BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD

TUESDAY, 30 APRIL 2019 AT 15:00 HOURS
IN COMMITTEE ROOMS 3 & 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1 **NOTICE OF RECORDING/WEBCAST**

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

2 **DECLARATIONS OF INTERESTS**

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

3 **APOLOGIES**

To receive apologies of inability to attend the meeting.

5 - 18

4 **MINUTES AND MATTERS ARISING (1500 - 1505)**

To approve as a correct record the Minutes of the meeting held on the 19 March 2019.

19 - 22

5 **ACTION LOG (1505 - 1515)**

To review the action arising from previous meetings

23 - 30

6 **HEALTH AND WELLBEING BOARD DRAFT FORWARD WORK PROGRAMME 2019 - 2020 (1515 - 1520)**

For Board Members to review and approve the Forward Plan for 2019-2020

7 **CHAIR'S UPDATE (1520 - 1530)**

To receive an oral update

8 **PUBLIC QUESTIONS**

Members of the Board to consider questions submitted by members of the public.
The deadline for receipt of public questions is 3.00pm on Thursday 25 April 2019. Questions should be sent to:
HealthyBrum@Birmingham.gov.uk
(No person may submit more than one question)
Questions will be addressed in correlation to the agenda items and within the timescales allocated. This will be included in the broadcast via the Council's Internet site (www.civico.net/birmingham). **NB: The questions and answers will not be reproduced in the minutes.**

31 - 46 9 **BIRMINGHAM JOINT STRATEGIC NEEDS ASSESSMENT: DIVERSITY AND INCLUSION DEEP DIVE 2019/20 (1535 - 1550)**

Elizabeth Griffiths, Public Health Division will present the item.

47 - 66 10 **JOINT STRATEGIC NEEDS ASSESSMENT REPORT UPDATE (1550 - 1605)**

Elizabeth Griffiths, Public Health Division will present the item

67 - 92 11 **HEALTH PROTECTION FORUM 2018-19 (1605 - 1620)**

Chris Baggott, Service Lead for Public Health Division will present the item.

93 - 104 12 **BIRMINGHAM OLDER PEOPLES PROGRAMME (BOPP)PROGRESS UPDATE**

This item is for information

105 - 112 13 **SUSTAINABILITY TRANSFORMATIONAL PLAN (STP) UPDATE - LIVE HEALTHY LIVE HAPPY**

This item is for information

113 - 130 14 **PRIMARY CARE NETWORKS**

This item is for information

15 **UPDATE ON THE GREEN PAPER CONSULTATION**

This item is for information

131 - 140 16 **PROPOSAL TO RELOCATE AND IMPROVE THE ADULT SEXUAL ASSAULT REFERRAL CENTRES WHICH SERVE BIRMINGHAM, SOLIHULL AND THE BLACK COUNTRY**

This item is for information

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

To note that the next Birmingham Health and Wellbeing Board meeting will be a Health and Wellbeing Board Development Session on Wednesday 15 May 2019 at 1300 hours in the Auditorium, 10 Woodcock Street | Birmingham, B7 4BL.

18 **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.

19 **EXCLUSION OF THE PUBLIC**

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

Exempt Paragraphs 1 and 2

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

20 **HEALTH PROTECTION FORUM REPORT 2018/19 INCIDENT REPORT (1625 - 1645)**

Item Description

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

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

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD TUESDAY, 19 MARCH 2019

MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON TUESDAY 19 MARCH 2019 AT 1500 HOURS IN COMMITTEE ROOMS 3 AND 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM B1 1BB

PRESENT: -

Councillor Paulette Hamilton, Cabinet Member for Health and Social Care in the Chair.
Charlotte Bailey, Executive Director Strategic Partnerships, Birmingham and Solihull Mental Health Trust
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Councillor Kate Booth, Cabinet Member for Children's Wellbeing
Dr Peter Ingham, Clinical Chair, NHS Birmingham and Solihull CCG
Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG
Carly Jones, Chief Executive, SIFA FIRESIDE
Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS Foundation Trust
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Peter Richmond, Chief Executive, Birmingham Social Housing Partnership
Antonina Robinson, Think Family Lead Birmingham, Department for Work and Pensions
Dr Justin Varney, Director of Public Health, Birmingham City Council

ALSO PRESENT:-

Elizabeth Griffiths, Public Health Specialist Registrar
Julie Davies, Strategic Lead for SEND
Errol Wilson, Committee Services

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

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NOTICE OF RECORDING/WEBCAST

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DECLARATIONS OF INTERESTS

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

APOLOGIES

356 Apologies for absence were submitted on behalf of Professor Graeme Betts, Director for Adult Social Care and Health Directorate
Andy Cave, Chief Executive, Healthwatch Birmingham
Andy Couldrick, Chief Executive, Birmingham Children's Trust
Professor Nick Harding, Chair of Sandwell and West Birmingham CCG
Dr Robin Miller, Head of Department, Social Work and Social Care, Health Services Management Centre, University of Birmingham and Sarah Sinclair (but Julie Davis as substitute).

MINUTES AND MATTERS ARISING

357 **RESOLVED: -**

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

ACTION LOG

358 The following Action Log was submitted:-

(See document No. 1)

The Chair introduced the item and invited Dr Justine Varney, Director of Public Health to update the Board concerning the Action Log.

Dr Varney advised that members of the Board were sent a letter on the 27 March 2019 in relation to IPS Mental Health and that a further letter of correspondence was to be circulated this week, which NHS colleagues had provided around the available support from employers concerning this opportunity. In relation to the second action point, a volunteer from the Board was still being awaited. The Chair commented that a request for a volunteer was made, but that if no one had volunteered, as Chair she would volunteer a member of the Board.

Log No. 344 refers – this would be discussed today as part of the agenda. In relation to the development and engagement plan, they would not be bringing that to the Board today as it would be going to the JSNA Steering Group before it comes to the Board for discussion.
Log No. 346 refers – this will be covered during the Board Development Day scheduled for the 14 May 2019.

Log No. 347 refers – has been completed
Log No. 349 refers – The Sustainability Action Plan has been completed
Log No. 351 refers – Mr Jennings advised that they had agreed that there will be a meeting with Dr Varney and Professor Betts and a representative from Solihull to look at this issue. The long-term plan would be in place by December,
Log No. 352 refers – this was to be moved as an **action** as it was a point for consideration moving forward. Dr Varney stated that he was hoping to return to the Board later in the year on how the public health grant was spent on the commissioning plans.

HEALTH AND WELLBEING BOARD FORWARD PLAN

359 The following draft Forward Plan was submitted:-

(See document No. 2)

Dr Justine Varney, Director of Public Health introduced the item and advised the Board that the item was for information, but that they would encourage Board members to peruse the Forward Plan and contact the secretariat if they had items that they would like to be considered at future meetings so that they could populate the FP. This was based on the items they had to date. Where possible, they were trying to cluster topics around particular meetings. A meeting was planned later in the year which was based particularly on adults with sustained and multiple challenges which bring together homelessness which the Chair was keen that they dedicate some time to discuss.

CHAIR'S UPDATE

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

(See document No. 3)

PUBLIC QUESTIONS

361 There were no public questions submitted. It was noted that public questions must be submitted 3 clear working days prior to the Birmingham Health and Wellbeing Board meeting being held.

Councillor Bennett enquired what steps had been taken to publicise this as it was a good initiative, so that the public would be made aware they could ask questions.

The Chair advised that no steps were taken, but that the item was placed on the agenda and it was raised at this meeting for the first time. The Chair added that it was hoped that for the next month this would be publicised. The Chair further requested that all Board members and others who were present at the meeting advertise this information through their contacts etc.

BIRMINGHAM HEALTH AND WELLBEING BOARD PRIORITIES: HEALTH INEQUALITIES

The following report was submitted:-

(See document No. 4)

Dr Justine Varney, Director of Public Health presented the item and advised that the purpose of the report was to give some context ahead of the discussion for the Development Day. The key action they needed to agree today was to formally agree that health and inequalities was a priority for the Board that had been previously agreed at a Development Day and it was for the Board to ratify that agreement formally for this item.

At this juncture, the Chair formally moved that health and inequalities was a priority for the Board and enquired whether there were any objections. The Board agreed the motion.

Dr Varney stated that the paper basically sets out some of the data in relation to health and inequalities in the city and highlights the challenges. They could talk about health and inequalities between Birmingham and the rest of the world and they could talk about health and inequalities within Birmingham - health and inequalities within Birmingham was in different parts of the city as well as within different geographical parts of the city.

Dr Varney drew the attention of the Board to the information in the report, particularly to page 4 of the report and stated that they had suggested highlighting this as one way of thinking that macro city level of inequalities between us and the rest of the world. At micro and community levels there were those that might be geographical definitions of a city and a third group was around special focus and the fact that inequality affects particular populations such as refugees and asylum seekers. Paragraph 5.4 refers to examples of different inequalities.

It was proposed that at the Away Day, some of the development time be used to focus on these three levels and think about measurable indicators they could look at that would allow the Board to tract progress on inequalities. One of the big challenges was that they often talk about health and inequalities, but when they got down to whether they had an indicator that they could follow that was measured in 'real time or good enough real time' and they had a geographical footprint that allows them to make any sense of that, it was quite difficult. The macro city level was straightforward, but there were many indicators some of which fluctuates significantly on a small number of people and infant mortality was a good example. Others took a long time to come through such as healthy life expectancy.

In a micro level/community level they had fewer indicators. The aim was to focus the discussion at the Away Day on selecting a couple of indicators under the three titles and they were keen that members of the Board reflect before the Away Day on the indicators they could bring to the table. It was important that they had a basket of indicators which was not purely national data and that they use the opportunity of some of the local data to drive this conversation. The second part of the Away Day would focus on how they then translate that into

smart actions and what it was that they were going to do about the indicators. The paper was to give some background information and pre-work ahead of the Away Day.

A brief discussion ensued, during which the following comments were made and responses were given to questions:-

a. The methodology being considered was sensible – the macro, micro etc. and would structure the Away Day.
b. Councillor Booth welcomed the report and stated that as Cabinet Member for Children's Wellbeing it identified with children particularly as they see with children later on in life, life expectancy for the older population of one to two years a lot of this started there.
c. In terms of whether information was available in relation to which of the indicators were determined by the wider social determinants and which of them were determined by the service levels in the particular areas, they did not presently had that level of granularity of most things.
d. It was important to reflect a bit on taking a whole system, whole person approach to all of these inequalities and indicators.
e. People lived their lives in a way in which the service provision was a small part in turning the tide of the challenges they faced.
f. One of the important pieces they were starting to do in building relationships between the Health and Wellbeing Board and the Sustainability and Transformation Plan Board was to get more clarity about who leads on which bit of the jigsaw which was played out in someone's lived experience.
g. There may be some indicators that come out in the Away Day where there was a clear service lead or a clear service component. If they took infant mortality for example which was one of the big headlines, there was a clear role and important issue around access and uptake of antenatal screening and maternity services. However, this did not allow them to ignore the role of child support and poverty and the socio economic impact on infant mortality.
h. We needed to dig down a little bit more into the employment statistics particularly when they were speaking about health and wellbeing as there were people on low wages, but there were also a huge number of people around 100,000 that was unemployed in Birmingham, 45% of which was claiming and fit for all work. Half of the 18 – 24 year olds not the NEETs.
i. Perhaps they could support some more informed discussions by bringing their state of the groups which would give the claimant count by Jobcentre across the 12 Jobcentres in Birmingham and would be able to state the age group and what they were claiming and the broad stroke health conditions they were aware of.
j. Having spent the last 6 years in PHE working with the DWP colleagues at a national level, there was a wealth of data that DWP held which would inform the granularity of the conversation particularly about that connection between work and health in a bi-directional nature at the individual level played out in the city in terms of our economic conclusion and our economic prosperity.
k. Any other Board colleague with data set that they would like to inform this day could contact Dr Varney by email so that this could be feed into the pack for the Away Day to help shape the discussion.

l. They were keen to move towards a dashboard for inequality which was not simply national data presented with the Birmingham silhouette around it. They needed to use their local intelligence much more effectively.
m. The Chair commented that she was pleased to see the report and the fact that they had two clear objectives of things that they would be discussing. In relation to paragraph 5.6 of the report if they could get this right it would be a good start. She added that the report was welcomed.
n. The approach taken in terms of the measurement was welcomed and having targets helped to keep the focus – that we will not just capture data trails but people's story.
o. The balance for the Board was the storey that they create around what they do that keeps them connected to people's lives and the hard edge of the target matrix that allows them to demonstrate progress.

362 **RESOLVED: -**

The Board –

- Agreed health inequalities as one of the Board's strategic priorities; and
- Noted that one of the focuses for the May 2019 Board Away Day will be developing a shared action plan to support the inequalities dashboard.

JOINT STRATEGIC NEEDS ASSESSMENT UPDATE

The following report was submitted:-

(See document No. 5)

Elizabeth Griffiths, Public Health Specialist Registrar, introduced the item and advised that the report was to update the Board on the Joint Strategic Needs Assessment (JSNA).

She then made the following points: -

1. That the Board was asked to **agree** a topic for the deep dive in-depth review on a diversity and inclusion topic.
2. That the Board **championed** the deep dive reviews for the JSNA this year by **naming** a Board member to be the champion for the review topics that they go through.
3. That the JSNA was an on-going process to identify our current needs as well as our future health and wellbeing needs of our local population. This looked at the services and the assets that were available to meet those needs.
4. Both the local authority and the NHS had a joint statutory duty to produce the JSNA in our area through the Health and Wellbeing Board.

Ms Griffiths then drew the Board's attention to the slide presentation accompanying the report.

A detailed discussion ensued, during which the following comments were made and responses were given to questions:-

1. Dr Varney advised that he had taken a strategic decision in terms of ensuring that they did not lose time this year to focus and test this methodology in the three areas which had been highlighted in the first month that he had been here where they did not have any intelligence and they did not have a strategic view.
2. That he took responsibility for this phase in not coming back to the Board in terms of the short list presented.

3. It was felt that they had to prioritise getting the core in the right place and these were the ones where he felt they had a need to address the issue. To give some context, the veterans were an issue that had arisen several times in the first couple of weeks from external stakeholders and members of the communities asking what the board was doing as a partnership in this phase.

4. Many other areas had carried out needs assessment of veterans' health and wellbeing base and approach, but we did not have that which was a straightforward piece to start with.

5. Similarly, individuals had raised concerns around end of life support in care and it was felt that they had a conversation of dying in the city in its broadest sense which would allow them to talk about the tragic losses recently through violence, but also the challenge of it for mortality. They had a broad discussion of dying and its impact on the community.

6. The public sector workforce was one that needed a requirement that NHS colleagues had in terms of addressing the health and wellbeing of the NHS workforce through the Forward Plan. It was one that was in the Council's particular pressing need which was the reason it had come in as the third.

7. They would have preferred to come back with a longer list for consultation, but in this particular year, in order to prioritise the capacity that they had within the team and discuss with the Chair the approach so that they focused those three and get on and started on them and have the broader discussion about the diversity inclusion one which was the more and less clear about the immediate need.

8. There was space about the discussion, but also to work through as a Board about how they make some decisions around this element to complement what they were doing across the rest of the system. They were informed based on what they were asked to look at by key stakeholders, based on partners and what was identified as risks in terms of the systems in his first couple of week within the organisation and where there was a requirement for them to demonstrate movement.

9. These were the three criteria that were used to make the decision. He apologised that he was not able to consult with the Board for a fuller discussion as he felt that it was important for us to demonstrate progress in this first year and to have a fuller discussion concerning the longer term Forward Plan.

10. Dr Varney noted Councillor Bennett's comments in relation to the public sector workforce etc., and stated that this was a fair challenge and to some extent this was the reason he had taken the division approach.

11. That having spent a significant proportion of time in his previous job, looking at the health and work issues at a national and taking a sectorial approach meant that that sector cared about what was said when no one else does.

12. The opportunity of the public sector in this particular point in time where each public sector organisation for different reasons were looking at the health of its workforce gives an opportunity to not make this conversation purely about NHS staff. It was a reasonable bundle on which to make reflections which will benefit the breath of businesses within the city.

13. Although the focus was on the public sector he did not believe that the findings and recommendations would be necessarily public sector specific, although it was believed that there were opportunities where they might find ways in which the public sector could work better together for their own benefit and for the benefit of the businesses in the city.

14. It was important for them to hold us to account as they go through the deep dive to keep reminding us that this was not a naval gazing exercise within the public sector.

15. It was taking that particular segment in its diversity both in terms of grading professional types to allow us to get a better understanding of what it was like to work in the city in its broader sense. The public sector was a large and significant portion of the workforce in the city.

16. The other opportunity presented was if they could shift the health and wellbeing of that population which at a rough count was several hundred thousand individuals directly and indirectly, working for the public sector, they would have an impact on the health of our adults in the city.

    At this juncture, Ms Jones commented that the voluntary sector makes an important contribution to the workforce in the city and that if they were having these discussions, it was important that they were not just talking about the public and private sector, but also the voluntary sector.
    The Chair commented that she was in agreement but that they would concentrate on the public sector this year and consider the voluntary sector next year.

17. Dr Varney noted the Chairs enquiry concerning death and dying – stabbings and people dying due to inequalities, the conditions they were living in and where they were living etc. and stated that the reason they talked about death and dying rather than end of life was to have a holistic conversation which talked about why do people die in Birmingham from the point of birth until when their life ends and why was that length of life different.

18. Reference was made to a suicide event he spoke at and stated that there was an element of looking at the data from the coroners as well as what they had statistically.

19. The questions were whether people were dying differently in Birmingham, whether we were learning from that when they die and were there lessons based on micro/macro level in terms of how they could help people not to die in that way. There was an important element, which was, we do not lose sight of how we help people who were dying to die with dignity.

20. One of the challenges was that we quickly become reactive to people who die in tragic and difficult circumstances and forget that hundreds of people would die across the city in a way which was planned etc. We need to ensure that when this happened we could support them and the people who were left behind in terms of their families and communities.

21. Dr Varney referred to the slide in relation to the Core Data set and stated that the key was in terms of consulting on the three year Forward Plan for the deep dive, the specific question they would be asking would be why would you like us to do a deep dive on this issue and how did it fit with commissioning intention – would you like us to look at transition for example from paediatric to adult services. This was where the deep dive information would come.

22. The key point was how the core data set got used. What they wanted to do over this year was to get to good enough for the autumn commissioning cycle with the council and NHS partners and do a reflection on whether that was good enough and what more was needed in a way that was transparent with the view that by next autumn they would be getting to good.

23. Part of the two year development phase would be a test year to see what was missing and what was needed in the core versus where they were making a specific transition and would be where the deep dive comes in.

    Action: The two decisions that were needed from the Board were: -
    A volunteer for each of the four deep dives as champions and to hold us to account; and
    A short discussion around where the Board would like us to look in terms of diversity and inclusion.

    The ambition and hope for the Board was to use the diversity and inclusion details in the deep dive to look at the space which was difficult for anyone organisation to look.

    All of us had a duty to address inequality in the city and sometimes these groups were difficult for us to have a conversation with, but if we look at them as a Board it allows for safer space to have a conversation around a particular group. To conserve on time Dr Varney requested that members of the Board could send an email to volunteer for the four deep dives and where they would like to go with the inclusion and diversity dive and why.

The Chair advised that members from the team would be visiting people and that it was hoped that on those visits they would have a few volunteers coming through with the things they were interested in doing. Board members were needed to take on some of these roles going forward or members could be nominated to take on a role.

363 **RESOLVED: -**

The Board noted

- The short term plans to create a core dataset for the Birmingham Joint Strategic Needs Assessment (JSNA) to include health, social care, housing and economic data from the Council, health data from the NHS and crime data from the Police and Community Safety Partnership;

- The proposed three year forward plan for deep-dive JSNA reviews; and

- Long term plans to develop an integrated JSNA bringing together knowledge, data intelligence and analysis from across the Council and its strategic partnerships.

