BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD

TUESDAY, 19 FEBRUARY 2019 AT 15:00 HOURS
IN COMMITTEE ROOMS 3 & 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1 **NOTICE OF RECORDING/WEBCAST**

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

2 **APOLOGIES**

3 **DECLARATIONS OF INTERESTS**

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

4 **MINUTES AND MATTERS ARISING**

3 - 14

To confirm the Minutes of the last meeting.

5 **CHAIR'S UPDATE (1505 - 1515)**

To receive an oral update.

6 **HEALTH AND WELLBEING BOARD PRIORITIES: UPDATE ON CHILDHOOD OBESITY (1515 - 1530)**

15 - 24

Fiona Grant, Children, Young People and Families Public Health Lead and Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG will

present the item.

25 - 104

7 **CHILDREN AND YOUNG PEOPLE WITH SEND - JSNA UPDATE (1530 - 1540)**

Fiona Grant, Children, Young People and Families Public Health Lead will present the item.

105 - 116

8 **BETTER CARE FUND (BCF) GOVERNANCE AND APPROVAL FOR SCHEME OF DELEGATIONS (1540 - 1550)**

Michael Walsh, Service Lead – Commissioning will present the item.

9 **SUSTAINABLE TRANSFORMATIONAL PLAN UPDATE (1550 - 1600)**

Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG will present the item

117 - 136

10 **CQC LOCAL SYSTEM REVIEW ACTION PLAN: PROGRESS MONITORING BY CQC (1600 -1610)**

Professor Graeme Betts, Corporate Director of Adult Social Care and Health Directorate will present the item

137 - 150

11 **NHS LONG TERM PLAN: A SUMMARY (1610 - 1625)**

Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG will present the item

151 - 174

12 **ADULT SUBSTANCE MISUSE TREATMENT PROVISION (1625 - 1635)**

Max Vaughan, Behaviour Service Integration Manager, Adults Social Care & Health and Karl Beese, Commissioning Manager, Adults Social Care & Health will present the item

13 **OTHER URGENT BUSINESS**

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

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

To note that the next Birmingham Health and Wellbeing Board meeting will be held on Tuesday 19 March 2019, at 1500 hours in Committee Rooms 3&4, Council House, Victoria Square, Birmingham, B1 1BB.

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD TUESDAY, 29 JANUARY 2019

MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON TUESDAY 29 JANUARY 2019 AT 1500 HOURS IN SEMINAR ROOM, BSMHFT, UNIT 1, B1, 50 SUMMER HILL ROAD, LADYWOOD, BIRMINGHAM, B1 3RB

PRESENT: - Dr Peter Ingham in the Chair;
Councillor Kate Booth, Professor Graeme Betts (part), Paul Jennings, Dr Robin Miller, Becky Pollard and Sarah Sinclair.

ALSO PRESENT:-

Danielle Oum, Chair, Birmingham Healthwatch
Sean Russell, Director of Implementation for mental health, Wellbeing and Radical Prevention
Ralph Smith, Service Manager – Intelligence, Adults Social Care and Health
Dario Silvestro, Joint Commissioning Manager, Mental Health Joint Commissioning Team
Mike Walsh, Service Lead - Commissioning, Adult Social Care and Health
Andy Williams, Accountable Officer, Sandwell and West Birmingham CCG
Errol Wilson, Committee Services

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APOLOGIES

326 Apologies for absence were submitted on behalf of Councillors Matt Bennett and Paulette Hamilton, Andy Cave (but Danielle Oum as substitute), Andy Couldrick, Professor Nick Harding (but Andy Williams as substitute), Steve Harris, Richard Kirby, Chief Superintendent Danny Long, Peter Richmond, Antonina Robinson, MBE, Carly Jones and Stephen Raybould.

Apology for lateness was submitted on behalf of Professor Graeme Betts.

DECLARATIONS OF INTERESTS

327 Members were reminded that they must declare all relevant pecuniary interests and non-pecuniary interests relating to any items of business to be discussed at this meeting. If a pecuniary interest is declared a member must not speak or

take part in that agenda item. Any declarations will be recorded in the minutes of the meeting.

DR PETER INGRAM, HEALTH AND WELLBEING BOARD VICE-CHAIR CHAIRED THE MEETING

MINUTES AND MATTERS ARISING

In relation to matters arising from the Minutes, the following were amongst the matters raised: -

- In relation to Minute No. 318, **Action: What are the priorities you see for the JSNA? Members are asked to send thoughts about priorities for JSNA to Becky Pollard which she will bring back to the board for agreement in February.** Becky Pollard stated that she had not received from the members their thoughts about priorities for the JSNA. She had received some thoughts about the priorities but these were not specifically from the Board members. Engagement was needed with the members and that they could ring or email her.

- **Action: A request for the JSNA engagement plan was made by Dr Miller.**
  Becky Pollard advised that the JSNA engagement plan would be on the agenda for Monday's meeting and that they would come back with a more firmed up plan. Dr Miller stated that a time line would be helpful

- Dr Miller refers to Minute No. 322,
  - **Metric**: **DToC** - Delayed Transfers of Care (delayed days)
    With regards to the barriers and pressures and suggested that a full discussion was needed in terms of what they could do better. This could be a future agenda item to inform of the processes etc.

  Becky Pollard stated that this could be put into the Forward Plan and split the meeting into an interactive session etc., so that they get more interaction. This could be discussed with the Chair Councillor Paulette Hamilton.

- **Action: The Long-term Plan should be bought to the HWBB for discussion when published.**
  Paul Jennings stated that this point was discussed at their pre-meeting. Becky Pollard advised that was in the Forward Plan for the next meeting.

328 **RESOLVED: -**

That the Minutes of the meeting held on 18 December 2018, having been previously circulated, were confirmed.

CHAIR'S UPDATE

329 Dr Peter Ingham, Deputy Chair, Birmingham Health and Wellbeing Board welcomed everyone to the meeting and read a briefing note from Councillor Paulette Hamilton to the Board.

(See document No. 1)

Councillor Hamilton apologised for not being in attendance at the meeting as a result of the meeting clashing with a recruitment panel for senior management positions within the Council.

Dr Ingham expressed thanks to Becky Pollard on behalf of the Board for her hard work and dedication during the interim period.

Councillor Kate Booth informed the Board of the inspection of Children Social Care and that she was delighted to report that the Children's Services had improved to "good". They were ensuring that the focus was on the wellbeing and voice of children in care was a high priority. There was good work being done around homeless children. The comment on the children guidance in place for care leavers was requiring improvement to be good. They were still required to be good.

Sarah Sinclair, Assistant Director, Children and Young People commented that this was a tremendous achievement for the city after more than a decade. A comment was that there was a lot of area for improvement. A brief discussion ensued and Sarah Sinclair undertook to forward the link to the recent Ofsted inspection for circulation to the Board.

CHANGE TO THE ORDER OF BUSINESS

330 The Chair advised that he would take agenda item 7 ahead of agenda items 5 and 6 due to the late arrival of the presenters for these items.

BIRMINGHAM OLDER PEOPLES PROGRAMME – PROGRESS UPDATE AND PLANNED ACTIVITY.

The following report was submitted:-

(See document No. 2)

Mike Walsh, Service Lead - Commissioning, Adult Social Care and Health presented the report and drew the Board's attention to the information in the appendix to the report. Mr Walsh provided the Board with an update on progress and planned activities for each work-stream of the Birmingham Older Peoples Programme. He highlighted the work that was being done and the persons who were leading on the different work-streams.

Page two of the appendix refers to the principles set out in terms of the work programme and the standards they were working to. They were working jointly with the City Council and the CCGs commissioning care across the city in terms

of how they could better work together to pool their budget and pool resources. There was a big area of work-stream around district levels to act as lead providers to build support in Perry Barr and Selly Oak and will offer contracts in Yardley etc.

In response to questions and comments, Mr Walsh made the following statements: -

a. A lot more programme managers were needed in terms of the intervention work. Community health providers were part of the ongoing support.

b. In relation to *Citizen Engagement* (paragraph 3.2.3) more work needed to be done around this. Healthwatch Birmingham had been offered funding by Healthwatch England and Healthwatch Birmingham was happy to support.

c. Richard Skelton was working on the engagement with portfolio. The comment was around early intervention programme and engagement – programme level and individual work-stream level.

d. In terms of paragraph 3.2.1, the difference in network was the language used that causes the difficulties – personalised support was linguistic. This was in relation to how they coordinate across the work-stream and how they organised themselves at the neighbourhood level.

e. This was a live issue and the only way was to test the situation on the ground.

   At this juncture the Chair commented that the locality was formed within the CCG – 250,000 populations.

f. General Practitioner Units were now starting to move into the network (almost unfortunately the issue that they spoke of) in relation to neighbourhoods in different ways.

g. There was work through ongoing personalised support - 30,000 - 50,000. A lot of the community groups they were working with maybe 10,000, with people viewing their neighbourhoods as a different thing. Grouping of 30,000 to 50,000 was where it was at.

h. As a Board this was something to be reviewed and challenged as the work-stream evolved.

   Dr Miller stated that it was good to get an overview, that it was really cutting edge. Meetings taking place in small group was not particularly strong. This was a key milestone that should be met across the Board so that they could provide that challenge.

   Becky Pollard stated that the long-term plan mirrors a lot of what was in the report. The question was whether there was anything that they needed to tweak in the programme to match the long-term plan.

331 **RESOLVED: -**

(i) That the Health and Wellbeing Board had a crucial role in ensuring delivery of programme. In particular the board was asked to:
- Maintain oversight of the programme.
- Provide support and challenge to the programme leads to ensure that work-streams were joined up and delivering against the integrated vision and a model of care which places the citizen at the centre.
- Act as champions for the programme within the Health and Social Care system in Birmingham to ensure that all partners maintain a focus and commitment to delivering at pace.

(ii) Specifically, at the current time, the Board was requested to note the work that was being progressed through the Ongoing Personalised Support work-stream to define and agreed a model and spatial delivery arrangements for providing integrated care and support to citizens with ongoing care needs. The Board was asked to support this approach to place-based care.

INCREASING EMPLOYMENT/MEANINGFUL ACTIVITY MENTAL HEALTH RECOVERY AND EMPLOYMENT

The following report was submitted:-

(See document No. 3)

Dario Silvestro, Joint Commissioning Manager, Mental Health Joint Commissioning Team introduced the item and advised that following the Birmingham Health and Wellbeing Board meeting in September they were asked to come back and give a further update. The support they would like from the Board was for the DWP representative on the HWB to commit to working with local providers to ensure the early identification of individuals who meet the criteria for Individual Placement and Support (IPS) (through Jobcentre Plus pathways).

Developing opportunities for people with severe mental illness (SMI) by promoting training and supporting employment opportunities within their organisations through the IPS programme. It was hoped that this would remain on the agenda. DWP work with local provider – spoke with the provider for a better pathway and DWP could provide an overview of the labour market so that they could be alerted to jobs. HWB was to be a member of group of organisation that was working together. There will be a meeting in October and the meetings were held on a quarterly basis. HWB members were asked to publicise the service on their websites etc. to raise the profile of service.

A bid was submitted to NHS England to expand the service into Solihull, extend the scope of the service so that they have Individual Placement and Support (IPS) workers embedded in the service and had applied for funding to develop this. They were working with existing Jobcentre Plus areas. Employment support allowance group established in Birmingham where the IPS work was involved.

They were getting more referrals than anticipated and the intention was to double the service and the number of people seen. If they did not get any

funding from NHS England they have been in touch with Social Finance Limited for impact bonds. Sustainability funding for 2019 – 2021 further two years of contract that they have at the moment.

In response to questions and comments, Dario Silvestro made the following points: -

- ✓ Some background information was to be provided to the Board. The whole purpose of the IPS was jobs rather than apprenticeship and the actual measure was people in jobs.
- ✓ In terms of cohorts that may not make it into jobs, this was a valid point, but the service was funded to create jobs and they would need further funding to provide for apprenticeship.
- ✓ Measuring jobs outcomes, job starts, the IPS service had to be part of the fidelity set out by Mental Health. Partners with better pathways and integrated with Mental Health team and worker comes from the IPS to support them.
- ✓ The numbers were not as good as they would like and people around the table need to challenge themselves as to what they could do in their organisations.
- ✓ The Board agreed the recommendations, but recommendation 3.2.4 was to be taken outside of the meeting. Mr Silvestro undertook to circulation some further information to the Board.

332 **RESOLVED: -**

a. A paper was presented to the Board in September 2018, which provided an update on the Mental Health Recovery and Employment Service (MHRE), which provides Individual Placement and Support (IPS) for individuals aged over 18 who have a mental illness or recognised mental health issue. Following that meeting the Board requested a further update on the service and also to highlight any support required from the Board.
b. An outline of the support that would be welcomed from the Board is highlighted below:
c. Health and Wellbeing Board (HWB) members become champions of Mental Health Employment and demonstrate corporate commitment by actively promoting and supporting employment opportunities for people with SMI within their organisations through the IPS programme.
d. To ensure that IPS remains a priority for the HWB, the programme will provide updates twice a year.
e. HWB DWP representative commits to working with local provider to ensure the early identification of individuals who meet the criteria for IPS support (through Jobcentre Plus pathways).
f. To endorse the development of IPS provision a member of the HWB to attend the IPS Employers forum. This group meets on a quarterly basis.
g. HWB members work with their respective communication teams to actively promote and support IPS. Members of the Board to raise awareness of the Mental Health Recovery and Employment service by promoting the service on corporate websites and through social media.

THRIVE UPDATE

333 Sean Russell, Director of implementation for Mental Health, Wellbeing and Radical Prevention introduced the item and gave the following verbal update: -

i. There were four lots of Individual Placement and Support (IPS) targeting the market. Lots of academic evaluation. The programme was started in June 2018 with 120 people, but the intention was to get 75,000 people back into work.
ii. They were struggling to get GPs to make referrals and had to be innovative in how they provide the discussions. It was difficult to evaluate thrive into work/thrive at work.
iii. There was funding from the government to do this and they should be doing a collective piece of work. All employers they were working with had signed up to the Health and Wellbeing Pledge supported by Public Health.
iv. The launch was in October/November and they already had 100,000 people signed up to the programme.
v. Over 17,000 people were trained into Mental Health First Aid, but this was only one part of the journey. Health literacy was supported by the Mayor. The response to the justice space was abysmal as they were targeting the wrong people which no one had identified.
vi. They had to do something different in terms of drug and alcohol as not enough was being done by the CCGs, Primary Care etc. Veteran – supporting Directors of Public Health across the region – behaviour changes were needed.
vii. Digital Social Prescribing? Housing First – complex need and those needing support were not left out. A brief discussion ensued and a suggestion was that they could do something exciting around the Commonwealth Games.

In response to questions, Mr Russell stated that: -

a. The programme for Housing First was a five year programme and they would link people into the programme when they were homeless. This was not something they would do to them but with them.
b. Connected into that space in terms of the Commonwealth Games, the question was what provision was available for the homeless across the Primary Care health system.
c. They were learning from the lessons that were happening elsewhere across the region. This was raised through the Mayor's objective and was pulling this together.

Becky Pollard advised that Public Health in Birmingham was working with Public Health around the Commonwealth Games and that it was hoped to bring a paper concerning this to February's Board meeting as it was felt that this was fragmented.

PLACE BASED DEVELOPMENT: INCLUDING WESTERN BIRMINGHAM

334 Andy Williams, Accountable Officer, Sandwell and West Birmingham gave the following verbal presentation on the item: -

1. That there were two things to say to the HWB – Ladywood and Perry Barr was different to the rest of the city.
2. As a CCG they were actively engaged in the STP process and programme engagement was in place.
3. The things he wanted to draw out about Ladywood and Perry Barr and was keen to do citywide was how they could come closer together as commissioners in trying to identify outcomes and recognised that little part of the city was different in terms of communities and demographics etc. and that they work specifically with those communities citywide.
4. There was opportunity in Ladywood and Perry Barr to take this forward. They were working with Primary Care network as … for Primary Care. This was a productive department for change one of which was to be clear what outcomes were in trying to change and improve.
5. The detail trajectory was that they were trying to home in on this as the outcome was important.
6. They were creating an envelope in which partners could work together which lends itself to a capitalised budget so that they could reach a transformational change i.e. employment opportunities etc.
7. It was important for this to be a broadly drawn characteristic. Time was also important to see movement. If they operate on a stock plan they will never see change.
8. They were trying hard to take this forward in Ladywood and Perry Barr if they could move partners to define outcomes and stick to this for a number of years whether this could bring about transformational change. They were keen to commit with partners.
9. The business of the HWB was to oversee this and it would be great to agree with partners through this forum to see what trajectory this works out to be.
10. They will begin a formal consultation process and the timeline for that draw looking at a process and HWB will be a contributor to this about March/April.
11. This did not prevent them from homing in on the particular challenges. It was hoped to be able to bring to a future HWB meeting an initial prototype.

Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG stated that there was conversation around what a city plan would look like. They got the STP and a bit more complicated with the STP footprint in terms of the overlap and they had to produce a 2019/2020 Plan. This was really about trying to fix it i.e. some of the substantive issues in the NHS. They had to do this collectively as a system and write the five year plan and how they make all the changes happen. They will have to be collectively engaged as a STP.

The new hospital had to make it work and help to make it sustainable in terms of the system. The kind of changes they were making was driven by leadership. They needed to be alert to this and do what they could to support the development. On the edge of a massive change. The type of mechanism they will use around artificial intelligence. That they did not leave people behind and the mental health work and to support people into meaningful employment.

Professor Graeme Betts commented that it was right to mention Perry Barr and Ladywood as this was an important and significant shift. Getting everything

right for the citizens and will achieve this if using best practice. It was better to say what was working well and what was not as it was the citizens that suffer. Birmingham older peoples programme work was an example. This was the key for him and a great place to start. Birmingham older peoples programme applies in Perry Barr.

Mr Williams commented that it was great to do both and focus on having a great plan for both. The question was how do we do it rather than state that it was tricky. Danielle Oum stated that Healthwatch Birmingham was supporting involvement around long term plan. Mr Williams stated that they had to be developed and people told about it and that they needed to have something to work with.

SUSTAINABILITY AND TRANSFORMATION PLAN – UPDATE

335 Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG gave the following verbal update: -

- The draft document which was a briefing note was to be circulated shortly. Good progress was made and the message had gotten across the Birmingham and Solihull was about doing things. It was not about reorganising the service or closing hospitals.
- The aim was to have a successful launch of workshop with citizens' agreement later this year.
- At the public event at Villa Park the STP Board was committed to using the existing programme to get the message out. The issue was what difference this would make to children etc. for people to see and measure.

Becky Pollard commented that the Public Health network would support the STP.

CARE QUALITY COMMISSION

336 Professor Graeme Betts, Corporate Director for Adult Social Care and Health Directorate advised that part of the national review CQC went back out to check where they were. He stated that this was a procedure report, but that he would bring this to the next Board meeting in terms of where they got to. The metrics were improving, but were challenged but they needed to put the older peoples programme into it.

Paul Jennings advised that there will be a meeting on Thursday at Chief Officer level.

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

337 The following report was submitted:-

(See document No. 4)

Becky Pollard, Interim Director of Public Health introduced the item and advised that this was a draft working agreement which was submitted to the Board for comment only, not to make a decision. It would then come back to the Board for it to be agreed. The report came about in relation to how Scrutiny was working and the role of Healthwatch Birmingham which was a statutory function. The report was really looking at HWB's role and Scrutiny and Healthwatch Birmingham to clarify responsibility. Page 6 of the document looked at referrals between Healthwatch Birmingham and Scrutiny. The report was for information only. Becky Pollard advised that any additional comments from the Board were to be sent to her.

Dr Robin Miller suggested that a similar thing could be done with HWB and STP in terms of partnership articulation.

MEMORANDUM OF UNDERSTANDING (MOU) BETWEEN BIRMINGHAM CITY COUNCIL AND PUNE MUNICIPAL CORPORATION (INDIA) FOR A SMART CITY PARTNERSHIP ON FOOD

338 The following report was submitted:-

(See document No. 5)

The Chair advised that the report was for information only.

Ralph Smith, Service Manger-Intelligence, Adults Social Care and Health advised that the document had been to several management boards and the next step was for the report to be signed off by Dawn Baxendale, Chief Executive, Birmingham City Council once it has been to the HWB. This was supported by Councillor Paulette Hamilton.

The HWB endorsed the contents of the MoU and requested future update reports as the work programme progressed.

OTHER URGENT BUSINESS

339 None submitted

DATE OF NEXT BIRMINGHAM HEALTH AND WELLBEING BOARD MEETING

340 It was noted that the next Birmingham Health and Wellbeing Board meeting will be held on 19 February 2019 at 1500 hours, in Committee Rooms 3&4, Council House, Victoria Square, Birmingham, B1 1BB.

The meeting ended at 1655 hours.

……..…….
CHAIRPERSON

Birmingham Health and Wellbeing Board

	Agenda Item: 6
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19th February 2019**
TITLE:	**UPDATE ON CHILDHOOD OBESITY**
Organisation	**Public Health, Birmingham City Council**
Presenting Officer	**Fiona Grant**

Report Type:	**Document update**

1. Purpose:
To update the Board on some of the interventions underway to address Childhood Obesity in Birmingham as requested by Becky Pollard (Interim Director of Public Health).

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

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

3.	**Recommendations**
3.1	The Board is asked to note some of the interventions already underway to address childhood obesity in the City and support future system wide approaches under development.

4.	**Background**
4.1	Obesity has been identified as a City Board Priory (Task and Finish Group) and a priority for the health and Wellbeing Board.
4.2	Paul Jennings, the Birmingham and Solihull CCG Chief Executive and identified obesity lead for the City Board and HWBB presented a strategic overview at the December HWBB and the proposed direction of travel to develop a multi-agency whole systems approach to addressing childhood obesity in Birmingham. Whilst the evidence tells us that obesity is a complex issue to tackle to which there is 'no magic' bullet , there is some emerging evidence of the benefits of adopting a whole systems approach to addressing obesity.
4.3	This paper outlines some of the interventions already underway in the city, which will form part of the proposed systems based approach to addressing childhood obesity.

5.	Future development
	At a strategic level, work is underway, led by Paul Jennings to further develop actions around a whole systems approach to obesity which will incorporate and build on existing interventions.

6.	Compliance Issues
6.1	***Strategy Implications***
	This work will contribute to the proposed Systems Strategy and Action Plan for Childhood Obesity for Birmingham.
6.2	***Governance & Delivery***
	Progress on addressing Childhood Obesity will be reported to the Health and Well Being Board and the City Board.
6.3	***Management Responsibility***
	Fiona Grant, Children Young People and Families Public Health Lead , BCC Dennis Wilkes, Assistant Director of Public Health, BCC and Becky Pollard, Interim Director of Public Health, BCC.

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

Appendices	
1.	Update on Childhood Obesity – Interventions in Birmingham

Obesity update – Health and Well Being Board

Background and Introduction

Compared to other UK core-cities, Birmingham has one of the highest rates of childhood obesity. Our rates have been consistently above the national average since 2006/7. The most recent figures show that 23.6% of 5 year-olds, and 40.5% of 11 year-old children in Birmingham are classed as overweight or obese (National Child Measurement Programme, 2017-18).

However, these rates only tell part of the story. We know the risk of obesity is even greater in our most deprived communities and, more importantly, this gap has been widening over time.

The adoption of childhood obesity as a focus for the City Board and the Health and Well Being Board, as well as developments around regional initiatives from the West Midlands Combined Authority, has provided an opportunity to re-fresh our approach to addressing childhood obesity in Birmingham.

What works?

The evidence has highlighted the complexity around effectively addressing obesity because of the range of factors involved, and that there is no single solution to deal with the problem.

However, whilst addressing obesity remains a challenge, there is some emerging international best practice (e.g. from Amsterdam and New York). In particular, the importance of political leadership and a joined up approach across key stakeholders has been identified to gain commitment to addressing the wide range of factors at an individual/family, social, and environmental level which impact on obesity. This reflects a whole system approach, based on the principle of stakeholder engagement and collaboration because it is ‘everyone’s responsibility’.

Paul Jennings (CEO Birmingham and Solihull CCG) provided strategic context and direction of travel at the December Health and Well Being Board

Key messages included:

- The importance of a whole systems approach and high level leadership buy- in, in line with emerging international evidence
- Addressing the environment - not just expecting children and families to change their behaviour

One of the five strategic elements, identified and proposed by the City Board (Task and Finish Group) to underpin the development of a Childhood Obesity Plan for the City, included reviewing what interventions the public sector are already offering across Birmingham. This paper describes, some examples of interventions already underway.

Examples of interventions underway:

a) National Child Measurement Programme

Every child in Reception and Year 6 have their height and weight measured as part of the NCMP. Letters are sent home to parents informing them of the weight status of their child.

b) Startwell

This is a service commissioned as part of 'Birmingham Forward Steps' by Birmingham City Council. Startwell works with providers of Early Years settings e.g. nurseries, to provide nutritional advice and opportunities for physical development. The aim is to enable provision of healthy environments for children in their care. The scheme is based on an awards system and may include cooking sessions with staff.

c) HENRY

HENRY is a nutritional support programme for families with preschool overweight children. It is delivered by Birmingham Forward Steps to individual families.

d) Healthy Start Vouchers

This is a government-led means tested initiative providing healthy food vouchers (milk, fruit and vegetables) to families receiving benefits with children aged 0-4 years.

Families are provided with vouchers to purchase these food items to the value of £3.10 per week, per child.

It is conservatively estimated that there is widespread underuse of the vouchers by eligible families resulting in an under-claim of £1.5 million in Birmingham. This results in a reduction in nutrition in these families and a loss of retail revenue in these communities.

Work is underway in Birmingham to increase the usage of Healthy Start vouchers by increasing registration for the vouchers, their use, and the retail spaces in which to use them. This will boost local retail income and provide healthy food to deprived families at no cost to the family, retailer, or Birmingham Public Services.

e) The Daily Mile

This aims to increase children's physical activity by 15 minutes every day. Birmingham is leading on the evaluation of the effectiveness of the Daily Mile on children's fitness, body mass index (BMI), wellbeing, academic attainment and quality of life by working with the University of Birmingham to conduct a randomized controlled trial in 40 schools located in Longbridge. This research has been funded by Birmingham Council Section 106 money with support from the National Institute for Health Research fellowship scheme (University of Birmingham)

f) Health For Life

This is a partnership initiative to promote healthier lifestyle activities across primary schools. Funded by the Mondelez International and delivered through Services for Education. Focused on healthy eating, cooking, growing food and physical activity.

g) Using 'Nudge' to Influence Food Choices in Schools

Schools provide an opportunity to observe the impact of nudge interventions on children's choices.

Working with CityServe and academics at the University of Birmingham, opportunities are being explored to put in place a number of different experiments across schools in Birmingham to research what works to influence children's choices towards healthier alternatives in the school canteen.

h) Work with retailers

Work is progressing with a major supermarket chain to design and test interventions to promote the buying of vegetables in deprived areas of Birmingham. Working with the economics team at the University of Birmingham, research will identify barriers to purchasing vegetables and then the supermarket will run a series of trials on the impact of simple 'nudges' to influence buying behaviours.

i) Nutrition Smart City

The Food Foundation is facilitating a 'Nutrition Smart City' initiative which involves a learning partnership between Birmingham and the City of Pune in India.
Birmingham is also signed up to the Milan Urban Food Policy Pact (MUFPP) and is an active member of the EUROCITIES food network.

j) Childhood Obesity Trailblazer Programme Local Government Association – EOI

Birmingham City Council and partners have recently successfully submitted an expression of interest to participate in the LGA's Trailblazer Programme Discovery phase around Childhood Obesity.

Our approach will draw on behavioural insights with a view to enabling communities to be able to more easily make healthier choices.

Birmingham has been a leading authority on developing and implementing the National TOMS framework (themes, outcomes,

measures and success) as a lever to realise social value. Our discovery phase will work directly with the communities to assess what matters in relation to the 5 themes underlying the framework, particularly creating healthier, safer more resilient communities and social innovation in terms of childhood wellbeing and obesity.

The key drivers we will focus on include: Access to unhealthy fast food, access to fruit and vegetables and early-years nutrition.

Conclusion and Recommendation:

There is an increased awareness among board members of some of the interventions currently in place in Birmingham to address childhood obesity; and the need to build on this with a multi-agency systems based approach.

Contact Officer

Fiona Grant

Children & Education - Public Health Lead

January 2019

Birmingham Health and Wellbeing Board

	Agenda Item: 7
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19th February 2019**
TITLE:	**CHILDREN AND YOUNG PEOPLE WITH SEND - JSNA UPDATE**
Organisation	**Birmingham City Council, Public Health**
Presenting Officer	**Susan Lowe and Fiona Grant**

Report Type:	**Update report**

1. Purpose:
To request Board approval and sign off of Birmingham's Children with Special Educational Needs and/or Disability (SEND) JSNA.

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

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

3. Recommendations

The Board is asked to:

- Note the findings and recommendations in the attached Children with SEND JSNA and approve and sign off the Children with SEND JSNA as meeting requirements to inform future strategies and commissioning plans in this area.

4. Background

4.1 In November the Board agreed to ownership of the Children and Young People with SEND JSNA.

4.2 The SEND Code of Practice 2015 sets out that each local area should have a JSNA considering the needs of the population. This is the responsibility of the HWBB. The JSNA should be used to inform joint commissioning and in turn the Local Offer for 0-25 year olds with SEND.

4.3 The JSNA process is now complete and has been taken to the SEND Improvement Board (SIB). The feedback and suggestions from SIB members has been reviewed and incorporated in to the final version of the JSNA.

5.	Future development
5.1	It is proposed that this JSNA is the single agreed 'picture' of needs of children with SEND within Birmingham that can be used for commissioning and planning of services.
5.2	This can only be achieved with the support and input of all partner organisations. Board members should ensure document is used by their organisations in strategies and commissioning plans.
5.3	The JSNA strategic group of the Board should incorporate the future update of the SEND JSNA into its future programme.

6.	Compliance Issues
6.1	***Strategy Implications***
	This JSNA will inform: Future Strategy development in relation to Children with SEND Future Strategy development in relation to Children and Young Peoples Services
6.2	***Governance & Delivery***
	The draft SEND JSNA was presented to the SIB in December 2018 for feedback/comments. The Board has ownership and responsibility for the SEND JSNA.
6.3	***Management Responsibility***
	Operational management responsibility for the delivery of the SEND JSNA will be via Public Health leads: Susan Lowe and Fiona Grant. Senior Management responsibility for the delivery of the SEND JSNA will be via Dr Dennis Wilkes and the Director of Public Health, Becky Pollard.

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

Appendices
1. Children and Young People with SEND JSNA

Children and Young People with Special Educational Needs and/or Disability in Birmingham

Joint Strategic Needs Assessment 2018

V0.6 - January 2019

Version Control	Date	Amendments	Author
V0.1	26/09/2018	First draft	Susan Lowe
V0.2	15/10/2018	Education, early years and health data analysis, review of the 2018 Ofsted/CQC inspection report	Susan Lowe
V0.3	05/12/2018	Mental health, supporting services, consultation. Reorganisation of layout to life course approach Comments /narrative – focus on gaps and recommendations	Susan Lowe Fiona Grant
V0.4	10/12/2018	Changes to key findings/recommendations and addition of adult social care, school attainment and out of city placement data	Fiona Grant Susan Lowe
V0.5	09/01/2019	Changes to key findings and recommendations to make consistent with slide set.	Fiona Grant
	10/01/2019	Changes to key findings and recommendations to reflect feedback from SIB colleagues	Fiona Grant
	20/01/2019	Changes to core document to reflect comments from SIB colleagues	Fiona Grant
	21/01/2019	Changes to core document to reflect comments from SIB colleagues.	Fiona Grant

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Table of Contents

1. Executive Summary

1.1. Introduction

Birmingham as a city is committed to fundamental change and improvement in how the local strategic partners work together to provide care and services to children and young people with special needs and/or disabilities (SEND) living within the local area. The purpose of this Joint Strategic Needs Assessment (JSNA) will help to understand and identify the needs of this population and for local strategic partners to use them to develop robust local commissioning plans.

An up-to-date JSNA is a mandated part of the Ofsted and CQC measurement framework. This JSNA looks at all the evidence available for children and young people with special needs and disabilities from Birmingham City Council, Birmingham Children's Trust and all health partners, combined with nationally published statistics and research materials. The evidence base looks at current literature and local intelligence about the prevalence and trends in special educational needs and/or disability in the city. It explores the characteristics of the children and young people and discusses the factors which can lead to a child having special educational needs and/or disability.

The JSNA represents an accurate picture of known data and information available as of August 2018.

1.2. Key Findings

The headings below are a summary of the key findings of this JSNA.

1.2.1. General

Birmingham is a young city with 450,047 of our population aged between 0-25 years and making up 40% of the total population compared to 32% at a national level.[1]

The local population aged 0-24 years is predicted to increase by 2% in 2022 (an extra 10,000) and by 6% in 2027 (an extra 24,000).[2] We expect demand to increase for all children's services including services for children and young people with SEND.

1.2.2. Deprivation and Ethnicity

Birmingham has high levels of deprivation with 40% of the population living in the 10% most deprived areas of England. There is a strong association between low income and higher rates of SEND prevalence.[3]

Birmingham is an ethnically diverse city. In 2011 46% of under 25 year olds in the city were of White ethnicity. This compares to 79% at a national level.[4]

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[1] Office for National Statistics, 2016 mid-year estimates
[2] Office for National Statistics, 2016-based subnational population projections
[3] Parsons S., Platt, L., Disability among young children: prevalence, heterogeneity and socio-economic disadvantage (2013)

1.2.3. Vulnerable Children

In Birmingham one in four Children in Care (CIC) have an Education, Health and Care Plan (EHCP) this is slightly less than the national average. However Children in Need (CIN) within the city are more likely to have an EHCP (28.4% Birmingham, 21.4% England).

1.2.4. Disability

In 2011 there were 19,598 children and young people aged 0-24 years in Birmingham[5], recorded with a long-term health problem or disability which limits daily activity. The prevalence is higher than the national average. The higher population prevalence of risk factors associated with disability, such as low infant birth weight and economic disadvantage, may be contributory factors to levels of SEND in the city.

1.2.5. SEND Prevalence

The total number of Birmingham children and young people aged 0-25 years, with an EHCP at January 2018, was 9,023 (includes early years and post-16 EHCPs).[6] Trend analysis for EHCPs show the numbers of children and young people with an EHCP have been increasing over the last 10 years.

The prevalence of pupils with an EHCP in Birmingham schools is 3.2%. This is significantly higher than the national figure of 2.9% and higher than other English core cities.

1.2.6. Early Years

The number of children accessing early years support services (Education) has been increasing over the past 5 years. In academic year 2017/18, there were 2,067 children notified to Early Years Inclusion Support. During 2017/18 the priority SEND need area most in demand in the 0-5 age range was communication and interaction.

1.2.7. Primary Schools

The proportion of pupils with EHCPs at Birmingham's primary schools is similar to the national average and to the other English core cities. The proportion of pupils receiving SEN support is higher than the national average but similar to other core cities. The most common category of SEND need is moderate learning difficulties (MLD). However the SEND need is sourced from nationally published school census data and its accuracy is dependent on the recording of the data at a local level. There are concerns that this picture doesn't match with local professional knowledge where the belief is that Autism and not MLD is the most common category of need.

1.2.8. Secondary Schools

The proportion of pupils at Birmingham's secondary schools with EHCPs (1.3%) and SEN support (11.7%) is similar to the national average and to the other English core cities. In

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[4] UK Census 2011
[5] UK Census 2011
[6] SEN2, January 2018

local area secondary schools, the most common category of SEND need is moderate learning difficulty (40%). As with primary pupils, a greater number of secondary pupils are categorised under the moderate learning difficulty than nationally leading to concern, that children's needs are not being accurately identified.

1.2.9. Special Schools

Birmingham has 27 state-funded special schools. In January 2018 there were 4,219 pupils attending this type of school in Birmingham.[7] This was a 20% increase in the number of children at state-funded special schools from 2014. Birmingham has a higher proportion of pupils attending special schools compared to England and the English core cities. Those at these schools make up the majority of pupils with EHCPs. This is a much higher proportion than England but similar to the core cities.

1.2.10. Exclusions, absence and educational attainment

2016/17 academic year overall absence rate for children with an EHCP was 9.2% compared to 8.1% for England.

The proportion of children excluded from Birmingham special schools for 2015/16 was nearly twice the national average and much higher than for the West Midlands and Statistical Neighbours.

Whilst educational attainment at KS4 for all Birmingham pupils is similar to England average, pupils with EHCPs in Birmingham do worse than England average when compared with other pupils with EHCPs. However attainment for SEN support pupils is similar to England.

