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

BIRMINGHAM CITY COUNCIL

HEALTH AND WELLBEING BOARD

WEDNESDAY, 30 SEPTEMBER 2015 AT 15:00 HOURS
IN COMMITTEE ROOM 6, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1 **NOTICE OF RECORDING**

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

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

2 **APOLOGIES**

3 **DECLARATIONS OF INTERESTS**

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

4 **CHAIR'S UPDATE**

To receive a verbal update.

5 **HOMELESS HEALTH SCRUTINY COMMITTEE INQUIRY**

3 - 10

To consider the findings of the Inquiry and actions to support and progress three of its recommendations.

11 - 16

6 **ROLE OF OPERATIONS GROUP**

To consider a report on the role and proposed new functions for the Operations Group.

17 - 38

7 **BIRMINGHAM HEALTH PROTECTION FORUM ANNUAL REPORT 2014/15**

To consider the Assurance Statement, Annual Report and major issues identified for 2014/15 and 2015/16.

39 - 60

8 **CARE ACT 2014: INTEGRATION, CO-OPERATION AND PARTNERSHIPS**

To consider an update relating to the Care Act 2014 and specifically the duties to integrate, co-operate and work in partnership.

61 - 66

9 **IMPROVING OUTCOMES FOR PEOPLE WITH MENTAL HEALTH PROBLEMS - CONSULTATION ON STRATEGY DIRECTION**

To consider the draft strategy and its direction.

67 - 74

10 **WORKING LOCALLY - WORKSHOP OUTCOMES**

To consider feedback from the workshop.

75 - 80

11 **WORK PROGRAMME**

To consider the Work Programme.

81 - 88

12 **MINUTES AND MATTERS ARISING**

To confirm the Minutes of the last meeting.

13 **OTHER URGENT BUSINESS**

NB: Only items of business by reason of special circumstances (which are to be specified) that in the opinion of the Chairperson are matters of urgency may be considered.

Birmingham Health and Wellbeing Board

	Agenda Item: 5
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30th September 2015**
TITLE:	**HOMELESS HEALTH SCRUTINY COMMITTEE INQUIRY**
Organisation	**Birmingham City Council**
Presenting Officer	**John Hardy - Development Officer**

Report Type:	**Discussion/Decision**

1. Purpose:

To summarise the findings of the inquiry and seek the Board's agreement to progress three of the recommendations.

2. Implications:

BHWB Strategy Priorities	Child Health	Y
	Vulnerable People	Y
	Systems Resilience	Y
Joint Strategic Needs Assessment		Y
Joint Commissioning and Service Integration		Y
Maximising transfer of Public Health functions		Y
Financial		Y
Patient and Public Involvement		Y
Early Intervention		Y
Prevention		Y

3. Recommendation

The Health & Wellbeing Board is asked to agree the actions to support and progress the following :

3.1 The three Birmingham Clinical Commissioning Groups exploring how to make it easier for homeless people to register with a GP and how they can be facilitated to maintain registration.

3.2 Services being commissioned in a joined up way where possible specifically for people with a dual diagnosis of mental health and substance misuse or alcohol problems and dementia.

3.3 The Joint Commissioning Team examining the feasibility of commissioning an emergency and/or out of hours specialist homeless primary care facility.

4. Background

4.1 Homelessness is about more than rooflessness. A home is not just a physical space it also has a legal and social dimension providing roots, identity, a sense of belonging and a place of emotional wellbeing. Homelessness is about the loss of all of these and is an isolating and destructive experience.

4.2 Homelessness and health are inextricably intertwined. Being homeless is physically and mentally difficult and has significant negative consequences on health with the result that people who are homeless experience some of the worst health problems in our society. They are vulnerable to illness, poor mental health and drug and alcohol problems and are more likely than the general population to have multiple and complex physical and mental health needs.

4.3 In spite of suffering worse health than the general population, homeless people often struggle to access healthcare services. Some of the barriers include difficulty in accessing primary care such as the inability to register with a GP. This is often due to a lack of proof of identity or inability to prove permanent residence in the catchment area or to provide other documentation required to register with a GP.

4.4 In addition health services are designed to treat one condition at a time but homeless people often experience multiple and complex health problems. This means that support needs to be accessed through different parts of the health system which can be difficult to navigate for people who are often leading chaotic lifestyles and dealing with issues relating to mental health and substance misuse. People with complex problems can often find it hard to comply with treatment and fail to attend appointments which can lead to them being excluded from services.

4.5 The inquiry into homelessness set out to explore how health outcomes for homeless households differ from the wider population and what can be done to close the gap. The aim was to develop a clear understanding of health issues experienced by vulnerable and excluded homeless households in terms of outcomes and service provision with a view to informing the future commissioning of health services for this group of people

4.6 The inquiry considered the following:

- Homelessness in Birmingham;
- Statutory homelessness;
- Young people and homelessness;
- Homelessness and rough sleeping;
- Joint working;
- Healthcare needs amongst homeless; and
- Medical care for the homeless: Primary care.

4.7 The inquiry concluded:

- There is an intrinsic link between health and homelessness;
- Homeless people face poorer health than the general population with many suffering long term physical and mental health problems. This can be difficult to manage for people who are living in hostels or on the street and they struggle to access the healthcare that most people take for granted.
- The failure to improve health at an early stage places a significant financial burden on the health system in terms of avoidable emergency admissions to hospital and reliance on long term care.
- Some services are very effective in addressing the health needs of homeless people and there are some excellent examples of innovative and flexible approaches to addressing the health needs of the homeless, with inclusive commissioning and effective joint working. However, it is clear that local authorities and homelessness services need to listen to what homeless people have to say in order to work together to provide more flexible and person centred services designed to meet the health needs of homeless people.

4.8 The inquiry generated nine recommendations and a full list can be seen in **Appendix A**. There are three recommendations that the Board are asked to consider, support and progress and are shown at the front of the report and highlighted in the list at **Appendix A**.

5.	**Compliance Issues**
5.1	***Strategy Implications***
	The proposals contained in this report are clearly linked and strongly support the objectives of the Health and Wellbeing Board. Vulnerable people and keeping people healthy are specific themes of strategy on a page with homelessness, mental health and common NHS and local authority approaches having specific outcomes.
5.2	***Governance & Delivery***
	The inquiry allocates responsibility for each recommendation as shown in **Appendix A,** which includes Cabinet Member for Health and Social Care and the three Birmingham Clinical Commissioning Groups.
5.3	***Management Responsibility***
	The Chair and Vice Chair of the Health and Wellbeing Board will be accountable for appropriate support and progress and Alan Lotinga will be responsible for day to day delivery.

6.	Risk Analysis
	The risk of the recommendations not progressing is medium as delivery relies on a range of agencies and organisations.

Appendices
Appendix A – Homeless Health Inquiry Recommendations

Signatures	
Chair of Health & Wellbeing Board (Councillor Paulette Hamilton)	P. A Hamilton
Date:	18/09/2015

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

John Hardy
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APPENDIX A

Summary of Homeless Health Inquiry Recommendations

	Recommendation	Responsibility	Completion date
RO1	That potential locations in the city centre be explored to find the most suitable venue which can be made available to be used as a central point where homeless people can go to access information, advice, and support on accommodation, benefits (including accessing a computer to start the process of registering to make a claim) and be referred to available health services without needing to make an appointment or travel to one of the customer service centres.	Cabinet Member for Neighbourhood Management and Homes Cabinet Member for Health and Social Care as Chair of the Health and Wellbeing Board	30th September 2015 for final version of Welfare Specification and new service to start 1st April 2016.
RO2	That the three Birmingham Clinical Commissioning Groups should explore: • How they can make it easier for homeless people to register with a GP even if they are only temporarily residing in an area and have a permanent address elsewhere or have no permanent address. • How homeless people can be facilitated to maintain registration on a GP list once they have registered even if, due to the transient nature of their lifestyle, they subsequently move out of that area.	Birmingham Cross City, Birmingham South Central and Sandwell and West Birmingham Clinical Commissioning Groups	31st March 2016 Health and Wellbeing Board Agenda 30th September 2015
RO3	That the multi-agency working that is already starting to happen to tackle the housing and health problems of people sleeping rough in the city centre by connecting rough sleepers to local support and services is strengthened. Groups already in existence need to be reviewed to establish whether they are working together effectively with a view to building on the existing protocol and the work already being done by the StreetLink multi- agency working group, to ensure that relevant agencies are alerted before major regeneration work starts, to provide an opportunity to support homeless people squatting or sleeping rough in the area.	Cabinet Member for Neighbourhood Management and Homes Cabinet Member for Health and Social Care	31st October 2015

RO4	That services should be commissioned in a joined up way wherever possible, specifically when commissioning services for people with a dual diagnosis of either; mental health and substance misuse or people with alcohol problems who also suffer from dementia, where there is currently a gap in service provision..	Cabinet Member for Health and Social Care	31st January 2016
RO5	That wherever possible services for homeless people should be designed to reach out to homeless groups who need them by moving away from a silo culture and exploring options for placing statutory services where homeless people already attend, such as the Homeless Health Exchange or SIFA Fireside, along the lines of the Inclusion Healthcare Social Enterprise Model.	Cabinet Member for Health and Social Care Cabinet Member for Neighbourhood Management and Homes	31st October 2015
RO6	That a forum or other appropriate mechanism be established between HM Prison Birmingham and Birmingham City Council to facilitate more joined up working with prisons and the probation services to provide improved pathways between prison and the general community with a view to: • Linking prison healthcare provision better to wider community healthcare services on release from prison in particular for prisoners with serious mental health, drug and/or alcohol problems; • Supporting prisoners into appropriate accommodation before and after discharge from prison; • Prioritising appropriate accommodation for homeless women in contact with the criminal justice system; • Supporting prisoners to link into the benefit system before and after release from prison; and • Providing/sharing information about services available in the community to facilitate improved pathways between prison and the general community.	Cabinet Member for Health and Social Care Cabinet Member for Neighbourhood Management and Homes	31st March 2016
RO7	That the Joint Commissioning Team should examine the feasibility of commissioning an emergency and/or out of hour specialist homeless primary care service for the city.	Cabinet Member for Health and Social Care Birmingham and Solihull Mental Health NHS Foundation Trust	31st December 2015

RO7 cont'		Cabinet Member for Neighbourhood Management and Homes	
RO8	That the best way to provide a direct line of communication between the City Council and people sleeping rough in the city centre who have a problem or a complaint, for example through advice surgeries in the city centre, be explored.	Cabinet Member for Neighbourhood Management and Homes	Already commenced – progress update 31st October 2015
RO9	That an assessment of progress against the recommendations made in this report be presented to the Health and Social Care O&S Committee.	Cabinet Member for Neighbourhood Management and Homes	31st October 2015

Birmingham Health and Wellbeing Board

	Agenda Item: 6
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30th September 2015**
TITLE:	**ROLE OF OPERATIONS GROUP**
Organisation	**Operations Group**
Presenting Officer	**Alan Lotinga Service - Director Health and Wellbeing**

Report Type:	**Decision / Endorsement**

1. Purpose:

To agree recommendations set out in section 4 of this report on the role and proposed new functions of the Operations Group.

2. Implications:

BHWB Strategy Priorities	Child Health	Y
	Vulnerable People	Y
	Systems Resilience	Y
Joint Strategic Needs Assessment		Y
Joint Commissioning and Service Integration		Y
Maximising transfer of Public Health functions		Y
Financial		Y
Patient and Public Involvement		Y
Early Intervention		Y
Prevention		Y

3. Recommendation

The Health & Wellbeing Board is recommended to agree:

3.1 The Operations Group taking on a more active role as detailed in section 4.
3.2 The Operations Group developing and agreeing the H&WBB agenda with the Chairand Vice Chair.
3.3 That any items or reports for information are included in the Operations Group standing agenda item report and full versions are circulated electronically in advance of the meeting.
3.4 That items and reports presented to the Board are directly linked and support the strategic priorities and outcomes of the 'strategy on a page'.

4.	Background
4.1	The Operations Group wishes to take on a more proactive and supportive role in their relationship to the Health and Wellbeing Board. One of the main aims is to ensure that Board meetings, Board development workshops and themed discussions outside of the Board agenda make effective use of time and that any reports/items presented to the Board are linked and help to deliver the strategic priorities and outcomes of the 'strategy on a page'. A position statement re the 'stategy on a page' can be seen at **Appendix A**.
4.2	The proposed new role of the Operations Group would include: • Developing and agreeing agenda for Board meetings and content of Board development workshops with Chair. • Taking forward any actions agreed at Board meetings and reporting back to Board as appropriate. • Reporting back to Board on development workshops inviting discussions regarding next steps. • Reporting back to Board on any outcomes of themed discussions outside of Board agenda. • Producing a standard agenda item report which would include highlights of annual reports, progress against outcomes and review of measures and targets. • Ensuring each report or item presented to the Board is clearly linked to the strategic priorities and outcomes of 'strategy on a page' and the contribution they make. • Responsibility for appropriate people being present at Board meetings or themed discussions outside of the Board agenda to enable a fully informed discussion where required.
4.3	To make effective use of time at Board meetings it is proposed that: • Any reports or items for information only are circulated electronically in advance of meetings, are listed on the agenda so members have the opportunity to make any comments and key points are summarised in the Operation Group report. • A comprehensive work programme is developed with clear links between the Board and Operations Group that is focused on the themes, priorities and outcomes of the 'strategy on a page'.

5.	Compliance Issues
5.1	***Strategy Implications***
	The proposals contained in this report are clearly linked and strongly support the objectives of the Health and Wellbeing Board. All reports and items to be presented to the Board will illustrate how they support and contribute to the themes, priorities and outcomes of 'strategy on a page'.

