we will revisit the issue to follow up these actions.

How is this report being used as a lever for positive change within Birmingham?

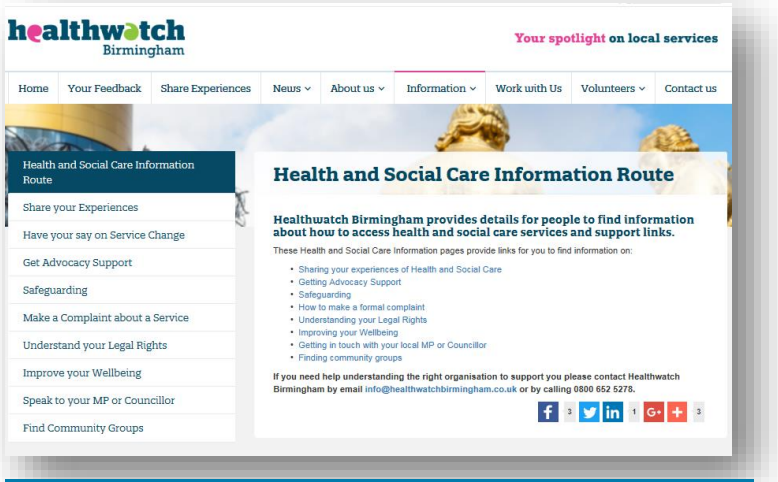
As a result of Healthwatch Birmingham's exploration of this topic, BSMHFT will put this report through their formal governance process and provide a work programme through either the Trust's Quality Committee or Full Trust Board. This will give a formal feedback loop.

We will follow up on the Trust's work programme, and report any changes in the proportion of people with SMI that have care plans. A follow-up report will be written in early 2017, and if no changes are found relevant regulatory bodies in Birmingham will be notified.

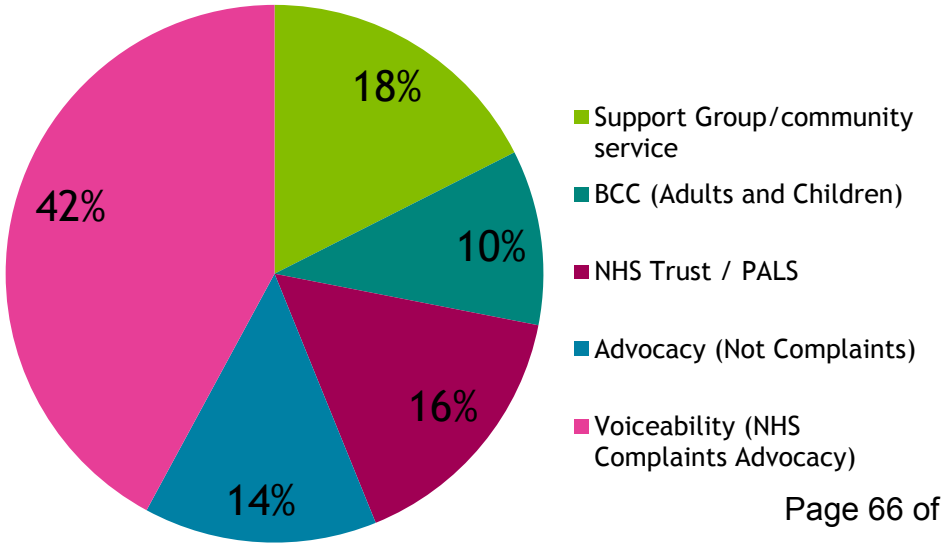
Information and signposting

Access Map

Easy to navigate, self help section of the website directs individuals to where they can find the most up to date information.



Information and Signposting Line



Signposting Audit

We are interested in the level of service individuals receive through advocacy providers.

Raising the level and quality of patient and public insight, experience and involvement.

Healthwatch Birmingham's Quality Standard

- In the pilot phase of the Quality Standard: using patient and public insight, experience and involvement to reduce health inequality and to drive improvement.
- 14 West Midlands CCGs are completing a self-assessment against the objectives Quality Standard as part of the NHS England West Midlands CCG Assurance process.
- Later this year we are testing the Quality Standard with a large NHS Provider Trust, Social Care and a regulatory board in Birmingham.

Our role on Boards and meetings

Identify any potential health inequity

Challenge the quality and impact of PPI in making decisions and service change

Meetings Attended

- West Midlands Quality Surveillance Group
- Birmingham Health and Wellbeing Board
- Healthwatch England Advisory Task and Finish Group
- Birmingham HOSC
- Joint HOSC – Solihull / Sandwell
- Birmingham Adult Safeguarding Board
- Birmingham Children's Safeguarding Board
- BVSC – Third Sector Assembly
- Primary Care Commissioning Committee S&WB CCG, BXC CCG, BSC CCG
- Birmingham Better Care Fund
- West Midlands Urgent Care Network

What's next

Hearing more and more

Volunteering

- Increase the number of active volunteers in key listening roles, ensuring recruitment from across Birmingham populations.

Marketing

- Continue with our marketing plan to raise the profile of Healthwatch Birmingham and feedback routes including: Bus Campaign, #FeedbackonFriday, Hospital Radio.
- Increase the number of providers with the Feedback Widget

Community Engagement

- Continue to increase the number of engagement activities by targeting all 10 districts, areas of deprivation and key population groups.

What's next

More impact leading to improved services

Investigations

- Complete the current round of our Topic Identification Prioritisation System for investigation.
- Generate high quality reports to hold commissioners and decision makers to account for service improvement.

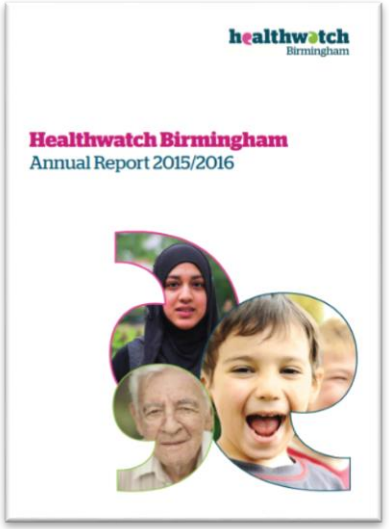
Quality Standard

- Complete the testing of the Quality Standard with 14 CCGs, a NHS provider Trust and social care.
- Deliver a launch event of the Quality Standard in early 2017.
- Roll out a programme of self-assessment and audit.

For more information

Healthwatch Birmingham Annual Report

- For more information about Healthwatch Birmingham and the way we work. Please see our annual report.



Healthwatch Birmingham Reports

- For more copies of Healthwatch Birmingham reports please see our reports page.

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Website: www.healthwatchbirmingham.co.uk
Twitter: @HWBrum

Healthwatch Birmingham
Annual Report 2015/2016

Contents

Message from our Chair

This year has been one of transformational change for Healthwatch Birmingham. The development and implementation of a new strategy provides a clear direction going forward so we can better support those who access health and social care services in the city.

When the board commissioned a new strategy, our goal was to make sure Healthwatch Birmingham was performing effectively to meet its mission and aims. Achieving this change so quickly has been due to the commitment and hard work of staff, volunteers, and non-executive directors. They have shown an outstanding dedication and focus in a changing working environment. Championing the consumer voice remains at the forefront of our work, ensuring the public feel supported and listened to by providers and commissioners.

I was delighted that this transformational approach was recognised at Healthwatch England's commissioning conference, where Candy Perry (Interim Chief Executive Officer), our Commissioner (Charles Ashton-Gray of Birmingham City Council) and I presented Healthwatch Birmingham's journey and how that was realised.

The organisation is now in a much stronger position to support people to get the most from their local health and social care services. The re-launch of Healthwatch Birmingham's Feedback Centre, increased engagement with the public and the extensive work done to develop investigations has provided stronger routes for consumers to share their experiences and help influence service improvement.

The Young People's Survey shows the quality of Healthwatch Birmingham's activities. Our work to engage with communities about health and social care issues that are important to them provides vital insight into how services need to be improved. The team have signposted people towards information about accessing services and have helped check and challenge how people's needs are being met.

This period of change for Healthwatch Birmingham has also seen changes to the board and staff team. We have appointed two new non-executive directors whose expertise has added to that of the existing board, and strengthened the implementation of the strategy going forward. We have welcomed new staff and are delighted that the number of volunteers is growing. This will ensure we reach more people within communities across Birmingham.

I'm honoured that the board have appointed me into the role of chair of Healthwatch Birmingham until June 2017 and I look forward to working with the team to continue the organisation's development and support for the citizens of Birmingham.

I would like to say thank you to Candy Perry, for her passion and drive in leading the organisation through this transformation as Interim Chief Executive Officer and delighted to announce that from May 2016 we welcome Andy Cave as the new Chief Executive Officer.

My thanks go to staff, volunteers, members of the board and all the supporting stakeholders who have contributed to the continued successes of Healthwatch Birmingham throughout 2015/2016.

Brian Carr
Chair

Message from our Chief Executive Officer

2015/2016 saw Healthwatch Birmingham working hard to place the public, patients, service users and carers at the heart of health and social care service improvement.

The development of a new strategic approach was our opportunity to reassess Healthwatch Birmingham's statutory role in ensuring people's views are listened to, and taken account of, by the health and social care system. In June we held a focus group looking at the constraints to effective patient and public involvement (PPI). This was a key element of the new strategy, helping us understand our statutory responsibilities to promote PPI in health and social care commissioning and providing decisions. Findings from that group can be found via the report on our website. As a result we began to develop our quality standard.

Over the past 6 months we have worked collaboratively with NHS England to develop a quality standard for effective PPI to reduce avoidable health inequity. The tool will support the improvement of quality PPI, and we will be encouraging its use by commissioners, service providers and system partners. We look forward to rolling out the quality standard more widely over the next year.

A milestone achievement for this year was the Young People's Survey. We asked over 300 young people about the level of patient centred care they experienced when accessing primary care services in Birmingham. Concerns such as a lack of care, compassion and barriers to accessing GP services were key findings. Recommendations to CCGs and their responses are included in the report, showing that people can really shape the improvement of services that are important to them. I would like to say thank you to our volunteers and staff whose hard work saw us engage with young people from every district in Birmingham for the first time.

Listening to the experiences of people using health and social care services is a top priority. In March we re-launched our online Feedback Centre which continues to be a valuable source of patient and public feedback. Our Index of Avoidable Health Inequity enables us to develop problem statements from those experiences. A consensus exercise involving members of the public and key stakeholders in the health and social care system helped transparently select those problem statements, that if investigated would have the most impact on the way that services are arranged, and will deliver results sufficient to effect change for patients and the public.

Our objectives and our development could not have been achieved without the commitment and motivation of the staff team. Their work has supported people in Birmingham to share their experiences, concerns and enquiries and they have worked hard to ensure people can find the solutions they need.

We welcomed new staff into new positions whose roles are aligned with our future goals. The growing number of volunteers is playing an increasingly important role in supporting our investigative process – their involvement and passion is valued by both staff and the board.

Candy Perry
Interim Chief Executive Officer

Healthwatch Birmingham also welcomed Andy Cave as the new Healthwatch Birmingham Chief Executive Officer in May 2016, who will lead the organisation and drive our vision forward.

2015/2016 has seen Healthwatch Birmingham working hard to ensure its role is clearly defined and understood by the health and care system. The coming year will focus on growth - building on what we have developed to ensure we are performing effectively.

Our goals include the wide implementation and use of the quality standard by regulators, commissioners and service providers to drive improvement to the quality of care for patients and the public. The next stage of our involvement strategy will see us work more closely with lay members, training them in the use of the quality standard to pose key challenge questions on boards.

We want to ensure people in Birmingham are at the heart of service change and improvement in health and social care.

We will be promoting the Feedback Centre widely through community engagement and encouraging more service providers to adopt our Feedback Widget, so people have the best opportunity to share their experiences directly and help shape change.

Andy Cave
Chief Executive Officer

"The team have worked hard showing commitment and passion to drive the organisation forward to meet the needs of patients and the public in Birmingham."

Andy Payne,
Head of Network Development
Healthwatch England

The year at a glance...

Our volunteers have helped us with our investigations process and community engagement

People from *every* district of Birmingham contributed and listened to

New strategic approach places people at the heart of health and social care service change and improvement in Birmingham

Promoted patient and public involvement through contributing to consultations

Widened our reach through our digital marketing and social media

Who we are

Healthwatch Birmingham is the local independent consumer champion of health and social care for Birmingham.

We gather people's real experiences of using health and social care services to drive change. This helps us build a picture of where services are doing well and where improvement is needed.

We identify and investigate unfair or avoidable differences in health and wellbeing - which may be caused by the way health and social care services are set up and run.

We are part of a network, with a Healthwatch in every local authority area, alongside our national body Healthwatch England.

Our Vision

Patients, public, carers and service users are at the heart of every change made in the name of service improvement in health and social care in the city of Birmingham.

Our Statutory Functions

The statutory functions of Local Healthwatch are to drive improvements in health and social care by:

1. Gathering the views and understanding the experiences of patients and the public.

2. Making people's views known.

3. Promoting and supporting the involvement of people in the commissioning and provision of local health and social services and how they are scrutinised.

4. Recommending investigations or special reviews of services via Healthwatch England or directly to the Care Quality Commission (CQC).

5. Providing information about access to services and support for making informed choices.

6. Making the views and experiences of people known to Healthwatch England and the Local Healthwatch network, and providing a steer to help it carry out its role as national champion.

Our Healthwatch Team

Top row (left-right): Chris Smith (Policy Officer), Barbara Hagger (Research Assistant), Jane Upton (Head of Evidence). Middle row (left-right): Candy Perry (Interim CEO), Phil Morgan (Audit Officer), Sarah Walmsley (Project Officer). Bottom row (left-right): Diane Hickey (PA to CEO and Secretary to the Board), Andy Cave (CEO), Claire Reynolds (Marketing and Events Officer).

Our Year of Transformational Change

Healthwatch Birmingham is an ambitious organisation. During 2015/16 we set ourselves the threefold challenge of becoming a:

1. Leading organisation in our local health and social care system.
2. Leading local Healthwatch in the Healthwatch network.
3. National leader in effective patient, public, service user and carer involvement.

This is at the heart of our year of transformational change. It enables us to clearly define and understand our unique position, role and purpose within the local health and social care economy as part of the scrutiny and regulatory system.