1.2.11. Early Identification, assessment and service provision

Early identification and appropriate intervention in relation to SEND is important.[8] This is may be adversely affected in Birmingham by low take up of early educational entitlement offer (at age 2) across the city and insufficient uptake of 2-2.5 year old assessments by universal early years services (Birmingham Forward Steps). There is currently insufficient capacity in the multi-disciplinary Child Development Centres (CDCs) to meet the demand created by referrals for child development assessments for under 5s resulting in long delays for families trying to access the service.

1.2.12. Specialist provision

Speech, language and communication services and other specialist provision e.g. occupational therapy and physiotherapy have been highlighted in the recent Ofsted and CQC SEND Inspection as lacking in capacity to meet demand. There is currently no commissioned autistic spectrum disorder multidisciplinary diagnostic pathway for children over four years old. As such, if children are not identified and assessed before 5, there is no commissioned multi-disciplinary team to assess their need.

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[7] January 2018 School Census
[8] SEND Code of Practice, 2015

1.2.13. Quality of EHCPs

In Birmingham an EHC assessment is more likely to result in the issue of an EHCP. In 2017 only 2.1% of EHC assessments did not result in an EHCP being issued. For England this was 4.9%. The reasons for this are not totally clear and it is suggested they are investigated further and reviewed in a future JSNA.

EHCPs can utilise personal budgets to enable greater personalisation and provide choice and control to the child and young person. However in Birmingham in 2017, only 4 personal budgets were issued, transferred or reviewed.[9]

There are currently no commissioned residential placements for 38/52 week placements in the City. For children with SEND who need this service, children are placed in independent specialist provision outside Birmingham.

1.2.14. Transition from children's to adults' services

Transition into adult services should start at 14 years according to the SEND Code of Practice. The SEND Inspection Report (2018) highlighted that more needs to be done to give young people in Birmingham a more positive experience of change in the level and types of service they receive as they grow older.

In Birmingham, there is an initial intention to start transition planning at age 13 or 14 (Birmingham Strategy for Transition). Though there is an aspiration to raise awareness from birth (with children and families) of the importance of preparing for adulthood. Key services are working together to improve transition pathways and to develop a wider offer of opportunities.

1.1.16 Primary Care

Parental dissatisfaction with primary care support for children and families around SEND was identified during the 2018 CQC Ofsted Inspection. The most recent data shows that just over a third of young patients on the GP Learning Disability Register had taken up the annual health check and had a health action plan.[10]

1.3. Recommendations

This JSNA makes the following recommendations based on analysis of the health and social care needs identified in our analysis.

1.3.1. Robust data

The availability of robust data is recognised locally and nationally as limited in relation to SEND data and to disability data.

Recommendation: Review opportunities to improve data collection/sharing and analysis to enable more informed commissioning. To include exploring opportunities to enable linkage

[9] Department for Education, Statements and EHCPs in England
t[10] NHS online available at https://www.nhs.uk/conditions/learning-disabilities/annual-health-checks/

between health, education and social care to allow cross referencing where a child has an EHCP/SEND need; also to enable assessment of level/ complexity of need.

Recommendation: consider adoption of a robust whole system approach to coding using a recognised tool to enable understanding of the level of complexity of SEND need.

1.3.2. Primary prevention:

There are a number of factors that are relevant to the Birmingham population (e.g. deprivation and low birth weight) that may be contributing to the levels of SEND in children and young people in the city.

Recommendation: Support a primary prevention approach to SEND, by identifying and supporting evidence based interventions which address SEND related risk factors, being delivered through other City-wide Strategies and work programmes (including Birmingham and Solihull United Maternity and Newborn Partnership and Local Sustainable Transformation Partnerships).

1.3.3. Early identification and appropriate intervention

Early identification in relation to SEND is important (SEND code of practice, 2015) but challenging in the under 5s.

Recommendation: Work with partners in education, health and care across the early years system to identify mechanisms to increase uptake of the universal 2-2.5 year health visiting assessment and the early years educational entitlement offer.

Recommendation:

Enhance the commissioning/contracting process, where needed across the system, to improve access/reach to those children, young people and families most in need.

Recommendation: Maintain efforts around work with SENAR and education, health and care partners to ensure that Children and Young People's SEND needs are robustly and accurately identified in line with best practice.

1.3.4. Child Development Centres

There is a **lack of capacity in Child Development Centres** to ensure that developmental needs assessments are delivered in a timely manner. Work is underway to address this through the development of the neurodevelopmental pathway; also solutions to address capacity issues are being sought.

Recommendation: Robust commissioning approaches are employed to ensure that there is sufficient capacity to adopt the proposed neurodevelopmental pathway

Recommendation: Commissioning approaches need to consider gaps around provision of speech language and communication, occupational therapy and physiotherapy services. Consideration should also be given to the capacity of Community Paediatric Services to deliver medical elements of assessments.

Recommendation: Consider commissioning additional capacity to enable developmental assessments to be available to children over 5, when necessary.

1.3.5. High Prevalence of Birmingham School Pupils with EHCPs

Birmingham has a higher proportion of children with EHCPs than the national average. There is a perceived lack of confidence among parents on receiving support for SEND needs without an EHCP.

Recommendation

Review current practice to ensure robust, transparent process is in place, in line with best practice, around EHCP assessment process. Programme of work already underway as part of SEND Written Statement Of Action.

Recommendation:

Explore the potential, through joint working with parents/carer and organisational partners, to identify what would be needed to build confidence amongst parents and other professionals that SEND related needs (education, health and care) can be appropriately met, through the local offer- with or without the need for an EHCP.

1.3.6. High proportion of children in special schools in Birmingham:

There is a higher than average proportion of children attending special schools compared to the national average.

Recommendation: Through review, already underway, help to more accurately understand the SEND needs of children in Birmingham, including complexity of need, in order to inform the need for specialist SEND provision.

Recommendation: Explore potential to provide a 'more attractive offer' for children with EHCPs as part of mainstream school provision, with a view to meeting childrens' needs more effectively, where appropriate and closer to home.

1.3.7. Residential Placements

There is currently no provision, in the city, for children with SEND who require a residential placement.

Recommendation:

Building on work already underway, complete review of needs of children with SEND who require a residential placement to assess if needs could be more appropriately met locally.

1.3.8. Health Check – learning disabilities heath check

In quarter 4 (2017/18) only 36% of patients (on the GP Learning Disability Register) had taken up the annual health check and had a health action plan.

Recommendation: Explore opportunities through Birmingham and Solihull CCG and primary care colleagues to identify opportunities to improve uptake and provide better support to children young people and their families around SEND.

1.3.9. Low Educational Attainment for Children with EHCPs

Pupils with EHCPs in Birmingham do worse than the England average, when compared with other pupils with EHCPs.

Recommendation:

Consideration of commissioned, joined up, wrap around service/care for mainstream and special schools, linking with existing provision to help support schools. With a view to reducing absenteeism and exclusions among children with SEND (building on work already underway to reduce school exclusions).

1.4. Transitions

Young people and their parents/carers should be preparing from age 14 years for the move from child to adult services in order that they are well prepared for future opportunities. The SEND Inspection Report (2018) highlighted that more needs to be done to give young people in Birmingham a more positive experience of change in the level and types of service they receive as they grow older.

Recommendation:

Ensure that processes are in place to prepare children and young people with SEND for transition into adult services and into adulthood from age 14 (at the latest),in line with SEND Code of Practice and the Birmingham Strategy for Transition (2018-2021)

1.4.1. Strategic Partnership Working

Recommendation:

Integrated models of care and joint commissioning approaches are developed across the health, education and care system, taking into account projected population increases, addressing the full range of needs of children and young people with SEND from prevention and early help to specialist services.

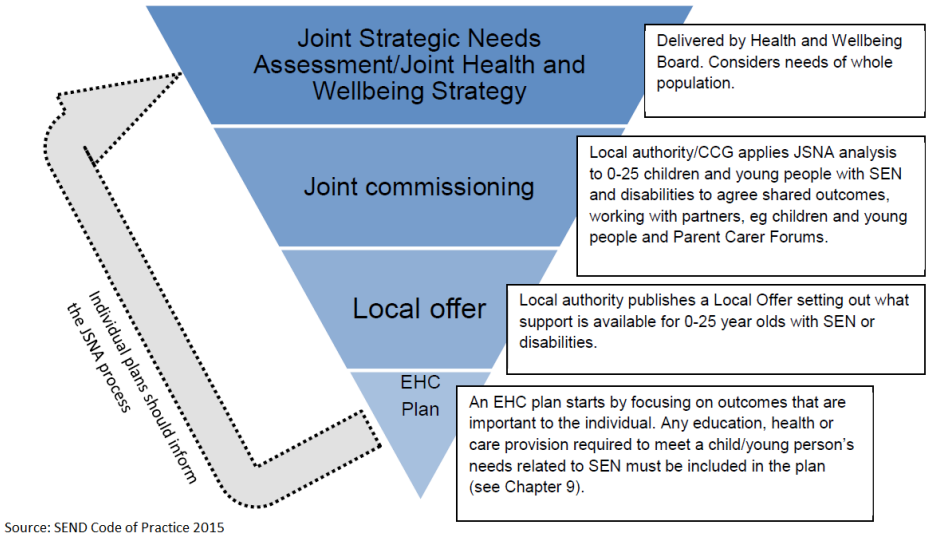
Recommendation:

The Health and Wellbeing Board strengthens strategic partnership working and ensures robust governance arrangements are in place between statutory and non-statutory bodies to monitor and promote the health and wellbeing of children with SEND

2. Introduction

2.1. Joint Strategic Needs Analysis (JSNA)

The purpose of a JSNA is to improve the health and wellbeing of the local community and reduce inequalities.[11] They are not an end in themselves but a continuous process of strategic assessment and planning. The aim is to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities. They will be used to determine actions local authorities, the local NHS and other parties need to take to meet health and social care needs and to address the wider determinants that impact on health and wellbeing.



Source: SEND Code of Practice 2015

2.2. Definitions and Scope

The scope of the JSNA is the current and future health and care needs of children and young people with special educational needs and/or disability (SEND) aged between 0-25 years as identified in the SEND Code of Practice. These are defined as:

- Child or young person (0-25 years) with a learning difficulty or disability which calls for special educational or training provision[12] at early years providers, maintained nursery schools, mainstream schools and mainstream post-16 institutions.
- Child or young person (0-25 years) with a disability under the Equality Act 2010 i.e. 'a physical or mental impairment which has a long-term and substantial adverse effect on their ability to carry out normal day-to-day activities'.[13]

A child or young person has SEN if they have a learning difficulty or disability that means they need special educational provision or support to help them learn. This means they have a significantly greater difficulty in learning than most of their peers, or they are not able to

[11] Local Government and Public Involvement in Health Act 2007 as amended by the Health and Social Care Act 2012
[12] Special Education Needs & Disability Code of Practice (2015) p15
[13] Ibid p17

use the universal provision available within their school because of their disability. The term 'SEN' applies across ages 0–25, although the term 'learners with learning difficulties and disabilities' (LLDD) is often used post 16 through to adult services.

Under the Equality Act 2010, a disability is defined as a physical or mental impairment which has a long-term and substantial adverse effect on their ability to carry out normal day-to-day activities. Children and young people with disabilities do not necessarily have SEN, but there is an overlap. Where a disabled child or young person requires special educational provision they will also be covered by the SEN definition.

In the Code of Practice[14] SEND is categorised into the following broad areas of need:

Cognition and Learning

- Moderate learning difficulty
- Severe learning difficulty
- Profound and multiple learning difficulty
- Specific learning difficulty

Communication and Interaction

- Speech, language and communication needs
- Autistic spectrum disorder

Sensory and/or Physical Needs

- Visual impairment
- Hearing impairment
- Multi-sensory impairment
- Physical disability

Social, Emotional and Mental Health

2.3. Why this topic is important

SEND is a broad concept encompassing a vast array of conditions. 8% of all children (0-18 years) in the UK have a disability.[15] The table below shows a breakdown by type of impairment.

Table 1 - Impairment types 2016/17. Source: DWP, Family Resources Survey

Impairment type	% of Children who are disabled
Mobility	22
Stamina/breathing/fatigue	26
Dexterity	11
Mental health	22
Memory	11
Hearing	7
Vision	9
Learning	37
Social/behavioural	41
Other	17

[15] Department for Work & Pensions, Family Resources Survey 2016/17

Children with neurodevelopmental impairments and conditions are the largest group of disabled children and young people. The estimated prevalence is around 3-4% of children in England.[16]

Children in socio-economically disadvantaged households in early childhood are twice as likely than the least disadvantaged children to develop a disabling condition in later childhood.[17] In addition, the household income for a household with a disabled child is 13% lower than those with non-disabled children.[18]

There are no commonly defined risk factors for SEND and in many cases the cause is unknown or can be due to a combination of factors. Conditions can be developmental or acquired after birth. Recognised risk factors include:[19]

1. Premature birth and low birth weight – Low birth weight and/or premature babies have around a 20% likelihood of developing a disability.
2. Physical injury – This can arise whilst the child is in- utero following injury to the mother during pregnancy or following accident or injury to the child after birth.
3. Economic disadvantage – Lower socioeconomic status and associated lifestyle factors increases the risk of childhood illness and disability.
4. Chromosomal and genetic abnormalities – these can give rise to conditions such as phenylketonuria, thalassemia and Downs syndrome.
5. Parental age - older and younger parents are at greater risk of pregnancy and birth complications that may result in disability.
6. Infectious diseases suffered by mothers and children – maternal infections during pregnancy including measles and HIV in addition to those acquired in early childhood such as meningitis can result in illness and disabilities such as deafness.
7. Poor maternal nutrition. Poor nutrition increases the risk of poor placental transfer of oxygen and nutrients to the baby. The lack of certain vitamins and mineral deficiencies, such as folate deficiency, can lead to adverse effects including spina bifida.
8. Exposure to drugs and radiation – in utero exposure to drugs, including medicinal ones, environmental pollutants and radiation can result in birth defects.
9. Maternal substance misuse – excess maternal drug and alcohol use can lead to disabilities such as foetal alcohol syndrome in the child.

Disabled children and young people are more likely to experience barriers to social participation, be at higher risk of violence and abuse and experience difficulties accessing key services and support.[20]

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[16] Emerson, E. (2012) Deprivation, ethnicity and the prevalence of intellectual and developmental disabilities. Journal of Epidemiology and Community Health; 66:218-244
[17] Sorenson, HT. et al, (1997) Birth weight and cognitive function in young adult life: historical cohort study. BMJ;315:401-403
[18] Woolley, M. (2004) Income and Expenditure of Families with a Severely Disabled Child. York: Family Fund
[19] Saggu and Wilkes (2013)
[20] Blackburn et al, Annual Report of the Chief Medical Officer 2012, Chapter 9

2.4. National Strategies and Policies

The SEND Code of Practice 2015 is the statutory guidance for SEND used by local authorities, schools, and other providers. It is underpinned by the legislation set out in the Children and Families Act 2014.

The Code of Practice is based on these key principles:

- Participation: The views of children, young people and their families must be central to decision making, at both individual and strategic levels.
- Identification of needs: Early years providers, schools and colleges should identify needs and make provision as soon as possible. All local agencies must work together in Health and Wellbeing Boards to assess health needs of local people.
- Choice and control: Services should be evidence based, taking examples from best practice and tailoring them to individual needs. Goals should focus on the child or young person's strengths and capabilities and the outcomes they want to achieve.
- Collaboration: Education, health and social care services must work together to assess local need and continually review SEND provision. Joint commissioning arrangements must be in place to support those with SEND, whether or not they have an EHCP.
- High quality provision: Schools and colleges should ensure provision of high quality teaching with high ambitions and stretching targets.
- Inclusive practice: Removal of the barriers to learning and participation in mainstream education. No discrimination of disabled children for a reason related to their disability.
- Preparation for adulthood: Aspiration for successful long-term outcomes in adult life. Local agencies should work together to help children and young people realise their ambitions for higher education, employment and independent living.

There is also the NICE guidance on transition from children's to adult's services for young people using health or social care services[21] which is relevant for some young people with SEND. The overarching principles are that young people and their carers are involved in planning, co-production and evaluation of transition services, the support should be strengths-based and person-centred, education, health and social care should work together to plan for young people with transition support needs.

2.5. Local Strategic Approach

'Our aim is for Birmingham to be an aspirational city to grow up in and a main priority for Birmingham City Council is to improve protection of vulnerable children and young people'.[22] Birmingham Health and Wellbeing Board recognise improving the wellbeing of children as a key priority.[23]

Birmingham had a joint local area SEND inspection by Ofsted and CQC in June 2018 which found significant areas of weakness in the local area's practice. In response to this Birmingham City Council, Birmingham and Solihull CCG, Birmingham Children's Trust and

[21] National Institute for Health and Care Excellence, NICE guideline NG43, February 2016
[22] Birmingham City Council Plan 2018-2022
[23] Birmingham Health and Wellbeing Board Strategy https://www.birmingham.gov.uk/hwb-strategy

Birmingham Community Healthcare NHS Foundation Trust have joined together to form the SEND Improvement Board (SIB), a local strategic partnership, with a collective commitment to fundamental change and improvement in how the local area works together to provide care and services to children with SEND.

The multi-agency partners of SIB have developed a set of principles that will support the delivery of these improvements. Underpinning these principles is the absolute commitment to a model that supports a child-centred approach modelled on trust and honesty irrespective of organisational boundary.

Local strategies and commissioning plans relating to children and young people with SEND include the following:

1. Child Health Improvement Programme (CHIP) part of the Birmingham and Solihull Sustainability and Transformation Partnership.
2. Neurodevelopmental pathway commissioning plan
3. Speech and Language Therapy (SALT) commissioning plan and commitment to a tiered communication strategy – universal, targeted and specialised
4. Designated Medical Officer (DMO) SEND expansion
5. Designated Clinical Officer (DCO) role
6. Children in Care (CiC) nursing expansion and join up of CiC and EHCP processes
7. Occupational Therapy (OT) commissioning plan
8. Physiotherapy commissioning plan
9. Social Care Transition Strategy 2018-2021
10. BCHFT Transition policy.
11. The Birmingham Strategy for Transition, 2018 – 2021.

3. The Birmingham Picture – level of need

3.1. 0-25 year old population in Birmingham

Birmingham is the largest local authority in Europe and the UK's second city, home to an estimated current population of 1,137,123.[24] The city has a younger population, a more diverse background and higher than average levels of deprivation compared to the rest of England.

An above average birth rate and high levels of immigration in recent years has increased the number of children and young people in Birmingham putting pressure on schools and children's services. There are approximately 17,000 births in the city each year.[25] Between 2013-2016 20,528 overseas migrants aged less than 18 years were newly registered with GPs in the city.[26] 30% of these were from Romania. The perception from Birmingham SEND professionals is that there is a high level of need and complexity in new to city cases across education, health and care.

[24] Office for National Statistics, 2017 mid-year population estimates
[25] Office for National Statistics, Births 2010-2016
[26] NHS Digital "Exeter" GP registration data 2013-2016

450,047 of our population are aged between 0-25 years and make up 40% of the total population. The city has several universities and higher educational establishments which contribute to the large numbers aged between 20-25 years in the city.

Table 2 – Age breakdown of Birmingham and England population

Age Groups	Birmingham	England
0-4	85,190	3,429,046
5-9	82,968	3,428,266
10-14	76,679	3,070,254
15-19	79,893	3,179,410
20-25	125,317	4,333,510
Total 0-25	**450,047**	**17,440,486**
All ages	1,137,123	54,786,237
% aged 0-25	**40%**	**32%**

Source: 2017 mid-year estimates, ONS

3.2. Ethnicity

According to the Census 2011 46% of the under 25 year olds in Birmingham were of White ethnicity. This compares to 79% at a national level. The next largest ethnic group was Asian with 33% of this age range with this ethnicity (10% for England). Between 2001 and 2011 the 0 to 24 age range had the most dramatic changes to its ethnic profile with an 80% increase in the Black population (+17,653). The Asian population increased by over a third (+33,996) during the 10 year period. The trend of increasing Black, Asian and Minority Ethnic (BAME) younger population in the city looks set to continue. Changes in the ethnic profile may affect demand for services.

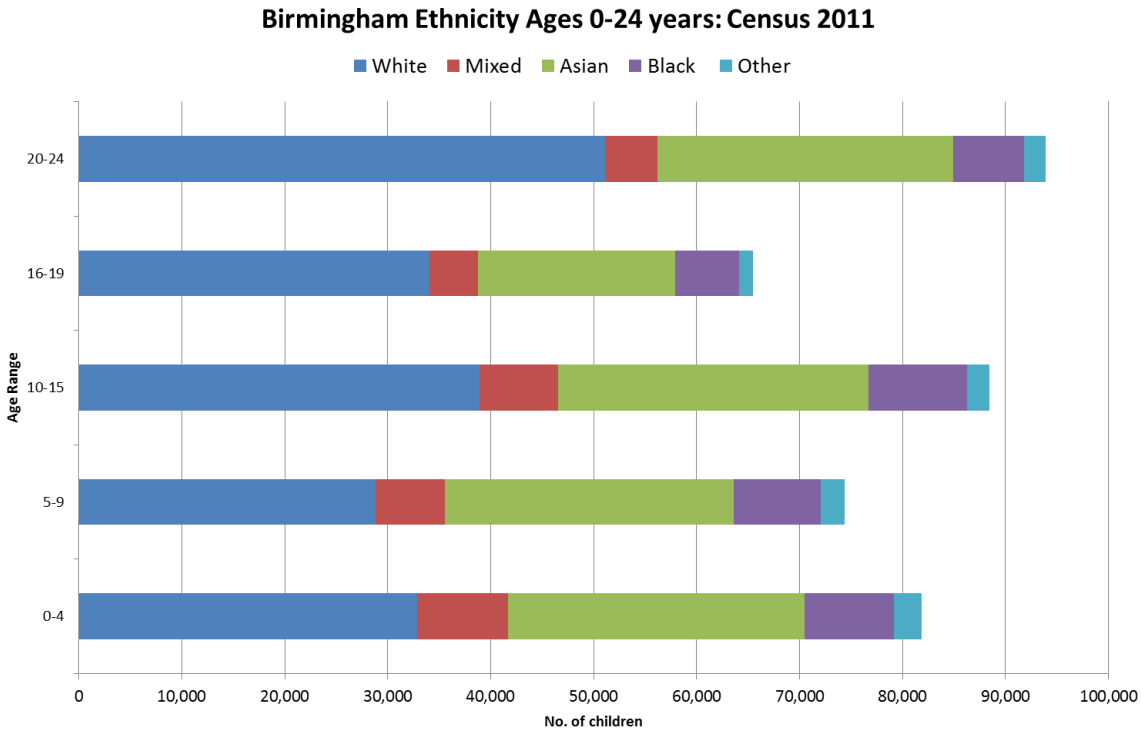

Figure 1 – Ethnicity of Birmingham population aged 0-24

3.3. Projected population increase

The local population aged 0-24 years is predicted to increase by 2% in 2022 (an extra 10,000) and by 6% in 2027 (an extra 24,000).[27] This will increase the demand for local schools and other services for children.

3.4. Deprivation

The Birmingham local authority area has high levels of deprivation with 40% of the population living in the 10% most deprived areas of England. The Index of Multiple Deprivation (IMD) is a measure of the relative levels of deprivation at small area levels. The figure below shows the local areas by their national rank, the darkest shading being the most deprived. There is a strong association between low income and higher rates of SEND prevalence.[28] Children identified as having SEND are more likely to experience poverty and have lower educational outcomes.[29]

[27] Office for National Statistics, 2016-based subnational population projections
[28] Parsons S., Platt, L., Disability among young children: prevalence, heterogeneity and socio-economic disadvantage (2013)
[29] Shaw B., Bernades, E., Trethewey, A. & Menzies, L. Special educational needs and their links to poverty (2016)

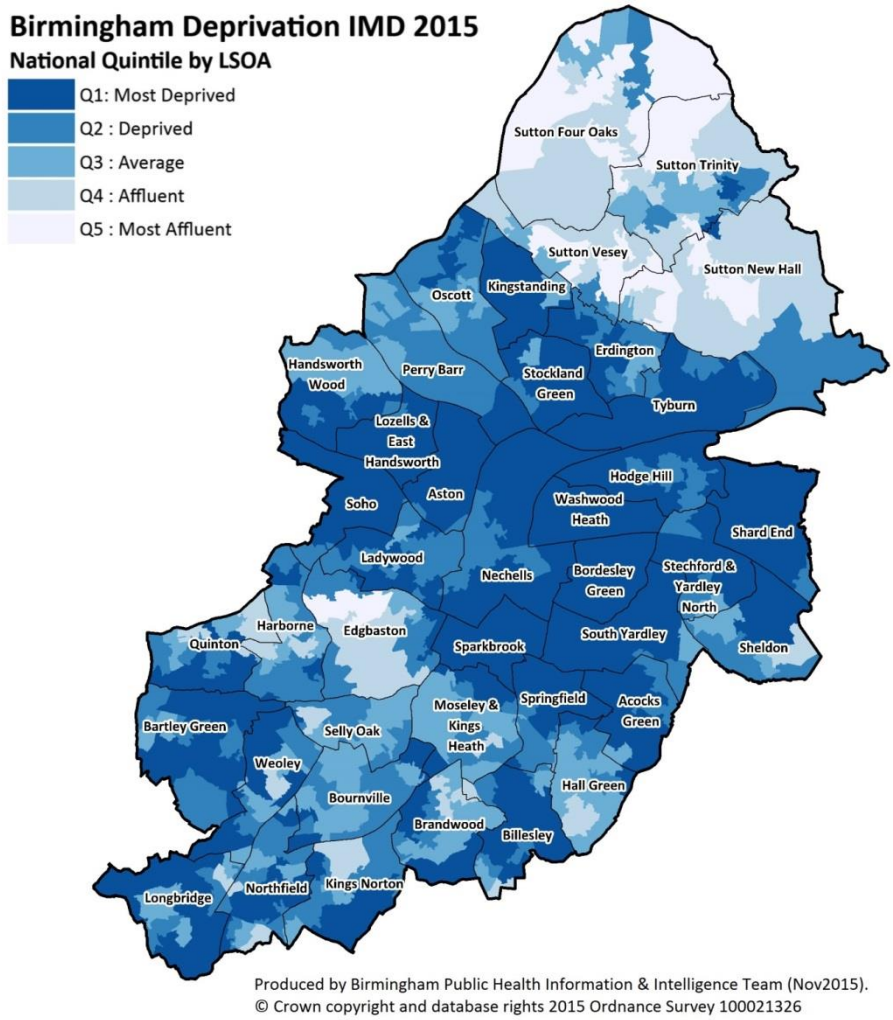

Figure 2 – map showing IMD2015 deprivation in Birmingham

3.5. Maternity and neonatal

The fertility rate of women is higher in Birmingham (69.7/1,000) compared to West Midlands (69.7) and England (62.5).[30] Birmingham has one of the highest infant mortality rates in the country (7.9/1,000 live births) and significantly higher than the England rate (3.9/1,000).[31] Low birth weight is a factor that can affect health outcomes and in Birmingham 9.7% babies were born at term with low birth weights which is higher than the West Midlands Regional (8.6%) and higher than the national average (7.3%).[32]

[30] ONS Births (2014-2016)
[31] ONS Births and Deaths (2014-2016)
[32] ONS Births (2014-2016)

3.6. Estimated prevalence of SEND

The limitations of data quantifying the number of children and young people with disabilities and their types and severities in the UK is widely acknowledged[33] with a notable absence of data nationally around trends and socio-demographics characteristic of disabled and special needs children. There are several different sources available to estimate the number of children with SEND. These include pupils with special educational needs (SEN), children with a limiting long term illness (Census 2011) and the Education Health and Care assessments are carried out when a school does not have the expertise or funding to identify a child's needs or are unable to make provision for the child's needs. The prevalence of pupils with an Education Health and Care Plan (EHCP) in Birmingham schools is 3.2%. This is significantly higher than the national figure of 2.9% and higher than other English core cities. Prevalence is calculated from the numerator of the number of pupils with EHCPs divided by denominator of total pupils from the annual School Census. Prevalence has remained constant since 2009. However as the number of children in Birmingham has increased by 11% over this period so have the number of children with EHCPs. There were 6,869 children recorded as having a plan within Birmingham schools in January 2018. However the total number of Birmingham children and young people aged 0-25 years with an EHCP at January 2018 was 9,023 (includes early years and post-16 EHCPs). The figure below shows that although the prevalence has decreased slightly in Birmingham since 2009, overall numbers have risen.

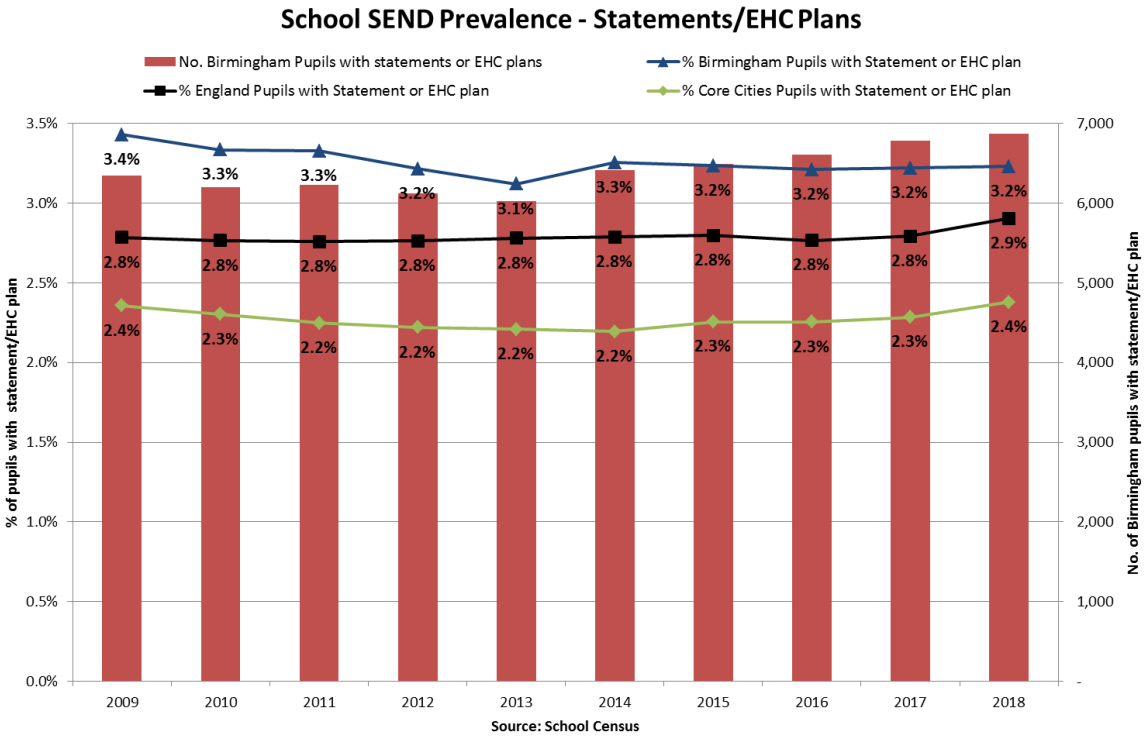

Figure 3 – SEN Statements and EHCPs, prevalence and numbers, 2009-2018

In addition to EHCPs, school staff will identify children that they can provide extra or different SEN support to within the school's own resources without a plan. Nationally and

[33] Hutchinson and Gordon, 2004

locally the proportion of pupils receiving SEN support fell between 2012 and 2016. Figure 3 shows that SEN support prevalence remains higher in Birmingham than nationally, however is similar to the other English core cities. In January 2018 there were 28,603 children recording as receiving SEN support at Birmingham schools.

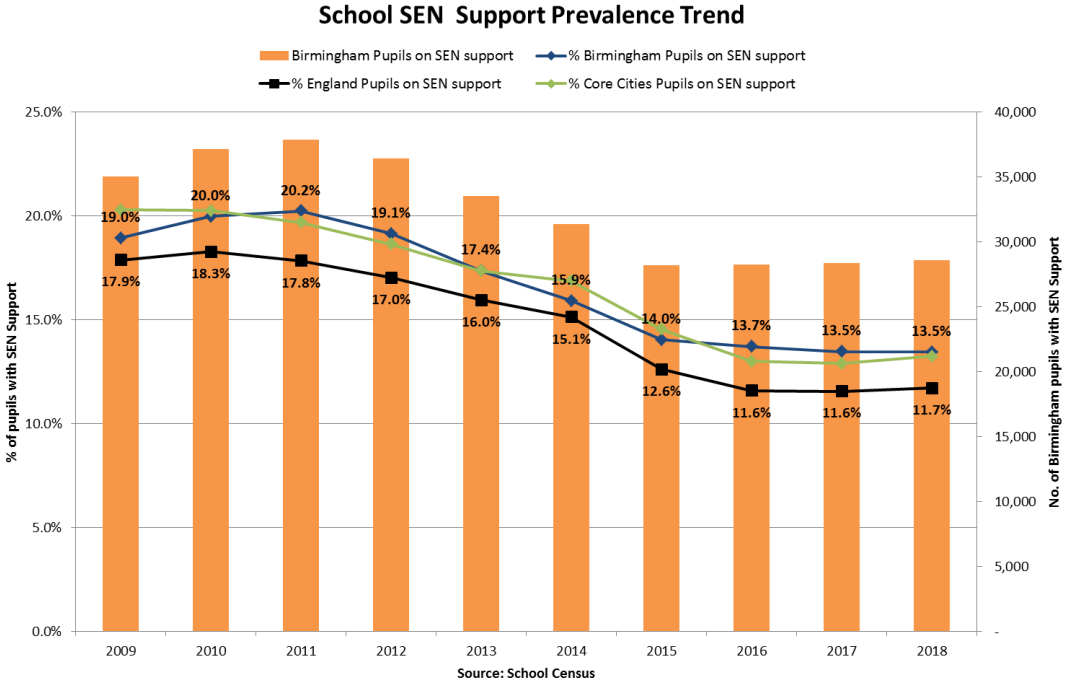

Figure 4 – SEN support without a statement or plan, prevalence and numbers, 2009-2018

The Census records the number of children with a long-term health problem or disability which limits daily activity. In 2011 there were 19,598 children and young people (aged 0-24 years) in this category. The prevalence is higher than the national average.

Table 3 – Numbers and prevalence of long-term health conditions limiting daily activity

Age Group	Birmingham limiting long term health	Birmingham prevalence	England prevalence
0-4	2,288	3%	2%
5-9	3,647	5%	4%
10-14	4,319	6%	5%
15-19	4,466	6%	5%
20-24	4,878	6%	5%
0-24	**19,598**		

Source: Census 2011

Although there is no single reliable source of prevalence for children and young people with SEND, the proxy data used indicates that the prevalence, in Birmingham, is higher than the national average.

4. SEND Services

4.1. Local Offer

The Local Offer is where all the information about provision available for children and young people who have SEND. This includes universal, targeted and specialised service across education, health and care. Birmingham's Local Offer is found on the Council's website[34] and is currently being reviewed.

4.1.1. Education, Health and Care Plans

The Special Education Needs Assessment and Review Service (SENAR) has responsibility for the Education Health and Care plans (EHCP) assessment process in the city. EHCPs address the health and social care needs of the child or young person as well as their educational needs and can be in force from the ages of 0-25. These are issued following formal assessment by a local authority and set out the child's needs and the extra help they should receive.

Children and young people with EHCPs are catered for at a variety of settings around the city; these include:

- Home education for pre-school children
- Maintained nursery
- Private, voluntary and independent early education settings
- Maintained primary
- Maintained secondary
- City technology colleges
- Academies – primary, secondary, special and alternative provision converters, primary, secondary and special sponsor-led and primary, secondary, special and alternative provision free schools
- Maintained special (including general hospitals)
- Non-maintained special
- Pupil referral units
- Independent schools

[34] BCC website https://www.birmingham.gov.uk/info/50034/birminghams_local_offer_send online accessed 11/12/2018

The trend analysis for EHCP (Figure 5) shows a large increase between 2017 and 2018. In January 2018 there were 9,023 children and young people, with EHCPs, living in Birmingham.[35] The reason for the large increase is due to the change to the new EHCP process particularly in capturing data for early years and post 19 children and young people.