5.2	*Governance & Delivery*
	The proposals will be managed by the Operations Group who report to the Health and Wellbeing Board at each Board meeting. Progress will be monitored at the Operation Group meetings and included in the standing agenda item report.
5.3	***Management Responsibility***
	The Chair and Vice Chair of the Health and Wellbeing Board will be accountable for delivery. Alan Lotinga, Director of Health & Wellbeing will be responsible for day to day delivery.

6.	*Risk Analysis*		
	The risk of the recommendations not progressing is low as all members of the Operations Group are committed to taking a more active role.		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Board and Operations Group not fully engaged in implementing recommendations.	Small	Significant	

Appendices
Appendix A – Position Statement re 'Strategy on a Page'

Signatures	
Chair of Health & Wellbeing Board (Councillor Paulette Hamilton)	P. A Hamilton
Date:	18/9/2015

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

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Appendix A

The strategy on a page is currently being reviewed by the Operations Group to ensure:

- Themes and outcomes are still relevant and a priority for all partners.
- Actions are relevant and deliverable.
- Measures and targets illustrate progress against each outcome and are robust.

A Task and Finish Group has been set up to take this forward and it was agreed that outcomes would be reviewed in stages. As reports to the Board begin to link to the strategy on a page it will become clearer where priorities lie and potentially provide relevant and robust actions, measures and targets.

Progress will be reported at each Board meeting through the proposed Operations Group standard agenda item report.

Birmingham Health and Wellbeing Board

	Agenda Item: 7
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30th September 2015**
TITLE:	**BIRMINGHAM HEALTH PROTECTION FORUM ANNUAL REPORT 2014/15**
Organisation	**Birmingham Public Health**
Presenting Officer	**Dr Adrian Phillips/Mr Chris Baggott**

Report Type:	**Endorsement**

1. Purpose:
To seek endorsement from the Board of the Health Protection Assurance Statement made by the Director of Public Health, and the annual Health Protection Report

2. Implications:		
BHWB Strategy Priorities	Child Health	Y
	Vulnerable People	Y
	Systems Resilience	Y
Joint Strategic Needs Assessment		
Joint Commissioning and Service Integration		
Maximising transfer of Public Health functions		
Financial		
Patient and Public Involvement		
Early Intervention		
Prevention		Y

3. Recommendations	
	The Health & Wellbeing Boards is recommended to;
3.1	Endorse the annual report of the Health Protection Forum (HPF) attached as **Appendix A**.
3.2	Accept the assurance statement from the Director of Public Health that

plans are in place or are being developed to protect the health of the population of Birmingham

3.3 Endorse the major issues of Health Protection identified for 2014/15, and for 2015/16 in the report and identify any additional concerns or contributions it can make.

4. Background

4.1 The health protection duty of local authorities (Health and Social Care Act 2012, section 6C) focus principally on arrangements for preventing and planning responses to health protection incidents and communicable disease outbreaks that do not require a multi-agency response.

4.2 The Health Protection Forum in Birmingham is chaired by the Director of Public Health and provides the space and time for the exchange of information necessary to ensure that all partners in the delivery of health within Birmingham are acting jointly to provide comprehensive services covering all aspects of Health Protection; and to evidence this to the satisfaction of the Director of Public Health.

4.3 The Health Protection Forum receives regular updates and reports from key partners involved in the five areas of Health Protection:

a. Communicable Diseases

b. Non-Communicable Diseases

c. Screening and Immunisations

d. Emergency Planning, Resilience and Response

e. Infection Prevention and Control

4.4 This annual report provides a review of the most significant issues within the five areas; updates on previously identified priorities, details on new issues, and any potential future challenges.

4.5 The three issues that have been identified as priorities for HPF over the last year have been:

- Addressing the high rates of Tuberculosis in Birmingham, and responding to issues raised by non-compliant patients.
- Reviewing and addressing lessons learned from health protection incidents.
- Ensuring that during and following organisational changes, the health protection roles of all stakeholders are clear and result in effective

health protection planning.

4.6 The Health Protection Forum facilitates the mandatory function of the Director of Public Health to assure himself that plans are in place to protect the health of the Birmingham population. This report notifies the Health and Wellbeing Board of the Director of Public Health's assurance that appropriate plans are in place. Where gaps in planning, or the need for new plans are identified, the Director of Public Health is confident that the Health Protection Forum facilitates their development.

5. Compliance Issues

5.1 Strategy Implications

This report fulfils one of the mandatory functions of Public Health in the Local Authority; the duty to ensure that there are plans in place to protect the health of the population.

Some aspects of the Health Protection work considered by the Health Protection Forum in Birmingham contribute to outcomes under the System Resilience section of the Strategy: common NHS and LA approaches; improve primary care management of common and chronic conditions.

5.2 Governance & Delivery

The report and decisions and comments from the Board will determine the work programme of the Health Protection Forum for 2015/16, and the governance of the Forum.

It is proposed that the HPF will continue to report annually to the Board. Day to day progress is managed by the formal meetings of the HPF and by the Director of Public Health between meetings.

5.3 Management Responsibility

The Director of Public Health is accountable for the delivery of an effective Health Protection Forum; and is supported by Chris Baggott (Public Health lead for assurance) and the members of the Forum.

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Board doesn't endorse the assurance statement of the director of Public Health	Low	Low	Clear statement of assurance in the annual report. DPH will still be accountable for being legally assured on Health Protection matters

Appendices
Appendix A - Health Protection Forum Annual Report to the Birmingham Health and Wellbeing Board

Signatures	
Chair of Health & Wellbeing Board (Councillor Paulette Hamilton)	P. A Hamilton
Date:	18/09/2015

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

Adrian Phillips – Director of Public Health
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Chris Baggott - Lead for NHSE, PHE & CCG Liaison and Assurance
Tel. No: 0121 303 4454
Email: Chris.Baggott@birmingham.gov.uk

All members of the Health Protection Forum
(all contactable via Tel No. 0121 303 4454)

Health Protection Forum Annual Report for 2014/15 to the Birmingham Health and Wellbeing Board

Contents

1. Assurance Statement

The Health Protection Forum facilitates the mandatory function of the Director of Public Health to assure himself that plans are in place to protect the health of the Birmingham population. This report notifies the Health and Wellbeing Board of the Director of Public Health's assurance that appropriate plans are in place. Where gaps in planning, or the need for new plans are identified, the Director of Public Health is confident that the Health Protection Forum facilitates their development.

2. Summary

This annual report on the work of the Birmingham Health Protection Forum (HPF) summarises the main areas of work that were identified as priorities for the forum in 2014/15.

The Public Health Outcomes Framework includes health protection indicators and these are shown in Figure 1.

The three issues identified as priorities for the HPF over in 2014/15 were:

- Addressing the high rates of Tuberculosis in Birmingham, and responding to issues raised by non-compliant patients
- Reviewing health protection incidents
- Ensuring that during and following organisational changes, the health protection roles of all stakeholders are clear and result in effective health protection planning

For The HPF will continue to address the above priorities in 2015/16, and has identified three new priorities:

- Identifying lessons learned from health protection incidents and ensuring they are addressed in action plans
- Improving the uptake rates of routine childhood vaccinations
- Addressing air quality as a public health issue and supporting improvement plans

3. Introduction

The health protection duties of local authorities (Health and Social Care Act 2012, section 6C) focus principally on arrangements for preventing and planning response to health protection incidents and communicable disease outbreaks that do not require a multi-agency response.

The Health Protection Forum in Birmingham is chaired by the Director of Public Health and meets bi-monthly. The Forum provides the space and time for the exchange of information necessary to ensure that all partners in the delivery of health within Birmingham are acting jointly to provide comprehensive services covering all aspects of Health Protection; and to evidence this to the satisfaction of the Director of Public Health, the Health and Wellbeing Board and the City Council.

The Health Protection Forum has defined five areas of health protection and it receives regular updates and reports from key partners involved in the areas of health protection listed below. This annual report provides a review of the most significant issues within the five areas; updates on priorities identified in the 2014 report, details on newly-emerged issues, and any potential future challenges.

HPF defined areas of health protection:

a. Communicable Diseases
b. Non-Communicable Diseases
c. Screening and Immunisations
d. Emergency Planning, Resilience and Response
e. Infection Prevention and Control

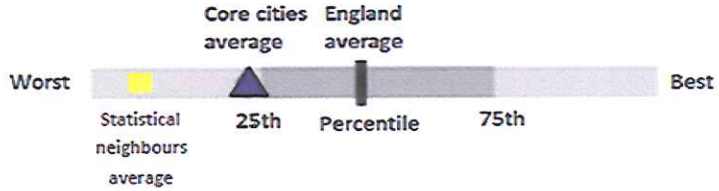
Figure 1. Health Protection Indicator Spine Chart (May 2015)

Birmingham Public Health Outcomes Framework May 2015

Key:

- Significantly Better than England average
- Not significantly different from England average
- Significantly Worse than England average
- No significance can be calculated
- Significantly Lower than England average
- Significantly Higher than England average

No Polarity



Domain	Indicator	B'ham Number	B'ham Stat	Eng Avg	Eng Worst	England Range	Eng Best	Core cities average	Statistical neighbours average
Health Protection	3.01 - Fraction of mortality attributable to particulate air pollution (2012)	n/a	5.7	5.1	7.7		3.0	5.0	5.8
	3.02 - Chlamydia detection rate (15-24 year olds) - CTAD (Males) (2013)	1,322	1505.3	1387.5	599.4		4262.0	1568.4	1472.7
	3.02 - Chlamydia detection rate (15-24 year olds) - CTAD (Females) (2013)	2,480	2785.2	2633.5	1093.7		6358.2	2961.1	2849.3
	3.02 - Chlamydia detection rate (15-24 year olds) - CTAD (Persons) (2013)	3,832	2166.6	2015.6	840.0		5758.5	2272.9	2163.7
	3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old) (2013/14)	16,131	91.5	94.3	78.6		98.4	94.2	93.7
	3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old) (2013/14)	16,213	93.1	96.1	81.6		99.1	95.9	95.9
	3.03iv - Population vaccination coverage - MenC (2012/13)	15,288	88.0	93.9	75.9		98.8	92.4	93.6
	3.03ix - Population vaccination coverage - MMR for one dose (5 years old) (2013/14)	15,123	94.1	94.1	74.8		98.6	94.8	93.5
	3.03v - Population vaccination coverage - PCV (2013/14)	16,077	91.2	94.1	78.2		98.3	93.7	92.8
	3.03vi - Population vaccination coverage - Hib / Men C booster (5 years) (2013/14)	14,661	91.3	91.9	72.7		98.1	92.2	89.7
	3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old) (2013/14)	14,996	86.2	92.5	76.6		98.1	91.4	92.0
	3.03vii - Population vaccination coverage - PCV booster (2013/14)	15,472	88.9	92.4	76.4		98.5	92.0	91.6
	3.03viii - Population vaccination coverage - MMR for one dose (2 years old) (2013/14)	15,365	88.3	92.7	78.3		98.3	91.9	92.2
	3.03x - Population vaccination coverage - MMR for two doses (5 years old) (2013/14)	13,537	84.3	88.3	63.8		97.4	88.0	87.7
	3.03xii - Population vaccination coverage - HPV (2013/14)	5,637	87.9	86.7	51.1		96.6	87.3	85.7
	3.03xiii - Population vaccination coverage - PPV (2013/14)	95,018	65.2	68.9	52.8		77.6	69.6	67.2
	3.03xiv - Population vaccination coverage - Flu (aged 65+) (2013/14)	112,270	71.1	73.2	62.9		80.5	74.7	71.0
	3.03xv - Population vaccination coverage - Flu (at risk individuals) (2013/14)	66,019	50.6	52.3	38.9		68.6	52.8	52.0
	3.04 - People presenting with HIV at a late stage of infection (2011 - 13)	156	48.3	45.0	77.3		25.9	49.2	56.0
	3.05i - Treatment completion for TB (2012)	340	85.9	83.3	40.7		100.0	83.2	84.9
	3.05ii - Incidence of TB (2011 - 13)	1,238	38.1	14.8	113.7		0.5	21.3	36.0
	3.06 - NHS organisations with a board approved sustainable development management plan (2013/14)	7	53.8	41.6	0.0		83.3	42.6	39.4
	3.07 - Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies (201	n/a	100.0	95.2	0.0		100.0	100.0	100.0

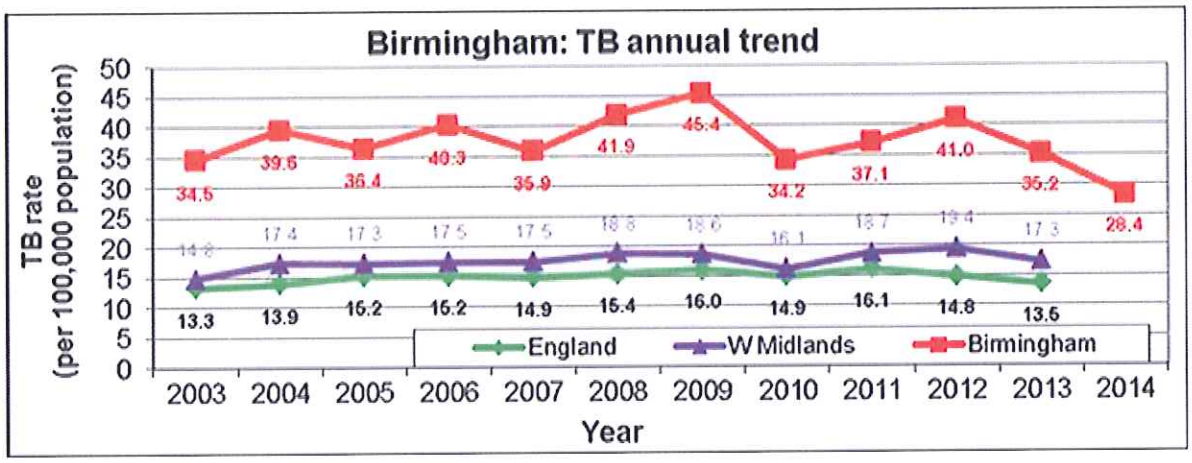
Note :-
1. For indicator 3.02 (ie Chlamydia rates - persons) the classification used is :- < 1,900 | 1,900 to 2,300 | >= 2,300
   For indicator 3.02 (ie Chlamydia rates) for Males and Females there are no current thresholds recorded on the fingertips website so these are currently imputed as "no significance can be calculated".
2. For indicator 3.02i (ie Chlamydia diagnoses - persons) the classification used is :- < 2,000 | 2,000 to 2,400 | >= 2,400
3. For indicator 3.02ii (ie Chlamydia diagnoses - persons) the classification used is :- < 1,900 | 1,900 to 2,300 | >= 2,300
4. For indicators 3.03iii to 3.03x (ie Population vaccination coverage) the classification used is :- < 90% | >= 90%
5. For indicators 3.03xii and 3.03xiii (ie Population vaccination coverage HPV/PPV), the classification used is :- < previous year's England value | >= previous year's England value
6. For indicators 3.03xiv and 3.03xv (ie Population vaccination coverage Flu), the classification used is :- < 75% | >= 75%
7. For indicator 3.04 (ie HIV at a late stage of infection) the classification used is :- < 25% | 25% to 50% | >= 50%
8. For indicator 3.05i (ie Treatment completion for TB) the classification used is :- < 85% | >= 85%

4. Communicable Disease

4.1. Tuberculosis

Birmingham has recently had a high incidence of tuberculosis (TB), with rates around 40/100,000 (Figure 1), the level used to define high incidence areas. TB is therefore one of the main issues of Health Protection concern for the Forum. TB incidence decreased for the second consecutive year in Birmingham with the total number of cases decreasing in 2014 to 312 (TB incidence 28.4 per 100,000 population), from 385 the previous year and 445 in 2012.