Why undertake transformational change?

Healthwatch Birmingham serves a population of 1.2 million. When we commissioned a systematic review of our services, we found that in trying to be all things to all of our stakeholders, conflicting dilemmas were arising.

We are publicly led

We strive to be a high performing organisation, making things better for citizens in Birmingham. In order to achieve this we must listen to people, and learn about their experiences using health and social care, and hold organisations providing or commissioning services to account for making improvements. This means we must be led by the public.

We must also take our lead from health and social care system partners

We must work within a very large, established, complex, health and social care system which is facing unprecedented challenges arising from increased service demand for care by a growing population, but facing decreasing budgets.

For Healthwatch Birmingham to make effective and long lasting differences, we must have influence and work in collaboration with like-minded organisations, particularly as a relatively young organisation.

Re-defining our role

In reviewing our services, we found that many commissioning and providing organisations perceived our role as a way for them to dispatch their patient and public involvement responsibilities.

Partners saw Healthwatch Birmingham as a way to represent the views of patients and the public on their boards and committees, expecting us to contribute the voice of the public. We received lots of requests to attend meetings to represent the public, which stretched our resources.

"Over the last 12 months the organisation has turned itself into a force to be reckoned with; it's developed new capacity and capability to effectively listen to people's experiences of using health and care, and use these to cause real change."

Charles Ashton-Gray, Service Lead - Commissioning Centre of Excellence, Birmingham City Council

As a result, we faced pressure to meet expectations from external partners. We worked harder and to meet the needs of system partners, which diverted resources away from listening to the views of patients and the public.

Addressing this dilemma is critical to our success, and led to our year of transformational change. The basis of our new strategy was the development of a robust logic model.

Our role is now clearly defined and understood

Following the review, Healthwatch Birmingham's role is now clear: placing patients and the public at the heart of health and social care service improvement through our ability to:

1. Lever Care Quality Commission (CQC)-registered organisations to use patient, public, service user and carer experience to help ensure changes are made in the name of service improvement and will meet their needs as determined by them.

2. Use patient, public service user and carer experience as a lever for service improvement by bringing it to the attention of CQC-registered organisations in such a way that action can be and is taken, to make improvements which matter.

We will measure our success by:

1. The number and impact of changes made in the name of service improvement by CQC-registered organisations as a result of our work.
2. Our performance against the targets set out in our outcomes framework.
3. Our performance against the Healthwatch England Quality Standards.

Our critical success factors:
Success towards our strategic objectives in 2015/16 was underpinned by four critical success factors. There is:

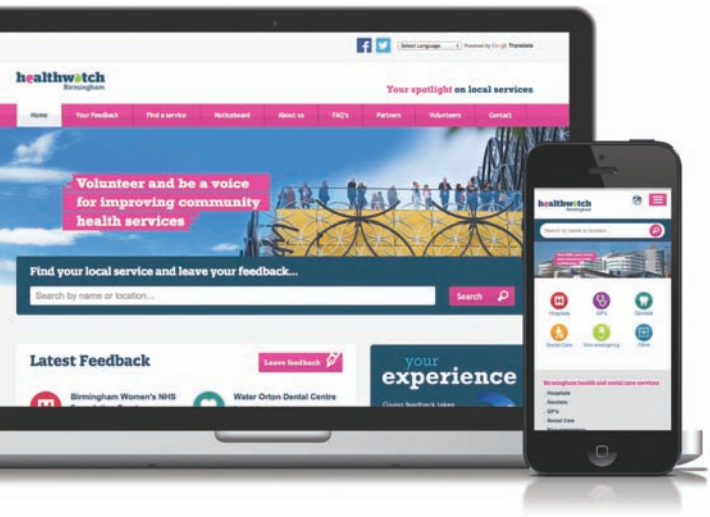
1. Effective Governance.
2. Effective Executive and Staff Team.
3. Effective Volunteer Team.
4. Effective stakeholder support.

Following a visit to Healthwatch Birmingham the Rt. Hon Lord Hunt stated:

"I was enormously impressed by your work and in particular your focus on the whole system in Birmingham."

Listening to people who use health and care services

Gathering experiences and understanding people's needs



Healthwatch Birmingham's Feedback Centre is our most important tool in gathering patient's and the public's experiences of health and social care.

This year we have seen a growth in the number of patients and people sharing their experiences with us through our online Feedback Centre. It continues to provide a valuable source of real-time data and a means of listening to people who are using health and social care services in the city.

We re-launched the Feedback Centre in March 2016. Improvements include the addition of the Friends and Family Test question, where people are asked whether they would recommend the services they have used. The information plays an important role in regional NHS data about individual providers. Sharing Feedback Centre data with those who deliver services locally, and with commissioners, is a key part of our evidence regarding health and social service quality and performance.

Improvements also mean providers now have the opportunity to respond to feedback submitted by the public about their services. We see this as a further step forward in making sure patient's and the public's views are known by those who deliver services. Providers can acknowledge positive feedback or address any issues raised and demonstrate accountability. This means patients and the public can feel they are making a difference in shaping service design and improvement. We are also linking to CQC reports on individual services which ensures users can have an informed view of services.

This year...

Average rating of services on the Feedback Cenre

Over 300 reviews

Over 130 services reviewed

"Great staff. Caring, always on the end of the phone if needed. Really helped my family"
Anonymous

"Trying to get an appointment is just too difficult. It is frustrating that when you need an appointment you can't get one"
Anonymous

Improving health and social care through patient and public feedback

- **Patient and public experience coming through the Feedback Centre is increasingly being used to inform Healthwatch Birmingham activities, especially our investigations.** Receiving feedback is enabling us to listen for any indicators of avoidable health inequity, which may be caused by the way health and social care services are set up and run, and is impacting on those who use those services. Read about our Young People's Report on page 21.

- **Analysing feedback data helps build a picture of where services are doing well and where improvement is needed.** Any recommendations we share, or concerns we raise, with commissioners, providers or system partners are grounded in real experiences gathered from patients or the public.

- **Reviews help us understands whether patients and the public are being appropriately involved in decisions about their care and treatment.** We are analysing whether people's needs are being met through rating key indicators like cleanliness, staff attitude, waiting times, treatment explanation, quality of care and quality of food of the services they are using.

What next?

We are promoting the Feedback Centre more widely through community engagement and digital marketing and encouraging more service providers to respond, and take action, as a result of patient experiences we receive.

Listening to a wide range of people in communities

Our Feedback Centre, Information and Signposting Line and community engagement activities are enabling us to listen to and understand the health and social care experiences of people from all groups to ensure everybody's voice is heard. Having a range of routes to feedback gives those who may be seldom heard or face barriers to sharing their views an easy and accessible way to tell us their experiences.

For example, people mentioning care for older adults through our Feedback Centre, told us about:

Helping people access information and support for relatives and carers

Over 2015/2016 we heard from people seeking information to ensure appropriate support in place for elderly patients using health and social care services. This is an important part of listening, but also providing people with links to get help:

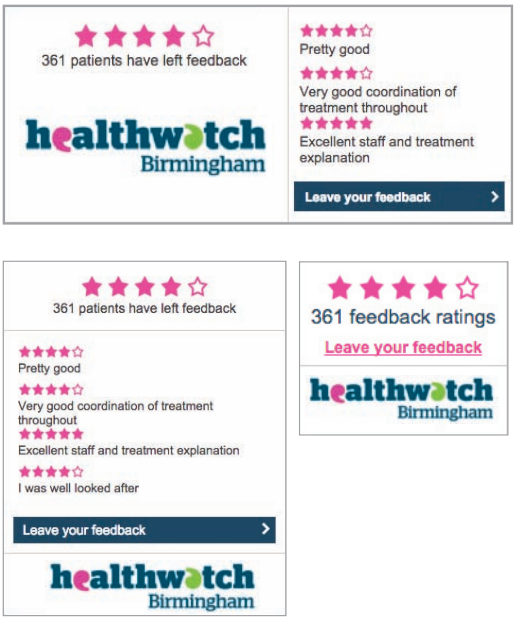
In an urgent adult safeguarding case for an elderly patient we heard from a relative who was concerned about the care arrangements and plan set out by a local social care team. This led to a case review by the local authority.

We also heard from a member of the public who wanted to challenge the care plan set in place for their elderly relative. We helped point them in the right direction for Patient Advice and Liaison Service (PALS) and a local carers hub.

What next?

We are recording experiences against key groups like disability, age, sex, gender identity, sexual orientation, race and ethnicity, religion and belief to ensure we are listening to people from diverse communities. Using this we are able to identify where we have gaps in data and increase our engagement in these areas.

Healthwatch Birmingham Feedback Widget



Our free Feedback Centre Widget is providing patients and the public with more direct opportunities to share their experiences about health or social care services.

Visible on provider's websites, it means people can share their views about services they are using, quickly and easily. It is also providing us with a greater understanding of current service quality and care, and gives providers added value and insight into patient and public experience.

This year we have worked hard to raise awareness of the Widget, and were delighted when the local Health and Wellbeing Board strongly encouraged service providers and organisations to adopt the patient feedback tool.

NHS Birmingham South Central Clinical Commissioning Group

We aim to provide an integrated approach to collecting experience data by encouraging providers to adopt the widget.

Two leading health and social care system organisations in Birmingham have placed the Feedback Widget on their websites - Birmingham Better Care and Birmingham South Central Clinical Commissioning Group (CCG). This acknowledges the importance of capturing patient and public experience.

We will now be working with system partners directly to discuss the benefits of using the Feedback Widget to demonstrate their commitment to listen, and act upon, patient feedback to improve services.

What have people told us about their experiences?

Healthwatch Birmingham's Feedback Centre is providing a route for people to share their positive or negative experiences of health or social care. This is what people have been sharing throughout 2015/2016.

Treatment and Care

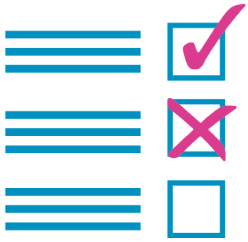
64% 32%

Effectiveness, quality, safety, treatment explanation

Staff

68% 32%

Attitude, capacity, training



Administration

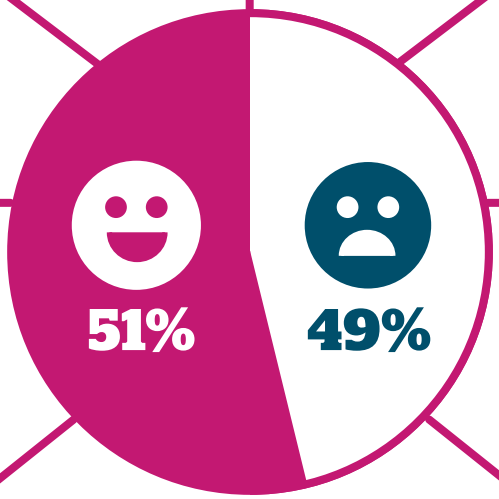
87% 13%

Appointment availability and booking appointments

Dignity and Respect

67% 33%

Confidentiality and privacy



Overall the experiences we receive through our Feedback Centre are positive. We know improvement is needed - that is why listening to people is so important.

Facilities and environment

65% 35%

Cleanliness, food and hydration

Medication

67% 33%

Medicines management, prescriptions

Access to services

79% 11%

Waiting times, referrals

Communication

80% 17%

Lack of written,verbal

Gaps in percentage totals a result of neutral feedback statistics

Community Engagement

Community engagement activities mean we can be a presence in local communities. Our volunteers have been vital to us engaging with and listening to people's experiences.

Our objectives of community engagement are to:

- Raise awareness of Healthwatch Birmingham and promote its services.
- Recruit and train volunteers to support the work of Healthwatch Birmingham.
- Collect people's experiences about health and social care services through standardised questions and the feedback centre.
- Roll out investigations as directed by the research team including questionnaires and surveys.
- Sign up members of the public who are interested in sharing their experiences on a regular basis.

This year we reviewed our engagement and involvement strategy and redesigned our community engagement volunteer role. To meet these changes we retrained our current volunteers to improve their skills. Our volunteers help us to be in the right place at the right time and help us to engage with people in public spaces, public venues and events.

We also introduced our information and signposting volunteer role. This means Healthwatch Birmingham can support more people through our Information and Signposting Line. Volunteers will point people towards supporting services and play a crucial role in listening for avoidable health inequities occurring in Birmingham.

Community engagement ensures that all the experiences we hear play an important role in our understanding of health and social care service quality (including our Feedback Centre). Patients and the public can feel informed to make their own choices about the services they use.

What next?

To build up our team of skilled community engagement volunteers through active recruitment.

To engage more members of the public and listen to more of their experiences.

To increase our reach through community engagement by increasing the number of partnerships we have with community and voluntary groups.

Attended Birmingham Pride 2015 to listen people's experiences

Surveyed over 300 young people about patient centred care

Listened to the experiences of a Carers Group and supported them to access information

What we've learnt from visiting services

During 2015/2016 Healthwatch Birmingham carried out 7 Enter and View visits across the city.

Healthwatch Birmingham has the power to Enter and View health and social care providers to observe service delivery directly and ascertain patient experience. We find out how the services are being run, gathering feedback from service users, their families and carers.

We report our findings and recommendations for improvement to the service providers directly. We ask them to respond to our suggestions and outline what action they will take, or are already taking, to improve service care, quality and experience for patients and members of the public.

Enter and View visits can be triggered in a number of ways:

- Healthwatch Birmingham may receive concerns from patients or members of the public about the quality of care or service, or receive positive feedback about services and want to share examples of best practice.
- We may also decide to visit a provider offering a unique service in the city or to find out more information about a service, particularly ones facing high demand pressures.
- Visits are conducted by authorised representatives who are trained members of staff and volunteers.

During the year, Healthwatch Birmingham carried out visits to a variety of health or social care services including pharmacies, opticians, a dental hospital, a walk-in centre and a care home.

