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

BIRMINGHAM CITY COUNCIL

HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

TUESDAY, 19 JANUARY 2016 AT 10:00 HOURS
IN COMMITTEE ROOMS 3 & 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1 **NOTICE OF RECORDING**

The Chair to advise/meeting to note that this meeting will be webcast for live and subsequent broadcast via the Council's Internet site (www.birminghamnewsroom.com) and that members of the press/public may record and take photographs.

The whole of the meeting will be filmed except where there are confidential or exempt items.

2 **APOLOGIES**

3 - 8

3 **MINUTES**

To confirm and sign the Minutes of the meeting held on 15 December 2015.

4 **DECLARATIONS OF INTERESTS**

9 - 12

5 **HEALTHWATCH BIRMINGHAM UPDATE: 10.00-10.35**

Brian Carr, Acting Chair, Healthwatch Birmingham.

13 - 26

6 **ADULTS WITH LEARNING DISABILITIES - HOUSING AND EMPLOYMENT SUPPORT: 10.35-11.10**

Kalvinder Kohli, Head of Service, Prevention and Complex, Commissioning Centre of Excellence, People Directorate.

27 - 32

7 **CHANGES IN TOBACCO SMOKING AND IMPLICATIONS FOR BIRMINGHAM 11.10-11.45**

Dr Adrian Phillips, Director of Public Health.

33 - 42

8 **INFANT MORTALITY: 11.45-12.20**

Dr Adrian Phillips, Director of Public Health.

43 - 50

9 **WORK PROGRAMME**

For discussion.

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

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

11 **OTHER URGENT BUSINESS**

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

12 **AUTHORITY TO CHAIR AND OFFICERS**

Chair to move:-

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

BIRMINGHAM CITY COUNCIL

HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE 15 DECEMBER 2015

MINUTES OF A MEETING OF THE HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE HELD ON TUESDAY 15 DECEMBER 2015 AT 1000 HOURS IN COMMITTEE ROOMS 3 AND 4, COUNCIL HOUSE, BIRMINGHAM

PRESENT: - Councillor Majid Mahmood in the Chair; Councillors Mohammed Aikhlaq, Sue Anderson, Maureen Cornish, Andrew Hardie, Mohammed Idrees, Karen McCarthy, Robert Pocock, Sharon Thompson and Margaret Waddington.

IN ATTENDANCE:-

Councillor Paulette Hamilton, Cabinet Member for Health and Social Care

Alan Lotinga, Service Director, Health and Wellbeing, BCC

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

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NOTICE OF RECORDING

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

APOLOGIES

281 Apologies for their inability to attend the meeting were submitted on behalf of Councillors Mick Brown and Brett O'Reilly.

MINUTES

In referring to Minute No. 270, Councillor Andrew Hardie commented that he had declared later in the meeting that he worked in the health service as a locum GP.

Councillor Robert Pocock drew attention to paragraph (c) of Minute No.274 and referred to it also having been agreed that an analysis be provided of how the data would be used to improve services. In concurring with the comments made, the Chair advised the Member that the matter would be followed-up.

282 The Minutes of the meeting held on 24 November, 2015 were, subject to the above amendments, confirmed and signed by the Chairperson.

DECLARATIONS OF INTERESTS

283 Councillor Andrew Hardie declared that he worked in the health service as a locum GP. Councillor Mohammed Aikhlaq declared that he was a governor of the Heart of England NHS Foundation Trust and Councillor Karen McCarthy that she served as a governor on the Birmingham Women's Hospital.

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (BIRMINGHAM)

284 **RESOLVED**:-

That Councillor Mohammed Aikhlaq be appointed to serve on the Joint Health Overview and Scrutiny Committee (Birmingham and Sandwell) in place of Councillor Karen McCarthy.

REPORT OF CABINET MEMBER FOR HEALTH AND SOCIAL CARE

285 The following report was received:-

(See document No. 1)

Councillor Paulette Hamilton, Cabinet Member for Health and Social Care introduced the report. Alan Lotinga, Service Director, Health and Wellbeing, BCC was also attendance.

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

a) The Cabinet Member reported that no joint working had yet taken place with the health service on the issue of personal individual budgets but indicated that negotiations were about to start.
b) In referring to some small scale pilots that had been undertaken a few years ago, the Service Director considered that the first wave of health service personal individual budgets would be around continuing health care.
c) Members were informed that Viscount House was full to capacity. It was highlighted that the idea behind the facility was that people with learning disabilities received help and guidance for a period of up to 6 months so that they could then live in society as independently as possible.
d) In concurring that there was a need to work with the health service on the commissioning of learning disability services, the Service Director referred to the need to particularly focus on improving the quality of provision. He also considered that there was a need for something similar to the Mental Health System Strategy Board that was in place.
e) The Service Director referred to main areas of in-house activity: home care enablement; day care for older adults: day care for people with learning disabilities, in respect of which there was limited choice available; and residential care for people with dementia, where he highlighted that more provision was required and using Care Centres needed to be pursued.
f) In relation to working with Executive Members for Districts on the Healthy Communities agenda, the Cabinet Member indicated that the Districts had been given an overall direction of travel within which they could then set

their own parameters and seek support. Reference was made to progress that had been made on the issue of mental health and considerable engagement which it was considered needed to take place with the Districts in the coming year.

g) Further to information on page 6 of the report relating to the Health and Wellbeing Board (HWB), the Service Director referred to a board meeting held earlier in the year where discussions had taken place around working collectively to bring down the level of domestic violence in the City. In also mentioning the Better Care Fund, he considered that as joint working developed there might be a need for the HWB to be reconstituted and become more a decision-making body rather than an influencing one.

h) In relation to public health cuts, the Service Director indicated that he considered that to address this there was a need to be more specific in commissioning services / robustly challenging costs and, in relation to preventative activity, ensuring that funding was used to best effect and not where it was not having the required impact.

i) The Cabinet Member informed the meeting that she considered that if the Government continued to squeeze funding then the level of preventative work would unfortunately have to reduce.

j) A Member highlighted that a preventative approach to improving the health of citizens was not only better for communities but also less costly overall. In pointing out, for example, that people with diabetes were recommended to drink plenty of fluid and take regular walks he asked that public toilets be provided in the City's parks. The Chair also highlighted that this request had been raised at a previous meeting (29 September 2015 - Minute No. 253 refers). The Cabinet Member undertook to pursue the issue and provide a written response.

k) A Member considered that the financial challenges across health and social care provided a huge impetus and opportunity for joined-up working - something which he considered should have begun on a greater scale many years ago. The Cabinet Member fully agreed that the amount of joined-up working had to increase but considered that being faced with budget cuts at the same time meant that the required remodelling work was that much more challenging. Nonetheless, she pointed out that the health service already commissioned all the mental health services across the City (Council funds were transferred) and that this was having a beneficial impact.

l) In relation to paid carers, the Service Director considered that recruitment and retention issues would be easier if they received a 'living wage' and the posts were made more attractive relative to other similarly paid occupations. However, he stressed that he in no way condoned any poor practice.

m) Members were informed that a further Eyes and Ears campaign was likely to commence in March 2016.

n) A Member queried why a few years ago the prevalence of tuberculosis had increased in the City and whether it was now under control. The Chair informed the meeting that arrangements would be made for the Committee to be provided with an update.

o) The Cabinet Member advised members that the introduction of payment cards / reducing bureaucracy, setting-up a team of specialist social workers to carry out assessments and ensuring that there were clear pathways to services were amongst measures being taken to encourage service users to opt for direct payments (only about 1,000 of the 7,000 approx. individuals who were eligible had done so) and take ownership of their care. However, she underlined that the Council could not compel individuals to do so.

The Chair thanked the Cabinet Member for attending and reporting to the meeting.

"HOW ARE WE DOING?" – LOCAL PERFORMANCE ACCOUNT 2014/15

286 The following information briefing and accompanying Local Performance Account (LPA) were received:-

(See document Nos. 2 and 3)

Alan Lotinga, Service Director, Health and Wellbeing introduced the information contained in the papers.

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

a) Further to Appendix 1 appended to the LPA, the Service Director undertook to provide details of the comparator group changes that had been made in 2014/15.
b) In concurring that the high level indicators told a mixed story in terms of satisfaction with care and support services, the Service Director indicated that he felt that the best way forward with a view to making service improvements was to examine anonymised individual cases with colleagues from the Citizen-led Quality Boards. In relation to adult safeguarding, he also referred to the importance of listening to those people who had been through the process. He felt that the overall statistics were helpful but to some extent only an avenue through which to ask further questions and focus on issues in more the detail.
c) The Service Director advised the meeting that figures suggested that about 25 percent of the people aged 65 and over that entered hospital did not need to do so. Furthermore, he considered that more could still be done (e.g. falls prevention work, better nutrition) to prevent older people from requiring hospital care and indicated that there were to plans to do so. He highlighted that a crucial part of the Better Care Fund (BCF) was to reduce non-elective (unplanned) hospital admissions, particularly of older people.
d) Members were advised that the number of delayed transfers of care attributable to social care were around half of what they were at the end of the 2014/15 financial year. He reported that there had been huge success working with the University Hospitals Birmingham NHS Foundation Trust in carrying out joint assessments and highlighted that this was currently being rolled out to other hospitals.
e) The Committee was informed that lessons learned from the shortcomings in respect of the Community Navigator Service project were being taken on board as part of the BCF work and that the aim was that Health and Wellbeing Coordinators would be available city-wide. He highlighted that what he and colleagues were told, and the evidence suggested, was that service users needed someone to help them and which they could trust in navigating what was to many a daunting health and social care system.
f) In relation to seeking to reduce hospital admissions, a Member stressed the importance of simple measures e.g. individuals wearing good footwear and taking regular exercise to improve their balance.

g) The Service Director concurred with comments made that improving communication between professionals across health and social care was an especially important factor in seeking to reduce hospital admissions and the number of delayed transfers of care. Furthermore, he stressed the need for common language / terminology to be used. In relation to social workers, community matrons etc clustering around different GP practices the Service Director indicated that he would favour one model of operation. He also highlighted the need for there to be information (e.g. a resource directory) on what support and facilities were available locally for service users.
h) Members were advised that bringing together of children's social workers, adults' social workers and family support workers to support young people with disabilities was well advanced and that a joint team had been established. He indicated that the ambition was to extend below the current 14-25 years age range.
i) The Committee was informed that increasing the percentage of safeguarding files rated as good during audits was a top priority and had been included in the Council Plan / high level targets. In addition, he highlighted that improvement had been made in the current financial year. At this juncture, he also referred to a national Making Safeguarding Personal initiative aimed at involving those who'd been through the safeguarding process in the shaping of services.
j) A Member questioned how much the data on levels of satisfaction with services reflected the Council's performance as against that of other care providers. He considered that service users did not on the whole differentiate between the two and that the current indicator was not therefore helpful. He therefore suggested that a whole service experience indicator be set in conjunction with partners. The Service Director undertook to give consideration to the issue raised.
k) In referring to published website information, the Chair queried to what extent service users views contributed to the care home providers quality ratings scores. The Service Director indicated that he did not have this information with him at the meeting. However, he highlighted that a Patient Experience Platform ("Widget") was being developed by Healthwatch Birmingham for use by health and social care providers which would provide people who used services with the opportunity to provide feedback.

The Service Director and adult social care staff were thanked for all their work and achievements particularly given the severe budget cuts being faced.

2015/16 WORK PROGRAMME

The following Work Programme was submitted:-

(See document No. 4)

The Chair referred to various visits that were being organised and informed Members that they would receive e-mails on the arrangements. Further to Minute No. 285 he also highlighted that the need for an update on tuberculosis would be added to the Work Programme.

At this juncture, a Member referred to a contract award for the School Health Advisory Service scheduled to be considered by Cabinet on 26 January 2016 and asked if Members could receive a report on the outcome and arrangements

that were being put in place, perhaps at the Committee's next available meeting after that date. The Chair indicated that this would be looked into with a view to the matter being brought to Committee at some point in the New Year.

287 **RESOLVED**:-

That the Work Programme be noted.