Figure 1. Annual TB rates for Birmingham, West Midlands, England



4.1.1. Progress against previous priorities

4.1.1.1. Clinical Leadership

In 2014/15 there was successful recruitment to the posts of clinical lead and paediatric lead. Cross-city multi-disciplinary team meetings have now been established where clinical teams from the three hospital treatment centres engage in discussion of complex cases. This has also strengthened the clinical leadership in support of the TB control programme.

4.1.1.2. Treatment Completion for Active and Latent TB

Completion of TB treatment is essential for effective control and the Chief Medical Officer has set a target of 85% treatment completion rates. The proportion of cases of active TB disease who complete treatment was already >85% in Birmingham and has increased further to 93-94% (Quarter 1-4, 2013). Treatment completion rates for latent TB infection have also been excellent with rates of 95-98% for the four quarters in 2013. Assessment and delivery of directly observed treatment (DOT) has improved for patients less likely to complete TB treatment with 97-100% of TB patients risk assessed for DOT and 92-99% of patients assessed as eligible being offered the service. The TB Service also offers Enhanced Case Management and DOT to Latent cases following assessment.

Significant service improvements have been made as a direct result of quarterly TB cohort review meetings which are now well established in Birmingham. These improvements include a considerable increase in the proportion of cases seen by the TB Service within two weeks; improved HIV testing; ensuring TB specialist medical input for all patients, especially with regard to paediatric patients; a system established for review of deaths; investigation of diagnostic delays among hospitalised cases; and feedback to GPs about delayed referrals.

4.1.1.3. Detection and Management of Latent TB Infection

Approximately 70% of TB cases occur in people born abroad of whom around 45% entered the UK within five years of diagnosis. Therefore establishing a robust system to detect and treat latent infections in migrants from high incidence countries, a priority identified in the recently published national TB strategy, should be an important part of the programme to control TB in Birmingham. A pilot was successfully completed to test and treat college ESOL (English for Speakers of Other Languages) students. More than 450 students, most from high incidence countries, were tested and over 65 cases of latent infection and 2 cases of active infection identified.

4.1.1.4. Effective and Integrated Commissioning of TB Services

Senior representation of commissioners on the TB Programme Board has been established. The clinical and nursing leads and senior clinicians have visited other services nationally (Manchester) and internationally (Netherlands and Spain) as a benchmark for comparison of local services.

4.1.2. New Priorities

4.1.2.1. Contact Tracing and Management

TB Cohort Reviews have consistently demonstrated the need to strengthen identification of social contacts of cases of infectious TB and uptake of screening among those identified. Priorities identified by the TB network include redesigning services to include TB screening of contacts in domestic settings similar to the Spanish/Barcelona model, and developing a business case for expansion of the community TB service to include recruitment of community health care workers to provide enhanced support for particular ethnic minority communities.

The nursing service is auditing which stages of treatment contacts drop out in order to develop strategies to reduce this.

4.1.2.2. New Entrant Screening

A key component of the national strategy for high incidence areas such as a Birmingham is for the implementation of screening for latent infections among migrants from high incidence countries. Intense collaboration will be required with local partners (NHS, CCGs, PHE, Local Authority Public Health and third sector), the West Midlands TB Control Board, and the national TB Strategy Implementation team to implement screening in this financial year.

4.1.2.3. 'One-Stop-Shop'

To improve access to treatment services for people from hard to reach communities an open door one stop service based at Birmingham Chest Clinic / Heartlands Hospital is being developed. Also the TB nursing team have begun assessing patients attending other services e.g. sexual health to increase access reduce inconvenience to patients.

4.1.3. Challenges

4.1.3.1. Poorly Adherent Patients

There is a lack of appropriate facilities in the UK for treatment of poorly adherent (and drug-resistant) cases that present a risk to public health, with the resulting risk of increasing spread of (drug resistant) infections. There is also a need for coordinated multi-agency public health strategy to manage local patients with (drug resistant) TB who have complex social needs.

4.1.3.2. National Strategy Implementation

Significant funding for new entrant screening will be available for 2015/16, but there have been delays to publication of the national strategy, establishment of structures to support its implementation and consequently release of the funds. There is a significant risk that due to the limited time available for implementing the new Board, adequate numbers of migrants will not be screened and consequently a danger to making the case for continued funding of the service beyond 2016. To mitigate against this Birmingham TB Service is planning to repeat ESOL screening in 15/16.

4.2. Blood-Borne Virus Infections (Hepatitis B and C, HIV)

Hepatitis B (HBV) and C (HCV) virus infections remain important public health problems that predominately affect marginalised groups of society, including People Who Inject Drugs (PWIDs) and minority ethnic groups.

In Birmingham it is estimated that only approximately 40% of HCV infected individuals are diagnosed so public health promotion and awareness-raising for the public and GPs are ongoing.

4.2.1. Progress against previous priorities

Health promotion activities for the public have taken place and awareness raising among GPs is ongoing with the recent roll-out of an e-learning module.

The newly commissioned sexual health and substance misuse services will risk assess and offer appropriate screening and testing to all service users, followed by referrals into treatment service if required.

HIV prevalence in Birmingham is above the 2/1000 threshold at which HIV testing in medical admissions and primary care registrations in adults is recommended. Progress is being made to implement this testing as part of the mobilisation of the newly commissioned sexual health service for Birmingham.

4.3. Ebola

Ebola is a rare but serious disease caused by Ebola virus. Since March 2014, there has been a large outbreak affecting Guinea, Liberia and Sierra Leone. Following significant in-country support to manage the outbreak, the situation is now improving. As part of the national Ebola response, Public Health England has been working with Government, NHS colleagues; Airport Authorities, UK Border Force and Local Authority partners to ensure the UK remained alert to, and prepared for, the risk of Ebola.

4.3.1. Screening

Preparedness has been essential to protect public health and one measure included targeted passenger screening at the UK's main ports of entry, including Birmingham Airport.

Screening commenced at Birmingham Airport on 31st October 2014. With no direct flights from West Africa to the UK, the dominant traffic routes to Birmingham are from the European hubs of Brussels, Charles de Gaulle and Amsterdam.

Passengers of concern were screened and categorised by level of risk, identified as having partaken in hazardous activity such as attending a funeral or having direct contact with bodily fluids and / or describing symptoms of pyrexia (temperature of ≥37.5C) or those clinically compatible with Ebola infection. Possible cases were risk assessed by discussion with the Imported Fever Service.

Screening involved clinical assessment by taking the passengers temperature using a tympanic thermometer and completing a health assessment form.

As of 11/5/2015, 178 at risk passengers have been screened at Birmingham Airport out of which 1 was referred to NHS as the passenger was symptomatic on arrival, 1 was a Category 3 passenger and 1 was a Category 2 passenger.

4.3.2. Challenges

The successful delivery of the screening programme was not without its challenges as a project of this nature had never been tackled before by PHE or the team. Key challenges faced and successfully overcome were:

- From across the West Midlands PHE Centre a body of over 100 volunteers were recruited and trained to carry out the screening task. A comprehensive operational plan was drafted and continuously updated to assist screeners in all aspects of their role, ranging from finding their way to and around the airport to an assessment algorithm and action card in the event of identifying a passenger requiring NHS care.
- The operational delivery arrangements for screening were developed with partners within a dynamic commercial environment. A well-regarded Health Protection Plan

for the Airport set the foundations for partner engagement through a common vision.

- Maintaining effective two way local to national communication was key. There was also a need to ensure effective operational management across all ports and this combined with considerable interest at the senior levels of government, required the timely and accurate passage of information. Material was regularly provided for public communication releases.
- At the same time as resourcing the screening process, communication at managerial level was essential in agreeing key priorities and sharing of limited resources across all parts of the organisational to maintain business as usual v staffing a Level 4 emergency.

4.3.3. Lessons Learned

Delivery of health protection measures relied on a whole system approach, rather than a medical model, with some elements being delivered by partners not usually recognised for their public health role.

Operating in a commercial environment required sensitivity to the local pressures and drivers. Strong leadership held the key to negotiation in order to develop a compatible implementation strategy.

The team were able to draw on previous relationships forged when the Health Protection Plan for the Airport was drafted in 2013 which detailed guidance on the management of a range of potential health scenarios.

Other keys to success were sharing learning between ports and identifying a range of contingencies to ensure a proportionate response to a dynamic situation.

Teamwork was essential; both within the Steering Group, between all volunteers and with staff holding the fort back at base. Trust within the relationships supported individuals to step outside of comfort zones and take informed risks.

5. Non-communicable Disease

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

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

5.1. Air Quality

The poor air quality in Birmingham was identified as a priority in last year's report, and the evidence base about it's impact on health outcomes is increasing.

5.1.1. Nitrogen Dioxide

The primary focus for air quality regulation remains the need to reduce concentrations of nitrogen dioxide in order to meet the levels stated within the Ambient Air Quality Directive (DIR2008/50/EC).

The EC is progressing infraction proceedings against the UK Government for continued breaches of the emissions limit for nitrogen dioxide. The West Midlands remains one of 16 regions in the UK to be in breach. The Government has reminded local councils that under the reserve powers of the Localism Act there exists the option for Government to transfer fines down to councils who are deemed to be insufficiently tackling the problem.

The main areas of concern for Birmingham remain the city centre and the M6 / A38(M) corridors.

The primary source of nitrogen dioxide emissions within Birmingham is from the exhaust emissions of motor vehicles, specifically from diesel powered engines.

5.1.2. Particulate Matter

The increase in mortality risk associated with long-term exposure to particulate air pollution is one of the most important, and best-characterised, effects of air pollution on health. In April 2014 Public Health England published a study assessing the local mortality burdens associated with particulate air pollution. This study estimated that 6.4% of all deaths in Birmingham within the over 25 age group could be attributable to anthropogenic particulate air pollution, accounting for 520 deaths and 5707 associated life-years lost per annum (based on 2010).

The primary source of anthropogenic particulate air pollution at the lower fractions (particles of 2.5 microns or lower) is from the exhaust emissions of motor vehicles, specifically from diesel powered engines, and from localised solid fuel burning e.g. biomass.

Particulate air pollution retains a high focus due to the heightened knowledge base around the health impacts arising, although the Local Authority does not have direct legislative responsibility for PM2.5 emissions. The Local Air Quality Management regime is however under review and it is anticipated that Government will insert a requirement for local councils to have regard to PM2.5 emissions when undertaking their statutory air quality function to support the national objective.

5.1.3. Primary City Council Interventions

- Atmospheric emissions from 236 local industrial facilities are regulated.
- Air quality across the city is monitored using 6 real time monitoring stations and an extensive network of nitrogen dioxide tubes (including assessing the impact from the 20mph trial areas).
- The City Council is leading on a study to assess the feasibility of deploying low emission zones to tackle the city centre nitrogen dioxide problems, with a preliminary report confirming diesel vehicles as the primary source. The project is expected to complete mid-2015.
- A low emission zone (LEZ) implementation trial is set to commence early spring utilising cameras to assess the types and ages of vehicles entering the city via key routes with a view to informing whether a LEZ is necessary and, if so, what form it should take.
- The Birmingham Mobility Action Plan which seeks to provide the future vision for transportation within the city acknowledges the issues around air quality and seeks to incorporate this problem into the solution.

5.2. Joint working

A joint role between Public Health and Regulation & Enforcement is facilitating a more strategic approach to both alcohol and tobacco control within the City, as well as closer working across other functions within the teams.

The Tobacco Control Alliance has been re-started to provide a multi-disciplinary approach to one of the biggest influences on health outcomes.

5.3. Infection control (Environmental Health)

The Environmental Health Officers (EHOs) play a pivotal role in infection prevention and outbreak investigations; liaising with Public Health England (PHE).

A review of capacity and policies is ongoing to inform the HPF about any areas of concern in this essential health protection function.