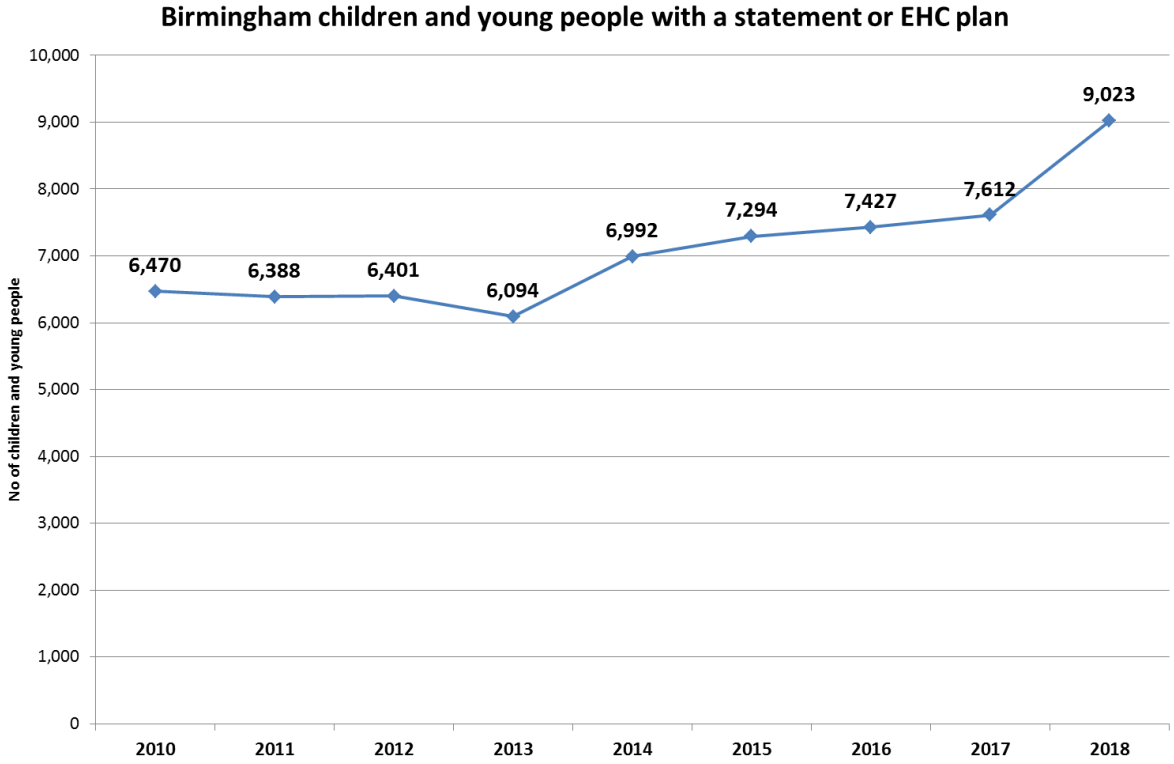

Figure 5 – Trend chart of EHCP and Statements in Birmingham 2010-2018 (SEN2)

The Birmingham process for EHCP assessment is set out in the EHC Pathway. The child or young person's needs are initially measured using a CRISP assessment (Criteria for Special Provision) by an Educational Psychologist. CRISP is nationally recognised as an effective model to assess need, determine provision and allocate resources.

EHCPs can utilise personal budgets to enable greater personalisation and provide choice and control to the child and young person. However, in Birmingham in 2017 only 4 personal budgets were issued, transferred or reviewed.[36] The average number of personal budgets for English Core Cities was 122. Nationally the average was 77. The low take-up may be due to lack of awareness or a lack of demand for this option in Birmingham.

In 2017 only 2.1% of EHC assessments did not result in an EHCP being issued. For England this was 4.9%. For the English Core Cities 2.8% of assessments do not result in a plan. This could mean that the process is more lenient (or thresholds are lower) in Birmingham or

[35] January 2018 School Census, General hospital schools census 2018 and School Level Annual School Census 2018
[36] Department for Education, Statements and EHCPs in England

that needs are being more effectively met, in other areas without having to go through the assessment process.

The 2018 SEND inspection found that EHCPs are usually completed within the prescribed timeline. However according to the Ofsted CQC inspectors the quality varies and too many are not of a good standard. A comment from the Ofsted CQC inspectorate was that EHCPs tend to be education led with little information about health and social care. There is a problem with outdated information with reviews undertaken not reflected in the plans. The statutory responsibility for the EHCP assessment process is with Education. The process is led by education staff with advice and support from health and social care professionals.

4.1.2. Community Health

There are a range of targeted community health services for children and young people with SEND in Birmingham. These services are provided by Birmingham Community Healthcare Foundation NHS Trust (BCHFT) and BWCT (Forward Thinking Birmingham). These services address a spectrum of health needs that are broadly categorised as:

- **'universal' services** provided to all children and families such as the routine immunisations, scheduled development checks, Birmingham Forward Steps integrated early years service (incorporates health visiting and children's centres) and the School Health Advisory Service (school nursing)

- **'specialist' services** provided to children and families with additional health needs who may require more specialised assessment and interventions such as those provided by the five child development centres, speech and language therapists, physiotherapists, occupational therapists, community children's nurses, palliative care nurses, complex care nurses, special school nurses, the Turtles short break unit or community paediatricians. In addition BCHCFT also provide specialist care for young people aged 19 and above with learning disability and for young people with a range of needs, but particularly cerebral palsy at the Regional Rehabilitation Unit in Selly Oak.

4.1.1. Access to community health services

Many of the children accessing the specialist services will be receiving SEN support or have an EHCP, but not all. This information is not currently routinely shared between Education and Healthcare services. From the information currently collected by BCHCFT it is not possible to categorise the complexity of need.

Data obtained from Birmingham Community Healthcare NHS Foundation Trust for 2017-18 shows that the most accessed service (excluding health visiting) was community paediatrics with 11,759 users of this service. This was followed by school nursing (in mainstream schools) with 11,192 users recorded. Most of the children using community healthcare services (62%) are aged 0-4 years. There are issues with data coding and we are unable to tell complexity and detail of the cases.

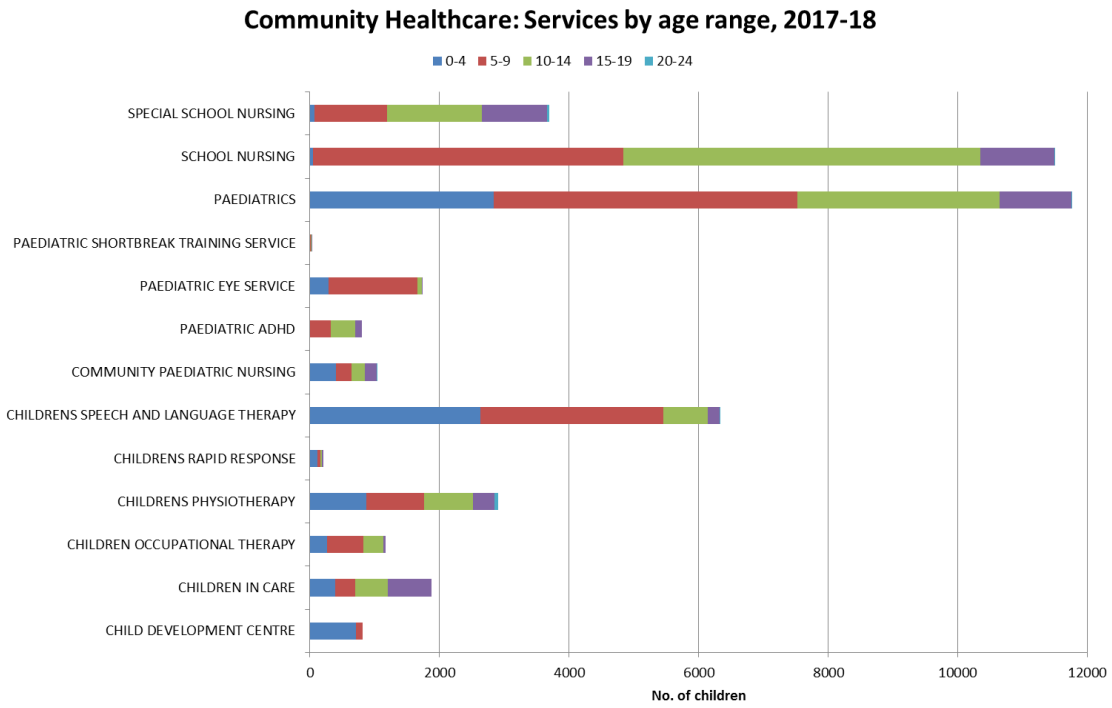

Figure 6 – Chart of community healthcare service use by age range. Source: Birmingham Community Healthcare Trust

The figure below shows the ethnicity for community healthcare patients aged between 0-25. 34% of the children and young people were of White ethnicity and 30% of Asian ethnicity. Ethnicity is not known or not stated for many patients.

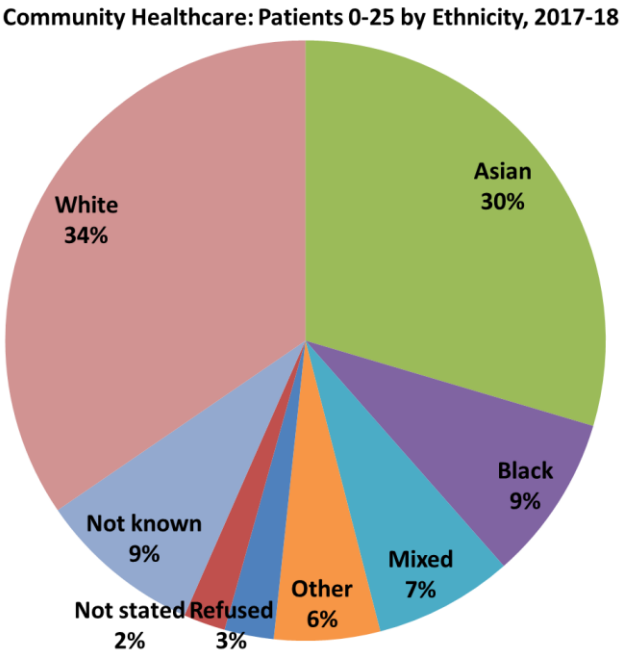

Figure 7 – chart of Community Healthcare patients by ethnicity

4.1.2. Social Care

Birmingham Children's Trust has a range of services for disabled children. Disabled Children's Social Care supports families who are caring for a child aged 0-18 years old with substantial, complex and critical needs. The area social care teams do also work with children and young people falling within the SEND definition however data on disabilities is not recorded therefore it is not possible to identify these children.

Children in Care (CIC), also known as Looked After Children, are those either accommodated under Section 20 of the Children's Act or subject to a care order where the local authority has legal responsibility for the child. In Birmingham 25.2% of CIC have an EHCP compared to 28.2% for England.[37] Children in need (CIN) are defined as children who are aged under 18 and need local authority services to achieve or maintain a reasonable standard of health or development, need local authority services to prevent significant or further harm to health or development or are disabled. In Birmingham 28.4% of CIN had an EHCP compared to 21.4% in England.[38]

Analysis of trend data from the local Carefirst information system on cases assigned to the Disabled Children's Social Care teams (DCSC) shows that the number of children in care has remained at a similar level between 2014 and 2018. During the same period the number of children in need has risen.

[37] Department for Education, Outcomes for Children Looked After by Local Authorities in England 2016/17
[38] Department for Education, Characteristics of Children in Need in England 2016/17

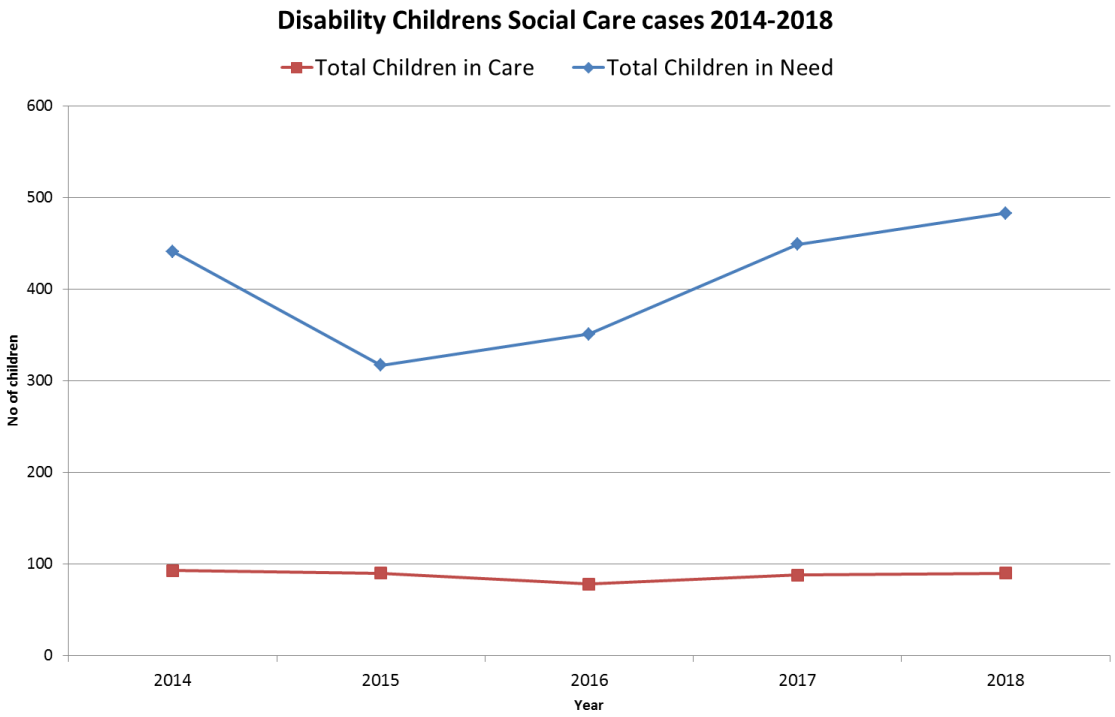

Figure 8 – Trend chart of Disability Children's Social Care cases 2014-2018. Source: Carefirst

The following types of service are currently provided by Birmingham Children's Trust:[39]

- Home Support – help with washing and dressing, support with developing social skills, providing outdoor activities and befriending services in the community.
- Direct Payments – Money for care and support allowing more choice and control.
- Short Break fostering –provide short term and permanent fostering arrangements.
- Children's Residential Homes – Charles House and Warwick House offer short breaks and overnight stays and Edgewood Road (Turtles Unit) that offers permanency and short breaks with nursing care from qualified NHS staff.
- Norman Laud Centre a voluntary organisation which offers overnight short breaks, day care and activity service; has indoor and outdoor facilities; and works in partnership with parents, carers and many professionals to provide high quality care.

Information obtained from Birmingham's Carefirst database shows that the most accessed resource was direct payments, followed by home support. The services are used mainly by school-aged children, the majority of these are of secondary school age.

Parents reported to Ofsted CQC inspectors that they were not aware which short breaks are offered or how to access them. The criteria are not clear on the local offer. Birmingham has spent less than other areas on short breaks. Short breaks are also provided by BCHCFT's Turtles unit and by Acorns Children's Hospice Trust.

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[39] Birmingham Children's Trust [online] https://www.birminghamchildrenstrust.co.uk/info/4/information_for_families_and_carers/62/disabled_children_s_social_care/1 (accessed 16/10/18)

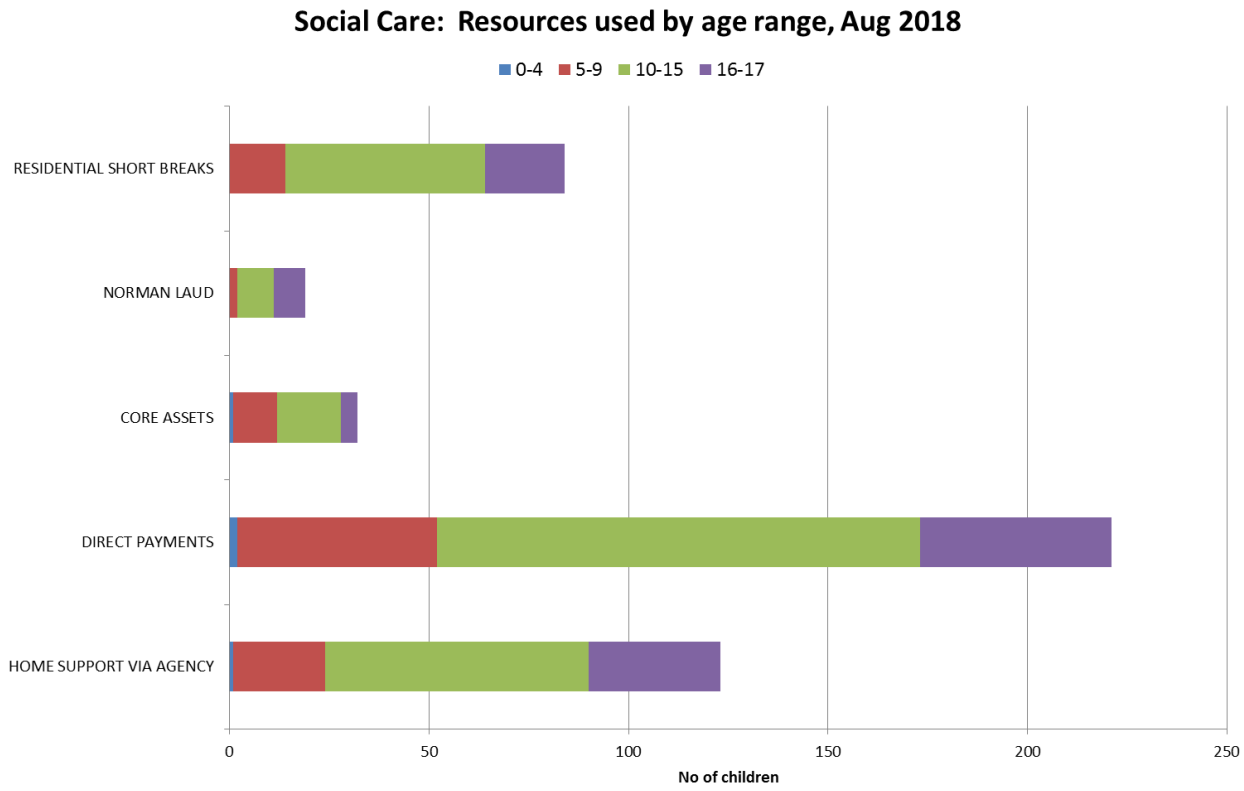

Figure 9 – Chart of resources used by age range. Source: Carefirst Aug 2018

Analysis of the age and gender of children in care and children in need assigned to the DCSC teams tells us that these children are more likely to be male and of secondary school age. 61% of children in care cases and 68% of children in need cases are male. 40% of the children in care assigned to DCSC and 55% of children in need are aged between 10-15 years.

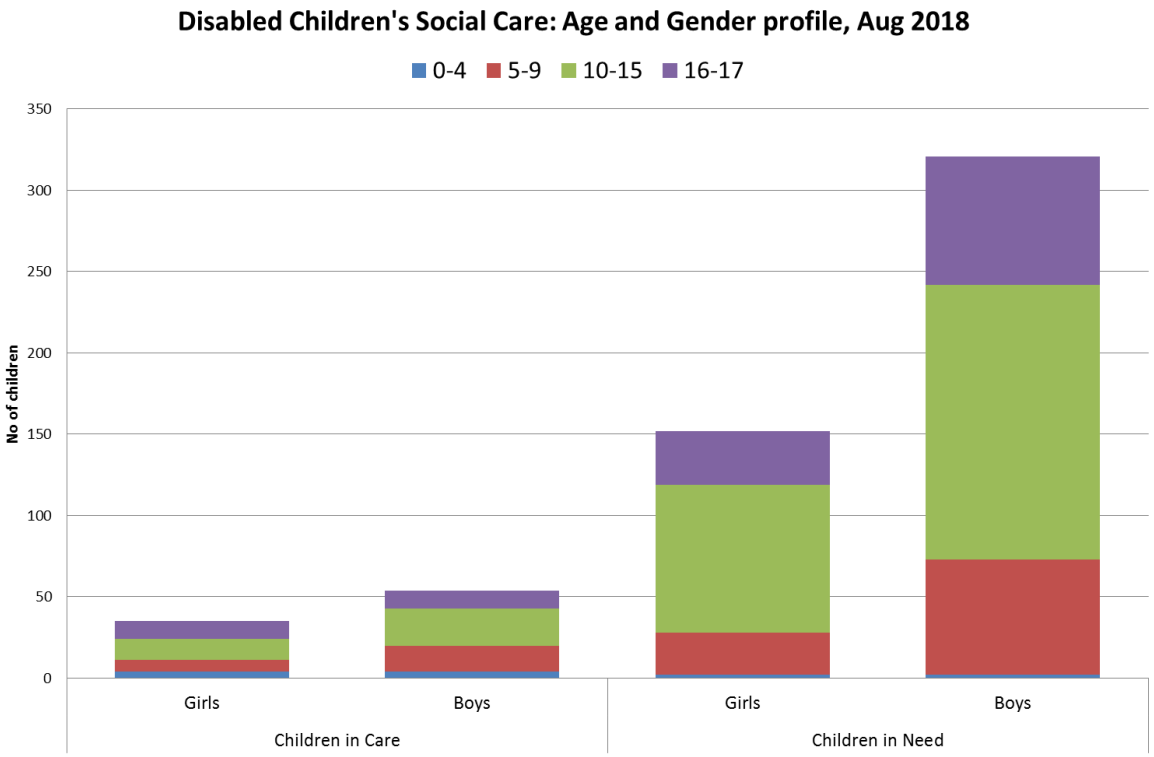

Figure 10 – Chart of disabled children social care clients by age and gender. Source: Carefirst Aug 2018

The figure below shows the ethnicity and gender for the social care cases. 43% of children in care assigned to DCSC are of White ethnicity. 45% of children in need are of Asian ethnicity.

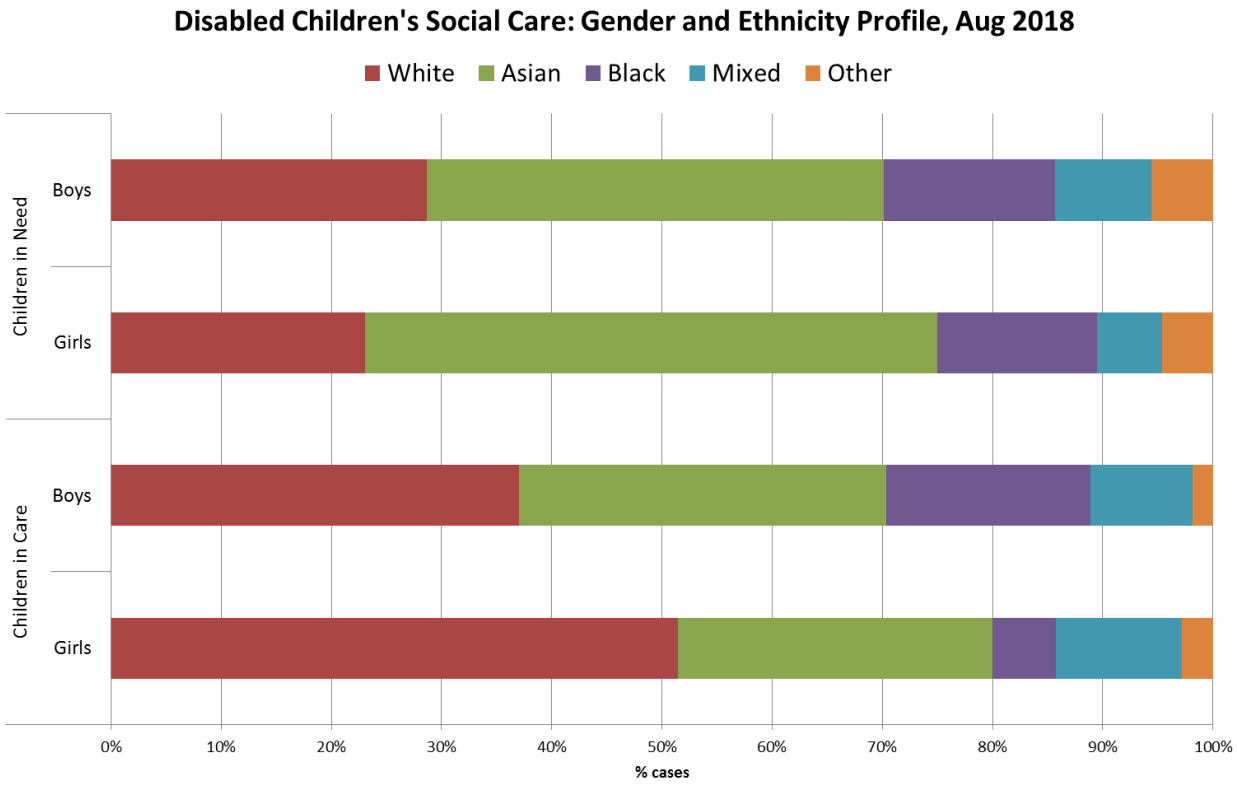

Figure 11 – Chart of ethnicity and gender of disabled social care clients. Source: Carefirst Aug 2018

4.2. Early years (0-5 years)

4.2.1. Birmingham Forward Steps (integrated Health Visiting and Children's Centre Service

This service works in the community offering mandated health visitor developmental assessments, support, advice and providing universal services to families.[40] It includes community nursery nurses, children's centre staff, clerical assistants, and community staff nurses. Health visitors receive updates from other services and place alerts with GPs relating to children with SEND. However, due to challenges in reaching families in the city, only around 67% (2017/18 data BFS) have received their 2-2.5 year old health visiting assessment. This is particularly relevant since the 2-2.5 year assessment provides a key point at which children with development needs can be identified and referred for further assessment, help and support as necessary. Indeed, anecdotally it is reported that a high proportion of referrals into early years services already come from health visitors. The provider is committed to seeking new approaches to addressing this issue.

[40] Birmingham Health Visitor Service [online] http://www.bhamcommunity.nhs.uk/patients-public/children-and-young-people/services-parent-portal/birmingham-health-visitor-service/ (accessed 16/10/2018)

4.2.1. Child Development Centres (CDCs)

This service is for pre-school children with physical or developmental delay who may need additional help, support or intervention to enable them to reach their potential. There is a multi-disciplinary team including clinical services co-ordinators, consultant paediatricians and registrars, link workers, nursery nurses, occupational therapy, physiotherapists, teachers, and speech and language therapists supported by secretarial teams.

At present, all children referred are initially seen for a medical and development assessment by a community paediatrician who then decides the appropriate route for a multidisciplinary team assessment. This can result in a delay in a child being placed on a waiting list for assessment as there is no direct referral route to the multidisciplinary team. It does, however, ensure that the correct children are being referred to the most appropriate pathway for assessment. An all age neurodevelopmental pathway has been proposed and is under consideration by the clinical commissioning group which would allow direct referral to a multidisciplinary team for neurodevelopmental assessment (after initial triage). It is argued that all of these children (under 5s) would need to see a community paediatrician in any event so direct access to MDT would not change the pressure on community paediatricians but should speed up the process since other members of the multi-disciplinary team could be seeing children in a parallel but ultimately joined up assessment process.

There is no autistic spectrum disorder multidisciplinary diagnostic pathway for children over four years old currently. This demand may have been created by demand pressures in the under 5s service resulting in some children not reaching the top of the waiting list in time, as well as children whose need for a developmental assessment has not emerged until school age. These assessments are carried out almost exclusively by the community paediatric team who are not commissioned to deliver this service. Resulting in long waiting times and assessments which are not always NICE compliant (partly since the wider MDT is not involved). The SALT service and other parts of the MDT are also not currently commissioned to support this work. The implementation of the proposed all age neurodevelopmental pathway would seek to address this major capacity and service gap in service provision in the city.

At the point at which a child is identified and referred to the CDC e.g. by a health visitor, GP or nursery staff, the child should also be referred into the Early Years Support Service via a referral to Access to Education. This then enables the process of evidence gathering in education to start to inform the educational aspects of the child's needs. This process can also be time consuming and therefore it is equally important that the child is referred into this service at the earliest opportunity.

4.2.2. Early Years Education

Early years providers include state-funded nursery schools, private, voluntary and independent (PVI) settings and childminders. A state-funded nursery must have a qualified teacher identified as the SENCO (Special Educational Needs Coordinator). PVI providers

are expected to identify a SENCO. Early years providers must have arrangements in place to identify and support children with SEND.[41] The Early Years Foundation Stage is the statutory framework for children aged 0 to 5 years. The majority of 3 and 4 year olds in Birmingham attend some form of early years provision. Since September 2014 2 year olds with Disability Living Allowance have been entitled to free early education. In the spring of 2018, 62% of eligible 2 year olds were taking up this entitlement. In comparison with the England take up of 72%. All 3 and 4 year olds have a free offer and the take-up in the city was 90%, compared to an England take-up of 94%.

Babies and pre-school children with SEND receive their educational support in four different ways according to their individual needs and circumstances and move flexibly between the types of provision at individual transition points.

- Children known to the Early Support Service:
    - Babies/children with SEND at home with their parents/carers who require coordinated multi-agency SEN support in the family home, leading into EHC assessment where required, before they access any other form of early years provision (PVI or maintained mainstream/special school).
- Children known to the Area SENCO team:
    - Children in PVI settings who require coordinated multi-agency SEN Support leading into EHC assessment where required.
    - Children in PVI settings who require SEN support (Early Identification/ Increased Differentiation).
- Children in maintained nursery schools who require SEN support.
- Children in nursery classes (primary schools) who require SEN support.

The numbers of children who are accessing early years support services (education) has been increasing over the past 5 years. In 2017/18 academic year there were 2,067 children notified to Early Years Inclusion Support.

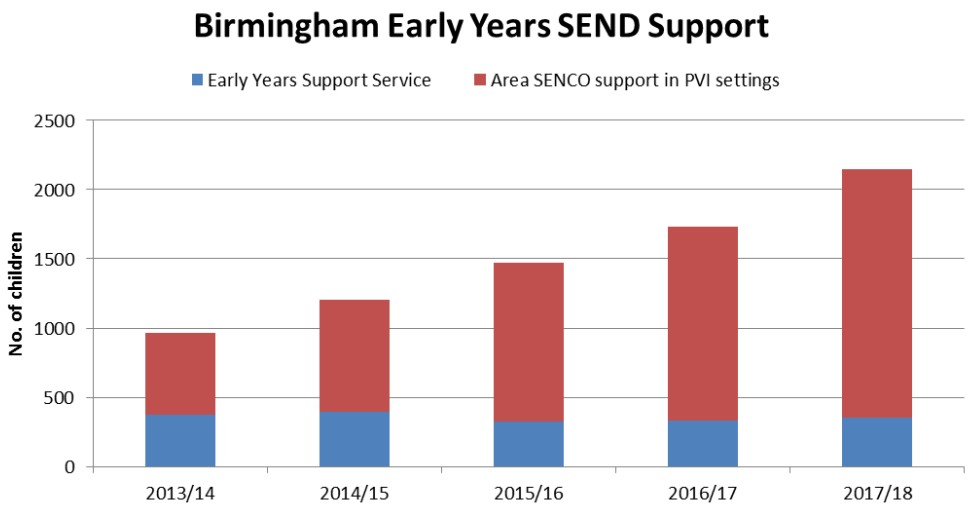

Figure 12 – Trend for Early Years SEND support services

[41] Early Years Guide to SEND Code of Practice, 2014, p9

According to the data collected during 2017/18 the priority need area most in demand in the 0-5 age range is communication and interaction. 73% of the in PVI settings receiving SEN support through a SEN and Early Support plan were categorised with this need. Using data on children with a SEN and Early Support plan and ONS 2016-based mid-year population estimates, a prevalence of 1.3% was calculated for Birmingham. The chart below breaks this down to constituency level and shows that the highest proportion of children with this type of support is in Sutton Coldfield constituency (this is at a statistically significantly higher level – the error bars show the level of certainty of the statistic). Prevalence is significantly lower in Erdington and Selly Oak constituencies.

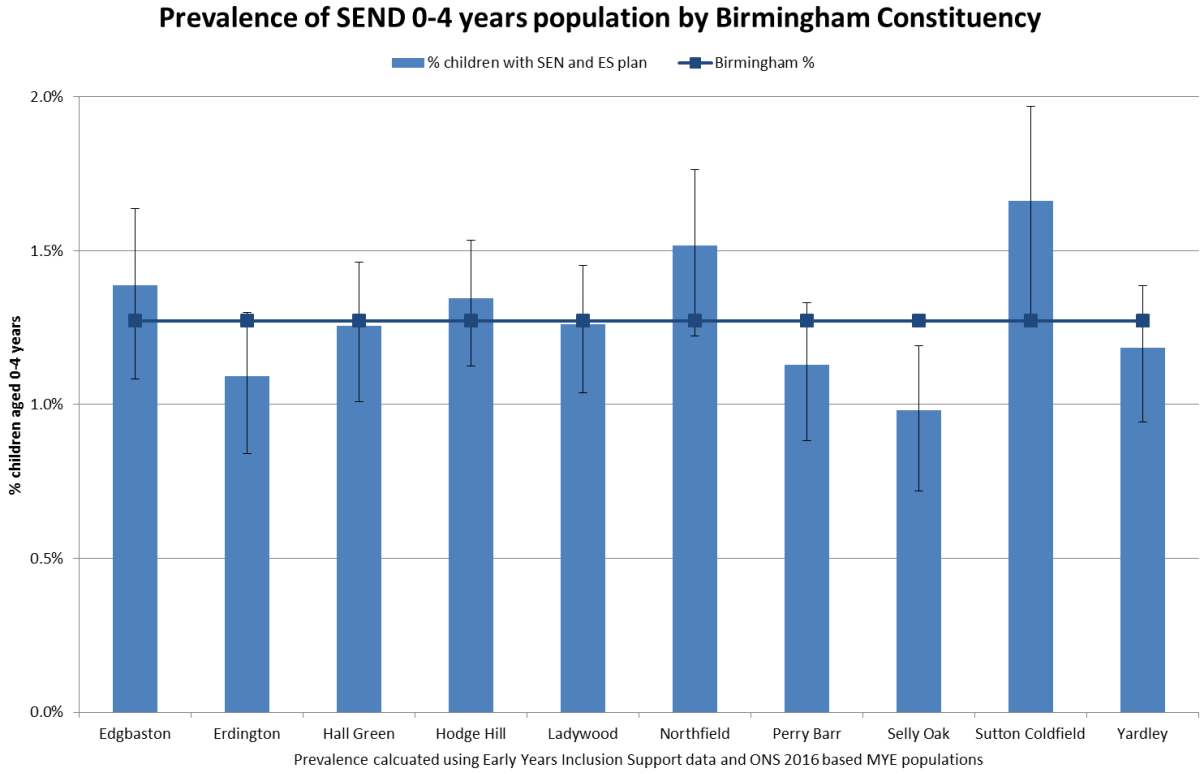

Figure 13 – SEND prevalence for 0-4 yrs population by District

4.2.3. State-funded nursery schools

There were 27 state-funded nursery schools in Birmingham in 2018 providing nursery education for 3,426 pupils. Overall numbers in Birmingham state-funded nursery schools have risen since 2014. In 2018 15 children (0.4%) at maintained nursery schools had an EHCP. 552 (16%) were receiving SEN support without a plan. The most common primary type of SEND need in nursery schools is speech, language and communication with 13% of all pupils in nursery schools recorded with this type of need.

4.3. School Aged Provision (5-18 years)

4.3.1. Special schools

Birmingham has 27 state-funded special schools. In January 2018 there were 4,219 pupils attending this type of school in Birmingham.[42] This was a 20% increase in the number of children at state-funded special schools from 2014. The table below shows that Birmingham has a higher proportion of pupils attending special schools compared to England and the English core cities. Those at these schools make up the majority of the total of school aged children with EHCPs. This is a much higher proportion of those with EHCPs attending special schools than England but similar to the core cities.

Table 4 – State-funded special school pupils, DfE 2018

	Birmingham	England	English Core Cities
Pupils at special schools	2.2%	1.5%	1.5%
Pupils with EHCP attending special schools	61.4%	46.5%	60.7%

The schools vary in size and area of expertise. Figure 5 shows the number of children attending the special schools by their primary need type. The largest school had 374 pupils and the smallest 61. 38% of the pupils at state-funded special schools were recorded as within the Autistic Spectrum SEND category.