AUTHORITY TO CHAIR AND OFFICERS

288 **RESOLVED**:-

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

The Chair wished everyone a Merry Christmas and Happy New Year.

The meeting ended at 1133 hours.

……..…….
CHAIRPERSON

Report of:	Brian Carr, Chair, and Candy Perry, CEO, Healthwatch Birmingham
To:	Health and Social Care Overview and Scrutiny Committee
Date:	January 2016

1.0 Purpose of the report

To update the Health and Social Care Overview and Scrutiny Committee on the implementation of Healthwatch Birmingham's new strategic approach including adoption and utilisation of Quality Standards for Local Healthwatch produced by Healthwatch England.

2.0 Strategic approach and implementation.

Healthwatch Birmingham is implementing a new strategic approach to use its statutory functions to help reduce avoidable health inequity across the City. It is a whole systems approach with two distinct parts to it:

1. Identifying inherent, avoidable health inequity in current services by seeking out and listening to the experiences of patients and the public accessing or trying to access health and social care services.
2. Preventing avoidable health inequity being built into services by taking action to ensure effective involvement of relevant patients and publics in commissioning, service design and redesign.

This approach is based on and underpinned by a robust logic model, theory of change and strategic change process which has included input and contribution from more than 30 health and social care commissioning, providing or policy-leading organisations locally and nationally, as well as volunteers and lay members of these organisations. As an approach it is attracting interest from Commissioners of Local Healthwatch in other parts of the country, and Healthwatch Birmingham has been asked by Healthwatch England to present it as a model at Healthwatch England's 2016 Conference in June.

2.1 Progress against part 1

This part of the Healthwatch Birmingham strategy is to identify inherent, avoidable health inequity in current services in three ways.

2.1.1 The first way, which is already up, running and working well, uses our consumer champion position through which national and local organisations are signposting members of the public to our Enquiry Line. Callers to our Enquiry Line most commonly are those who have tried to navigate the local health and social care system and failed. This means many calls are related to safeguarding, clinical quality, and complaints and these callers are signposted, or referred to the most appropriate national or local organisation depending on the nature of the call. Just as many are people needing help navigating the system and requiring advocacy support, and as many again are wanting to share their experience so that what happened to them can be used to try and make sure it doesn't happen to or for others.

All callers are logged and followed up to ensure they have received appropriate service from the organisation we have referred them to. This audit of our referrals is proving a useful way to accumulate data indicating gaps, bottlenecks and delays in the provision of services including advocacy services. The next development will be to grow our team of specialist volunteers to run this service before relaunching the Enquiry Line across the City.

2.1.2 The second way which is also already up and running and working well is the digital collection of patient and public experience feedback through our bespoke Feedback Centre platform which acts a little like Trip Advisor and incorporates CQC-type ratings as well as the Friends and Family Test questions. This is qualitative data and it is triangulated with qualitative information from our Enquiry Line as well as that found

on public social media platforms as well as with quantitative data from, for example, national observatory data sets. Analysis of this data is enabling us to identify themes which may warrant further investigation. For example at the end of last year we identified a theme indicating potential health inequity amongst young people accessing primary care. This caused us to survey nearly 400 young people during November using a validated questionnaire. This piece of work is expected to report towards the end of January and if appropriate raised for action with appropriate partners.

The next development in this area of Healthwatch Birmingham's identification of inherent health inequity is to relaunch a version of the Feedback Centre for use by health and or social care providers. City-wide adoption of 'the Widget' will enable Healthwatch Birmingham to more effectively take a whole systems approach to the gathering of feedback; enable all CQC-registered organisations to fulfil their statutory responsibilities to collecting patient experience; and offer people in Birmingham to give feedback to an independent organisation. Healthwatch Birmingham is a statutory member of the Health and Wellbeing Board whom it is hoped will endorse adoption of the widget and strongly urge all CQC-registered organisations to adopt it.

2.1.3 The third part of our identification of potential health inequity identification builds from our strong track record in community development although a more strategic approach is being developed. The processes underpinning this work are being developed and were greatly informed by the young people's survey mentioned in 2.1.2. Moving forward our community listening will be both purposely attached to a specific investigation and enabling generic listening through publicised presence in all districts.

2.2 Progress against part 2

This part of our strategy aims to prevent avoidable health inequity being built into services by taking action to ensure effective involvement of relevant patients and publics in commissioning, service design and redesign.

It is the result of a whole systems analysis initiated last year which included a large group intervention to uncover factors constraining effective patient and public involvement. A report on the findings of this work was published in October and has since been welcomed by a number of organisations and Boards including the West Midlands Quality Surveillance Group. The report can be found here: http://cdn.healthwatchbirmingham.co.uk/wp-content/uploads/2015/11/Whats-constraining-effective-patient-and-public-involvement-report.pdf

Consequent to this work Healthwatch Birmingham has lead work to map implications and impact of ineffective PPI and the link to avoidable health inequity, and is leading work with partners to develop a quality standard for effective patient and public involvement at three levels: Governance, including scrutiny committees; ongoing service improvement of existing services; and service redesign. The intention is the Quality Standard will be used in two ways: Firstly by organisations with legal responsibilities and or policy ambition to put patients and the public at the heart of health and social care services. Secondly by Healthwatch Birmingham as an audit tool as part of a programme of work to demonstrate the benefits of good involvement as well as areas for improvement.

Logic modelling which will underpin development of the quality standard is nearly complete. The next step will be development and piloting of the tool. A training support tool is anticipated to be part of the final piece.

3.0 Quality Standards

The establishment of robust quality standards for Local Healthwatch has moved forward apace over the last six months. This work is being led by Healthwatch England supported by Leeds Beckett University.

These quality standards revolve around 5 quality statements each defined by several quality indicators. The statements are:

1. Strategic context and relationships
2. Community Voice and Influence
3. Making a difference locally
4. Informing people
5. Relationship with Healthwatch England.

An example of the associated indicators are:

Making a difference locally:

- Is capturing the experience and aspirations of local people in its investigations and reports.
- Investigates issues in a way which is appropriate and ethical.
- Investigates, where appropriate producing recommendations for change that are heard and responded to by relevant decision makers.

The Quality Standards in their entirety can be found here:
http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/draft_quality_statements.pdf

Healthwatch Birmingham's strategy has been deliberately designed against the quality statements. We have worked closely with our BCC commissioner to ensure they dovetail with our contract performance management and meet regularly with them. We have met with the Chief Officers of all three CCGs and received assurance from them regarding their confidence in our approach.

Healthwatch Birmingham is imminently involved in pilot peer review of the standards potentially paired with Healthwatch Liverpool. This peer review is intended to test the effectiveness of the quality statements and we have volunteered to be part of the pilot which uses a framework of questions.

A final note on quality relates to Local Healthwatch Governance and in particular to a self-assessment toolkit for Local Healthwatch and Local Healthwatch Commissioners produced by the Local Government Association and published in July 2015. This also employs a question framework based around the following themes:

1. Clarity of purpose and priorities
2. Clarity of roles, responsibilities and accountabilities
3. Clear, effective and transparent decision making processes
4. Effective strategic relationships
5. Robust performance management and financial governance.

Healthwatch Birmingham's strategy was deliberately designed against this toolkit which is also being used centrally to guide the induction of new Board Members. The toolkit can be found here:
http://www.local.gov.uk/documents/10180/6869714/L15-261+Healthwatch+Governance+Toolkit-WEB.pdf

Report of:	**Kalvinder Kohli , Head of Service – Prevention and Complex, Commissioning Centre of Excellence, People Directorate**
To:	**Health and Social Care Overview and Scrutiny Committee**
Date:	**19th January 2016**
Title	**Adults with Learning Disabilities – Housing and Employment Support**

1.0 Purpose of the Report

To provide information to Health and Social Care Overview and Scrutiny Committee Members on the current position relating to support to adults with learning disabilities, with particular reference to housing and employment.

2.0 Housing

For some time, the direction of local and national policy for people with learning disabilities has been to enable individuals to live as independently as possible rather than in institutional care.

With advances in health care, people with a learning disability are living longer and want to access the full range of housing options, the same as any other older person. Some may be looking to stay in their own home with the help of adaptations, support and assistive technology. Some may want to access extra care housing, and others may be taking the opportunity to have more independence in where they live.

There is a range of support and housing provisions within Birmingham which offer people with learning disabilities the opportunity to live more independently within their communities.

3.0 Housing Support (Supporting People Programme)

The aim of housing support services is to enable vulnerable people to live independently within their communities. The preventative role of housing support is therefore described within this context:

1. Support to transition from residential or institutional care settings into more independent forms of living across a range of tenure.
2. Support to live independently by preventing the escalation of need into statutory responses.
3. Support to live meaningful and fulfilling lives which includes access to wellbeing and leisure services and also to employment, training and volunteering activities.

The current annual spend in 2015/16 for learning disabilities housing support services is £4,096,548. A further contribution of £150K is made to the in–house enablement service to develop independent living skills for citizens either exiting residential care or receiving a reduction in their packages of care.

On average, at any one time the existing arrangements support 756 citizens including 213 units of supported accommodation and support to people to live independently within the community. The current contracts are due to expire in March 2016.

The nature of the housing support is dependent on the needs of the individual and may include the following tenancy ready support:

1. Support to access social housing including assistance with bidding and tenancy sign-up.
2. Understanding on how to respond to communications (benefits, utilities, junk mail, landlord and tenant matters).
3. Budgeting and financial management support including support to set up payment plans.
4. Benefit entitlement and maximisation of income including support to complete benefit forms.
5. Health and safety within and outside of the home.
6. Support to maintain the home, including guidance and teaching relating to domestic skills including cleaning, operating electrical items safely.
7. Dealing with emergencies and unexpected events.
8. Health and wellbeing including healthy eating, engagement in health services, leisure services and social interaction.
9. Support to access employment, training and volunteering.
10. Staying safe, include recognising and reporting abuse.

The challenge facing the local authority is to seek solutions which deliver the right outcomes for people with learning disabilities at a lesser cost to the public purse. The allocated budget for 2016/17 will be £3,524,500.

An integrated commissioning approach has been adopted across the aligned prevention budget streams within the Commissioning Centre of Excellence for the People Directorate. This has enabled a pathway model to be co–designed with citizens, commissioners, service providers and relevant stakeholders for the disabilities client groups. The aim of the model is very much focused on resilience building for people with learning disabilities to be supported to do more for themselves and to move through, and exit the right services at the right time. The pathway requires service providers to work together to ensure the best use of resources available. The model places a particular emphasis on the better use of resources available within the universal space, in order to help to prevent crisis or higher cost interventions. At the same time the model would avoid overlap and duplication between organisations or commissioned services.

The pathway is outlined in **Appendix 1;** for some citizens the journey may be linear, for others they may access and exit at differing points. The intention is also not to create unnecessary demand or dependency on services.

In terms of housing support services, greater flexibility has been designed into the way that services can be delivered on the front-line where appropriate. Examples include use of group rather than one-to-one support for common activities such as budgeting and healthy eating. This means a lesser impact in terms of reductions in both services and a potential

slight increase in the numbers of citizens assisted to live independently within their own tenancies.

In real terms therefore, the new commissioning will provide 200 units of supported accommodation for people with learning disabilities, 13 less than the current arrangements; however, an overall increase in the total numbers of people, circa 860 – 1,100 supported to live independently within the community across a range of tenures.

Applications to social housing

In terms of housing allocations a provision is made within the new Allocation Scheme (due to be implemented later this year) for those ready to move on from Council Accredited Supported Accommodation Schemes Applicants, but who still need to be supported to live independently, to be awarded a Band 2 priority.

Applicants must be assessed as:

• in need of long term rather than short term on-going tenancy support

• ready to move to independent accommodation

• having a support package (if required) that has been assessed and is in place

• having a vulnerability whereby accommodation in the private rented sector would, through its short term nature, have a detrimental effect on their vulnerability.