6. Screening and Immunisation

All of the immunisation and screening programmes delivered in Birmingham are nationally specified and coordinated locally by a Public Health England team embedded in the NHS England West Midlands team. Updates are routinely reported to the Health Protection Forum on all of the screening and immunisation programmes delivered in Birmingham.

6.1. Screening Programmes

There are a total of 14 screening programmes in England across the life course. The progress, issues and challenges for selected programmes are detailed below.

6.1.1. Breast Cancer Screening

Breast Cancer Screening Programme coverage for Birmingham has increased from 70.4% in 2013 to 70.7% in 2014. Initiatives are being developed in Birmingham to continue the improvement in uptake.

The Screening and Immunisation team is working with the West Midlands Quality Assurance Reference Centre (QARC) and West Midlands Breast Screening and Clinical Genetics Services to develop a High Risk Breast Screening Pathway, in accordance with the NICE guidelines and NHS Breast Screening Programme service specification. The new service will offer eligible women at High Risk of Breast Cancer same day MRI and/or Mammography screening and assessment at a specialist High Risk Screening Service, with referrals being managed by their local Breast Screening Service. Breast Screening Services are now accepting referrals of newly diagnosed eligible women from the West Midlands Clinical Genetics Service.

6.1.2. Bowel Cancer Screening

This screening programme has a strong evidence base, but we have low uptake rates in Birmingham.

Improvements in uptake have been observed during 2014/15, but uptake across Birmingham varies considerably and the range of CCG level uptake reflects this. The West Birmingham area is a particular focus for the team with uptake in Sandwell and West Birmingham CCG lower but positivity higher than neighbouring CCG's. Reducing variation in uptake and improving overall uptake for Birmingham to above the 52% minimum standard remains a priority in the year ahead. Analysis of uptake and work to identify barriers to uptake in all areas is being undertaken.

As Bowel Scope Screening is implemented using a phased approach by provider Trusts and Faecal Immunochemical Testing is piloted by the Bowel Cancer Screening Programme, the Screening and Immunisation team will be working closely with screening providers to target poor uptake areas and reduce variation in uptake across Birmingham.

6.2. Immunisation Programmes

Through the life course, the Birmingham population are offered 17 routine vaccinations, protecting against 12 infectious diseases. In addition to this girls are also offered 3 HPV vaccinations at 12-13 years of age. There are an additional four vaccinations offered to at risk groups. The main challenges for the immunisation programmes are detailed below.

6.2.1. 0-5 year old Immunisations

Uptake for 0-5 Immunisations has improved since the Screening and Immunisation team has started working closely with Birmingham Child Health Records Department on improving data validation from GP vaccination records. Despite improvements there is still further work to be done to improve uptake to a level where national standards are being met. Improving uptake for these vaccination programmes is a priority for the Screening and Immunisation team and this is reflected in our planning with NHS England for 2015/16.

The uptake rates for the Meningitis C, Hib/Meningitis C and MMR vaccinations are significantly lower than the England average and the HPF will focus on improving the rates in Birmingham in 2015/16.

As data validation and accuracy improves the Screening and Immunisation team plans to undertake work with GP Practices and their respective CCG's to reduce variation in 0-5 immunisation uptake and improve uptake overall, reducing the risk of infectious disease within Birmingham's children.

The national Child Health Information System (CHIS) review has been a major undertaking for the Screening and Immunisation team and NHS England. The review has focused on data transfer and validation processes within Child Health Records Departments, comparing records held on CHIS against records held in primary care, and will report soon.

6.2.2. Healthy Children's School Based Flu vaccination and Community Pharmacy Pilot

The Screening and Immunisation team has piloted alternative methods of flu vaccine delivery. The pilot of the school based flu vaccination targeted children in school years 7 & 8 (age 11 to 13 years). Anticipating further expansion of school based immunisation delivery the school-based immunisation service has been procured.

The community pharmacy pilot targeted those over 65 years of age and patients 6 months to 64 years in clinical 'at risk' groups. In Birmingham the activity in the Pharmacy Flu Pilot was significantly higher than other areas in the Area Team. The pilot was designed to complement GP Practice delivery of seasonal flu vaccines although the transfer of vaccine administration records posed a significant challenge to the team ensuring all GP records are updated to reflect pharmacy delivered vaccines. The pilot has been evaluated and findings from the pilot will be used in planning delivery for the 16/17 flu season.

6.2.3. Seasonal Influenza Vaccination

Vaccination uptake has shown some improvement across England this year and this is partly reflected in Birmingham. The uptake for the Pregnant Women and 3 year cohort increased compared to 2013/14, with a 5% improvement in uptake for the cohort of pregnant women. Uptake for 6mths to 64yrs 'at risk' in Birmingham exceeded the national uptake, a big achievement for GP Practices and the Screening and Immunisation Team. Whilst improvements have been limited in areas there has been an increase in the eligible population, with overall activity increased on last year in Birmingham.

Uptake remains low across Birmingham with significant variation between GP Practices. This associated with an increase in the circulation of influenza in the community has resulted in a number of localised outbreaks of Influenza in schools and nursing/care homes across the Birmingham area. This has raised concerns in relation to at risk groups within vulnerable settings including residential homes and schools.

The screening and immunisation team set a priority for this year to improve uptake in those at risk, specifically pregnant women and children aged 2, 3 and 4. The priority is to develop joint action plans with key stakeholders to address quality issues in terms of reaching targets.

The Screening and Immunisation team has worked closely with Birmingham CCGs to drive increases in local uptake of vaccination provision in 14/15 and this will continue in 15/16.

6.2.4. Recent and Future Challenges

Birmingham, Solihull and the Black Country Area Team merged with the Arden, Herefordshire & Worcestershire Area Team on the 1st April 2015. The organisation is changing to a monitoring and assurance organisation as commissioning responsibility for primary care services moves to Clinical Commissioning Groups under co-commissioning arrangements.

Public Health England is also undertaking a strategic review of services. The West Midlands Centre will retain the same geographical area as it matches the NHS England structure. The Screening and Immunisation function is due for review in 2016/17.

7. Emergency Planning, Resilience and Response

The NHS Emergency Planning, Resilience and Response (EPRR) function is the responsibility of NHS England West Midlands. There have recently been organisational changes within NHS England locally and the recent and current capacity to provide assurance updates to the HPF has resulted in a lack of assurance reports over local EPRR arrangements for 14/15.

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

The HPF and NHS England EPRR are working to ensure that assurance is provided in 15/16.

8. Infection Prevention and Control

An Infection Prevention Service is provided to Birmingham Cross City CCG and Birmingham South Central CCG by Central Midlands Commissioning Support Unit.

8.1. MRSA Bacteraemia Post Infection Reviews

The national zero tolerance approach to MRSA bacteraemia was introduced on 1 April 2013 for all healthcare providers.

For MRSA bacteraemia there is a requirement to carry out a Post Infection Review (PIR) which is led by the assigned organisation. The PIR is conducted by a multi-disciplinary team of care providers and aims to identify the cause of the bacteraemia and agree what went well and where improvements could have been made. Lessons that will be acted on to drive improvements in patients care are also identified and will be cascaded across the CCG via the Quality & Safety Committee.

8.2. Incidents – Issues to note

The University Hospital Birmingham NHS Trust saw an increase in MRSA colonisation in the Burns Unit in January 2015; these cases were all typed as the same. An action plan was drawn up to include, education, screening and environmental cleaning. The ward is being monitored for further cases by screening.

During the year there has been a comprehensive programme of infection prevention audits in the nursing homes across the City. There were sporadic cases of Influenza around the City and one outbreak was reported in a BCC CCG home, which quickly settled.

There was an outbreak of Invasive Group A Streptococcus (IGAS) at one care home which has residents placed by the NHS and Council; 5 residents and 9 members of staff were affected. Nearly 300 swabs were taken from staff, residents and visiting staff to the home. All staff and residents in the affected areas were given prophylaxis antibiotics and all positive patients screened negative later. The home was closed from the 5th February 2015 to the 20th March 2015. An action plan was drawn up and all actions except one have been carried out. The outstanding action involves the removal of the carpet; this was advised as environmental swabbing grew IGAS from soft furnishings and similar outbreaks nationally have only been stopped when carpets have been replaced by alternative flooring. The issues that arose and lessons that need to be learned following this outbreak were around the funding of the antibiotics, the staff allocated to carry out the screening, and the ability to enforce decisions of the Incident Management Team.

There was a serious Salmonella community and hospital outbreak between May and June 2014. Salmonella was determined to be a contributory cause of death for 1 individual patient. The hospital Trust has conducted an internal review and the HPF is following this with a wider review of the outbreak; this is ongoing. Lessons learned so far have been used by the Trust to develop an action plan and procedures have been changed. Additional

lessons will come from the wider review and the HPF will ensure that they are shared and actions implemented.

8.2.1. Lessons learned and challenges

Incidents demonstrate that collaboration between Public Health England, CCG's and the Local Authority is essential to ensure incidents are managed in an effective, efficient, and timely manner. Funding, responsibilities and challenges to recommendations and guidance continue to challenge incident response.

	Agenda Item: 8
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30th September 2015**
TITLE:	**CARE ACT 2014: INTEGRATION, CO-OPERATION AND PARTNERSHIPS**
Organisation	**Directorate for People, Birmingham City Council**
Presenting Officer	**Alan Lotinga, Service Director Health and Wellbeing**

Report Type:	**Information**

1. Purpose:
To update Board members on the Care Act 2014 and specifically the duties to integrate, co-operate and work in partnership.

2. Implications:		
BHWB Strategy Priorities	Child Health	N
	Vulnerable People	Y
	Systems Resilience	N
Joint Strategic Needs Assessment		N
Joint Commissioning and Service Integration		Y
Maximising transfer of Public Health functions		N
Financial		N
Patient and Public Involvement		N
Early Intervention		Y
Prevention		Y

3. Recommendation
The Health & Wellbeing Board is asked to note and discuss the contents of this report and implications for its Health and Wellbeing Strategy, and ask their respective teams to make themselves aware of Section 15 of the Care Act 2014 statutory guidance (attached as **Appendix A**).

4. Background

4.1 The Care Act 2014 consists of five Parts, eight Schedules, and is supported by 506 pages of statutory guidance. Much of the Act is about consolidating and modernising relevant care and support legislation passed since the late 1940's into one Act. But, there are also a wide range of new duties and responsibilities, many effective from April 2015, others from April 2016. The Board may be aware of recent Government statements made to delay the implementation of significant aspects of those due to be implemented in April 2016, including the capping of care costs and associated matters, until at least 2020.

4.2 This report relates specifically to Part 1 of the Act - Care and Support, which covers such things as the general responsibilities of local authorities, meeting needs for care, assessing needs, charging and assessing financial resources, direct payments, deferred payment agreements, continuity of care when an adult moves, establishing where a person lives, safeguarding adults at risk of abuse and neglect, provider failure, market oversight, transition for children into adult care and support, independent advocacy support and enforcement of debts. Part 2 of the Act covers Care Standards, including the "duty of candour", making the provision for national regulations to ensure appropriate information is given in cases where incidents affecting a person's safety occur in the course of the person being provided with a service. Part 4, a short section, gives statutory backing to the setting up of the Better Care Fund, which the Board is well aware of.

4.3 The main aims of the Care Act are to ensure that care and support:

- Is **clearer** and **fairer**;
- Promotes people's **wellbeing**;
- Enables people to **prevent and delay** the need for care and support, and carers to maintain their caring role; and
- Puts **people in control** of their lives so they can pursue opportunities to realise their potential.

4.4 The Act and statutory guidance have an underpinning principle of wellbeing, supported by a number of key duties and responsibilities (prevention, integration/partnerships/transition, information/advice/advocacy, diversity of provision and market oversight, safeguarding), and processes (assessment and eligibility, care and support planning, charging and financial assessment, personal budgets and direct payments, review).

4.5 To further assist the Board in this, promoting individual wellbeing relates to any of the following; personal dignity (including treatment with respect), physical and mental health and emotional wellbeing, protection from abuse and neglect, control by the individual over day-to-day life, participation in work/education/training or recreation, social and economic wellbeing, domestic/family and personal relationships, suitability of living accommodation and the individual's contribution to society.

4.6 Section 15 of the statutory guidance is attached as **Appendix A**. This covers integration, co-operation and partnerships i.e. how the local authority should

be looking to integrate with other local services (in relation to strategic planning and integrating service provision and combining or aligning processes), co-operation of partner agencies (the general duty to co-operate, who must co-operate, co-operation within local authorities, co-operating in specific cases), working with the NHS (the boundary between the NHS and care and support e.g. with regard to Continuing HealthCare cases, delayed transfers of care), working with housing authorities and providers and working with welfare and employment support. Partner agencies for this are other local authorities within the area (e.g. District Councils in shire counties), neighbouring councils or from areas where people are being placed, NHS bodies in the local authority's area, local offices of the Department for Work and Pensions, Police services and Prisons and Probation services in the local area.

4.7 In summary:

- The Care Act ensures that people should experience provision that works well together and where each participant knows what the others are doing and why;
- The responsibility goes wider than just integration and co-operation with health services to other services that provide care and support; and
- The duty to co-operate is not just one way, and involves both a general requirement to co-operate as well as a specific requirement in the case of individuals.

4.8 Board members are asked to make their respective teams/colleagues aware of Section 15 of the Care Act 2014, in particular the statutory guidance.

5. Compliance Issues

5.1 Strategy Implications

Section 15 of the Care Act is about organisations working together to provide the support and services required by vulnerable people, in particular older people. The links to 'strategy on a page', hence strategic implications, are:

- Vulnerable people – support older people to remain independent and increase the independence of people with a learning disability or severe mental health problem, including prevention and early intervention; and
- Keep people healthy – common NHS and Local Authority approaches, including joint commissioning and health and acre system in financial balance.