[42] January 2018 School Census

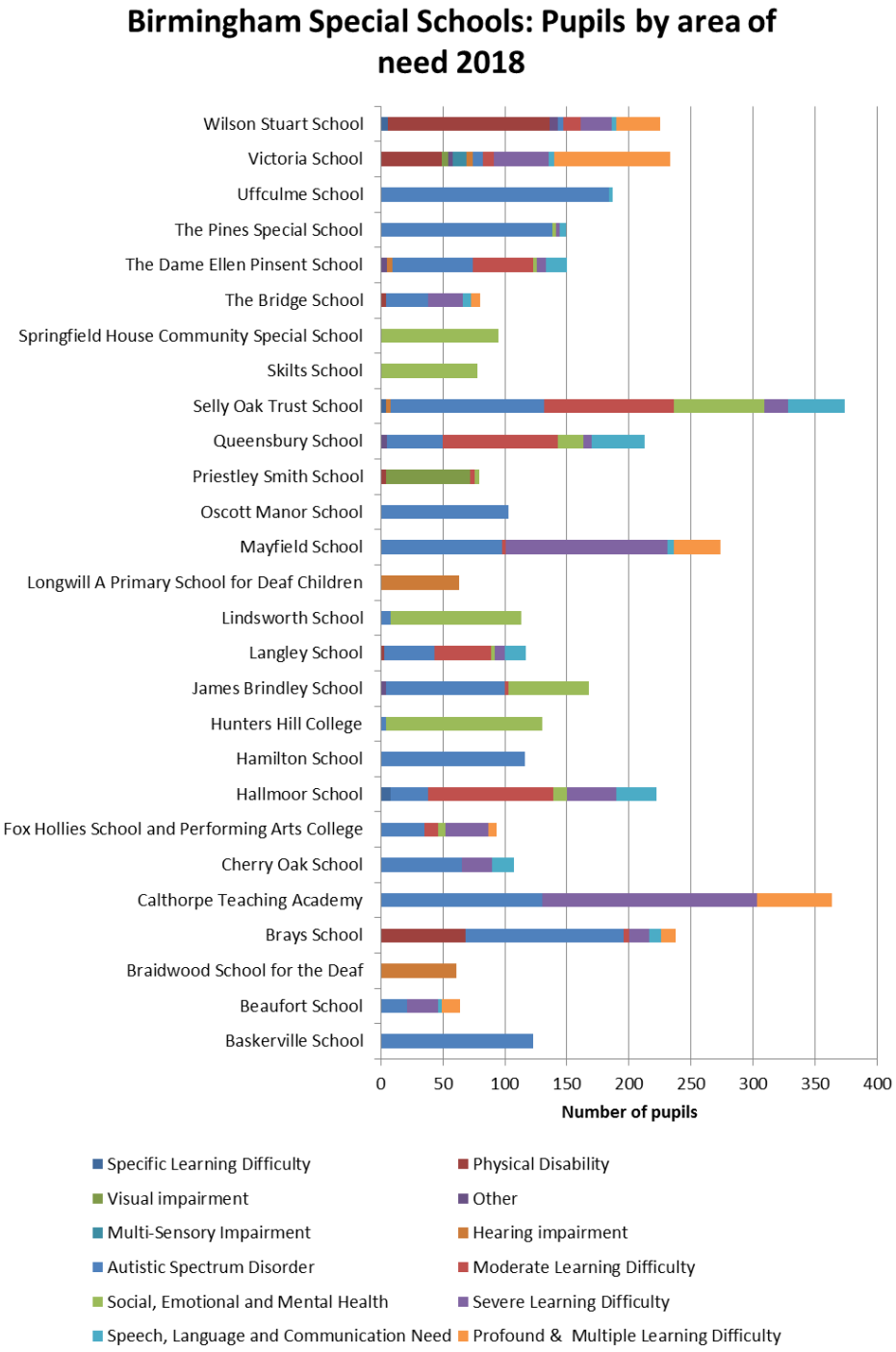

Figure 14 – Chart showing Birmingham Special State-funded Schools by size and primary need type, 2018

Key stage 4 (KS4) attainment

Pupils in KS4 are aged between 14 and 16 years during this time pupils are working towards GCSE and equivalent qualifications that are completed in Year 11. The total number of children at each special school entered for these qualifications is very low so it is not possible to capture attainment levels in these subjects. Data is available on the numbers of students by subject at the end of KS4 and how many of these were entered for the

qualification and is shown in the table below. There were approximately 350 Year 11 pupils at Birmingham state-funded special schools in 2018.

Table 5 - 2017 Birmingham State-funded Special School qualification data. Source: Dept for Education

Qualification	Total Students at end of KS4	Total Entered for Qualification
GCSE Maths (General)	158	49
GCSE English Language	107	36
GCSE Art & Design	165	40
GCSE Science (General/Combined)	189	59
BTEC Certificate Level 1 Computer Appreciation/Introduction	183	12
BTEC Certificate Level 1 Hospitality/Catering Studies	183	12
VRQ Level 1 Art & Design	102	16
VRQ Level 2 Computer Appreciation/Introduction	269	17

Special School exclusions

Birmingham excludes more pupils from special schools compared to England, statistical neighbours and the West Midlands region.

Table 6 – Permanent exclusions from special schools 2015-16. Source: DfE

Area	No. of Pupils excluded	Total No. of Pupils	% Pupils Excluded
Birmingham	**6**	**3,980**	**0.15%**
England	90	107,635	0.08%
West Midlands	10	14920	0.07%
Statistical Neighbours	6	9640	0.06%
Barking and Dagenham	0	310	0.00%
Coventry	0	854	0.00%
Enfield	0	608	0.00%
Greenwich	<3	456	*
Luton	0	421	0.00%
Manchester	0	1,243	0.00%
Newham	0	140	0.00%
Nottingham	0	551	0.00%
Slough	0	311	0.00%
Waltham Forest	0	766	0.00%

The proportion of children excluded from Birmingham special schools for 2015/16 was nearly twice the national average and much higher than for the West Midlands and Statistical Neighbours. However the actual number of exclusions is very low and therefore we should be careful in how we interpret this data.

Fixed term exclusions are more common; in 2016/17 431 pupils were excluded over a fixed term period from city special schools. The table below shows the reasons for exclusion and the percentage of children excluded from Birmingham special schools compared with those excluded from maintained primary and secondary schools.

Table 7 - Fixed-term exclusions from Birmingham Schools. Source: DFE Permanent and fixed-period exclusions in England 2016/17

Reason	Special schools	Primary and Secondary schools
Physical assault against a pupil	24%	25%
Physical assault against an adult	23%	5%
Verbal assault against a pupil	3%	4%
Verbal assault against an adult	12%	14%
Bullying	2%	2%
Racist abuse	1%	2%
Sexual misconduct	1%	1%
Drug and alcohol related	1%	2%
Damage	5%	3%
Theft	1%	2%
Persistent disruptive behaviour	12%	22%
Other	14%	18%

4.3.2. State-funded primary and secondary schools

Children with SEND receive support at schools through EHCPs. However, these are not the only SEND help provided in schools. There is also **SEN support** which is **extra or different help** from that provided as part of the school's usual curriculum without a formal assessment process. This category has replaced the former 'School Action' and 'School Action Plus' categories. Most children with SEND in state-funded primary and secondary schools are supported through SEN support. Following implementation of the School Funding Reforms (April 2013) the way in which SEN funding was allocated to schools and individual pupils changed significantly. The reforms meant that mainstream schools became responsible for funding high incidence, low cost SEN provision from their delegated budgets using their AWPU (Age Weighted Pupil Unit) element (assumed nationally at £4,000 per pupil) and up to £6,000 per pupil from their notional SEN budget. This includes support for those with and without an EHCP.

Primary

There are 298 state-funded (mainstream) primary schools within Birmingham. In January 2018 there were 116,745 pupils attending these schools. 1,105 children had a statement or EHCP (0.9% of all pupils). 17,532 were receiving SEN support at the primary school without a plan (15% of all pupils).

There has been a decline in the numbers of children with EHCPs in Birmingham primary schools (16% fewer (-215) compared to 2014). Numbers of children receiving SEN support without a plan have risen each year 2015.

The proportion of pupils at Birmingham's primary schools with EHCPs is similar to the national average and to the other English core cities. The proportion of pupils receiving SEN support is higher than the national average but similar to the core cities.

Table 8 – State-funded primary school pupils, DfE 2018

	Birmingham	England	English Core Cities
Primary pupils with EHCP	1.1%	1.4%	0.8%
Primary pupils with SEN support	15.0%	12.4%	14.2%

Of the pupils receiving SEND support (via an EHCP or school SEN support) the most common primary category of need is moderate learning difficulty (47%), followed by speech, language and communication (26%). A greater number of pupils are categorised under the moderate learning difficulty than nationally leading to concern that children's needs are not being accurately identified. Ofsted and CQC inspectors reported that there was a lack of willingness and ability by some mainstream schools to meet the needs of children with SEND.[43] However the SEND need is sourced from nationally published school census data and its accuracy is dependent on the recording of the data at a local level. There are concerns that this picture doesn't match with local professional knowledge where the belief is that Autism and not MLD is the most common category of need.

Since the 2018 inspection work has begun around the quality of EHCPs to make sure needs are more accurately identified.

[43] Ofsted and CQC, Joint local area SEND inspection in Birmingham (2018)

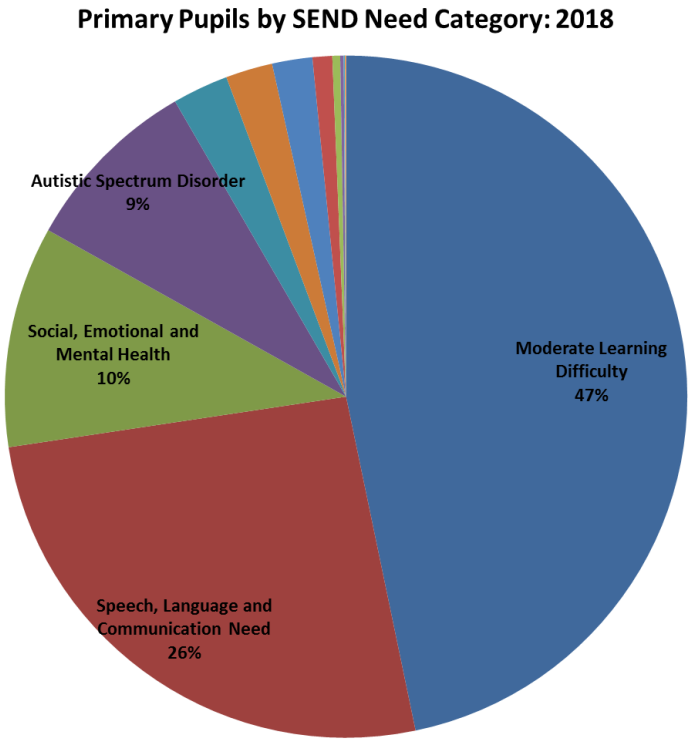

Figure 15 – Pie chart of state-funded primary pupils by SEND need category

Resource bases

There are 44 Resource Bases that offer additional resources to pupils with EHCPs. These are located at school sites around the city.[44] These specialise in different areas of SEND needs i.e. Autistic Spectrum, Cognition and Learning Difficulties, Physical and Sensory needs, Moderate Learning Difficulty, Speech, Language and Communication, Hearing Impairment and Visual Impairment. Work is underway to match identified SEND need in children and young people with current provision in Special schools and Resource bases to determine any gaps / overcapacity in provision.

State-funded secondary schools

There are 86 state-funded secondary schools (excluding special schools) within Birmingham (7 of these schools are "all through" schools which cater for both primary and secondary pupils). In January 2018 there were 79,001 pupils attending these schools. 981 children had an EHCP (1.3% of total pupils). 9,257 were receiving SEN support at the secondary school without a plan (12% of pupils).

There has been a decline in the numbers of children with EHCPs in Birmingham secondary schools (17% fewer (-199) compared to 2014) and for children receiving SEN support without a plan (23% fewer (-2,728) compared to 2014).

The proportion of pupils at Birmingham's secondary schools with EHCPs and SEN support is similar to the national average and to the other English core cities.

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[44] Birmingham City Council, online at https://www.birmingham.gov.uk/directory/24/birmingham_schools/category/699 accessed 4/12/2018

Table 9 – State-funded secondary pupils, DfE 2018

	Birmingham	England	English Core Cities
Secondary pupils with EHCP	1.3%	1.6%	1.2%
Secondary pupils with SEN support	11.7%	10.6%	11.9%

Of the pupils receiving SEND support (via an EHCP or school SEN support) the most common category of need is moderate learning difficulty (40%), followed by social, emotional and mental health (18%). As with Primary pupils a greater number of secondary pupils are categorised under the moderate learning difficulty than nationally leading to concern that children's needs are not being accurately identified.

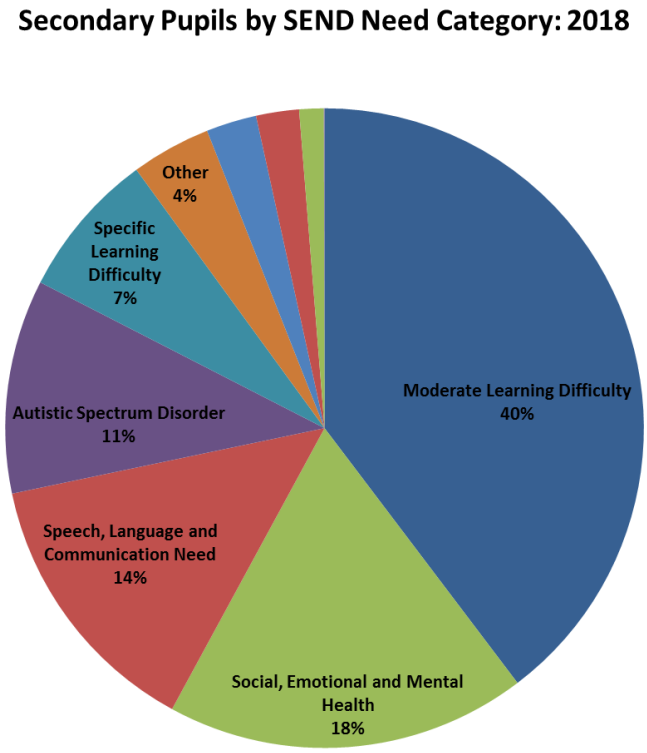

Figure 16 – pie chart of state-funded secondary pupils by SEND need category

Exclusions

The Ofsted and CQC inspection found that professionals have worked closely with leaders of secondary schools to help them manage behaviour more effectively. This had led to a reduction in permanent exclusions, including a decline in the number of pupils who have SEND who are excluded. However fixed term and permanent exclusions of pupils with

SEND are higher than for other pupils in the city.[45] In total 18 children with EHCP were permanently excluded from Birmingham schools during the 2016/17 school year (6% of all exclusions). In total 132 children recorded as having SEN support without EHCP were permanently excluded from Birmingham schools during the 2016/17 school year (44% of all exclusions).[46]

Absence

Attendance of pupils who have SEND is lower than for other pupils in Birmingham and the national average. For 2016/17 academic year the overall absence rate for children with an EHCP was 9.2% compared to 8.1% for England.[47]

Attainment

Academic outcomes for pupils who have SEND do not match those of other pupils. By the end of key stage 4 educational attainment is lower for children with an EHCP than all pupils nationally and other pupils in Birmingham. The table below show the average Attainment 8 score per pupil for Birmingham, England, the local region, other core cities and statistical neighbours. Attainment 8 measures a student's average grade across eight subjects. This measure is designed to encourage schools to offer a broad, well-balanced curriculum.

Table 10 – Pupil Attainment 8 achievement by the end of KS4 by SEN provision 2016/17. Source: DfE

Area	Pupils with no identified SEN	SEN support	SEN with a statement or EHCP	All pupils
Birmingham	50	31.2	11	46.1
England	49.7	31.9	13.9	46.4
West Midlands	49	31.5	12	45.4
Barking and Dagenham	49	31.0	16	46.7
Bristol, City of	48	31.6	14	44.0
Coventry	46	28.8	10	42.8
Enfield	49	30.7	14	46.2
Greenwich	49	33.7	15	45.9
Leeds	49	30.3	12	45.1
Liverpool	48	30.1	8	44.2

[45] Ofsted and CQC, Joint local area SEND inspection in Birmingham (2018)
[46] Birmingham local exclusion data 2016/17
[47] Department for Education, Pupil Absence in Schools in England

Manchester	47	26.5	12	43.4
Newcastle upon Tyne	47	30.6	13	43.3
Newham	52	33.5	11	48.4
Nottingham	43	26.6	5	40.3
Sheffield	48	29.3	13	44.6
Waltham Forest	51	33.6	9	45.5

However, year on year improvement for pupils with EHCP and SEN support at Key Stage 2 has occurred at Birmingham schools over the last 3 years. At Key Stage 2 there has been an increase in the percentage of all children achieving the required standard.

Table 11 - Key Stage 2 Percentage achieving expected standard for reading, writing and maths 2016-2018

	EHCP/Statement			SEN Support			All SEN			All non-SEN		
	2016	**2017**	**2018**	**2016**	**2017**	**2018**	**2016**	**2017**	**2018**	**2016**	**2017**	**2018**
England	7%	8%	TBA	16%	20%	TBA	14%	18%	TBA	62%	70%	TBA
Birmingham	5%	4%	6%	10%	17%	21%	9%	15%	18%	57%	67%	71%

However for Key Stage 4 there has been a decrease in achievement for all pupils. Pupils with an EHCP have worse performance at this stage than the national average. However attainment for SEN support pupils is similar to England.

Table 12 - Key Stage 4 Attainment 8 2016-2018

	EHCP/Statement			SEN Support			All SEN			All non-SEN		
	2016	**2017**	**2018**	**2016**	**2017**	**2018**	**2016**	**2017**	**2018**	**2016**	**2017**	**2018**
England	17	13.9	TBA	36.2	31.9	TBA	31.2	27.1	TBA	52.9	49.5	TBA
Birmingham	14.4	11.4	11.7	35.1	31.2	30.4	29.7	26.2	25.4	53.3	49.8	49.3

Transport to School for SEND pupils

Local authorities have a statutory duty to make travel arrangements for eligible children to enable them to attend school including those with SEND, particularly those school-aged children who cannot be reasonably expected to walk to school because of mobility problems or associated health and safety issues relating to SEND. Each child should be assessed on an individual basis.

Travel Assist Service provides travel assistance for 5,870 pupils daily. 4,250 on transport and 1,600 with a bus pass. There are 600 routes per day on average. 80% of vehicles used for school transport are minibuses. 478 pupils are in a wheelchair. Over 600 guides are provided to support journeys.

The shortest journey for a pupil is 0.2 miles and the longest 44 miles. For one school there are 47 minibuses transporting children to the school from around the city.

Travel Assist are experiencing budget pressures as are other local authorities across England. The service is benchmarking its services across other local authorities. Birmingham's service is cost effective and provides value for money. The service is taking steps to update and improve transport including more engagement with schools, independent travel training and SENAR.

4.3.3. Pupil referral units

There are 7 pupil referral units within Birmingham including the City of Birmingham School located at several sites and 6 free schools – alternative provision. In January 2018 there were 711 pupils attending these units. 14 children had an EHCP (2% of total pupils). 598 were recorded as receiving SEN support at the pupil referral unit without a plan (84% of pupils).

Of the pupils receiving SEND support (via an EHCP or school SEN support) the most common area of need is social, emotional and mental health (99%).

4.3.4. Placements outside Birmingham and at independent schools

There are children and young people with an EHCP whose needs cannot be met within the state-funded schools in Birmingham (primary, secondary and special). In December 2018 there were 305 school aged pupils (4-18 years) receiving this type of support through an EHCP. The chart below shows the placement types by education year group. Most of placements are at independent special schools (159 pupils) followed by independent mainstream providers (91). The independent special schools offer specialist provision in areas of SEND need e.g. Autism Spectrum. Many of these schools are outside the local area.

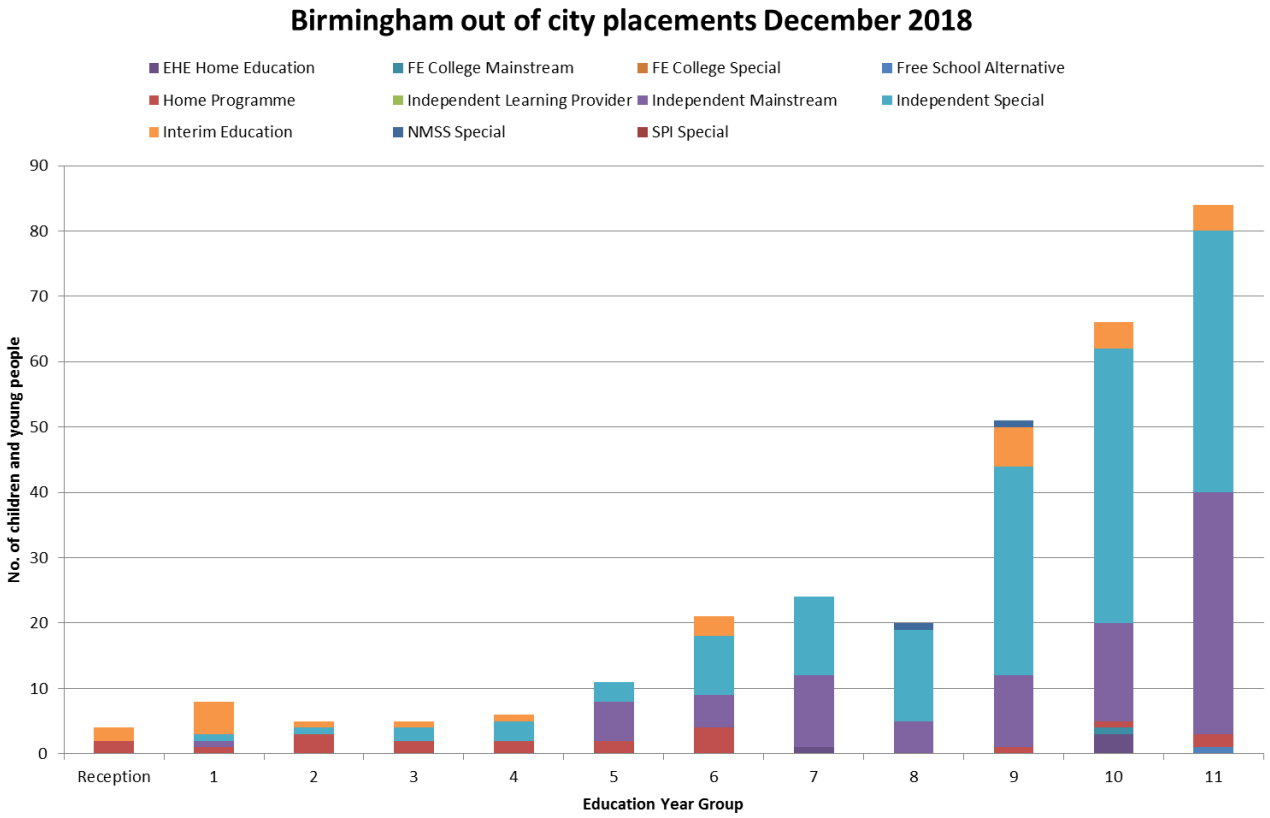

Figure 17 - Chart of Birmingham's out of city placements, Dec 2018

4.3.5. Communication and Autism Team

The Communication and Autism Team (CAT) is a specialist educational support service, supporting children and young people in Birmingham with autism. They provide advice and support these children and young people to access learning, to be included and maximise educational, social and employment potential. The service supports children and young people from the ages of 2-25, providing them with support in numerous areas of life.

4.3.6. Sensory Support

Sensory Support (SS) is a team of specialist staff working with children and young people with hearing or vision impairment at all stages of their educational development; in homes, early years settings, mainstream schools, special schools and colleges. SS aim is to minimise the impact of a sensory impairment on a pupil's learning and development and to raise attainment. SS supports schools with specialist teaching and other staff to support the education of deaf or vision impaired children and young people.

4.3.7. Pupil and School Support

Pupil and School Support (PSS) work with schools and other educational settings to help pupils with cognition and learning difficulties.[48] This service works with schools to develop SENCOs to lead whole school improvement, development of all teachers and staff to early identify need. The service also works with children and young people to increase their confidence and engagement.

4.3.1. School Nursing

Children have access to school nursing, special school nursing and children's community nursing service. The Ofsted CQC inspectors described these services as flexible and having a positive engagement with children and families.

4.3.2. Learning Disability

Forward Thinking Birmingham (FTB) have a learning disability (LD) team that works with approximately 300 young people up to the age of 19 years with a moderate / severe LD and almost all of these young people will have an EHCP. This work relates to both the neurodevelopmental and behavioural management pathways within Forward Thinking Birmingham (FTB). Once aged 19, these young people transfer to BCHCFT's LD service.

4.3.1. Learning Disabilities Health Check (14-18 years)

GPs in England offer a learning disabilities (LD) health check scheme for adults and young people with a learning disability.[49] A free annual health check is available to anyone aged 14 or over who is on their GP's learning disability register. This is dependent on the GP accessing training on how to deliver the health checks. Not all GPs have accessed the training.

GPs located within Birmingham had a total of 571 patients aged between 14-18 years recorded on the LD register in 2018. This is just over 1% of the population in this age group. In Quarter 4 2017/18 36% of these patients had taken up the annual health check and had a health action plan.

Table 13 – Patients with a learning disability health check, 2017/18 Q4

Description	Patients at Birmingham GPs
Registered patients aged 14-18	53,111
Registered patients aged 14-18 with QOF diagnostic learning disability	571
With a health check and health action plan	207

[48] Access to Education online available at: http://accesstoeducation.birmingham.gov.uk/index.php/PSS/welcome-to-the-pupil-and-school-support-service.html accessed 4/12/2018

[49] NHS online available at https://www.nhs.uk/conditions/learning-disabilities/annual-health-checks/

Source: NHS Digital, Q4 2017/18

The Ofsted CQC inspection identified a high level of dissatisfaction with GPs amongst several parents. This included a view that GPs lack an awareness of the needs of children and young people who have SEND.

4.4. Transitions and Young People (19-25 years)

The need for a rich and fulfilling transition from childhood to adulthood features as key elements of the Children and Families Act, 2014, the Care Act, 2014 and NICE guidelines, 2016 andis recognised in Birmingham's Strategy for Transition. This strategy has been adopted by all partners in the city.

Birmingham acknowledges its moral and legal duty to prepare and support children and young people to be resilient who are likely to continue to have additional needs through childhood and into adulthood.

The way that statutory services are configured and operate has meant that some young people and their families have had a negative experience of change in the types and levels of support as they grew older, as recognised by the SEND Inspection Report of 2018 and although there have been some improvements, more still needs to be done to ensure young people have better opportunities to be healthy, in employment or education, safe and well, connected to their community with strong friendships.

The Birmingham Strategy for Transition, 2018-2021, outlines five key strategic intentions:-

- Early Identification, Intervention and Prevention: To develop a graduated approach to transition and the preparation for adulthood which is founded on early identification, intervention and prevention which will require sound shared data aligned to shared and aligned financial commitments

- Reclaim Practice: To develop a graduated whole system approach to the reclaiming of practice, moving away from traditional silo assessments of need to a conversational model which starts with the person and not with a Service

- Personalisation and Innovation: To further develop and embed personalisation across the whole system

- Workforce Development: To build a workforce which is resilient, developing and improving skills and building capacity based on the concept of the wide sharing and realignment of resources across the whole system to support integrated delivery

- Joint Commissioning: To commission for better outcomes across the whole system by aligning strategies and pooling current resources to effectively manage and shape the market to ensure choice and value for money

The Birmingham Vision and shared principles will apply to the transition from childhood to adulthood, with an initial intention to start transition planning at the age of 13 to 14, or in school year 9,.

Birmingham City Council's Adult Social Care Directorate is responsible for the social care for people from the age of 18 and over.

There is a transitions service within Adult Social Care who begin working with young people at age 14 years to manage the process towards adult services. The threshold for adult services is higher than for children's social care and this is reflected in the number of young people accessing services. In January 2018 there were 502 service users aged between 18-25 years in receipt of services. The majority of these were classified in the Learning Disability (LD) client group.

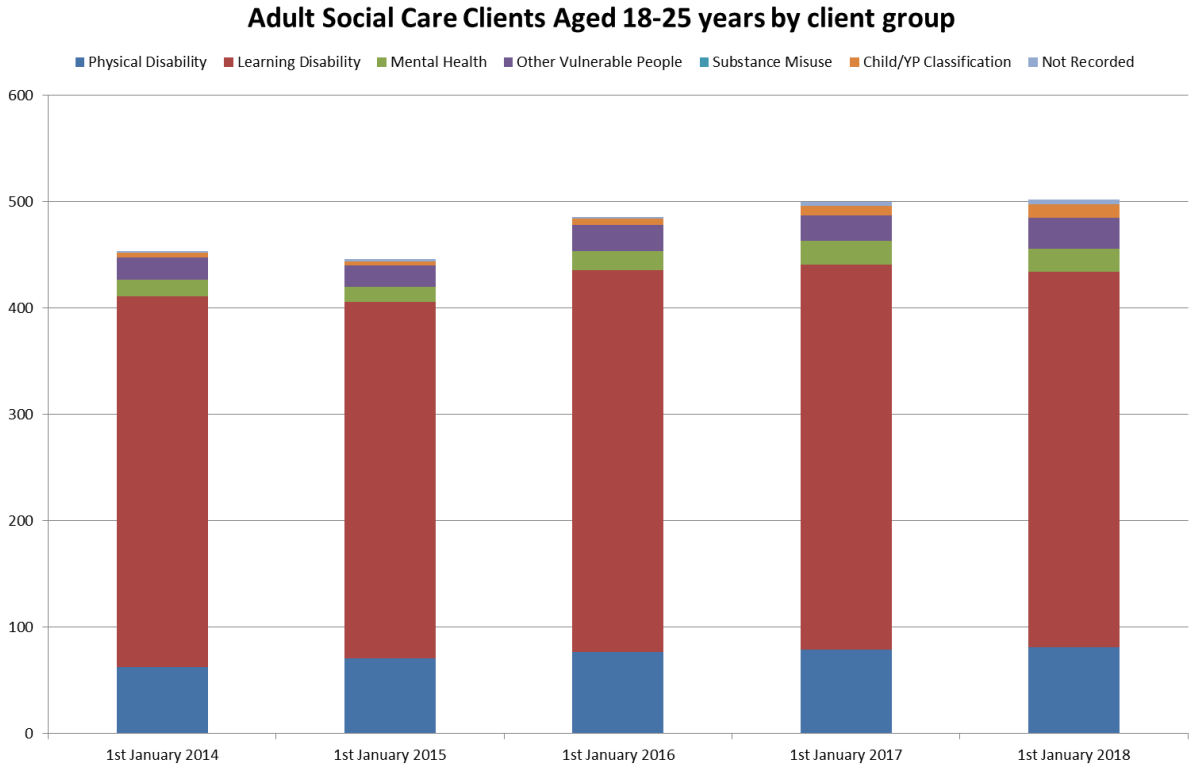

Figure 18- Chart of 18-25 year old Adult Social Care Clients 2014-2018

Services available to Adults Social Care clients include direct payments, residential care, home care and supported living. Clients can access a range of these services. Table 13 shows that the most commonly accessed service is direct payments, followed by day care.

Table 14- Adult social care services accessed by 18-25 year olds 2014-2018

	1st January 2014	1st January 2015	1st January 2016	1st January 2017	1st January 2018
Unique People	**454**	**446**	**486**	**500**	**502**
Direct Payments	252	241	249	236	212
Home Care	73	61	61	62	63

Supported Living	5	14	31	55	51
Extra Care	0	0	0	0	0
Day Care	79	75	88	100	114
Shared Lives	21	19	22	19	25
Residential	59	70	74	71	82
Nursing	2	1	1	1	2

4.4.1. Young Adults Specialist Clinic

This is a specialist clinic provided by BCHFT for young people aged 16 years and over.[50] The aim of the clinic is to help young people with a physical disability address the many issues they may encounter as they move from child centred health care systems to adult ones. The issues covered are around care needs, accessing services or education and being more independent. The service also provides advice on exercise programmes to maintain health or knowing when and how to see a Consultant or GP.

4.4.2. Learning Disability Service for Adults

Young people with LD transfer from Forward Thinking Birmingham (FTB) to BCHCFT at 19 years. The service provides healthcare for people with LD living in the community.[51] It has a multi-disciplinary team and works collaboratively with other agencies for complex needs such as epilepsy, challenging behaviour, forensic needs and mental health conditions. The service provides short breaks and day services and community health services.

4.4.3. Employment

A criticism raised in the 2018 inspection was that not enough young people with SEND are entering employment or supported employment.

There are no specific data on young people with SEND in employment but the proportion of supported working age adults with a learning disability in paid employment is an indicator in the Adults Social Care Outcomes Framework (ASCOF).[52] Birmingham has one of lowest proportions in the country with less than 1% in employment during 2017/18. Nationally approximately 6% of people with a learning disability have paid employment (ASCOF 2016-17).

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[50] BCHCFT online at http://www.bhamcommunity.nhs.uk/patients-public/rehabilitation/young-adults-specialist-clinic/ Accessed 4/12/2018
[51] BCHCFT online at http://www.bhamcommunity.nhs.uk/patients-public/learning-disability-service/ Accessed 4/12/2018
[52] ASCOF online at https://digital.nhs.uk/data-and-information/publications/clinical-indicators/adult-social-care-outcomes-framework-ascof/current accessed 4/12/2018

4.4.4. Education

Attainment of Level 3 equates to achievement of 2 or more A-levels or equivalent qualifications. The percentage of 19 year olds qualified to Level 3 in Birmingham with an EHCP in 2016/17 was 11.6% compared to 13.1% for England.[53] For 2015/16 the percentage was 14.4% and higher than the England average.

Achievement rates for LLDD aged between 19 and 25 are lower than for other learners. The achievement gap between LLDD and other learners aged between19-25 did not close between 2014-2017.

4.5. Services across age ranges

4.5.1. Physiotherapy

Physiotherapy is provided by the NHS Trusts in the city. BCHCFT provide the community-based service which accepts referral for children aged 0-18 years. The service provides assessment and treatment for babies and children with delay in gross motor skills which may be affecting their normal childhood development. Babies, children or young people with abnormal muscle tone and /or patterns of movement, children and young people with musculoskeletal conditions causing pain or loss of function, will be offered advice and recommendations for specialist equipment or orthotics which will assist in achieving either postural control / management or mobility. There is liaison and cooperation between BCHCFT physiotherapy and the Women's and Children's Hospital Trust physiotherapy services. There is an ambition, in light of the NCEPOD report on service for children with chronic neurodisability[54] to implement a collaborative care pathway across the NHS trusts in the city to improve children's access to physiotherapy and a range of services to manage spasticity and reduce the need for orthopaedic interventions further. The Ofsted and CQC inspection described access to community physiotherapy as good.

4.5.2. Speech and Language Therapy (SALT)

This service provides support to children (0-19) with a range of specific speech, language and communication difficulties and those with difficulties swallowing, eating and drinking. The service accepts referrals for children with a Birmingham GP. There is a high threshold of complex need to access the service. Pupils with EHCPs identifying a speech and language need may not meet the threshold for a SALT intervention. The 2018 inspection found that there were long waiting times to access (SALT).

4.5.3. Mental Health

Forward Thinking Birmingham (FTB) is a mental health service for the 0-25 age range.[55] FTB has an open referral process for parents and young people as well as professionals

[53] Department for Education, Level 2 and 3 attainment by young people aged 19
[54] National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Chronic Neurodisability: Each and Every Need, 2018 [online] https://www.ncepod.org.uk/2018cn.html (accessed 06/11/2018)
[55] Forward Thinking Birmingham [online] https://www.forwardthinkingbirmingham.org.uk/services (accessed 16/10/2018)

through their Access Centre with clinical oversight of referrals. FTB liaises with young people and their families from the point of referral in respect of any learning needs. Care planning takes into account emotional and developmental age and supports flexible progress to adult services. There are thresholds that a child or young person must meet before they can access FTB services.

Autistic Spectrum Disorder (ASD) assessments are offered to children and young people who have not yet been diagnosed and who are experiencing mental health issues categorised as moderate or severe. Services offered include counselling, therapy and group work.

There are 4 wider community teams but it is not possible to state how many of the young people in these services have specific education needs. FTB are moving towards be able to track young people with an EHCP.

There is a training workshop offered by the FTB children in care pathway lead to improve school staff understanding of children who have experienced trauma.

Primary mental health workers within the early help team are an effective resource for the schools in managing emotional and mental health and wellbeing in schools.

Young people aged between 18-25 years who have ASD and attention deficit hyperactivity disorder (ADHD) are being helped to move into employment through joint working by FTB and a third-sector organisation. The scheme offers bespoke training and multidisciplinary meetings to help identify young people who would benefit.

4.5.4. Personal Health Budgets

A personal health budget is an amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local clinical commissioning group (CCG). Personal health budgets are one way to give people with long term health conditions and disabilities more choice and control over the money spent on meeting their health and wellbeing needs.

The 2018 inspection reported that few personal health budgets have been taken up within Birmingham. The findings suggested that community nursing staff are not familiar with the process and have found it difficult to support parents to access this support.