There has also been a channel shift towards self - service for applications. In order to apply applicants must complete an on-line application form. The on-line form is intuitive and will feature helpful hints and FAQs. It is however recognised that some applicants particularly those with disabilities/vulnerabilities will require support in completing the application process, providing the necessary supporting documentation and navigating through the bidding process. This support can be requested by telephone, or through prior arrangements at designated offices.

The scheme has always identified the need for ongoing case management to support those in the most need to manage their application and to make appropriate bids for accommodation through the Choice-based letting system. The operational design for this is still being developed but will ensure that the most vulnerable are able to access support.

4. Birmingham City Council tenancy support

New Tenancy support

New tenancy data March 2014–2015 shows that of the 1297 tenancies let, 94 new tenants have indicated to the local authority that they have a learning disability. Clearly this data is not as accurate as we would like, given that there is no obligation to disclose this information.

Access to the service

The housing computer records system has person alerts set which enable staff and repair contractors, to respond appropriately to individual customer needs and requirements. At the point of service delivery, staff will be alerted to provide the service in the way that has been requested by the individual. Where required, staff will also engage carers and advocates when communicating with people having a learning disability.

For instance, during home visits, our housing officers will provide assistance with completing housing benefit and other application forms and documents to those tenants who have a specific need. Officers will take time to explain our policies clearly to tenants who may not readily understand them making use of appropriate language formats.

Letting support to new tenants

All new tenants are offered a 12 week support package to help them cope with the demands of managing their home. Working through a support plan they may be assisted with for example benefit applications, debt advice, furniture grants or other assistance, which will help them to live independently within their home and community. This includes support to access services provided by organisations that deliver support to people with learning disabilities.

Supporting tenancy sustainment

The housing teams are fully engaged in multi-agency approaches to enable tenancy sustainment by convening case conferences or actively referring any tenants needing support to other specialist agencies that may assist them, including Adults Social Care.

Neighbourhood Caretakers are on hand to give advice about reporting repairs or how to use waste disposal or recycling facilities on local estates. Their knowledge of tenants within their schemes gives them an awareness of any changing needs or vulnerabilities and will alert other housing colleagues to ensure any support needs are met.

The Anti-Social Behaviour teams take a ‘customer centred’ approach when dealing with reports of anti-social behaviour. Officers will recognise that a person having a disability is more likely to be a victim of anti-social behaviour. When complaints are received our ASB teams will provide support to victims through an agreed action plan. Where there may be a literacy difficulty in recording evidence for example, alternative means of doing so are discussed and agreed. This may involve the victim’s support worker recording the evidence or provision of Dictaphones where suitable. A ‘vulnerability matrix’ assessment tool has been introduced to help our anti-social behaviour teams to identify key risks. The principle underlying the matrix is that even if an incident is low key and not serious, the potential vulnerability of the victim is considered, which in turn may escalate the incident for priority action.

There is an expectation that tenants comply with their conditions of tenancy. If problems arise and legal action becomes necessary then checks are in place to ensure that the Council has accounted for any specific needs and addressed them before action is taken. Every effort is made to ensure that as far as we can be aware the tenant is capable of

understanding any action to be taken. If legal action is necessary then the Council will arrange a litigation friend to act on their behalf at a court hearing.

Making the best use of stock

The Place Directorate have worked in partnership with Birmingham Mencap for the last 10 years by leasing a sheltered scheme to help people with severe learning disabilities learn how to live and integrate into the community. We are currently in the process of extending the lease again for a further period of time.

5. Adult social care alternatives to residential accommodation

In his 2013 report 'Birmingham – a review of demand management in adult social care', Professor John Bolton highlighted a disproportionately high level of spend on residential care for people with learning disabilities relative to best practice around the country. It highlighted the challenge to the local authority to put in place support for people to achieve greater levels of independence and to reduce the numbers of people in residential care.

Birmingham is committed to offering individuals the greatest opportunity to achieve greater independence and live in the least restrictive form of accommodation. Where in the past we have become overly reliant on residential care, alternative models have emerged, including Supported Living (tenancy based accommodation with a bespoke care package built around the person) and Shared Lives (adult placements within family homes) and it is this type of accommodation Birmingham has sought to develop in recent years and continues to promote in its future market shaping activity.

Shared Lives – Birmingham has set ambitious targets to increase the number of Shared Lives placements to become 'best in class' when compared with other core metropolitan councils. Shared Lives (or adult placement as it is sometimes known) is a form of support where vulnerable adults/young people live at home with a specifically recruited and trained carer and their family. The service runs in a similar way to a Foster Placement, but this service is specifically designed for adults and young people. It is a nationally recognised model of care which delivers consistently high outcomes for service users. The Shared Lives model is based on the notion that an 'individual or family' is paid a modest amount to include the individual in their family and community life. This lends itself to the service user developing a number of close contacts within their local social community.

In 2015 Person Shaped Support, an external Shared Lives provider was commissioned alongside the Council's own service to recruit additional Shared Lives carers. The contract value for the 18 month pilot is £199,684. The provider has so far delivered on its initial 6 month goal to recruit 5 new carers. During the same period the Council's own Shared Lives service has increased the number of approved carers from 60 to 70 since April 2015.

Shared Lives Enablement Fund – Work is currently underway to establish an enablement fund for new Shared Lives carers who do not have the financial means to pay for adaptations to their properties in order to ensure that their property is suitable for the citizen moving in with them. The fund is proposed to be a total of £195,000 and to consist of £150,000 capital funding and £45,000 revenue funding. The fund is to run for three years and will be £50,000 capital funding per annum and £15,000 revenue funding per annum.

The adaptations may amount to several hundred pounds (for cosmetic changes) to several thousand pounds (where structural changes are required). This fund can also help and support new Shared Lives carers who wish to move out of small rented accommodation to a larger property in order to have a citizen placed with them. The fund can be utilised to pay for security deposits on the new rented accommodation or once again for any minor adaptations. We believe Birmingham is the first authority to set up this fund and shows the progressive nature to do things differently for the benefit of the Citizens.

Supported Living – Birmingham has set similarly ambitious 'best in class' targets in terms of Supported Living placements. In recent years Commissioners have made significant efforts to encourage the development of 'core and cluster' accommodation, where groups of independent flats are clustered around a care hub. This model enables efficiencies to be made in terms of the care and support delivered, while maintaining individualised approaches and ensuring that individuals and their staff teams are not isolated. Commissioners have worked to bring in new providers to Birmingham and also to encourage existing providers to consolidate disparately located accommodation into core and cluster schemes. As a result a number of small schemes have been developed across the City.

Autumn 2016 will see the completion of a large Supported Living scheme in East Birmingham, where Upward Housing and Care are developing The Bromford. This is intended to offer accommodation for in the region of 60 people in high specification flats, and will include a 'care hotel' for short breaks and respite care, an outward facing community hub and employment opportunities in retail units.

In late 2016 Lifeways will also complete their development in Bartley Green. This will comprise 32 independent flats for people with learning and physical disabilities and additional 9 bed specialist provision for people with complex autistic spectrum disorder related needs.

6. The Pathway towards Employment, Training and Volunteering

The current statistics available from the Foundation for People with Learning Disabilities clearly illustrate the gulf between the aspirations of people with learning disabilities who want to work and the numbers who actually obtain and sustain paid employment:

- Only 6.6% of adults with learning disabilities were reported to be in some form of paid employment. The majority of people with learning disabilities, who are in employment, work part–time.
- Men were more likely to be working 30+ hours per week than women (1.3% v 0.4%). Employment rates varied considerably across Local Authorities, ranging from 0-36%.
- It is estimated that 65% of people with learning disabilities would like a paid job.

(Source: Report - Valuing Employment Now 2010).

Current Diversity data available for 15483 Birmingham City Council Employees grades 1 to JNC level indicates that only 23 employees have identified that they have a learning disability.

Needs analysis

"Following a recent service redesign, the Council's Employment and Skills service has had to reconfigure its capacity around direct delivery of front line employment support services and is now working much more through a partnership and commissioning model. Within this approach the previous Disability Employment Solutions team function has been downscaled and subsumed within a streamlined Employment & Skills Service. The previous Work Choice sub-contract which the Council was directly delivering to adults with disabilities and learning difficulties has time-expired and the approach adopted is now to review all of the teams commissioned activities and generic recruitment campaigns to ensure that they offer accessible routes to employment for all vulnerable groups.

To that end the Employment and Skills service is currently working with colleagues from Public Health in the context of JSNA assessments to inform the Council's future strategy to engage with vulnerable groups. The strategic assessment will be supported by more detailed needs assessments, three of which have been prioritised for 2015/16, including the theme of employment and vulnerable people.

Work on the employment and mental health assessment has already started with the first set of findings due to be published by end of January 2016. Work on learning and physical and sensory disabilities client groups commences January 2016.

7. Preparation support

Supporting people with learning disabilities into employment is a long-term journey for all those involved. The commissioned housing support services provide the initial support to begin this journey. Furthermore, many of the commissioned organisations bring together their organisational resources, expertise and networks to provide holistic packages of support in order to achieve better outcomes relating to employment training and volunteering.

The pathway to support citizens into training and employment starts at the initial needs assessment stage as part of the life skills section of the assessment. The assessor identifies the training and education needs as well as support needs around getting into voluntary or paid work and subsequently this information is incorporated into the support planning process. Working with the customer, under the 'Enjoy and Achieve' and 'Achieve Economic Wellbeing' sections of the support plan the outcomes identified in the needs assessment are broken down into a series of achievable goals and the steps and support required to achieve these results are agreed with the citizen.

It is important to recognise that supporting a person with a learning disability to be work ready is only the first stage of a holistic approach to prepare the person to understand the principles of employment as well as developing their skills. In practice, people with learning

disabilities who need to get into training or work-like activities may not be ready due to a lack of confidence, issues with social skills and anxieties, lack of independent travel skills, or inertia brought about by having no meaningful activities throughout their adult life, amongst other things. The pathway into training and work-life activities is also supported by various internal activities, for example, social networking opportunities such as those offered by Trident Reach Reach2Friends, coffee mornings, arts and crafts, cycling club, the allotment project and Reach for the Stars which gives the citizens an opportunity to meet new people and participate in activities of interest, helping them to improve their social skills and functioning and building confidence. As citizens gain in confidence they have the opportunity to start participating in the planning, organising and facilitating of activities on a voluntary basis. As volunteers they are expected to adhere to particular codes of behaviour, communicate appropriately with peers and start to problem solve independently. These are further skills that will be applicable in work or training environments.

Most organisations also offer travel training to help citizens gain the confidence to get from place to place independently which is an identified support need for many individuals. In addition, some citizens may also be signposted for this training externally as they require more intensive training. There is also recognition that for some citizens who have not participated in any form of training for a very long time, going directly into college would prove daunting. Therefore in such cases, the citizen is encouraged to participate initially in the training programmes that are run internally by organisations. These are bite-sized sessions which cover areas such as cooking, self-care, health and safety and basic computers. Some internal courses are delivered in partnership with organisations such as People in Partnership around personal safety, rights and responsibility and safe relationships. Citizens have an opportunity to run and co-facilitate these sessions once they have completed them.

Practical support sessions include Birmingham Rathbone supporting citizens with job searches: how to write a curriculum vitae, support to complete job application forms, mock interviews, practice presentational skills and even be accompanied to job interviews. The organisation also train, coach and mentor citizens, sometimes through peer support of more experienced service users to develop skills, confidence and self-esteem to be able to get and keep a paid or voluntary position.

Those who have participated in internal organisational initiatives or those who do not need to utilise them are then signposted externally for either training or voluntary/paid work. Friendship Care and Housing successfully supported 50 people into voluntary work positions this year.

Most of the citizens require support around finding the courses that they are not only interested in but which are appropriate for their needs and capabilities. Staff provide support to citizens to contact and apply to the different training providers. In terms of work-like activities, organisations work in partnership with organisations such as Birmingham Voluntary Service Organisation, Disability Resources Centre, Jericho and BITA Pathways to identify and match citizens with the right voluntary work options. A flexible approach and matching individuals' personal interests with the volunteering opportunities has been found to be most effective in sustaining the placements. Even once the citizens are in training or

voluntary work the support workers continue to offer encouragement and support and liaise with the placements to minimise the risk of placement breakdown.