THE MENTAL HEALTH PARTNERSHIP AND PRIORITY PARTNERSHIPS FOR THE FUTURE

The following report was submitted:-

(See document No. 6)

Charlotte Bailey, Executive Director Strategic Partnerships, Birmingham and Solihull Mental Health Trust, presented the report and stated that the report was to bring to the Board an update on mental health priorities and how they were managing those priorities around working in partnership, most importantly making request that the agencies were supporting that partnership agenda for mental health. Ms Bailey then drew the Board's attention to the information contained in the report and highlighted paragraphs 4.2 – 4.4 of the report pertaining to the changes to the governance structure.

She advised that in order to ensure they were focussed on the right things whether it be the Sustainability Transformation Plan (STP) or individual organisations, or to help the partnership have thought leadership around specific priorities, they had produced a partnership document that states that by 2030 these were the priorities that they needed to be focussing on over the forthcoming years around mental health. There were 11 priority partnerships for the future. In terms of the updates she wanted to ensure partners were aware of the changes that had taken place.

A discussion ensued, during which the following comments were made:-

a. Suicide prevention was a component of how they move to a whole system approach to supporting people to be mentally well about their lives.

b. The 2030 vision document was useful and it was important that people understand the challenges. The STP along with other partners had embraced the programme. The Chair expressed thanks to Paul Jennings, Chief Executive, NHS Birmingham and Solihull. The City Council was fully supportive of what the Mental Health Trust was trying doing.

c. To maintain this, a simple approach would be taken. There will be four sessions over the year to keep people's commitment. Thought leadership was a 'hot' topic which would self-motivate people to stay in that and keep the communication going.

364 **RESOLVED: -**

i. For Health and Wellbeing Board members to understand the Mental Health priorities, which are managed within the Sustainability Transformation Plan and the partnership projects;
ii. Health and Wellbeing Board members to nominate representatives from each organisation to attend the Mental Health Partnership meetings, which meets quarterly and take a proactive link in the partnership. (Nominations required by the end of March 2019); and
iii. Where purposeful, for the Health and Wellbeing Board to request the Mental Health Partnership to undertake a piece of work for the Board.

PUBLIC HEALTH GREEN PAPER CONSULTATION

The following report was submitted:-

(See document No. 7)

Dr Justin Varney, Director of Public Health, introduced the item and made the following statements: -

i. That having inherited this green paper, the aim was to move towards how this become a conversation with citizens in the city about how they tackle some of the entrenched inequalities that affects individuals in the city.
ii. The purpose of the presentation was to give an overview of the consultation approach that they were taking. He then drew the Board's attention to the information contained in the slide presentation.
iii. In agreement with the Chair, the consultation will be extended from six to eight weeks to have a full engagement schedule, but this still allowed them to come back to Cabinet and Council with the reflections on what they had been told over the late summer and autumn.
iv. In terms of the engagement plans, the Green Paper will be taken to the formal Boards – STP Board CCG Boards etc. He will be writing shortly to the Elected Members to encourage them to play a role in raising awareness, but also having conversations about the priorities that had been identified.

v. Working with key stakeholders in the city including Ward Forums and target engagement with communities, reaching out to colleagues within the faith community groups and voluntary and community sector organisations to ensure we were trying to make an effort to engage the non-traditional voices.

vi. Through the process they will be having a series of themed weeks where they highlight focus on a particular priority bundles and through that holding some community forums, cafés and using social media to launch the consultation.

vii. In terms of the consultation materials, it was recognised that the Green paper itself was not particularly an easy read document, but alongside this they were trying to produce a series of collateral materials which would make it easier to read and process. The challenge he had given the team was would an 8 year old person understand it.

At this juncture, Dr Varney drew the Boards attention to the infographics circulated at the meeting and advised that one was created for each ward in the city and the aim was to offer every ward a presentation as part of the Ward Forum meetings. The infographics will be made electronically available.

viii. Dr Varney continued - the consultation will begin this week and will run for 8 weeks with the findings brought back to Cabinet and the Health and Wellbeing Board.

ix. There will be no written public health strategy for the city, but a health and equalities framework document will be written for the city setting out how they were going to respond to these challenges as a partnership, clearly identifying the different strategic documents across the partnerships the actions being taken, so that a clearer metrics approach was developed to find solutions.

x. That it was not believed that any of the challenges could be solved by a single document. By weaving a golden thread of tackling health and inequalities across a collective strategic approach of the city, it was hoped that they could turn the tide of over a decade of inequalities.

xi. The ambition was that they bring the skeleton of this back in the late autumn and consult and engage with how they develop a framework which was meaningful, that people could commit to and take the shared leadership and hold each other accountable to as they move forward in addressing some of the challenges.

The Chair commented that Dr Varney had come into this role and just wanted to get out into the community. This was something that Public Health and others would be doing on an on-going basis. She added that her challenge will be that if there was an area that other parts of the Council and other partners wanted to share with us to get information.

Dr Ingham commented that the infographics by ward was useful for their locality meetings as there were five localities in Birmingham and this was amazing. He added that this felt like they were going in a good direction.

Dr Varney acknowledged his team as it was a collective effort and they had stepped up to the challenge he had given them.

Stephen Raybould commented that it was good to see that Dr Varney was getting out to the citizens directly. He suggested that one of the things he would like (and would be happy to facilitate it) to talk to the voluntary sector as a whole and that they would be happy to pull that together. One of the challenges for the city was that it was not a collective narrative around what was happening either around health and inequalities or outside the broader space of service provision.

The Chair commented that whilst they were out last week and since she was approached by a number of people in relation to social prescribing and that not many of the GPs were employing link workers or that people that were helping to co-ordinate and pull things together … The Chair suggested that a bit more work be done with Dr Varney and others to see how they could make this more cross-cutting as people wanted to do social prescribing, but there appeared to be a breakdown.

365 **RESOLVED: -**

The Board noted that the Birmingham Public Health Green Paper consultation runs from t 18 March 2019 to the 28 April 2019.

BIRMINGHAM HEALTH AND WELLBEING BOARD, HEALTHWATCH BIRMINGHAM AND HEALTH SCRUTINY WAYS OF WORKING AGREEMENT

366 The following report was submitted:-

(See document No. 8)

The Chair advised that this item was for information.

DATE OF NEXT BIRMINGHAM HEALTH AND WELLBEING BOARD MEETING

367 It was noted that the next Birmingham Health and Wellbeing Board meeting will be held on 30 April 2019 at 1500 hours, in Committee Rooms 3&4, Council House, Victoria Square, Birmingham, B1 1BB.

The meeting ended at 1622 hours.

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CHAIRPERSON

Item 5

BIRMINGHAM HEALTH & WELLBEING BOARD

Action Log 2019

Rag rating :
- Overdue
- In progress
- Complete

Index No	Date of entry	Agenda Item	Action or Event	Named owner	Target Date	Date Completed	Outcome/Output	Comments	RAG
362	19.03.2019	Joint Strategic Needs Assessmnet Update	The two decisions that were needed from the Board were: - A volunteer for each of the four deep dives as champions and to hold us account; and a short discussion around where the Board would like us to look in terms of diversity and inclusion.	Elizabeth Griffiths	30th April 2018				
	29.01.2019	IPS - Mental Health	The Chair has requested that a member of HWBB volunteer to attend the IPS Employers Forum to support the development of IPS.	All Board	19.03.2019				
346	19.02.2019	Childhood Obesity	DPH was asked to reflect on potential for social marketing high profile campaign - similar to the partnership approach to 'sugar free' month promoted by Sandwell Council and partner organisations and 'Fizz Free Feb' led by Southwark Council.	Justin Varney	Development day 14.05.2019				
351	19.02.2019	NHS Long Term Plan	It was agreed that, as the local 5-year plan was being drafted, consultation should take place with the Health and Wellbeing Board and engagement with key leaders in the City to enable them to give an input to the plan.	Paul Jennings	19.03.2019				
352	19.02.2019	Substance Misuse	Consideration to be given to partners' involvement and public engagement in the future commissioning cycle, and to the funding position, taking on board comments made at the meeting.	Max Vaughan	Date to be confirmed				

Index No	Date of entry	Agenda Item	Action or Event	Named owner	Target Date	Date Completed
	29.01.2019	IPS - Mental Health	To send a letter to all Board members to encourage them to actively promote and support employment opportunities for people with SMI within members' organisations through the IPS programme.	Board Admin		27.03.2019
		JSNA SEND	Remove the recommendations from the report and send them to the SEND Improvement Board as a reference item.	Fiona Grant	19.03.2019	
		Sustainability Transformation Plan (STP)	To submit written bi-monthly update reports to the Board, with updates from the portfolio boards.	Paul Jennings	28.05.2019	
344	19.02.2019	JSNA Update	Public Health Division to present the JSNA development and engagement plan at the next	Justin Varney	19.03.2019	
	29.01.2019	IPS - Mental Health	members to encourage them to actively promote and support employment opportunities for	Board Admin		27.03.2019

Outcome/Output	Comments	RAG
The letter has been sent out to all Board Members on the 27.03.2019	Awaiting information from Dario Silvestro regarding the Support available for employers	
	Item in Matters Arising in the minutes	
been sent out to all Board Members on the	information from Dario Silvestro regarding the	

Birmingham Health and Wellbeing Board

Draft Forward Work Programme

2019-2020

Board Chair: Councillor Paulette Hamilton

Vice Chair: Dr Peter Ingham

Board Members:

Andy Cave	Chief Executive of Healthwatch	Healthwatch Birmingham
Andy Couldrick	Chief Executive of Birmingham Children's Trust	Children's Trust
Antonina Robinson, MBE	Think Family Lead Birmingham	Department of Work and Pension
Councillor Kate Booth	Cabinet Member for Children's Wellbeing	Birmingham City Council
Councillor Matt Bennett	Opposition Spokesperson on Health and Social Care	Birmingham City Council
Councillor Paulette Hamilton	Cabinet member for Adult Social Care and Health	Birmingham City Council
Dr Justin Varney	Director of Public Health	Birmingham City Council
Dr Peter Ingham	Clinical Chair	NHS Birmingham and Solihull CCG
Dr Robin Miller	Head of Department, Social Work & Social Care Co-Director, Centre for Health & Social Care Leadership	University of Birmingham Education Sector – Health Services Management Centre.
Paul Jennings	Chair Executive	NHS Birmingham and Solihull Clinical Commissioning Group

Peter Richmond	Chief Executive of Birmingham Housing Trust.	Birmingham Social Housing Partnership
Professor Graeme Betts	Corporate Director for Adult Social Care and Health Directorate	Birmingham City Council
Professor Nick Harding	Chair, Sandwell and West Birmingham CCG.	Sandwell and West Birmingham CCG.
Richard Kirby	Birmingham Community Healthcare NHS Foundation Trust	Birmingham Community Healthcare NHS Foundation Trust
Sarah Sinclair	Interim Assistant Director for Children and Young People Directorate	Birmingham City Council
Co – optees		
Carly Jones	Chief Executive of SIFA FIRESIDE.	SIFA FIRESIDE
Charlotte Bailey	Executive Director Strategic Partnership.	Birmingham and Solihull Mental Health Trust
Stephen Raybould	Programmes Director (Ageing Better)	Birmingham Voluntary Services Council

Board Support:

Committee Board Manager
Landline: 0121 675 0955
Email: errol.wilson@birmingham.gov.uk

Business Support Manager for Governance & Compliance
Landline:0121 303 4843
Mobile : 07912793832
Email : Tony.G.Lloyd@birmingham.gov.uk

Schedule of Work: April 2019-March 2020

Board Meeting Date	Deadlines	Scheduled Agenda Items	Presenting Officers
Formal Meeting 30th April 2019 Venue : Committee Rooms 3 & 4, Council House, 3pm -5pm	Draft Report Deadline for Pre-agenda : 4th April Final Report Deadline: 18th April Agenda and Reports Dispatch Date: 20th April	**Presentation Items** Health Protection Report Update **PRIVATE ITEM** Health Protection Incident Report Update Birmingham joint strategic needs assessment: diversity and inclusion deep dive 2019/20 Joint strategic needs assessment update **Information Items** Feedback on Public Health Green Paper Consultation **(verbal)** Care Quality Commission Quarterly Update – Combined with Birmingham Older People Programme(BOPP) Sustainable Transformational Plan (STP) Bi – Monthly Update Proposal to relocate and improve the Adult Sexual Assault Referral Centres which serve Birmingham, Solihull and the Black Country. Primary Care Network	Chris Baggott Chris Baggott Elizabeth Griffiths Elizabeth Griffiths Elizabeth Griffiths N/A N/A N/A N/A
*** PLEASE NOTE – AT THE BEGINNING OF EACH MUNCIPAL YEAR THE NEW DATES OF THE BOARD MUST BE AGREED BY BOARD MEMBERS BFEORE PUBLICATION , SO THESE DATES ARE TENTATIVE UNTIL AGREED BY BOARD MEMEBERS AT MAY'S BOARD MEETING*****			

Board Development Day 14th May 2019, Venue: Committee Rooms 3 & 4, Council House.	Time : 1pm -5pm	**Workshop Group Discussion Items** **Health Inequalities** Health and Wellbeing Board Priorities indicators and work programme & new TOR **Childhood Obesity** Whole System Approach to tackling childhood obesity – developing a partnership action plan for the city	 TBC TBC
Informal Meeting **18th June 2019** **Venue : Seeking to secure Sparkbrook Community Centre**	Draft Report Deadline for Pre-agenda : TBC Final Report Deadline: tbc June 2019 Agenda and Reports Dispatch Date: tbc June 2019	***Themed : Making Every Adult Matter*** **Discussion Items** Homelessness Prevention Plan (Rough Sleepers) Severe Enduring Mental Health Public Health Annual Report Substance Misuse Vulnerable individuals Offenders HealthWatch	 TBC TBC TBC TBC TBC TBC TBC
Formal Meeting 30th July 2019 Venue : Committee Rooms 3 & 4, Council House, 3pm – 5pm	Draft Report Deadline for Pre-agenda : TBC Final Report Deadline: 19th July 2019 Agenda and Reports Dispatch Date: 22nd July 2019	**Presentation Items** ***Standing Item*** JSNA (Joint Strategic Needs Assessment) Update Health and Wellbeing Board Priorities Update: Childhood Obesity Action Plan Clean Air / Air Quality **Information Items** Mental Health CCG Commissioning Strategy Sustainable Transformational	 TBC TBC TBC N/A

		Plan(STP) Bi – Monthly Update Suicide Prevention Strategy	N/A N/A
August 2019 – NO BOARD MEETING – Half – Term			
Formal Meeting 17th September 2019 Venue: Committee Room 3&4, Council House, 3pm – 5pm	Draft Report Deadline for Pre-agenda : TBC Final Report Deadline: 6th September 2019 Agenda and Reports Dispatch Date: 9th September 2019	**Presentation Items** Care Quality Commission Quarterly Update – Combined with Birmingham Older People Programme(BOPP) Health and Wellbeing Board Priorities Update: Health Inequalities - JSNA Deep Dive DTOC Discussion **Information Items** Health and Wellbeing Board Priorities Update: *Childhood Obesity*	TBC TBC TBC TBC N/A
Informal Meeting 29th October 2019 Venue : TBC **Health Walk - TBC**	Draft Report Deadline for Pre-agenda : TBC Final Report Deadline: 18th October 2019 Agenda and Reports Dispatch Date: 21st October 2019	**Presentation Items** Sustainable Transformational Plan(STP) Bi – Monthly Update BAME Health Inequalities discussion item **Information Items** Homelessness Quarterly Update	TBC TBC TBC
Informal Meeting 26th November 2019 Venue: TBC	Draft Report Deadline for Pre-agenda : TBC Final Report Deadline: 15th November 2019	**Presentation Items** Health and Wellbeing Board Priorities Update: *Childhood Obesity* **Information Items**	TBC

	Agenda and Reports Dispatch Date: 18th November 2019		
Formal Meeting December 2019, Date and Venue tbc, 3pm - 5pm	Draft Report Deadline for Pre-agenda : TBC Final Report Deadline: TBC Agenda and Reports Dispatch Date: TBC	**Presentation Items** Sustainable Transformational Plan (STP) Bi – Monthly Update Disability Health Inequalities – discussion **Information Items** Health and Wellbeing Board Priorities Update: Health Inequalities – *Lifestyles* Care Quality Commission Quarterly Update – Combined with Birmingham Older People Programme(BOPP)	TBC TBC N/A TBC
Formal Meeting 21th January 2020 Venue: Rooms 3 & 4, Council House, 3pm - 5pm	Draft Report Deadline for Pre-agenda : TBC Final Report Deadline: 10th January 2020 Agenda and Reports Dispatch Date: 13th January 2020	**Presentation Items** Health and Wellbeing Board Priorities Update: Health Inequalities - JSNA Update **Information Items** Homelessness Quarterly Update	 TBC TBC N/A
Informal Meeting 18th February 2020 Venue: TBC	Draft Report Deadline for Pre-agenda : TBC Final Report Deadline: 7th February 2020 Agenda and Reports Dispatch Date: 10th February 2020	**Presentation Items** Sustainable Transformational Plan (STP) Bi – Monthly Update LGBT+ Health Inequalities discussion **Information Items**	TBC TBC

Formal Meeting 17th March 2020 Venue : Rooms 3 & 4, Council House – 3pm - 5pm	Draft Report Deadline for Pre-agenda : TBC Final Report Deadline: 6th March 2020 Agenda and Reports Dispatch Date: 9th March 2020	**Presentation Items** Care Quality Commission Quarterly Update – Combined with Birmingham Older People Programme(BOPP) Health and Wellbeing Board Priorities Update: Health Inequalities **Information Items** Health and Wellbeing Board Priorities Update: *Childhood Obesity* Gender based Health Inequalities discussion	TBC TBC N/A N/A
Development Day 28th April 2020 Venue: TBC	TBC	TBC	TBC

Birmingham Health and Wellbeing Board

	Agenda Item: 9
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30th April 2019**
TITLE:	**BIRMINGHAM JOINT STRATEGIC NEEDS ASSESSMENT: DIVERSITY AND INCLUSION DEEP DIVE 2019/20**
Organisation	**Birmingham City Council**
Presenting Officer	**Elizabeth Griffith, Acting Assistant Director of Public Health**

Report Type:	**Action Report**

1. Purpose:
To seek a decision from the Board on the Diversity and Inclusion topic area for the 2019 Joint Strategic Needs Assessment Deep Dive**.**

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

3.	Recommendations
3.1	It is recommended that the Health and Wellbeing Board: • Agree a topic for the 2019/20 diversity and inclusion deep dive needs assessment; • Agree a named Board member champion to support the 2019/20 diversity and inclusion deep dive.

4.	Background
4.1	The Joint Strategic Needs Assessment (JSNA) is an ongoing process to identify the current and future health and wellbeing needs of the local population and the services and assets available for meeting those needs.
4.2	Local Authorities and local NHS have a joint statutory duty to produce a JSNA via the Health and Wellbeing Board.
4.3	A work programme has been agreed for developing the Birmingham JSNA, comprising three parallel programmes: 1. Improvements to the Core JSNA dataset to inform the autumn 2019 commissioning cycle. 2. A three year forward plan for deep dive JSNA reviews to inform commissioning rounds in 2020-22. 3. Integration of City wide partner data to move to a fully refreshed JSNA to inform the autumn 2020 commissioning cycle.
4.4	Deep dive JSNA reviews will allow for in-depth data analysis on key areas of need. Each year one of the four deep dive reviews will be reserved for a diversity and inclusion topic.
4.5	This report seeks a decision from the Board on the diversity and inclusion deep dive topic for 2019/20 and asks for a named Board member to champion the review.
4.6	We plan to consult with the Board membership on a forward plan for the Deep Dive topics from 2020-2022 later in the year. This will include the mandatory deep dives such as the Pharmaceutical Needs Analysis (PNA).