4.6. Advice, Information and Support

The Birmingham Special Educational Needs & Disability Information, Advice and Support Service (SENDIASS) offers impartial information, advice and support to children and young people with special educational needs or disabilities. The service is available weekdays during office hours.

The Birmingham Parent Carer Forum is a group of parent-carers of disabled children who work with education, health and care providers to make sure the services they plan and deliver meet the needs of disabled children and families.

There is a Citywide Disability Forum were complex cases can be taken for advice and support from a panel which includes social care, early years professionals, school nurses and other support organisations such as housing.

5. Lived experience

5.1. SEND Partnership Survey 2018

Consultation was carried out with parents, carers and voluntary organisations working with children and young people with SEND in Birmingham. An online survey and consultation event sought opinions and views during October and November 2018. The main findings from the online survey were:

- Only a quarter of respondents who had gone through the EHCP assessment process rate the experience as good or very good. Reasons given for dissatisfaction were delays, complexity and lack of assistance.
- The main problems reported with EHCPs were refusals, gaps between expectations and actual experience, delays, lack of support and timescales not being met.
- Suggestions from parents to improve the process were:
    - Better leadership
    - Easier process
    - Parent and child view taken seriously
    - Following the SEND code of practice process
    - Online access to progress
    - Listen to parents and children.
- The majority of parents rated contact with the SENAR service as unsatisfactory or very unsatisfactory. Suggestions from parents for improvements related to better communication and understanding of parents' needs.
- Suggestions from parents on how to make co-production of SEND services work were to have clear outcomes, better promotion of consultations, the creation of local peer support networks and consideration of times of meetings.
- 60% of respondents reported having to tell their child's story more than 5 times to different SEND professionals. This was not a positive experience for the majority of parents. Suggestions for improvements included reducing waiting lists, creating a more understanding and supportive environment and improve communications between services.
- Suggestions for improvement to communication included joined up working, listening, doing what is promised to parents.
- 79% of parents who had raised a concern did not feel that their complaint had been effectively resolved.
- Waiting for speech and language therapy, occupational therapy and physical therapy was an area of concern. 91% of parents did not feel supported

through the waiting period. Suggestions for improvement included the use of online support and a telephone helpline.
- Other types of support suggested by parents were support groups, workshops.
- The Local Offer website was not considered useful as it did not have up-to-date information and was not easy to navigate. Suggestions for improvement were clear language and better signposting.
- Although not many respondents had transitioned, for the majority of those that had this had not been a good experience. This would be improved if the process had started earlier than at age 18.

The key messages from the consultation event were:

- Parental engagement, satisfaction of parents and co-production. *Key messages – focus on the whole picture around families, meaningful, to build trust, demonstrative actions, join up!*

- Absence and exclusions. *Key messages – Early intervention with a single point of contact, transitions from primary to secondary to reduce anxieties, better wrap around service*

- Waiting times. *Key message – updates to progress need improving, look at ways to support parents on the waiting list, Early interventions*

- Quality of EHC Plans. *Key messages – Robust & Individualisation, trust and confidence, it needs to work for the child*

- The local offer. *Key messages – needs to be accessible, quality information which is easy to find, google search needs to be dramatically improved and the site title needs to be improved.*

5.2. 2018 Inspection findings

During the 2018 Ofsted and CQC inspection of local services the views of parents, children and young people were collected.[56] The main issues identified were:

- Parents feel they must initiate their involvement to make their voice heard.
- Many parents reported not knowing what the local offer was. Those who had accessed it did not find it useful.
- Most parents, children and young people who spoke with the Ofsted CQC inspectors reported that although now they were in the right setting, they had negative experiences in at least one setting prior to their currently placement. They reported needs not being met, high levels of fixed-term exclusions and some SENCOs not having the skills and experience to make good progress.
- Dissatisfaction from parents about the quality of provision. Waiting times are long, poor communication, needs not being met in their local area, not being heard, having to “battle” to get what they need, not knowing how to access services and having to tell their story several times.
- Parents report waiting times longer than 18 months for therapies – SALT, OT, neurodevelopmental.

[56] Ofsted and CQC, Joint local area SEND inspection in Birmingham (2018)

- Once placed in an appropriate setting, many parents report that schools and colleges are making a positive contribution to outcomes. Specialist provision is most valued.
- Parents have praised service received from Special Educational Needs Information Advice and Support Service (SENDIASS).
- The Ofsted and CQC inspection identified a high level of dissatisfaction with GPs amongst several parents. This included a view that GPs lack an awareness of the needs of children and young people who have SEND.
- Most of the children and young people who spoke to the inspectors said that they were happy in their current setting and that they feel supported and listened to. They value the careers education that they have received but feel that there are limited options for them in Birmingham post-16 and post-19.

5.3. Neurodevelopment Pathway service users access to information

In 2018 a survey, several focus groups and semi-structured interviews were held with service users with autism and/or ADHD and parent-carers.[57] One of the most frequent messages was of feeling "in the dark" and "a bit lost" by the lack of information available. The findings were that service users are often doing their own research and having to fight to be taken seriously by health and education professionals. The lengthy assessment process was described as "the often cruel, gruelling and dismissive assessment process!"

5.4. Community healthcare feedback

Friends and family feedback from Birmingham Community Healthcare NHS Foundation Trust patients during 2018 indicated a high level of satisfaction with services. 94% of those who responded would recommend the services that they received.

[57] Birmingham City Council, Public Health, Not Diagnosis and Dump, Report for the All-age Neurodevelopmental Pathway Project Group, May 2018

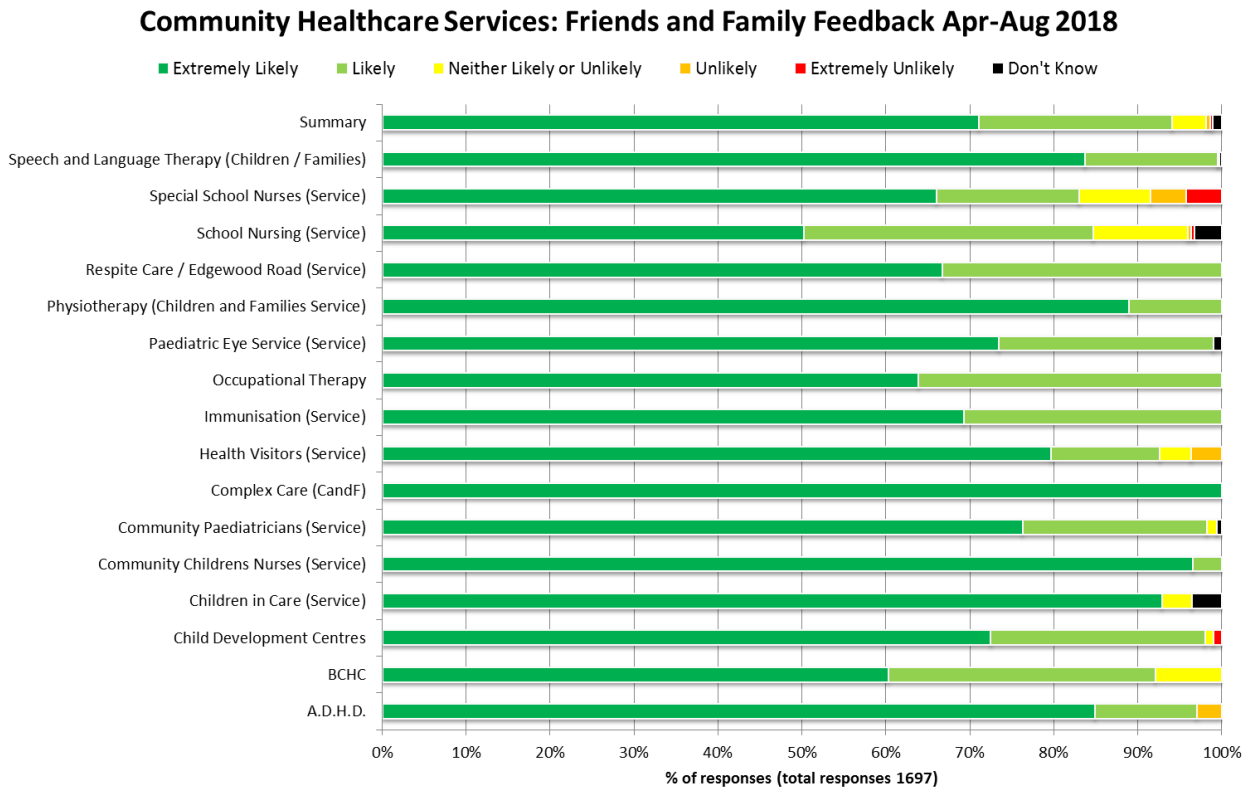

Figure 19: BCHCFT friends and family feedback 2018

6. Gaps in Provision/Unmet Need

In this section we compare the overall need in the city with the level of service provision currently in place and highlight potential gaps in provision.

6.1. Availability and Robustness of Data

There is no robust data collection for example to enable cross referencing whether child has an EHCP with health and also no measure of level or complexity of need. In addition there is a lack of data related to disability including:

- how many children are visually impaired in Birmingham;
- how many children are hearing impaired in Birmingham
- how many children have a cerebral palsy in Birmingham
- how many children have Down's syndrome in Birmingham
- how many children use a wheel chair in Birmingham
- how many children use augmented communication in Birmingham

This inevitably leads to limitations in our ability to commission services to meet the needs of children and young people with SEND.

6.2. Challenges in reaching children and families to identify development needs in the early years.

Early identification and intervention in relation to SEND is an important principle of the SEND code of practice (2015). Key to this is the ability of universal early years services to reach and engage with children and families in order to identify SEND needs at an early stage. This is may be adversely affected in Birmingham by low early educational entitlement offer (at age 2) across the city and insufficient uptake of 2-2.5 year uptake of assessments by universal early years services (Birmingham Forward Steps).

6.3. Insufficient capacity in Child Development Centres to cope with demand (referrals for medical and developmental assessment)

There is currently insufficient capacity in health (multi-disciplinary team CDCs) to meet the demand created by referrals for child development assessments, for under 5s, resulting in long delays.

There are excessive waiting times to access speech and language therapies, occupational therapies and neurodevelopment assessments. This was identified as part of the recent OFSTED and CQC SEND inspection.

There is, currently, no commissioned autistic spectrum disorder multidisciplinary diagnostic pathway for children over four years old . As such, if children are not identified and assessed before 5, there is no commissioned multi-disciplinary team to assess their need.

6.4. Insufficient quality of EHCPs

Highlighted as part of CQC/OFSTED inspection – considerable variation in quality of EHCPs, with many poor. - making it more difficult to define needs and address effectively.

Quality of reports from partners across education, health and care affects EHCP decision making process and outcome. Work is underway to address this, tool kit being developed for partners

In 2017 only 2.1% of EHC assessments did not result in an EHCP being issued. For England this was 4.9%. i.e do we have higher levels of complex need in the city or we give out EHCPs more readily.

Feedback form the Parents Survey results (12/2018) suggests that the demand for an EHCP may be fuelled by parents/carers believing that this is the only way to make sure that their child's needs are properly addressed.

EHCPs can utilise personal budgets to enable greater personalisation and provide choice and control to the child and young person. However in Birmingham in 2017, only 4 personal budgets were issued, transferred or reviewed.[58]

[58] Department for Education, Statements and EHCPs in England

6.5. Insufficient special school places in the city

Despite the high level of specialist SEND provision in the City, there is insufficient Special School capacity provision in Birmingham to meet the needs of children with SEND – a number of children attend independent specialist provision outside the city.

There is no provision, in the city, for children with SEND who require a residential placement (e.g. those requiring 38 week and 52 week placements).

There is a need to ensure that children are receiving their SEND support in the right classification of school/resource unit to meet the child's primary need. A review is already underway to better understand how the SEND needs of children map against specialist provision in the city.

6.6. Less children with EHCPs in mainstream schools

Despite the aspiration that children with SEND should in most instances be included in mainstream schools, there is a higher prevalence of children in Birmingham with EHCPs who attend special schools than national and statistical comparators. Conversely, we have a lower proportion of children with SEND in mainstream schools.

This may be due to children with SEND having more complex needs, though data not currently available to analyse this, or for other reasons e.g. historical, cultural reasons or availability of several special schools in the City.

Parent feedback through the CQC OFSTED inspection OSTED and CQC inspectors reported that there was a lack of willingness and ability by some mainstream school to meet the needs of children with SEND.

The Parents Survey Results (December 2018) suggested that better wrap around services (to provide the right level of external support for children with complex needs) were needed to support schools around children with SEND.

6.7. Support for Parents/Carers

Birmingham has spent less than other areas on short breaks for parents/carers of children with SEND.

6.8. Transition to adult services

Young people and their parents/carers should be preparing from age 14 years for the move from child to adult services in order that they are well prepared for opportunities in employment and education and to be healthy, safe and well connected to their communities.. In Birmingham, this has not been happening until much later. As recognised by the SEND Inspection Report (2018), more need to be done to give young people in Birmingham a more positive experience of change in the level and types of service they receive as they grow older.

6.9. Primary care support

Learning Disability health checks should be available from the age of 14 to patients on a GP's LD register. Currently uptake is low compared with other areas. Parents have voiced dissatisfaction with service from GPs.

7. Recommendations

This section identifies the areas of need to address through commissioning. These recommendations are to strategic partners creating strategies and commissioning plans for children and young people with SEND. They are based on the needs and gaps identified during the JSNA process.

7.1. Robust data

The availability of robust data is recognised locally and nationally as limited in relation to SEND data and to disability data.

Recommendation: Review opportunities to improve data collection/sharing and analysis to enable more informed commissioning. To include exploring opportunities to enable linkage between health, education and social care data to allow cross referencing where a child has an EHCP/SEND need; also to enable assessment of level/ complexity of need.

Recommendation: consider adoption of a robust whole system approach to coding using a recognised tool to enable understanding of the level of complexity of SEND need.

7.2. Primary prevention

There are a number of factors that are relevant to the Birmingham population (e.g. deprivation and low birth weight) that may be contributing to the levels of SEND in children and young people in the city.

Recommendation: Support a primary prevention approach to SEND by identifying and supporting evidence based interventions which address SEND related risk factors being delivered through other City-wide Strategies and work programmes (including Birmingham and Solihull United Maternity and Newborn Partnership and Local Sustainable Transformation Partnerships).

7.3. Early identification and appropriate intervention

Early identification in relation to SEND is important (SEND code of practice, 2015) but challenging in the under 5s

Recommendation: Work with partners in education, health and care across the early years system to identify mechanisms to increase uptake of the universal 2-2.5 year health visiting assessment and the early years educational entitlement offer.

Recommendation: Enhance the commissioning/contracting process, where needed across the system, to improve access/reach to those children, young people and families most in need.

Recommendation: Maintain efforts around work with SENAR and education, health and care partners to ensure that Children and Young People's SEND needs are robustly and accurately identified in line with best practice.

7.4. Child Development Centres

There is a **lack of capacity in Child Development Centres** to ensure that developmental needs assessments are delivered in a timely manner. Work is underway to address this through the development of the neurodevelopmental pathway; also solutions to address capacity issues are being sought.

Recommendation: Robust commissioning approaches are employed to ensure that there is sufficient capacity to adopt the proposed neurodevelopmental pathway

Recommendation: Commissioning approaches need to consider gaps around provision of speech language and communication, occupational therapy and physiotherapy services. Consideration should also be given to the capacity of Community Paediatric Services to deliver medical elements of assessments.

Recommendation: Consider commissioning additional capacity to enable developmental assessments to be available to children over 5, when necessary.

7.5. High prevalence of Birmingham pupils with EHCPs

Birmingham has a higher proportion of children with EHCPs than the national average. There is a perceived lack of confidence among parents on receiving support for SEND needs without an EHCP.

Recommendation: - Review current practice to ensure robust, transparent process is in place, in line with best practice, around EHCP assessment process. Programme of work already underway as part of SEND Written Statement Of Action.

Recommendation:

Explore the potential, through joint working with parents/carer and organisational partners, to identify what would be needed to build confidence amongst parents and other professionals that SEND related needs (education, health and care) can be appropriately met, through the local offer- with or without the need for an EHCP.

7.6. High proportion of children in special schools in Birmingham:

There is a higher than average proportion of children attending special schools compared to the national average.

Recommendation: Through review, already underway, help to more accurately understand the SEND needs of children in Birmingham, including complexity of need, in order to inform the need for specialist SEND provision.

Recommendation: Explore potential to provide a 'more attractive offer' for children with EHCPs as part of mainstream school provision, with a view to meeting childrens' needs more effectively, where appropriate and closer to home.

7.7. Residential Placements

There is currently no provision, in the city, for children with SEND who require a residential placement.

Recommendation: Building on work already underway, complete review of needs of children with SEND who require a residential placement to assess if needs could be more appropriately met locally.

7.8. Learning disabilities heath check

In quarter 4 (2017/18) only 36% of patients (on the GP Learning Disability Register) had taken up the annual health check and had a health action plan.

Recommendation: Explore opportunities through Birmingham and Solihull CCG and primary care colleagues to identify opportunities to improve uptake and provide better support to children, young people and their families around SEND.

7.9. Low Educational Attainment for Children with EHCPs

Pupils with EHCPs in Birmingham do worse than the England average, when compared with other pupils with EHCPs.

Recommendation: Consideration of commissioned, joined up, wrap around service/care for mainstream and special schools, linking with existing provision to help support schools . with a view to reducing absenteeism and exclusions among children with SEND (building on work already underway to reduce school exclusions).

7.10 Transitions

Young people and their parents/carers should be preparing from age 14 years for the move from child to adult services in order that they are well prepared for future opportunities. The SEND Inspection Report (2018) highlighted that more needs to be done to give young people in Birmingham a more positive experience of change in the level and types of service they receive as they grow older.

Recommendation: Ensure that processes are in place to prepare children and young people with SEND for transition into adult services and into adulthood from age 14 (at the latest), in line with SEND Code of Practice and the Birmingham Strategy for Transition (2018-2021)

7.11 Strategic Partnership Working

Recommendation: Integrated models of care and joint commissioning approaches are developed across the health, education and care system, taking into account projected population increases, addressing the full range of needs of children and young people with SEND from prevention and early help to specialist services.

Recommendation: The Health and Wellbeing Board strengthens strategic partnership working and ensures robust governance arrangements are in place between statutory and non-statutory bodies to monitor and promote the health and wellbeing of children with SEND

8. References

Birmingham City Council, Education Health and Care Pathway for New Assessments, 2015

Birmingham Community Healthcare NHS Foundation Trust, Children and Families Division, Service Summaries

Department for Education, Early years: guide to the 0 to 25 Special Educational Need and Disability code of practice (2014)

Department for Education, Special educational needs in England: January 2017 (2017)

Department for Education and Department for Health, Special educational needs and disability code of practice: 0 to 25 years (2015)

Ofsted and CQC, Joint local area SEND inspection in Birmingham (2018)

Saggu and Wilkes, Children with Disabilities and Special Educational Needs in Birmingham: An Assessment of Need for Services to Support Strategic Decision Making (2013)

Birmingham Working Together, Transitions Strategy 2018-2021, Working Together in Equal Partnership to Prepare Young People with Additional Needs for Adult Life (2018)

Blackburn, C., Read, J., Spencer, N., Annual Report of the Chief Medical Officer, Chapter 9: Children with neurodevelopmental disabilities (2012)

BVSC, Output from consultation event and output the Birmingham SEND Partnership Survey of parents, carers and voluntary organisations in Birmingham (2018)

Appendix 1 – SEND JSNA Glossary

Term	Description
ADD	Attention Deficit Disorder
ADHD	Attention Deficit and Hyperactivity Disorder
ASD	Autistic Spectrum Disorder – category
Attainment 8	Attainment 8 measures a student's average grade across eight subjects – the same subjects that count towards Progress 8.
BAME	Black, Asian and Minority Ethnic
BCC	Birmingham City Council
BCHT	Birmingham Community Healthcare NHS Foundation Trust
BCT	Birmingham Children's Trust
BWCT	Birmingham Women's and Children's NHS Foundation Trust
CCG	Clinical Commissioning Group – They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
CDC	Child Development Centre
CIC	Children in care – refers to any child in the care of the local authority. This can mean being placed in a children's home, foster placement, receiving respite care or on a full care order but living at home
CIN	Children in need – children who are aged under 18 and need local authority services to achieve or maintain a reasonable standard of health or development, need local authority services to prevent significant or further harm to health or development or are disabled.
CHIP	Child Health Improvement Programme forming part of Birmingham and Solihull Sustainability and Transformation Partnership
Core Cities	Comparison Group. 10 regional cities in the United Kingdom outside Greater London: Birmingham, Bristol, Cardiff, Glasgow, Leeds, Liverpool, Manchester, Newcastle, Nottingham and Sheffield.
CRISP	Criteria for Special Provision – a model for assessing need and allocating resources.

DCO	Designated Clinical Officer
DMO	Designated Medical Officer
EHC	Education, Health and Care
EHCP	Education, Health and Care Plan
EP	Educational Psychologist
FTB	Forward Thinking Birmingham – mental health services for children aged 0-25 years in the city.
HI	Hearing Impairment
JSNA	Joint Strategic Needs Assessment – these are assessments of the current and future health and social care needs of the local community. The aim is to develop local evidence-based priorities for commissioning which will improve the public's health and wellbeing and reduce inequalities.
KS4	Key Stage 4 is the 2 years of school education in maintained schools normally known as Year 10 and Year 11 when pupils are aged between 14 and 16 years.
MLD	Moderate Learning Disability
OT	Occupational therapy
PRU	Pupil Referral Unit is a type of school that caters for children who aren't able to attend a mainstream school. Pupils are often referred there if they need greater care and support than their school can provide.
PVI	Private, voluntary and independent childcare settings
SALT	Speech and Language Therapy
SEN	Special Educational Needs
SENAR	Special Education Needs Assessment and Review Service
SENCO	Special Educational Needs Coordinator - a teacher who coordinates the provision for children with SEND in schools. Many are also class teachers, and fulfil their SENCO duties on a part-time basis. SENCOs who were in position before 2009 may have been trained on the job, but now SENCOs have to complete a Masters level National Award for Special Educational Needs.
SEND	Special Educational Needs and/or Disabilities – Children or young people (0-25 years) with a learning difficulty or disability which calls for special educational or training provision at early years providers,

	maintained nursery schools, mainstream schools and mainstream post-16 institutions.
SEMH	Social, emotional and mental health - category
SIB	SEND Improvement Board - a local strategic partnership, with a collective commitment to fundamental change and improvement in how the local area works together to provide care and services to children with SEND.
SLD	Severe learning disability
Statistical Neighbours	Comparator group produced by Department for Education of councils with similar features.
VI	Visual impairment

SEND JSNA

Health and Well Being Board – February 2019

Birmingham City Council

Robust Data

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Recommendation: consider adoption of a robust whole system approach to coding using a recognised tool to enable understanding of the level of complexity of SEND need.

Primary Prevention

There are a number of factors that are relevant to the Birmingham population (e.g. deprivation and low birth weight) that may be contributing to the levels of SEND in children and young people in the city.

Recommendation:

Support a primary prevention approach to SEND, by identifying and supporting evidence based interventions which address SEND related risk factors, being delivered through other City-wide Strategies and work programmes (including Birmingham and Solihull United Maternity and Newborn Partnership and Local Sustainable Transformation Partnerships).

Early identification and appropriate intervention

Early identification in relation to SEND is important (SEND code of practice, 2015) but challenging in the under 5s.

Recommendation:

Work with partners in education, health and care across the early years system to identify mechanisms to increase uptake of the universal 2-2.5 year health visiting assessment and the early years educational entitlement offer.

Recommendation:

Enhance the commissioning/contracting process, where needed across the system, to improve access/reach to those children, young people and families most in need.

Recommendation:

Maintain efforts around work with SENAR and education, health and care partners to ensure that Children and Young People's SEND needs are robustly and accurately identified in line with best practice.

High Prevalence of Birmingham School Pupils with EHCPs

Birmingham has a higher proportion of children with EHCPs than the national average. There is a perceived lack of confidence among parents on receiving support for SEND needs without an EHCP.

Recommendation:

Review current practice to ensure robust, transparent process is in place, in line with best practice, around EHCP assessment process. Programme of work already underway as part of SEND Written Statement Of Action.

Recommendation:

Explore the potential, through joint working with parents/carer and organisational partners, to identify what would be needed to build confidence amongst parents and other professionals that SEND related needs (education, health and care) can be appropriately met, through the local offer- with or without the need for an EHCP.

High proportion of children in special schools in Birmingham

There is a higher than average proportion of children attending special schools compared to the national average.

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Recommendation: Explore potential to provide a 'more attractive offer' for children with EHCPs as part of mainstream school provision, with a view to meeting childrens' needs more effectively, where appropriate and closer to home.

Low Educational Attainment for Children with EHCPs

Pupils with EHCPs in Birmingham do worse than the England average, when compared with other pupils with EHCPs.

Recommendation:

Consideration of jointly commissioned, wrap around service/care for mainstream and special schools, linking with existing provision to help support schools. This would be with a view to reducing absenteeism and exclusions among children with SEND (building on work already underway to reduce school exclusions).

Strategic Partnership Working

Recommendation:

The Health and Wellbeing Board strengthens strategic partnership working and ensures robust governance arrangements are in place to monitor and promote the health and wellbeing of children with SEND

Birmingham Health and Wellbeing Board

	Agenda Item: 8
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19 February 2019**
TITLE:	**BETTER CARE FUND (BCF) GOVERNANCE AND APPROVAL FOR SCHEME OF DELEGATIONS**
Organisation	**Better Care Fund Commissioning Executive**
Presenting Officer	**Graeme Betts**

Report Type:	**Decision**

1. Purpose:
To seek Board approval for Better Care Fund governance arrangements and approval of the scheme of delegations

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

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

3. Recommendations

The Health and Wellbeing Board is asked to :

- Note the governance arrangements for the BCF programme
- Approve the HWB – Better Care Fund terms of reference
- Approve the scheme of delegations for the Birmingham Better Care Fund

4. Background

4.1 Integrated working promotes a system-wide approach to improving health and wellbeing which contributes to the Council's outcome framework and also contributes to the creation of a sustainable health and care service in Birmingham

4.2 The BCF provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, the Disabled Facilities Grant (DFG) and funding paid directly to local government for adult social care services – the Improved Better Care Fund (iBCF)

4.3 The governance document attached deals exclusively with the governance arrangements for the Better Care Fund.

4.4 The governance framework demonstrates at which board level decisions and delegated decisions are made and describes the key responsibilities of all BCF partners.

4.5 A streamlined and coherent governance framework will speed up decision making and create a positive environment within which BCC and CCG commissioners collaborate.

4.6 The governance controls will provide assurance that:-

- Funding decisions / allocations made are aligned to the 2017-19 BCF plan and have been appropriately authorised;
- Adequate financial monitoring processes are in place for the BCF programme;
- Effective performance monitoring arrangements are in place to ensure the key objectives and outcomes detailed within the 2017-19 Birmingham BCF plan are achieved;
- The requirements of any section 75 agreements entered into by the Council as part of the BCF programme are being fully complied with; and
- Appropriate mechanisms are in place for reporting the ongoing delivery and performance of the overall BCF programme within the Council and to CCG's governing bodies.

5.	**Future development**
	The terms of reference and governance arrangements will be reviewed annually or as required.

6.	**Compliance Issues**
6.1	***Strategy Implications***
	Health and Wellbeing Boards have overall responsibility to ensuring the integration of health and care functions within their localities. It is a requirement of the BCF that local plans are agreed by HWB as the body who has overall accountability for the delivery of the BCF plan, and for the operation of the associated Section 75 agreement.
6.2	***Governance & Delivery***
	Governance arrangements include the Better Care Fund Programme Board, the Commissioning Executive Board, and link firmly with the STP plans for

	Birmingham – BSoL and the Black Country STP areas, Adult Social Care, and NHS Commissioning Reform. The recommended arrangements in this report were signed off by the Better Care Fund Commissioning Executive Board on 1st February 2019.
6.3	***Management Responsibility***
	Louise Collett, Service Director – Commissioning, Adult Social Care & Health

6. Risk Analysis

The recommended governance arrangements are intended to mitigate the risks as detailed in the table below :

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Failure to achieve the key objectives contained within the 2017-19 BCF plan	Medium	High	Ensure accountability as part of the revised Terms of Reference
Failure to effectively administer and monitor BCF related expenditure	Medium	High	Clear financial monitoring in place supported by a defined decision making process with appropriate schemes of delegation.
Failure to comply with BCF local and NHSE national conditions	Medium	High	Accountability as part of the revised Terms of Reference
Failure to provide the required monitoring information to all key stakeholders within required timescales	Medium	Medium	Accountability as part of the revised Terms of Reference

Appendices	
1.	Better Care Fund governance arrangements document

Better Care Fund Governance

1.0 Preface

This document sets out the governance arrangements for local partners that agree and administer the Better Care Fund (BCF) 2017-19 plans; Clinical Commissioning Groups (CCGs), local authorities (LAs) and Health and Wellbeing Boards (HWBBs). This document deals exclusively with the governance arrangements for the Better Care Fund.

2.0 Background

The BCF was established by Government in 2013 to provide funds to local areas to support the integration of health and social care. The fund is made up of two distinct funding streams; the Better Care Fund (BCF) and Improved Better Care Fund (iBCF). The BCF is the national programme, through which local areas agree how to spend a local pooled budget in accordance with the programme's national requirements. The pooled budget is made up of CCG's funding as well as local government grants, one of which is the Improved Better Care Fund (iBCF). The iBCF is paid as a direct grant to local government, with a condition that it is pooled into the local BCF plan.

The prime objective of BCF is to enable people to manage their own health and wellbeing and live independently in their communities for as long as possible. BCF encourages integration by requiring CCGs and LA's to enter into pooled budget arrangements and agree an integrated spending plan; this pooled fund is known as the Section 75 Agreement (s75).

Section 75 (s75) of the 2006 National Health Service Act gives powers to LA's and CCG's to establish and maintain pooled funds. In order to start a pooled budget, partners must have a signed s75 agreement which outlines which budgets money will be taken to be pooled. The pooled budget total for 2018/19 is £151,119,218 and is made up of a BCF total contribution of £100,537,504, iBCF funding of £47,327,714 and £3,326,000 monies carried forward. This fund enables payment to be made towards expenditure incurred in the exercise of prescribed local authority and prescribed NHS functions.

Birmingham City Council (BCC) has responsibility for commissioning and/or providing social care services on behalf of the population of Birmingham. Birmingham and Solihull Clinical Commissioning Group (BSol CCG) & Sandwell and West Birmingham Clinical Commissioning Group (SWB CCG) are responsible for commissioning health services in Birmingham and Sandwell. The Birmingham Integration and Better Care 2017-19 narrative plan sets out the joint vision and approach for integration. It links to the direction set in the Next Steps on the NHS Five Year Forward View, the development of Sustainability and Transformation Partnerships (STPs), the requirements of the Care Act (2014) and wider local government transformation in the area.

The BCF focuses on supporting the stabilisation and modernisation of adult social care and the development of joined- up services and approaches in health and social care both through statutory and non-statutory service developments. The focus is on preventing and delaying the need for care (*keeping people well where they live)* and the approach aims to embed BCF across current city-wide health & social care transformation programmes.

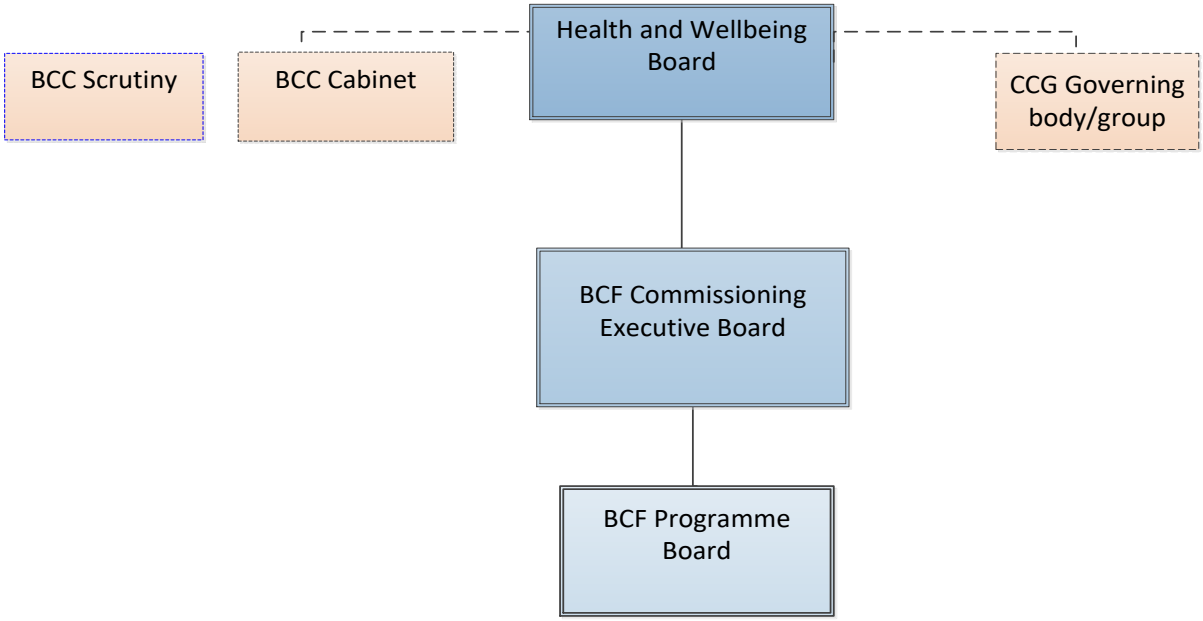
The Birmingham BCF vision is to proactively intervene to support people at the earliest opportunity ensuring that they remain well, are engaged in the management of their own health and wellbeing, and wherever possible enabled to stay in their own homes. We aim to accomplish this by taking the decisions and actions in managing markets and our own

assessment functions which improve quality and place a focus on enablement and support rather than service.

2.1 Accountability

As legal recipients of the funding, CCGs and LAs are the accountable bodies for the respective elements of the BCF allocated to them, and therefore responsible for ensuring the appropriate use of the funds. This means that they retain responsibility for spending decisions and monitoring the proper expenditure of the funding in accordance with the approved plan and their general duties.

3.0 BCF Governance structure chart



4.0 BCC Cabinet and CCG governing bodies

4.1 Role

BCC Cabinet and CCG governing bodies have a statutory responsibility for the delivery of statutory services and are accountable for the proper use of resources. BCC's Cabinet is made up of elected representatives and is accountable for making decisions on behalf of the citizens of Birmingham. NHS BSoL CCG is led by its Governing Body, which is responsible for the development of its vision and strategy, planning and commissioning health services for people living in Birmingham and Solihull, and monitoring the performance and quality improvement of our providers. It ensures good governance and promotes a culture of strong engagement with patients, their carers, GP members, the public, staff and other stakeholders.

4.2 Authority

- To sign off the BCF s75 Agreement between CCGs and BCC.
- To determine any additional contributions from the respective organisations to the BCF pooled budget beyond the required minimum.

5.0 The Health and Wellbeing Board (HWB)

5.1 Role

The Health and Wellbeing Board has overall responsibility for ensuring the integration of health and care functions within their localities and it is a requirement of the BCF that local plans are agreed by HWB's.

They have statutory ownership of the BCF and have overall accountability for the delivery of the BCF plan and for agreeing high level commissioning intentions. They have a statutory duty to encourage integrated working between commissioners and oversee the strategic direction of the BCF and the delivery of better integrated care. They are responsible for gaining system-wide buy-in to the Better Care Plan, which sets out the broad commissioning intentions for the use of the BCF. The Birmingham HWB board receives regular BCF plan progress reports from the BCF Commissioning Executive.

The HWB is a committee of the LA and include lead members and chief officers from the LA and health and social care system, HWB's are accountable to elected members and ultimately to the electorate.

5.2 Authority

- Overall accountability for approval and delivery of the BCF annual programme
- To approve and sign off the BCF plan
- To sign off of the BCF quarterly returns
- To make decisions relating to commissioning and decommissioning of services in relation to the BCF.
- To identify opportunities for further integration of health and social care services.
- Reallocating financial resources between programme elements

5.3 Delegated authority to Health and Wellbeing board

- Approval of the s75 on behalf of the respective organisations
- Overall accountability for the operation of the s75 agreement
- Spending decisions relating to the use of the s75 pooled budget
- Agree to the BCC and CCG contributions for the pooled budgets

5.4 Delegated authority from HWBB to the BCF Commissioning Executive

- The management and oversight of the delivery of the BCF plan
- To make decisions relating to commissioning and decommissioning of services in relation to the BCF
- Decision making and sign off responsibility for the s75 annual plan.
- Sign off of the BCF quarterly returns
- Decisions relating to decommissioning or commissioning of services in relation to the BCF.
- To determine the use of unallocated financial resources

5.5 Terms of Reference

ToR%20Health%20and%20Wellbeing%20Bc

6.0 BCF Commissioning Executive

6.1 Role

The Commissioning Executive acts as a collective vehicle for integrated commissioning on behalf of the CCG's and LA. It has been established to develop and operate the BCF pooled budget arrangement (s75) and to provide strategic oversight and decision making relating to the delivery of BCF plan. The group oversees the operational and financial delivery of BCF and monitors its performance through bi-monthly meetings.