Action taken by service providers as a result of our recommendations:

- **Improved waiting time for residents when they call for assistance:** following our recommendations a care home has increased staffing levels to address the issue and continues to monitor the call response waiting times. This means resident's immediate needs are dealt with more quickly and they are not waiting longer than necessary for help.
- **Mental Health awareness training for staff:** after an Enter and View at a walk in centre, we recommended that staff have 'mental health awareness' and 'managing challenging behaviour' training. The centre reported that a clinician with a mental health background is on duty who can manage situations and there is access to mental health teams for staff. Both service users and staff are in a safe and comfortable environment, staff can defuse difficult situations and patient's needs can be met.
- **Improvements for easier mobility access:** during our Enter and View visits to high street pharmacies and opticians, we recommended they make it easier for people with mobility needs to access their premises. A pharmacy addressed this problem and now has an automatic door making it easier for people to use their services and access support.
- **Training for staff in relation to personalised care:** following recommendations to a care home, a monitoring plan and chart is in place to ensure staff regularly monitor individual patient's care needs. For residents this means improvements at meal times and their personalised care needs are prioritised.

- **Improved waiting times to avoid patients experiencing delays:** after an Enter and View visit a Dental Hospital assessments and treatment sessions have been equalised over the morning and afternoon period to improve waiting times for patients with appointments. Staff at the service also keep patients in the waiting room better informed about any delays.

- **Clearer advertising on the premises about complaints policies:** following visits to pharmacists we recommended clearer advertising about their complaints policies so service users could easily find information about how to feedback about their experiences. We were told policies are clearly displayed within the premises and service users can raise any concerns appropriately.

"We were very pleased to welcome the Healthwatch Birmingham Enter and View team members to the Dental Hospital & School of Dentistry.

Their visit supports us to focus on what needs to be done and review our priorities. It is another opportunity for us to respond to patient/public feedback in our mission to deliver an excellent service."

Anne Smith, Governance Manager, Birmingham Dental Hospital & School of Dentistry.

- **Health and safety reviews:** after conducting an Enter and View at a care home we recommended that they needed to improve the environment for residents. This is happening and residents are now living in a safe and secure environment.

- **Training for staff to provide better information about products and services:** following Enter and View visits to opticians, we recommended that staff be trained further in relation to product and service knowledge so they can better explain treatment when service users book appointments. As a result, the opticians have stated that further training has been developed and launched, incorporating our feedback.

Our recommendations are made with patients and the public's needs at the heart, and are often influenced by feedback directly received from service users.

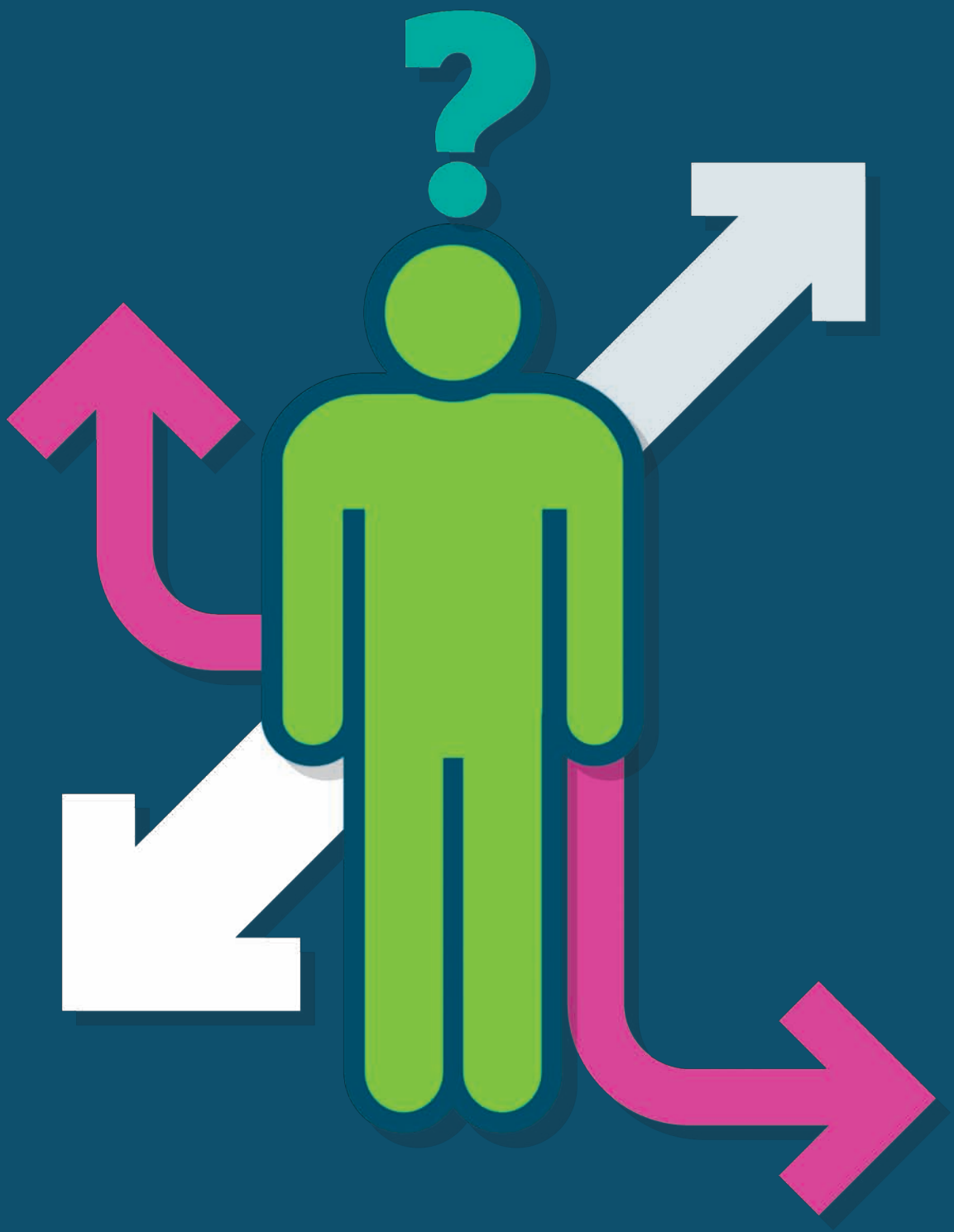
We would like to thank our authorised representatives for supporting our Enter and View activity in 2015/2016:

Alex Davis
Amanda Dickinson
Andy Cave
Claire Lockey
Jane Reynolds
Jason Mistry
June Phipps
Keith Hulin
Mark Lynes
Mike Tye
Nina Davis
Patricia Coyle
Patricia World
Steve O'Neill
Tina Brown-Love
Trevor Fossey

What next?

Enter and View is just one of the tools Healthwatch Birmingham use to understand patients' experiences and is carried out when we feel it is the most appropriate way to collect information about potential health inequities impacting patients and the public.

Giving people advice and information



Helping people get what they need from local health and social care services

Healthwatch Birmingham's Information and Signposting Line is guiding people to find the information they need to access health and social care support. The number of calls we receive has grown and we are supporting more people to find the answers they need.

Often patients, service users and members of the public get in touch because they don't know who they need to speak to for support when things go wrong, are unsure how to access health and social care services that meet their needs or have exhausted all other routes of information. This year, the majority of calls through the Information and Signposting Line have been about primary care, e.g GP medical centres, or about the care that patients or service users have received in hospitals or through mental health services.

We have provided information on a wide range of topics and have guided people to find support including:

- How to make a complaint.
- How to access advocacy support.
- Understanding their choices about accessing health and social care.
- How to access support information for relatives around specific issues like social care, mental health and housing.
- Understanding their rights when accessing services.

We have signposted people to a variety of organisations and information including:

- Complaints advocacy providers, including VoiceAbility and PohWER, when people need support to make a complaint.
- Patient Advice and Liaison Services (PALS), particularly when enquiries involve hospitals.
- Birmingham City Council's Adults and Communities Access Point (ACAP) when people need to find information about support like adult social care.
- Local clinical commissioning groups (CCGs) when enquiries or concerns are about specific GP services in a particular area. For example we signpost to Sandwell and West Birmingham CCG's Customer Care Team who help people to resolve issues with their GP practice.

My relative is being discharged from hospital, but we don't agree with the care plan in place and are worried. What are my rights to challenge the decision?

Caller to the Information and Signposting Line. We signposted to a Patient Advice and Liaison Service and a local carers hub.

Helping understand patient experience

Our Information and Signposting Line has also enabled us to listen to more people's health and social care experiences. This can highlight issues in service quality and care, indicate that a service may not be meeting patients' or service user's needs, or point to avoidable issues with the ways the services are set up or run. We have used these experiences to guide our work on avoidable health inequity.

From this service we know people are experiencing vast differences in the quality of care they receive. People are telling us they are not being appropriately involved in their own care and their treatment is not being fully explained by the health or care services they use.

In pointing people in the right direction (signposting), Healthwatch Birmingham is not only helping people to find solutions to their enquiry, but also helping them to gain knowledge about navigating the health and social care system. We have worked hard to ensure people receive the right information for them, to resolve their problem.

> ***"Thank you, So happy - don't know what I would have done without you Healthwatch Birmingham."***
>
> ***Anonymous, call to the Information & Signposting Line.***

We also use the Information and Signposting Line to map potential trends in service quality and care, or gaps in public knowledge. This feeds into the decision making process for our investigations (see page 37) and has supported us to develop our online Information Route.

Making sure people get the support they need

Healthwatch Birmingham aims to provide high quality services, and we expect the same from other services that citizens in Birmingham access. That is why we audit the organisations we signpost people to, making sure people are getting the support they need.

We want to ensure organisations are following up with individuals and have communicated clearly with them. We do this by getting in touch with the person who originally called the Information and Signposting Line to see how matters have progressed and whether their problems have been resolved. From this we can understand the use, successes or required improvements of our service for people getting in touch.

An example of the benefits of auditing signposted organisations can be found on page 28.

What next?

Healthwatch Birmingham will be promoting the Information and Signposting Line more widely through digital marketing and communications, and raising awareness through other organisations in the system.

We will continue to follow up calls and audit the organisations we signpost to, ensuring people receive a service that meets their needs and they get their problems dealt with.

Volunteers have been trained to operate the Information and Signposting Line and will be taking calls more regularly going forward.

The launch of our new online Information Route on our website is another way we support people to find the information links they need.

Free, accessible and easy to use, it offers people the opportunity to independently find information about navigating the health and social care system.

We provide links for people to get advocacy support, access to safeguarding, how to make a complaint, understand their legal rights, improve their wellbeing and more.

We also aim to make sure services meet people's needs. We have a short feedback form which we ask users to complete to check we are providing the right links to meet peoples' needs.

How we have made a difference

Our reports and recommendations

Young people's experiences of patient centred primary care in Birmingham.

Between October and December 2015, we investigated the level of patient centred care experienced by young people using primary care services in Birmingham.

We had received some negative feedback from service users and decided it warranted further investigation.

Comments we receive through our Feedback Centre often focus on patient centred care:

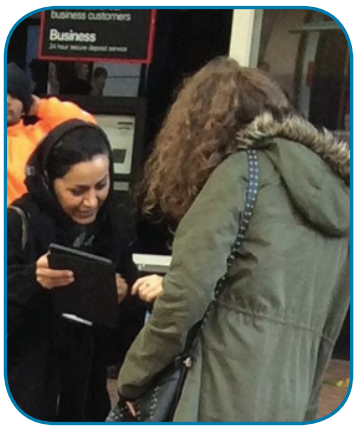
"A lot of doctors, around 5 or 6, all but 2 didn't seem to listen to what I was saying. One just fobbed me off and made out as though I was making it up"

"Awful, uncaring, rude"

"GPs are always good for me and listen to me"

"Always there for you"

Staff and volunteers asked more than 300 young people (aged 16-25 years) about their experiences in general practice consultations and about their use of health services. Volunteers support and commitment enabled us to engage with large numbers of young people, and marks the first time we have been able to listen to people from every district in Birmingham. We found surveying young people in public spaces outside music concert venues an innovative and successful method of engaging with our key demographic.



What did young people tell us?

The level of patient centred care experienced by young people in Birmingham is not consistent or good enough.

- One in five young people rated the level of patient centred care they experienced as either 'poor' or 'fair.'
- When asked: 'How good was the receptionist at showing care and compassion?' more than four in ten responded 'poor' or 'fair.'

Many young people experience avoidable barriers to attending their general practice.

- Nearly one in three respondents felt embarrassed about a health problem.
- A quarter said they found it difficult to obtain an appointment.
- One in five were put off by having to disclose a health concern to the receptionist.

Some young people are 'voting with their feet' and going elsewhere.

- Nearly a quarter went to a walk in centre.
- Around one in 6 attended A&E.
- One in five sought advice in the pharmacy.

Our recommendations to improve patient experience

One of our key statutory responsibilities is to listen to patient's and the public's views and bring them to the attention of those who commission and deliver services.

The report presents our findings to Birmingham's local CCGs, providing recommendations about how they could use these views to improve services for young people:

- Listening to their experiences acting on them by encouraging general practices to provide high quality care to this age group.
- Encouraging young people to become involved in Patient Participation Groups (PPGs).
- Collating the views of young people and using them to improve patient centred care.
- Encouraging all providers they commission to upload our Feedback Centre Widget on their website and make a note of any feedback left by young people.
- Auditing the level of shared decision-making between young patients and clinicians in general practice.

CCG responses to our recommendations included:

- Commitment to encourage the involvement of young people in PPGs through a PPG toolkit, including resources for recruiting new members.
- Making stronger links with schools and colleges to enable young people's needs to be listened to and encourage young people to join PPGs.
- Plans to host a focused event to explore the practical next steps for young people in relation to our findings.
- Commitment to work with Healthwatch Birmingham to host joint Ideas Café drop-in sessions to feedback how the recommendations are being taken forward.
- Plans to host a Question and Answer Panel for young people at a local college, to explore the themes raised.
- The introduction of a Young People friendly scheme in primary care services to ensure services meet their needs.
- Developing training and customer care for practice staff within existing training programmes, to ensure that they are delivering healthcare that meets young peoples' changing needs.

Full investigation findings, recommendations and CCG's responses can be found in the report accessible via our website.

Our report provides a glimpse into children and young people's actual experience of using primary care services and offers an insight into the ways that services need to be improved. It reveals indicators of avoidable health inequity, which could have lasting implications for the way young people use health services for the rest of their lives.

Involving young people in their own care and listening to their views is key to improving health and social care services and ensuring it meets their needs.

We will be working with all three CCGs to understand their timelines and progress against our recommendations and when Healthwatch Birmingham should expect to see differences for children and young people accessing primary care in Birmingham.

What's constraining effective patient and public involvement (PPI) in health and social care service improvement in Birmingham?