5.	**Discussion**
5.1	We would welcome the Board to discuss and agree a focus for the fourth deep dive into a diversity and inclusion area.
5.2	The Protected Characteristics under the Equality Act are: • Age • Disability • Gender reassignment • Marriage and civil partnership • Pregnancy and maternity • Race • Religion or belief • Sex • Sexual orientation
5.3	The deep dive format provides the opportunity to drill down into a sub-group within a protected characteristic and look at that group's needs across the spectrum of health and social care. Further details on the process for each deep dive can be found in **Appendix 1.**
5.4	Rather than exploring where routine demographic data on single characteristics is available, the deep dive explores the granularity of data available and identifies any health inequalities experienced. For example, if the topic chosen was sensory impairment, the deep dive would consider the health and wellbeing needs of those with sensory impairment across the life course from birth to death and also the needs of those with sensory impairments in different protected characteristics such as LGBTQ+ or across different races.
5.5	An important role of the diversity and inclusion deep dive is to highlight where information is <u>not</u> available on protected characteristic groups and to make recommendations for improved data collection in the future. Improved local data collection will allow us to gauge the degree of health inequalities experienced across the protected characteristics within our City and to see if the services we have in place are effectively meeting the needs of these groups.
5.6	A framework of possible diversity and inclusion deep dive topics can be found in **Appendix 2** to aid the Board in its decision on the deep dive topic area for 2019/20.
5.7	Once the topic is agreed, the Board is asked to nominate a lead member to champion the review.

6.	Future development
6.1	A project plan including timetable will be produced for the diversity and inclusion review. Progress shall be monitored via the JSNA Steering Group and the Board's nominated Champion.

7.	Compliance Issues
7.1	***Strategy Implications***
	This paper sets out one element of local delivery of the Health and Wellbeing Board's statutory duty to produce a Joint Strategic Needs Assessment – the deep dive review.
7.2	***Governance & Delivery***
	Monitoring of progress will be undertaken by the Board; planning and delivery of the JSNA will be managed by the JSNA Steering Group with a deep dive topic lead from across the Board's partner organisations monitoring progress.
7.3	***Management Responsibility***
	The JSNA process will be overseen by Elizabeth Griffiths, Acting Assistant Director in Public Health and the delivery of the deep dive led by Susan Lowe in the PH Knowledge and Governance team. They are accountable to Dr Justin Varney, Director of Public Health, for delivery of the JSNA and its aligned products in line with the timeframes set out in this paper.

8.	Appendices
	1. JSNA Deep Dive Process Document 2. Diversity and Inclusion deep dive topic framework

Joint Strategic Needs Assessment Deep Dive Process

V0.2 - April 2019

Author: Susan Lowe, Lead Officer Knowledge, Evidence and Governance Team

Partnerships, Insight and Prevention Directorate: Public Health Division

Version Control	Date	Amendments	Author
V0.1	03/04/19	Creation of draft document	Susan Lowe
V0.2	10/04/19	Expansion of scope and engagement sections following input from Elizabeth Griffiths	Susan Lowe

1 Purpose

This document sets out the process and content for Birmingham's JSNA Deep Dives, including

- Roles and responsibilities
- Prioritising topics
- Process for production.

2 Background

The Joint Strategic Needs Assessment (JSNA) is an ongoing process to identify the current and future health and wellbeing needs of the local population and the services and assets available for meeting those needs. Local Authorities and local NHS have a joint statutory duty to produce a JSNA via the Health and Wellbeing Board.

The 2018 CQC Birmingham Local System Review raised specific concerns over the capacity of the Birmingham JSNA to inform future commissioning decisions. To address these concerns a multi-agency steering group is now in place and a plan for development is set out below.

Deep dives allow for in depth data analysis on key areas relating to health and wellbeing. The aim is to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities. They will be used to determine actions local authorities, the local NHS and other parties need to take to meet health and social care needs and to address the wider determinants that impact on health and wellbeing.

The new Director of Public Health has set out a vision for a rolling annual programme for deep dive JSNA reviews whereby 4 deep dives are completed a year (one to be reserved for a protected characteristic under the Equality Act 2010) using the following methodology:

- 1 month for scoping.
- 2 months for data/evidence collection and community engagement.
- 1 month for analysis and write up.

3 Roles and Responsibilities

Topic Champions

Champions will be Health and Wellbeing Board members. The role of the champions will include:

- Challenging the scope and breadth of the deep dives
- Scoping and agreeing the content with Topic Lead
- Ensure assessment is able to drive local commissioning and decision-making
- Encourage involvement of key partners organisations to secure capacity, skills, data and knowledge required
- Promoting the use of JSNA by strategic partners
- Finalising the topic report and presenting to the JSNA Steering Group and Health and Wellbeing Board (with Topic Lead).

Topic Leads

The role of the topic leads is to manage the deep dive process and includes:

- Identifying the partners to be involved in the work (a reference group)
- Scoping and agreeing the content with Topic Champion
- Coordinating the data and evidence to be utilised
- Ensuring citizen views and lived experience are incorporated
- Ensuring assets as well as needs are captured
- Finalising the topic report and presenting to the JSNA Steering Group and Health and Wellbeing Board (with Topic Champion).

4 JSNA process

4.1 Prioritising Topics

The topics for 2019-20 will be agreed by the Health and Wellbeing Board. For future development 2020-23 a long-list of deep dive topics has been produced based on future commissioning requirements and Health and Wellbeing Board strategic planning. Prioritisation of the 4 topics per year from 2020-21 onwards will be through a Delphi Panel process.

4.2 Scoping

Once a topic has been agreed and is in the programme it will need to be scoped by the Topic Lead and Champion. Scoping is an important part of the JSNA process as it should define the needs assessment and enable tasks, resources and deadlines to be applied. The proposed scoping process is set out in the table below.

Stage	**Detail**
Identify and engage with stakeholders	This should involve professionals, commissioners and community representatives related to the subject area. The purpose is to create a joint ownership of the process and ensure we are capturing the bigger picture including assets as well as needs. This stage should identify the reasons for undertaking the deep dive and capture what about stakeholders wish to understand about the subject.
Define the population of interest	This should be as inclusive as possible. Consideration should be given to the geographical area, protected characteristics etc. By involving individuals, patients and services users in scoping the definition you are more likely to get a full picture of the subject area. The JSNA deep dive should be strategic providing a whole system insight into that topic.
Identify data sources	The data should include • Demographics of the population of interest including key subgroups • Health issues – incidence and prevalence affecting the population • Current services • Benchmarking with core cities, national, regional or other comparators • Evidence for interventions • Cost data including cost-effectiveness

Stage	Detail
	In scoping attention should be paid to what is publicly available but also what can partners provide. There is more detail on data requirements in Section 4.3.
Develop a communications plan	A JSNA should involve a wide range of stakeholders. It is important to consult and engage to capture the full range of views on the topic area. Topic leads should identify the target audience so that the messages can be tailored to best meet their needs. There is more information on engagement is Section 4.4
Define JSNA deep dive products	A JSNA deep dive will be a detailed assessment report. However to support this other products should be developed. These can include infographics, posters, and presentations. Considerations should include: • Style – Health and Wellbeing Board template • Accessibility • Visual impact
Set timescale	The recommended timescale for completion of a JSNA is 4 months. Detailed mapping of tasks at an early stage are required to plan the delivery of the deep dive.

4.3 Data and evidence collection

This part will be the undertaken by the Topic Lead and Reference Group. Data is just one part of the process. There is no mandatory dataset to be included but the guidance states that both quantitative (numerical) and qualitative (reason, opinion, motivation) evidence should be included.

A good JSNA should include the following data:

- Population – total numbers by age, gender and ethnicity. Births and deaths.
- Wider social, economic and environmental factors – employment, housing, educational attainment, crime and disorder, community cohesion.
- Lifestyle determinants of health – smoking, diet, substance misuse, obesity, physical activity.
- Epidemiology – life expectancy, morbidity, mortality, disease prevalence.
- Service use – hospital admissions, screening uptake, social care.
- Evidence of effectiveness – good practice, literature reviews, NICE guidance and quality standards.
- Community perspectives – views, expectations and experiences of the local communities.

4.4 Engagement and consultation

Engagement and consultation are essential elements of the JSNA. It is especially important to involve the population whose needs are being assessed in the JSNA deep dive. We can deliver more efficient and effective services and more person-centred care if we listen to what people are

telling us. Strategic partners, third sector organisations and Birmingham citizens also need to be involved. Stakeholders can include service users, front line staff and providers.

The level of engagement will vary according to the JSNA subject but there must be an opportunity for stakeholders to contribute to the JSNA. This will be developed at the scoping stage in the Communications Plan. Methods for engagement may include:

- Be-heard online consultation
- Focus groups
- Surveys
- World café events.

The Scottish Health Council has produced a Participation Toolkit[1] which includes various engagement methods as well as checklists to ensure an effective approach. To avoid duplication previous consultation and engagement should be considered before undertaking new campaigns. Examples of existing engagement can include Friends and Family Test data, online resource of people's health experiences e.g www.heathtalk.org and provider customer surveys.

4.5 Analysis and write up

This is the responsibility of the Topic Lead. The data and evidence collected should be analysed to build the intelligence to inform priorities and drive change. The write up should highlight areas of need and opportunities for action. There is a JSNA deep dive template to provide guidance for Topic Leads.

[1] Scottish Health Council online resource available at http://scottishhealthcouncil.org/patient__public_participation/participation_toolkit/the_participation_toolkit.aspx

Appendix 2

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

Diversity and Inclusion deep dive topic framework

Protected characteristic	Sub-Group options	Purpose of JSNA Deep Dive?	Local picture / inequalities observed What makes this a priority for Birmingham in 2019/20?
Disability	Sensory impairment	To better understand the needs of those with sensory impairment in Birmingham to inform service delivery	People with a learning disability (LD) are more likely to have a visual or hearing impairment than the general population. Adults with LD are ten times more likely to have a visual impairment than adults without LD. The Foundation for People with Learning Disabilities estimates that around 40% of adults with a LD have moderate to severe hearing loss, and that hearing impairment is particularly common among people with Down's syndrome.[1] Hearing impairment in people with learning disability may be overlooked as it can 'get lost' among other problems.[2] Action on Hearing Loss state that there is evidence suggesting some BME groups may experience high levels of hearing loss, particularly among recent immigrants from developing regions where poverty, poor healthcare, and lower immunisation coverage may contribute to a higher risk of hearing loss.[3] The World Health Organisation (WHO) states that people with vision impairment are more likely than those without to experience higher rates of poverty and disadvantage.[4]

[1] Foundation for People with Learning Disabilities http://www.learningdisabilities.org.uk/help-information/learning-disability-a-z/h/hearing-loss/ accessed 11/04/2019

[2] Timehin and Timehin (2004) Prevalence of hearing impairment in a community population of adults with learning disability: access to audiology and impact on behaviour. British Journal of Learning Disabilities 32(3): 128–132.

[3] Action on Hearing Loss (2011) Facts and figures on hearing loss and tinnitus

[4] World Health Organisation https://www.who.int/blindness/en/ accessed11/04/2019

Disability	Learning disabilities and intellectual impairment	To better understand the needs of those with learning disabilities and intellectual impairment in Birmingham to inform service delivery	The Disability Rights Commission's "Equal Treatment: Closing the Gap", [5] explored physical health inequalities experienced by people with learning disabilities and/or mental health problems. This showed that people with learning disabilities and people with mental health problems are much more likely to have significant health risks and major health problems than other people. For people with learning disabilities, these particularly include obesity and respiratory disease and for people with mental health problems, obesity, smoking, heart disease, high blood pressure, respiratory disease, diabetes and stroke.[6]
	Mobility impairment	To better understand the needs of those with mobility impairment in Birmingham to inform service delivery	The Equality and Human Rights Commission (EHRC) found that people with physical disabilities are more likely to experience health inequalities and major health conditions, and are likely to die younger than other people. It suggested the extent of these health inequalities was difficult to assess because of limited data on outcomes for disabled people collected by NHS providers and commissioners. It further suggested that accessibility of services was problematic, and disabled people were less likely to report positive experiences in accessing healthcare services.[7,8]
Ethnicity	Eastern European community	To better understand the needs of Birmingham's Eastern European community to inform service	An evidence review undertaken by Liverpool John Moores University found that when compared to the UK-national population, Eastern European populations have: poorer mental health; higher mortality dues to heart attacks and stroke; higher levels of obesity; increased risk of sexual ill-health; higher smoking rates and higher lung cancer

[5] Disability Rights Commission (2006) https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/DRC-Health-FI-main.pdf accessed 11/04/2019

[6] Disability Rights Commission, Equal Treatment: Closing the Gap (2006) https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/DRC-Health-FI-main.pdf accessed 11/04/2019

[7] The Equality and Human Rights Commission, Being Disabled in Britain (2017) https://www.equalityhumanrights.com/sites/default/files/being-disabled-in-britain.pdf accessed 11/04/2019

[8] Department of Health. Healthy Lives, Healthy People: a call to action on obesity (2011) https://www.gov.uk/government/publications/healthy-lives-healthy-people-a-call-to-action-on-obesity-in-england accessed11/04/2019

		delivery	prevalence. These health inequalities are compounded by poor or insecure housing, low pay, isolation, unemployment or underutilisation of skills and prejudice.[9] A recent investigation into suicides in Birmingham (November 2018) identified that Eastern Europeans are at increased risk of suicide.
	African-Caribbean Communities	To better understand the needs of Birmingham's African-Caribbean community to inform service delivery	Obesity is higher in black Africans, especially adolescent girls. [10,11] The majority of HIV infections in the UK is in heterosexual black Africans.[10,11] Caribbean-born men are 50% more likely to die of stroke than the general population. [10,11] There is a greater incidence of schizophrenia in UK black Caribbeans. Recent local NHS data suggests that 8% of in-patients in Birmingham are of black ethnicity – higher than expected. In addition, those of black ethnicity make up 12% of in-patients in Birmingham with a mental illness and 9% of psychiatric attendances – two times more than expected.
Faith		To better understand the issues affecting faith communities, particularly around infant mortality and	South Asians – predominantly Muslim, Hindu and Sikh are at increased risk of: • Cardiovascular disease (CVD) • Type 2 diabetes – overall, six times more common for men and women of South Asian descent – Bangladeshi, Pakistani, Indian. The exact level of prevalence varies according to country of origin and sex. • Smoking – much higher smoking rates in

[9] Centre for Public Health Liverpool John Moores University. A targeted needs assessment of the Eastern European population in Warrington (2014) http://www.cph.org.uk/wp-content/uploads/2014/11/Eastern-European-Health-Needs-Assessment_Final-Report.pdf accessed 11/04/2019

[10] Local Government Association (2014) Working with faith groups to promote health and wellbeing https://www.local.gov.uk/sites/default/files/documents/working-faith-groups-prom-6ff.pdf accessed 12/04/2019

[11] FaithAction (2014) https://www.faithaction.net/ accessed 12/04/2019

		mental health	Bangladeshi men, but lower rates in Indian men.[12,13] Health inequalities in some Jewish and Muslim communities: • Consanguinity more than doubles the risk of recessively inherited disorders such as congenital deafness and heart disease. Marrying blood relatives is more common in some Jewish and Muslim communities where it is a social and cultural, rather than religious, behaviour.[12,13] Health inequalities in Christians: • White Irish men and women, largely Catholic, are most likely of any ethnic group to exceed alcohol guidelines. • Obesity is higher in black Africans, especially adolescent girls. A high proportion of black Africans report themselves to be Christian. • The majority of HIV infections in the UK is in heterosexual black Africans. • Caribbean-born men are 50 per cent more likely to die of stroke than the general population. • Greater incidence of schizophrenia is consistently recorded in UK black Caribbeans.[12,13]
Sexual orientation and/or gender reassignment	LGBT	To better understand the issues affecting LGBT communities	Rates of depression amongst LGBT (28-40%) are high compared to an estimated annual rate of depression of 6% and lifetime rate of more than 15% in the general population.[14] Estimates suggest most young men with eating disorders are gay or bisexual. A fifth of all women

[12] Local Government Association (2014) Working with faith groups to promote health and wellbeing https://www.local.gov.uk/sites/default/files/documents/working-faith-groups-prom-6ff.pdf accessed 12/04/2019

[13] FaithAction (2014) https://www.faithaction.net/ accessed 12/04/2019

[14] Meads et al (2009) A systematic review of LGBT Health. University of Birmingham. http://www.birmingham.ac.uk/Documents/college-mds/haps/projects/WMHTAC/REPreports/2009/LGBThealth030409finalversion.pdf

with eating disorders are lesbian or bisexual.[14]

Evidence points to LGBT people experiencing poorer physical health due to poorer diet, lack of exercise, smoking and excessive drink and drug use.[14]

LGBT people are much more likely to smoke than the general population: 32-45% of Gay and Bisexual men smoke; 29-48% of lesbian and bisexual women smoke; compared to 22% of the general population.[14]

LGBT people have higher rates of problem drug and alcohol use than the general population: 35% of Gay and Bisexual men used recreational drugs in the year 2007 compared to 13% in the general population; 26% of lesbian and bisexual women compared to 8% in the general population.[14]

Lesbian and bisexual women were up to 10 times less likely to have had a cervical screening test in the past three years, suggesting poor re-attendance. 12% - 17% of lesbian and bisexual women have never had a cervical screening test.[15]

[15] Fish, J (2009) Cervical screening in lesbian and bisexual women: a review of the worldwide literature using systematic methods. De Montford University – referenced in https://blgbt.org/wp-content/uploads/2018/10/14-02-13-Equal_Access_LGBT_health_and_wellbeing_strategy_2013_REVISED.pdf

	Agenda Item: 10
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30 April 2019**
TITLE:	**JOINT STRATEGIC NEEDS ASSESSMENT UPDATE**
Organisation	**Birmingham City Council**
Presenting Officer	**Elizabeth Griffiths, Acting Assistant Director of Public Health**

Report Type:	**Information Report**

1. Purpose:
To update the Board on plans to improve the Birmingham Joint Strategic Needs Assessment (JSNA).

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

3.	Recommendations
3.1	It is recommended that the Health and Wellbeing Board: • Note the proposed outline of a core dataset for the JSNA to include health, social care, housing and economic data from the Council, health data from the NHS and crime data from the Police and Community Safety Partnership;

4.	Background
4.1	The Joint Strategic Needs Assessment (JSNA) is an ongoing process to identify the current and future health and wellbeing needs of the local population and the services and assets available for meeting those needs.
4.2	Local Authorities and local NHS have a joint statutory duty to produce a JSNA via the Health and Wellbeing Board.
4.3	The 2018 CQC Birmingham Local System Review raised specific concerns over the capacity of the Birmingham JSNA to inform future commissioning decisions. To address these concerns a multi-agency steering group is now in place and a plan for development is set out below.
4.4	In addition, an internal audit has been commissioned to explore the extent the JSNA is being used to inform commissioning decisions; and, a member of Public Health staff is on a secondment to work with Public Health England to explore JSNA best practice.

5.	Discussion
5.1	<u>Core JSNA dataset</u>
5.1.1	The core JSNA dataset will bring together data, intelligence and analysis of a number of key topics throughout the life course from pregnancy, birth and health protection for new babies through to frailty and physical disability in older people and end of life issues.
5.1.2	Building on the Southampton model, each core data topic will be structured as follows: • Overview of the topic. • Details of who is at risk and why. • The level of population need. • Current services to meet this need.

- Future projections for need.
- Stakeholder views.
- Evidence of what works.
- Recommendations.
- Links to data resources.

5.1.3 In each section we will highlight health inequalities and variations in outcomes at a city and population level.

5.1.4 This process will draw together information, such as service and forecasting data, from across partner agencies and partnerships including the Sustainability and Transformation Partnerships (STPs) and the Community Safety Partnership (CSP). Learning from Solihull and Sandwell to strengthen the NHS data content in the JSNA will be used.