As part of the transitions support for young people, **Birmingham City Council** are currently working to provide 50 placements/taster days for young people aged 14-25 with Special Educational Needs/Disabilities between January and March 2016. This continues to build upon the number of placements provided by the local authority for students with Disabilities over the last few years.

(*This activity will be covered in a Report to the Education and Vulnerable Children's Overview and Scrutiny Committee on the 20th January 2016*).

The wider issue of relating to the need for much earlier preparation of children with Special Education Needs/Disabilities into the world of work sit outside of the remit of this report. However contributions to this report from members of the Health and Wellbeing Board point to the broader considerations of support to schools and academies from Birmingham City Council as a large employer and commissioner of works, services and infra -structure developments.

8. Support to maintain employment

Once an individual has found employment, to sustain their employment employers need to understand and recognise the requirements for supporting a person with a learning disability into employment. Employers need to adapt their approaches to look at the support and learning mechanisms they have in place to support individuals to sustain employment. A lack of support or understanding from the employers can result in a failed employment opportunity. Therefore, whether it be training, voluntary or paid work, providers acknowledge that there may be occasional breakdowns and working with the customers as a service provider to understand what worked/did not work in each situation ensures that these occurrences do not result in individuals giving up, but finding a better way to achieve their identified outcomes.

Supporting People commissioned providers have had notable successes with some citizens who have gone through the activities outlined: starting from the internal activities, external training, voluntary work and eventually paid work. The service delivery outcomes identified for housing support services for people with learning disabilities therefore includes access to employment training or volunteering.

The current housing support (Supporting People) commissioned services also includes the potential match funding opportunities from the **European Social Fund (ESF).** The aim of this funding is to support people the furthest away from the labour market into work opportunities.

The bid submission is being led by the Economy Directorate on behalf of Birmingham and Solihull to progress the first of these ESF opportunities through the Youth Employment Initiative for people aged 15 – 29 NEET). This funding is being made available for regions across Europe with high levels of youth unemployment. If successful the funding will support in the region of 16,000 young people into employment and training opportunities. The delivery model, works on two levels 1) Support to the individual to access and remain

engaged in employment and training activities 2) Support to the employer particularly where specific presenting vulnerabilities may require some focused intensive support input within the workplace. The proposed delivery model includes dedicated intervention workers to support young people with learning disabilities (and young people with mental health conditions).

9. Birmingham Business Charter for Social Responsibility (BBC4SR)

One of the key requirements of the BBC4SR focuses upon local employment. Organisations bidding for contracts with the local authority are specifically required to demonstrate how they will create local employment opportunities, including for those individuals that have disabilities or face challenges.

10. Case studies from Birmingham Rathbone

Rathbone work with clients and their employers to ensure that there is clarity about the role and relationships from the start and that support is available when problems occur. In the past year Rathbone have supported 18 people into paid or voluntary positions, and worked with 13 people and their employers to iron out workplace problems successfully; 21 people started their journey towards employment by accessing formal external training and a further 27 accessed the Rathbone in-house training programme.

For example, Rathbone helped a person with Downs Syndrome to obtain a job at a newly opened large supermarket in Birmingham, however, the individual got into disciplinary problems for breaking company policies. Rathbone worked with the employer and the individual and uncovered this was all about a lack of accessibility to the policies. She was not deliberately breaking the policies or trying to be insubordinate. Working with the employer to reproduce the policies which applied to the employee in an easy read format and explaining them and the reasons behind them in a way the client could understand resolved the problem.

Another person with Asperger's, working in a supermarket in the City was threatened with disciplinary action for not carrying out his tasks properly. His supervisor would tell him to do something but was dissatisfied with his performance. Rathbone worked with the individual and the employer to try to resolve the issue and maintain his employment. The problem was that the individual required literal instructions so telling him to go and clear up a particular room was too vague and resulted in the appearance that instructions were not being followed. However, by telling him specifically to empty any dregs from cups into the sink, empty the bins into a black plastic bag, reposition all the chairs at their respective tables etc. his performance improved and he completed all tasks satisfactorily. Again this was about appropriate communication for the person and clarity, but without our support he probably would have lost his job.

11. Case studies from Trident Reach

Trident Reach in the last four quarters has supported 84 people with learning disabilities into employment and training.

NH was initially referred to the service through social services. During his initial needs assessment it was identified that he was interested in working in the retail sector, however, having never worked before, he struggled with communicating with new people. With the support of his allocated worker NH started attending the gardening group with other customers in the service which is facilitated in conjunction with The Conservation Volunteers (TCV) charity once a week. This helped NH to learn to communicate and work with new people, develop positive working relationships with others and learn to follow through any new tasks. NH was also signposted to a life skills course with Midland Mencap which covered subjects such as health and safety, fire safety and keeping himself safe. NH successfully completed the course and is currently waiting to enrol at Fircroft College for some personal and social development courses, learning to 'improve assertiveness and decision making skills, 'understanding human behaviour in situations'. With support NH has been able to get voluntary work at a Scope Charity Shop as well as at PDSA. This is helping him to start gaining the practical skills in his area of interest which is retail. NH would like to eventually find paid work in retail and continues to work with his support worker to build up his skills towards this.

HM was initially referred to the service through the Police. HM's main support needs were to find appropriate accommodation and get into paid work. In terms of getting into work, HM did not understand what she needed to do in order to secure employment. HM was supported to enrol for an internal course around the use of computers. This covered basic subjects such as using email, Word and producing a CV. HM's interest was in getting into care work. Her support worker worked with HM to look at the different ways in which she could search for a job and supported her to write a CV and register with the Government's gateway job site as well as other job sites. HM managed to secure a part-time job with a domiciliary care agency. She was supported by her support worker to deal with DWP around her benefits due to the changes in her circumstances. This included filling in timesheets appropriately for the job centre due to working varying hours. This ensured that HM was paid ESA when she worked under 16 hours and continued to have an income. After 4 months HM lost her job due to redundancies; she was then supported to apply for Jobseekers Allowance and supported at a few meetings with job centre advisors. She was supported to request a disability advisor to support her with her specific needs and difficulties and who helped her to complete her job search evidence booklet each week to present to the Advisor on signing days. A few agencies have invited HM to attend interviews; however she has been unsuccessful on these occasions, although she felt the interview went well. HM has been advised to contact the companies for feedback. HM is being supported to look at tips and techniques for when she is invited to interviews. HM and her Support Worker have been researching questions and answers on a weekly basis which will possibly come up in interviews, this helps to reduce HM's anxieties about interview questions. HM has been supported to enrol into adult education to enable her to improve her functional skills in Math and English. She is currently attending a Level 2 in Creative Computing. HM is attending each week and building on her current knowledge around the internet, search engines, emails and typing letters in word document. HM is enjoying the course and feels that it is only a matter of time before she can get another paid job.

JA was supported by Trident Reach Learning Disabilities Floating Support Service for 11 months and is from North Birmingham. He had a job working for Valour in Birmingham for

25 years working in their warehouse loading and unloading gas and electric fires. Unfortunately JA was made redundant in May 2012 because of the recession. After leaving Valour JA looked after his elderly father until he passed away. JA has a learning disability and a diagnosis of borderline autistic spectrum disorder. Among his support needs were: sorting out benefits, securing his tenancy and dealing with repairs. However JA's priority was wanting assistance to get back into employment as he was finding it very frustrating trying to find a job and getting nowhere with his search. This was because JA described approaching various companies about employment but it appeared he lacked the communication skills to explain what he wanted to say and how to sell himself clearly to employers. In light of JA's difficulties obtaining employment JA's support worker supported him through being aware of difficulties he may face. It appeared JA may have faced discrimination by potential employers because of his learning disability and his poor verbal communication skills. Support and encouragement was provided, looking at his abilities rather than his disability, for example, it was evident JA had wide experience in his previous job of warehouse duties including cleaning and forklift truck driving; the challenge was to recognise these and then provide support to him to get across to training providers or employers what JA was capable of and successfully obtain a job offer.

Initially JA was supported through signposting him to training providers and employment organisations such as Lisieux Trust, a work training programme or the direct employment team who could help him find permanent employment. Support included advocating his needs and assisting with his communication skills when attending appointments or meetings, for example, the support worker assisted JA by arranging with him to be interviewed by a disability employment adviser at Erdington Job Centre. This led to JA being referred to The Work Right programme that could assist him with writing CVs, interview skills and communication skills. Also JA was assisted to obtain a copy of a reference letter from his previous employer that he could use to support job applications.

JA was supported to register with Pertemps and was offered a temporary warehouse position. Over the next 8 months JA worked for Pertemps at several Kuehne and Nagel Warehouses. JA talked about his experiences of getting back into employment, "at the one place I was just standing around labelling wine bottles but at the second place I found it a nicer environment and I got on with people. In January 2014 Pertemps phoned me up and offered me a permanent job at the second Kuehne and Nagel site". This was a really positive breakthrough because JA had demonstrated to Pertemps that he was able to really work hard, was punctual and never complained about the work. Reflecting on this result JA says "I feel great now and I've got a real sense of achievement that I managed to find a permanent job again."

12. Midland MENCAP Volunteering into Employment Programme

Until 2014 Midland Mencap ran the Volunteering into Employment programme using grant funding from both Birmingham City Council and the Department of Works and Pensions. There has been some very useful learning from this programme.

This was a pathway programme aimed at supporting individuals to develop a range of skills that could enhance their prospects of entering the workforce. The similarity of this model to the case studies above included working with employers from many sectors to develop volunteering opportunities for individuals that gave them experience & skills but also helped build a CV. This programme was hugely popular and successful, particularly in developing

long term volunteering placements. Over 200 individuals successfully went through that programme.

A small number, less than 10, gained paid employment but even that number was well above the national average in % terms.

The issue for programmes like this is more complicated than it first looks, however, in brief:

- At the point individuals entered the programme little or no previous investment/preparation in them had been offered to prepare them for the reality of work, paid or otherwise. So the majority of people with a learning disability, as individuals, are as distant from the labour market as it is possible to be.
- Considering all of these individuals have been to school we have to ask ourselves strategically what are schools doing to prepare people with a learning disability for a life of work? The answer is not very much. Education is a major part of changing this for people otherwise why bother going to school?
- The pathway to employment is most likely going to be through volunteering schemes or placement opportunities that give people a point of reference to work towards. Preparation for this can take time and typically on this programme it could take up to two years to support someone to be ready to try a work placement.
- Potential employers need a lot of support too, both in ensuring the correct support is available to both parties to make a success of the opportunity but importantly to ensure the workplace culture is supportive. Every employee has to buy into supporting a learning disability colleague in the workplace.
- The programme we ran had workplace mentoring that was for both worker & employer, it was probably the single most thing that glued people to their jobs.

Mencap have done a lot of work nationally in this area, the question to be answered is why should an organisation employ somebody with a learning disability?

- Best practice employers should recruit and retain a workforce that reflects the wider society.
- By employing people with a learning disability, and receiving support from organisations like Midland Mencap to make any necessary adjustments, businesses and organisations will become more disability confident.
- People with a learning disability can be extremely efficient employees and are competent in a range of quite complex procedures.
- People with a learning disability provide untapped talent suitable for hard-to-fill vacancies.

- Disability confident employers save the time and costs of having to rehire new staff in areas where they employ people with learning disabilities as people tend to stay in roles three times longer and take fewer sick days.

Considerations

Policy findings from the Valuing People Now (2010) reports make reference to the following recommendations;

* raising the expectations of people with disabilities, their families and professionals

* improving the transition from education to employment

* the inclusion in work of people with severe and/or complex learning disabilities

* quality standards for supported employment

* a framework for workforce qualifications

The link documents below provide further information.