In developing our strategic approach, we undertook several pieces of work to clearly define and understand our role and function within the health and social care system in Birmingham.

A key piece of work included developing our role in promoting PPI in commissioning and providing decisions.

In November 2015 we published our report "What's constraining effective public and patient involvement in health and social care service improvement in Birmingham?" This followed a focus group held earlier in the year, which bought together organisations across the system to understand what was constraining those with statutory responsibilities to seek, listen to and take account of patient and public views of health and social care services.

The intervention, and subsequent report, informed Healthwatch Birmingham's strategic approach going forward in regards to meaningfully discharging our responsibility to promote and support PPI.

The focus group, attended by stakeholders from Birmingham City Council, local NHS provider Trusts and CCGs, voluntary and community sector organisations and volunteers, was designed to generate new knowledge and understanding and posed the question:

"If the solution is Healthwatch Birmingham promoting and supporting the involvement of people in the commissioning and provision of health and social care services - what's the problem?"

We asked attendees what constraints or barriers statutory organisations face in effectively involving and engaging patients and the public.

Responses included:

- Pressures of externally driven deadlines.
- Lack of common consensus about how to measure effectiveness of activities.
- Budgets and resources.
- Lack of understanding about how to engage with patients and the public.
- Lack of consensus about what good engagement looks like.

As a result, our work confirms the existence of a number of unintended consequences of not effectively engaging with the public. These avoidable health inequities are caused by a number of factors constraining effective engagement.

The group realised that the main constraint is the absence of quality measures in relation to effective engagement. This led to us developing our quality standard.

Healthwatch Birmingham is now working with our system partners and the public to develop appropriate quality measures. We will use these, as part of the local assurance and scrutiny system, to develop a role in assuring the quality of patient and public involvement and assurance.

This work also has highlighted how we could use our position to improve effective PPI to benefit commissioning, providers and ultimately improve services for people in Birmingham.

Consultations - Promoting patients and the public at the heart of decision making

Promoting and supporting the involvement of local people in health and social care commissioning and decision making is an integral part of Healthwatch Birmingham activity.

Volunteers and staff, together, responding to consultations is one of the ways we promote and scrutinise patient and public involvement. This could be about a service review, a future strategy or a whole system governance change like local devolution plans.

This year Healthwatch Birmingham responded to seven consultations:

1. Birmingham City Council Early Years Health and Wellbeing Consultation.
2. The National Maternity Review.
3. Integrated Palliative and End of Life Care Commissioning Strategy for Birmingham – Birmingham South Central and CrossCity Clinical Commissioning Groups (CCGs).
4. The Care Quality Commission (CQC) Strategy 2016-2021.
5. Birmingham City Council Local Performance Account for Directorate for People Adults' Social Care Services.
6. The West Midlands Combined Authority Consultation.
7. Non-Emergency Patient Transport Consultation.

Consistent topics and issues raised by Healthwatch Birmingham in our consultation responses included transparency, comprehensive information and data and impacts of resource or service changes.

Transparency

- In reviewing and responding to the consultations, we raised concerns about the lack of full details publicly available within some of the consultation documents. We highlighted that full information would help members of the public feel informed, engaged and able to form better responses.

- Healthwatch Birmingham called for organisations consulting on their future strategy or governance plans to outline their strategy for engagement as proposals did not clearly state whether patients and the public had been involved, and at what stage.

- Knowing why changes are happening, who is making decisions and when is crucial to ensure patients and the public do not feel left out on discussions about changes that will impact them.

  In our response to the CQC 2016-2021 strategy we commended their clarity about the consultation's timescales, enabling people to understand at what point they could get involved and expect proposal updates.

> **Consultations provide the opportunity for us to check whether organisations are actively involving patients and the public, engaging with relevant communities, and that impacts of any decisions are made clear.**

Comprehensive information and data

We share information and feedback evidence we receive, as part of our consultation responses. This shapes the issues that we raise as we make certain service user's needs and experiences are taken into account.

- We promoted the inclusion of patient and public experience, so decision makers can understand fully how health and social care services are used and how changes will affect people. Our responses encouraged the use of third party experience data to improve the range and depth of intelligence that organisations have available when reviewing future services or strategies.

- Healthwatch Birmingham's responses also centred on what mechanisms or processes were in place by these organisations to collect feedback from people to find out the impact of service changes, or how they were going to use experiences gathered to drive service quality and performance.

Impacts of service or resource changes

- We encouraged organisations to better outline what reductions in resources or budgets will mean for patients and the public. We called for the consultations and proposals to provide better information about future support, what services users can expect and how much support organisations will be able to offer going forward.

- We promoted the involvement of patients and the public in these discussions through a variety of engagement methods, by holding consultation meetings in public for example that are widely promoted and accessible.

In service criteria or eligibility changes, we asked how patients and the public had been involved in developing those criteria and whether support provision had been established for those who didn't meet the required eligibility level. Moves towards alternative support, like 'self-help' plans outlined in the Early Years Health and Wellbeing consultation, caused us to question whether this would raise safeguarding issues.

Have patients and the public been involved in decision making and has their feedback been considered?

Responding to consultations posed challenging questions for organisations about how they are involving people in their work. We asked how organisations are going to tackle the possible health inequity that may result from services changing and what action they were taking to ensure redesign and improvement of health and social care services reflect the needs and wants of local people.

Our responses promoted the needs of particular groups, like those living with learning disabilities or from a migrant community, using real feedback we had received to ensure organisations better listen, involve and engage people from all communities.

Healthwatch Birmingham track how our recommendations and responses influenced the consultation process and how services were developed as a result. We report this via our website.

An example of how we have promoted patient and public involvement in the commission of a new service can be found in our Non-Emergency Patient Transport case study on page 30.

Quality Accounts - promoting the role of patient experience in the quality improvement process

Each year Healthwatch Birmingham is invited to comment on the draft Quality Accounts of several local health and care providers.

Quality Accounts are an important way for NHS services to report on the quality of care they provide and demonstrate any improvements that have been made over the last year. They also allow providers to communicate their quality improvement goals for the coming year.

Responding to Quality Accounts allows Healthwatch Birmingham to promote the role of patient experience and PPI as part of the quality improvement process. It also gives us the opportunity to ask for more information and make suggestions for improvement.

Healthwatch Birmingham commented on 8 Quality Accounts in 2015/2016, including:

1. Birmingham Community Healthcare NHS Trust.
2. Heart of England NHS Foundation Trust.
3. Sandwell and West Birmingham Hospitals NHS Trust.
4. Birmingham Children's Hospital NHS Foundation Trust.
5. Royal Orthopaedic Hospital NHS Foundation Trust.
6. University Hospitals Birmingham NHS Foundation Trust.
7. Birmingham and Solihull Mental Health NHS Foundation Trust.
8. John Taylor Hospice.

Responding to Quality Accounts provides us with an opportunity to:

- **Comment on the health or care provider's performance.** This is considered both in terms of general performance and in relation to the specific quality goals each provider has outlined in the previous year's Quality Account.
- **Scrutinise next year's quality goals, the plans in place to achieve them and how they will be evidenced.** It is important providers demonstrate accountability to the public in an open and transparent way and we pose questions and challenge their plans for improving service quality.
- **Comment on the various ways Trusts are collecting feedback from patients and public.**
- **Comment on the extent to which the plans set out in the Quality Account show the provider is responding to the patient feedback it is collecting.**
- **Look in-depth and comment on the provider's use of PPI.**
- **Communicate any relevant feedback Healthwatch Birmingham has received about their service.** This will include a consideration of the extent to which the major themes arising from our feedback corresponds with the feedback collected by the providers.

Commenting and providing recommendations through Quality Accounts ensures we highlight the importance of providers engaging with, listening to and involving patients, the public and service user's when developing services.

What next?

We will:

Promote the importance to providers of demonstrating where they have sought to reduce inequities in care and experience.

Challenge more, requesting immediate changes to Quality Accounts when we feel there is a need for more clarity or information.

Track the changes providers have made as a result of our feedback to help us better evaluate the impact of our engagement.

Improve the coordination between our Quality Account responses and community engagement activities. This will allow us to increase the amount of patient, public, service user and carer feedback we include in our responses.

Working with other organisations

This year, Healthwatch Birmingham designed key challenge questions to help NHS England West Midlands with their assurance of CCG Patient and Public Involvement.

Over the last year Healthwatch Birmingham has made a growing contribution to discussion during West Midlands Quality Surveillance Group meetings.

As a direct result we were invited to contribute to NHS England's CCG Assurance Framework – in particular to design and then pilot a series of key PPI challenge questions in two of NHS England West Midlands CCG's quarterly assurance meetings in December 2015. As a consequence they adopted many of the key challenge questions into their briefing pack for 7 of their CCG's end of year assurance meetings and invited us to actively participate.

In wanting to ensure PPI is properly embedded, the regional team and Healthwatch Birmingham were working to a common agenda. The collaboration has created important opportunities for us to discuss our work on effective PPI in monitoring and scrutiny.

NHS England's Assurance Framework Operating Manual talks about PPI being an end-to-end 'golden thread'. For this to be assured we suggested looking for:

- How does the CCG Board assure itself of the quality, contribution and effectiveness of the PPI undertaken by its own commissioning managers?
- How does the CCG Board assure itself of the quality, contribution and effectiveness of the PPI when approving operational plans of primary and secondary care organisations?
- How does the CCG use ongoing, continuously received, patient and public feedback to specifically upgrade, improve or refresh existing operational plans or services?
- What multiple evidence can the CCG provide which demonstrates the centrality of patients and the public's needs and views in service design and redesign? What changes have they made to services which were the direct result of public input?

Having many of these questions adopted into the format of the end of year assurance meetings and our invitation to participate has enabled Healthwatch Birmingham to:

- Feed into the follow up debate led by the assurance team on how that CCG was assessed at year end.
- Develop a greater understanding on the CCG assurance process, and how performance and leadership is assessed.
- Share information about the development of our quality standard to improve PPI and linking it to avoidable health inequity.

Our involvement clearly shows the regard NHS England West Midlands has for ensuring PPI is an important aspect in monitoring, performance management and delivering high quality services.

In embedding PPI in assessments, citizen's involvement is taken seriously and CCGs will improve their PPI going forward. This will strengthen decision making, which leads to improved patient care.

"Healthwatch Birmingham's thinking and involvement proved really valuable. Their work on meaningful and effective Patient and Public Involvement added real credibility to our testing and assurance."

Natalie Penrose, Head of Performance and Delivery, NHS England.

Auditing the Information and Signposting Line leads to better collaboration and information sharing

When we refer members of the public to advocacy support providers we need to be confident they receive the appropriate level of service suited to their needs. We therefore audit services we refer to, and if needed discuss the findings with those organisations. As a result of our Information and Signposting Line audit process, we now more effectively collaborate with a local complaints advocacy provider, VoiceAbility.

- Both organisations now clearly understand each other's roles and functions.
- Regular meetings take place to discuss any issues that have arisen.
- VoiceAbility are clear about our audit process, and know what we do with the findings.

They encourage staff and partners (people that use their service) to share possible health inequities they know of in local health and social care services with Healthwatch Birmingham.

We are delighted to work more closely with VoiceAbility. This closer relationship is beneficial to both VoiceAbility and to Healthwatch Birmingham.

It will facilitate more and more cases of possible health inequity heard by VoiceAbility staff and experienced by their partners to be communicated to us.

Safeguarding

After raising a safeguarding alert to Birmingham's Adults and Communities Access Point (ACAP), we met with the ACAP service manager to better understand how to report safeguarding cases securely and quickly.

During this meeting we expressed concerns about their administration backlog in handling incoming email alerts. This meant that some safeguarding alerts were not being dealt with as quickly as they should.

We wrote a formal letter of concern to the ACAP team. This resulted in the escalation of this issue to senior management. New members of staff were recruited and trained to handle the backlog of cases. Incoming email alerts to ACAP are now dealt with more promptly.

Healthwatch Birmingham and the ACAP team continue to communicate well and are mutually supportive.

Our work in focus

Our Work in focus: Case Study One

Healthwatch Birmingham challenged initial proposals in the commissioning of a new non-emergency patient transport service, resulting in improved quality for all patients and prevention of avoidable health inequity.

In April 2017, the single largest contract for non-emergency patient transport (NEPT) jointly commissioned for Birmingham, Sandwell and Solihull will go live. This will affect thousands of patients who use NEPT to get to and from their healthcare services every day.

The new outlined proposal will see big changes to NEPT services - from multiple contracts delivering services of varying quality for patients to a single universal service that drives efficiency and improves quality for service users. NEPT across the region provides an estimated 350,000 journeys a year and the value of the contract is estimated at £40 million[1].

Healthwatch Birmingham met with the Commissioning Project Team, led by Birmingham CrossCity Clinical Commissioning Group (CCG), who arranged a briefing session pre-public consultation. We wanted to understand how proposed specifications and new eligibility criteria would impact patients using the new service. We were particularly interested in their development of new waiting time standards.

Healthwatch Birmingham challenged the CCG's initial proposals, which outlined a waiting time of up to one hour for patients. The challenge was also raised by Nick Flint, Chair of the Queen Elizabeth Hospital Kidney Patient Association.

Candy Perry, Interim Chief Executive Officer, highlighted the implications of the proposal: *"We felt this would have impact on one particular group of patients, renal patients, who would have to wait up to an hour for dialysis transport. National Institute of Health and Care Excellence (NICE) guidelines say 30 minutes waiting time for renal patients[2]. If these new standards were implemented they would have breached guidelines, hardwiring avoidable health inequity into a significant new service."*

Healthwatch Birmingham was told renal patients account for about 44% of NEPT users by the project team. This would mean considerable impacts in the quality of service and patient experience for a large number of users. We demonstrated that the result would be NEPT services not meeting patients' needs and not delivered in line with best practice.

Les Williams, Director of Performance and Delivery at Birmingham CrossCity CCG stated that the group went back and re-considered the waiting time in the specification: *"Healthwatch Birmingham's challenges definitely made us re-evaluate our approach, and led us to set the standard to be achieved as a maximum wait of 30 minutes for all patients using the service. This is now included in the service specification which is now going through procurement."*

Les explained aiming for the best possible waiting time was clearly good practice. Most importantly it also provides a better quality of patient experience:

> ***"When implemented this will result in a real improvement in quality for patients, thanks to Healthwatch Birmingham's challenge."***

Our involvement raised the issue with commissioners, whose service proposal would have resulted in avoidable health inequity for patients using NEPT. As a result renal patients

will now be able to access NICE guidelines-based care. It also means eligible patients will have their transport service improved by 50% from the original specification and patients will be treated equally, regardless of their condition.