5.2 Governance & Delivery

Board members will be responsible for making their respective teams aware of Section 15 of the Care Act and updates may be required by the Board.

5.3	*Management Responsibility*
	Board: Chair and Vice Chair. Day- to-day: Alan Lotinga – Service Director for Health & Wellbeing.

6.	**Risk Analysis**		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Teams are not made aware of Section 15 of the Care Act.	Low	Low	An update will be requested to ensure teams are made aware.

Appendices
Appendix A – Section 15 Care Act.

Signatures	
Chair of Health & Wellbeing Board (Councillor Paulette Hamilton)	P. A Hamilton
Date:	18/09/2015

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

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15. Integration, cooperation and partnerships

This chapter provides guidance on:

- *Sections 3, 6, 7, 22, 23, 74 and Schedule 3 of the Care Act 2014;*
- *The Care and Support (Provision of Health Services) Regulations 2014;*
- *The Care and Support (Discharge of Hospital Patients) Regulations 2014.*

This chapter covers:

- integrating care and support with other local services;
  - Strategic planning;
  - Integrating service provision and combining and aligning processes;
- cooperation of partner organisations;
  - General duty to cooperate;
  - Who must cooperate;
  - Cooperation within local authorities;
  - Cooperating in specific cases;
- working with the NHS;
  - The boundary between the NHS and care and support;
  - Delayed transfers of care from hospitals;
- working with housing authorities and providers;
- working with welfare and employment support.

15.1. For people to receive high quality health and care and support, local organisations need to work in a more joined-up way, to eliminate the disjointed care that is a source of frustration to people and staff, and which often results in poor care, with a negative impact on health and wellbeing. The vision is for integrated care and support that is person-centred, tailored to the needs and preferences of those needing care and support, carers and families.

15.2. Sections 3, 6 and 7 of the Act require that:

- local authorities **must** carry out their care and support responsibilities with the aim of promoting greater **integration** with NHS and other health-related services;

- local authorities and their relevant partners **must cooperate generally** in performing their functions related to care and support; and, supplementary to this,
- local authorities and their partners **must cooperate** where this is needed in the case of **specific individuals** who have care and support needs.

Integrating care and support with other local services

15.3. Local authorities **must** carry out their care and support responsibilities with the aim of joining-up the services provided or other actions taken with those provided by the NHS and other health-related services (for example, housing or leisure services). This general requirement applies to all the local authority's care and support functions for adults with needs for care and support and carers, including in relation to preventing needs (see chapter 2), providing information and advice (see chapter 3) and shaping and facilitating the market of service providers (see chapter 4).

15.4. This duty applies where the local authority considers that the integration of services will:

- promote the wellbeing of adults with care and support needs or of carers in its area;
- contribute to the prevention or delay of the development of needs of people;
- improve the quality of care and support in the local authority's area, including the outcomes that are achieved for local people.

15.5. The local authority is not solely responsible for promoting integration with the NHS, and this responsibility reflects similar duties placed on NHS England and clinical commissioning groups (CCGs) to promote integration with care and support.[117] Under this provision, NHS England must encourage partnership arrangements between CCGs and local authorities where it considers this would ensure the integrated provision of health services and that this would improve the quality of services or reduce inequalities. Similarly, every CCG has a duty to exercise its functions with a view to securing that health services are provided in an integrated way, where this would improve the quality of health and/or reduce inequalities in access or outcomes. The Care Act adds further coherence by placing an equivalent duty on local authorities to integrate care and support provision with health services and health related services, for example housing (see paragraphs 15.7-15.8 below about the integration of health and health related services).

15.6. There are a number of ways in which local authorities can fulfil this duty, where they think this will integrate services: at the strategic level; at the level of individual service; and in combining and aligning processes. Some examples are discussed below.

Strategic planning

Integration with health and health-related services

15.7. A local authority **must** promote integration between care and support provision, health and health related services, with the aim of joining up services.

15.8. To ensure greater integration of services, a local authority should consider the different mechanisms through which it can promote integration, for example;

[117] See sections 13N and 14Z1 of the National Health Service Act 2006

(a) Planning – using adult care and support and public health data to understand the profile of the population and the needs of that population. For example, using information from the local Joint Strategic Needs Assessments to consider the wider need of that population in relation to housing. The needs of older and vulnerable residents should be reflected within local authorities' development plans with reference to local requirements for inclusive mainstream housing and specialist accommodation and/or housing services.

Case study: Promoting the integration of housing, health and social care across Leicestershire

District Councils in Leicestershire have taken a strategic approach to working with county wide providers on priority issues, including housing, health and wellbeing. A District Chief Executive leads across the 7 District Councils working with a network of senior managers in each individual council.

This has built the influence and credibility of District Councils with health and social care leaders who now have an increasing understanding of the vital role housing and housing based services play in the delivery of better outcomes for vulnerable people.

The Housing Offer to Health in Leicestershire is built into the County's Better Care Fund priorities and work is underway across health, social care and housing in the following key areas:

- Housing's Hospital to Home discharge pathway – looking to place housing options expertise within the day-day discharge assessment and planning work of both acute and mental health providers so that the planning and decisions around an individual's hospital discharge includes early consideration, and actioning of appropriate and supportive housing options.
- Establishing an integrated service to provide practical support to people in their own homes across all tenures so that aids, equipment, adaptations, handy person services and energy efficiency interventions are available and delivered quickly. Through this we hope to reduce the time taken to provide practical help to individual people with care and support needs, reduce process costs for services paid for through the public purse and support vulnerable people to access the low level practical support that helps them remain independently at home.
- Establishing a locality based approach to prevention and housing based support which includes Local Area Co-ordination, Timebanking and delivery of low level support services to vulnerable older people through a mixture of community volunteers and multi-skilled workers.

(b) Commissioning – a local authority may wish to have housing represented at the Health and Wellbeing Board/Clinical Commissioning Groups (CCGs) making a visible and effective link between preventative spend (including housing related) and preventing acute/crisis interventions. Joint commissioning of an integrated information and advice service covering health, care and housing would be one way to achieve this.

(c) Assessment and information and advice – this may include integrating an assessment with information and advice about housing, care and related finance to help develop a care plan (if

necessary), and understand housing choices reflecting the person's strengths and capabilities to help achieve their desired outcomes. There may be occasions where a housing staff member knows the person best, and with their agreement may be able to contribute to the assessment process or provide information.

(d) Delivery or provision of care and support – that is integrated with an assessment of the home, including general upkeep or scope for aids and adaptations, community equipment or other modifications could reduce the risk to health, help maintain independence or support reablement or recovery. For example, some specialist housing associations and home improvement agencies may offer a support service which could form part of a jointly agreed support plan. A housing assessment should form part of any assessment process, in terms of suitability, access, safety, repair, heating and lighting (e.g. efficiency).

Joint Strategic Needs Assessments

15.9. Local authorities and clinical commissioning groups already have an equal and joint duty to prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS) through health and wellbeing boards. JSNAs are local assessments of current and future health and care needs that could be met by the local authority, CCGs or the NHS Commissioning Board, or other partners. JHWSs are shared strategies for meeting those needs, which set out the actions that each partner will take individually and collectively.

15.10. Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies are therefore key means by which local authorities work with CCGs to identify and plan to meet the care and support needs of the local population. JHWSs can help health and care and support services to be joined up with each other and with health-related services.

15.11. Under the Act, local authorities, when contributing to JHWSs, must consider greater integration of services if doing so would achieve any or all of the objectives set in paragraph 15.4 above (promoting wellbeing; preventing or delaying needs; improving the quality of care). The JHWSs should set the local context and frame the discussion with partners on how different organisations can work together to align and integrate services. However, local authorities should bear in mind that carrying out the JSNA and JWHS on their own is unlikely to be sufficient to fulfil the requirement to promote integration; it will be the agreed actions which follow the strategies and plans that will have the greatest impact on integration and on the experience and outcomes of people.

Integrating service provision and combining and aligning processes

15.12. There are many ways in which local authorities can integrate care and support provision with that of health and related provision locally. Different areas are likely to find success in different models. Whilst some areas may pursue for integrated organisational structures, or shared funding arrangements, others may join up teams of frontline professionals to promote multi-disciplinary working. There is no required format or mechanism for integrating provision, and local authorities should consider and develop their strategy jointly with partners.

15.13. At the strategic level, there are many examples of how local authorities can integrate services including:

- the use of "pooled budgets", which bring together funding from different organisations to invest jointly in delivering agreed, shared outcomes.[118] For example, the Better Care Fund, which provides local authorities and CCGs with a shared fund to invest in agreed local priorities which support health and care and support, will be a key opportunity to promote integration in provision.[119]
- the development of joint commissioning arrangements.

15.14. In terms of working practices to encourage greater integration at an individual level, this could include recruiting and training individual care coordinators who are responsible for planning how to meet an adult's needs through a number of service providers. Another example could be in relation to working with people who are being discharged from hospital, where staff from more than one body may be involved with providing or arranging care and support to allow the person to return home and live independently.[120] As with other examples of integration, this would not necessarily require structural integration – i.e. organisations merging – but a seamless service, from the point of view of the person, could be delivered by staff working together more effectively, for example, integrating an assessment with information and advice about housing options see paragraphs 15.54-15.75 on housing and integration.

15.15. Local authorities, together with their partners, **should consider** combining or aligning key processes in the care and support journey, where there may be benefit to the individual concerned from linking more effectively. For example, combining assessments may allow for a clearer picture of the person's needs holistically, and for a single point of contact with the person to promote consistency of experience, so that provision of different types of support can be aligned. A number of assessments could be carried out on the same person, for example a care and support needs assessment, health needs assessment and continuing health care assessments. Where it is not practicable for assessments to be conducted by the same professional, it may nonetheless be possible to align processes to support a better experience, for example , the 2nd or 3rd assessor could be obliged to read the 1st assessment (provided there is a lawful basis for sharing the information) and not ask any information that has already been collected, or the different bodies could work together to develop a single, compatible assessment tool. Local authorities have powers to carry out assessments jointly with other parties, or to delegate the function in its entirety.

Co-operation of partner organisations

15.16. All public organisations **should** work together and co-operate where needed, in order to ensure a focus on the needs of their local population. Whilst there are some local services where the local authority must actively promote integration, in other cases it must nonetheless co-operate with relevant local and national partners.

15.17. Co-operation between partners **should** be a general principle for all those concerned, and all should understand the

118 http://www.england.nhs.uk/wp-content/uploads/2012/10/lga-nhscb-concordat.pdf

119 Link to BCF guidance: http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

120 Hospital 2 Home guide http://www.housinglin.org.uk/hospital2home_pack/

reasons why co-operation is important for those people involved. The Act sets out five aims of co-operation between partners which are relevant to care and support, although it should be noted that the purposes of co-operation are not limited to these matters:

- promoting the wellbeing of adults needing care and support and of carers;
- improving the quality of care and support for adults and support for carers (including the outcomes from such provision);
- smoothing the transition from children's to adults' services;
- protecting adults with care and support needs who are currently experiencing or at risk of abuse or neglect;
- identifying lessons to be learned from cases where adults with needs for care and support have experienced serious abuse or neglect.

15.18. The processes and systems behind the areas noted above, as well as how working with partners is integral to achieving the best outcomes, are set out in more detail in other chapters of this guidance.

15.19. Local Authorities and relevant partners **must** co-operate when exercising any respective functions which are relevant to care and support. This requirement relates to organisations existing functions only, and the Act does not confer new functions.

15.20. "Co-operation", like integration, can be achieved through a number of means, and is intended to require the adoption of a common principle, rather than to prescribe any specific tasks. There are a number of powers which local authorities may use to promote joint working. For example, local authorities may share information with other partners, or provide staff, services or other resources to partners to improve co-operation. Some of the actions may be the same as those undertaken to promote integration, for example under section 75 of the NHS Act 2006, a local authority may contribute to a "pooled budget" with an NHS body – a shared fund out of which payments can be made to meet agreed priorities. Other actions may be specific to particular circumstances or the needs of a specific group, for example the local authority co-operating with prisons in its area to develop a joint strategy for meeting the care and support needs of prisoners.

Who must co-operate?

15.21. The local authority **must** co-operate with each of its relevant partners, and the partners **must** also co-operate with the local authority, in relation to relevant functions. The Act specifies the "relevant partners" who have a reciprocal responsibility to co-operate. These are:

- other local authorities within the area (i.e. in multi-tier authority areas, this will be a district council);
- any other local authority which would be appropriate to co-operate with in a particular set of circumstances (for example, another authority which is arranging care for a person in the home area);
- NHS bodies in the authority's area (including the CCG, any hospital trusts and NHS England, where it commissions health care locally) [see paragraphs 15.29-15.53 about care and support and the NHS];
- local offices of the Department for Work and Pensions (such as Job Centre Plus) [see paragraphs 14.75-14.81 about care and support, welfare and employment];
- police services in the local authority area;

- prisons and probation services in the local area [see chapter 17 on care and support in Prisons].

15.22. In addition, there may be other persons or bodies with whom a local authority **should** co-operate if it considers this appropriate when exercising care and support functions, in particular independent or private sector organisations. Examples include, but are not limited to, care and support providers, NHS primary health providers, independent hospitals and private registered providers of social housing. In these cases, the local authority should consider what degree of co-operation is required, and what mechanisms it may have in place to ensure mutual co-operation (for example, via contractual means).

Ensuring co-operation within local authorities

15.23. Local authorities fulfil a range of different functions that have an impact on the health and wellbeing of individuals, in addition to their care and support responsibilities (e.g. children's services, housing, public health). It is therefore important that, in additional ensuring co-operation between the local authority and its external partners, there is internal co-operation between the different local authority officers and professionals who provide these services. Local authorities **must** make arrangements to ensure co-operation between its officers responsible for adult care and support, housing, public health and children's services, and should also consider how such arrangements may also be applied to other relevant local authority responsibilities, such as education, planning and transport.