A key focus of the commissioning executive role is to take a whole system approach to maximise investment of any schemes funded under BCF. The board report quarterly to HWB and make recommendations for the strategic direction and management of the BCF. The Commissioning Executive is supported by the BCF Programme Board.

6.2 Authority

- To develop the annual programme
- To make strategic decisions relating to the delivery of the plan to ensure BCF objectives are achieved
- To authorise the procurement of significant new initiatives
- To approve key project related decisions/reports/change requests where applicable
- To review the s75 agreement annually and recommend ratification to governing bodies.
- To monitor financial spend
- To manage any differences in view and escalate unresolved or disputed issues

6.3 Delegated authority

- The management and oversight of the delivery of the BCF plan
- Sign off of the BCF quarterly returns
- Delegated decision making and sign off responsibility for the s75 annual plan.
- Make decisions relating to decommissioning or commissioning of services in relation to the BCF.
- To determine programme priorities and reallocate financial resources as required
- To determine the use of unallocated financial resources above the value £100k

6.4 Terms of Reference

ToR%20Better%20Ca
re%20Commissioning'

7.0 The BCF Programme Board

7.1 Role

The Programme Board provides a joint commissioning framework for the delivery and implementation of the BCF Plan for Birmingham and Solihull. The board is responsible for

overseeing financial and performance monitoring to ensure compliance with national conditions. The programme board report on progress to the BCF commissioning executive and to NHSE as necessary.

7.2 Authority

- To agree the scope of the programme
- To deliver the Better Care Plan of behalf of HWB
- Operational management of the schemes funded by BCF
- To maintain oversight and reporting to the HWBB and NHSE
- To sign off expenditure on projects agreed as part of the annual programme
- To determine the use of unallocated financial resources below £100k

7.3 Delegated authority

- To be responsible for delegated decision making for S75
- Sign off of the BCF quarterly returns

7.4 Terms of Reference

ToR%20%20Better%20Care%20programm

8.0 BCF project lead

8.1 Role

The role of a Better Care Fund project lead officer is to monitor and manage performance of a service which may be operating wholly or partly as a BCF scheme.

8.2 Authority

- To manage the scheme on behalf of the BCF programme board.
- To report the performance of the BCF scheme metrics to the Programme Board.

9.0 Terms of reference for a BCF project

ToR%20BCF%20projects%20V0.4.doc

10.0 BCF Governance – reporting structure overview

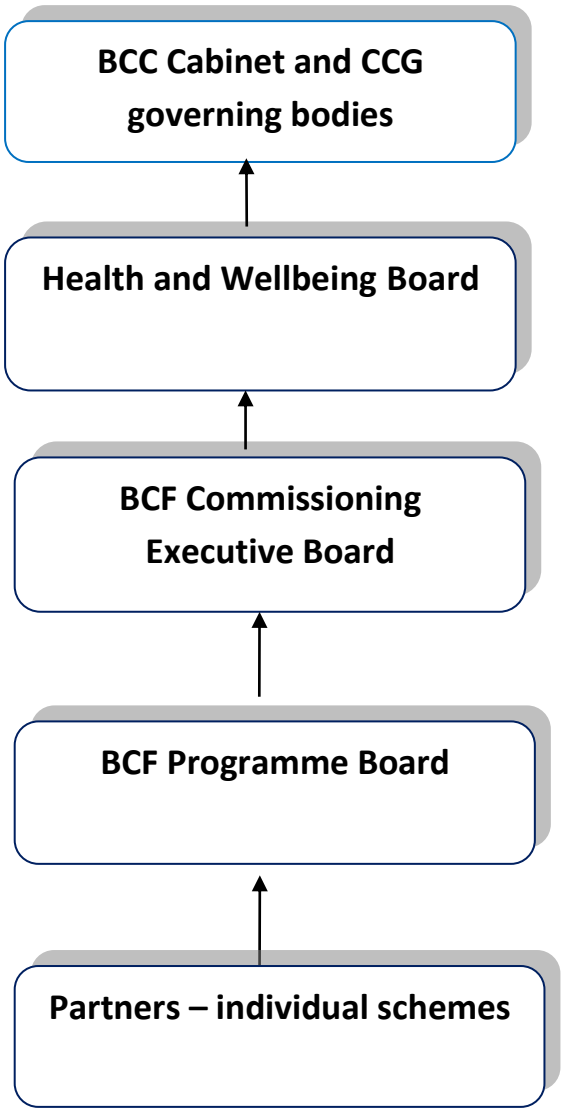
S75 decision making

Overall accountability for BCF programme
Accountability for delivery of Section 75 agreement
Decision making

Strategic direction
Key programme commissioning decisions
Finance and Performance overview
Development of the annual plan

Delivery of the BCF plan
Operational oversight of BCF schemes
Monitoring performance

Oversee schemes implementation
Report progress against performance targets and outcomes to the programme board



11.0 Local, regional & national governance arrangements

NHS England regional offices are involved in the assurance of the BCF plan alongside regional local government colleagues. Overall plans are approved and permission is given to spend the BCF once NHS England and the Integration Partnership Board have agreed that funding conditions have been met.
Appendix 1 sets out the regional and national assurance process for the approval of the Better Care Plan.

appendix 1 BCF regional and national

Birmingham Health and Wellbeing Board

	Agenda Item: 10
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19th February 2019**
TITLE:	**CQC LOCAL SYSTEM REVIEW ACTION PLAN: PROGRESS MONITORING BY CQC**
Organisation	**Birmingham City Council**
Presenting Officer	**Graeme Betts – Corporate Director of Adult Social care and Health Directorate, Birmingham City Council**

Report Type:	**Update**

1. Purpose:
For information

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

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

3.	**Recommendations**
	The Board is asked to • Note the CQC Birmingham Local System Review Progress Monitoring report at Appendix 1. • Agree to future reporting of progress forming part of wider reporting on the Birmingham Older People Programme rather than as a separate report.

4.	**Background**
4.1	In January 2018, CQC carried out a Local System Review in Birmingham at the request of the Secretaries of State for Health and Social Care and for Housing, Communities and Local Government. In response to their recommendations from this review an Action Plan was created; progress against this has been monitored by DoH.
4.2	CQC wrote to system leaders in October 2018 advising that they had been asked to monitor the improvement made since the review. Their monitoring consisted of reviewing performance data, reviewing progress against the Action Plan, and telephone interviews with key system leaders. In response CQC have provided a draft progress monitoring report – Appendix 1.
4.3	CQC's draft report concludes that there is confidence that the Birmingham system will deliver its Action Plan in full with the commitment of local leaders.

5.	Future development
5.1	Comments on the accuracy of CQC's draft monitoring repot have been submitted to them and they have advised they will be in touch with a final report, including any next steps, in due course. In the meantime, delivery against the Action Plan continues until 2020.
5.2	In terms of future reporting on the CQC Action Plan to HWB, it would seem practical to merge reporting into reporting on the wider Birmingham Older People Programme so that HWB do not receive repetitive information.

6.	Compliance Issues
6.1	***Strategy Implications***
	The actions contained within the Action Plan contribute to the BCC corporate priority 'Birmingham is a fulfilling city to age well in' and the Birmingham Older People's Programme priority 'Making Birmingham a great place to grow old in'.
6.2	***Governance & Delivery***
	As Senior Responsible Officer for the Birmingham Local System Review, Graeme Betts reports directly to the Department of Health.
6.3	***Management Responsibility***
	As paragraph 6.2

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

Appendices	
1.	CQC Birmingham Local System Review Progress Monitoring report.

Local system reviews

Progress monitoring

Birmingham

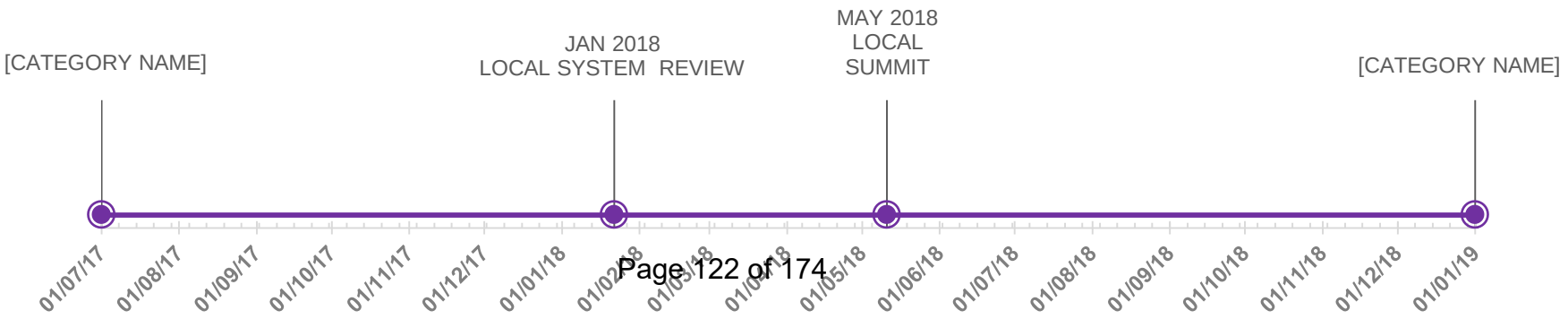
Introduction

Following CQC's programme of 20 local system reviews, we were asked by the Department of Health and Social Care and Ministry for Housing, Communities and Local Government to provide an update on progress in the first 12 areas that received a local system review.

Birmingham's local system review took place in January 2018 (report here) and the system produced an action plan in response to the findings. This progress update draws on:

- Birmingham's self-reported progress against their action plan (at 31.10.2018).
- Our trend analysis of performance against the England average for six indicators. With the exception of DToC, the data goes up to end 2017/18. DToC data goes up to July 2018.
- Telephone interviews with four system leaders involved in delivering and overseeing the action plan.

Timeline of activity



Overview progress against indicators

A&E attendances (65+)	Remained consistently above the England average over 2017/18 but little variation compared to their own history
Emergency admissions (65+)	Consistently significantly higher than England average over 2017/18 and in Q4 was significantly higher than their own average performance.
Emergency admissions from care homes (65+)	Remained consistently above the England average over 2017/18 and in Q4 was significantly higher than their own average performance.
Length of stay (65+)	Changed very little, generally staying in line with the England average over 2017/18.
Delayed transfers of care	Remained consistently higher than England average (significantly so in April 2018), but remained within upper and lower limits of its own average performance
Emergency readmissions (65+)	Remained consistently above the England average, but not varied much compared to their own average.

Overview reported progress against action plan

Leadership and governance	Chair of HWB is now a member of the STP board and STP Lead has a permanent seat on the HWB Board. Clear reporting and assurance from STP to HWB formally outlined in STP governance refresh. Document "Making Birmingham a great place to grow old in" sets out the vision for the integration of health and social care services for OP in Birmingham. Document represents collective voice of the Chair of HWB, Director of Adult Social Care, Leader of STP, and Chief Execs of the CCG and local Health trusts. There is a developing Health and Social Care Integration Framework.
Workforce	A 5 year workforce strategy has been developed but not well communicated or embedded, however LWAB has developed a workforce strategy and priorities for 2018/19 and these were presented to the STP Board in October 2018. Communications around Ageing Well have been developed and briefings are taking place. A single team approach progressed through the Early Intervention work stream pilot, November 2018.

Information sharing	Funding identified to undertake initial work and to build a comprehensive project plan to move to a person centred record. Anticipated that convergence of GP, Maternity and Mental Health records will occur within locally agreed time frame. Mandate from CCG Chief Executive also agreed to proceed with work on a citizen centred record.

Overview reported progress against action plan

Communicating and engaging with people who use services and public	CCG currently reviewing its communications and engagement strategy. Includes improved links use of engagement, patient experience and complaints data, to better identify themes and effectively act on patient feedback to improve services. Engagement activities undertaken to capture views and experiences of local people aged 55+ years that use local services, to: • Provide people an opportunity to engage with the LA and NHS in relation to health and social care on what works well, what doesn't and how this can be improved. • Provide information to people and providers of future plans around health and social care, as well as highlighting local services available and other wellbeing activities. Governance framework agreed and delivery groups established for Older Person's Strategy.
Prevention	To ensure a consistent approach is taken to identify high risk population groups and to manage risks to people within the community the council has developed a 'predicting demand' work stream. Initially will model population level demand for residential care based around primary care medical services risk stratification for frailty. Local intelligence is being utilised as part of the planned neighbourhood multi-disciplinary approach. OP subgroup set up and includes various stakeholders to inform direction of the JSNA.

Overview reported progress against action plan

Early intervention	Following prototype testing and evaluation a new intermediate care model is to be rolled out to other parts of the city. Work has commenced on preparation for rollout but the October 2018 target date has been revised to late 2019 as part of the early Intervention project plan. To enable leaders to continue to address performance issues governance arrangements established around OP Strategy linked to STP Board. Progress also feeds into A&E Delivery Board.
Personalised support	CCG has put in place a programme board to strengthen governance across CHC including adults and personal health budgets to manage CHC changes and developments more strategically. Work is ongoing system-wide through cross-system group to make operational improvements, and address issues as they arise. To provide assurance there is capacity of good quality services within the social care market a new care sector framework has been established with a focus on quality not price. New IT system (CareMatch) went live September 2018. Key focus for system is finding best quality care available that meets the needs of people.

Overview reported progress against action plan

Locality working	To rationalise the local health and social care landscape with clear points of access workshops held September 2018 to progress work. Focus was to progress against three mandates: 1) Development of a model of integrated care for the city; 2) Development of a clear vision and set of principles & 3) structuring the city in to 30k - 50k neighbourhoods. Progress: • Vision for Neighbourhood Teams drafted for sign off November and work continues on developing a workable model for each locality; • For four localities (North, East, South & Central) there will be a local workshop, November, to agree proposed model for neighbourhood teams. For the West Birmingham locality further discussion with CCG will be held to ensure a fit with primary care networks; • Development of a clinical operating model for the integrated neighbourhood teams to create a multi-disciplinary approach to improve care for patients has commenced; • Formal agreement for the neighbourhood team model will be sought via the Birmingham OP Programme Board and Birmingham & Solihull STP Ageing Well Portfolio Board, January 2019; • Stakeholder workshops (one for each locality) to be held early 2019.

Stakeholder reflections

Overall progress

The system confirmed that the January 2018 LSR findings proved to be constructive, helpful and timely having encouraged people across the system to think differently and pull together collectively to help drive improvement.

To strengthen relationships between the STP Board and the Health and Wellbeing Board (HWB) the Chair of the HWB is now a member of STP board and the STP lead has a permanent seat on the HWB. This approach has ensured that performance oversight covering health and social care activity system wide is now robust and embedded The HWB is positioned to deliver leadership and challenge, which is helping offer focus, direction, clarification and with an increased voice.

The appointment of new senior leaders across the system has helped offer fresh impetus, drive and ambition. This coupled with the merger of the three previous CCG's is helping ensure approaches and commissioning intentions are consistent and increasingly effective.

A basic refresh of the local JSNA has been undertaken to support local priorities and direction of travel with longer term plans to complete a comprehensive refresh that will be supported by a newly appointed director of Public Health. Improving communications and engagement with partners, providers and local communities are also helping support commissioning intentions and to continually improve existing service delivery.

To improve the quality of local services within the social care market a new care sector framework was recently established with a focus on quality not price. The LA is also working with inadequate care providers to either improve their service or to decommission.

The LA recently launched a tender for home support services and contracts will be awarded in January 2019. A 12 month transition period will be in place to support people to transfer their care to a new provider with an increased emphasis on the use of direct payments.

Stakeholder reflections

Direction of travel

Plans are developing at pace to deliver and implement five locally based neighbourhood teams comprising of key integrated health and social care services that will meet the needs of local communities including older people. Using Better Care Funds the system continues to work with Newton Europe and recently implemented a place-based pilot promoting an integrated pathway for intermediate services with a one-team approach that includes:

- MDT with 7 day working;
- Quick response in a crisis;
- Home and bed-based enablement – *with a focus on getting people home.*

The model will be rolled out to other parts of the city and although work has commenced on preparing for rollout the October 2018 target date has been revised to late 2019 as part of the Early Intervention project plan. Local data highlights this approach is helping maintain vulnerable older people in the community and is impacting positively on DToC and hospital admission rates.

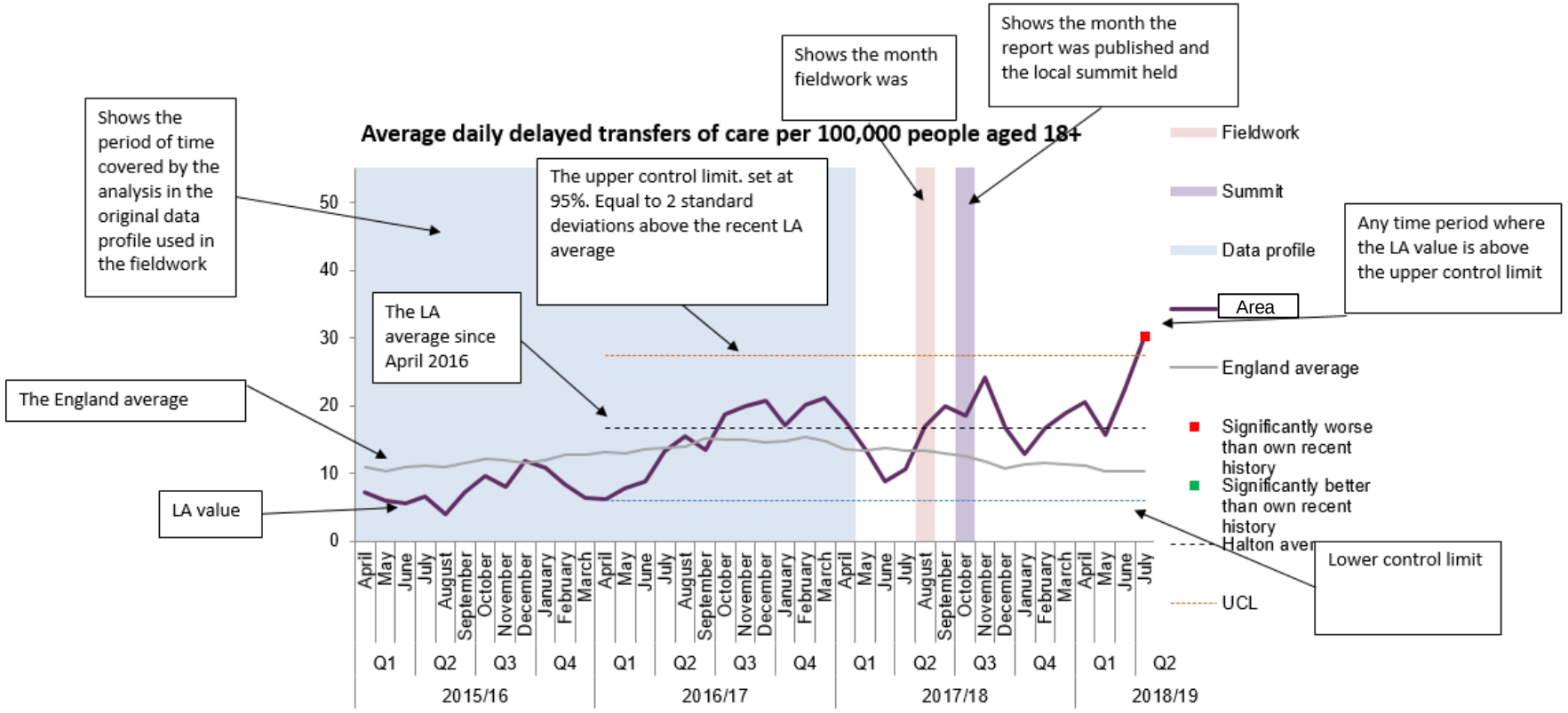
Although work is in progress to move to a person centred record the system acknowledges that further work is required to achieve this ambition, which will help improve information sharing across the health and social care interface and support effective integrated working.

Have undertaken a comprehensive workforce analysis of current and future needs in the context of locality working there is a drive to develop a Birmingham workforce/ careforce strategy. However, delivery remains dependent upon the developing neighbourhood working model.

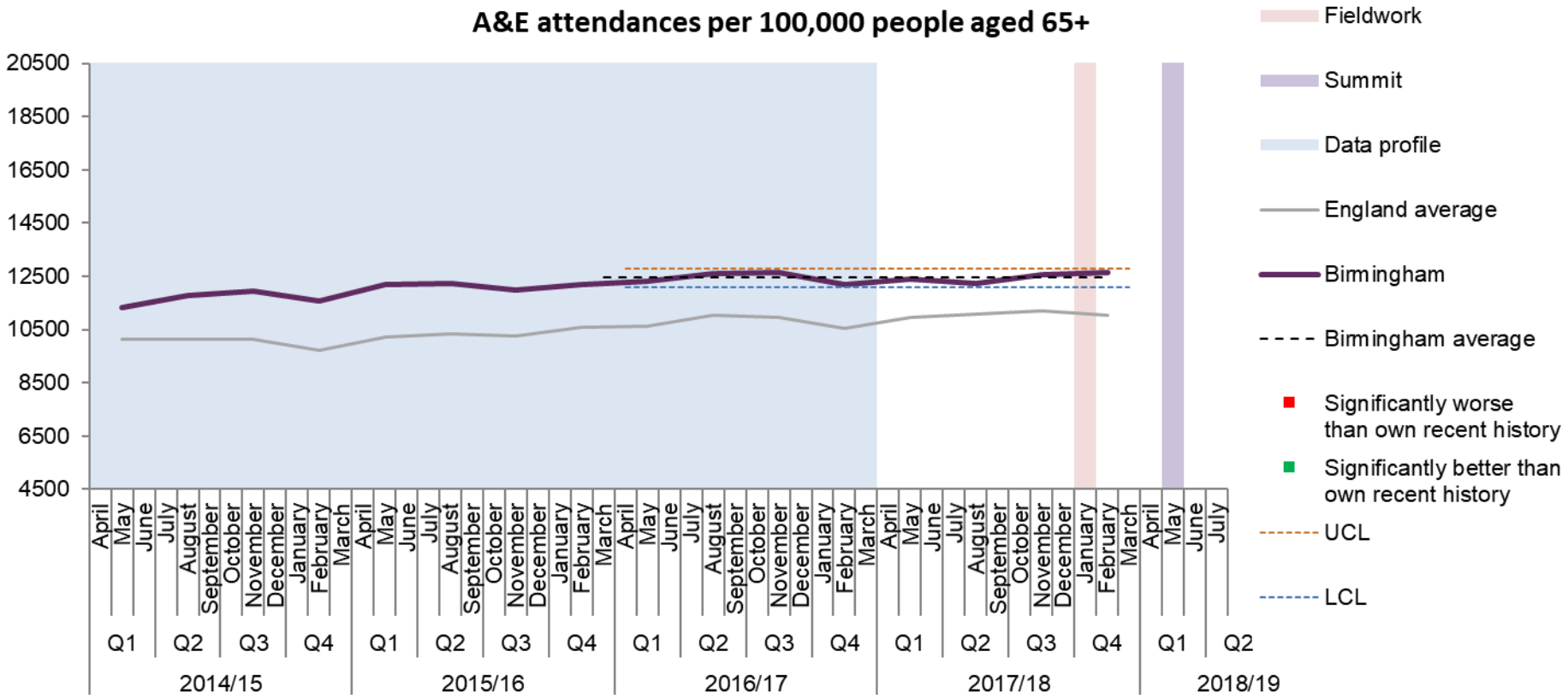
With the drive and commitment of local leaders there is confidence that the system will deliver its LSR action plan in full.

Appendix: Trend analysis introduction

The following slides present a trend analysis for six indicators. The **dummy** diagram below shows how to interpret the graphs. If you have any questions please contact warren.coppin@cqc.org.uk

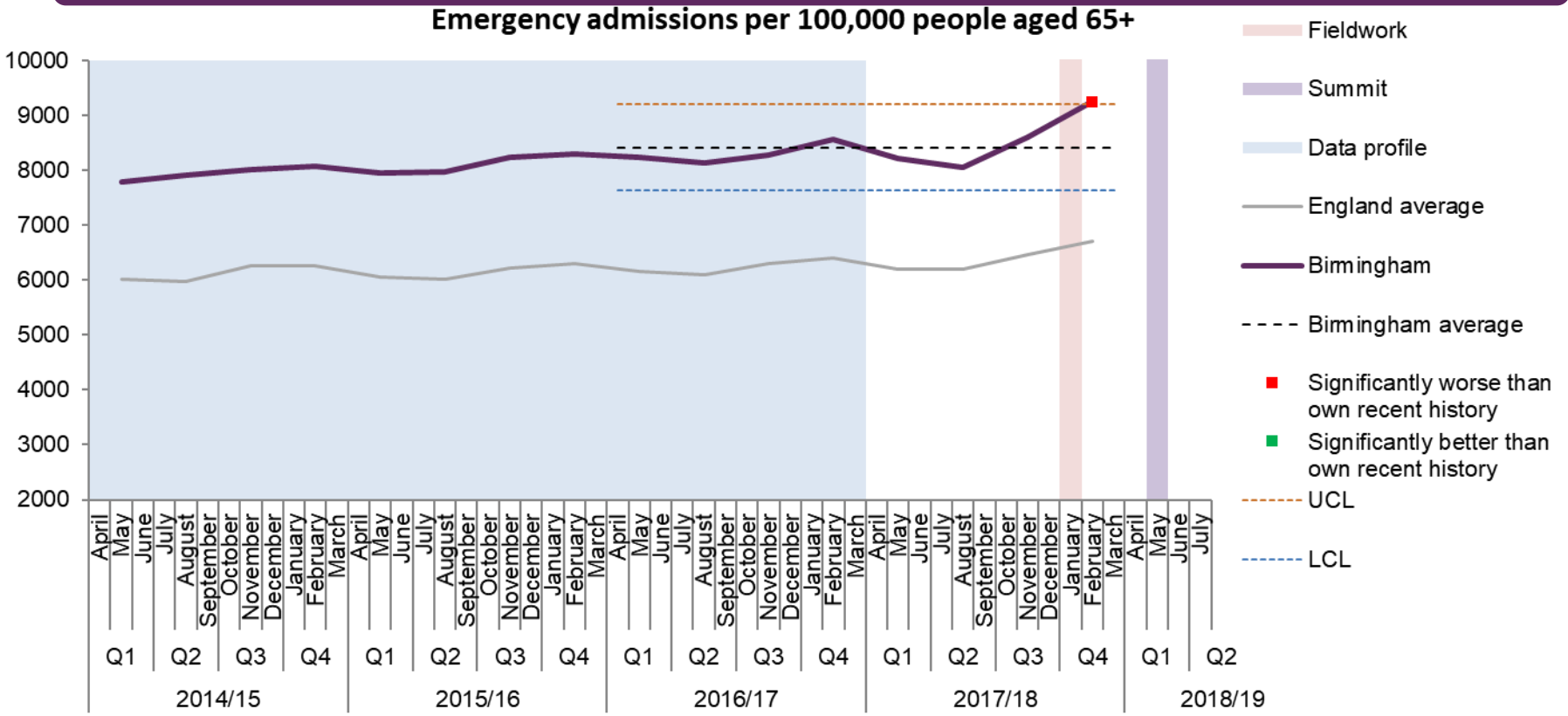


Appendix: A&E attendances



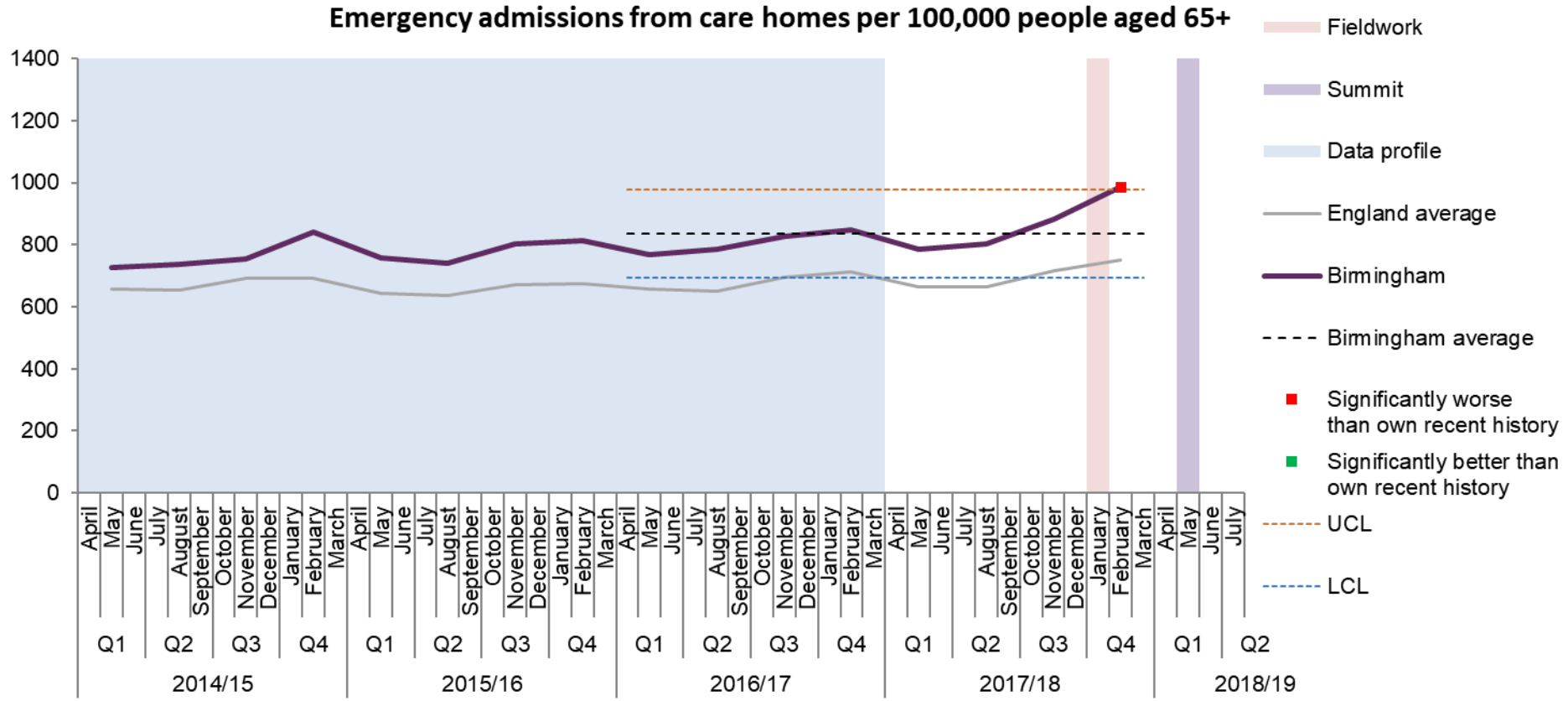
Since we produced the data profile for the original local system review, Birmingham's performance for A&E attendances (65+) has remained consistently above the England average and has shown little variation – performance has remained within the upper and lower limits of their own average rate over the last 2 years.

Appendix: Emergency admissions



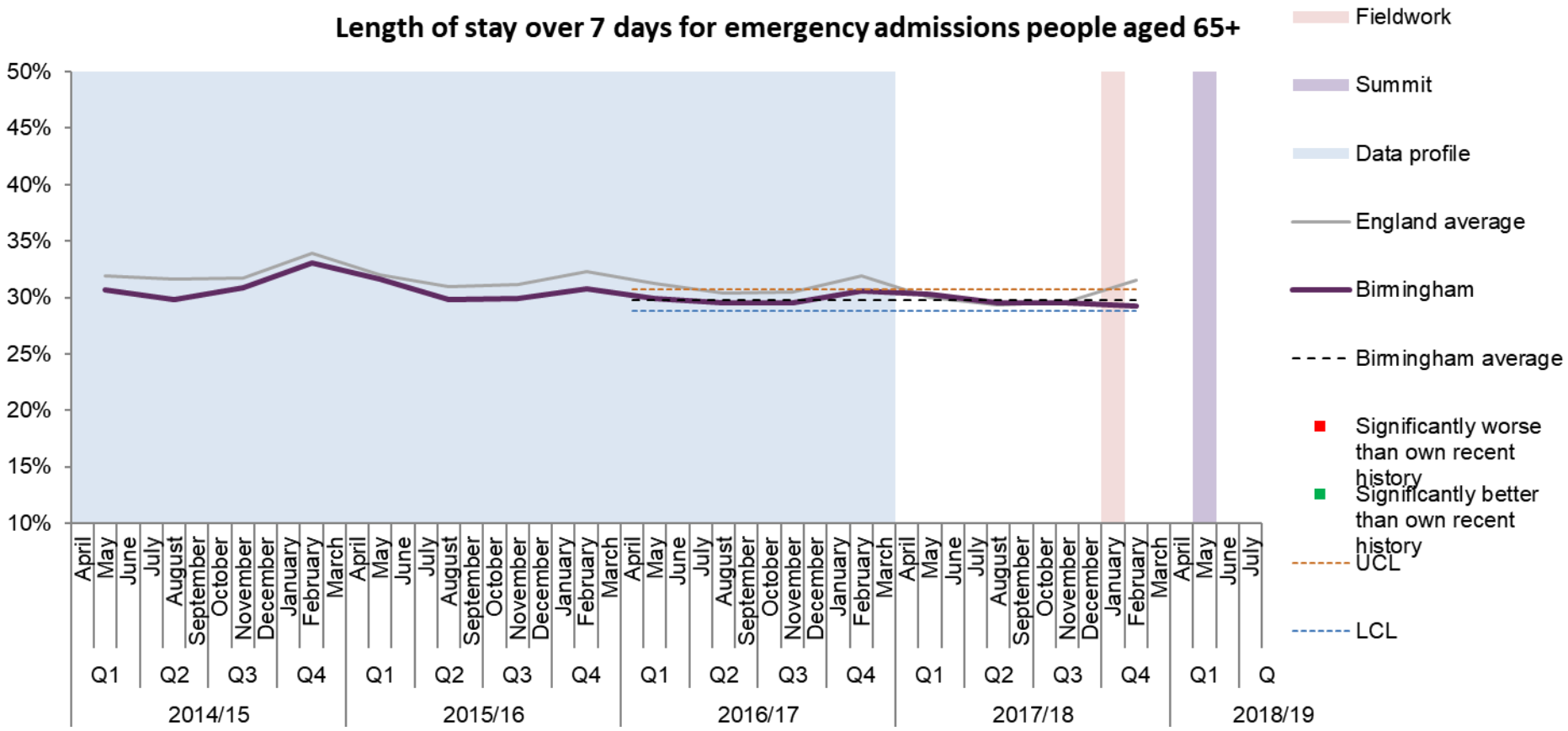
Since we produced the data profile for the original local system review, Birmingham's performance for emergency admissions (65+) remained consistently significantly higher than the England average over 2017/18 and in the last quarter was significantly higher than their own average performance over the last 2 years.