5.1.5 This will sit alongside the recently published local area profiles.

6.	**Future development**
6.1	The following short-term outputs have been agreed. • A project plan including timetable will be produced for the core JSNA dataset. Progress shall be monitored via the JSNA Steering Group • Core JSNA dataset (city level) published August 2019.

7.	**Compliance Issues**
7.1	***Strategy Implications***
	This paper sets out the proposed method of delivery of the Health and Wellbeing Board's statutory duty to produce a Joint Strategic Needs Assessment.
7.2	***Governance & Delivery***
	Monitoring of progress will be undertaken by the Board; planning and delivery of the work programme and long-term delivery of an integrated JSNA will be managed by the JSNA Steering Group.

7.3	*Management Responsibility*
	The JSNA process will be overseen by Elizabeth Griffiths, Acting Consultant in Public Health and the delivery led by the Public Health Knowledge, Evidence and Governance Leads in the Public Health Division. They are accountable to Dr Justin Varney, Director of Public Health, for delivery of the JSNA and its aligned products in line with the timeframes set out in this paper.

8.	**Appendices**
	Outline of Core JSNA content 2019

Service Birmingham

Joint Strategic Needs Assessment: Outline of Core JSNA content 2019

April 2019

Ralph Smith – Lead Officer Knowledge, Evidence and Governance Team

Partnerships, Insight and Prevention Directorate: Public Health Division

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Version Control	Date	Amendments	Author
V0.1	05/04/19	Creation of draft document for consideration by JSNA steering group	Ralph Smith

Contents

OVERARCHING KEY INDICATORS

Life expectancy and health life expectancy

Inequality in life expectancy

CHILDREN AND YOUNG PEOPLE - BEST START IN LIFE [0-18]

Infographic to summarise section

Demographics

- Number/% (summarise with pop pyramid)
- Time trend
- Geographic trend within the city
- Comparison
- Projections (or in *future projections for needs* section below?

(Sources: ONS MYE, ONS pop projections)

Maternal and Early Years

Overview of the topic

This section summarises the health needs and the services that meet those needs, for Birmingham's early years population, from pregnancy through to the age of 18(25?).

'A great city to grow up in' for children is one of the city's four main priorities[i].

Birmingham Children's Trust works with the most disadvantaged children and young people of the city to keep them safe, happy and healthy. The success of the Trust will mean

- healthy, happy, resilient children living in families
- families able to make positive changes
- children able to attend, learn and achieve at school
- young people ready for and contributing to adult life
- children and young people safe from harm

The Trust's services relative to this section include: early help, family support, children in care and adopting and fostering.

Birmingham Public Health priorities also include

- Reducing infant mortality
- Taking a whole systems approach to childhood obesity
- Supporting the mental and physical health of our most vulnerable children

Describe the high level demography of these ages groups in a para.

Details of who is at risk (*of poor outcomes*) and why

To ensure good health and well-being outcomes for children and young people, it is essential that everyone gets a good start in life. Demographic factors such as age, ethnicity and health of mothers; educational attainment and lifestyles of children and young people; the socio-economic environment children grow up in and the experience of those with special educational needs; all contribute to the chance of having that best start to life.

The level of population need

Pregnancy, Birth and Health Protection for New Babies

- Live births – number, types (caesarean), time trend and projections
- Low birthweights
- Infant mortality
- Fertility rates
- Breastfeeding – initiation/6-8 weeks
- 0-4 Vaccs
- 0-4 injuries – IP and A&E
- Smoking mothers
- Perinatal mental health
- Obesity in pregnancy
- Teenage conception
- Child deprivation (IDACI)

Oral health

- Decay free children

Early years education

- % achieving a good level of development
- Free School Meals
- School Readiness

Current services to meet this need

- Early years
- BUMP
- BCHC services health visitors and school nurses
- Healthy Child Programme
- Smoking cessation
- Breastfeeding initiatives
- Healthy Eating projects?
- Children's centres
- Children's Trust
- Birmingham Forward Steps

Future projections for need

Diversity and inclusion

Outline diversity and inclusion issues concerning this chapter

Inequalities

Outline any inequality issues arising from the content of this chapter

Stakeholder views

- Seek from partners

Evidence of what works

Describe main evidence here

Recommendations

- *SMT/HWBB to provide?*

Links to data resources.

School Years

Overview of the topic

Details of who is at risk and why

The level of population need

Health eating, exercise and obesity

School educational attainment

School absence and exclusions

Wellbeing at school

Current services to meet this need

- NCMP
- Healthy start vouchers
- Daily mile

Future projections for need

Stakeholder views

Evidence of what works

Recommendations

Links to data resources.

Young people's lifestyles and preparedness for adulthood

Overview of the topic

Details of who is at risk and why

The level of population need

Mental health

Self-harm

Substance misuse

Alcohol

Smoking

Teenage pregnancy and sexual health

First time entrants into youth criminal justice system

NEETS

Educational attainment post 16

Current services to meet this need

Future projections for need

Stakeholder views

Evidence of what works

Recommendations

Links to data resources.

Vulnerable and disadvantaged young people

Special Educational Needs

Children with autism

Child protection

Looked After Children and care leavers

Children and young people in poverty

Homelessness and young people's housing needs

WORKING AGE ADULTS [18-64 years]

Infographic to summarise section

Demographics

[16-64 years]

- Number/%
- Time trend
- Geographic trend within the city
- Comparison
- Projection
- Deprivation

(Sources: ONS MYE, ONS pop projections)

Health and wellbeing

Overview of the topic

Details of who is at risk and why

The level of population need

Limiting Long term illness –

Preventable and premature mortality

Health Checks

Screening

Current services to meet this need

Future projections for need

Stakeholder views

Evidence of what works

Recommendations

Links to data resources.

Adults with care needs

Overview of the topic

Details of who is at risk and why

The level of population need

Social care support

Physical disabilities

Learning disabilities

Mental health needs

Autism

Sensory impairment

Current services to meet this need

Future projections for need

Stakeholder views

Evidence of what works

Recommendations

Links to data resources.

Adult lifestyles

Overview of the topic

Details of who is at risk and why

The level of population need

Physical activity and healthy eating

Obesity and diabetes

Smoking

Alcohol

Substance misuse

Current services to meet this need

Future projections for need

Stakeholder views

Evidence of what works

Recommendations

Links to data resources.

Inclusive growth and employment

Overview of the topic

Details of who is at risk and why

The level of population need

Economic growth and jobs

Employment and employment inequalities

Unemployment

Income and wages

Adult skills

Current services to meet this need

Future projections for need

Stakeholder views

Evidence of what works

Recommendations

Links to data resources.

NEEDS OF OLDER PEOPLE [65+ years]

Infographic to summarise section

Demographics

-

- Number/%
- Time trend
- Geographic trend within the city
- Comparison
- Projection
- Deprivation

(Sources: ONS MYE, ONS pop projections)

Health of older people

Overview of the topic

Details of who is at risk and why

The level of population need

Life Expectancy at 65

Excess winter deaths

Current services to meet this need

Future projections for need

Stakeholder views

Evidence of what works

Recommendations

Links to data resources.

Older people's care and support needs

Overview of the topic

Details of who is at risk and why

The level of population need

Fraility and physical disability

Falls and hip fractures

Dementia

Depression and social isolation

Long Term Conditions

Current services to meet this need

Future projections for need

Stakeholder views

Evidence of what works

Recommendations

Links to data resources

Providing care for older people

Overview of the topic

Details of who is at risk and why

The level of population need

Imms. and vaccs.

LA funded social care

End of life

Current services to meet this need

Future projections for need

Stakeholder views

Evidence of what works

Recommendations

Links to data resources.

Older people in the community

Overview of the topic

Details of who is at risk and why

The level of population need

Self-funders of care and support

Carers

Loneliness and social isolation

Older people's specialised housing

Current services to meet this need

Future projections for need

Stakeholder views

Evidence of what works

Recommendations

Links to data resources.

SUSTAINABLE COMMUNITIES AND HEALTHY ENVIRONMENTS

Housing and homeless

Overview of the topic

Details of who is at risk and why

The level of population need

Housing in the city

Homelessness

Housing affordability and need

Current services to meet this need

Future projections for need

Stakeholder views

Evidence of what works

Recommendations

Links to data resources.

Environment and transport

Overview of the topic

Details of who is at risk and why

The level of population need

Green space

Air quality

Transport

Current services to meet this need

Future projections for need

Stakeholder views

Evidence of what works

Recommendations

Links to data resources.

Safer communities

Overview of the topic

Details of who is at risk and why

The level of population need

Fear of crime

Reported crime

Offenders and victims

Domestic abuse

Current services to meet this need

Future projections for need

Stakeholder views

Evidence of what works

Recommendations

Links to data resources.

[i] Birmingham City Council Vision and Priorities 2017 - 2020

Birmingham Health and Wellbeing Board

	Agenda Item: 11
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**18/4/19**
TITLE:	**HEALTH PROTECTION FORUM REPORT 2018/19**
Organisation	**Birmingham Public Health**
Presenting Officer	**Justin Varney/Chris Baggott**

Report Type:	**For decision on recommendations**

1. Purpose:

1.1 This report updates the Health and Wellbeing Board on the local health protection system in Birmingham, the planning and assurance functions that exist, and the top priorities for the organisations in the City that contribute to health protection activities.

1.2 Recommendations are presented for the Board to consider so that further improvements to health protection plans can be delivered.

2. Implications:

BHWB Strategy Priorities	Detect and Prevent Adverse Childhood Experiences	
	All children in permanent housing	
	Increase the control of individuals over their care through Integrated Personal Commissioning (Personal Health Budgets and Direct Payments)	
	Increasing employment/ meaningful activity and stable accommodation for those with mental health problems	

	Improving stable and independent accommodation for those learning disability	
	Improve the wellbeing of those with multiple complex needs	Yes
	Improve air quality	Yes
	Increased mental wellbeing in the workplace	
Joint Strategic Needs Assessment		
Joint Commissioning and Service Integration		
Maximising transfer of Public Health functions		Yes
Financial		
Patient and Public Involvement		
Early Intervention		Yes
Prevention		Yes

3. Recommendations

3.1 Members of the Health and Wellbeing Board accept the report

3.2 Members support the assurance statement

3.3 CCG, NHS England and Local Authority (Public Health, Environmental Health and Social Care) members of the Board (as appropriate) commit their organisations to engage with specific task and finish groups to address issues identified in the full report:

a. To implement the TB/housing framework (CCGs and Local Authority already working collaboratively)
b. To identify and address gaps in community infection prevention and control provision (CCGs and Local Authority Social Care)
c. To reduce variation in the uptake of screening and immunisation programmes, and reduce inequality (NHS England and CCGs)
d. To address novel challenges to health protection that don't sit with any one organisation

4.	Background
4.1	Health protection is one of the three domains of Public Health, and it is therefore an essential part of achieving and maintaining good public health in Birmingham. Health protection is about preventing and reducing the harm to the population's health caused by communicable and non-communicable diseases, and from environmental hazards such as chemicals and radiation. Key activities that contribute to the daily delivery of health protection activities include strategic and emergency planning, surveillance and response to incidents and disease outbreaks. Programmes such as national immunisation and screening programmes and the provision of services to diagnose and treat infectious diseases are important parts of the system to protect the health of the Birmingham population.
4.2	To assist the Birmingham DPH role in the mandated health protection assurance role, a Health Protection Forum (HPF) has been established since 2013. The HPF is chaired by the DPH (or a representative) and meets bi-monthly; it provides the space and time for the exchange of information necessary to ensure that relevant partners in Birmingham are acting jointly and adequately to provide comprehensive services covering all aspects of Health Protection. The forum also provides evidence and assurance to the DPH to facilitate the delivery of the statutory role.
4.3	The HPF has defined five areas of health protection that it receives regular updates and reports from key partners about: a. Communicable Diseases b. Non-Communicable Diseases (focus on Environmental Health) c. Screening and Immunisations d. Emergency Planning, Resilience and Response e. Infection Prevention and Control
4.4	**This report explains the scope of each of the five areas, identifies the key challenges and provides a review of the most significant recent and current issues.**

5.	Future development
5.1	As the Health Protection Forum identifies issues and challenges in the local system plans are improved or developed; some of this includes the setting up of specific task and finish groups and these form the basis of the recommendations proposed to the Board.
5.2	Future Board reports will update on the recommendations actioned and future health protection assurance.

6.	**Compliance Issues**
6.1	***Strategy Implications***
6.1.1	This report fulfils one of the mandatory functions of Public Health in the Local Authority; the duty to ensure that there are plans in place to protect the health of the population.
6.1.2	Some aspects of the Health Protection work considered by the Health Protection Forum in Birmingham contribute to outcomes related to healthcare System Resilience; improve primary care management of common and chronic conditions.
6.2	***Homelessness Implications***
6.3	***Governance & Delivery***
6.3.1	The report and decisions and comments from the Board will inform the work programme of the Health Protection Forum for 2019/20, and the governance of the Forum.
6.3.2	It is proposed that the HPF will continue to report annually to the Board. Day to day progress is managed by the formal meetings of the HPF and by the Director of Public Health between meetings.
6.4	***Management Responsibility***
6.4.1	The Director of Public Health (Dr Justin Varney) is accountable for the delivery of an effective Health Protection Forum; and is supported by Chris Baggott (Public Health lead for health protection) and the members of the Forum.

7.	**Risk Analysis**		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**

Appendices	
1.	Health Protection Forum Report for 2018/19 (currently DRAFT and awaiting final comments/amendments)

Health Protection Forum Report for 2018/19

to the Birmingham Health and Wellbeing Board

April 2019

Contents

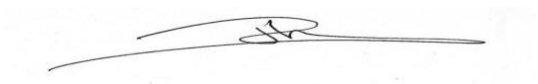
Foreword

Birmingham is a large, vibrant and diverse city and this presents us with many opportunities, but this can also present challenges for health protection.

The 2018/19 Birmingham Health Protection Forum report presents to the Health and Wellbeing Board some of the health protection challenges for the City, and some areas where the Director of Public Health is seeking further improvement and assurance.

Health Protection is one of the three domains of public health, and it is therefore an important pillar that contributes to the improvement and maintenance of the health of everyone living in, working in and visiting Birmingham.

The Health Protection Forum brings together partners from across the City to report on health protection planning and outcomes, and it creates an environment for all stakeholders to work in partnership to make improvements. The Forum also monitors emerging issues so that they can be addressed; ensuring the health of Birmingham citizens continues to be protected.



Dr Justin Varney
Director of Public Health for Birmingham

1. Introduction

1.1. Health Protection

Health protection is one of the three domains of Public Health, and it is therefore an essential part of achieving and maintaining good public health in Birmingham. Health protection is about preventing and reducing the harm to the population's health caused by communicable and non-communicable diseases, and from environmental hazards such as chemicals and radiation. Key activities that contribute to the daily delivery of health protection activities include strategic and emergency planning, surveillance and response to incidents and disease outbreaks. Programmes such as national immunisation and screening programmes and the provision of services to diagnose and treat infectious diseases are important parts of the system to protect the health of the Birmingham population.

1.2. Health Protection Forum

The Health and Social Care Act (2012) gave local authorities health protection duties and also identifies clear roles for Public Health England (PHE), NHS England and Clinical Commissioning Groups (CCGs) that all contribute to delivering health protection at regional and local levels.

The Birmingham Director of Public Health (DPH) is legally accountable to the Secretary of State for the health of the City's population, but most health protection functions are delivered by teams and organisations that are not part of the local authority public health team, such as PHE, NHS England, CCGs, local authority Environmental Health and Resilience teams. As part of this accountability the DPH has a statutory mandated role to be assured that all relevant local organisations have plans in place to protect the health of the population. This means that as well as local authority public health teams working closely with local organisations to provide support, knowledge, insight and guidance, the DPH or a representative also has a role to challenge and question local planning.

To assist this DPH role in Birmingham a Health Protection Forum (HPF) has been established since 2013. The HPF is chaired by the DPH (or a representative) and meets bi-monthly; it provides the space and time for the exchange of information necessary to ensure that relevant partners in Birmingham are acting jointly and adequately to provide comprehensive services covering all aspects of Health Protection. The forum also provides evidence and assurance to the DPH to facilitate the delivery of the statutory role.

The HPF has defined five areas of health protection that it receives regular updates and reports from key partners about:

a. Communicable Diseases
b. Non-Communicable Diseases (focus on Environmental Health)
c. Screening and Immunisations
d. Emergency Planning, Resilience and Response

e. Infection Prevention and Control

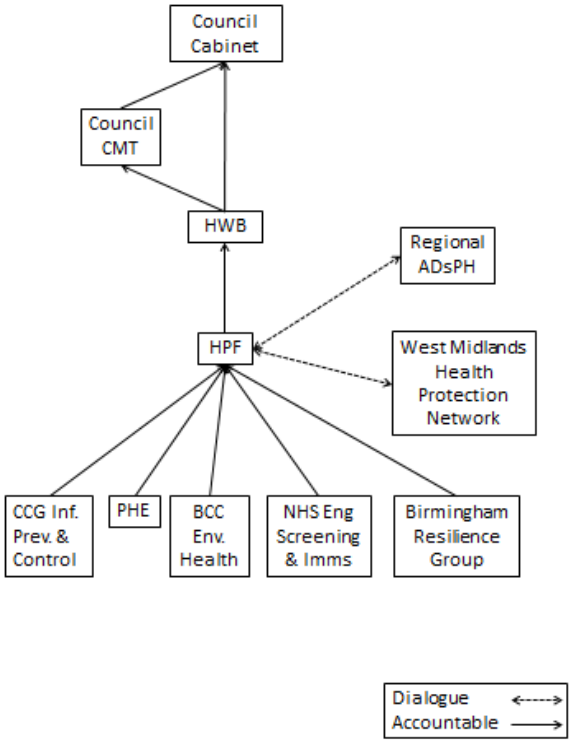
This report explains the scope of each of the five areas, identifies the key challenges and provides a review of the most significant recent and current issues. Details on emerging issues, and any potential future challenges are also presented.

1.3. Assurance Statement

This report notifies the Health and Wellbeing Board that as Director of Public Health currently has some concerns that there are specific areas of health protection where development is needed. I am assured that there are action plans in place to address these areas and will monitor these closely through the Health Protection Forum. The DPH is working through the HPF with its members to address the main concerns: childhood vaccinations, cancer screening programs, community infection prevention and control, and healthcare emergency planning.

1.4. Health Protection Governance Map

The local Health Protection system is complex and involves many different partners, each with their own processes and groups. The governance map following is not fully comprehensive but is included in a simplified form to provide a context for where the HPF sits and how it relates to other local systems.



2. Communicable Diseases

2.1. Introduction

Communicable diseases, also known as infectious, transmissible or contagious diseases, are illnesses that can spread between people and result from the infection, presence and growth of pathogenic (capable of causing disease) biological agents in individual human hosts.

Some diseases do not present a significant public health risk because their impact is relatively minor (e.g. common colds), but others can have a very significant impact on public health and lead to serious illness and even death (e.g. measles). Infectiousness varies between disease-causing organisms, and this must be taken into account, alongside health impact when assessing the risks that diseases pose and planning appropriate responses.

In the HPF the main assurance and reporting for this area of health protection is received from the PHE Health Protection Team.

2.2. Specific health protection issues for the City

2.2.1. Seasonal Flu

Seasonal Influenza (flu) can have significant health impacts, particularly on people with existing health conditions and weaker immune systems due to age.

Flu is a largely preventable disease with an effective vaccination for those at risk.

Every winter, flu outbreaks occur in care settings (residential and nursing homes), presenting a risk to health, risks to social care and service continuity.