15.24. For example, it is important that local authority officers responsible for housing work in co-operation with adult care and support, given that housing and suitability of living accommodation play a significant role in supporting a person to meet their needs and can help to delay deterioration. Similarly, the transition from children's social care to adult care and support will require local authority officers in the respective departments to co-operate to share information, prepare for transition, and ensure the young person's needs are met.

Co-operating with partners in specific cases

15.25. Co-operation should be a general principle for partners, which should inform how they undertake their day-to-day activities. However, there will be circumstances where a more specific approach will be required, and a local authority or partner will need to explicitly ask for co-operation which goes beyond the general approach, where this is needed in the case of an individual. The Care Act provides a new mechanism for the local authority, or partner, to use in such cases.

15.26. Where the local authority requires the co-operation of a partner in relation to a particular individual case, the Act allows for the local authority to request co-operation from that partner. The relevant partner **must** co-operate as requested, unless doing so would be incompatible with the partner's own functions or duties. The converse also applies: where a relevant partner asks for co-operation from a local authority in the case of an individual, then the local authority **must** co-operate, again providing this is compatible with its functions and duties.

15.27. This mechanism is intended to support partners with a means of identifying specific cases in which more targeted co-operation is required. In practice, it may be the case that general working protocols and

relationships between organisations mean that this further process is not required. However, there will be situations that arise which that necessitate a more tailored response to fit around the person concerned. This might include, for example:

- when a person is planning to move from one area to another, and the authorities involved require co-operation to support that move;
- when an assessment of care and support needs identified other needs that should be assessed (for instance, health needs that may indicate eligibility for NHS Continuing Healthcare);
- when a local authority is carrying out a safeguarding enquiry or review, and requires the support of another organisation.

15.28. Where the local authority or relevant partner decide to use this mechanism, they should notify the other in writing, making clear the relevant Care Act provisions. If the local authority or the relevant partner decide not to co-operate with a request, then they **must** write to the other, setting out reasons for not doing so. Local authorities and their relevant partners **must** respond to requests to cooperate under their general public law duties to act reasonably, and failure to respond within a reasonable time frame could be subject to judicial review.

Working with the NHS

The boundary between care and support and the NHS

15.29. Local authorities **must** carry out an assessment where someone appears to have needs for care and support. It has a duty to meet those needs for care and support that meet the eligibility criteria. Similarly, in the case of carers, the local authority must carry out an assessment if a carer appears to have, or is likely to have, needs for support and it has a duty to meet those needs for support that meet the eligibility criteria. However, local authorities cannot lawfully meet needs in either case by providing or arranging services that are clearly the responsibility of the NHS.

15.30. In order to support joint working, it is important that all partners involved are clear about their own responsibilities, and how they fit together. Section 22 of the Care Act sets out the limits on what a local authority may provide by way of healthcare and so, in effect, sets the boundary between the responsibilities of local authorities for the provision of care and support, and those of the NHS for the provision of health care.

15.31. Where the NHS has a clear legal responsibility to provide a particular service, then the local authority may not do so. This general rule is intended to provide clarity and avoid overlaps, and to maintain the existing legal boundary. However, there is an exception to this general rule, in that the local authority may provide some limited healthcare services as part of a package of care and support, but only where the services provided are "incidental or ancillary" (that is, relatively minor, and part of a broader package), and where the services are the type of support that an authority could be expected to provide.

15.32. The two most obvious relevant examples of healthcare that are clearly the responsibility of the NHS (and thus not something a local authority may provide) are nursing care provided by registered nurses, and services that the NHS has to provide because the individual is eligible for NHS Continuing Healthcare.

15.33. NHS Continuing Healthcare is a package of ongoing care that is arranged

and funded solely by the health service for individuals outside a hospital setting who have complex ongoing healthcare needs, and who have been found to have a 'primary health need'. Such care is provided to people aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. NHS Continuing Healthcare is not dependent on a person's condition or diagnosis, but is based on their specific care needs.

15.34. Where the person has a 'primary health need' as set out in regulations[121] and as determined following an assessment of need under national guidance (the *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care*[122] ('the National Framework'), it is the responsibility of the health service to meet all assessed health and associated care and support needs, including suitable accommodation, if that is part of the overall need.

15.35. The National Framework sets out a process for the NHS, working together with its local authority partners wherever practicable, to assess health needs, decide on eligibility for NHS Continuing Healthcare, and provide that assessed care. 'NHS-funded Nursing Care', is the funding provided by the NHS to care homes providing nursing, to support the provision of nursing care by a registered nurse. If an individual does not qualify for NHS Continuing Healthcare, the need for care from a registered nurse must be determined. If the person has such a need and it is determined that their overall needs would be most appropriately met in a care home providing nursing care, then this would lead to eligibility for NHS-funded Nursing Care. Once the need for such care is agreed, a CCGs (or in some case NHS England) must pay a flat-rate contribution to the care home towards registered nursing care costs.

15.36. The regulations and guidance referred to above, set out how the 'primary health need' test takes account of the limits of local authority responsibility. Although the regulations and guidance pre-date the coming into force of the Care Act 2014, the limits of local authority responsibility have not been changed by the Care Act 2014.

Supporting discharge of hospital patients with care and support needs

15.37. The provisions on the discharge of hospital patients with care and support needs are contained in Schedule 3 to the Care Act 2014 and the Care and Support (Discharge of Hospital Patients) Regulations 2014 ("the Regulations"). These provisions aim to ensure that the NHS and local authorities work together effectively and efficiently to plan the safe and timely discharge of NHS hospital patients from NHS acute medical care facilities to local authority care and support. The purpose of these provisions is to update existing provisions to reflect the current NHS and care and support landscape; in particular, the drive to improve integration between health and social care provision for those people whose needs span both areas.

121 See regulations under the National Health Service Act 2006 and the Health and Social Care Act 2012 (see Part 6 of *The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012,* as amended by *The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013)* ('the Standing Rules'),

122 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf

15.38. Schedule 3 to the Care Act covers:

- the scope of the hospital discharge regime and the definition of the patients to whom it applies;
- the notifications which an NHS body must give a local authority where the NHS considers that it is not likely to be safe to discharge the patient unless arrangements for meeting the patient's needs for care and support are in place;
- the period for which an NHS body can consider seeking reimbursement from a local authority, where that local authority has not fulfilled its requirements to assess or put in place care and support to meet needs, or (where applicable) to meet carer's needs for support, within the time periods set such that the patient's discharge from hospital is delayed.

15.39. The Regulations and guidance both set out further details of the form and content of what the various types of NHS notification notices must and should contain to ensure the local authority has relevant information to comply with its requirements to undertake assessments, and to put in place any arrangements necessary for meeting any of the patient's care and support needs, or where applicable, carer's needs for support. They set out the circumstances when assessment notices and discharge notices must be withdrawn, and determine the period and amount of any reimbursement liability which a local authority may be required to pay the NHS for any delay in the transfer of care.

Definitions of delayed transfers of care

15.40. Delayed Transfers of Care (DTOC) mean that individuals are in a setting that is recognised as not being appropriate for the care they need. This potentially contributes to worse outcomes for the individual, particularly in the context of their quality of life, as well as placing additional and sometimes costly burdens on the NHS and local government.

15.41. The definition of a DTOC is when a patient is ready for transfer after being in receipt of acute care, when:

- A clinical decision has been made that a patient is ready for transfer; **AND**
- A multi-disciplinary team decision (involving the NHS body and the local authority) has been made that a patient is ready for transfer; **AND**
- The patient is safe to discharge/transfer; **YET**
- The patient is still occupying a bed.

15.42. NHS and local authorities **should** work together in order to reduce the number of delayed days where a patient is ready to be transferred from NHS acute medical care to other settings but where arrangements for care and support needs are not in place in order to ensure a safe discharge from hospital. The NHS **may** seek reimbursement from local authorities for a delayed transfer of care in certain circumstances. The potential for reimbursement liability is intended to act as an incentive to improve joint working between the NHS and local government. However, the use of these reimbursements is discretionary.

15.43. The potential for NHS seeking reimbursement from local authorities is not to be seen to operate in isolation, but to be considered as part of the bigger picture in terms of promoting joint working between the NHS and local government. For example, the Better Care Fund, which aims through the establishment of £3.8 billion of joint funding between the NHS and local authorities to

promote joint working, includes performance on delayed discharge as one of the national indicators against which progress will be assessed and resources released. This, with the significant resources available will therefore be a powerful driver to improving performance on delayed discharge.

15.44. Also, even if a particular case falls outside the scope of the provisions so that no reimbursement could be sought, this **should not** prevent the NHS and local authority still working together to plan the safe and timely discharge of all its patients. Both the NHS and local authorities are under a common law duty of care to people with care and support needs, and the good practice guidance on safe discharge planning and duties to co-operate and promote integration will apply.

15.45. As around 70% of delayed discharge days are attributable to the NHS and because the issues behind them are within their gift to address, it is important that NHS organisations in particular review this guidance alongside other guidance such as the updated April 2013 SitRep Guidance,[123] which provides clear advice on the steps the NHS needs to take in relation to undertaking NHS Continuing Health Care and the way that data should be collected and reported, irrespective of whether delays are reimbursable days or not.

To whom do the delayed transfers of care provisions apply

15.46. The delayed transfers of care regime only applies to NHS hospital patients in England who are receiving acute care, and who the NHS considers are likely to have care and support needs after discharge from hospital.

15.47. No notification notices can be issued, and accordingly no reimbursement liability could arise, in respect of any patient who falls outside scope of the regime. However, notwithstanding that a patient's case falls outside the reimbursement regime, this does not mean that the NHS and local authorities should not be working together to deliver the safe and timely discharges of all hospital patients with care and support needs for the reasons set out at paragraph 15.42 above.

15.48. NHS Hospital Patient in England: A hospital patient is a person who is ordinarily resident in England who is accommodated in an NHS hospital in England, or in an independent hospital in the United Kingdom under arrangements made by an English NHS body.

15.49. Adult Care and Support Needs: In terms of age, the discharge of hospital patient provisions do not apply in respect of patients who will be under the age of 18 at the proposed date of discharge, as they will have their relevant care and support needs met by children's social services provided under other provisions (e.g. the Children's Act 1989).

15.50. Acute Care: The provisions only apply to patients who are receiving, have received or can reasonably be expected to receive, acute care. Acute care means intensive medical treatment provided by or under the supervision of a consultant that lasts for a limited period after which the person receiving the treatment no longer benefits from it.

[123] *Monthly Delayed Transfers of Care Sitreps Definitions and Guidance Version 1.07,* www.england.nhs.uk/.../Monthly-**Sitreps**-Definitions-DTOC-**v1.07**.doc,

NHS hospital patients to whom the provisions do not apply

15.51. The following cases are excluded from the discharge provisions in the Care Act:

(a) **Mental health care –** Mental health care means psychiatric services, or other services provided for the purpose of preventing, diagnosing or treating illness, the arrangements for which are the primary responsibility of a consultant psychiatrist. However, if the patient is receiving treatment in an acute setting for a physical condition and is under the care of an acute medical consultant but has post-care needs that relate, for example, to their dementia, the case could fall within the scope of the discharge of hospital patient provisions. If a person is admitted with a physical condition but during their stay is subsequently transferred to the care of a consultant psychiatrist, then delays to that person's discharge would not count towards any potential reimbursement. However delayed discharges for patients under the care of a consultant psychiatrist should be recorded as is expected under the DTOC Sitrep reporting requirements and the duties to co-operate in improving discharge arrangements clearly apply.

(b) **Palliative care –** Patients with palliative care needs are excluded.

(c) **Private patients –** As the regime only applies to NHS patients, the Discharge of Hospital provisions do not apply to patients who have given an undertaking to pay for their care in an NHS hospital or who are accommodated at an independent hospital under private arrangements. However, patients who are admitted to NHS hospitals as private patients but who subsequently elect to change their status and become NHS patients while still receiving acute medical treatment fall within the scope of the Act from the point at which they start to be treated as NHS patients.

(d) **Other –** In addition, maternity care, intermediate care (this is where patients, their families and carers are provided with support to help them manage illness and avoid becoming dependent on long-term care), and care provided for recuperation or rehabilitation are excluded from the definition of acute care.

Patients in independent hospitals receiving NHS-commissioned acute care

15.52. NHS patients can receive acute treatment which is arranged and funded by an NHS body, but which takes place in an independent sector hospital. As they are NHS patients, they are covered by the Discharge of Hospital Patient provisions and as such the requirements to plan and provide services in order to facilitate a safe discharge **must** be implemented.

15.53. As such, the duty to issue notices will apply in respect of these cases, as may the potential for the NHS to seek reimbursement from the local authority for any delayed transfers of care. The Act allows an NHS body which has commissioned acute treatment at an independent hospital within the UK to make arrangements for the independent provider to issue assessment or discharge notifications on its behalf. This means that independent providers can take decisions such as whether the patient is likely to need care and support services, when the patient is to be discharged, what follow-up health needs they may have, etc. However, the NHS body will retain ultimate responsibility for the functions, including

any claim for reimbursement that might be appropriate.

Working with housing authorities and providers

15.54. Housing or suitable living accommodation is a place which is safe, healthy and suitable for the needs of a person, so as to contribute to promoting physical and emotional health and wellbeing and social connections. For example, a healthy home would be dry, warm and insulated and a safe home would meet particular needs, e.g. of an older person. Housing refers to the home and the neighbourhood where people live, and to the wider housing sector including staff and services around these homes.

15.55. Suitable living accommodation includes all places where people live; for example a house, flat, other general dwelling or an adult placement or other specialist housing.