Healthwatch Birmingham also used the meeting with the project team to ensure relevant patients and public had been appropriately involved in the design of the new contract.

"We take our role extremely seriously in helping ensure patient and public experience and involvement is effectively used to improve services. We asked questions about how the specifications had been developed, whether they had engaged with patients and the public and how their input had shaped any decision making." **Candy Perry.**

With such a large service change in the commissioning of this new contract, promoting and supporting patient and public involvement was vital for ensuring the new service considered user's needs. After commissioners engaged with the public, key proposals will mean that there will be one eligibility criteria for the NEPT services, communication with patients will be improved and that a patient charter will outline expectations around standards of care for service users.

Healthwatch Birmingham's involvement in service decision making and commissioning discussions has enabled us to effectively champion the rights of patients and the public to be at the heart of service design from the outset.

Further information about the NEPT contract:
All four local CCGs (Birmingham CrossCity, Birmingham South Central, Sandwell and West Birmingham and Solihull) were involved in the consultation for this universal NEPT service. The CCG's consultation findings report can be accessed via CrossCity CCG's website.

The consultation looked at NEPT for the following hospitals: Birmingham Women's Hospital NHS Foundation Trust, Birmingham Community Healthcare NHS Trust, Heart of England NHS Foundation Trust, Royal Orthopedic NHS Foundation Trust, University Hospital Birmingham NHS Foundation Trust and Worcestershire Acute NHS Trust.

1. Non-Emergency Patient Transport Stakeholder Briefing (February 2016) Available at: http://bhamcrosscityccg.nhs.uk/about-us/publication/non-emergency-patient-transport-nept/2769-non-emergency-patient-transport-stakeholder-briefing-2/file. [Accessed March 2016].

2. National Institute for Health and Care Excellence (January 2015) Available from: https://www.nice.org.uk/guidance/qs72/chapter/quality-statement-6-patient-transport [Accessed March 2016].

Our Work in focus: Case Study Two

How working collaboratively with health and social care system partners is creating positive change for patients.

Following an urgent referral, Healthwatch Birmingham immediately acted upon concerns about a patient's care and safety at a local Neuro-Rehabilitation Centre.

Healthwatch Derby contacted us as they had received a complaint from the patient's family who had expressed concerns that their relative's health had deteriorated since being admitted to the Centre. They felt that he wasn't receiving adequate support.

Healthwatch Birmingham spoke with the family member directly to find out more and, in listening to their experiences, was alarmed to hear about a severe lack of quality care and safety.

They reported that:

- Their relative had multiple complex health issues and wasn't receiving the specialised one-to-one support they needed. This indicated a lack of personalised care.
- The Centre was short staffed and lacked appropriately trained staff. This resulted in delays in care and poor communication to patients and their relatives.
- There were instances where the patient was left unattended for long periods of time so his care needs were not dealt with.
- The safety at the facility was inadequate, as visitors were not appropriately screened on entering the Centre. This meant patients were not in a safe and secure environment.
- They had tried to make complaints to the Centre directly but meetings with management kept being cancelled. The relatives of the patient felt they were not being listened to.

From this, Healthwatch Birmingham identified serious care and safeguarding issues and immediately contacted Birmingham City Council's Adults & Communities Access Point (ACAP) safeguarding team to raise an alert. We looked through the existing patient experience data in our Feedback Centre and noticed other negative issues raised about the service.

We contacted the Care Quality Commission (CQC), to see if a review of the service, or any investigations, were currently taking place. The CQC notified us that an inspection of the Centre was not due to take place for another two months. We felt was too far away in relation to the severity of the report we had received.

As a result of raising our concerns an unannounced inspection of the service provider was undertaken by the CQC within two weeks.

As part of the investigation the ACAP safeguarding team were also involved. The family member was signposted to a complaints advocacy provider who could support them through the formal complaints process.

As a result of Healthwatch Birmingham mobilising system partners to investigate further, a new manager was bought in the next day for the Centre and staff undertook appropriate training. The CQC have completed full inspection and the safeguarding team continued to be involved.

The patient's care has improved and their relatives feel like their voice is being heard.

"Healthwatch has made a massive difference because we had nowhere to go and we did not know what to do; it has made a big turn-around in the care that's being provided. People are actually listening now." **Family relative.**

Healthwatch Birmingham is ensuring patient, public or service user experience is used in the instigation of appropriate scrutiny and investigations into health and social care providers, placing the public at the heart of improvement made to services.

"The information sharing was instrumental and was used as part of the intelligence gathering for the responsive inspection that took place. Healthwatch Birmingham offered another source in which to obtain information through the view point of the carers and service users involved from their feedback on the Healthwatch website." **Sonia Isaac, Inspector, CQC.**

This case also shows the strength of the Healthwatch network in enabling patients and the public to find information about what to do when things go wrong and they need support.

"It was a pleasure to link up this feedback, and also to hear more about what happened following the referral. It shows the strength of the Healthwatch network as patient concerns no matter where they are picked up, are always correctly signposted and due diligence is given to amplify the voices of patients and carers. Local Healthwatch working together can make a difference and help improve outcomes." **Samragi Madden, Quality Assurance & Compliance Officer, Healthwatch Derby.**

Following the resolution of the complaint, Healthwatch Birmingham is now working more closely with the CQC to build stronger links to benefit continuous health and social care service improvement in the region.

- Both organisations displayed a willingness to understand each other's roles better within the health and social care system.
- We are clearer on information sharing and what needs to be done to mobilise the CQC.
- The feedback and experiences Healthwatch Birmingham gathers is taken into account by the CQC when they undertake investigations and inspections.
- We meet more frequently with the CQC to discuss developments and knowledge sharing.
- We share information and communications about CQC activity, encouraging patients and the public share their experiences about health and social care services they are using.
- CQC have invited Healthwatch Birmingham to collaborate with them on future inspections in order to maximise the potential of information and resource sharing.

As a result Healthwatch Birmingham is escalating people's concerns to organisations so we can take collective action to resolve issues. We are committed to working together with system partners to create positive change for patients using health and social care.

Patients and the public, who feel their voice is not being heard, are supported by Healthwatch to ensure their experiences are taken into account to help shape service change and improvement.

Future priorities

Future priorities

The last twelve months for Healthwatch Birmingham has seen a whole system review of our role putting us in a powerful position for 2016/17.

We have a new staff team in place who are specialists in their fields to drive our new strategy forward seeing more and more impact throughout the year ahead.

Our new strategy means that we are able to systematically listen to patients and the public to identify avoidable health inequity and use this gained knowledge to make clear decisions about our investigations involving a range of stakeholders.

Critical to this success is to build and grow our team of volunteers to carry out community engagement activity enabling everyone to share their experiences of health and social care when and where they want to, across all ten districts of Birmingham.

The priority for 2016/17 is to build on the results of our transformation. Our role and ways of working are clear and our goal is to grow and build on the new foundations formed in 2015/16.

This will see:

- Growth in the number of feedback experiences we hear from patients and the public.
- Growth in our reach through community engagement and digital media activity.
- Growth in the number of individuals accessing our Information and Support Line.
- Increased impact through investigations into identified avoidable health inequity using a range of methodologies.
- Improved quality of PPI across the health and social care system using our PPI quality standard.
- More and more involvement of patients and the public in consultations and opportunities publicised by Healthwatch Birmingham.

Our people

Decision making

Developing Healthwatch Birmingham's Topic Identification and Prioritisation System

In our legislative duty we must provide authoritative, evidence-based feedback to organisations responsible for commissioning or delivering local health and care services.

One of the ways we do this is by analysing patient experience datasets. If these data raise concerns we either discuss the issue directly with a provider or commissioner, or we may launch an investigation into a provider or system. We have published our **'procedure for making relevant decisions'** on our website.

This specifies that investigations into health and social care services are guided by the Healthwatch Birmingham's Topic Identification and Prioritisation System. This system has been piloted over the early part of 2016.

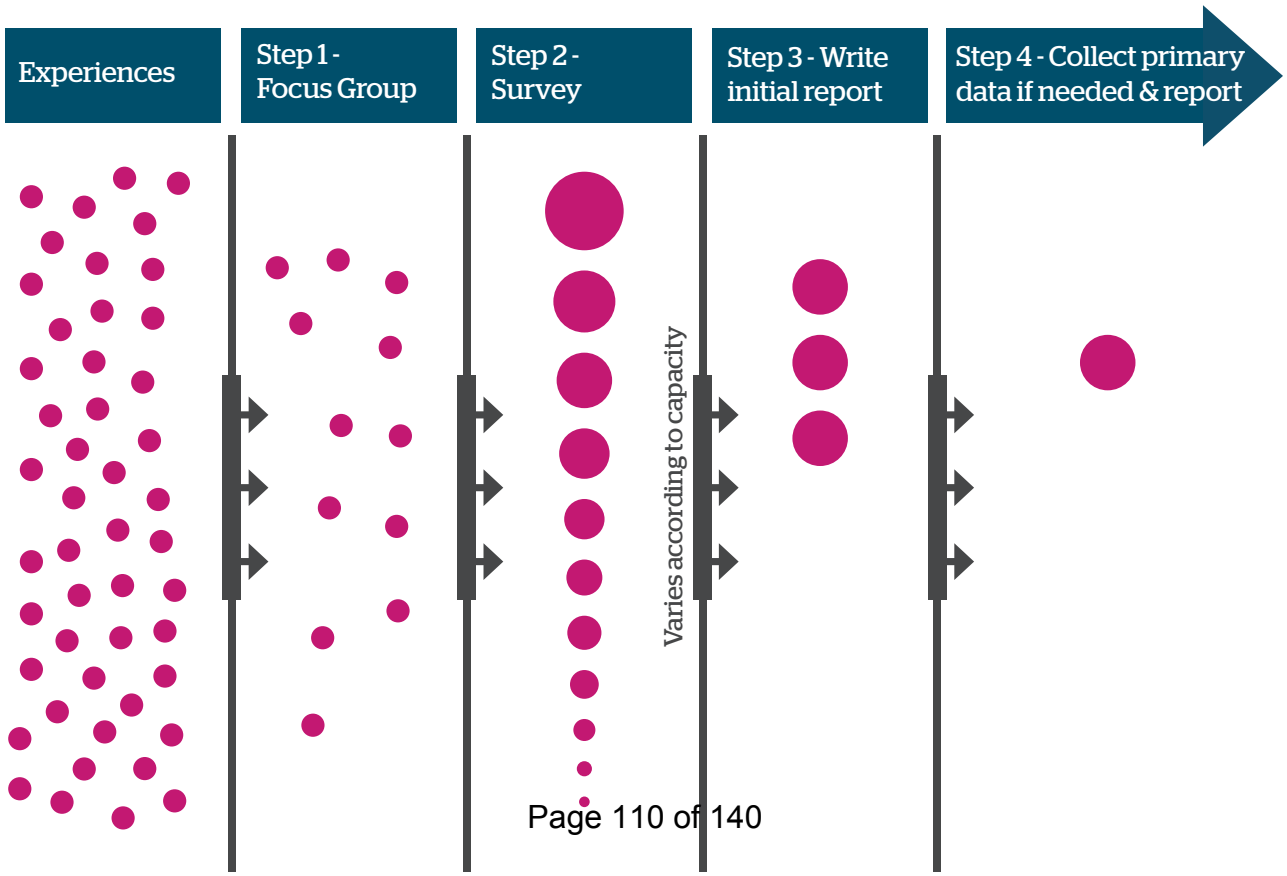
Piloting our Topic Identification and Prioritisation System

Experiences of Health and Social care services in Birmingham were heard from members of the public. We also recorded and collated possible avoidable health inequities heard by staff at external Board meetings.

Step 1. A list of 250 public and patient experiences, as well as possible avoidable health inequities heard at external board meetings were collated. These were discussed in a focus group consisting of Board members, our volunteers and staff. Focus group participants rewrote the experiences as 'problem statements' and selected eleven to continue through the prioritisation system.

Step 2. These eleven problem statements were sent to a wider group of key stakeholders via a questionnaire and shared via social media. Respondents were asked to select three problem statements they thought warranted further investigation by Healthwatch Birmingham. They were also asked how they thought the results of the investigation could be used to drive change in the health and care system in Birmingham.

Our robust process of investigation decision making



Fifty-eight respondents completed the questionnaire. These were from across the health and social care system in Birmingham, as well as members of the general public.

Twenty-seven respondents (61%) selected the problem statement "Only 60% of patient with severe mental illness have care plans, although they should have one." Of these, twenty respondents (74%) specified how the results of the investigation could be used to drive change in the health and care system in Birmingham.

The second most commonly selected problem statement was "Some people don't get general practice appointment when an urgent health problem arises." Twenty-five respondents selected this problem statement (57%), with 16 of these (59%) stating how the investigation could be used to drive change.

Involving members of the public, volunteers and our Board in decisions about our future activities ensures we operate in an open and transparent way.

Including stakeholders in decisions about what to investigate supports us to understand local priorities within the health and social care system, which when addressed will prompt action to effect positive changes for service users in Birmingham.

What next?

We will revise the Topic Identification and Prioritisation System by:

Analysing the feedback of people who have participated in the piloting to revise this process.

Reflecting on the investigations and reports that are produced as a result of this system, and the ability to use these as a lever for positive change in the health and social care system in Birmingham.

This updated system will be used to select the next round of topics for investigation. The focus group will be run immediately prior to the Autumn Board Meeting.

Our role on Boards

The Healthwatch Birmingham Executive team's role on external key Boards is to be the consumer watchdog of health and social care services. In doing so we support improvement of the delivery and design of services.

On these Boards we:
Seek assurance from Board members for the quality and effectiveness of their public involvement and engagement in service design and redesign.

Proactively share information relating to potential or actual issues we have identified in the course of dispatching our statutory functions.