Appendix: Emergency admissions from care homes



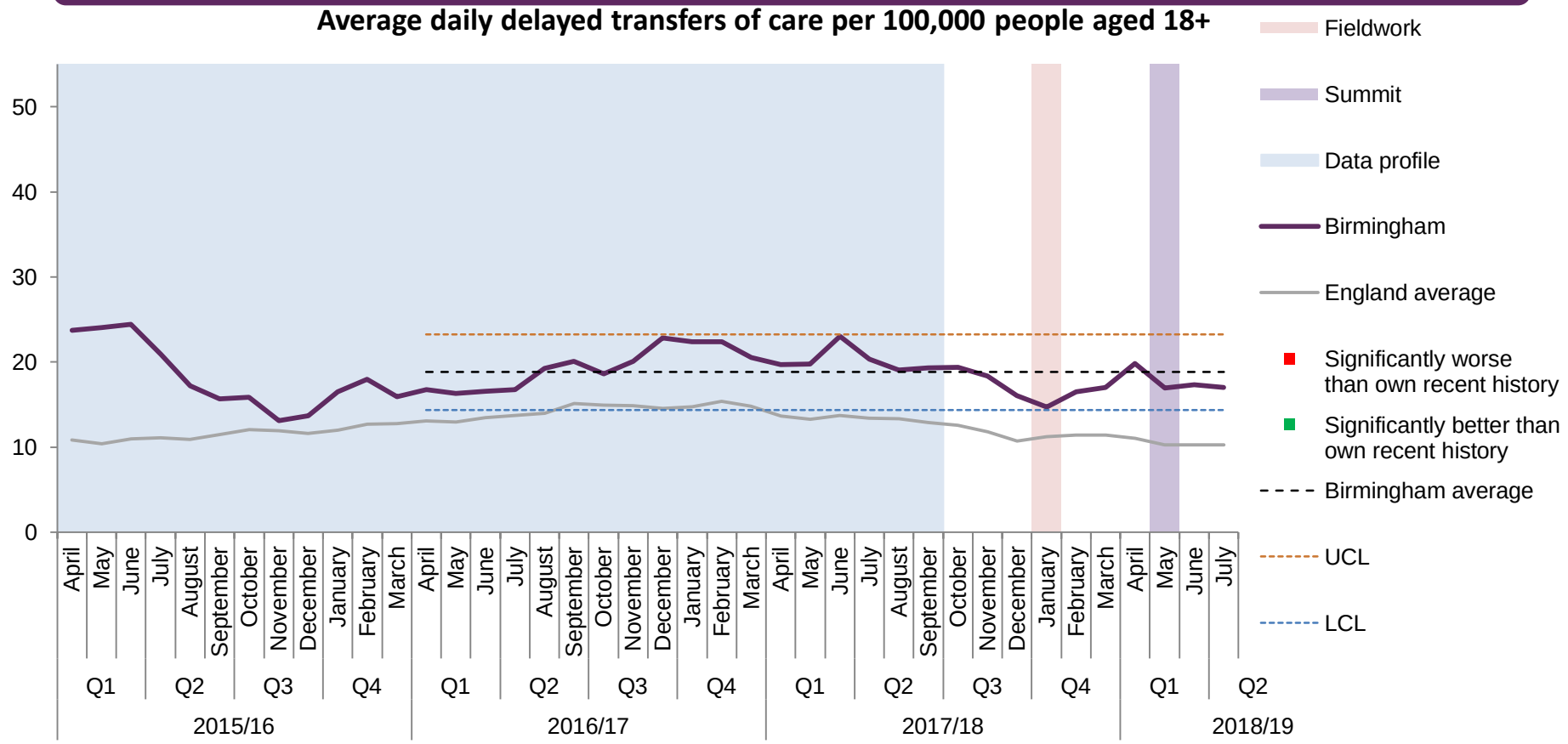
Since we produced the data profile for the original local system review, Birmingham's performance for emergency admissions from care homes (65+) remained consistently above the England average over 2017/18 and in the last quarter was significantly higher than their own average performance over the last 2 years.

Appendix: Lengths of stay over 7 days



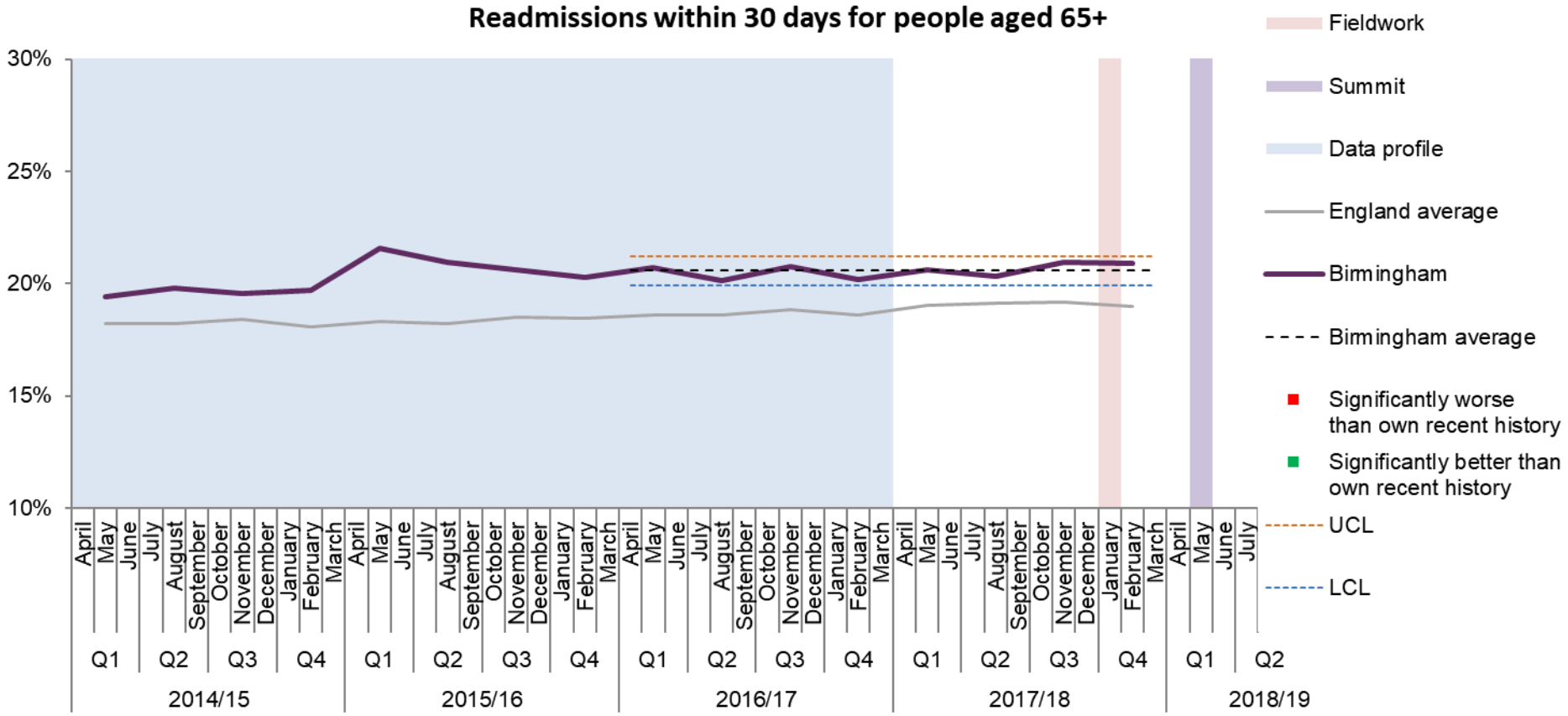
Since we produced the data profile for the original local system review Birmingham's performance for lengths of stay over 7 days (65+) has changed very little, generally staying in line with the England average over 2017/18.

Appendix: Delayed transfers of care



Since we produced the data profile for the original local system review, Birmingham's DToC performance has remained consistently higher than the England average (significantly so in April 2018), however it has remained within the upper and lower limits of its own average performance.

Appendix: Emergency readmissions



Since we produced the data profile for the original local system review, Birmingham's emergency readmissions (65+) have remained consistently above the England average, but have not varied much compared to their own average.

Birmingham Health and Wellbeing Board

	Agenda Item: 11
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19 February 2019**
TITLE:	**THE NHS LONG TERM PLAN – A SUMMARY**
Organisation	**NHS Birmingham and Solihull CCG**
Presenting Officer	**Paul Jennings – Chief Executive**

Report Type:	**Information**

1. Purpose:

1.1 This report provides a summary of the recently published NHS Long Term Plan**.** It sets out the key things we can expect to see and hear about over the next few months and years, as local NHS organisations work with their partners to turn the ambitions in the plan into improvements in services.

2. Implications:

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

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

3.	**Recommendations**
	The Health and Wellbeing Board is asked to receive this report for information and assurance.

4.	**Background**
4.1	The NHS Long Term Plan was published on Monday 7 January 2019.
4.2	The plan has been drawn up by those who know the NHS best, including frontline health and care staff, patient groups and other experts.

5.	**Future development**
5.1	Work is now happening to understand what NHS Long Term Plan means for Birmingham and Solihull.
5.2	The Sustainability and Transformation Partnership (STP) need to develop and implement our own strategy, for the next five years, by Autumn 2019.

6.	Compliance Issues
6.1	***Strategy Implications***
6.2	***Governance & Delivery***
6.3	***Management Responsibility***

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

Appendices	
1.	Strategic Policy Briefing Note NHS Long Term Plan January 2019
2.	The NHS Long Term Plan – A Summary
3	Full Policy Briefing - NHS Long Term Plan January 2019

Birmingham City Council

Strategic Policy Briefing Note
NHS Long Term Plan (January 2019)

Context

The NHS has published its 'Long Term Plan' setting out its strategic approach and priorities for the next ten years. The plan outlines how the NHS plans to become 'fit for the future', modernising services and getting the best value for money for patients.

The approach can be characterised along three broad themes: increased integration of services; a focus on prevention; and an awareness of the social, cultural and economic factors that affect health outcomes – so-called 'wider determinants of health'.

Importance to Birmingham and Key Services/Policies Affected

The NHS Long-Term Plan is likely to have a big impact on adult and children's social care services, especially for those working with older adults and people who need support to live independently at home.

The proposals to replace Sustainability and Transformation Partnerships (STPs) with Integrated Care Systems (ICSs) by April 2021 will give local authorities such as Birmingham City Council (BCC) a much larger role in the design and delivery of health and social care services.

This strategy recognises the important role that local government plays in health, especially when addressing the wider determinants of health such as economic and social inequalities. However, it also states that the NHS and the Government will be considering if the NHS needs to play 'a stronger role' in the commissioning of some public health services. It is unclear what this means at this stage.

Summary

The NHS Long Term Plan sets out a number of actions and goals across five areas for improvement:

1. A new service model

- A new service model for the NHS with more coordinated and joined-up services, and a more personalised approach to care.
- Integrated Care Systems (ICSs) across the whole country by April 2021, growing out of current Sustainability and Transformation Partnerships (STPs).

2. Prevention and health inequalities

- A renewed and expanded NHS prevention programme, with recognition of the health impacts of socioeconomic inequality.
- A range of new interventions/services to tackle some of the leading factors affecting health: smoking, obesity, alcohol and drug use, and air pollution.

3. Health outcomes

- Increased investment in mental health (both children and young people's services, and adult services).
- Range of measures to tackle the five leading causes of premature death: cancer, heart disease and stroke, respiratory conditions, dementia, and self-harm (including suicide).

4. Workforce development

- A full workforce implementation plan to be published later in 2019 to address workforce challenges, including a shortage of key staff and recruitment of staff from overseas.

5. Technology and digitally enabled care

- Redesign of clinical pathways to offer 'digital first' options for patients, especially in primary care and outpatient services, to free up more time for face-to-face appointments for those patients who need them.
- Increased use of health data and new technologies including artificial intelligence (AI) to identify groups of people at risk of health issues and improve outcomes.

A full policy briefing, which goes through the Long Term Plan and its implications in detail, is attached.

Additional Commentary

The NHS Long Term Plan has received a mixed response from stakeholders and commentators, with support for its broad themes but concern that the Plan may not be realistically deliverable.

This is an ambitious and forward-thinking strategy to modernise the NHS and rethink how we deliver health and social care services. However, there are various factors that will make the Long Term Plan difficult to deliver, including historically low levels of investment in the NHS (in real terms), a continued NHS workforce crisis with 100,000 unfilled vacancies, and the continued uncertainty posed by Brexit.

The future of the NHS is now intrinsically linked to adult social care and public health services, however the Government has yet to publish its Green Paper on adult social care outlining how it will be funded in the future. Until this is published, it is difficult to assess how successful the NHS Long Term Plan will be.

Author and contact details

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The NHS Long Term Plan – a summary

Find out more: **www.longtermplan.nhs.uk** | **Join the conversation:** **#NHSLongTermPlan**

Health and care leaders have come together to develop a Long Term Plan to make the NHS fit for the future, and to get the most value for patients out of every pound of taxpayers' investment.

Our plan has been drawn up by those who know the NHS best, including frontline health and care staff, patient groups and other experts. And they have benefited from hearing a wide range of views, whether through the 200 events that have taken place, and or the 2,500 submissions we received from individuals and groups representing the opinions and interests of 3.5 million people.

This summary sets out the key things you can expect to see and hear about over the next few months and years, as local NHS organisations work with their partners to turn the ambitions in the plan into improvements in services in every part of England.

What the NHS Long Term Plan will deliver for patients

These are just some of the ways that we want to improve care for patients over the next ten years:

Making sure everyone gets the best start in life

- reducing stillbirths and mother and child deaths during birth by 50%
- ensuring most women can benefit from continuity of carer through and beyond their pregnancy, targeted towards those who will benefit most
- providing extra support for expectant mothers at risk of premature birth
- expanding support for perinatal mental health conditions
- taking further action on childhood obesity
- increasing funding for children and young people's mental health
- bringing down waiting times for autism assessments
- providing the right care for children with a learning disability
- delivering the best treatments available for children with cancer, including CAR-T and proton beam therapy.

Delivering world-class care for major health problems

- preventing 150,000 heart attacks, strokes and dementia cases
- providing education and exercise programmes to tens of thousands more patients with heart problems, preventing up to 14,000 premature deaths
- saving 55,000 more lives a year by diagnosing more cancers early
- investing in spotting and treating lung conditions early to prevent 80,000 stays in hospital
- spending at least £2.3bn more a year on mental health care
- helping 380,000 more people get therapy for depression and anxiety by 2023/24
- delivering community-based physical and mental care for 370,000 people with severe mental illness a year by 2023/24.

Supporting people to age well

- increasing funding for primary and community care by at least £4.5bn
- bringing together different professionals to coordinate care better
- helping more people to live independently at home for longer
- developing more rapid community response teams to prevent unnecessary hospital spells, and speed up discharges home.
- upgrading NHS staff support to people living in care homes.
- improving the recognition of carers and support they receive
- making further progress on care for people with dementia
- giving more people more say about the care they receive and where they receive it, particularly towards the end of their lives.

How we will deliver the ambitions of the NHS Long Term Plan

To ensure that the NHS can achieve the ambitious improvements we want to see for patients over the next ten years, the NHS Long Term Plan also sets out how we think we can overcome the challenges that the NHS faces, such as staff shortages and growing demand for services, by:

1. **Doing things differently:** we will give people more control over their own health and the care they receive, encourage more collaboration between GPs, their teams and community services, as 'primary care networks', to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners, as 'Integrated Care Systems', to plan and deliver services which meet the needs of their communities.

2. **Preventing illness and tackling health inequalities:** the NHS will increase its contribution to tackling some of the most significant causes of ill health, including new action to help people stop smoking, overcome drinking problems and avoid Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems.

3. **Backing our workforce:** we will continue to increase the NHS workforce, training and recruiting more professionals – including thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships. We will also make the NHS a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients.

4. **Making better use of data and digital technology:** we will provide more convenient access to services and health information for patients, with the new NHS App as a digital 'front door', better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.

5. **Getting the most out of taxpayers' investment in the NHS:** we will continue working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS' combined buying power to get commonly-used products for cheaper, and reduce spend on administration.

What happens next

Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs), which are groups of local NHS organisations working together with each other, local councils and other partners, now need to develop and implement their own strategies for the next five years.

These strategies will set out how they intend to take the ambitions that the NHS Long Term Plan details, and work together to turn them into local action to improve services and the health and wellbeing of the communities they serve – building on the work they have already been doing.

This means that over the next few months, whether you are NHS staff, a patient or a member of the public, you will have the opportunity to help shape what the NHS Long Term Plan means for your area, and how the services you use or work in need to change and improve.

To help with this, we will work with local Healthwatch groups to support NHS teams in ensuring that the views of patients and the public are heard, and Age UK will be leading work with other charities to provide extra opportunities to hear from people with specific needs or concerns.

Find out more

More information is available at www.longtermplan.nhs.uk, and your local NHS teams will soon be sharing details of what it may mean in your area, and how you can help shape their plans.

Full Policy Briefing - NHS Long Term Plan

January 2019

Context

On 7 January 2019 the NHS published its 'Long Term Plan' setting out its strategic approach and priorities for the next ten years. The NHS Long Term Plan is supported by the new NHS five-year funding settlement agreed in June 2018, increasing funding by £20.5 billion per year (in real terms) by 2023/24, an average rise of 3.4% per year.

The NHS Long Term Plan outlines how the NHS plans to become 'fit for the future', modernising services and getting the best value for money for patients. The strategic approach can be characterised along three broad themes: increased integration of services; a focus on prevention; and an awareness of the social, cultural and economic factors that affect health outcomes – so-called 'wider determinants of health'.

Key Proposals

The NHS Long Term Plan sets out a number of actions and goals across five areas for improvement. The key points, as relating to Birmingham City Council, include:

1. A new service model

- A new service model for the NHS with more coordinated and joined-up services, and a more personalised approach to care.
- Commitment to increase investment in primary and community care services as a share of NHS spend – worth at least an extra £4.5 billion per year by 2023/24.
- The creation of fully integrated community-based healthcare, with community multidisciplinary teams aligned with new primary care networks of GP practices.
- By 2023/24, upgraded NHS support to all care home residents who would benefit.
- Achieve and maintain a Delayed Transfer of Care (DToC) figure of 4,000 or less delays, and then reduce further over the next five years.
- Expansion of social prescribing, with over 1,000 trained social prescribing link workers in place by the end of 2020/21.
- Acceleration of the adoption of Personal Health Budgets (PHBs) including people receiving mental health services, with a learning disability, receiving social care support, and end of life care.
- Integrated Care Systems (ICSs) across the whole country by April 2021, growing out of current Sustainability and Transformation Partnerships (STPs).
- A new ICS accountability and performance framework to provide a consistent set of performance measures, including a new 'integration index' measuring the extent that local health and social care partners are delivering joined-up care.
- Development of new approaches to combining health and social care budgets where appropriate, to be set out in the upcoming Green Paper on adult social care.
- A review of the Better Care Fund (BCF) funding mechanism, to be completed in ealy 2019.

2. Prevention and health inequalities

- A renewed and expanded NHS prevention programme, with recognition of the health impacts of socioeconomic inequality.
- NHS and national government to reconsider the role of NHS in commissioning certain public health services including health visitors and school nurses.
- A range of new interventions/services to tackle some of the leading factors affecting health: smoking, obesity, alcohol and drug use, and air pollution.
- NHS England to target a higher share of funding towards geographies with high health inequalities, worth over £1billion by 2023/24.
- All local health systems will need to produce plans setting out how they will specifically reduce health inequalities by 2023/24 and then again by 2028/29.
- Additional investment of up to £30million on meeting needs of rough sleepers including specialist homelessness NHS mental health support.
- NHS to encourage national adoption of carers' passports.
- Investment in NHS specialist clinics to support people with serious gambling problems.

3. Health outcomes

- Maternity and neonatal health – a range of actions to achieve a 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.
- Children and young people's mental health services
    - Commitment to increase proportion of NHS budget spent on CYP mental health services, including community-based services and eating disorder services.
    - Mental Health Support Teams to be rolled out to schools and colleges in around 25% of the country by the end of 2023
    - A new model of mental health services for 0-25 year olds, integrated across health, social care and education services
- Learning disability and autism
    - By 2023, national learning disability improvement standards to apply to all services funded by NHS.
    - By 2023/24, all CYP with a learning disability and/or autism to have a designated keyworker.
    - Renewed focus on enabling CYP with a learning disability and/or autism to use Personal Health Budgets (PHBs).
- Range of measures to tackle the five leading causes of premature death: cancer, heart disease and stroke, respiratory conditions, dementia, and self-harm (including suicide).
- Adult mental health services
    - Increased investment in adult mental health services, worth at least an extra £2.3 billion a year by 2023/24.
    - By 2023/24, local areas supported to redesign community mental health teams to move towards place-based, multidisciplinary services across health and social care.

- By 2020/21, 24/7 community-based mental health crisis response available for adults and older adults.
- Ending acute out of area placements by 2021.
- Reducing suicide rates to remain an NHS priority over next decade.

4. Workforce development

- A full workforce implementation plan to be published later in 2019 to address workforce challenges, including a shortage of key staff and recruitment of staff from overseas.

5. Technology and digitally enabled care

- Redesign of clinical pathways to offer 'digital first' options for patients, especially in primary care and outpatient services, to free up more time for face-to-face appointments for those patients who need them.
- Over the next five years, all patients will be able to access their GP digitally and opt for 'virtual' outpatient appointments where appropriate.
- Development of the NHS App and a range of condition-specific apps, in partnership with developers and the voluntary sector, to enable patients to manage and monitor their health at home.
- Continued expansion of digital Personal Health Records (PHRs) and Summary Care Records (SCRs) that patients and services can access online.
- Increased staff access to mobile digital services and patient/care records online.
- From April 2020, NHS organisations will no longer use fax machines.
- Increased use of health data and new technologies including artificial intelligence (AI) to identify groups of people at risk of health issues and improve outcomes.

Importance to Birmingham and Key Services/Policies Affected

The NHS Long-Term Plan is likely to have a big impact on adult and children's social care services, especially for those working with older adults and people who need support to live independently at home.

The proposals to replace Sustainability and Transformation Partnerships (STPs) with Integrated Care Systems (ICSs) by April 2021 will give local authorities such as Birmingham City Council (BCC) a much larger role in the design and delivery of health and social care services. The NHS expects local commissioners to develop streamlined, integrated commissioning processes that deliver personalised, place-based care for citizens, with an emphasis on multidisciplinary approaches to care and support. Health and social care services will draw ever closer together over the next decade, with shared budgets and financial arrangements where possible. Birmingham City Council has placed considerable importance on partnership working approaches over the last year, and thus should be in a good position to take advantage of the opportunities that the Long Term Plan provides to improve services and outcomes for people in Birmingham.

The themes laid out in the NHS Long Term Plan align closely with our own Vision and Strategy for Adult Social Care and Health, with an emphasis on delivering personalised care

and support, working in partnership with other organisations, social prescribing, and the importance of prevention and early intervention. This is strong confirmation that we are on the right track with our approach to health and social care services.

This strategy recognises the important role that local government plays in health, especially when addressing the wider determinants of health such as economic and social inequalities. However, it also states that the NHS and the Government will be considering if the NHS needs to play 'a stronger role' in the commissioning of some public health services such as sexual health services, health visitors, and school nurses. It is unclear what this means at this stage. The Local Government Association (LGA) has sent a letter to the Secretary of State for Health and Social Care requesting clarification on the terms of reference for any strategic review of public health and the role of local government, to which Birmingham City Council has contributed.

Additional Commentary

The NHS Long Term Plan has received a mixed response from stakeholders and commentators, with support for its broad themes but concern that the Plan may not be realistically deliverable.

This is an ambitious and forward-thinking strategy to modernise the NHS and rethink how we deliver health and social care services. The emphasis on joined-up services, 'digital first' outpatient and primary care, and the use of new technologies such as apps, wearables and artificial intelligence (AI) will fundamentally change the way that people access and interact with healthcare services. It is particularly significant that this plan recognises the impact of wider social, cultural and economic factors on healthcare outcomes, especially for a city such as Birmingham with high levels of economic and health inequalities.

However, there are various factors that will make the Long Term Plan difficult to deliver, especially at pace. The NHS five-year funding settlement will increase funding to the NHS by £20.5 billion a year by 2023/24, however commentators such as The Nuffield Trust and The Kings Fund have doubts that this will be enough, as it is still below historic average funding increases, and below the 4% uplift some argue is required. The uncertainty posed by Brexit will also have a heavy impact on the NHS budget. The Nuffield Trust estimates that a no-deal Brexit could cost the NHS £2.3 billion a year in additional costs.

Successful delivery of the Long Term Plan will also depend on solving the NHS workforce crisis. The NHS already has around 100,000 unfilled vacancies, set to rise to around 250,000 by 2030. Again, the uncertainty posed by Brexit will impact on staff shortages if the NHS cannot find a way to recruit and attract staff from overseas.

Finally, as we move towards integrated health and social care systems, the future of the NHS is now heavily dependent on the success of local government, including social care and public health services. The recent public health funding settlement cut funding by £240m in real terms, which could pose a significant setback to the prevention approach outlined in this strategy. The Government has yet to publish its Green Paper on adult social care (first

scheduled for release in summer 2017), which will outline how they plan to fund the massive rise in demand for adult social care services. Until this is published, it is difficult to fully assess whether the new service model proposed here is realistic and deliverable.

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Birmingham Health and Wellbeing Board

	Agenda Item: 12
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19th February 2019**
TITLE:	**ADULT SUBSTANCE MISUSE TREATMENT PROVISION**
Organisation	**Birmingham City Council**
Presenting Officer	**Max Vaughan**

Report Type:	**For information/ endorsement**

1. Purpose:

Inform the Board of the current commissioning arrangements for Adult Substance Misuse Treatment services in the City and how these can be developed with partners into the future.

2. Implications:

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

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

3. Recommendations

3.1 To maintain the current treatment system response which has an aim to address the harms caused by drug and alcohol misuse on affected individuals. There is Cabinet permission to award the current treatment provider a contract extension from 2020 to 2022. A review of their contract performance and the current service specification validates the decision to extend for this period. Any reduction in contract value as part of the Council' saving plan for the extension period will aim to be minimised.

3.2 During the contract extension period a whole systems review of adult substance misuse prevention, treatment and recovery services is planned to be undertaken to maximise the outcomes of the current system and to develop the future commissioning approach and intentions for when the contract or service functions are re tendered in 2022.

3.3 This review with health, criminal justice and social care partners will aim to develop more effective services pathways, collaborations and identify how resources can best be aligned. The Joint Commissioning Group for Substance Misuse will be reconvened to oversee this work with partners from the criminal justice, social care and health sectors.

4. Background

4.1 Overview

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

4.1.2 Drug treatment has been evaluated by researchers on a wide range of measures, including drug use, abstinence from drug use, drug injecting, overdose, health and mortality, crime, social functioning including employment, housing, family relations, and the perceptions of service users about their recovery status. The breadth of these measures reflects the broad range of benefits anticipated from drug treatment. England has a well-established network of locally commissioned and run public systems and services that provide this treatment. There is extensive international research evidence on the interventions provided by these services and how people can be helped to tackle drug misuse and recover. This evidence forms the basis of guidance for the commissioning of local treatment systems such as Birmingham's service provision.

4.1.3 Modelling from the Social Return on Investment tool shows the effect of treatment services on crime figures. It is estimated that 2016/17 investment in Birmingham drug and alcohol treatment resulted in over 150,000 fewer crimes and over £50 million in economic and social benefits.

4.1.4 See appendix 1 - Substance Misuse Intelligence Summary 2018.

4.2 Birmingham Treatment Service Arrangements

4.2.1 Current drug and alcohol treatment provision is delivered by the third sector organisation 'Change Grow Live' (CGL) in the City.

4.2.2 The CGL five year contract ends in March 2020 – there is cabinet permission to extend the contract by a further two years if required, this is being worked towards to be secured.

4.2.3 Expenditure on drug and alcohol treatment services was reduced from £27m to £18m in 2014/15. Expenditure has further reduced to £15m in 2018/19. As part of the Public Health savings plan there has been planned a further £1.5m (10%) reduction on expenditure from 2020. This would take the annual budget to £13.5m.

4.2.4 The demand on these treatment services continue to increase with regards to the prevalence of misuse of Heroin, Cocaine, Novel Psychoactive substances and alcohol in the City. The complexity of presentations also continues to increase.

4.2.5 A range of stakeholders report that a further reduction in service provision would have a very serious detrimental effect on drug and alcohol treatment

provision which is already under considerable stress due to previous reductions. These stakeholders include the acute sector, Police, Probation Service, mental health services, Community Safety Partnership, Department of Work and Pensions, Primary Care, housing and homelessness services. Service users have also expressed their concerns.

4.2.6 A contract negotiation process has been undertaken regards the potential extension of the contract. This process included an analysis of the trends regards drug and alcohol misuse in the city, current contract performance, and provider and service user perspective. CGL have concluded as part of the negotiation process that they are only able to reduce the contract value by 5% if the safe delivery of services is to be maintained. CGL's current position is that they are unwilling to continue to deliver the service if a 10% reduction in contract value is applied.

4.2.7 Public Health England have expressed concerns that the reductions in funding for drug and alcohol services is decreasing at a more rapid rate than the annual decreases in the Public Health Grant allocation.

5. Future development

5.1 Proposed commissioning intentions for the two year extension period.

During the negotiation process a number of commissioning intentions have been defined in conjunction with the provider given the needs of the City. These would be implemented if the two year contract extension from 2020 is granted:

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

5.2 Future developments in substance misuse provision

During the contract extension period there is an opportunity to undertake a fundamental review to how treatment responses to substance misuse can be addressed alongside prevention and recovery interventions:

- Understand how the wellbeing of those with multiple complex can be improved i.e. those individuals with issues related to substance misuse, offending, homelessness and mental health.

- Explore the potential for shared budgets and integrated commissioning opportunities.
- Further develop key pathways and collaborative working opportunities including those with the criminal justice sector, acute sector, mental health services, DWP and others.
- Strengthen the prevention and recovery elements of how drug and alcohol related harms are addressed.
- Ensure that access to alcohol treatment services and the new type of drugs are improved including Novel Psychoactive Substances.
- Start to develop a systems approach with partners in line with the 2017 National Drug Strategy to include the following pillars:
  - Reducing demand
  - Reducing supply
  - Building recovery
  - Global action
- Consider other key strategic documents such as the NHS 10 year plan and the Birmingham City Council Vision for Adult Social Care.

6.	**Compliance Issues**
6.1	***Strategy Implications***
	N/A
6.2	***Governance & Delivery***
	The commissioning of substance misuse services is overseen by the Public Health Contracts Board and the Adult Health Management Team of Birmingham City Council. The service area sits within the Councillor for Health and Well Being's portfolio. The Joint Commissioning Group for Substance Misuse provides an interface with criminal justice, health and social care partners.
6.3	***Management Responsibility***
	Commissioning within adult social care and Public Health has direct management responsibilities for adult substance misuse treatment services.

6. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Contract not extended due to financial issues.	Medium	High	Negotiating with the current provider a level of manageable financial value contract reduction.

Appendices	
1.	Substance Misuse Intelligence Summary 2018

Birmingham City Council

Substance Misuse Intelligence Summary 2018

Introduction

This report summarises current information on drug and alcohol use and treatment in Birmingham. It is set in the context of the Government's 2017 Drug Strategy[1], which aims to "reduce illicit and other harmful drug use" and "increase the rates recovering from their dependence". It draws on deaths and hospital activity information as well as data collected by the National Drug Treatment Monitoring System (NDTMS) and other sources to present a view of prevalence, treatment, service need and outcomes which will inform commissioning priorities. In Birmingham, substance misuse services for adults aged 18 and over have been provided by CGL (change, grow live) since March 2015.

Key Messages

- The estimated number of dependent drinkers in Birmingham was 13,603 (2014).
- 8,234 estimated opiate users and 6,689 crack users in Birmingham (2014/15). Rates were higher than national average.
- Rates of opiate use by 25-34 year olds have fallen significantly from 2011/12 to 2014/15 but not for other age groups.
- There were 373 alcohol specific deaths in the period from 2014 to 2016 and 173 deaths from substance misuse.
- There were 6,102 hospital admissions for alcohol specific conditions in 2016/17.
- There are approximately 500 admissions each year due to substance misuse (excluding alcohol).
- A&E attendances related to alcohol and substance misuse are increasing each year mostly due to alcohol related attendances. However, this could be, at least in part, due to variation in A&E data coding practice and quality. There were nearly 4,000 alcohol and substance misuse related attendances in 2016/17.
- There were 6,292 adults in drug treatment in Birmingham in 2016/17, 1,895 dependent drinkers in alcohol treatment and 584 in treatment for drug and alcohol dependence.
- The numbers in treatment for opiates have fallen from approximately 6,000 in 2009-10 to approximately 5,000 in 2016-17.
- The numbers of new presentations have fallen from approximately 1,800 for opiates in 2009-10 to approximately 1,600 in 2016-17.

[1] HM Government 2017 Drug Strategy
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/628148/Drug_strategy_2017.PDF

- New presentations for alcohol peaked in 2013-14 at approximately 1,800 before falling to approximately 1,100 in 2016-17.
- Numbers for non-opiate and non-opiate/alcohol also peaked in 2013-14 before falling to approximately 500 and approximately 350 respectively in 2016-17.
- There are approximately 6,000 to 7,000 (50%) dependent drug users not in treatment and 10,000 (85%) dependent drinkers not in treatment.
- 62% of people in drug treatment were aged under 40, whereas half that proportion, 31% of people in alcohol treatment were aged under 40.
- An increasing proportion of opiate clients are older, more complex with longer opiate use careers.
- Around a third of opiate clients, 40% of non-opiate and 1 in 10 alcohol clients in treatment were in contact with the Criminal Justice system.
- The current rate of successful treatment completion with no representation within 6 months is currently around 40% for alcohol and non-opiates, but only 6.3% for opiate users. Completion rates are similar to PHE local outcome comparator (LOC) groups for opiate clients but better than LOC groups for non-opiate clients.
- Unplanned exits from treatment are higher than LOC groups between 1 and 3 months.
- There was a drop in successful completion of drug and alcohol treatment in 2015, followed by an improvement in 2016 possibly due to the change in provider. Total numbers of completers are lower than in 2013.
- Only 15% of people who have completed alcohol treatment remain abstinent for 6 months, less than half the rate for drug treatment.
- The percentage of opiate treatment clients in Birmingham who have had 10 days or more employment was approximately 20% in Q3 2017/18 and was similar to the national rate.
- In Birmingham 23% of opiate clients who were still using after 6 months treatment had a housing issue in September 2017 which was slightly higher (not significantly) than the national figure of 21% for the same period.

Prevalence and health burden due to drugs and alcohol

Alcohol

In Birmingham the estimated number of dependent drinkers in 2014 was 13,603 (CI: 10,138 – 19,336), 1.66% of the population (CI: 1.24 – 2.36), a non-significant increase of 3% since 2010. Prevalence for England was 1.39%. (PHE: APMS)

Drugs

In Birmingham the estimated number of opiate and/or crack users (OCU) in 2014/15 was 9,705 (95 CI: 8,184 – 11,470); 8,234 opiate users (95% CI: 6,933 – 9,398) and 6,689 crack users (95% CI 4,692 – 8,743). The rate of OCU was 13.48 per 1000 (95% CI 11.97 – 15.93), compared to a rate of 8.57 for England. Differences between 2011/12 and 2014/15 were not statistically different for Birmingham, whereas nationally there was a significant increase in crack cocaine use.

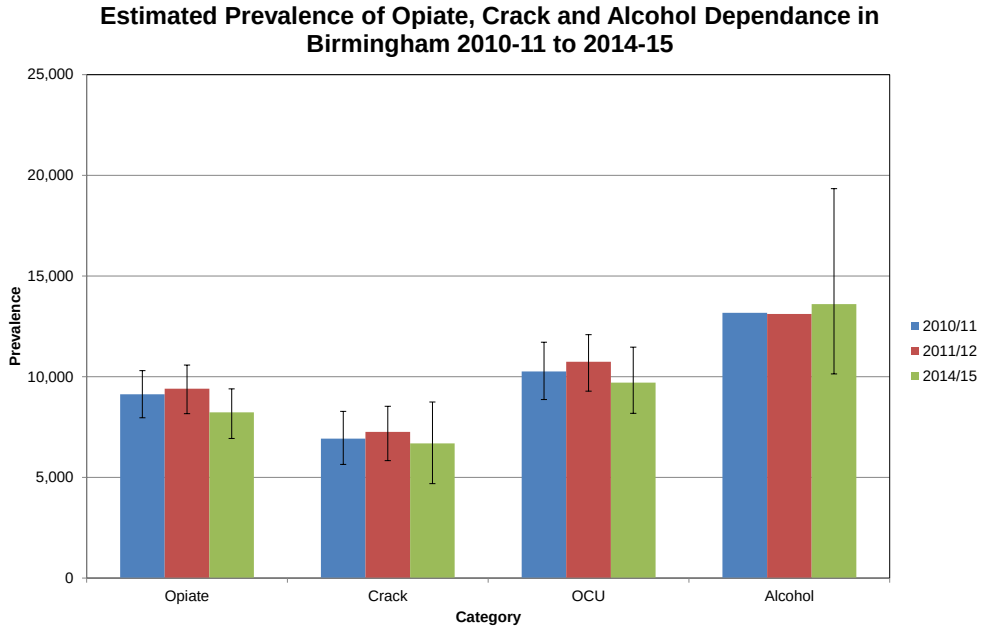

Figure 1
Source: PHE Opiate and crack cocaine use: prevalence estimates for local populations (2017), PHE Alcohol dependence prevalence in England (2017)

Opiate use for 25-34 year olds reduced significantly by 42% between 2011/12 and 2014/15, however this was not the case for other age groups. Highest usage is now highest amongst 35-64 year olds with 60% of users in this age group. 9% of users are estimated to be aged 15-24.