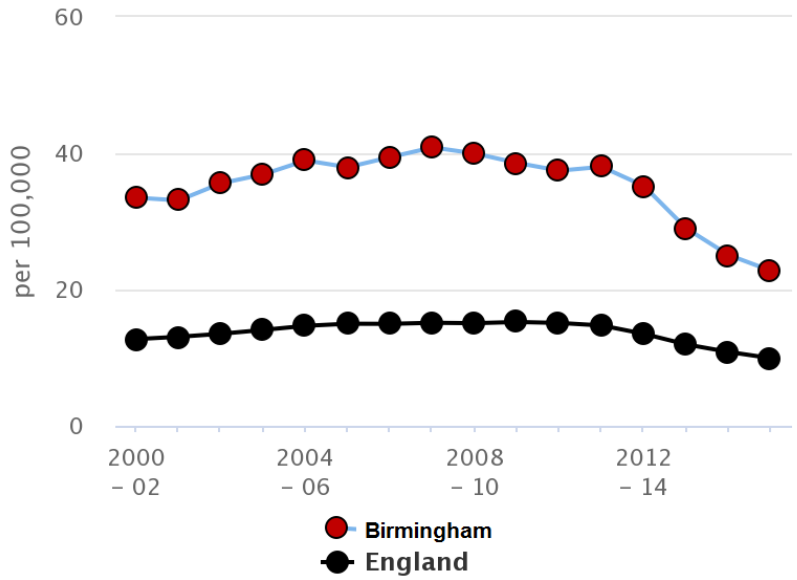
2.2.2. Tuberculosis

Tuberculosis (TB) is a health and a social care issue; it is often a disease of deprivation, poverty, complex social risks and chaotic lifestyles, and engagement with the criminal justice system.

Tuberculosis is a bacterial disease, it can affect many different parts of the body, and it can be present in inactive (Latent TB Infection – LTBI) or active forms. LTBI occurs when a person is infected with TB but the infection does not actively grow and cause symptoms, but survives in the body in a dormant phase; this can become an active TB infection after several years and then cause symptomatic illness. TB becomes infectious and can spread from person to person when active TB affects the lungs, leading to airborne transmission to occur. It is not usually highly infectious, and often needs several hours of exposure to be spread between people.

Indicator	Year	England	West Midlands	Birmingham	Birmingham Trend
TB incidence (3 year average) (per 100,000)	2015-17	9.9	11.9	22.8	↓
Proportion of drug sensitive TB cases who had completed a full treatment course by 12 months (%)	2016	84.4	83.7	85.2	↑
Proportion of pulmonary TB cases starting treatment within four months of symptom onset (%)	2017	68.8	70.8	74.4	↑

TB incidence (3 year average)



All data from PHE Public Health Profiles (https://fingertips.phe.org.uk/)

The infection risk is increased by living or working in crowded, poorly ventilated places, poor sanitation and poor general health. This means that those most often affected by TB have complex patterns of social risk and chaotic lifestyles: homelessness, substance misuse, prisoners, and people living in overcrowded situations.

TB has very high prevalence in many countries around the world which means that some people migrating to Birmingham may have been exposed in their home country and be infected with the latent form of TB.

To reduce the number of LTBI infections that become active TB it is important to diagnose and treat them; this is the aim of the national LTBI treatment program that is delivered locally by the Birmingham CCGs. Patients that meet the required criteria for testing are screened in GP Practices and then offered treatment if they test positive. Locally not all Practices are delivering the program, but those with higher rates of TB are engaged and the program is delivering good results. The TB service is also working with the Birmingham Refugee and Migrant Centre and delivers LTBI screening and testing clinics for their service users on a regular basis.

Further information on the local LTBI program is available at:

https://www.birminghamandsolihullccg.nhs.uk/your-health/latent-tuberculosis

https://sandwellandwestbhamccg.nhs.uk/latenttb

Birmingham Public Health is a member of a local (Birmingham, Sandwell and Solihull) TB Program Board that provides strategic oversight of services working to control the public health risk of TB. Key performance indicators are monitored and improved healthcare outcomes have been facilitated over the last five years.

When TB treatment is compromised drug resistance can occur and this leads to multi-drug resistant TB (MDRTB) and extensively drug-resistant TB (XDRTB). Cases of both MDR and XDR-TB occur in Birmingham, and present particular challenges to both the health and social care system.

2.3. Improvement Plan

Secure housing provision is an essential step in supporting particularly vulnerable patients to adhere to TB treatment, and often this is hard to provide, particularly when patients have no recourse to public funds (NRPF). A regional task and finish group has developed a TB and housing framework to suggest a way for housing needs to be addressed, but this needs to be adopted and implemented in Birmingham.

2.4. Recommendations

There is a need to develop closer working between the TB Service, mental health services, substance misuse services, and relevant local authority departments (e.g.housing) to address the needs of people with social risk factors earlier in treatment (e.g. homelessness, drug and alcohol abuse, prison history) so that the risk of TB transmission is reduced.

Local stakeholders (CCGs, Local Authority public health and housing teams) should develop a Birmingham framework to address housing need for vulnerable TB patients, using the regional TB and Housing Framework. This will help patients to successfully complete their TB treatment programmes so that their TB is cured and the public health risk reduced.

3. Non-Communicable Diseases

3.1. Introduction

Non-communicable diseases (NCDs) include cardiovascular disease, all types of diabetes, cancer, chronic respiratory diseases and renal disease. Many non-communicable diseases can result from individual behavioural risk factors like smoking, alcohol, poor diet, and risk factors that are amenable on a local or national scale such as air quality or vaccination and screening programmes. Many non-communicable diseases are therefore preventable.

Birmingham Public Health and City Council Officers in the Regulation and Enforcement Division (including Environmental Health, Trading Standards and Licensing) lead on services and projects with outcomes contributing to reduced impacts of NCDs on health outcomes.

At the HPF this health protection work area is reported on by Birmingham Environmental Health, with support from PHE and NHS England.

3.2. Specific health protection issues for the City

3.2.1. Air Quality

Poor air quality (air pollution) has a significant impact on health, and it affects everyone living in, working in, or visiting an area where it occurs. Short-term and long-term exposures to air pollution have different effects on health, and current evidence shows that there are no safe levels of pollution.

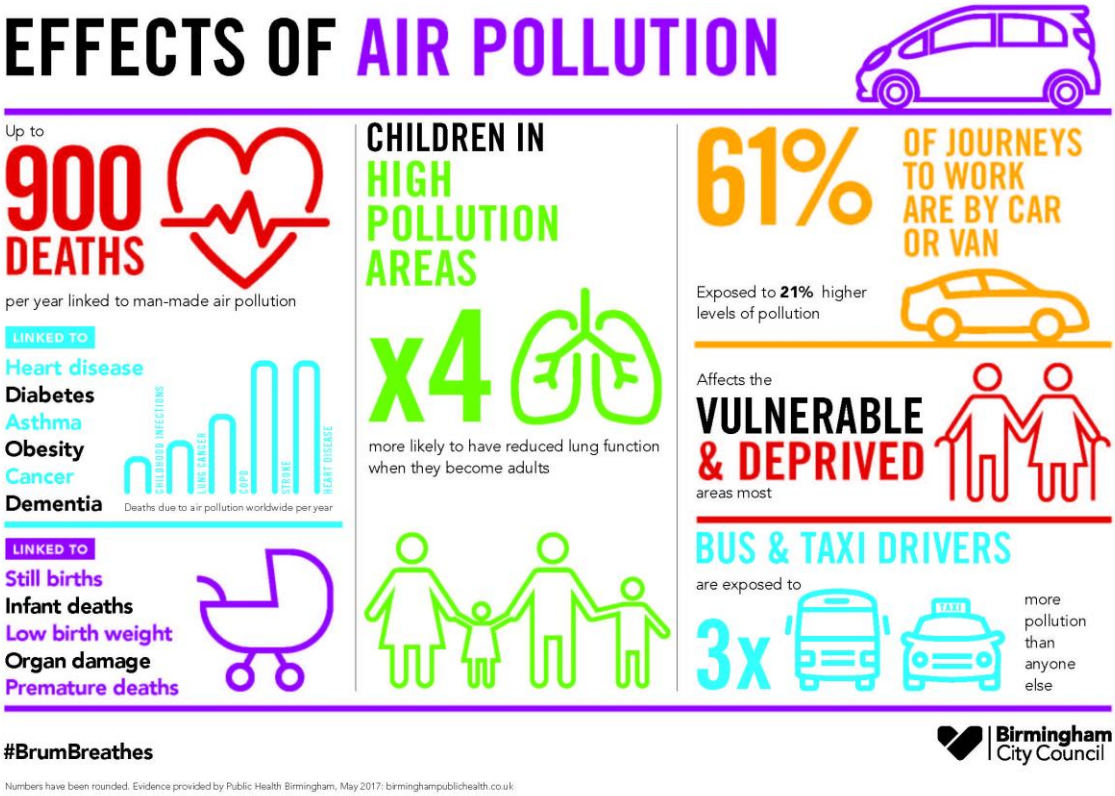
High air pollution is linked to low birth weight and premature births. Being exposed to air pollution during pregnancy and after birth, affects a baby's lung function development.

There is a strong link between air pollution and the worsening of asthma symptoms; it may also play a part in causing asthma in some people. The more children with asthma are exposed to air pollution, the more they suffer with long-term respiratory symptoms. Higher amounts of air pollutants are associated with more asthma attacks, more hospital admissions and a higher death rate.

Air pollution increases the risk of death from cardiac (heart and blood vessels) and respiratory (lungs and breathing) causes, especially among people with pre-existing cardiac and respiratory conditions. It contributes to about 1 in 13 cases of lung cancer and causes coughs and phlegm in adults.

There is also evidence to suggest that poor air quality may also increase the risk of other health conditions such as bladder cancer and type 2 diabetes.

Poor air quality in Birmingham remains a priority for the City Council and current modelling suggests that poor air quality contributes to more than 900 premature deaths in Birmingham every year.



Some parts of Birmingham have levels of air pollution above legal limits, but many other parts of the City also have high levels of pollution that still affect health. A consultation has been launched on introducing a Clean Air Strategy for the City of Birmingham, addressing pollution levels across all city Districts and not just those with the greatest concentrations that breach the legal limits. This will allow the Council to act beyond legal duties by tackling pollutants at concentrations just below the legal limits and also pollutants for which no legislative limit directly applies e.g. small particles (PM2.5). Council Cabinet has endorsed the principle of 'going beyond legal duties'; this will be an important contributor over the next few years to protect the health of more of Birmingham's population.

3.2.2. Food Safety, sampling and investigations

Safe and hygienic food is an important contributor to maintaining health in the population, and it is important that food that is prepared and sold (in restaurants and takeaways), and food that is processed in Birmingham does not present a risk to health.

The Birmingham Environmental Health team continue to have a yearly inspection programme of food premises within Birmingham to ensure food hygiene and safety. More than 3,900 food hygiene inspections and over 2,200 food standards inspections were carried out (96% of those planned) during 2017/2018. All manner of food premises are inspected including manufacturers, retail, caterers, mobiles and takeaways. During 2017/2018, 81

premises were found to present an imminent risk to health and were closed immediately until all necessary works were carried out. Although this could be considered a large number, it only represents 2% of premises which seriously failed to meet basic hygiene requirements and put their customers at risk.

All sporadic cases and outbreaks of gastro-enteritis are investigated by the Environmental Health team. During 2017/2018, 1,169 sporadic cases and 4 outbreaks were investigated. Officers work with the PHE Health Protection Team to ensure a joined up approach to controlling the spread of gastro-enteritis and food poisoning. As part of the work involved in outbreak investigations, and regular inspection the Environmental Health team promote infection prevention best practice and hygiene.

3.2.3. Non-Regulated Issues

There have been a number of activities / businesses that have come to the fore that have fallen between agencies and regulation regimes but have health protection risks associated with the activity. Such activities include mobile circumcisions, Vit C use in autistic children, new blood labs seeking approval, legionella in residential properties and particular beauty treatments. On occasion it has been difficult for agencies to take on an investigation or coordinate a response to an incident as well as determine the best course of action. The system is there between agencies to deal with the 'usual' but not the 'unusual'. A task and finish group to explore these types of issues could identify a suitable solution.

3.3. Recommendations

Local NHS, Public Health and Local Authority stakeholders need to consider how novel non-regulated challenges to health protection can be addressed effectively.

4. Screening and Immunisations

4.1. Introduction

Many infectious diseases of public health concern can be prevented by one of the most clinically and cost effective public health interventions; vaccination. Some non-communicable conditions and cancers can also be diagnosed and patients put on effective, evidence-based treatment pathways as part of a screening program.

All of the immunisation and screening programmes delivered in Birmingham are nationally specified, co-ordinated and commissioned locally by a PHE team embedded in the NHS England West Midlands Team. Updates are routinely reported to the HPF on all of the screening and immunisation programmes delivered in Birmingham. The local services are provided by different healthcare providers (including GP Practices, Community Pharmacies, Hospital and Community Trusts).

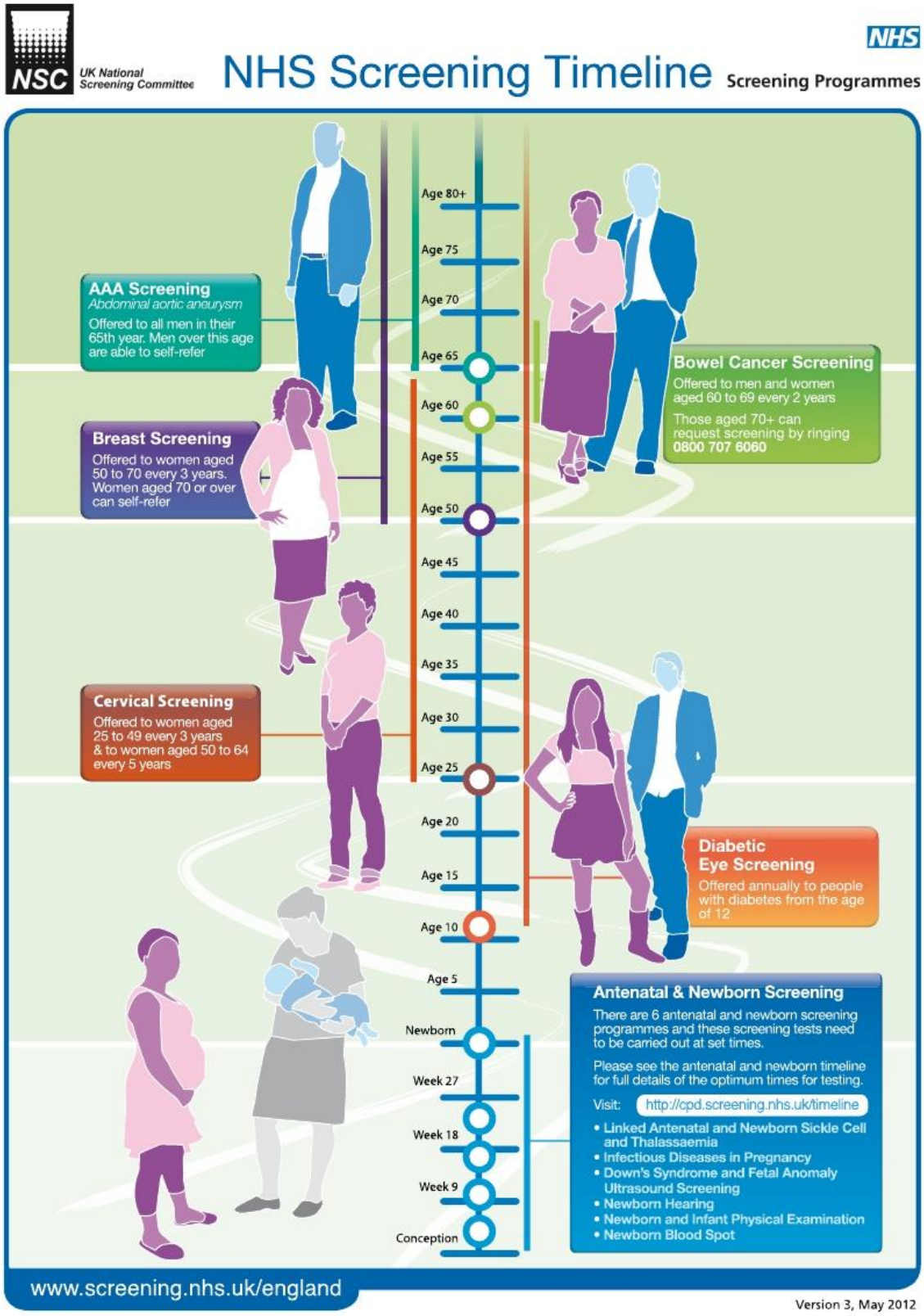
The routine immunisation schedule for England is very detailed and can be found at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/741543/Complete_immunisation_schedule_sept2018.pdf

It includes vaccinations for:

- Infants and children
- Teenage females (males will be included soon)
- Older adults
- Babies born to hepatitis B infected mothers
- Infants with a parent or grandparent born in a high TB incidence country
- All people with specific conditions
- Pregnant women

The screening programmes are represented on the following page.


NSC
UK National Screening Committee
NHS Screening Timeline
NHS
Screening Programmes
AAA Screening
Abdominal aortic aneurysm
Offered to all men in their 65th year. Men over this age are able to self-refer
Breast Screening
Offered to women aged 50 to 70 every 3 years. Women aged 70 or over can self-refer
Cervical Screening
Offered to women aged 25 to 49 every 3 years & to women aged 50 to 64 every 5 years
Bowel Cancer Screening
Offered to men and women aged 60 to 69 every 2 years
Those aged 70+ can request screening by ringing 0800 707 6060
Diabetic Eye Screening
Offered annually to people with diabetes from the age of 12
Antenatal & Newborn Screening
There are 6 antenatal and newborn screening programmes and these screening tests need to be carried out at set times.
Please see the antenatal and newborn timeline for full details of the optimum times for testing.
Visit: http://cpd.screening.nhs.uk/timeline
• Linked Antenatal and Newborn Sickle Cell and Thalassaemia
• Infectious Diseases in Pregnancy
• Down's Syndrome and Fetal Anomaly Ultrasound Screening
• Newborn Hearing
• Newborn and Infant Physical Examination
• Newborn Blood Spot
Age 80+
Age 75
Age 70
Age 65
Age 60
Age 55
Age 50
Age 45
Age 40
Age 35
Age 30
Age 25
Age 20
Age 15
Age 10
Age 5
Newborn
Week 27
Week 18
Week 9
Conception
www.screening.nhs.uk/england
Version 3, May 2012

4.2. Performance summary (selected indicators)

	Indicator	Year	England	West Midlands	Birmingham
Screening	Breast cancer screening coverage (%)	2018	74.9	74.3	68.5
	Cervical cancer screening coverage (%)	2018	71.4	70.9	65.2
	Bowel cancer screening coverage (%)	2018	59.0	57.4	48.1
	Abdominal aortic aneurysm screening coverage (%)	2017/18	80.8	83.1	78.7
	Newborn hearing screening coverage (%)	2017/18	98.9	98.6	99.1
Immunisation	MMR vaccination coverage for one dose (2 years old) (%)	2017/18	91.2	91.2	87.6
	MMR vaccination coverage for two doses (5 years old) (%)	2017/18	87.2	87.6	81.6
	Hib/MenC booster vaccination coverage (2 years old) (%)	2017/18	91.2	90.8	87.4
	Flu vaccination coverage, at risk individuals (%) [target 55%]	2017/18	48.9	49.0	47.7
	Flu vaccination coverage, aged 65+ (%) [target 75%]	2017/18	72.6	71.8	69.3
	Flu vaccination coverage, 2-4 years old (%) [target 65%]	2016/17	38.1	38.2	36.2
	PPV vaccination coverage (%) [target 75%]	2017/18	69.5	68.7	66.8
	Shingles vaccination coverage (%) [target 60%]	2017/18	44.4	44.5	39.8
	HPV vaccination coverage for 2 doses, females 13-14 years old (%) [target 90%]	2017/18	83.8	84.1	77.2
	% of eligible persons entering drug misuse treatment completing hepatitis B vaccination course	2016/17	8.1	7.0	5.2
	Hepatitis B vaccination coverage, 1 year old (%)	2017/18	No data	No data	100

4.3. Specific health protection issues for the City

4.3.1. Breast Cancer Screening

Breast cancer is the most common type of cancer in the UK; about one in eight women are diagnosed with breast cancer during their lifetime. It is important to note that there is a good chance of recovery if it is detected in its early stages. For this reason regular self-examinations are recommended and for women at higher risk (50-70 years old) breast cancer screening is offered.