1. West Midlands Quality Surveillance Group.
2. Health and Wellbeing Board.
3. NHSE PPI Working Group.
4. HWE Advisory Task and Finish Group.
5. Birmingham Health Oversight and Scrutiny Committee.
6. Joint Health Oversight and Scrutiny Committee - Solihull.
7. Joint Health Oversight and Scrutiny Committee - Sandwell.
8. West Midlands Local Healthwatch Network.
9. Birmingham Adult Safeguarding Board.
10. Sandwell and West Birmingham Primary Care Commissioning Board.
11. Cross City Primary Care Commissioning Board.
12. South Central Primary Care Commissioning Board.
13. Third Sector Assembly.
14. Birmingham Children's Safeguarding Board.
15. Right Care Right Here.
16. Better Care Fund.
17. West Midlands Urgent Care Network.

Our volunteers

Healthwatch Birmingham would like to say a big thank you to our volunteers who have supported us this year in everything from our investigative decision making, our consultation responses, our community engagement and our Young People's Report.

Alex Davis
Amanda Dickinson
Barbara Garrett
Christine Spooner
Fatemah Mossavar
Gillian Richards
Houston Pearce
June Phipps
Keith Hulin
Khairun Butt
Khakan Quereshi
Mandeep Dosanjh
Mark Lynes
Mike Tye
Mustak Mirza
Nina Davis
Olga Cojocaru
Pat Coyle
Patricia World
Sandra Ali
Shanice Brown
Steve O'Neill
Sulaiman Marrakchi
Tina Brown Love
Trevor Fossey

Our Board

We would like to thank all of our board members, past and present. We would like to acknowledge the contribution Norman Howell made to Healthwatch Birmingham as a member of our board, who sadly passed away in 2015.

Board meetings are held quarterly in public. In addition the senior management team attended in an advisory capacity. Healthwatch Birmingham's 2015/2016 board members:

Brian Carr - Chair
Carol Burt
Clenton Farquharson
Jasbir Rai
Jonathan Driffill
Mike Hughes
Marcia Lewinson
Dr Peter Rookes

left-right: Mike Hughes and Tilly, Brian Carr, Carol Burt, Jasbir Rai, Dr Peter Rookes, Jonathan Driffill

Our finances

Our Finances

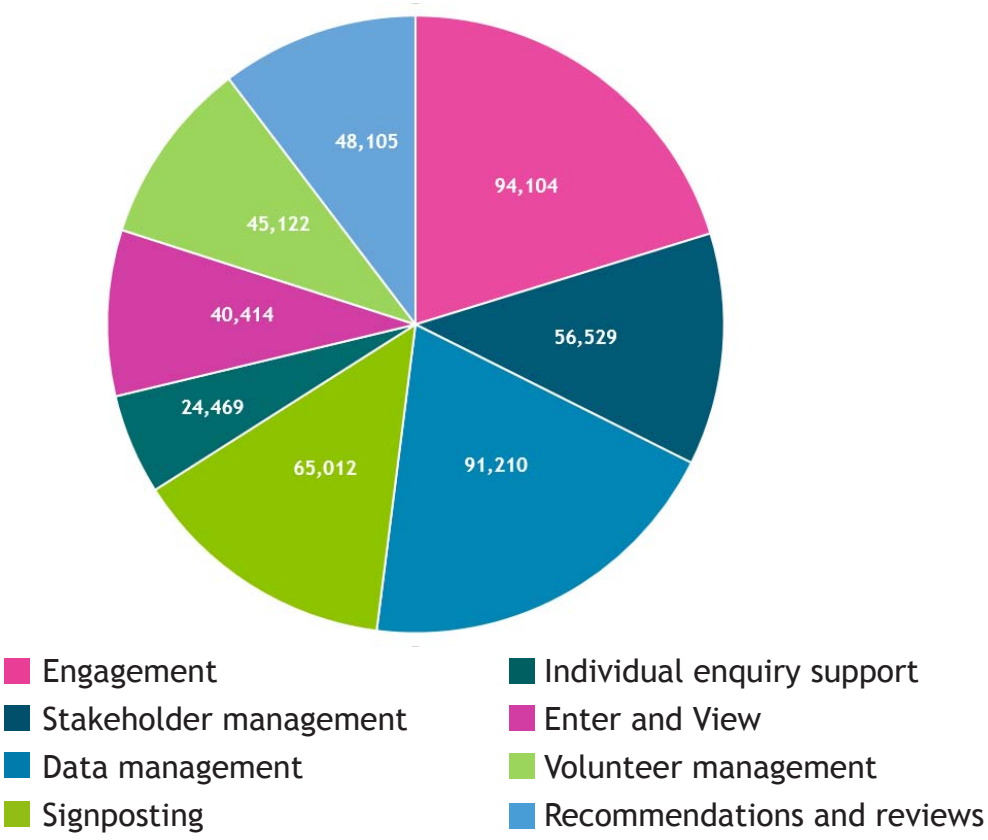
Income

Funding received from local authority to deliver local Healthwatch statutory activities	£445,374
Plus reserves from previous year	£26,984
Additional income	£904
Total income	**£473,262**

Expenditure

Operational costs	£101,258
Staffing costs	£321,021
Office costs	£42,686
Total expenditure	**£464,965**
Balance bought forward	£8,297

Healthwatch Birmingham expenditure by function



Contact Us

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Twitter: @HWBrum

Facebook: /HealthwatchBirmingham

We will be making this annual report publicly available by the 30th June 2016 by publishing it on our website and circulating it to Healthwatch England, the Care Quality Commission, NHS England, local Clinical Commissioning Groups, Birmingham City Council Health and Social Care Overview and Scrutiny Committee and Birmingham City Council.

Healthwatch Birmingham Company Registration Number: 08440757.

Acknowledgements

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Healthwatch Birmingham

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Healthwatch Birmingham Company Registration Number: 08440757.

Health, Wellbeing and the Environment Overview & Scrutiny Committee 2016/17 Work Programme

Committee Members: Chair: Cllr John Cotton

Cllr Uzma Ahmed
Cllr Deirdre Alden
Cllr Sue Anderson
Cllr Mick Brown
Cllr Carole Griffiths
Cllr Andrew Hardie
Cllr Kath Hartley
Cllr Mohammed Idrees
Cllr Simon Jevon
Cllr Karen McCarthy
Cllr Robert Pocock

Committee Support:

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

Schedule of Work

Meeting Date	Committee Agenda Items	Officers
21 June 2016	Formal Session – Appointments to Deputy Chair and Joint HOSCs Informal Session – Briefings and Background Documents	Dr Louise Lumley, Clinical Lead for Urgent Care. Karen Richards, Head of Urgent Care, Gemma Caldecott, Senior External Commas & Eng. Manager Alan Lotinga, Service Director, Health & Wellbeing / Judith Davis, Programme Director, Better Care Fund/John Wilderspin, Strategic Programme Director Sustainability & Transformation Plan Adrian Phillips, Director of Public Health Alan Bowley, Reduce, Reuse, Recycle Programme Manager

19 July 2016 @ 10.00AM	Use of Enhanced Assessment Beds including capacity in Care Centres Tracking of the 'Mental Health: Working in Partnership with Criminal Justice Agencies' Inquiry	Diana Morgan, AD Specialist Care Services Joanne Carney, Associate Director, Joint Mental Health Commissioning Team, CrossCity CCG, Robert Devlin, Senior Strategic Commissioning Manager, Peter Wilson, Stephen Jenkins, BSMHFT
19 July 2016 @ 1.00PM	From Waste to Resource Workshop	Alan Bowley, Reduce, Reuse, Recycle Programme Manager
9 August 2016	Urgent Care in Birmingham (including the re-procurement of NHS 111 Service)	Karen Richards, Associate Director of Urgent Care / Carol Herity, Associate Director of Partnerships, CrossCity CCG
27 September 2016 @ 10.00AM	Cabinet Member for Health and Social Care Birmingham & Solihull Sustainability & Transformation Plan - progress update Cabinet Member for Clean Streets, Recycling & Environment Healthwatch – Update	Cllr Paulette Hamilton/ Peter Hay, Strategic Director, People Directorate Cllr Lisa Trickett / Jon Lawton Andy Cave, CEO, Healthwatch Birmingham
27 September 2016 @ 2.00PM	Tracking of the 'Tackling Childhood Obesity in Birmingham' Inquiry Tracking of the 'Living Life to the Full with Dementia' Inquiry	Charlene Mulhern, Senior Officer – Collaboration, Birmingham Public Health Mary Latter, Joint Commissioning Manager Dementia

25 October 2016	Urgent Care in Birmingham – Consultation Plan	Karen Richards, Associate Director of Urgent Care
	Mental Health Day Services	Carol Herity, Associate Director of Partnerships, CrossCity CCG
	Update on Care Centres and Enhanced Assessment Beds	Diana Morgan, AD Specialist Care Services / Alison Malik, Head of Service, Complex & Statutory Services, Commissioning Centre of Excellence
	West Midlands Mental Health Commission	TBC
	Forward Thinking Birmingham – Mental Health Care for 0-25s (Update 6 months into the new contract)	Denise McLellan, Managing Director
22 November 2016	Update on Umbrella – the Sexual Health Services in Birmingham and Solihull Contract	Max Vaughan, Head of Service, Universal and Prevention
	Sustainability & Transformation Plan – Briefing	Judith Davis, Project Director STP / John Wilderspin, Strategic Programme Director STP
	Tracking of the 'Homeless Health' Inquiry	John Hardy, Policy & Development Officer
	Birmingham Substance Misuse Recovery System– Review of first 12 months	John Denley, AD People Directorate, Nic Adamson, Director CRI
13 December 2016	15/16 Local Performance Account Report	Alan Lotinga, Service Director Health & Wellbeing
	West Midlands Challenge of Birmingham Adult Care	Alan Lotinga, Service Director Health & Wellbeing
	Update on the Effects of Shisha Smoking	Dr Adrian Phillips, Director of Public Health, Janet Bradley, Alcohol & Tobacco Control
17 January 2017	Impact of Air Pollution on Health	TBC

21 February 2017	Tracking report for From Waste to Resource – A Sustainable Strategy for 2019 Tracking report for Household Recycling Centres	Jacqui Kennedy, Strategic Director – Place / Chloe Tringham, FWM Chloe Tringham, Fleet & Waste Management
28 March 2017		
25 April 2017	Cabinet Member for Health and Social Care	Cllr Paulette Hamilton / Suman McCartney

Items to be scheduled in Work Programme
• Mental Health Strategy (To be confirmed) • Housing Adaptations (To be confirmed)

Joint Birmingham & Sandwell Health Scrutiny Committee Work		
Members	Cllrs John Cotton, Carole Griffiths, Kath Hartley, Deirdre Alden, Sue Anderson	
Meeting Date	**Key Topics**	**Contacts**
5 July 2016 at 2.00pm in Birmingham	• Right Care Right Here – Its Evolution (transition to the Black Country Sustainability & Transformation Plan) • Update on Sandwell and West Birmingham End of Life Care Service	Jayne Salter-Scott, Head of Engagement, SWBCCG Jon Dickens, Chief Operating Officer – Operations, SWBCCG, Sally Sandal, Senior Commissioning Officer
Late October TBA		
Early December TBA Birmingham	• Findings of Improving Day Hospice Service Consultation – Sandwell and West Birmingham CCG	Jon Dickens, Chief Operating Officer – Operations, SWBCCG, Sally Sandal, Senior Commissioning Officer

Joint Birmingham & Solihull Health Scrutiny Committee Work		
Members	Cllrs John Cotton, Rob Pocock, Mohammed Idrees, Mick Brown, Uzma Ahmed, Andrew Hardie, Simon Jevon.	
Meeting Date	**Key Topics**	**Contacts**
27 July 2016 at 5.00pm in Birmingham	• NHS Procedures of Lower Clinical Value – Solihull and Birmingham	Gemma Caldecott, Senior External Communications & Engagement Manager, CROSSCITY CCG Neil Walker, Chief Contract & Performance Officer, Solihull CCG, Rhona Woosey, Network & Commissioning Manager, B'ham South Central CCG, Clinical Lead TBC
3 October 2016 at 6.00pm in Solihull	• HoEFT o Update on the performance/finance position o Report on progress made on implementing plans o Planned changes as a result of need to make savings to address deficit issues.	Dame Julie Moore, Interim Chief Executive / Jacqui Smith, Interim Chair / Rachel Cashman, Project Director, Integration Programmes / Kevin Bolger, Interim Deputy Chief Executive, Improvement

West Midlands Regional Health Scrutiny Chairs Network		
Meeting Date	**Key Topics**	**Contacts**
15 June 2016 10.00am	The Work of the West Midlands Mental Health Commission Mental Health Service Provision – from a provider perspective	Steve Appleton Managing Director – Contact Consulting West Midlands Mental Health Commission Secretariat and Project Manager Sue Harris, Director of Strategy and Business Development Stephen Colman, Director of Operations
5 October 2016 TBC	Sustainability and Transformation Plans (STPs) Scrutiny and STPs Planned Merger of the 3 Birmingham CCGs	Brenda Cook, CfPS
November TBC	Follow up on the Implementation of the West Midlands Combined Authority Mental Health Commission Recommendations	Rt Hon Norman Lamb MP, Chair of the Commission TBC

CHAIR & COMMITTEE VISITS		
Date	**Organisation**	**Contact**
To be advised	West Midlands Ambulance Service – Visit to an Ambulance Hub.	Diane Scott, Deputy CEO
To be advised	Birmingham Substance Misuse Recovery System:- Visit to CRI premises, Scala House, Birmingham.	John Denley, AD Commissioning Centre of Excellence / Nic Adamson, Director CRI
7 September 2016	Visit to Norman Power and Ann Marie Howes Care Centres	Diana Morgan, AD Specialist Care Services

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

Councillor Call for Action requests

Cabinet Forward Plan - Items in the Cabinet Forward Plan that may be of interest to the Committee			
Item no.	**Item Name**	**Portfolio**	**Proposed date**
002078/2016	Waste Depots Modernisation Programme Phase 1 – Full Business Case PUBLIC	Clean Streets, Recycling and the Environment	20 Sep 16
002086/2016	Natural Rivers – Improving the ecological condition and habitat connectivity on the River Rea catchment	Clean Streets, Recycling and the Environment	15 Nov 16

Report of:	**Cabinet Member for Health and Social Care**
To:	**Health, Wellbeing & the Environment Overview and Scrutiny Committee**
Date:	**29th September 2016**

Progress Report on Implementation: Tackling Childhood Obesity in Birmingham Inquiry

Review Information

Date approved at City Council:	8th April 2014
Member who led the original review:	Councillor Susan Barnett
Lead Officer for the review:	Rose Kiely
Date progress last tracked:	29th September 2015

1. In approving this Review the City Council asked me, as the appropriate Cabinet Member for Health and Wellbeing, to report on progress towards these recommendations to this Overview and Scrutiny Committee.
2. Details of progress with the remaining recommendations are shown in Appendix 2.
3. Members are therefore asked to consider progress against the recommendations and give their view as to how progress is categorized for each.