Companies fear employing people with

Quarter of employers say staff not happy wo

Kalvinder Kohli - Head of Service - prevention and Complex,
Commissioning Centre of Excellence
People Directorate

Appendix A: Citizen Pathway

Integrated Commissioning Plan o

Contributions to this report have been received from:

Commissioning Centre of Excellence, People Directorate

Place Directorate

Economy Directorate

Trident Reach

Birmingham Rathbone

Midland MENCAP

Friendship Care and Housing

Health and Wellbeing Board

Birmingham City Council

Information briefing

Report from: **Strategic Director for People**

Report to: **Health and Social Care Overview and Scrutiny Committee**

Date: **19 January 2016**

Title: **Changes in Tobacco Smoking and Implications for Birmingham**

Summary

There have been major changes in cigarette usage over the past 5 years.
There is a need to respond to these shifts and potentiate the health improving effects.
The council has a much bigger role as a civic leader with regards to tobacco control.

Recommendations

To note this report

Background

Smoking tobacco has been shown to be extremely harmful to health for over 70 years though attempts to curtail tobacco smoking have been minimal until recently. Tobacco smoke causes many fatal illnesses such as lung cancer (causing over 90% of all such cancers), heart disease, stroke, upper gastro intestinal cancers and cancers of the mouth, lip and pharynx. These are all very common in Birmingham. In addition it is a major culprit in non-cancerous lung disease such as chronic bronchitis and emphysema, both of which are also major causes of ill-health in the city.

The commonest method of smoking tobacco is currently through cigarettes. The use of pipe-smoking and cigars have reduced dramatically over two decades. Tobacco contains nicotine which is addictive and has been likened to class A drugs in its addictive potency. However nicotine does not cause the major health harms described previously, it just causes people to be addicted to the tobacco product.

Making and selling tobacco products is extremely profitable. Evidence for this abounds – one of the highest ranked investment funds is CF Woodford Equity fund which has over 17% of its stock in tobacco companies, including Imperial Tobacco (7.54%) British American Tobacco (5.52%) and Reynolds American (3.96%) (figures from Hargreaves Lansdown). The West

Midlands Council Pension Fund also invests in like companies (about £53M, Birmingham Post). It is ironic that the CF Woodford fund holds nearly 30% of its stock in the pharmaceutical and biotechnology fields, where most of the business of these companies relate to treating tobacco related diseases.

Recent attempts to reduce tobacco smoking have had significant effects. These include increasing price (through taxation), setting up smoking cessation initiatives, legal moves concerning smoking in workplaces (bars etc.) and more recently smoking in cars in the presence of young people.

Tobacco smoking habits have changed since the last war and more dramatically in the last decade. We know that more women are smoking whereas previously it had been mainly men. Local school surveys results show the commencement of smoking is the same, if not greater in young girls. It is commoner in lower socio-economic classes' than higher groups.

But smoking tobacco is not just about physical ill-health; it's also about burning money as the average amount spent per week is between £20 to £25 or over £1000 per year. If two adults in a household smoke, that is over £2000 each year.

Detail

Most hard data on smoking comes from the national "Smoking Toolkit Study". The latest conclusions are:

- Cigarette smoking prevalence has declined by 0.8 % per year and is now 18.8%
- Take up of smoking has declined by 1.5 % per year
- Smoking prevalence remained higher in men, those with lower social grade and in younger smokers
- Daily cigarette consumption has declined by 0.3 cigarettes per day
- Exclusive use of hand-rolled cigarettes has increased by 2.9 % per year
- Average cost of smoking has increased by 49p per week per year
- The percentage of smokers trying to reduce the amount they smoke has declined from 2007
- Smokers trying to quit each year declined from 2007 to 2011 and then increased to 2014 but has declined again in 2015
- Use of most cessation aids declined but Champix increased to 2010 and then declined slightly while use of e-cigarettes increased markedly after 2011 and is now the biggest aide
- Smokers quitting abruptly and using Champix and e-cigarettes were more likely to achieve medium term smoking cessation than those using no aid. NRT on prescription also helped.
- Smokers using NRT bought over the counter were not more successful at quitting.
- The percentage of recent ex-smokers (<12 months) also using a nicotine product increased because of an increase in use of e-cigarettes that was larger than a decline in use of NRT

- The proportion of long term ex-smokers increased to 7% with similar proportions using NRT and an e-cigarette and did not change with age, social grade and gender
- Smoking cessation rates were lower in those with lower social grade but similar in men and women and in older vs younger smokers
- Fewer people were prompted to quit by their GP

Figure 1 shows the drop in national smoking prevalence over the past 8 years.

Figure 1 Cigarette smoking prevalence 2007-2015 in England

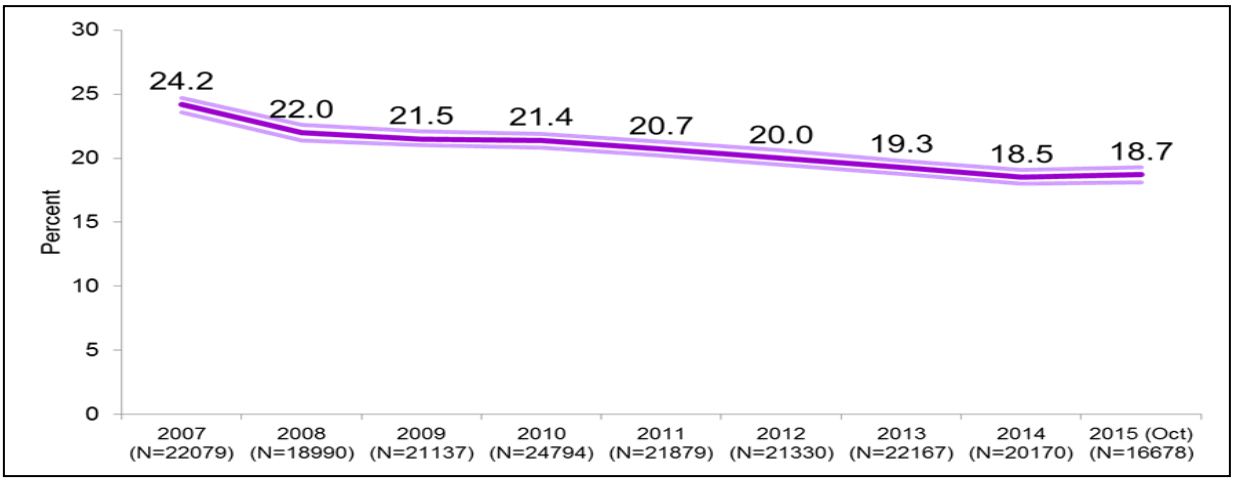
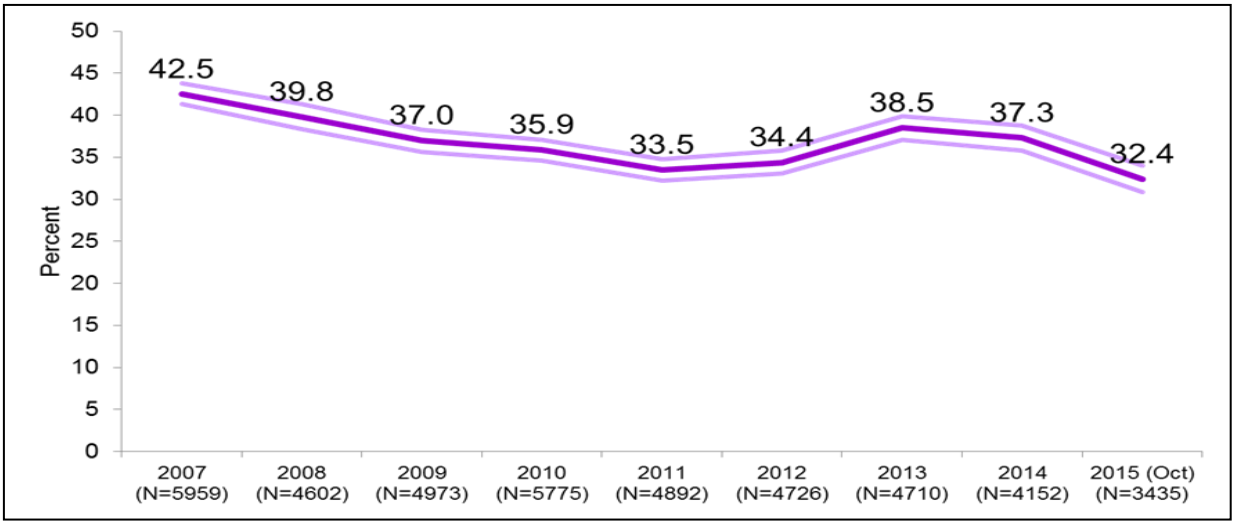
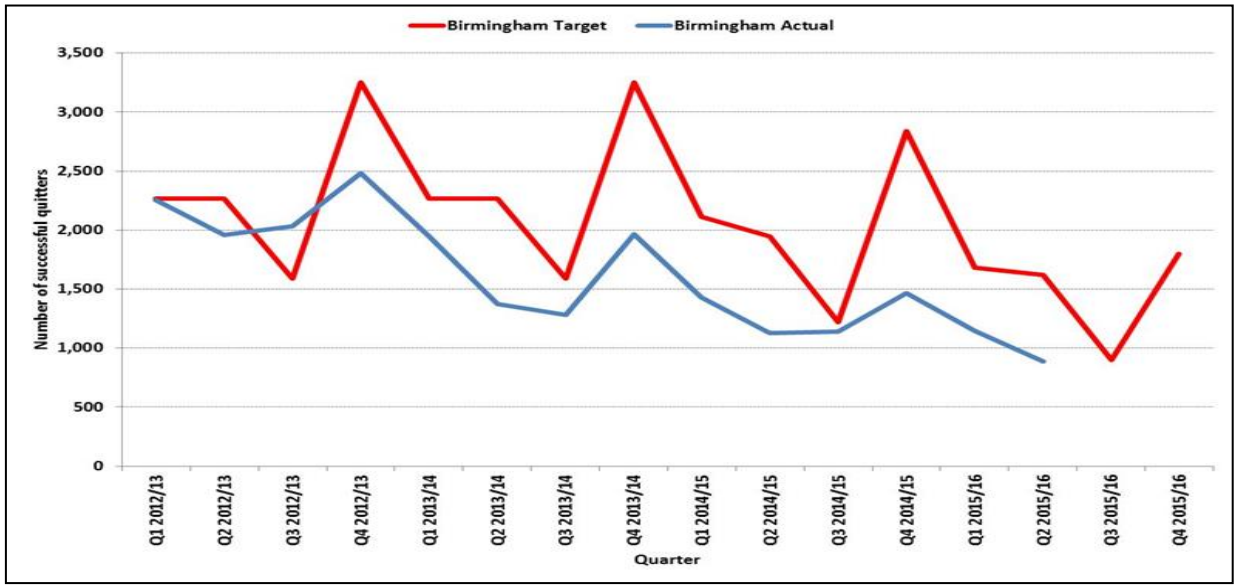


Figure 2 National data on people who have tried to stop smoking in past year



This reduction is replicated in the local data collected by the local "smoking quit" service (see Figure 3) which shows a near halving of quitters and especially a reduced proportion quitting in the New Year (or 4th quarter). It should be noted that a maximum of 15% of quitters occur through formal quit services, most happen spontaneously.



Discussion

Whilst large, welcome, changes have occurred in tobacco smoking in the last decade, much more is required to minimise both physical and financial harm to individuals. The power of large multi-nationals cannot be overstated. But there is no doubt that e-cigarettes have had great effects.

E-cigarettes do not contain tobacco smoke and are likely to be at least 20 times safer than cigarettes. Evidence suggests that they are a powerful tool in quitting. Finally they are a lot cheaper than tobacco. All these can combine to make them attractive to smokers and we know that at least 15% of smokers use them. Furthermore they are more attractive economically to large companies – they are cheaper to make etc.

There is no doubt that e-cigarettes are an important tactic in reducing the harm to individuals from tobacco. There is some evidence that their take-up is slowing.

National evidence shows that the number of people “triggered” into quitting because of their GP has fallen substantially since 2012 and may relate to the transfer to councils of this responsibility.