Breast cancer screening coverage is low for the City, and there are also specific communities and population groups with very low uptake. Changes to the screening service provider contract were made (2017-2019) to develop and implement an improvement strategy to address low uptake and barriers to access of screening. The programme in Birmingham targets the lowest uptake Practices with a range of interventions, such as engagement and practice visits.

There was a national breast screening programme incident in 2018 that meant some women were not followed up correctly after their screening. The numbers affected in Birmingham were small and urgent plans to respond to the incident were put in place. All local women affected have now been properly followed up by appropriate services.

NHS England West Midlands commissioned a high risk breast screening service (commencing April 2016). This offers the appropriate imaging, assessment and care to women referred into the pathway by clinical genetics. Local breast screening services register the women in the service, contact women, and provide local imaging.

4.3.2. Flu Vaccinations

Seasonal Influenza (flu) can have significant health impacts, particularly on people with existing health conditions and weaker immune systems due to age. An effective vaccine is matched to the predicted flu strains every year and made available free to target groups to reduce flu infection and the risk that it may present. The comprehensive national flu vaccination programme targets different population groups that are able to access services from a range of providers in Birmingham:

- 2-4 year olds – GP Practices
- School aged children in school years 0-5 – School-based immunisation provider
- Pregnant women – GP, Pharmacy and Maternity Services
- People <65 years with an existing health condition – GP and Pharmacy
- People 65 years or over – GP and Pharmacy
- Carers and social care staff – GP, Pharmacy and Employer

The uptake of flu vaccinations of the target groups varies significantly. None of the programmes in Birmingham achieve the targets or recommended levels of uptake. Variation in uptake at GP Practice level is also significant.

Every winter, flu outbreaks occur in care settings (residential and nursing homes), presenting a risk to health, risks to social care and service continuity.

It is very important to achieve the target levels of vaccination uptake and ensure that variation within the different population groups in Birmingham is reduced by improving uptake for those that could benefit.

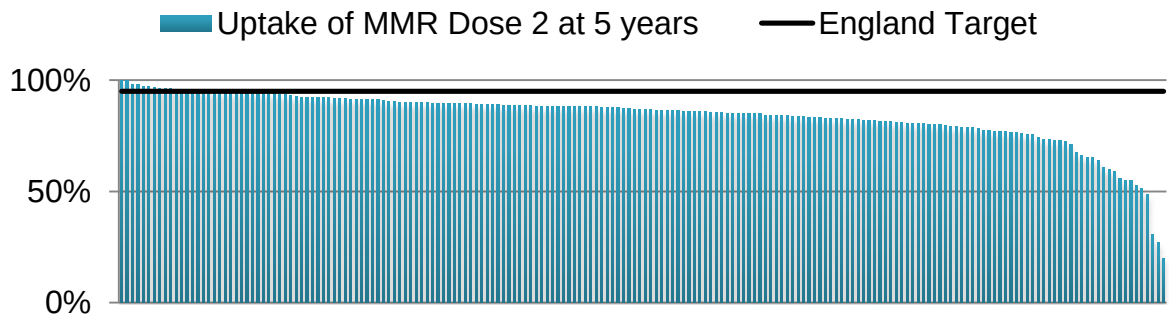
4.3.3. MMR vaccination

Measles is a highly infectious viral illness that can be very unpleasant and sometimes lead to serious complications and death. It is now uncommon in the UK because a safe and effective vaccine is available.

The MMR vaccine is a safe and effective combined vaccine that protects against 3 serious infections – measles, mumps and rubella (German measles) – in a single injection. The full course of MMR vaccination requires 2 doses. Although measles is rare in the UK, outbreaks do still occur when not enough of the population are vaccinated.

There was a local outbreak of measles in November 2017 that affected the Birmingham and Solihull areas. The outbreak was first seen among a specific population group with low levels of vaccination coverage, and there were many unique challenges to overcome during the response. Close partnership working among local organisations (NHS England, CCGs, PHE, Local Authorities) contributed to the outbreak incident being de-escalated in June 2018. Investigations during the outbreak highlighted the scale of the number of young people in Birmingham that had no, or incomplete vaccinations. During the outbreak the focus was on increasing MMR vaccination uptake in the areas and communities affected.

As well as geographic and demographic variation in uptake, there is variation across the GP Practices; some Practices have vaccinated only 1 in 5 children, others have achieved 100%:



4.4. Improvement Plans

4.4.1. Screening Programmes

Sandwell and West Birmingham CCG (SWB CCG) have proposed a cancer screening plan for the next 5 years which, if agreed will include the introduction of cancer champions in the community and primary care, closer working with pharmacies and a non-responder pilot project.

Local reductions in coverage of some screening programmes are also seen nationally, notably cervical cancer. The SIT will continue to address these with providers and a national awareness raising campaign is running in Spring 2019.

4.4.2. Immunisations

Following the local measles outbreak a measles elimination group has been set-up that is developing a local plan in-line with the national measles elimination strategy: https://www.gov.uk/government/publications/measles-and-rubella-elimination-uk-strategy

The local group is tasked with understanding the MMR uptake variation and developing plans to increase uptake in the populations and communities where it is lowest. This will ensure that more people are protected against measles and help Birmingham get closer to the national uptake target.

4.4.3. Inequalities

Sandwell and West Birmingham CCG are implementing a 12 month pilot to introduce a Health Protection role across their Primary Care Networks. The role will support practices to audit and improve their screening and immunisation rates.

The West Midlands SIT has recently hosted a regional Screening Inequalities event to develop and disseminate good practice to address inequity in screening across the region. A cancer screening health equity audit has also been commissioned and will commence in Spring 2019. The aim of this is to provide meaningful and actionable priorities for screening services to reduce local inequity. The SIT will be following up the event by developing a health inequalities strategy.

4.5. Recommendations

NHS England, Public Health and CCGs need to identify uptake variation in screening and immunisation programmes, then develop and deliver plans to reduce to low uptake and the inequalities that exist.

5. Emergency Planning, Resilience and Response

5.1. Introduction

It is important that the local healthcare system has plans in place to respond to emergencies and big events that could present a risk to health.

The NHS Emergency Planning, Resilience and Response (EPRR) function is the responsibility of NHS England West Midlands and local CCGs. NHS England has major incident plans in place and conducts their emergency planning through the Local Health Resilience Partnership (LHRP). The LHRP reports into the local regional meeting of the Directors of Public Health. Close working between NHS England EPRR, PHE and Directors of Public Health is ongoing to ensure that the response to small public health incidents is adequate, effective and well-coordinated.

NHS Hospital Trust EPRR planning and assurance is the responsibility of the two Birmingham CCG Emergency Planning Leads.

NHS EPRR reporting into the HPF does not routinely occur, but information is shared and the wider system assurance is provided by the Local Authority Resilience team that sit on the Local Resilience Forum.

Birmingham City Council Resilience Team does attend the HPF and provides verbal updates on general EPRR strategic issues.

5.2. Specific health protection issues for the City

The main challenge relating to EPRR in Birmingham is how the changes in teams, organisational structures and capacity are impacting on reporting and assurance. Reporting and accountability relationships need to be reviewed so that they properly reflect the current structures.
The issues that present the main current challenges are:

- Brexit planning and contingency
- Major resilience risks (e.g. infrastructure, IT failures)
- Mass casualty incidents

All of these risks are being addressed by NHS and Local Authority working groups and plans are in place to respond to incidents of these types, and others.

6. Infection Prevention and Control

6.1. Introduction

Infection prevention and control (IPC) is a systematic approach, and practical solution designed to prevent harm to patients, service users and health or social care workers from infections. Health and social care service users are often vulnerable so it is essential to minimise the risk of them acquiring or transmitting infections.

Infection prevention and control (IPC) services in Birmingham are delivered and reported mainly by teams based in the Clinical Commissioning Groups (CCGs) while working very closely with local partners including PHE and other NHS partners.

The CCGs are responsible for monitoring and managing improvement plans for Healthcare Acquired Infections (HCAIs) and infection prevention in various community settings.

6.2. Specific health protection issues for the City

6.2.1. IPC service

The biggest challenge in Birmingham is the variation and scope of IPC services and support. All hospitals in Birmingham have IPC Teams and processes in place to identify and manage any HCAIs that present.

Community IPC provision is a more variable situation; Birmingham and Solihull CCG (BSol) has an IPC team in place and they have a robust IPC process that supports CCG-commissioned service providers across the CCG area. This mainly focusses on GP Practices and Care Home settings (nursing homes with CCG-commissioned beds).

Sandwell and West Birmingham CCG community IPC service was provided by the local NHS Commissioning Support Unit until March 2018, but since then the service has not been provided in the West Birmingham part of the CCG footprint. This is a significant gap in IPC provision that the HPF has recognised and challenged the CCG for a response.

In addition to the IPC provision for CCG-commissioned providers described above, there are many other community residential and care providers across Birmingham, and there is not currently an IPC service commissioned to support them for prevention training or to assist with an incident response.

The gaps in IPC provision identified present a challenge for the local health protection system that need to be investigated and addressed.

6.2.2. Antimicrobial Resistance

The resistance of microbiological organisms to antimicrobial drugs is an international, national and local public health priority. Antimicrobial resistance (AMR) is addressed locally in Birmingham predominantly by the work of CCG Medicines Management Teams, alongside Hospital Prescribing Teams, PHE, pharmacy training providers and Public Health.
If organisms continue to develop resistance to drugs then infections that we now consider treatable and procedures that we now consider straightforward will become more significant public health risks in the future.

In Birmingham the focus is on ensuring that antimicrobial drugs are prescribed and used appropriately. The rate of antibiotic prescribing by GPs in Birmingham has been falling alongside national trends for the last 3 years and is currently higher than the England rate, but lower than the rate across the West Midlands.

Indicator	Year	England	West Midlands	Birmingham
Adjusted antibiotic prescribing in primary care by the NHS	2017	1.04	1.08	1.06

Local strategies to tackle AMR follow the national approaches; further information can be found at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784894/UK_AMR_5_year_national_action_plan.pdf

A West Midlands AMR network has been established to share best practice and facilitate strategic coordination; it is jointly chaired by PHE and NHS England.

6.2.3. Non-clinical IPC

Several beauty and cosmetic service provider training institutes are based in Birmingham and the local region. They have the capacity to train high numbers of practitioners that will operate locally and nationally. Many of the procedures covered in the training can present an infection risk if they are not carried out in accordance with high standards of hygiene.

A working group has been established with representatives from Birmingham Environmental Health (EH), Wolverhampton EH, PHE and a Trainer from WM Nail and Beauty Academy to develop and deliver a 'Train the Trainer' programme and infection prevention toolkit for beauty technicians in infection prevention and control needed to reduce infection.

Work is also ongoing to review and update local legislation to include a number of new activities into scope and revise the hygiene and training standards and sterilising procedures.

6.3. Recommendations

A task and finish group needs to be convened, to include Local Authority Public Health and Social Care, and CCGs to map out the limits and gaps in current community IPC provision (including nursing and residential homes), and to develop and implement plans to address the issues found.

All of the key local stakeholders (CCGs, PHE, NHS England and the Local Authority) also need to develop outbreak/incident agreements to define roles and responsibilities, and ensure that joint working is effective.

7. Summary

A City the size of Birmingham and with the level of population diversity has many strengths, but these factors also present multiple challenges for public health, and health protection in particular.

The Director of Public Health has concerns about specific health protection issues, but is working closely with local system partners to address these.

Screening and immunisation programme uptakes are lower than they need to be to ensure preventable conditions are avoided, and diseases are identified early so that effective treatment can start.

There are also specific concerns about community infection prevention and control that the appropriate CCG and Adult Social Care will be seeking to address.

As a global city Birmingham will be hosting the Commonwealth Games in 2022. This gives the Health Protection Forum a clear timescale for action to ensure that the local health protection system is effective and resilient.

Further details on two health protection incidents are described in the private report for the Health and Wellbeing Board to highlight the complexity the system faces and the need for close, multi-agency working.

Birmingham Health and Wellbeing Board

	Agenda Item: 12
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30th April 2019**
TITLE:	**BIRMINGHAM OLDER PEOPLE'S PROGRAMME – PROGRESS UPDATE**
Organisation	**Birmingham City Council**
Presenting Officer	**Graeme Betts, Director of Adult Social Care**

Report Type:	**Information**

1.	**Purpose:**
1.1	To provide the Health and Wellbeing Board with an update on progress of the Birmingham Older People's Programme, the Better Care Fund programme and the CQC Local System Review Action Plan, all of which are interlinked and contribute to system transformation and the development of an integrated care model for older people.

2.	**Implications:**	
BHWB Strategy Priorities	Detect and Prevent Adverse Childhood Experiences	
	All children in permanent housing	
	Increase the control of individuals over their care through Integrated Personal Commissioning (Personal Health Budgets and Direct Payments)	x
	Increasing employment/ meaningful activity and stable accommodation for those with mental health problems	
	Improving stable and independent accommodation for those learning	

	disability	
	Improve the wellbeing of those with multiple complex needs	x
	Improve air quality	
	Increased mental wellbeing in the workplace	
Joint Strategic Needs Assessment		
Joint Commissioning and Service Integration		x
Maximising transfer of Public Health functions		
Financial		
Patient and Public Involvement		x
Early Intervention		x
Prevention		x

3.	**Recommendations**
3.1	The Board is asked to note the progress, in particular information pertaining to communication and engagement activities following their request to have a better understanding of this aspect of the Older People's Programme.

4.	**Background**
4.1	This report builds upon the information provided at the 29th January meeting and details recent activity under the Older People heading. As the CQC Local System Review focussed specifically on older people, and the related Action Plan was one of the drivers for the Birmingham Older People Programme, commentary is brought together into a single report. The Birmingham Better Care Fund (BCF) is also referenced as it provides the funding for aspects of the Older People Programme and is accountable to the HWBB. See **Appendix 1.**
4.2	The report includes risks, issues and dependencies across the programme and provides information on how citizens are being engaged in the individual

	workstreams, as requested by HWB.

5.	**Future development**
5.1	Ongoing development and delivery will be through the three workstreams of the Birmingham Older People programme and the BCF Commissioning Executive.

6.	**Compliance Issues**
6.1	**Strategy Implications**
	The report details progress against implementing the vision of the Birmingham Older People Programme.
6.2	**Governance & Delivery**
	Governance for the programme is through the Birmingham Older People Programme Board. This Board is accountable to both the Health and Wellbeing Board and the Birmingham and Solihull STP Board. Progress on the CQC Local System Review Action Plan is reported to HWB and DoH, and CQC undertook its own monitoring earlier this year. The BCF Programme is governed by the BCF Commissioning Executive.
6.3	**Management Responsibility**
	Graeme Betts, Director for Adult Social Care, is the Senior Responsible Officer for the Birmingham Older People's Programme.

6.	**Risk Analysis**
6.1	To date risks have been noted against the individual workstreams that form the Older People Programme the most significant of which are detailed below. However, as the workstreams progress and work converges, there are plans for workstream leads to meet and review the risks at programme level; where decisions are required, risks will be referred to BOPPB.
6.2	Key risks for individual workstream lists are recorded within **Appendix 1.**

Appendices	
1.	BOPP Progress Update.

Birmingham Older People's Programme, Birmingham Better Care Fund and CQC Local System Review Action Plan

Progress update to Health and Wellbeing Board

30th April 2019

1. Purpose

To provide the Health and Wellbeing board with a progress update on the work of the Birmingham Older People's Programme, the Birmingham Better Care Fund and the CQC Local System Review Action Plan, all of which are interlinked and contribute to the transformation of services for Older People.

2. Progress update

The Older People's Programme is working towards an integrated model of health and social care being delivered at a local level through 3 interrelated workstreams which cover the whole range of support provided for older people. The themes, and the latest progress against each, are detailed below:

2.1 Prevention

The Prevention workstream is working towards a universal wellbeing offer which enables people to manage their own health and wellbeing, based in local communities. Information and advice are key, as well as addressing the issues that lead to older people entering into formal health and care systems.

2.1.1 Neighbourhood Network Schemes

Neighbourhood Network Schemes (NNS) are locality and constituency based networks which enable engagement with, and investment in, local communities and are currently operating in 6 constituencies, with the remaining 4 in development.

Innovation Funding is helping to test and trial new activity to support the NNS and social prescribing, with 3 projects being supported to date, including Binding Pages which provides arts and cultural activities for older people and people with care and/or health needs. Positive feedback has been received from across sectors about the model and the approach being taken via NNS and the potential to generate value for a variety of people. A directory of assets is being compiled to understand the strengths and gaps across the city's community asset base, as well as key issues which have been identified by community groups and organisations, social workers and citizens which need investing in at a local and citywide level.

A progress report on the initial six months of activity allowed citizens to identify the services they thought were currently missing: the key areas identified were transport to access community assets; information, advice and guidance around income maximisation and for those whose first language is not English; accessible support and activities for people with limited mobility and physical care needs; and specific activities for men. Having identified areas of priority for citizens, the report will advise the schemes going forward.

2.1.2 Social Prescribing

BCF is being utilised to fund a Social Prescribing model being delivered by Health Exchange and Our Health Partnership GP practices. Patient Activation Measures are being used as a means to demonstrate impact and guide clinical conversations. In collaboration with West Midlands Combined Authority, a clinical trial of the Thrive into Work programme is being supported to demonstrate the value of employment specialist activity to support patients with long term conditions and/or mental health needs back into work. Training has commenced to support Social Prescribing across Birmingham and Solihull.

2.1.3 Intergenerational activities

This project aims to bring young and older people together in purposeful, mutually beneficial activities which promote greater understanding and respect between generations and which contribute to building more cohesive communities.

Utilising a toolkit developed within Solihull, events have been held which to bring together schools and care homes, with three projects proceeding to date. Positive outcomes have been reported with young people gaining confidence from the interaction, and older people becoming more engaged in activities than they were previously. A newsletter is being written detailing the benefits of the project and to encourage more schools and care homes to get involved and a blog is also being developed.

2.1.4 Risk Identification – Supporting Adults Panels

The Supporting Adults Panels (SAPs) take place on a monthly basis and were originally run by Community Safety but have potential to be expanded into wider stakeholder groups which could link with the Neighbourhood Networks. The SAPs are now being strengthened with clinical input and scoping work is being undertaken to determine if they can be facilitated by the Social Work service in the future.

2.1.5 Carers

A system-wide Carers' Board has been established and the first joint Carers' Strategy has been drafted with pooled funding for three years to deliver a single approach to supporting carers across the life-course. During the first quarter of 2019 service specifications were jointly developed between BCC, Children's Trust and BSoL CCG. This ensured that commissioned carer services were joined up with a clear pathway for service users.

The new service model has three main components (and three lots for tender); Birmingham Carers' HUB, Young Carers services and Mental Health Services. The successful providers will be expected to work together to ensure smooth transitions between services when required.

Within Birmingham Carers' HUB will be specialist dementia services and a health liaison project linking into hospitals and GP surgeries. Current contracts and grant funding arrangements with community sector providers for support to carers have been extended up to 31st March 2020. The appointed provider will carry out appropriate levels of market engagement on proposed new models of delivery and decide alongside commissioners what they should look like in the future.

The tenders are currently being evaluated with the intention that contracts are up and running by 1st July 2019 ending on 31st March 2022.