Appendices

1	**Scrutiny Office guidance on the tracking process**
2	**Recommendations you are tracking today**
3	**Recommendations tracked previously and concluded**

For more information about this report, please contact

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E-Mail:	Charlene.mulhern@birmingham.gov.uk

Appendix ❶: The Tracking Process

In making its assessment, the Committee may wish to consider:

- What progress/ key actions have been made against each recommendation?
- Are these actions pertinent to the measures required in the recommendation?
- Have the actions been undertaken within the time scale allocated?
- Are there any matters in the recommendation where progress is outstanding?
- Is the Committee satisfied that sufficient progress has been made and that the recommendation has been achieved?

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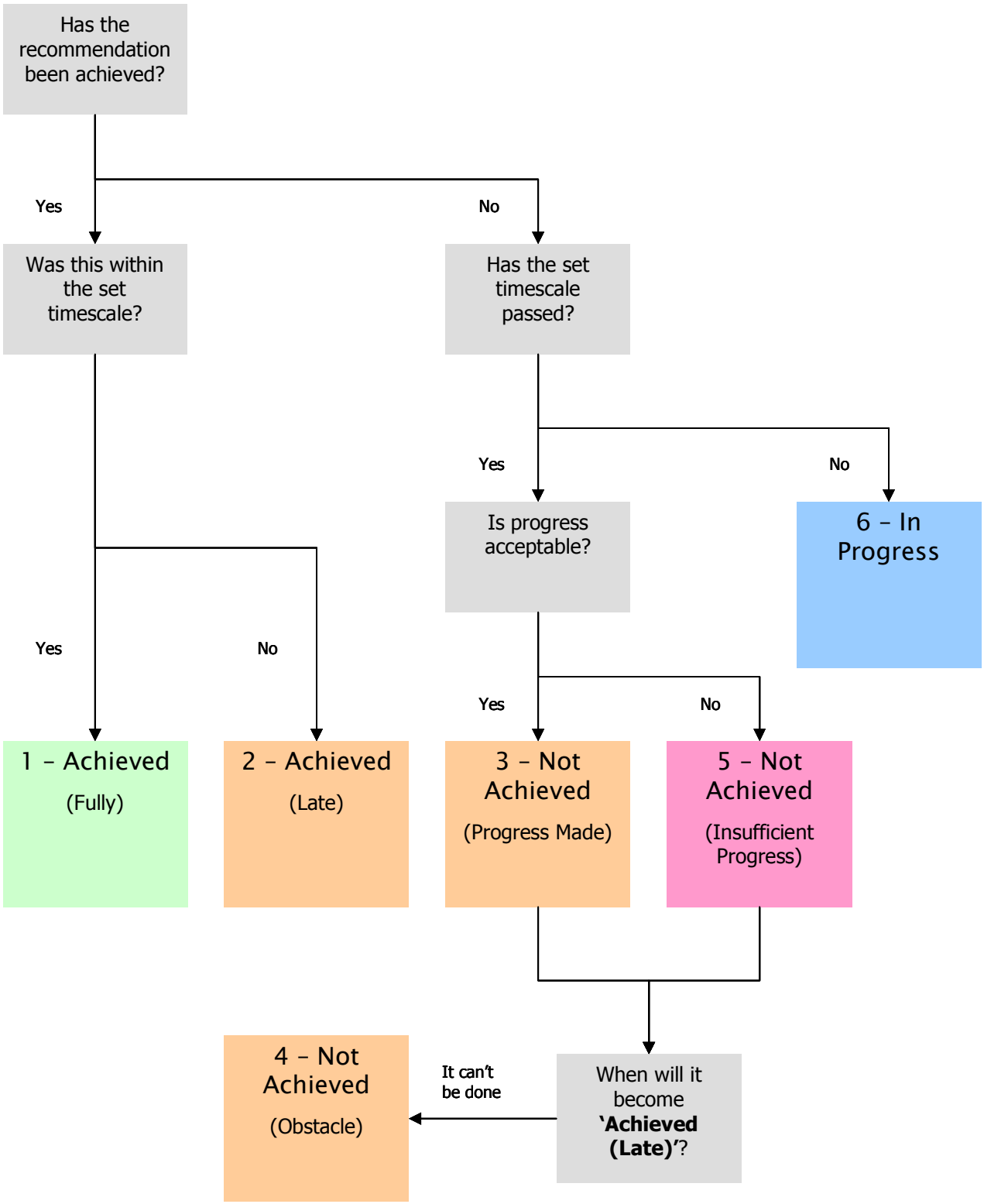
6: In Progress	It is not appropriate to monitor achievement of the recommendation at this time because the timescale specified has not yet expired.

The Tracking Process



Appendix ❷: Progress with Recommendations

No.	Recommendation	Responsibility	Original Date For Completion	Cabinet Member's Assessment
R02	That the Chair of the Education and Vulnerable Children Overview and Scrutiny Committee meet with the Chair of the Birmingham Educational Partnership to explore how the recommendations of the Health and Social Care Overview & Scrutiny Committee can be supported by the School Food Plan 2013 and also to develop more systematic engagement with all schools including free schools and academies on school food standards, healthy lifestyle options such as increasing walking and other healthy eating initiatives commissioned by Public Health.	Chair of Education and Vulnerable Children Overview and Scrutiny Committee	June 2016	3 (Not achieved, progress made)
Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')				
As previously presented the Director of Public Health (DPH) and Childhood Obesity Strategic Lead met with BCC CEO on 16th June '15 to discuss childhood obesity and how we create conditions to improve the health and wellbeing of children. Actions agreed at this meeting included; - Interim Executive Director for Education agreed to include health and wellbeing in the BEP service specification under the relation to District based service -BEP CEO agreed to disseminate 6 key health themed messages to schools during the academic year -The BEP agreed a further conversation following transition would be useful to look at options for expanding the offer 2015/16 update: Follow up meetings with BEP CEO and BEP Health lead have taken place. Some changes in how BEP operate mean that the health themed messages had not been possible and also following the unsuccessful Headstart bid meant that work that was planned hasn't occurred. Discussion around childhood obesity levels and WHO report on Ending Childhood Obesity and role of schools and links to proposed Third Sector Health framework have taken place. In addition, exemplars of good practice in Birmingham have been highlighted through the Public Health National Childhood Measurement Programme head teacher interviews project. Nine primary schools across Birmingham have been interviewed based on slight improvements in their obesity data. The aim of this project is to share best practice across the city by featuring their case studies in the NCMP letters to encourage others schools to take action.			

No.	Recommendation	Responsibility	Original Date For Completion	Cabinet Member's Assessment
R04	That the approach described by Birmingham Children's Hospital (BCH) as a stakeholder in the wider health and wellbeing of children and in starting to build a wider commitment by provider trusts to contribute to the public health agenda including the possibility of establishing a health promoting network for hospitals in Birmingham be supported and that BCH be requested to update the Health and Social Care Overview and Scrutiny Committee on progress.	Birmingham Children's Hospital Consultant in Public Health Medicine	June 2016	1 (Achieved)

Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

- The development of the Sustainability and Transformation Plan process, with a core focus on collaborating to improve health and wellbeing has now superseded the need to develop a separate provider network
- The inclusion of health and wellbeing measures within the national NHS CQUIN contract means that all NHS trusts now have a responsibility about improving their food offer to patients and staff, as well as implementing a range of additional health and wellbeing initiatives.
- The partnership working between BWH and BCH has now progressed to formal consideration of the business case by NHS Improvement

No.	Recommendation	Responsibility	Original Date For Completion	Cabinet Member's Assessment
R05	That through the Childhood Obesity Care Pathway, a children's service offer is developed which includes diet and behaviour, as well as physical activity, and that all services have the flexibility to offer family based interventions if appropriate.	Birmingham South Central, Birmingham Cross City and Sandwell and West Birmingham Clinical Commissioning Groups	June 2016	1 (Achieved)

Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

A referral pathway for Children's Weight Management has been in place since Dec 2013 and was promoted to clinicians at the CPD workshops as well as though individual local commissioning networks from 2014 onwards. Children's Weight Management Referral forms have been integrated onto all GP clinical systems to support increased uptake of referrals. Public Health is currently reviewing how they will respond to individuals or schools going forward.

Work is ongoing to achieve a more comprehensive pathway which includes access to family physical activity through a Be Active Children's/family Offer. The inception of the Wellbeing Service has seen the team undertaking a significant programme of culture change, workforce development (and basic qualifications such as children's first aid) to change the focus and provide a wide ranging offer both indoors and outdoors for children and families (there is literally hundreds of activities every week). Update from the Wellbeing Service includes:

- Mailout raising awareness about the service and how to make a referral to all GPs completed in July 2016
- There is CCG representation on the Wellbeing Governance Board
- Attended Primary care service information and signposting event (practice nurses, GPs, HCAs, surgery admin staff) to disseminate information and pathways into the service as well as what's on offer locally
- Linking in with CCGs re approaches to communicating service level information to surgeries
- Have met with and shared relevant service information with GP organisations i.e. Our Health Partnership and Modality
- Have Twitter accounts, facebook page etc
- Undertaken a digital mapping exercise that will now enable us to do direct marketing and communications to specific target groups for relevant service information

No.	Recommendation	Responsibility	Original Date For Completion	Cabinet Member's Assessment
R06	That the Health and Wellbeing Board through the Third Sector Assembly and the three Birmingham Clinical Commissioning Groups examine the best way to develop stronger strategic links between GPs and the Third Sector which may have the potential to facilitate further and better engagement with, and delivery of the childhood obesity agenda.	Cabinet Member for Health and Wellbeing as Chair of Health and Wellbeing Board	June 2016	1 (Achieved)

Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

To date Birmingham Childhood Obesity Strategic Steering Group have hosted numerous workshops to engage clinicians and third sector groups on this critical agenda with a particular focus on the child healthy weight care pathway. Examples of workshops include;

- the a citywide CPD workshop for GP's which focused on their role as a GP in tackling Childhood Obesity and the risk of not doing so and;
- two additional clinical CPD events were held for Birmingham midwives to support them on raising the issue of obesity and health weight gain during pregnancy.
- 9 / 10 Districts have chosen childhood obesity as a priority. As a result some districts have requested childhood obesity workshops e.g. Perry Barr, Northfield and Yardley.

A Third Sector representative has been chosen to sit on steering group. The representative feeds into the third sector assembly through the Children and Young People Network. The representative is leading on developing a third sector public health framework. The framework will aim to celebrate successes or further compliment any of the healthy lifestyle programmes that exist, or are in the pipeline. A scoping exercise is taking place to decide on scale and format of the proposed third sector public health framework including contacting Public Health England and asking via their national network if there is any information on other schemes in England. At the moment it seems that no other LA has attempted this. Initial discussions look to use a simplified version of the Public Health Outcomes Framework and elements of the Social Charter as a proposed framework. A first draft will be available for wider circulation by December 2016. This along with a written update will be circulated to HOSC.

In addition, we will be utilising crowdfunder to enable the Childhood Obesity Steering Group to engage with the wider community of Birmingham and explore ways to deliver a fundamental change in food consumption, physical activity or culture by providing a system by which the council/partner funds can efficiently target match funds and support to stimulate grass roots projects.

Furthermore the Wellbeing Service are engaging with CCGs and GPs as well as working with a significant number of community and voluntary organisations to raise awareness of services and work in co-production to develop and deliver services locally

No.	Recommendation	Responsibility	Original Date For Completion	Cabinet Member's Assessment
R08	That the Planning Committee start discussions with a view to adopting a policy development approach which commits to design out the obesogenic environment by following a process similar to the one that was followed when putting together Birmingham's Green Commission. Through this approach an environment can be designed that encourages physical activity, active travel and healthy lifestyle choices.	Chair of the Planning Committee	June 2016	1 (Achieved)

Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

The Birmingham Obesogenic Environment Group (including planning department representation) are leading a coordinated effort to impact on the obesogenic environment at all levels, this includes policy change, partnerships, communications as well as specific interventions. The group has been exploring innovative approaches to design out the obesogenic environment, improve health and tackle health inequality. Testimony to the joint work carried out by the group has resulted in;

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- Stronger partnership with BCC Planning department; secured £400k of Section 106 funding for healthy living revenue project in Birmingham - A first for Birmingham and, ensured the Hot food takeaway policy was included in the Birmingham Development Plan which is a positive step forward
- Stimulated novel sources of resources through developing partnerships with SHIFT a behaviour change charity to deliver a pilot to redesign the obesogenic environment by transforming the health impact of takeaway food in specified locations in Birmingham. Through these pilot activities, the service aims to

gradually increase the availability of healthy, affordable takeaway food in low-income areas and help improve the diets and health outcomes of local people

- National interest in the Developer Toolkit Pilot which aims to ensure that planning authorities, developers and architects are engaged at the earliest opportunity in considering health as part of the planning and development process. Implementation of the toolkit has begun in Birmingham. The developer toolkit covers 11 distinct themes including; housing quality and design, access to healthcare services and other social infrastructure, access to open space and nature etc
- BCC's street side advertising contract now includes a requirement to display nutritional information on all street side adverts. This included dialogue with BCC legal team and Corporate Strategy Team, Cabinet members and the Deputy Leader as well at Department of Health and Public Health England. This is a first for any Local Authority in England
- The Steering group has signed the Urban Food Policy Pact on behalf of Birmingham City Council (BCC). Prof Tim Lang *(Professor of Food Policy, City University, London)* says 'the pact signals the return of the City Region as a powerful voice in modern food policy'.
- Public Health and the Smart City Alliance are working together to deliver the second Smart City Alliance Workshop which will involve businesses taking part and potentially considering 'Crowd Funder' as a model to identify obesity/food related projects that the public are interested in and opportunities for co-funding. This is seen as an exciting opportunity to work with business to create a healthier environment in Birmingham.
- We have also seen some positive results working with large local organisations about Healthier, More Sustainable Procurement and meeting *Government Buying Standards* for Food and Catering. This includes both nutrition and sustainability standards and applies to all food served/sold to the public. Conversations are underway around how BCC can adopt these standards and been seen as an exemplar of best practice.