The recent focus on protecting children and young people from the effects of tobacco smoke in cars is welcomed. There is evidence that tobacco smoke has particular effects on the developing lungs of children. Furthermore it is well known that children are twice as likely to smoke themselves if their parents smoke. The council has been approached by a number of organisations in Birmingham to consider further steps to protect children from tobacco smoke. These include Birmingham Children’s Hospital as well as a number of primary schools. It is possible to enact local requirements under the “Localism Act” but these have to follow attempts to use voluntary codes. We are looking at these possibilities.

Controlling the use of tobacco is not just through restrictive legislation, taxation or quitting techniques. There is good evidence that positive role-modelling and strong civic leadership is vital. The council has an obvious part to play in this regard and it is sad that all too often the public sees smoking outside many of its high profile buildings such as Woodcock Street and Lancaster House. It is feasible to include smoking at work as part of the Business Charter.

The council also has a role in "demand management" of littering as cigarette stubs are one of the commonest forms of street rubbish. Fixed Penalty Notices will generate some income but will not reduce this problem and help make the streets cleaner..

Next Steps

The responsibility for smoking cessation and tobacco control passed to the City Council as part of the transfer of Public Health duties and powers from the NHS. We are currently reviewing the support offered in the city.

The evidence suggests that Birmingham City Council should:

- Consider focussing the "quit service" much more closely with GPs
- Look at ways to maximise the potential of e-cigarettes across the city and use them as part of helping smokers to quit
- Provide leadership to other organisations with respect to tobacco control in the workplace
- Consider how it works with organisations in the city who want to enact local tobacco control initiatives, perhaps supported by the "Localism Act"

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Birmingham City Council

Information briefing

Report from: **Strategic Director for People**

Report to: **Health and Social Care Overview and Scrutiny Committee**

Date: **19th January 2016**

Title: **Infant Mortality**

1 Background

The Birmingham Health and Wellbeing Strategy identified a key action to facilitate the outcome of improving Child Health was "to review the intelligence related to infant mortality". This report to the Health Overview and Scrutiny Committee outlines some of the current intelligence.

Previous reports presented to the Health and Wellbeing Board have shown that:

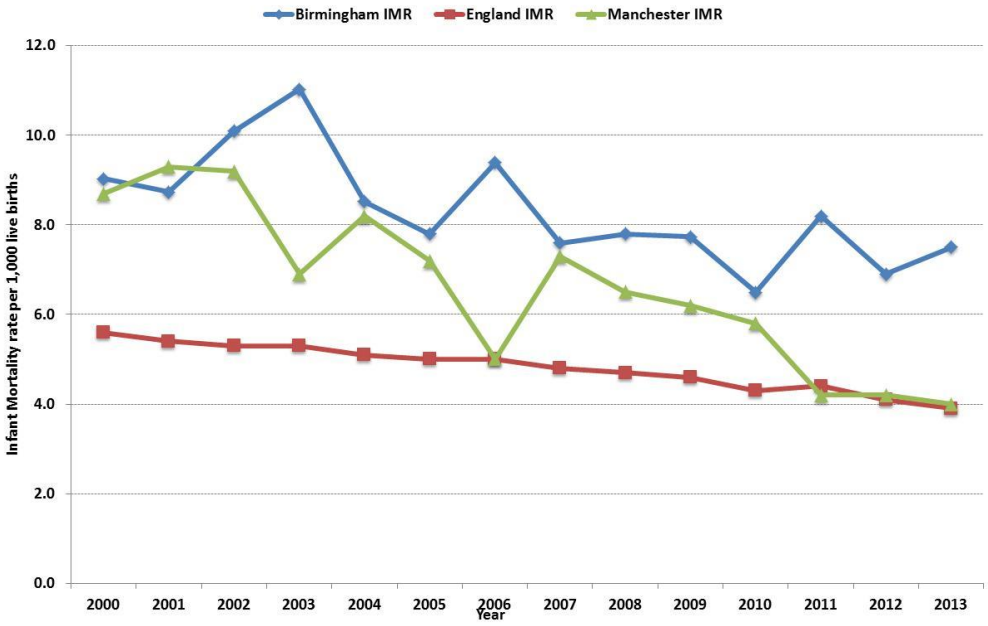
- Birmingham has one of the highest infant mortality rates in England
- Early neonatal deaths contribute most to the total infant mortality rates and early neonatal deaths account for most of the local variation
- Gestational age predicts survival and very few survive if born before 22 weeks
- Nearly a fifth of infant deaths in Birmingham occur in foetuses with a gestational age of 21 weeks or less
- Maternal ethnicity is not recorded in over a third of infant deaths
- Gestational age is not known in over 10% of infant deaths

2 Detail

Infant mortality is defined as deaths in children aged less than 12 months. It has long been accepted as one of the best indicators of the overall health of a nation. The rate in England has dropped dramatically over the last century and now the numbers of infant deaths are fortunately low. But each infant death is a tragic experience for every family.

Birmingham has one of the highest infant mortality rates in England and this is shown in Figure 1. Manchester is also shown as it has reduced significantly in the past 5 years. These facts have not changed since the last report. This has not significantly changed in 2014, if anything the gap with England is widening.

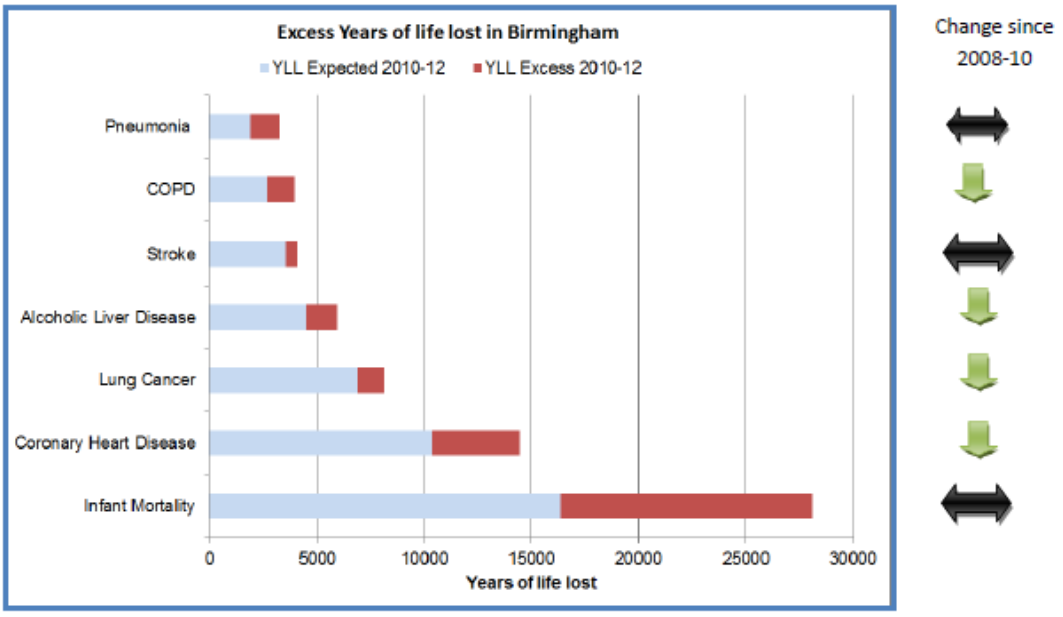
Figure 1 Trend in Infant Mortality Rates (IMR) between 2000 and 2013



Source: ONS

Infant mortality is a key driver of life expectancy as every early death has a dramatic effect on the calculation. It is most starkly seen in “years of lost life” where a death at aged one loses 74 years (with 75 years as the bench mark) whilst a death at 74 only loses one life year. Infant mortality is the top cause of our life expectancy gap. This is seen in Figure 2 which shows the key causes of the life expectancy gap with England.

Figure 2 Conditions in Birmingham Accounting for 70% of the Excess Years of Life Lost with England (2010-2012)



Source: ONS

Infant mortality is not only a significant outlier by itself in the NHS Outcome Frameworks; it causes adverse effects upon life expectancy in both the Public Health and NHS Outcomes Frameworks

This local information suggests that an extra 50 infants in Birmingham don't survive beyond 1 year compared to that expected from the national rate. This has not changed recently.

Whilst we are an outlier for Infant Mortality Rates (under 1), we are not for Child Mortality Rates which is defined as deaths in children aged 1-17 (Source CHIMAT – child health profiles). The underlying associations for deaths in infancy also affect deaths in childhood (deprivation etc.). The big discrepancy in the two rates cannot easily be explained.

3. Definitions

An understanding of the definitions is vital to comprehend some of the issues in Birmingham. These have been defined in legislation and reported by the Office for National Statistics (ONS). These are shown below:

Miscarriage - born before 24 weeks completed gestation and which did not, at any time, breathe or show signs of life
Stillbirth – born after 24 or more weeks completed gestation and which did not, at any time, breathe or show signs of life
Early neonatal deaths – deaths under 7 days
Late neonatal deaths – deaths between 7 and 28 days
Post neonatal deaths – deaths between 28 days and 1 year

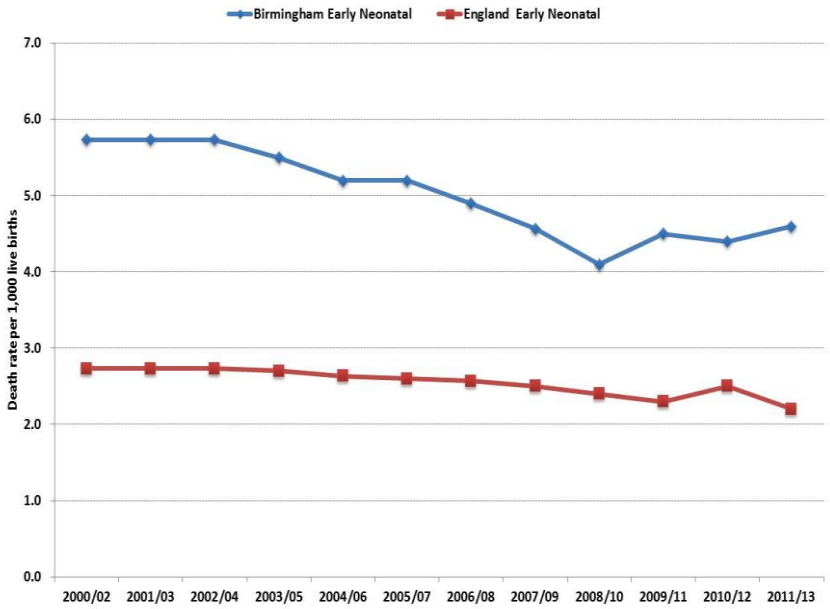
Neonatal mortality rates include all deaths between 0 - 28 days (both early and late neonatal deaths) with all live births being the denominator. Infant deaths are defined as all deaths under 1 year of age and include neonatal and post-neonatal deaths.

Perinatal mortality relates to all stillbirths and early neonatal deaths and if described as a rate, uses all stillbirths and live births as a denominator.