15.56. Housing and the provision of suitable accommodation is an integral element of care and support. The setting in which a person lives, and its suitability to their specific needs, has a major impact on the extent to which their needs can be met, or prevented, over time. Housing is therefore a crucial component of care and support, as well as a key health-related service.

15.57. Local authorities have broad powers to provide different types of accommodation in order to meet people's needs for care and support. The Care Act is clear that suitable accommodation can be one way of meeting needs. However, the Act is also clear on the limits of responsibilities and relationship between care and support and housing legislation, to ensure that there is no overlap or confusion. Section 23 of the Care Act clarifies the existing boundary in law between care and support and general housing. Where housing legislation requires housing services to be provided, then a local authority must provide those services under that housing legislation. Where housing forms part of a person's need for care and support and is not required to be provided under housing legislation, then a local authority may provide those types of support as part of the care and support package under this Act.

15.58. This provision is to clarify the boundary in law between a local authority's care and support function and its housing function. It does not prevent joint working, and it does not prevent local authorities in the care and support role from providing more specific services such as housing adaptations, or from working jointly with housing authorities.

15.59. Housing plays a critical role in enabling people to live independently and in helping carers to support others more effectively. Poor or inappropriate housing can put the health and wellbeing of people at risk, where as a suitable home can reduce the needs for care and support and contribute to preventing or delaying the development of such needs. Housing services should be used to help promote an individual's wellbeing, by providing a safe and secure place in which people in need of care and support and carers can build a full and active life. That is why suitability of living accommodation is one of the matters local authorities must take into account as part of their duty to promote an individual's wellbeing.

15.60. Housing is an integral part of the health and care system and a local authority's responsibility for care and support. This could be in relation to a local authority's duty on prevention (see chapter 2) or through the duty to assess an adult or carer's needs for care

and support (see chapter 6), or in providing advice and information (see chapter 3).

15.61. Enabling individuals to recognise their own skills, ambitions and priorities and developing personal and community connections in relation to housing needs can help promote an individual's wellbeing. By way of example, providing good quality information and advice can help people make early choices about housing options and avoid leaving these until they are in crisis or decisions have to be taken by relatives or carers. Adaptations, modifications or extra support can help people stay independent for longer.

15.62. Health, care and support and housing services **should** centre on the individual and where appropriate their family and should support them in meeting the outcomes they want to achieve. By putting individuals and families at the centre and helping them to articulate the outcomes they want to achieve a local authority may be able to provide some support in or through the home.

Considering accommodation within the wellbeing principle

15.63. Local authorities have a general duty to promote an individual's wellbeing when carrying out their care and support functions. The Act is clear that one specific component of wellbeing is the suitability of living accommodation. Wherever relevant, a local authority **should** consider suitable living accommodation in looking at a person's needs and desired outcomes.

15.64. Housing has a vital role to play in other areas relating to a person's wellbeing. For example access to a safe settled home underpins personal dignity. A safe suitable home can contribute to physical and mental wellbeing and can provide protection. A home or suitable living accommodation can enable participation in work or education, social interactions and family relationships.

15.65. In relation to housing, a local authority can make an important contribution to an individual's wellbeing, for example by providing and signposting information that allows people to address care and support needs through specific housing related support services, or through joint planning and commissioning that enables local authorities to provide (or arrange for the provision of) housing and care services or housing adaptations to meet the needs of the local population.

Housing to support prevention of needs

15.66. In many cases, the best way to promote someone's wellbeing will be through preventative measures that allow people to live as independently as possible for as long as possible.

15.67. A local authority **must** provide or arrange for the provision of services that contribute towards preventing, reducing or delaying the needs for care and support (see chapter 2). The provision of suitable living accommodation can be a way to prevent needs for care and support, or to delay deterioration over time. Getting housing right and helping people to choose the right housing options for them can help to prevent falls, prevent hospital admissions and readmissions, reduce the need for care and support, improve wellbeing, and help maintain independence at home.

15.68. Housing and housing services can play a significant part in prevention, for example, from a design/physical perspective, accessibility, having adequate heating and

lighting, identifying and removing hazards or by identifying a person who needs to be on the housing register. In addition, community equipment, along with telecare, aids and adaptations can support reablement, promote independence contributing to preventing the needs for care and support.

15.69. A local authority may wish to draw on the assistance of the housing authority and local housing services. Housing-related support staff and scheme managers can contribute to prevention, for example by being alert to early signs of ill health, e.g. dementia, and signposting or supporting individuals to access community resources which may prevent, reduce or delay the need for care and support or a move into residential care.

15.70. The links between living in cold and damp homes and poor health and wellbeing are well-evidenced.[124] Local authorities may wish to consider the opportunities to prevent the escalation of health and care and support needs through the delivery or facilitation of affordable warmth measures to help achieve health and wellbeing outcomes.[125,126]

Integrating information and advice on housing

15.71. A local authority **must** establish and maintain a service for providing information and advice relating to care and support, and this **must** include advice on relevant housing and housing services which meet care and support needs. The authority is not required to provide all elements of this service, rather, they are expected under this duty to understand, co-ordinate and make effective use of other statutory, voluntary and or private sector information and advice resources within their area in order to deliver more integrated information and advice.

15.72. A person-centred approach to information and advice will consider the person's strengths and capabilities and the information or advice that will help them to achieve their ambitions. Information and advice **should** include services in the home that bring health, care and housing services together. This means that information and advice on housing, on adaptations to the current home, or alternative housing options services should be included. This will enable a person to choose how best they can meet or prevent their needs for care and support. (See chapter 3 on information and advice).

15.73. A person using care and support or carer **should** be supported to make fully informed decisions about how to prevent or meet their needs for care and support. A local authority **should** make use of information and advice that is already available at local and national levels. Examples of some national resources are;

www.firststopcareadvice.org.uk

www.moneyadviceservice.org.uk

www.nhs.uk/CarersDirect/Pages/CarersDirectHome.aspx

www.foundations.uk.com

15.74. People's care and support needs, their housing circumstances and financial resources are closely interconnected. It is only with full knowledge of the care and

124 (http://www.instituteofhealthequity.org/projects/the-health-impacts-of-cold-homes-and-fuel-poverty, www.gov.uk/government/collections/housing-health-and-safety-rating-system-hhsrs-guidance).

125 The Energy Companies Obligation: https://www.gov.uk/government/policies/helping-households-to-cut-their-energy-bills/supporting-pages/energy-companies-obligation-eco

126 Energy Saving Advice Service: http://www.energysavingtrust.org.uk/Organisations/Government-and-local-programmes/Programmes-we-deliver/Energy-Saving-Advice-Service

Case Study: Putting health back into housing

The Gloucestershire Affordable Housing Landlords' Forum (GAHLF), comprising of the seven leading local housing providers in the county, have set out an 'offer' to the Health and Wellbeing Board that demonstrates how each is working to improve the quality of life of their residents, the neighbourhoods and wider communities, by investing in new homes, supporting independent living, developing the community and supporting older and vulnerable people.

£12 million is being invested, by Stroud District Council, over five years, to improve the quality of housing stock and reduce fuel poverty for tenants. Stroud has been upgrading the heating supply in properties not currently served by mains gas. Many properties have electric storage heating which does not give the same level of control and is more expensive than gas or renewable energy. Dryleaze Court is a Supported Housing unit where 53 properties have had mains gas installed this year. At the same time, the team has also installed uPVC privacy panels, replaced porches with insulated cavity brick walls and fitted new double-glazed windows. The works have improved tenants' quality of life, helping them to live more comfortably and reduce their fuel bills.

All in all, over the three years ending March 2013, GAHLF has improved over 14,900 homes, with an estimated savings to the NHS of around £1.4 million per annum.

http://www.housinglin.org.uk/_library/Resources/Housing/Regions/South_West/GAHLF_Health_and_Wellbeing_V.II1.pdf

support options open to them, including possible housing options and the related financial implications that people will be able to exercise informed choice. For example, some people with their families have made early decisions about moving into residential care possibly sooner than is necessary. Information and advice about the full range of accommodation/housing options and how these might be funded can contribute to more informed decision making for individuals and can extend independent living.

Link to further Case Study - Commissioning Advice Services in Portsmouth

http://www.adviceuk.org.uk/wp-content/uploads/2013/06/Breaking-the-Mould-Portsmouth.pdf

Working with employment and welfare services

15.75. Local authorities and local offices of the Department for Work and Pensions (i.e. the JobCentre Plus) **must** co-operate when exercising functions which are relevant to care and support. "Co-operation" and integration can be achieved in a number of ways and will depend on local circumstances as outlined above. When considering opportunities for fuller integration of commissioning, planning and delivery of local services local authorities **should** consider the links between care and support, employment and welfare (see chapter 4 on market shaping and commissioning).

15.76. In particular, when working to promote a diverse market under section 5, local authorities **must** consider the importance of enabling people to undertake work, education and training. Local authorities **should** also recognise the importance of identifying the needs of those

carers in their local population when drawing up Joint Strategic Needs Assessments, including their need to participate in paid employment alongside caring responsibilities.

15.77. The Disability and Health Employment Strategy[127] identified that many disabled people and people with health conditions, particularly those with more **complex needs**, receive a range of different services at local level, for example, care and support, primary and secondary health services, as well as support offered by Jobcentre Plus and contracted providers. It highlighted feedback from stakeholders that the support on offer at a local level to disabled people and people with health conditions can be confusing and inconsistent and often results in them having to give the same information to different services.

15.78. Local authorities **must** establish and maintain an information and advice service, but they are not required to provide all elements of this service. Rather, local authorities are expected to understand, co-ordinate and make effective use of other statutory, voluntary and/or private sector information and advice resources available to people within their areas. The information and advice available to the local population should include information and advice on eligibility and applying for disability benefits and other types of benefits and, on the availability of employment support for disabled adults.

15.79. Different people will need different levels of support from the local authority and other providers of financial information and advice depending on their capability, their care needs and their financial circumstances. People may just need some basic information and support to help them rebalance their finances in light of their changing circumstances. Topics may include welfare benefits, advice on good money management, help with basic budgeting and possibly on debt management. The local authority may be able to provide some of this information itself, for example of welfare benefits, but where it cannot, it should work with partner organisations to help people access it.

15.80. Local authorities, working with their partners, **must** also use the wider opportunities to provide targeted information and advice at key points in people's contact with the care and support, health and other local services. This **should** include application for disability benefits such as Attendance Allowance and Personal Independence Payments, and for Carers Allowance and access to work interviews.

Considering individual employment, training and education needs

15.81. In addition to considering how to join up care and support at a local level local authorities **must** consider education, training and employment when working with individuals. In particular:

- local authorities **must** promote wellbeing when carrying out care and support functions, or making a decision in relation to a person. This applies equally to people with care and support needs and their carers. In some specific circumstances, it also applies to children, their carers and to young carers (when they are subject to the transition assessments discussed in chapter 16). The definition of wellbeing includes participation in work education and training. As such local authorities **must** consider whether participation in work, education or training is a relevant

[127] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266373/disability-and-health-employment-strategy.pdf

consideration when they are promoting wellbeing.

- local authorities, when carrying out a needs assessment, carer's assessment or child's carer's assessment **must** have regard to whether the carer works or wishes to do so, and whether the carer is participating in or wishes to participate in education, training or recreation and this should be reflected, as appropriate in the way their needs are met. Local authorities and the Department for Work and Pensions should cooperate to ensure people are given appropriate employment support and opportunities – in particular where this is a person's preferred outcome. This should include consideration of how direct payments may be used for employment support.[128]
- sections 37 and 38 of the Act support people to move, including to pursue employment opportunities or move closer to family members. Local authorities **must** ensure continuity of care and support when people move between areas so that they can move without the fear that they will be left without the care and support they need (see chapter 20).

Sources of information

15.82. The integration clauses mirrors similar duties placed on Clinical Commissioning Groups and NHS England. There are a number of relevant documents that local authorities may find of interest:

- The Functions of Clinical Commissioning Groups, NHS England March 2013 http://www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf
- Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, Department of Health, April 2012. See part 4: Promoting integration between services. http://www.wakefield.gov.uk/NR/rdonlyres/37D0E9D1-C438-4388-B270-A527139D9F37/0/StatutoryGuidanceonJSNAsandJHWSs_DH2013.pdf
- National Voices, a national coalition of health and social care charities, have produced a narrative for person-centred co-ordinated care and support, showing what this would look like from the perspective of people with care and support needs: http://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf

The following links provide further sources of information in relation to housing service and practical examples which support integration with care and support on a local level:

- http://www.housinglin.org.uk/Topics/browse/Housing/hwb/?parent=3691&child=8169
- http://www.cih.org/publication-free/display/vpathDCR/templatedata/cih/publication-free/data/Developing_your_local_housing_offer_for_health_and_care
- https://www.gov.uk/government/collections/housing-health-and-safety-rating-system-hhsrs-guidance
- http://www.housinglin.org.uk/hospital2home_pack/

[128] An example of personal budgets being used as a way to support and enterprise and employment can be found at: http://www.serendipity-chic.co.uk/

Birmingham Health and Wellbeing Board

	Agenda Item: 9
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30th September 2015**
TITLE:	**IMPROVING OUTCOMES FOR PEOPLE WITH MENTAL HEALTH PROBLEMS – CONSULTATION ON STRATEGY DIRECTION**
Organisation	**Mental Health System Strategy Group**
Presenting Officer	**Dr. Adrian Phillips – Director of Public Health**

Report Type:	**Discussion/Endorsement**

1. Purpose:

The Mental Health System Strategy Group is currently consulting with stakeholders on the direction of the 'Improving Outcomes for People with Mental Health Problems Strategy'. The Health & Wellbeing Board is asked to discuss whether the current direction is appropriate.