In addition, there is work underway with the West Midlands Combined Authority On the Move 2016-30 Physical Activity Strategy. The draft strategy is the start of a region-wide change in emphasis to significantly increase physical activity in the 3 LEPs using the excellence that already exists but creating a clearer focus on scale and effectiveness and with a sense of urgency and importance not seen before in any region of the UK

Appendix ❸: Concluded Recommendations

These recommendations have been tracked previously and concluded.
They are presented here for information only.

No.	Recommendation	Responsibility	Date Concluded by Overview and Scrutiny Committee	Tracking Assessment
R01	That letters be sent to: (a) the Secretary of State for Health to lobby for a stronger UK wide response towards childhood obesity with particular reference to addressing the food industry and producers, the role of education and schools and in relation to strengthening planning policy with a view to giving stronger planning powers to local Councils to enable them to deal more effectively with the proliferation of hot food takeaways; (b) the Secretary of State for Communities and Local Government to lobby for a change in policy guidance which would allow planning applications for inappropriate schemes to be refused on health grounds; and (c) Birmingham MPs to ask them to campaign in the House of Commons and lobby the Secretary of State for Health in relation to these issues.	Cabinet Member for Health and Wellbeing Chair of Health and Social Care Overview and Scrutiny Committee	November 2014	2
R03	That the Chair of the Education and Vulnerable Children Overview and Scrutiny Committee meets with the Chair of the Birmingham Governors Network to ensure that governors: (a) are systematically engaged and well informed in relation to the resourcing and funding decisions needed to support initiatives to tackle childhood obesity; and (b) are aware that they have the power to object to planning applications especially in relation to proposed hot food takeaways near schools and of the appropriate planning grounds they should consider whilst recognising that an objection in itself does not necessarily lead to refusal; and (c) understand their responsibility as school governors around meeting the school food guidelines.	Chair of Education and Vulnerable Children Overview and Scrutiny Committee	November 2014	2

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Concluded

No.	Recommendation	Responsibility	Date Concluded by Overview and Scrutiny Committee	Tracking Assessment
R07	That the Street Trading Consultation Process be amended to include the Director of Public Health as a consultee where Street Trading Consents are being sought for food outlets so that any representation made by the Director of Public Health can be taken into consideration before any decision is made.	Director of Regulation and Enforcement with Cabinet Member for Health and Wellbeing as Chair of Health and Wellbeing Board	November 2014	1
R09	That the Partnerships, Engagement and Communication Group, as an integral part of their work on developing and implementing a communications strategy, establish what advertising the Council and other stakeholders have control or influence over with a view to using this influence to promote healthy eating and physical activity.	Cabinet Member for Health and Wellbeing	September 2015	1
R10	That an assessment of progress against the recommendations and suggestions made in this report should be presented to the Health and Social Care Overview and Scrutiny Committee.	Cabinet Member for Health and Wellbeing	November 2014	2

Report of:	**Cabinet Member for Health and Social Care**
To:	**Health, Wellbeing and the Environment Overview & Scrutiny Committee**
Date:	**27th September 2016**

Progress Report on Implementation: Living Life to the Full with Dementia

Review Information

Date approved at City Council:	4th November 2014
Member who led the original review:	Councillor Susan Barnett
Lead Officer for the review:	Rose Kiely
Date progress last tracked:	N/A

1. In approving this Review the City Council asked me, as the appropriate Cabinet Member for Health and Wellbeing, to report on progress towards these recommendations to this Overview and Scrutiny Committee.
2. Details of progress with the remaining recommendations are shown in Appendix 2.
3. Members are therefore asked to consider progress against the recommendations and give their view as to how progress is categorized for each.

Appendices

1	**Scrutiny Office guidance on the tracking process**
2	**Recommendations you are tracking today**
3	**Recommendations tracked previously and concluded**

For more information about this report, please contact

Contact Officer:	Mary Latter
Title:	Joint Commissioning Mental Health Manager (Dementia)
Telephone:	07545 421 968
E-Mail:	mary.latter@nhs.net

Appendix ❶: The Tracking Process

In making its assessment, the Committee may wish to consider:

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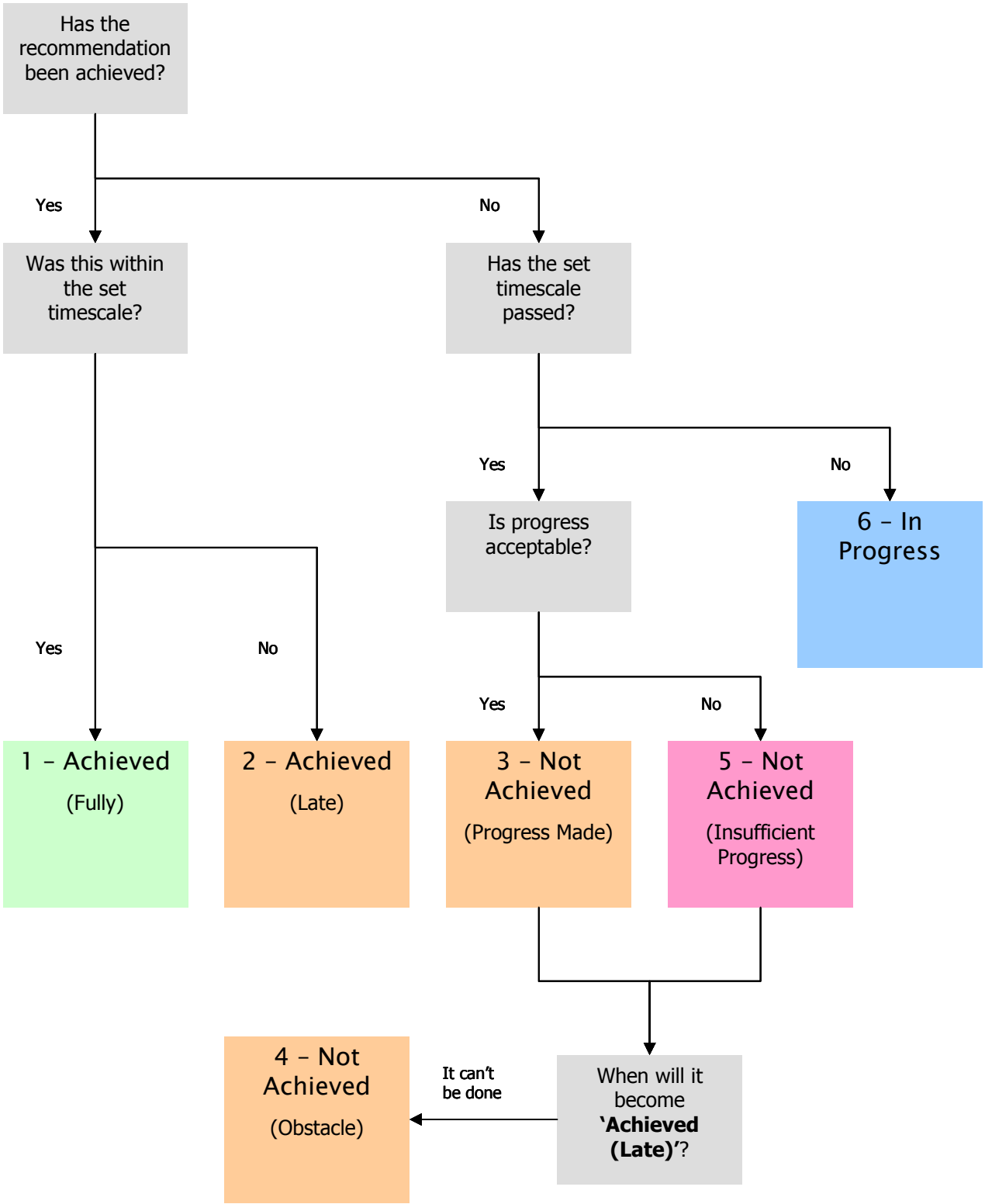
The Tracking Process



Appendix ❷: Progress with Recommendations

No.	Recommendation	Responsibility	Original Date For Completion	Cabinet Member's Assessment
R02	That the impact on dementia care and support is considered in relation to all major actions, commissioning and decommissioning intentions arising from the emerging Better Care Fund arrangements.	Cabinet Member, Health & Social Care as Chair of Health and Wellbeing Board	November 2016	**1**
Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')				
Oversight of the implementation of the Dementia Strategy and Dementia Commissioning moved from Joint Commissioning to the Better Care Fund Team in February 2015. Since then the aim has been to ensure that partners and stakeholders are clear about the key actions that need to be undertaken to ensure the implementation of the strategy and the provision of appropriate support for people with dementia and their carers across the city. This has been supported by the inclusion of dementia in strategic planning for the Clinical Commissioning Groups, including in terms of their commissioning intentions, and there has been some in-year procurement of services for people with dementia by Birmingham Cross City CCG, Birmingham South Central CCG and the Better Care Fund. A section 75 pooled budget has been set up (as part of the BCF Pool) to provide clear governance and accountability for commissioned services. Working group being set up with Commissioning Centre of Excellence to agree Dementia Commissioning Plan and that will also include CCoE and CCG's as part of STP work.				

No.	Recommendation	Responsibility	Original Date For Completion	Cabinet Member's Assessment
R04	That dementia awareness information is disseminated to all City Council Members and made available to all staff.	Cabinet Member, Health & Social Care	November 2015	**1**
Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')				
Information will be disseminated to all City Council employees via People Solutions and Corporate Communications bulletin in September 2016.				

No.	Recommendation	Responsibility	Original Date For Completion	Cabinet Member's Assessment
R10	That an integrated commissioning pathway model should be developed for those people with a dual diagnosis of a learning disability and dementia.	Cabinet Member, Health & Social Care	November 2016	**1**
Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')				

The move of dementia commissioning to the Better Care Fund has pooled together funding to protect existing dementia services. Learning disabilities services have been recommissioned through the Supporting People programme including dementia as one of the components. Next steps are to establish an integrated pathway.

No.	Recommendation	Responsibility	Original Date For Completion	Cabinet Member's Assessment
R12	That the feasibility of developing alternative models of respite care other than bedded respite care, such as providing domiciliary care for people with dementia, be explored.	Cabinet Member, Health & Social Care with Chairs of CCGs	November 2016	**1**

Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

A proposal was been submitted and approved in October 2015, by the Lead Commissioner, to the Better Care Fund Commissioning Board to fund the provision of home based 'sitting ' services to people with dementia across the city. This would provide around 11,000 hours of sitting /care and is against funding made available under Section 256 of the 2006 NHS Act which ring-fenced and transferred Health funding to the Local Authority for the provision of carers services.

It is intended that this will support a co-ordinated approach to supporting the management of people with dementia in their own home and reducing the incidence of non-elective admissions to acute hospitals. The service will be delivering support in collaboration with the integrated multidisciplinary community team and will work in partnership with the patient's carer and with the key worker in the multidisciplinary community team who will be coordinating the patient's care. It is in the process of being commissioned currently.

No.	Recommendation	Responsibility	Original Date For Completion	Cabinet Member's Assessment
R13	That the model of support used by Dementia Information and Support for Carers (DISC) is highlighted as best practice and is considered for replication in other locations across the city.	Cabinet Member, Health & Social Care Chairs of CCGs	November 2015	**1**

Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

A proposal was approved in October 2015, by the Better Care Fund Commissioning Board to fund the extension of the DISC model of support across the city (there are currently geographical limitations on access due to historic commissioning arrangements and limited capacity). This proposal is against funding made available under Section 256 of the 2006 NHS Act which ring-fenced and transferred Health funding to the Local Authority for the provision of carers services.

This extension of the service will more than triple service capacity to 8.5 wte workers for the Birmingham area. It will also provide capacity for support to community groups who wish to develop their own capacity to support carers of people with dementia.

Appendix❸: Concluded Recommendations

These recommendations have been tracked previously and concluded.
They are presented here for information only.

Concluded

No.	Recommendation	Responsibility	Date Concluded by Overview and Scrutiny Committee	Tracking Assessment
R01	That the City Council should appoint a Lead Member for Dementia with specific responsibility to ensure high-quality dementia services.	Cabinet Member, Health & Social Care	February 2015	2
R03	That the Cabinet Member for Children and Family Services writes to all Birmingham secondary schools to request that they consider including dementia awareness (using the available Dementia Resource Suite for Schools) as part of the PSHE (Personal, Social & Health Education) curriculum for Year 9 students. Information sent to Cllr Brigid Jones 8/7/16  Letter Template - DF.KeyStage.May2016  Dementia Friends request form - Young	Cabinet Member, Children and Family Services	November 2015	1
R05	That the City Council works towards making Birmingham a dementia-friendly city beginning at District level.	Cabinet Member, Health & Social Care with District Chairs	November 2015	1
R06	That Birmingham Community Healthcare NHS Trust develops a process to identify people, using their community services, who may have dementia.	Birmingham Community Healthcare NHS Trust	November 2015	1
R07	That Commissioners explore with Birmingham and Solihull Mental Health Foundation Trust and primary care, the possibility of adopting a shared protocol for prescribing anti-dementia medication as part of locally based integrated care services that support vulnerable people, including those with dementia, in the community.	Birmingham and Solihull Mental Health NHS Foundation Trust CCG Commissioners	November 2015	1

R08	That West Midlands Fire Service should receive referrals for fire safety checks via:- a) The City Council as fire risk will form part of a care assessment. b) GPs who identify vulnerable or high risk patients	Cabinet Member, Health & Social Care Chairs of CCGs.	November 2015	1
R09	That the Alzheimer's Society continues to develop its work with multi-cultural communities and faith groups and updates the Health and Social Care O&S Committee on progress.	Alzheimer's Society	November 2015	1
R11	That the ExtraCare Charitable Trust should explore with the Birmingham Clinical Commissioning Groups the feasibility of establishing a community nursing service for its schemes/villages across Birmingham and a "locksmith" service in the community	The Extracare Charitable Trust Chairs of CCGs	November 2015	1
R14	That an assessment of progress against the recommendations made in this report be presented to the Health and Social Care O&S Committee.	Cabinet Member, Health & Social Care	November 2015	1