4 Trend analysis

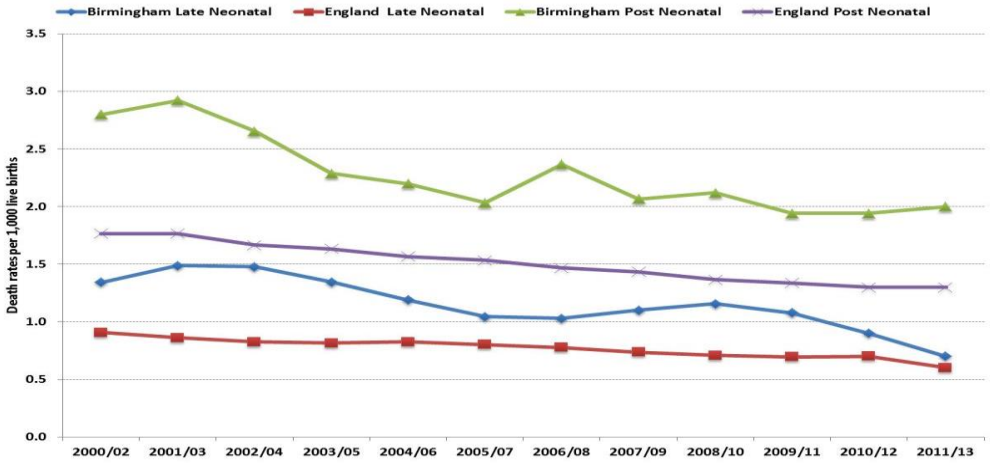
Infant mortality rates can be broken down to look at early and late and post neonatal periods.
The updated trends in Birmingham are shown in Figure 3 and Figure 4

Figure 3 Three Year Rolling Early Neonatal Death Rates (2000/2 – 2011/13)



Source: ONS Deaths/Births

Figure 4 Three Year Rolling Late and Post Neonatal Death Rates (2000/2 – 2011/13)

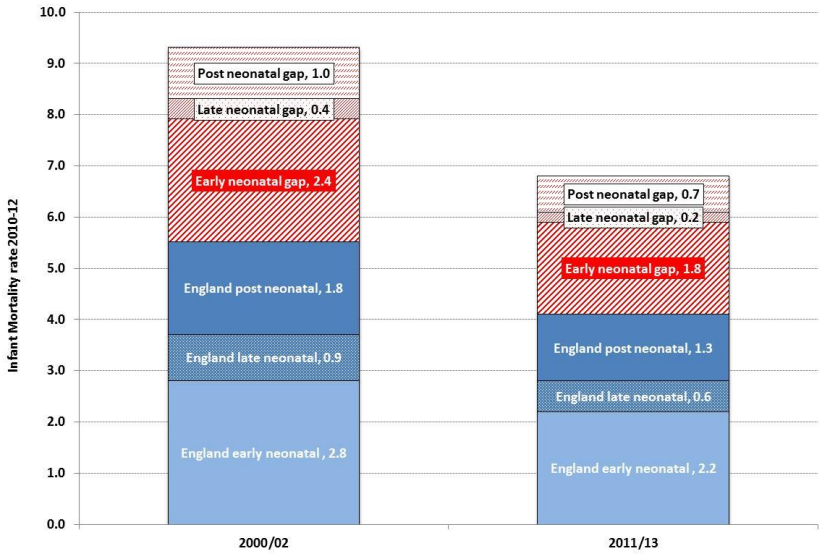


Early neonatal deaths contribute most to the total infant mortality rates and early neonatal deaths account for most of our local variation. The gap with England has not closed. We still have 75% more early neonatal deaths than the national average.

This is shown more clearly in Figure 5. It shows the excess in Birmingham for the three main periods in infancy compared to the national average and the change over the past decade. Birmingham has closed some of the gap with England but the biggest excess, both numerically and proportionally is in the early neonatal period.

The excess of deaths in this early period accounts for 70% of the total gap with the national average. The increases seen in the other two categories are small, even the increase in the post neonatal period only accounts for a fifth of the overall excess compared to England.

Figure 5 English Infant Mortality and the Birmingham Excess by Neonatal Time Period, 2000/2 and 2011/13

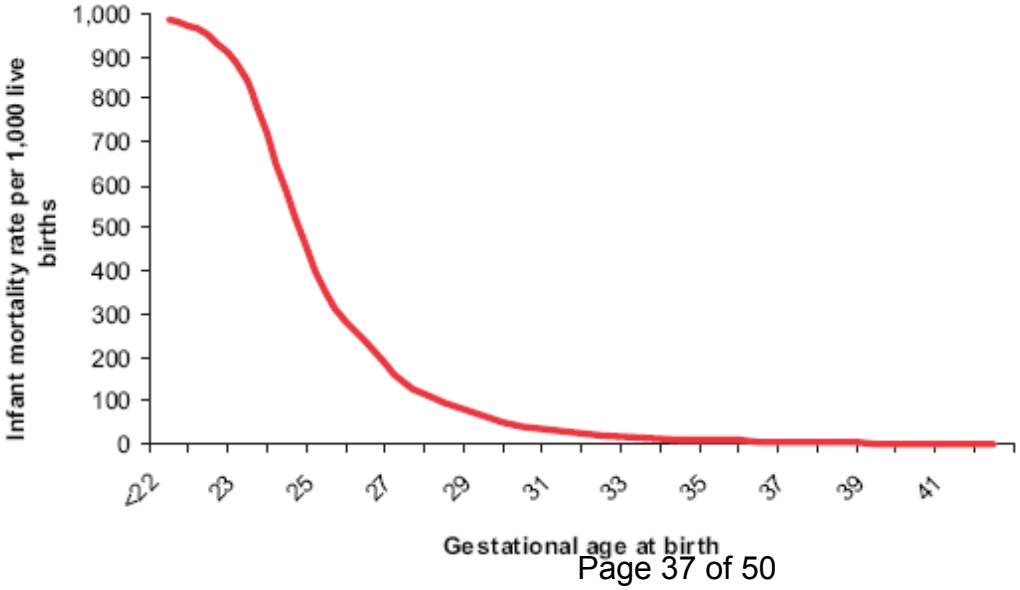


5 Gestation at Birth

A pregnancy which lasts the full 40 week term results in optimal growth and development. The gestational age at birth is the biggest influence on survival. Babies with a very low gestational age are much more likely to die of immaturity; whilst more mature babies are more likely to die from other causes especially congenital causes. There is now considerable research in this field, both in this country and internationally.

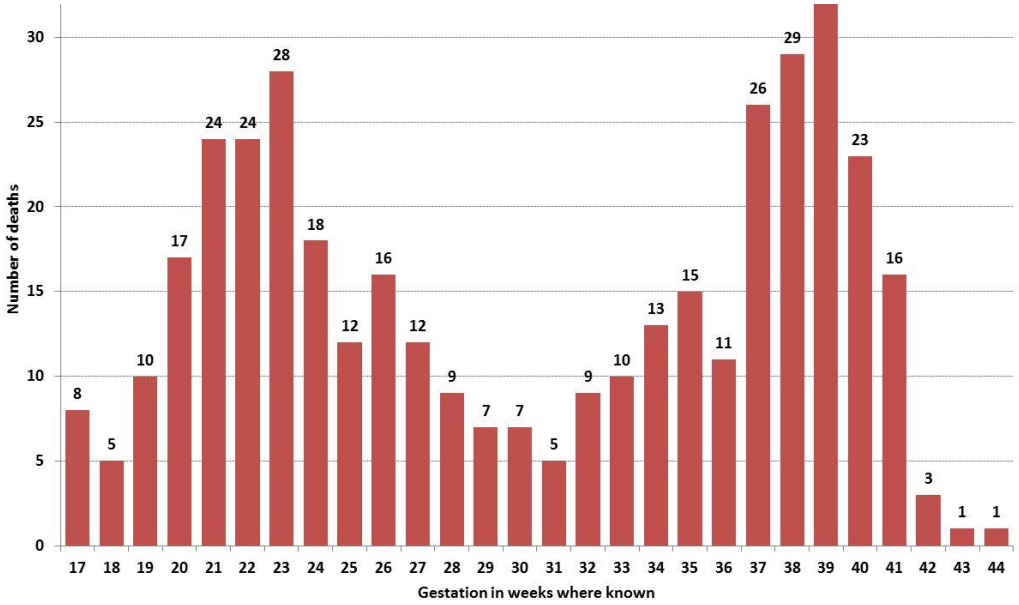
The National Perinatal Epidemiology Unit based in Oxford is an authority in this area. It has shown that there is a real increased risk of infant death with decreased gestational age. This is shown using national data in Figure 6. This has been mirrored by other centres outside England. This research indicates that very few of those born at less than 22 weeks gestation survive. This position has not changed in the intervening 10 years despite advances in medical technology.

Figure 6 Infant Mortality Rate by Gestational Age for England and Wales, 2005



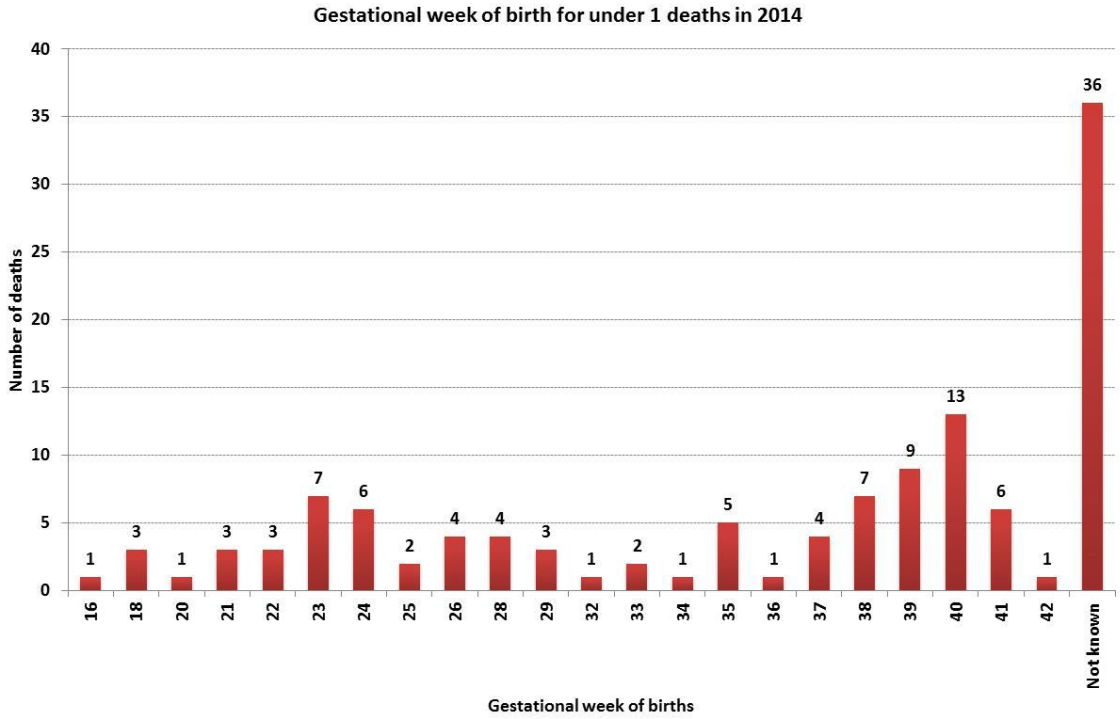
Statistics relating to gestational age stopped routinely being reported nationally over 8 years ago. Thus there is less certain local intelligence on this important parameter. We have used hospital data to look at the local picture. It is unfortunate that a considerable minority (at least 25%) of births have no gestational data. Figure 7 shows the local picture over the past 4 years.

Figure 7 Deaths by Gestation at Birth (April 2009 to December2013)



Whilst the numbers are smaller, Figure 8 shows the picture for 2014. They have some similarities, especially in the number of deaths coded where the gestational age is under 22 weeks and even at 17 weeks – when there is no international evidence for survival.

Figure 8 Gestational Age at Birth of Infant Deaths in 2014



Source: ONS Deaths/Birth & SUS

The other feature of note is that nearly 50% have no coded gestational age. We have good evidence that most of these births die within 24 hours and are very likely to be early gestational ages.

Thus approximately a fifth of all infant deaths in Birmingham (where the gestational age is known) occur in foetuses where the best evidence has shown that the chance of survival is negligible. This has not recently altered.

This would account for at least a fifth of our overall infant mortality rate or approximately a third of our excess.

The definitions related to infant mortality have been stated. There is individual interpretation of "shows signs of life". The professional body for Obstetricians has guidance on this as well as death certification (a duty of either a doctor or the coroner). These facts would suggest that there is a need for more consistent local interpretation which is in line with national and international practices.

A useful development would be an audit of a sample of deaths with a gestational age under 22 weeks. This is being proposed in the Staffordshire/Shropshire/Black Country Maternity Network.

Inclusion of foetuses under 22 weeks severely hampers our analysis of the causation of avoidable infant deaths in the City. A consistent approach to these unfortunate events is urgently needed.

5 Ethnicity

Unfortunately ethnicity is not recorded on death certificates. However it is possible to match maternal data with infant data and this is now published at a national level. Thus ethnicity is usually of the mother, and not necessarily the infant. Table 1 shows that there is variation in infant mortality by maternal ethnicity. It should be noted that there is an increased infant mortality rate in all ethnic groups in Birmingham compared to that seen in England and that the greatest difference is in the White group.