Opiate use is significantly lower for women: 4.92 per 1000 (95% CI: 3.32 – 6.81), compared to 18.04 per 1000 (95% CI: 14.78 – 21.3) for men. Male opiate use in Birmingham is significantly higher than the national average of 11.18 per 1000. For women, rates in Birmingham are higher than the national average, but not significantly so.

Deaths

Alcohol

In Birmingham there were 373 deaths from causes specific to alcohol in 2014-16 (PHE, Local Alcohol Profile 2.01). Rates in Birmingham have been consistently significantly higher than England over the past 10 years but crude Rates in Birmingham are lower than those for statistical neighbours and core city comparator areas (11.2 per 100,000 population in 2014-16 vs 13.5 and 12.4 respectively (differences are not statistically significant). Mortality rates by age show higher rates at a younger age in Birmingham when compared to national figures (see Figure 4 below).

In 2016 there were 6,920 potential years of life lost due to alcohol in Birmingham (PHE, LAPE 1.02). Mortality rates are significantly around 3 times higher for men than for women (DSR 22.9 vs 7.8). Mortality rates are significantly higher than the Birmingham average in Erdington district.

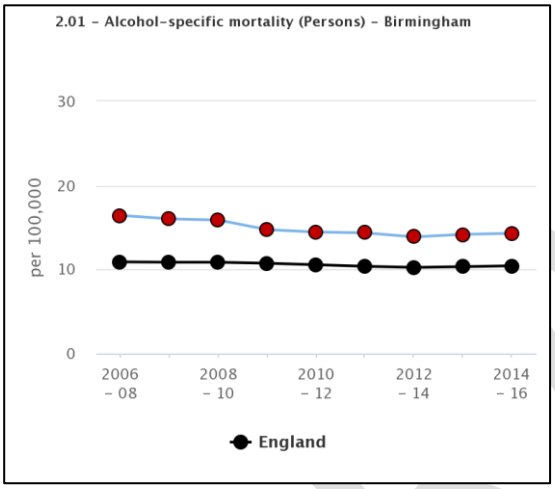

Figure 2
Source: PHE Fingertips

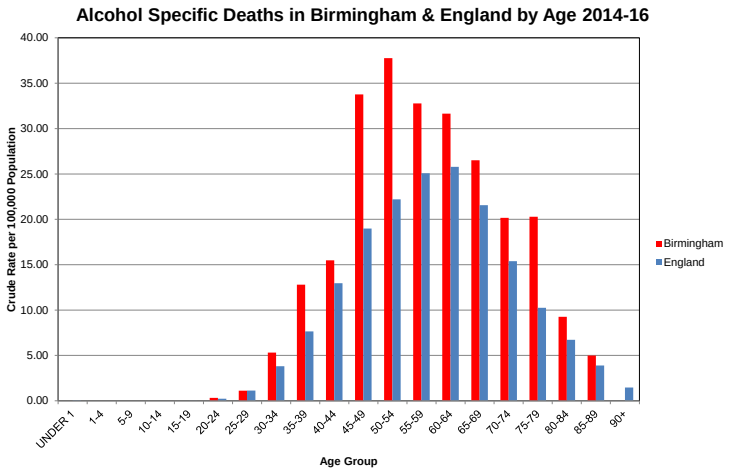

Figure 3
Source: England data: "ONS Alcohol-related deaths by sex, age group and individual cause of death, UK constituent countries, deaths registered 2001 to 2016", Birmingham data: ONS Annual Deaths Data and ONS Population Estimates

Drugs

There were 173 deaths in Birmingham from drugs misuse in 2014-16 (PHOF 2.15iv). The total premature life years lost between 2012 and 2016 was 10,386 – an average of 2,000 per year (PCMD). Crude mortality rates in Birmingham are higher than those for statistical neighbours (5.2 per 100,000 population in 2014-16 vs 3.7 not statistically significant) but lower than core city comparator areas (6.5 per 100,000 not statistically significant). The age profile of drugs deaths in Birmingham is similar to England and Wales (see chart below). Mortality rates are significantly higher for males than females and peak in the 40-49 age group.

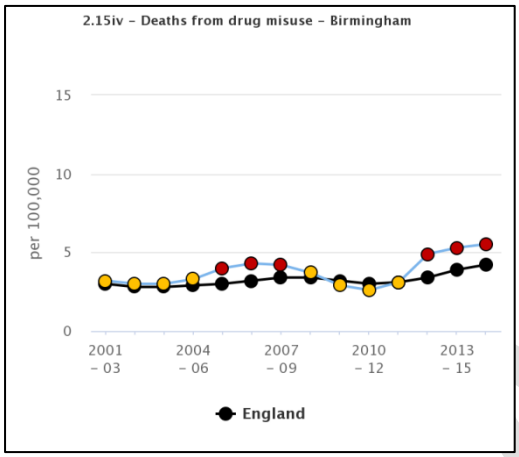

Figure 4
Source: PHE Fingertips

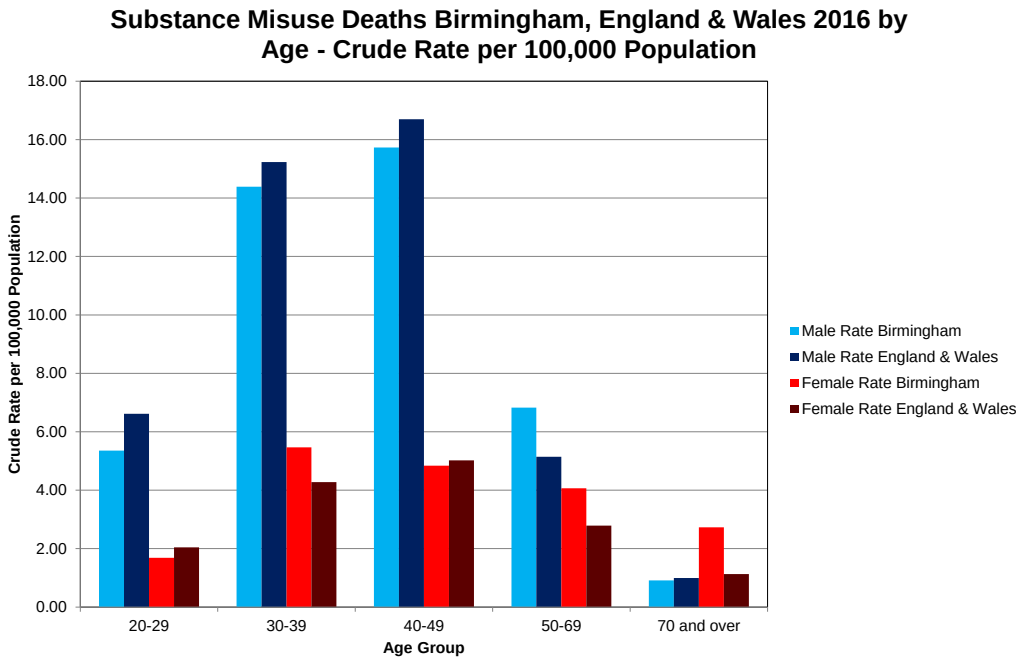

Figure 5
Source: ONS Annual Deaths Data, ONS Population Estimates, ONS Deaths related to drug poisoning in England and Wales, 1993 - 2016

Hospital admissions

Alcohol

There were 6,102 hospital admissions from alcohol-specific conditions in 2016/17 (PHE, LAPE 6.02). The hospital admission rate for males was nearly 3 times the female rate (DSR 985 per 100,000 for males vs 337 for females) (PHE, LAPE 6.02). The admission rate for females was similar to the England rate, whereas for males it was significantly higher than nationally (England rate is 784). Directly standardised rates by ward in Birmingham in 2015-16 were highest in Acocks Green followed by Bartley Green and then Nechells.

Drugs

There are on average around 500 drugs-related admissions per year in Birmingham (HES, NHS Digital). Men account for around 60% of admissions, with a peak in ages 30-34. The rate for males is significantly higher than the national average, but similar to (CIPFA) statistical nearest neighbours. For women it is similar to the England average, but lower than the rate for CIPFA neighbours. Admission rates are higher for white and mixed ethnicities than black and Asian groups. Admission rates are high in Stockland Green and Bournville wards.

A&E attendances

There were nearly 4,000 alcohol and drug use related attendances at A&E for Birmingham residents aged 20-64 in 2016/17 (HES, NHS Digital). Alcohol accounted for more than half the A&E attendances for drug and alcohol misuse (see chart below). The number of alcohol related attendances was higher for men than women. The peak age group for females was 15-19, whereas for men it was around 30-54. There are known quality issues with the coding of A&E attendances and therefore this data only represents those attendances where the primary diagnosis includes a valid drug or alcohol related diagnosis code. Increased attendances could be affected by increased completeness of the diagnosis coding.

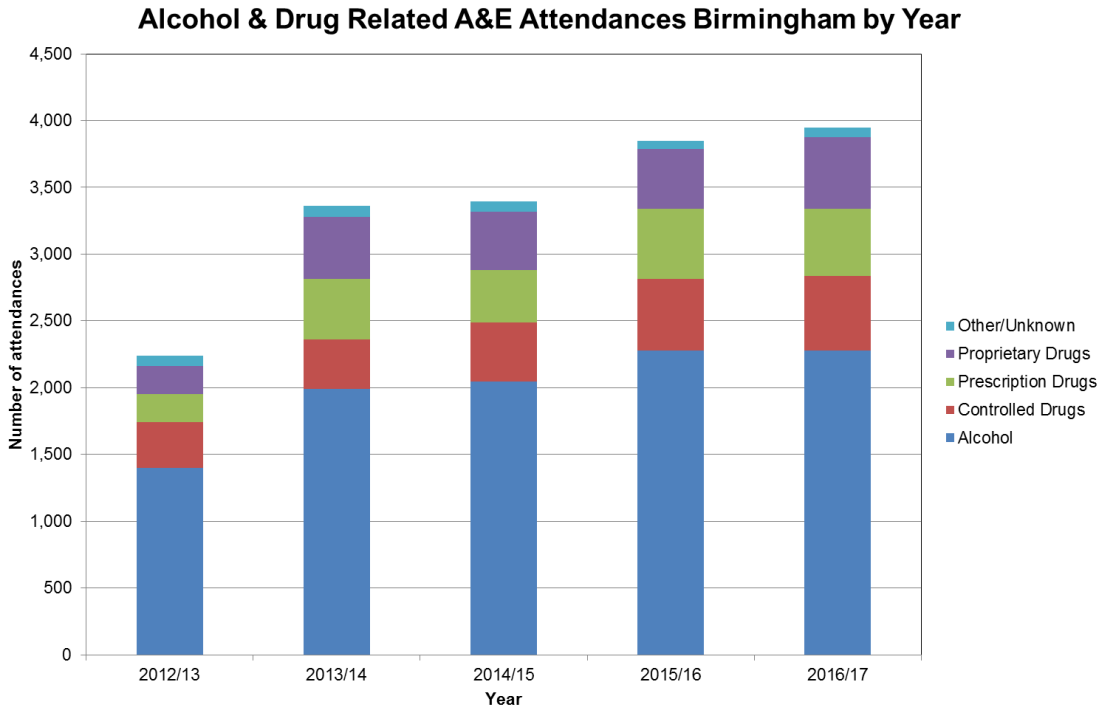

Figure 6

Source: NHS Digital Hospital Episode Statistics

Numbers in treatment

There were 6,292 adults in drug treatment in Birmingham in 2016/17, 1,895 dependent drinkers in alcohol treatment and 584 in treatment for drug and alcohol dependence. The numbers in treatment for opiates have fallen from approximately 6,000 in 2009-10 to approximately 5,000 in 2016-17. Numbers in treatment for Non-opiates and alcohol have remained fairly consistent for the same time period (approximately 2,000 for alcohol, 700-900 for non-opiate and 500-700 for non-opiate and alcohol).

The numbers of new presentations have fallen from approximately 1,800 for opiates in 2009-10 to approximately 1,600 in 2016-17. New presentations for alcohol peaked in 2013-14 at approximately 1,800 before falling to approximately 1,100 in 2016-17. Numbers for non-opiate and non-opiate/alcohol also peaked in 2013-14 before falling to approximately 500 and approximately 350 respectively in 2016-17. In 2016/17 61% of clients were being treated for opiate usage (37% with crack cocaine), 40% for alcohol, 22% for cannabis and 12% for cocaine.

62% of people in drug treatment were aged under 40, whereas half that proportion, 31% of people in alcohol treatment were aged under 40. Only 23% of people in drug treatment were female, compared with 34% of people in alcohol treatment. New presentations to treatment in under 25s have fallen for opiates, cannabis and cocaine between 2009-10 and 2016-17 whilst new presentations for opiates in over 40s have increased.

The proportion of clients who have been using opiates for 21 years or more has gone up from 24% in 2015-16 to 32% in Sep-17, while the proportion who have been using for less than 18 years has fallen year on year. The trend is similar nationally, but a higher proportion (42%) have been using opiates for 21 years or more. Clients that have been using opiates for less than 3 years are 2.5 times more likely to complete treatment than those using for 21 years plus (PHE RDT). The completion rate also falls for opiate and alcohol clients who have had more treatment journeys. The numbers of injecting opiate users in treatment has consistently increased from 2012-13 to 2016-17. In Birmingham 40% of opiate clients were classified as complex in September 2017 which is higher than the national average of 32%.

In Birmingham 37% of alcohol clients were treatment naïve (1st treatment journey) compared to 20% of all clients in treatment. Nationally 41% of alcohol clients were treatment naïve.

The number of new presentations for new psychoactive substances has increased since they were first recorded in 2013-14 but numbers are still low compared to the total numbers of new presentations. According to the latest figures 8% of new treatment clients reported “club drug” use. Of new psychoactive substances (NPS), predominantly cannabinoid types were most commonly cited.

In 2016/17, 704 children in Birmingham were living with clients in treatment. However, Birmingham clients in treatment less likely to be living with children than national average (13% vs 20% of new presentations), although similar proportions have children.

Around a third of opiate clients, 40% of non-opiate and 1 in 10 alcohol clients in treatment were in contact with the Criminal Justice system. Rates of clients in contact with criminal justice were significantly much higher than national averages, particularly for non-opiates, which have increased by two thirds over the last 2 years (see charts below).

The number of referrals from other services into treatment for alcohol has fallen by more than 50% between 2013-14 and 2016-17.

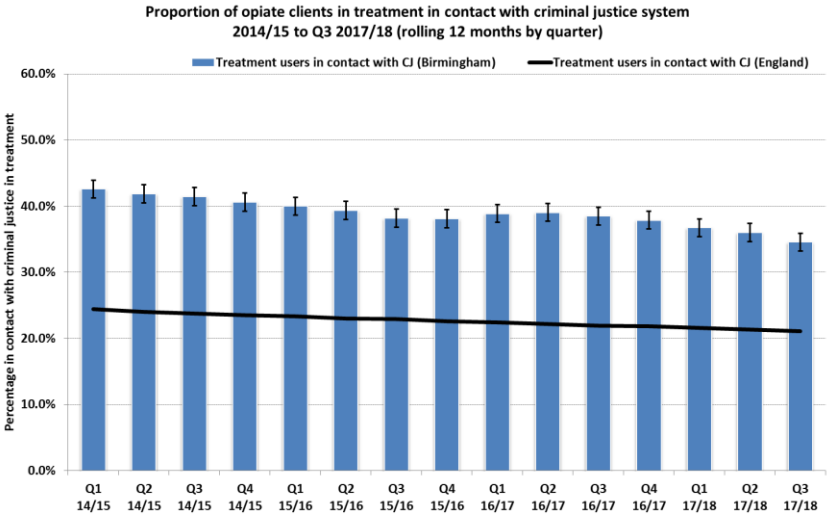

Figure 7
Source: NDTMS

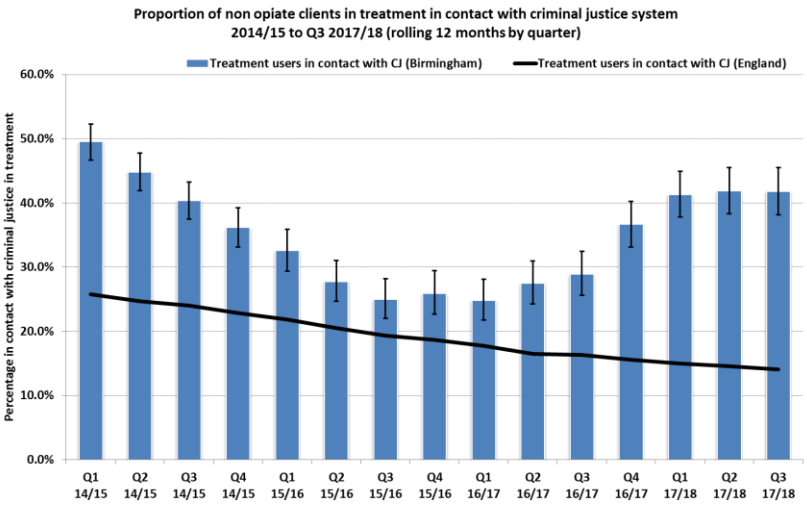

Figure 8
Source: NDTMS

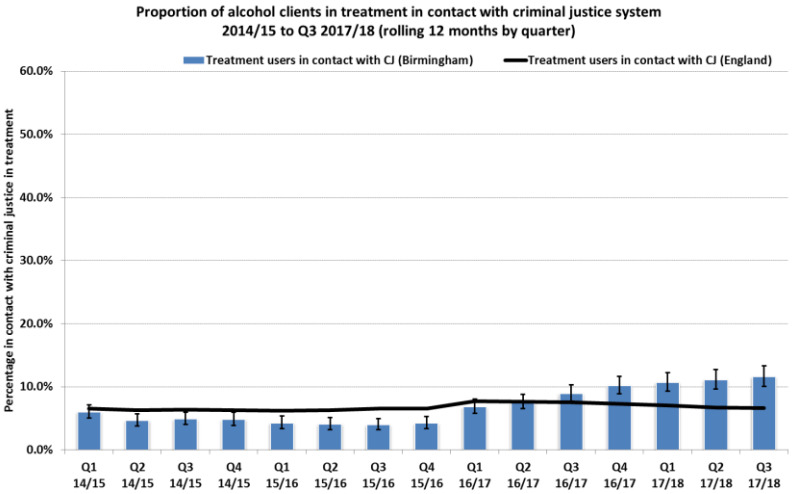

Figure 9
Source: NDTMS

Service penetration/unmet need

The estimated proportion of people dependent on drugs in Birmingham that are in treatment as remained consistently around or just below 50% since 2014/15. Rates are similar to the national average. The estimated numbers not in treatment in Birmingham are approximately 6000 to 7000.

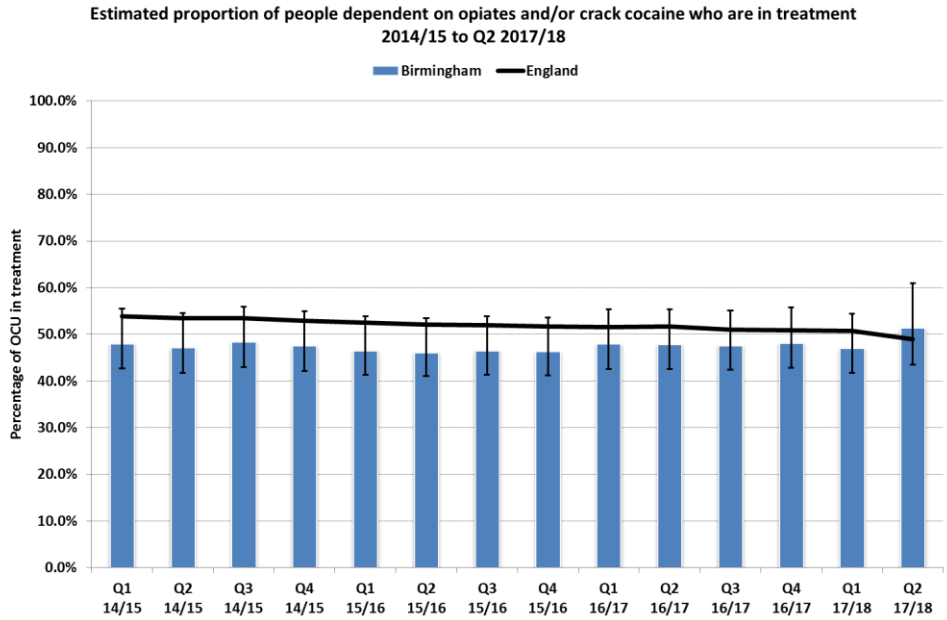

Figure 10
Source: NDTMS

Unmet need for alcohol treatment is estimated to be much higher, at 85% not in treatment, which is close to the national average. In Birmingham the estimated numbers of dependent drinkers not in treatment is approximately 10,000.

Successful treatment completion

There was a drop in successful completion of drug and alcohol treatment in 2015, followed by an improvement in 2016 (PHOF 2.15i-iii). Similar patterns have been seen in other areas which have also had a change in treatment provider. However, latest quarterly data show that successful treatment completion has returned to levels similar to the England average. Whilst the proportion of clients successfully completing as risen the total number of completers per year is lower than 2013 for opiate, non-opiate and alcohol clients. The current rate of successful treatment completion with no representation within 6 months is currently around 40% for alcohol and non opiates, but only 6.3% for opiate users. Completion rates for opiate clients are similar to PHE Local Outcome Comparators (LOCs) and higher than LOCs for non-opiate clients. Clients in contact with criminal justice have slightly higher successful completion rates for alcohol and non opiates, but slightly lower success rates for opiates.

As of September 2017 27% of opiate clients had been in treatment for more than 6 years. National data show that increased time in treatment is associated with falling completion rates. The proportion of treatment population in treatment for less than 1 year is higher than LOC groups but completion rate is lower. The proportion of treatment population in treatment for 6 years and over is lower than LOC groups but completion rates are higher. Unplanned exits from treatment by opiate clients are higher than LOC groups between 1 and 2 months.

The proportion of non-opiate clients in treatment for less than 1 year is higher than LOC groups. Unplanned exits from treatment by non-opiate clients are higher than LOC groups between 1 and months.

Only 15% of alcohol clients have been in treatment for more than 12 months as of September 17. This is similar to the national figures. Completion rates for alcohol clients were between 45% and 48% for those in treatment over 3 months and slightly lower for those in treatment for shorter periods. Unplanned exits from treatment by alcohol clients between 1 and 3 months are higher than national average.

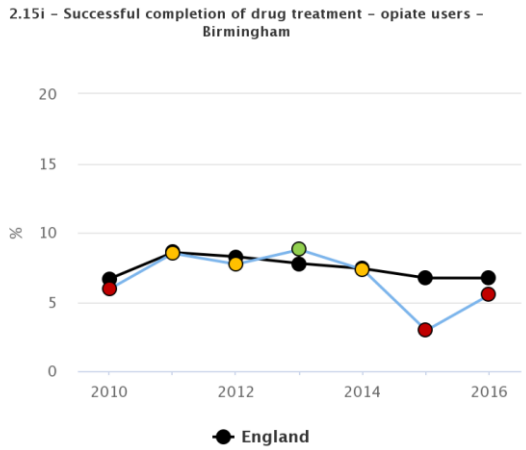

Figure 11

Source: PHE Fingertips

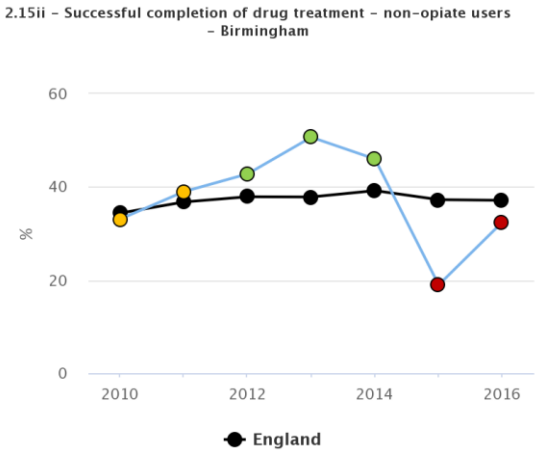

Figure 12

Source: PHE Fingertips

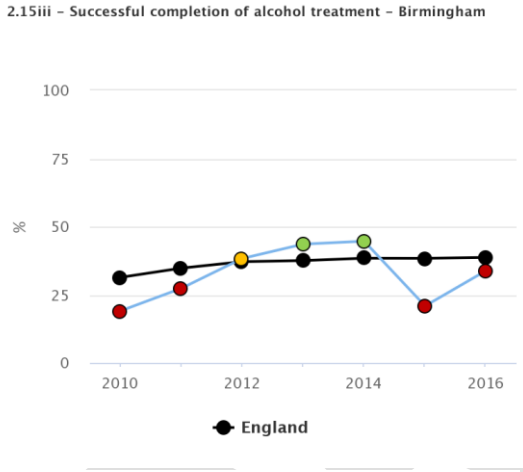

Figure 13

Source: PHE Fingertips

Approximately half of deaths in treatment were opiate clients (NDTMS). There are no clear trends in deaths in treatment but the number of opiate clients that died in treatment was higher in 2016-17 than at any other point from 2009-10 on.

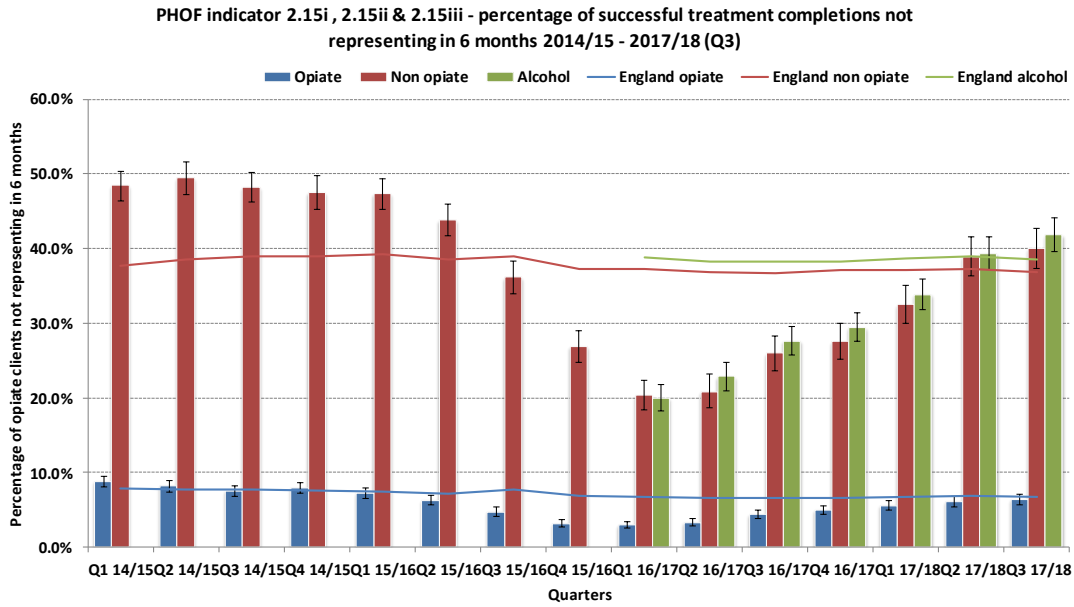

Figure 14
Source: PHE Fingertips

Representation rates for opiate clients were 20% in September 2017 which were higher than local outcome comparators (local authorities with similar complexity clients as defined in PHE recovery diagnostic toolkit) where the rate was 17%. Representation rates for alcohol clients were lower at 6% and lower than national rates of 8%. Early drop outs are higher in Birmingham than national average (22% vs 17%) and are highest for non-opiate (27%).

A high proportion were referred through the criminal justice system in Birmingham (38% vs 20% for England). Of these, the proportion successfully engaging with treatment has doubled over the past 2 years to reach the national average of 30%.

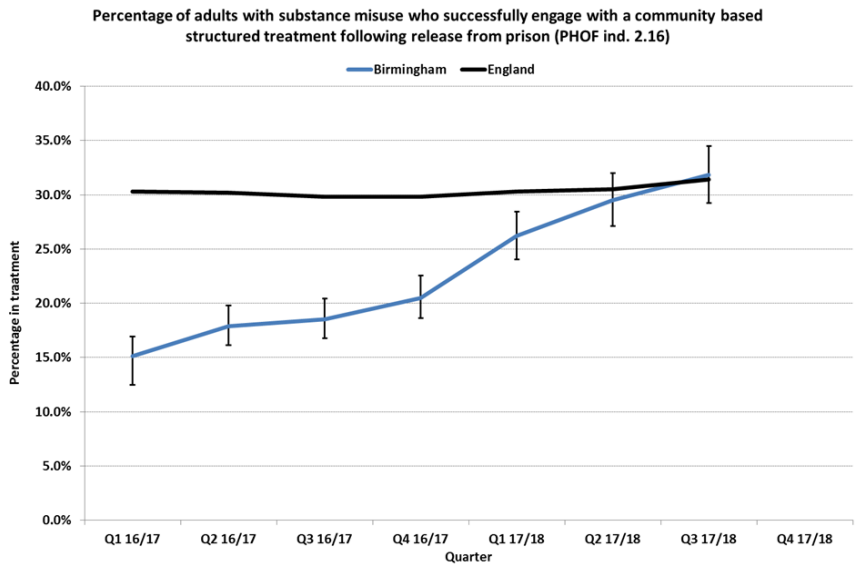

Figure 15
Source: NDTMS

Outcomes

Only 15% of people who have completed alcohol treatment remain abstinent for 6 months, less than half the rate for drug treatment.

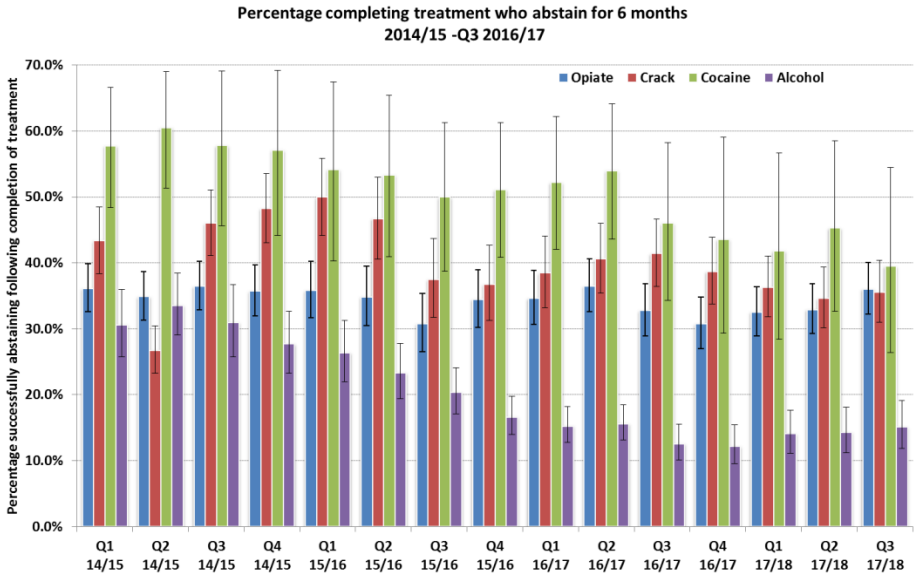

Figure 16
Source: NDTMS

Twelve month outcomes for opiate clients showed that 39.4% had stopped using and 25.3% had reduced use as at September 2017. The mean days of use for opiate clients was 17.9 at the start of treatment and 8.9 days at 12 months.

The percentage of opiate treatment clients in Birmingham who have had 10 days or more employment was approximately 20% in Q3 2017/18 and was similar to the national rate. Employment rates were higher in Q3 2015/16 at approximately 30%. Employment rates for non-opiate addicts were higher at just below 40% in Q3 2017/18.

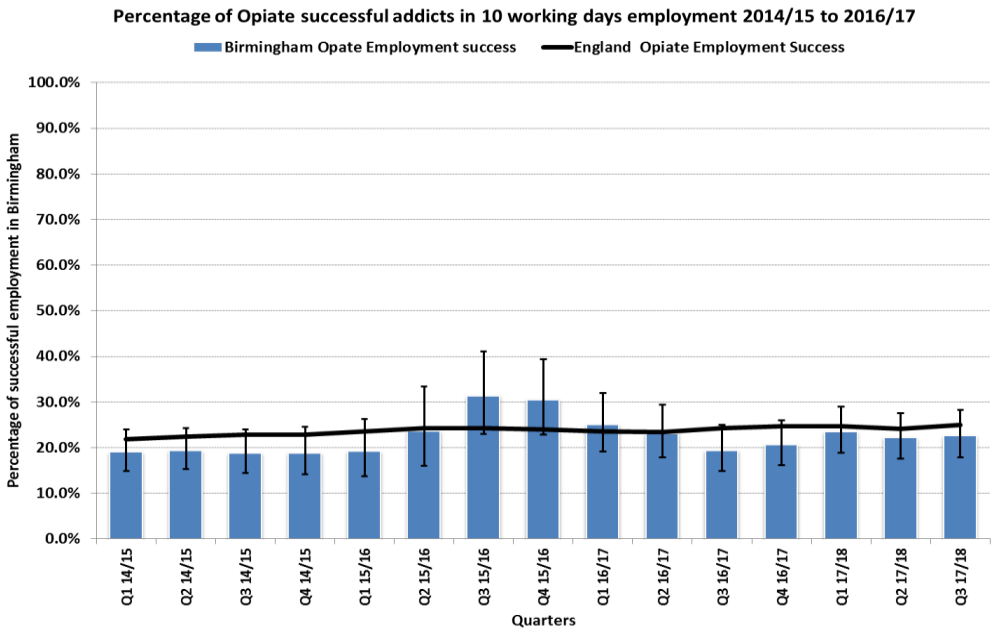

Figure 17
Source: NDTMS

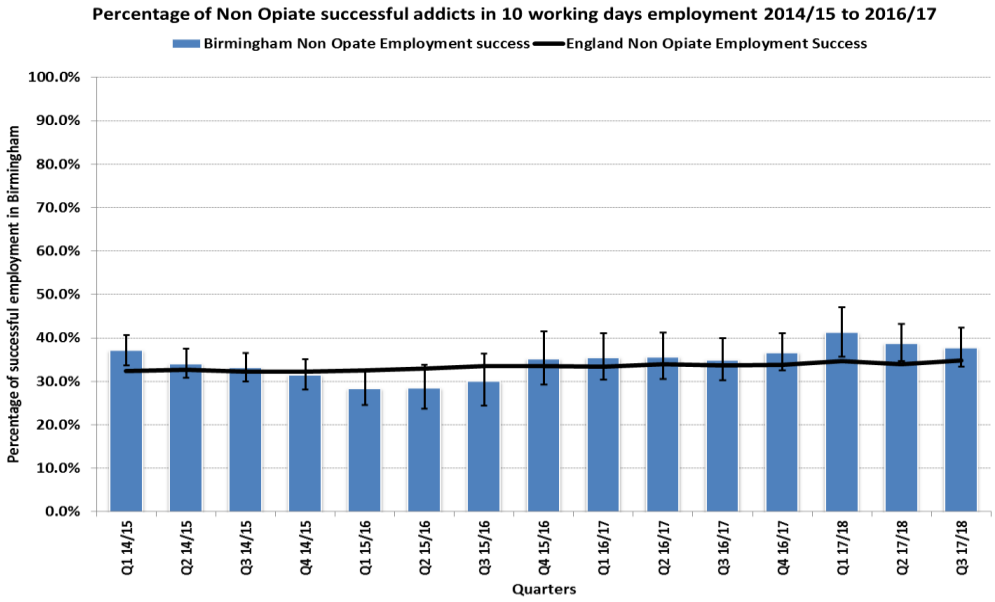

Figure 18
Source: NDTMS

In Birmingham 23% of opiate clients who were still using after 6 months treatment had a housing issue in September 2017 which was slightly higher (not significantly) than the national figure of 21% for the same period. National figures indicate that being housed improves completion rates.

Social return on investment

Modelling from the SROI tool shows the effect of treatment services on crime figures. It is estimated that 2016/17 investment in drug and alcohol treatment resulted in over 150,000 fewer crimes and over £50 million in economic and social benefits.

Useful links

Public Health Outcomes Framework
http://www.phoutcomes.info

Sources

Public Health Outcomes Framework: Public Health England
PHE Estimates of alcohol dependent adults and children living with alcohol dependent adults March 2017
PHE Estimates of opiate and crack cocaine use prevalence: 2014 to 2015 September 2017
PHE Recovery Diagnostic Toolkit (RDT) September 2017
PHE Local Area Trend Report 2016-17
PHE National Drug Treatment Monitoring System (NDTMS)

Produced by Birmingham Public Health Intelligence

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