2.2 Early Intervention

This workstream addresses the critical interface between health and social care in terms of acute hospital admissions, flow through hospitals and maximising independence back into the community. This area is the primary focus for the BOPP in terms of investment of BCF being prioritised for improvement work. Newton Europe has been engaged to support the system to transform delivery and outcomes for older people.

2.2.1 Locality testing

Having completed component testing, whereby each aspect – or component - of the model was tested to ensure it delivers the expected outcome, locality testing has now commenced. Locality testing will ensure that the components work in combination as expected and demonstrate how best to roll them out more widely. This will allow all of the smaller tests which have taken place to be put together, and the combined impact of the changes understood and improved until they are ready to be rolled out across Birmingham.

There are five locations in the south of the city currently testing new ways of delivering Early Intervention services. Staff in these locations are working collaboratively for the first time across organisational boundaries. With a system-wide perspective, they are looking at how older people are supported to make a quick recovery and what can be done to make sure a 'home first' ethos is adopted at each site. Each location has a lead member of staff who is responsible for driving this work. The leads, who meet fortnightly to share learnings and ideas, have various health and social care roles and include occupational therapists, nurses, social workers and consultants.

2.2.2 Care continuity

A group of health and social care professionals alongside colleagues from IT have started to look at how older people can have one clear and consistent plan when they need EI services. One of the workstream's challenges is how multiple organisations can have sight of a single care plan and how this can be made accessible to the older person. They will also be looking at how to ensure seamless and timely handovers between different locations.

2.2.3 Improvement managers

Eight dedicated 'Improvement Managers' have been recruited from our organisations to work with the Newton Europe team and our staff to support this programme. One of their initial tasks was to undertake a review of flow through non-acute beds – as a result reviews of the timing of social work intervention, delays around therapy intervention and the review of patients by community based teams to facilitate discharge, will all be incorporated into future testing.

2.2.4 Rollout

Locality testing continues until rollout, which is due to commence in June 2019 and continue until December. In preparation, the focus will widen to incorporate enabling aspects and engagement with key individuals to agree ways forward with regards to workforce, estates and IT.

2.3 Ongoing Personalised Support

The purpose of this workstream is to deliver a better experience and outcomes for people with long-term care and support needs.

2.3.1 Neighbourhood working

As the main focus for this workstream, the development of neighbourhood teams of health and social care professionals will provide seamless, wrap-around care for older people with long-term care needs via multi-disciplinary teams which bring together health and social care support.

Significant preparation work has been carried out in terms of defining the neighbourhoods that the multi-disciplinary teams will serve and developing the care model which will become a standard offer across all neighbourhoods. This work dovetails with the NHS Long Term Plan requirement for all GP practices to form Primary Care Networks, whereby a wider range of services are provided to service users on a local basis. As the timescale for the development of PCNs is June 2019, the development of neighbourhood teams will follow on once these are in place.

2.3.2 Enhanced support to Care Homes

By providing more support to Care Homes there are opportunities to reduce the amount of non-elective admissions into emergency care and allow more people to die within their own homes. This project is looking to have a standard offer of support to Care Homes and, following a stakeholder workshop held in February, which included both Care Home and service user representatives, is creating a new model of support which will first be piloted before roll-out. It is recognised that communications and workforce training are key, as well as building trust between stakeholders. The project is utilising learning from transformative work in Walsall. Support to Care Homes is one of the requirements of the new Primary Care Networks, previously mentioned.

2.3.3 Long term conditions: Respiratory and Diabetes

Services for those with respiratory conditions and diabetes are being redesigned to address inequality in existing patterns of provision and access to services across Birmingham and Solihull by implementing an integrated and consistent model. Cases for change for both services have now been signed off by the CCG. Delivery of services will be via the Primary Care Networks.

2.3.4 Assistive Technology

The ambition is to develop an integrated offer for citizens with ongoing care and support needs that is personalised and maximises independence. An Assistive Technology Strategy for BCC has been approved. The next step is to build a case for change for the large-scale implementation of digital and sensory technology within people's homes to help meet independence and choice outcomes. It is important that this work is across the health and social care system to ensure that an integrated approach is delivered.

2.3.5 Dementia

BCF funding is being utilised to provide a Dementia Navigator Service and Dementia Cafes, both of which provide timely information, advice and support to individuals and their families, friends or carers throughout their journey with dementia. The Dementia Strategy for Birmingham is currently being refreshed.

3 Citizen Engagement and Communications

3.1 Initial engagement

The basis of the Older People's programme was the initial work conducted with BCC 'experts by experience' which developed the 'I/We' statements below:

- We want to stay at home for as long as possible
- We want help to understand our illnesses and how to manage them,
- We don't need experts all the time
- We worry about having to go into hospital and about when we can't look after ourselves anymore
- We worry about our carers
- GP surgeries are important points for us but we don't always need to see a doctor
- We need people who can help and advise us, not put barriers in our way to stop us getting what we need.
- We want to be understood.

3.2 Programme-wide communications

It had been anticipated that support would be available on communications and engagement via the STP, however, this resource has not been available. At recent meetings of workstream leads and BOPPB, having a dedicated resource to coordinate communications across the whole of the BOPP programme has been identified as crucial to successfully embed new services and ensure consistent messages. BOPPB is currently considering how best to action this. In terms of citizen engagement we are working with Healthwatch at a programme level to map existing arrangements, identify good practice and gaps and develop a comprehensive plan for engagement.

3.3 Early Intervention

3.3.1 The initial diagnostic work that led to the Early Intervention project included c300 multi- disciplinary case reviews and analysis of large amounts of data. A number of anonymous representative case studies were identified for use in communications. The measures identified alongside the published case studies provided graphic evidence of the experience of individuals within the intermediate care

system. These findings were supported by the CQC system review and Healthwatch recognise them as relevant data. Citizen Representatives will be working throughout the programme to ensure service user experience is improved through co-production.

3.3.2 A workshop at a BCC citizens forum in February 2019 focused on the desired experience for people using EI services; their families identified the following key elements for people:

- They want to tell their story as few times as possible
- Consistency of staff is important
- Trust and honesty – they want to fell listened to and treated as an equal
- Establishing a common language, not using jargon is important.

These statements have been used to develop a series of statements to be used within the test sites to bring the experience perspective:

- I know what's going to happen next with my care
- I have to keep repeating information about myself to different health professionals
- I feel listened to and feel I have a say in my care.

Healthwatch have advised that the best way to apply these statements would be part of a structured conversation and are supporting the application of these conversations in test sites with their volunteers to ensure direct feedback from those citizens using the services. Healthwatch are working with the workstream to deliver engagement at the five test sites and to develop a plan for meaningful engagement as the workstream moves to roll-out. Understanding experience across the whole intermediate care system has been identified as a key output.

3.3.3 A briefing pack has been produced for stakeholders and regular newsletters are issued to staff to detail the changes and keep them abreast of the development of services and the relevant timelines.

3.4 Prevention

3.4.1 Neighbourhood Network Schemes

During the process of developing the schemes, citizens have been involved in the procurement process as panel members and will continue to do so. Citizens are part of the decision making process of those organisations and groups that are awarded funding from IAG Service, Prevention First: Investing in Communities" programme. Citizens will also play a key role in phase two of the scheme, by being part of the steering groups for each of the constituencies. Communications to these groups are supported by the NNS online blog and asset register.

3.4.2 Social Prescribing

The social prescribing pilot being delivered through the GP providers Health Exchange and Our Health Partnership hold pop up clinics in the community to determine what level of service citizens want at a neighbourhood level.

3.4.3 Intergenerational activities

Over sixty schools and care homes were invited to an event in January 2019, which launched a toolkit developed by Solihull MBC and to offered practical help, network opportunities and explore potential matches. A newsletter is being developed to demonstrate outcomes of current projects to encourage further care homes and schools to initiate intergenerational projects and encourage feedback on developing the network further.

3.5 Ongoing Personalised Support

3.5.1 Assistive Technology

The Assistive Technology Strategy has six key principles, including co-production to ensure that equipment and technology solutions will be identified and developed with citizens and their families and the carers' network. By including citizens in this way, they can better understand the need for change and what benefits can be achieved. At a recent workshop, citizens were consulted on how they currently use technology and how they felt about the increased use of technology. This will be followed up with another session to demonstrate equipment. An active citizen working group is developed and utilised to test current thinking on the use of technology and equipment in social care.

3.5.2 Long term conditions: Respiratory Services

In redesigning respiratory services, patient views on the service specification have been considered through engagement with the Respiratory Clinical Network (RCN) and wider stakeholders across Birmingham and Solihull (BSol) respiratory services. A comprehensive respiratory service review was carried out in 2013, which was re-tested in the January 2018 Optimal Design Workshop (ODW). The ODW had representation from all stakeholders including patients and carers, and informed the basis of the decision for this proposal.

3.5.3 Neighbourhood working

As work progresses on development of neighbourhood multi-disciplinary teams, place-based workshops will be held which will include local service users.

4 Key Programme Risks and Mitigation

Workstream	Risk	Mitigation
Prevention	Social Prescribing: Greater focus on prevention (NHS 10 year plan) may mean external pressures to fund services under the umbrella term of 'social prescribing'.	Ensure robust framework /position statement is developed to support future commissioning of social prescribing schemes
	Neighbourhood Network Schemes: Outcome of procurement process is that contracts have not been awarded to potential suppliers in several Constituencies, which will mean there is either a delay or lack of coverage entirely for NNS in those areas.	Alternative options being progressed for affected Constituencies.
Early Intervention	Community workforce for rollout: A temporary approach to identifying non-registered community workforce had been identified for prototype testing, however, for rollout a permanent solution will be required. If a workforce is not available, this will delay the project.	Service Development and Improvement Plan with BCHC planned in 19/20 contract. Weekly multi-organisational working group established to ensure support across the system. Two options to secure staff are being explored.
	Workforce culture changes: The unprecedented level of culture change required across clinical and professional practice and development of new cultures is not supported by all key managers and influential individuals resulting in failure to implement plans.	Initial scoping of issues emerging from prototype has identified the most significant issue is in the establishment of interdisciplinary working. Discussion with senior professional leads within organisations planned. Engagement surveys being established to understand some of the differences and training to be considered to address some differences.

Workstream	Risk	Mitigation
Ongoing Personalised Support	Neighbourhood multi-disciplinary teams: Stakeholder agreement on neighbourhood footprints.	Clearly planned locality workshops supported by comprehensive stakeholder support and activity analysis.
	Neighbourhood multi-disciplinary teams: Agreement on a consistent approach to neighbourhoods within West Birmingham that has alignment with wider Birmingham planning.	Further discussion is required with West Birmingham colleagues as to how the model will work in this area.

5 CQC Local System Review Action Plan

In January 2019 CQC undertook a monitoring exercise to gauge progress made against our Action Plan since the review of Birmingham's local health and care system a year before (as reported to HWB in February).

CQC's monitoring report notes the strengthened relationship between STP Board and HWB and that oversight of the health and social care system has become more robust. Though they point out that performance against key metrics remains challenging, they conclude that there is confidence that the Birmingham system will deliver its Action Plan in full with the drive and commitment of local leaders.

Delivery against actions will continue as part of the Birmingham Older People's Programme. There is no requirement from CQC for further reporting to them on the Local System Review.

Birmingham Health and Wellbeing Board

	Agenda Item: 13
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30 April 2019**
TITLE:	**STP Update - Live Healthy Live Happy**
Organisation	**Live Healthy Live Happy STP**
Presenting Officer	**Paul Jennings STP System Leader**

Report Type:	**Update- for information item**

1. Purpose:

1.1 This paper is to provide an update to the Health and Wellbeing Board in the delivery of the STP strategy and system partnership working.

1.2 The report is for information and further information can be found at www.livehealthylivehappy.org.uk

2. Implications:

Joint Strategic Needs Assessment		
Joint Commissioning and Service Integration		
Maximising transfer of Public Health functions		
Financial		
Patient and Public Involvement		
Early Intervention		
Prevention		

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

4.	**Background**
4.1	The HWBB has requested regular updates from Live Healthy Live Happy STP. A monthly report will be provided to HWBB and further information can be found on www.livehealthylivehappy.org.uk

5.	**Future development**
5.1	We will discuss the forward work plan for STP agenda items, including deep dives at the request of the HWBB, as part of the HWBB development day. All will be aligned to the STP delivery plan

6.	**Compliance Issues**
6.1	***Strategy Implications***
	STP strategy aligns to JSNA system priorities and tackles local inequalities in health and wellbeing through a system partnership approach.

6.2	***Homelessness Implications***
6.3	***Governance & Delivery***
6.3.1	Please refer to STP governance, provided in previous updates to HWBB
6.3.2	HWBB remains the highest authority in STP governance and assurance of our delivery and impact on improving outcomes.
6.4	***Management Responsibility***
	Rachel O'Connor Assistant CEO, Live Healthy, Live Happy Birmingham and Solihull STP

7.	**Risk Analysis**		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
#	#	#	#

Appendices	
1.	Health and Wellbeing Board Live healthy Live happy STP Update 30 April 2019

Health and Wellbeing Board
Live healthy Live happy STP Update
30 April 2019

1. Stakeholder Engagement Events May/June 2019

Live healthy Live happy (LHLH) is organising the second in its series of key stakeholder engagement events across Birmingham and Solihull, during May and June.

The purpose of the events is to update professional stakeholders on the LHLH progress so far, share the draft strategy and priorities, receive feedback as well as showcase some practical examples of what the partnership is already delivering through partnership working from the following organisations/work streams:

- Birmingham and Solihull United Partnership
- Primary Care Mental Health Liaison Model in East Birmingham
- Coordinated End of Life Care across Birmingham and Solihull
- Feedback from new ways of delivering early intervention services for older people

These stakeholder events will help ensure that all stakeholders continue to be happy to be advocates for the work of LHLH as detailed plans continue to be developed and implemented. The events will be held between 3pm-5pm at five different venues with a choice of dates:

- 15th May – BVSC, Birmingham City Centre
- 16th May – St Paul's Conference Centre, Bordesley Green
- 28th May – Norman Power Centre, Edgbaston
- 11th or 12th June (tbc) – The Studio at the Core, Solihull
- 30th May – St Barnabas Church, Erdington

For more information contact Jennifer Chatham (Jennifer.chatham@nhs.net)

2. Developing the STP and Place Outcomes Framework

LHLH has proposed the development of a Birmingham and Solihull STP Outcomes Framework, it will be a coproduced framework with the Health and Wellbeing Boards (HWBB), built up from a place-based outcomes framework. Our Directors of Public Health and Locality Directors are taking forward this work.

The framework will enable monitoring of its work and drive its ambitions to deliver a reduction in inequalities and variation in outcomes. It would be a framework that can best measure the improvements that LHLH makes in its system to realise its STP vision and place- based strategies. This could evolve to a future framework by which it can commission for outcomes as strategic commissioners.

The purpose of outcome framework development is to;

- Maximise the opportunities of a well-established partnership. Solihull Together and Birmingham Partnership forums as the delivery engine for the HWBB, utilising the expertise and influence of those involved
- Respond to the request for greater clarity on aims and aspirations
- Shape the programme – is LHLH working on the right things?

- Simplify any aspirations so all members can easily articulate them and are clear about their own contribution towards achievement
- Ensure LHLH knows that whether what it is doing is working effectively
- Pull together the various conversations across the system so there is consistency in approach
- Move away from collating the elements being routinely measured, to transformational measures that really matter to the people of Birmingham and Solihull

The development of an outcomes framework proposal has been strongly supported by the STP Board, Health Overview and Scrutiny Committee and HWBB. It was a key recommendation from stakeholders at the STP conference in December. The draft outcomes framework should be ready for approval through committees in June. This would sit alongside the final STP strategy for approval and post the engagement events in May/early June.

It also recognised that contributing to improving outcomes in inequality are multifactorial and cross organisational and sector boundaries. The transformational outcomes would be a more sophisticated approach of the laying of a number of input measures that contribute to a wellbeing and person-centred outcome.

An example

Currently we measure the number of patients surviving major trauma. A more transformational measure would be to measure the number of patients that return to work following a major trauma, recognising that within that there would be a number of multi-agency outcomes that contribute together. For example, ambulance response time, time to CT scan, time to surgery, rehabilitation goals, employment support etc.

It is accepted that we will need to have some dual running as the current national standard and key performance indicators remain a statutory responsibility to deliver. However, in developing our own outcomes framework, it does allow for us to demonstrate our progress as a system to self-regulate and is a key element of strategic commissioning by which we would hope to commission from in the future.

To ensure LHLH has a consistent single place-based Outcome Framework for Birmingham, Sandwell and West Birmingham Clinical Commissioning Group is a key partner in the coproduction.

Our next step is to schedule a HWBB coproduction session to commence work on the framework and build on examples of good practice and early thinking from across the partnership

For sight of the full paper please contact Rachel O'Connor (rachel.oconnor@nhs.net) or Jennifer Chatham (Jennifer.chatham@nhs.net)

3. Healthwatch Birmingham 'What would you do?' campaign

Independent health and care champion Healthwatch Birmingham is involved in the national 'What would you do?' Healthwatch campaign to encourage people in the city to share their views about what changes to local NHS services should look like. T

The Government is investing £20 billion a year in the NHS as part of the NHS Long Term Plan and has commissioned Healthwatch to engage with local people on their feedback on the plan.

The public are being asked for their views about how NHS services could be improved - for example mental health support, cancer services, learning disability, autism and dementia care. They will also be asked to share their ideas on how people can live healthier lives and what improvements they think could be made to help people access services quickly.

People are being invited to tell Healthwatch Birmingham what their local NHS can do to help them and their community stay well and provide better support by completing the national survey. People living with cancer, mental health conditions, heart and lung diseases, long-term conditions, such as diabetes and arthritis, learning disabilities, autism, conditions such as dementia are also being asked complete the specific national survey.

The Healthwatch initiative will complement the planned public stakeholder engagement activity of Live healthy Live happy (LHLH), Birmingham and Solihull's Strategic Transformation Partnership. LHLH is working together with local partners in the voluntary, community and independent sectors to find the most effective ways to manage the health and care needs of the local population. The 'What would you do?' campaign will deliver early public feedback and help further shape LHLH's areas of focus. **For more information visit www.livehealthylivehappy.org.uk**

People can share their views by contacting Healthwatch Birmingham at info@healthwatchbirmingham.co.uk or 0800 652 5278 or 0121 636 0990 or visit https://www.healthwatch.co.uk/what-would-you-do

4. Population Health Management Development Programme

The North and West Midlands Population Health Management (PHM) development programme led by NHS England. STP Programme Directors and STP Population Health Leads for all 7 STP's in the North and West Midlands, has procured a 12- month capability and capacity building programme covering 7 STP's across the West and North Midlands.

Procured in partnership with the national PHM Team and Public Health England, the programme of work provides opportunity to improve the health and well-being of the people that live and work in the midlands, as well as those that provide their care. The 7 STP footprint of the Population Health work covers approximately 6.7 million people.

The development programme will enable STP's to develop the capability and capacity to embed population health intelligence, leadership and approaches into their ICS development. It is based on the three core capabilities for PHM:

- Infrastructure
- Intelligence
- Interventions

Each of the 7 STP's participating in the programme will develop individual programme plans over the next few weeks.

A local launch of the programme will take place on the 10th April with the PHM core STP programme team which includes our Directors of Public Health, digital and business intelligence leads and professional and clinical leads.

The initial meeting will consider the two PHM pilot areas for LHLH to undertake on the programme.

For sight of the full paper please contact Rachel O'Connor (rachel.oconnor@nhs.net) or Jennifer Chatham (Jennifer.chatham@nhs.net

Birmingham Health and Wellbeing Board

	Agenda Item: 14
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30th April 2019**
TITLE:	**PRIMARY CARE NETWORKS**
Organisation	**Birmingham & Solihull CCG**
Presenting Officer	**Karen Helliwell, Director of Integration, Birmingham and Solihull CCG**

Report Type:	**INFORMATION**

1. Purpose:

To inform the board on the development of Primary Care Networks (PCNs) in Birmingham and on the process and timetable for agreeing PCNs for the City.