Table 1 Infant Mortality by Maternal Ethnicity (per 1000 live births

Ethnicity	Birmingham 2012	England (2010)
White	5.3	3.6
Asian	4.4	7.0
Black	7.1	6.7
Other	4.3	4.4
Not Stated	7.9	4.3
All	6.9	4.1

Source: ONS Deaths & SUS

The technique has been replicated locally although there are a number of data constraints. Small numbers are excluded from the published information and are shown in Table 2.

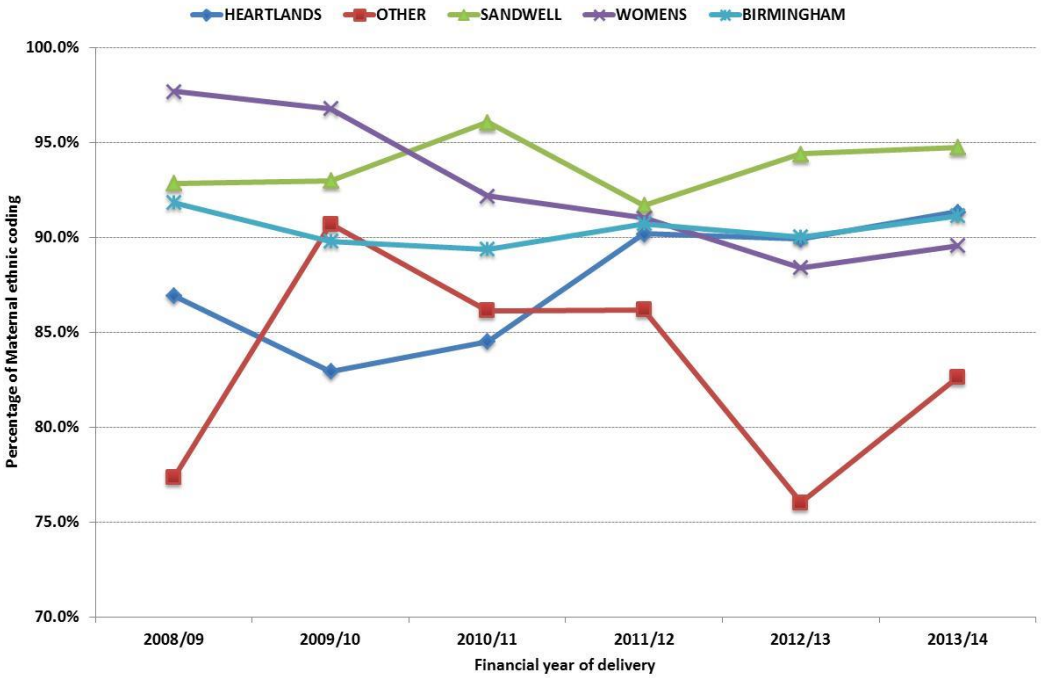
Table 2 Infant Deaths by Gestational Age and Maternal Ethnicity (April 2009–December 2013)

Ethnic breakdown	22 weeks and under	23 -29 weeks	30-34 weeks	35-39 weeks	40+ weeks	Gestation unknown	Total
White	32.5%	40.0%	21.4%	19.5%	32.6%	11.3%	22.2%
Mixed	5.0%	4.0%	0.0%	4.4%	9.3%	1.6%	3.4%
Asian	26.3%	24.0%	35.7%	39.8%	37.2%	17.8%	26.4%
Black	17.5%	5.0%	4.8%	11.5%	2.3%	4.9%	7.5%
Any other ethnic group	10.0%	1.0%	0.0%	2.7%	7.0%	4.0%	4.0%
Ethnic group not known	8.8%	26.0%	38.1%	22.1%	11.6%	60.3%	**36.5%**

The table shows that the number of infant deaths to White mothers is just over 22%, as opposed to over 26% for Asian mothers However the pattern is quite different with many more infant deaths to British women occurring under 29 weeks gestation whereas many more of the deaths to Asian mothers occurs between 30 and 39 weeks.

A major problem in this analysis is the poor coding of both ethnicity and gestation. This is seen in the table where maternal ethnicity is not recorded in over a third of infant deaths and gestation is not known in over 10% of infant deaths. This is a major obstacle in any further analysis or comparison with national data. Where national comparators of coding are available, the Birmingham picture is worse. Ethnic information is over 95% complete at a national level. Table 3 shows the variation in ethnicity coding at delivery by major provider in Birmingham.

Table 3 Data Completeness of Maternal Ethnicity at Delivery by Provider Unit



6 Summary

This report has shown the following:

1. Birmingham has one of the highest infant mortality rates in England
2. Early neonatal deaths contribute most to the total infant mortality rates and early neonatal deaths account for most of the local variation
3. Gestational age predicts survival and very few born at less than 22 weeks gestation survive
4. Nearly a fifth of infant deaths in Birmingham occur in foetuses with a gestational age of 21 weeks or less
5. Maternal ethnicity is not recorded in over a third of infant deaths
6. Gestational age is not known in over 10% of infant deaths and in 2014 nearly 30%
7 The inclusion of this group of “infant death” hampers meaningful analysis of the remainder of the deaths in infants under 1 year.

The following people have been involved in the preparation of this board paper:

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

Committee Members: Chair: Cllr Majid Mahmood

Cllr Mohammed Aikhlaq
Cllr Sue Anderson
Cllr Mick Brown
Cllr Maureen Cornish
Cllr Andrew Hardie
Cllr Mohammed Idrees
Cllr Karen McCarthy
Cllr Brett O'Reilly
Cllr Robert Pocock
Cllr Sharon Thompson
Cllr Margaret Waddington

Committee Support:

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

Schedule of Work

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

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

15 December 2015 10.00am	Cabinet Member – Health and Social Care Local Performance Account 2014-15 (Adult Social Care Services) including an update on the West Midlands Peer Review Action Plan.	Cllr Paulette Hamilton/ Suman McCartney, Cabinet Support Officer Alan Lotinga, Service Director, Health and Wellbeing David Waller, AD
19 January 2016 10.00am	Healthwatch Birmingham Update (Including implementation of new strategic approach and HWE Quality Standards) People with Learning Disabilities: Support with Employment and Housing Smoking Cessation including e-cigarettes Infant Mortality in Birmingham - Intelligence Update	Brian Carr, Acting Chair Healthwatch Birmingham Kalvinder Kohli, Service Lead Prevention & Complex, Commissioning Centre of Excellence Dr Adrian Phillips, Director of Public Health
23 February 2016 10.00am	Update on the Sexual Health Services in Birmingham and Solihull – Umbrella - 6 months into the new contract (TBC) CrossCity CCG Draft Operational Plan 2016/17 Prostate Cancer and Health Inequalities – Information Briefing	John Denley, Consultant, Public Health Les Williams, Director of Performance & Delivery, CrossCity CCG Mr. Richard Viney Consultant Urological Surgeon and Senior Lecturer in Urology, UHB
22 March 2016 10.00am	CrossCity CCG Primary Care Strategy Birmingham Community Healthcare NHS Trust - Update on new telephone triage system to access unscheduled dental care appointments at Birmingham Dental Hospital.	Karen Halliwell/ Lesley Evans, Interim Director of Primary Care & Integration, CrossCity CCG Carol Herity, Associate Director of Partnerships, B'Ham CrossCity CCG Andy Harrison, Chief Operating Officer Janet Clarke, Associate Director of the Birmingham Community Healthcare Trust Combined Community Dental Service

	Diabetes Prevention Enhanced Access to GPs	Dr Andrew Coward, Chair, NHS Birmingham South and Central CCG Dr Andrew Coward, Chair, NHS Birmingham South and Central CCG
26 April 2016 10.00am	West Midlands Ambulance Service NHS Foundation Trust • General Trust Overview • Operational/Clinical Performance Update for 2014/15 (including winter) • WMAS 5 Year Strategy and Initiatives • Demonstration of an Automated External Defibrillator	Diane Scott, Deputy CEO Nathan Hudson, General Manager Birmingham Division Mark Docherty, Director of Nursing, Quality and Clinical Commissioning
June 2016	Tracking of the 'Tackling Childhood Obesity in Birmingham' Inquiry 0-25 Community Mental Health Services Forward Thinking Birmingham – 6 months into the new contract (TBC) Tracking of the 'Mental Health: Working in Partnership with Criminal Justice Agencies' Inquiry	Dr Adrian Phillips, Director of Public Health/Charlene Mulhern/Dr Andrew Coward, Chair, B'ham South Central CCG Denise McLellan, Managing Director, Forward Thinking Birmingham Michael Kay/Louise Collett/ Suman McCartney
July 2016	Tracking of the 'Living Life to the Full with Dementia' Inquiry Tracking of the 'Homeless Health' Inquiry	Mary Latter, Joint Commissioning Manager Dementia/ Cllr Paulette Hamilton/Suman McCartney, Cabinet Support Officer John Hardy, Policy & Development Officer / Jim Crawshaw, Integrated Service Head Homeless & Pre-Tenancy Services
December 2016	15/16 Local Performance Account Report West Midlands Challenge of Birmingham Adult Care	Alan Lotinga, Service Director Health & Wellbeing Alan Lotinga, Service Director Health & Wellbeing

Items to be scheduled in Work Programme	
• Urgent Care Strategy (To be confirmed)	
• Mental Health Strategy (To be confirmed)	
• Congenital Heart Disease Review – outcome from consultation on standards and service specification and next steps	
• Tuberculosis Update	
• Move of Health Visitors to Local Authority	
Suggested items	**Link to Council Priority**

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

Joint Birmingham & Solihull Health Scrutiny Committee Work		
Members	Cllrs Majid Mahmood, Mohammed Idrees, Mick Brown, Robert Pocock, Andrew Hardie, Margaret Waddington, Sue Anderson	
Meeting Date	**Key Topics**	**Contacts**
21 July 2015 5.30pm in Birmingham	• Non-Emergency Patient Transport • HoEFT CQC Inspection Report	Carol Herity, CrossCity CCG Sam Foster, Chief Nurse, NoEFT
6 October 2015 4.30pm tea 5.00pm start in Solihull	• Non-Emergency Patient Transport – results of consultation and proposed model • HoEFT Surgery Reconfiguration Update – Site Plans for all 3 Trust Hospitals and update on CQC inspection issues. • CCGs on Surgery Reconfiguration public consultation	Carol Herity, CrossCity CCG Ruth Paulin, Lisa Thompson, Richard Steyn
10 February 2016 5.00pm in Birmingham	• HoEFT – o Report on the outcome of the Monitor financial investigation. • Non-Emergency Patient Transport (NEPT) Consultation o Further information around the feasibility of a fee paying service in the new contract	Dame Julie Moore, Interim Chief Executive, HoEFT, Rt Hon Jacqui Smith, Chair, HoEFT Les Williams, Director of Performance & Delivery, CrossCity CCG
April TBA	• Non-Emergency Patient Transport (NEPT) Consultation o Detailed Consultation Plan	Les Williams, Director of Performance & Delivery, CrossCity CCG Dr Peter Ingham, GP Contracting Lead, CrossCity CCG

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

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

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

Councillor Call for Action requests

Cabinet Forward Plan - Items in the Cabinet Forward Plan that may be of interest to the Committee

Item no.	Item Name	Portfolio	Proposed date
000298/2015	Public Health Grant Reduction	Health & Social Care	26 January 2016
000355/2015	Public Report - Purchase of a Home Support Visit Monitoring System Full Business Case and Contract Award	Health & Social Care	26 January 2016
000542/2015	Policy for the Use of Private Rented Sector to Meet Housing Needs	Health & Social Care	19 April 2016
000545/2015	Lifestyles Re-design Commissioning and Procurement Programme	Health & Social Care	08 December 2015
000582/2015	Independent Living Fund	Health & Social Care	19 October 2015
001045/2016	Extension of Community Equipment Service Contract (C0115) - Public	Health & Social Care	26 January 2016