2. Implications:

BHWB Strategy Priorities	Detect and Prevent Adverse Childhood Experiences	
	All children in permanent housing	
	Increase the control of individuals over their care through Integrated Personal Commissioning (Personal Health Budgets and Direct Payments)	
	Increasing employment/ meaningful activity and stable accommodation for those with mental health problems	
	Improving stable and independent accommodation for those learning disability	

	Improve the wellbeing of those with multiple complex needs	
	Improve air quality	
	Increased mental wellbeing in the workplace	
Joint Strategic Needs Assessment		
Joint Commissioning and Service Integration		Y
Maximising transfer of Public Health functions		
Financial		Y
Patient and Public Involvement		Y
Early Intervention		
Prevention		

3.	**Recommendations**
3.1	Presented for information

4.	**Background**
4.1	Primary care networks form a key building block of the NHS long-term plan.
4.2	They are a formal way of bringing general practice together to work at scale to: • Improve the ability of practices to recruit and retain staff • To manage financial and estates pressures • To provide a wider range of services to patients • To more easily integrate with the wider health and care system.

5.	**Future development**
5.1	All GP practices are expected to come together in geographical networks covering populations of approximately 30–50,000 patients by June 2019.
5.2	Primary care networks will be focused on service delivery, rather than on the

	planning and funding of services.
5.3	Responsibility for planning and funding will remain with commissioners –New national network contract.
5.4	Community leadership. Primary Care Network Clinical Directors will provide strategic and clinical leadership to help support change across primary and community health services.
5.5	In the first year focus will be on establishing networks, staffing, development support and delivering increased GP access for patients.
5.6	Primary care networks will eventually be required to deliver a set of seven national service specifications.
i.	Structured Medications Review and Optimisation;
ii.	Enhanced Health in Care Homes, to implement the vanguard model;
iii.	Anticipatory Care requirements for high need patients typically experiencing several long term conditions, joint with community services;
iv.	Personalised Care, to implement the NHS Comprehensive Model;
v.	Supporting Early Cancer Diagnosis;
vi.	CVD Prevention and Diagnosis; (By 2021)
vii.	Tackling Neighbourhood Inequalities (By 2021)

6.	**Compliance Issues**
6.1	***Strategy Implications***
	PCNs are expected to be the building blocks around which integrated care systems are built. NHS England has significant ambitions for primary care networks, with the expectation that they will be a key vehicle for delivering many of the commitments in the long-term plan and providing a wider range of services to patients.
6.2	***Governance & Delivery***
	PCNs will be commissioned through the CCG via the Primary Medical Services Contract.

6.3	***Management Responsibility***
	Karen Helliwell – Director of Integration, Birmingham and Solihull CCG

6.	**Risk Analysis**		
	The recommended governance arrangements are intended to mitigate the risks as detailed in the table below :		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**

Appendices
PCN Presentation attached

Primary Care Networks

Update for Stakeholders

What are Primary Care networks ?

- Primary care networks form a key building block of the NHS long-term plan.
- Formal way of bringing general practice together to work at scale to:
  - Improve the ability of practices to recruit and retain staff
  - To manage financial and estates pressures
  - To provide a wider range of services to patients
  - To more easily integrate with the wider health and care system.

National Context

- The NHS Long Term Plan – 7th January 2019
- Investment and evolution - A five-year framework for GP contract reform to implement The NHS Long Term Plan – 31st January 2019
- Network Contract Directed Enhanced Service 29th March 2019
- Network Contract DES contract specification 29th March 2019

PCN Model- 30-50k population of groups of general practice

- All GP practices are expected to come together in geographical networks covering populations of approximately 30–50,000 patients by June 2019.
- Primary care networks will be focused on service delivery, rather than on the planning and funding of services.
- Responsibility for planning and funding will remain with commissioners –New national network contract.
- Expected to be the building blocks around which integrated care systems are built.
- Community leadership. Primary Care Network Clinical Directors will provide strategic and clinical leadership to help support change across primary and community health services.

What will Primary Care Networks do ?

- NHS England has significant ambitions for primary care networks, with the expectation that they will be a key vehicle for delivering many of the commitments in the long-term plan and providing a wider range of services to patients.
- In first year focus will be on establishing networks, staffing, development support and delivering increased GP access for patients.
- Primary care networks will eventually be required to deliver a set of seven national service specifications.

What will Primary Care Networks do ?

During 2019 and 2020, NHS England will develop seven specifications and seek to agree these as part of annual contract changes

The seven national service specifications are:

i. Structured Medications Review and Optimisation;

ii. Enhanced Health in Care Homes, to implement the vanguard model;

iii. Anticipatory Care requirements for high need patients typically experiencing several long term conditions, joint with community services;

iv. Personalised Care, to implement the NHS Comprehensive Model;

v. Supporting Early Cancer Diagnosis;

vi. CVD Prevention and Diagnosis; (By 2021)

vii. Tackling Neighbourhood Inequalities(By 2021)

What will Primary Care Networks do ?

- Expected to provide a wider range of primary care services to patients, involving a wider set of staff roles than might be feasible in individual practices.
- For example, first contact physiotherapy, extended access and social prescribing.
- Networks will receive specific funding for clinical pharmacists and social prescribing link workers in 2019/20,
- Funding for physiotherapists, physician associates and paramedics in subsequent years
- Each Network will have a named **accountable Clinical Director** – they will play a critical role in shaping and supporting their Integrated Care System and dissolving the historic divide between primary and community care

What will Primary Care Networks do ?

- They will also be the footprint around which integrated community-based teams will develop, and community and mental health services will be expected to configure their services around primary care network boundaries.
- These teams will provide services to people with more complex needs, providing proactive and anticipatory care.
- Will build upon the work undertaken within the BSOL system through Solihull Together /Birmingham Older Peoples Programme Board.

Network Area- How will they be formed

- Each Primary Care Network must have a boundary that makes sense to: (a) its constituent practices; (b) to other community-based providers, who configure their teams accordingly; and (c) to its local community, given it marks the extent of PCN accountability for the health and wellbeing of a defined place.
- Through the registration process, all the ‘Network Areas’ will be agreed with the local CCG at the same time. The CCG does this on behalf of, and with the agreement of, the local Integrated Care System (ICS) or Sustainability and Transformation Partnership (STP). Subsequent changes to network areas will require CCG approval. Boundaries will require active support from both the local CCG and NHS England.

Network Agreement

A national Network Agreement has been developed to support the Network Contract DES and PCNs will be required to use it.

- The Network Agreement sets out the collective rights and obligations of GP providers within the core of the PCN and is required to claim its collective financial entitlements under the Network Contract DES. It also sets out how the practices will collaborate with non-GP providers which make up the wider PCN

- PCNs will be required to submit an initial Network Agreement by 15 May 2019. PCN will be required to:
  - By 30 June 19; complete Network Agreement and confirm to the commissioner that the completed Network Agreement has been signed by all GP practices in the PCN

Timetable

Date	Action
Jan-Apr 2019	PCNs prepare to meet the Network Contract DES registration requirements
By 29 Mar 2019	NHS England and GPC England jointly issue the Network Agreement and 2019/20 Network Contract DES
By 15 May 2019	**All Primary Care Networks submit registration information to their CCG**
By 31 May 2019	**CCGs confirm network coverage and approve variation to GMS, PMS and APMS contracts**
Early Jun	NHS England and GPC England jointly work with CCGs and LMCs to resolve any issues
1 Jul 2019	**Network Contract DES goes live across 100% of the country**
Jul 2019-Mar 2020	National entitlements under the 2019/20 Network Contract start: • year 1 of the additional workforce reimbursement scheme • ongoing support funding for the Clinical Director • ongoing £1.50/head from CCG allocations
Apr 2020 onwards	National Network Services start under the 2020/21 Network Contract DES

BSOL approach

- **BSOL STP Task and Finish Group** established to liaise with STPs (BSOL /Black Country) Agreed a set of principles for the system and General practice to work to in considering the formation of PCNs .Meeting scheduled for 25th April 2019 .
- **STP integration-** Building on STP work through Ageing well/ Solihull Together around integration of networks.
- **Localities – supporting the practices** Locality teams working closely with General practice to support them with discussions and issues. Early submission on progress requested on 5th April 2019 to review level of coverage and support any areas further.
- **LMC engagement –** Task and Finish members /meetings /member of review panel
- **PCCC** – sub group to recommend proposed PCNs.
- **PCN development and support-** Led by Director of OD and Partnership/Locality teams

BSOL approach

- Commissioning responsibilities
  - BSOL CCG will enter into network contract with PCNs
  - Primary Care Commissioning Committee has delegated authority for managing the contracts ,funding and commissioning of any additional local services that the system wishes them to deliver .
  - Ensuring 100% coverage of networks across BSOL

  Lead SRO Karen Helliwell ,Director of Integration

- Support and Development to PCNs

  - BSOL CCG will lead the co-ordination and development of a PCN development plan (with engagement from the STP and providers)

  -Support through Locality teams within the CCG on delivery

  Lead SRO Paul Sherriff, Director of OD& Partnerships

Birmingham Health and Wellbeing Board

	Agenda Item: 16
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30th April 2019**
TITLE:	**PROPOSAL TO RELOCATE AND IMPROVE THE ADULT SEXUAL ASSAULT REFERRAL CENTRES WHICH SERVE BIRMINGHAM, SOLIHULL AND THE BLACK COUNTRY**
Organisation	**NHS England and Improvement**
Presenting Officer	**Sarah Forrest, Head of Health & Justice Commissioning (Midlands)**

Report Type:	**For information**

1. Purpose:
To advise partners of proposals to relocate the adult Sexual Assault Referral Centre services from the 2 current sites (Walsall and Castle Vale) to a single facility in Hodge Hill.

2. Implications:		
BHWB Strategy Priorities	Detect and Prevent Adverse Childhood Experiences	
	All children in permanent housing	
	Increase the control of individuals over their care through Integrated Personal Commissioning (Personal Health Budgets and Direct Payments)	
	Increasing employment/ meaningful activity and stable accommodation for those with mental health problems	
	Improving stable and independent accommodation for those learning	

	disability	
	Improve the wellbeing of those with multiple complex needs	
	Improve air quality	
	Increased mental wellbeing in the workplace	
Joint Strategic Needs Assessment		
Joint Commissioning and Service Integration		
Maximising transfer of Public Health functions		
Financial		
Patient and Public Involvement		
Early Intervention		
Prevention		

3.	**Recommendations**
3.1	The Board is asked to note the proposal and identify any queries or concerns to NHS England/Improvement.

4.	**Background**
4.1	Adult SARC services for Birmingham, Solihull and the Black Country are currently split across two sites: Horizon Castle Vale and Horizon Walsall. The Walsall premises are also shared with the regional Children and Young People's SARC. (*Please note: there are no plans to move the Children and Young People's SARC.)*
4.2	Previous needs assessments have indicated that we need to improve SARC services for the local population. The 2011 Health Needs Assessment identified that *"Many stakeholders provided a strong rationale for centralising services within a single SARC*" and "*In terms of location, stakeholders in favour of centralisation considered that Birmingham - as the central point within the West Midlands Police Force Area - was an ideal city in which to locate a SARC*."

4.3 The 2016 Adult SARC Health Needs Assessment recommended that *"stakeholders highlighted the need for better SARC facilities to service the West Midlands area. For the West Midlands, the preferred option was for a new single purpose-built site located within easy access to the motorways and away from the city centre."*

4.4 How will service users get to the new SARC location?

Most service users are taken to the SARC and then home by the Police. Those service users who self-refer can make their own way to the SARC by personal or public transport. Alternatively, the SARC can provide a taxi if assistance is required to attend the SARC.

4.5 What is the age range for adult and children and young peoples' services?

Within the SARC service people are classed as adults if they are aged 18 years. Survivors aged under 18 are classed as children and young people (CYP).There is provision for 15-17-year-olds to attend either the CYP or adult service based on the survivor's personal preference.

4.6 How many survivors travel to the SARC from each area?

January - December 2018

Area	Number of service users by area	% across the region	Average number of attendances a week by area	Number of self referrals by area
Birmingham	215	47.7%	4	71
Solihull	15	3.3%	0	7
Coventry	13	2.9%	0	4
Dudley	34	7.5%	1	12
Sandwell	47	10.4%	1	14
Walsall	43	9.5%	1	16
Wolverhampton	54	12.0%	1	18
Out of area	13	2.9%	0	6
Unknown	17	3.8%	0	8

4.7 How often will service users have to travel to the SARC?

Only once. Once the initial assessment has been completed at the SARC, survivors are referred into services local to them for any ongoing care and

support such as sexual health, mental health, counselling, GP or other services. The Crisis Worker from the SARC supports this by arranging appointments, in consultation with the survivor.

4.8 Will SARC staff numbers be cut when the number of sites are reduced?

No, there are no plans to reduce service provision through this relocation.

4.9 What is wrong with the current premises?

The Walsall site currently houses a regional children and young people (CYP) service and the adult service. There is limited space available and it is necessary to provide separate facilities for CYP and for adults which further reduces the space for each. Moving the adult service provides more room at Hodge Hill but also frees up space at the Walsall site. It will enable NHS England to establish an age specific environment for CYP in Walsall. NHS England is aiming to invest in both the Walsall and Hodge Hill sites to improve the facilities for survivors of sexual assault.

4.10 What will happen to the CYP service?

This service will remain at the Walsall SARC site.

4.11 Will the new facilities be able to meet the needs of Adults with Care and support needs?

Hodge Hill Primary Care Centre is Disability Discrimination Act compliant including the area to be used by the SARC service.

4.12 Have other locations been considered?

Yes, the STP/CCG led an estates review and options appraisal which considered a range of vacant premises across Birmingham, Solihull and the Black Country. An estates assessment was then completed based on the quality of the premises, location, size, privacy and availability. Hodge Hill Primary Care Centre ranked the highest when scored against these factors.

4.13 Why isn't a formal consultation being undertaken?

NHS England has reviewed this and identified that:

- The proposed co-location of the SARCs in a building with space for closer

working between partner organisations is not a significant service change.

- There will be no loss of service to the area served (Birmingham, Solihull and the Black Country).
- There is a small number of people affected and a low impact on those people. On average 10 survivors use the service each week from across Birmingham, Solihull and the Black Country. In most cases each survivor only attends the SARC once. They are then referred for follow-up treatment in their own home areas.

4.14 Why is this being considered now?

A suitable space is currently available; NHS England is aware of estates pressures across the region and wants to secure this site for the benefit of survivors who use this vital service. There is pressure on space within the Walsall SARC that needs to be addressed to support patient care.

5.	**Future development**
	Moving to Hodge Hill will support efficiencies in staffing and minimise staffing travelling. Hodge Hill provides additional space which could provide a more seamless survivor experience; this includes two examination suites and onsite Police facilities which would avoid the need for the survivor to then attend the local Police Station for interviews. In addition, a room for Independent Sexual Violence Advisor (ISVAs) would also be available should these services wish to have an onsite presence. Having relevant professionals available within the SARC to engage with the survivor at the same time would provide a better patient experience and would support multi-agency working. The building would be fitted out as an age-appropriate facility.

6.	**Compliance Issues**
6.1	***Strategy Implications***
6.2	***Homelessness Implications***
6.3	***Governance & Delivery***
	The project is being overseen by a Project Board consisting of NHS England, the CCG and the Landlord.

	An Expert Reference Group is developing the premises specification. Representation includes: NHS England Commissioners, West Midlands Police Force, West Midlands Forensic Laboratory, the SARC Provider and a provider of Counselling and ISVA services.
6.4	***Management Responsibility***
	SARCs are a statutory commissioning responsibility of NHS England/Improvement and the Police

7.	**Risk Analysis**		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
#	#	#	#

Appendices	
1.	Briefing: Adult Sexual Referral Centres Proposal for Birmingham, Solihull and the Black Country March 2019

Proposal to relocate and improve the Adult Sexual Assault Referral Centres which serve Birmingham, Solihull and the Black Country.

We would like to inform you about our proposal to bring together the existing two Adult Sexual Assault Referral Centres into a single, upgraded setting at Hodge Hill.

To comment on the proposal, or to arrange to discuss it with a senior member of our team, please contact us via the details below. **Please note:** the closing date for providing feedback for consideration is 5pm on 18 April 2019.

What is a SARC?

The purpose of a Sexual Assault Referral Centre (SARC) is to assess the health and well-being needs of survivors following either a recent or historic sexual assault. Referrals are then made to services in the survivor's home area.

The SARC is also equipped for the collection of forensic evidence from a person who has suffered a recent sexual assault. This is stored for seven years and may be used to secure a criminal conviction if the survivor requests a prosecution.

Where are the existing SARCs?

Adult SARC services for Birmingham, Solihull and the Black Country are currently split across two sites: Horizon Castle Vale and Horizon Walsall. The Walsall premises are also shared with the regional Children and Young People's SARC. (Please note: there are no plans to move the Children and Young People's SARC.)

Where are the proposed new premises?

We have considered several possible venues and identified a building with excellent facilities in a very suitable location at: Hodge Hill Primary Care Centre, Roughlea Avenue, Birmingham B36 8GH.

Why is the change necessary?

Needs assessments for the area have indicated that we need to improve SARC services for the local population. The recommendation to bring two Adult SARC services under one roof has been made jointly by West Midlands Police and NHS England, with support from a professional advocate of those who use the service.

How does this benefit survivors?

Moving the Adult SARC from its current split sites will benefit survivors in the following ways:

- We will reduce waiting times for examination. The new site will have two forensic suites, doubling existing provision at each SARC. This will reduce delays caused by the essential deep cleaning process after each examination.
- We will create an age-appropriate environment for adults by separating the Adult SARC from the Children and Young People's SARC at Horizon, Walsall.
- We will have enough space within the building to further develop the Adult SARC at Hodge Hill if demand for the service increases over future years.
- A single facility will make it easier for the different agencies involved in supporting survivors to work more closely together, and provide the capacity for the service to grow and evolve.

Is this a cut in services?

No. If the proposal goes ahead we will be investing additional funding into the area's SARC service.

Why have you chosen the building at Hodge Hill?

- The building is already in use by the NHS and has a suitable, unused space for the current and future needs of the service.
- It is well located for access by car for patients from across the area. It is also well served by bus routes (X12, X70, 28, 70 and 94).
- The location allows for forensic samples to be transported within the necessary time frame to the laboratory at Birmingham Women and Children's Hospital.
- The building will have a discreet, separate entrance, protecting the privacy and dignity of people who attend the SARC. The SARC service will be in a separate section of the building from the areas used by other services, which include a GP surgery and pharmacy

Will people need to travel further?

Relocating the service at Hodge Hill means some people must travel several miles further, but for others the distance will be shorter.

A slightly increased travel time will have little impact on those who use the service. This is because most people only attend the SARC once and are referred for follow-up support in their home area.

Are there benefits for staff?

- Yes. Staff can work together more effectively and invest the time they currently spend travelling between sites in enhancing patient services.
- We will remove the duplication of tasks caused by managing facilities and supplies in two buildings.

Have SARC users been engaged?

Yes. We are inviting the views of people who have previously used the service. We will respond to any concerns raised as we design the service for the future.

Will there be an impact on residents?

We do not predict any impact on local residents. Additional traffic to the site will be very limited as on average 10 people use the service each week. There is ample parking on the site so vehicles are unlikely to be parked on surrounding streets.

What are the next steps?

Before proceeding with detailed design work, we are asking for feedback from local authority leaders, HOSC and OSC chairs, ward councillors and other stakeholders.

How do I give feedback or find out more?

Please email your comments or questions to: england.northmidscomms@nhs.net or call Donna Follows on: 01138 249025 who will arrange for a senior member of our team to return your call.

The deadline for providing feedback for consideration is 5pm on 18 April 2019.

Views of the Hodge Hill premises

The spacious, attractive building which could host the Adult SARC.