2. Implications:

BHWB Strategy Priorities	Child Health	Y
	Vulnerable People	Y
	Systems Resilience	
Joint Strategic Needs Assessment		
Joint Commissioning and Service Integration		Y
Maximising transfer of Public Health functions		
Financial		
Patient and Public Involvement		
Early Intervention		Y
Prevention		Y

3. Recommendation

In line with the consultation questionnaire currently being completed by stakeholders across Birmingham, the Health and Wellbeing Board is invited to comment on the strategy and its direction.

4.	**Background**
4.1	'Improving Outcomes for People with Mental Health Problems', sets out a vision for mental health services across Birmingham. Delivery of the strategy is overseen by the Mental Health System Strategy group. This group includes representation from NHS Birmingham Cross-City, Birmingham South Central and Sandwell and West Birmingham CCGs, alongside Birmingham City Council.
4.2	While lots of progress has been made in delivering this strategy to date, in order to reflect the changing needs of a diverse city like Birmingham, leaders from across the city have come together to review the strategy direction, to make sure we are still focusing on the areas that need our attention most.
4.3	The 4 recommended outcomes of the strategy are as follows: • Prevent mental ill-health and get earlier help for people starting to suffer poor mental wellbeing; • Protect those who are most vulnerable from the adverse effects of mental ill-health; • Better management of mental health crises and preventing them from occurring; and • Recovery of people with mental health problems into everyday life.
4.4	The strategy document is attached as **Appendix A**.

5.	**Compliance Issues**
5.1	***Strategy Implications***
	The attached strategy affects all aspects of the strategy concerned with mental health and wellbeing i.e. • Make children in need safer. • Improving the wellbeing of vulnerable children. • Increase the independence of people with a learning disability or severe mental health problem.
5.2	*Governance & Delivery*
	Any actions raised by the Health & Wellbeing Board will be reported to the Operations Group and back to the MH System Strategy Group.
5.3	***Management Responsibility***
	Adrian Phillips – Director of Public Health

6.	**Risk Analysis**
	No identified risks relevant at this stage. Analysis will be carried out upon decision of any future actions concerning this document from the Health & Wellbeing Board

	Appendices
	Appendix A - Improving Outcomes for People with Mental Health Problems.

Signatures	
Chair of Health & Wellbeing Board (Councillor Paulette Hamilton)	P. A Hamilton
Date:	18/09/2015

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

Hazel Imrie,
Public Health Intern,
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Improving outcomes for people with mental health problems

We want to provide better help for people who are suffering from, or who are at severe risk of, mental health problems.

We recognise that this will not be a quick or simple task, so will be focussing on the following four outcomes in the first instance.

1. Prevent mental ill-health and get earlier help for people starting to suffer poor mental wellbeing;
2. Protect those who are most vulnerable from the adverse effects of mental ill-health;
3. Better management of mental health crises and preventing them from occurring; and
4. Recovery of people with mental health problems into everyday life.

So, what will this look like?

1. **Prevent mental ill-health and get earlier help for people starting to suffer poor mental wellbeing**

What will this mean?
We want to increase the 'resilience' of young people to withstand episodes of low mental wellbeing, such as that related to exam stress or family disputes. We know that employment (or education) is important in promoting mental wellbeing. We would like more children in care and ex-offenders in work (paid or unpaid), or in training. Domestic abuse and all types of violence are also major causes of mental illness, which affect whole families and future generations. We want to tackle these huge issues much earlier.

How will we measure success?
We will see:

a. Fewer children affected by their parents poor mental health;
b. Fewer 0-25 admissions to A&E for deliberate self-harm;
c. Fewer suicides;
d. Improved school survey relating to mental wellbeing;
e. Fewer repeat violent episodes; and
f. Fewer children and young people reporting they are frequently bullied.

What are some of the things we need to do?
We need to describe the effect of poor adult mental health and behaviour on children and families.

We need to be much better at understanding the change from child to adult, and the consequences for some on their mental health.

We need to understand the effects of isolation on wellbeing and how we can improve this.

2. **Protect those who are most vulnerable from the adverse effects of mental Ill-health**

What will this mean?
Mental ill-health impacts upon certain groups more than others.
These include: the homeless; people who were in 'care'; prisoners and ex-prisoners; people who misuse alcohol and drugs and members of the LGBT and Afro-Caribbean community. We want to ensure these very vulnerable people have excellent support to protect them from declining mental health. Additionally we know that certain groups are vulnerable to crime and other types of anti-social behaviour.

How will we measure success?
We will see:

a. Fewer Afro-Caribbean men in mental health services;
b. Fewer unresolved dual diagnosis (mental health and substance misuse) clients;
c. Fewer homeless people;
d. Fewer repeat offenders;
e. Better physical health of these groups; and
f. Fewer people with dementia and learning disability suffering crime.

What are some of the things we need to do?
We need to redefine complexity and recognise that our systems aren't simple to understand, especially for the most vulnerable. Put simply, complexity is about our systems and organisations, not people. We also need clear rules on managing people who have both mental ill health and misuse substances.

We also need better intelligence on these very vulnerable groups.

3. **Better management of mental health crises and preventing them from occurring**

What will this mean?
Fewer people of all ages will have mental health crises or develop urgent problems, due to misuse of drugs and alcohol. We will see fewer people with deteriorating mental health problems in police cells and emergency departments. People with chronic mental health disorders will have excellent management plans to prevent rapid worsening of their condition. We will provide better support for all carers to prevent and reduce crisis, especially people with dementia.

How will we measure success?
We will see:

a. All crisis assessments will be within four hours;
b. No children in police cells;
c. Fewer repeat admissions for mental health crises; and
d. Fewer acute medical admissions precipitated by dementia.

What are some of the things we need to do?
We need to get faster access to specialist mental health support, to the police and probation services and emergency departments. We need to ensure that there is adequate professional support to processes which manage people with multiple needs e.g. MAPPA and IOM. We need to re-define a crisis, which must be about the person, not the organisation. We need support to be much more accessible to those affected by a crisis. We need to make sure that carers of people suffering dementia can get meaningful help quickly in a crisis.

4. Recovery of people with mental health problems into everyday life

What will this mean?
It means all of those things that we take for granted such as having a job, having a home, having relationships and not being discriminated against. For young people it means going to school, having friends and not being bullied or made fun of.

How will we measure success?
We will see:

a. Less re-offending;
b. More people who previously misused substances at work;
c. More young people in education, training or employment;
d. Employment of people with chronic mental health problems;
e. Reduced adult homelessness; and
f. Reduced youth homelessness.

What are some of the things we need to do?
We need to re-define the purpose of mental health services; especially for people over 25 to return to normal life and not to treatment. We need to link with services which aim to increase education and employment. We also need to recognise that lack of a job is a crucial factor in developing chronic conditions and perpetuating discrimination.

Birmingham Health and Wellbeing Board

	Agenda Item: 10
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**30th September 2015**
TITLE:	**WORKING LOCALLY (WORKSHOP OUTCOMES)**
Organisation	**Operations Group**
Presenting Officer	**Alan Lotinga - Service Director Health and Wellbeing**

Report Type:	**Information/Decision**

1. Purpose:

To update the Health & Wellbeing Board on the outcomes of the workshop and consider and discuss how the Board can take things forward.

2. Implications:

BHWB Strategy Priorities	Child Health	Y
	Vulnerable People	Y
	Systems Resilience	Y
Joint Strategic Needs Assessment		Y
Joint Commissioning and Service Integration		Y
Maximising transfer of Public Health functions		Y
Financial		Y
Patient and Public Involvement		Y
Early Intervention		Y
Prevention		Y

3. Recommendations

The Health & Wellbeing Board is recommended to:

3.1 Note the outcomes of the workshop.

3.2 Consider:

- Having a quarterly newsletter.
- Holding health seminars on prevention, physical exercise and links to mental health.
- Developing a Health & Wellbeing Board work plan at a local level so

Districts can communicate with the Board and work collaboratively.

3.3 Agree and approve the Operations Group responding to questions raised and providing feedback to delegates.

4. Background

4.1 One role of the Health and Wellbeing Board is to develop partnerships across the city with the NHS and other related organisations to encourage integrated working to improve health and wellbeing in the city.

4.2 Earlier this year the Board agreed to undertake a workshop with Council Districts interested in developing their own health and wellbeing arrangements. Key to this would be to understand the relationship between the Board and Districts in terms of structure and outcomes and priorities.

4.3 The workshop provided the opportunity to consider:

- How local health and wellbeing partnerships and plans are developing in terms of structure and outcomes and priorities.
- How the Board and its outcomes and priorities relate to this.
- How the Board can best support local areas in developing partnership working.

4.4 Four main priorities emerged from the workshops:

- Older people – including falls prevention and dementia.
- Health – including cardiovascular diseases and lifestyle/behaviour changes.
- Social – including isolation and local people not involved in local community.
- Services – including access to GP services and communication.

4.5 A range of issues were identified under each priority and these included:

- Communication between CCGs and Districts is poor.
- Districts don't have a direct link to the Board and are not aware of what is being discussed.
- Social clubs are being privatised and libraries closed.
- Need to be aware of impacts on local health and what is happening on the ground.
- Clinicians (NHS) feel the full impact of broken communities.

4.6 There was a lot of discussion around what could be done to address the priorities and issues which included:

- Training people in the community to become dementia friends.
- Local individuals supported to take some responsibility for their health.
- Encouraging people to be active and educate and raise awareness in community about lifestyle services.
- Learning from good practice.

- Creating pathways for hard to reach communities.
- Mapping of local assets, health services, District services and networking channels.
- Developing clearer channels of communication.

4.7 A number of areas were identified for the Board to consider taking forward;

- Hold health seminars on prevention, physical exercise and links to mental health.
- Producing a quarterly newsletter.
- Develop a H&WBB work plan at a local level so Districts can communicate with the Board and work collaboratively.

4.8 Delegates raised a series of questions which the Operations Group will take forward and in addition arrange to feedback to delegates. Full details of priorities, issues, what could we do and questions can be seen in **Appendix A.**

5.	**Compliance Issues**
5.1	***Strategy Implications***
	The report is aligned to the objectives of the Health and Wellbeing Board and makes recommendations for future delivery.
5.2	***Governance & Delivery***
	It is suggested that the Board consider the recommendations and the Operations Group move things forward and report back to the Board at a future meeting.
5.3	***Management Responsibility***
	Board: Chair and Vice-Chair Day-to-day: Alan Lotinga and Jenny Drew/Jill Crowe.

6. Risk Analysis

Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
No feedback is provided to delegates and questions are not considered.	Low	Low	Operations Group provides feedback and considers questions report back to Board.
Suggested actions by H&WBB are not considered or taken forwards	Low	Medium	Actions are considered during meeting and any commitments noted in the minutes.

Appendices
Appendix A – Working Locally Workshop

Signatures	
Chair of Health & Wellbeing Board (Councillor Paulette Hamilton)	P. A Hamilton
Date:	18/9/2015

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

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Birmingham Health and Wellbeing Board

Appendix A - Working locally workshop

Priorities	Issues	What could we do?
Older People: Improving older people's quality of life. Support on dementia. Falls prevention for over 65's. Isolation.	Social clubs are being privatised and libraries closed. These are places where many older people go to do activities and socialise. Many older people will have nowhere to go to socialise or be unable to afford the activities and not be aware of alternatives. Blood tests are now booked on line, which can be difficult for many older people.	Should have a system in place so that people are aware of local events in their area such as walking and gardening clubs in Balsall Heath. Train people in the community to become dementia friends. Older people with long term conditions only have 10 minutes consultation time with GPs, need to consider other options.
Health priorities: Cardiovascular diseases. Lifestyle/behaviour changes requiring support and assistance. Mental health issues. Obesity. Childhood obesity and the need for more physical activity.	Vulnerable people with mental health issues or disabilities going into employment has not yet been covered by H&WBB and needs to be looked at. Need to be aware of impacts on local health and know what is happening on the ground.	Local individuals need to take some responsibility for their health and need to be supported to do so. Educate and raise awareness in the community about lifestyle services. Hold health seminars on prevention, physical exercise and links to mental health. Encourage people to be active. Hold joint seminars and events such as working locally workshop.
Social priorities: Isolation young mothers Isolation young people. Vulnerable children. Local people not involved.	There is a lot of isolation at both a city and local level and we need to stop working in silos. The services for children with mental health issues and domestic violence are not co-ordinated and the Implemented strategy not used effectively. There are many deprived neighbourhoods in Birmingham. Clinicians (NHS) feel the full impact of Broken communities.	Communicate what we mean by community cohesiveness. More needs to be done in getting local people involved in Neighbourly Neighbourhoods, including Healthy Villages. Must know how to engage with local People and a neighbourhood forum approach, such as Balsall Heath, could be a way forward. Need to learn from good practice in Community engagement in areas such as Sutton or Solihull. Provide local people with the necessary tools and skills to use them effectively so they feel confident in engaging at a local and potentially city level. Develop social support networks. Strengthen community resilience. Create pathways for hard to reach communities.

Birmingham Health and Wellbeing Board

Priorities	Issues	What could we do?
Service priorities: Access to GP services. (Often A&E services are used instead). Demand led services. Communication.	Roles of Districts and Birmingham City Council are unclear. There is a need for a community strategy. Have not pushed people geographically to work together. It is hard to have a discussion with GPs and pharmacies as they are hardly ever available. Communication between CCGs and Districts is poor. Districts don't have a direct link with H&WBB and are not aware of what is being discussed. In addition the minutes are not distributed. There is conflicting terminology across organisations. Budgets are being cut including; development portfolio, community development funding and Third Sector grants. People arrive in primary care services who are trying to catch up with social/funding system.	Districts to work more closely with Public Health, NHS and Third Sector and agree shared priorities. Need to establish how best to work together to achieve goals. Expertise in place to take things forward to ensure we have the right data and that it is shared. 'Tap into' existing community knowledge. Key decision makers need to take ownership. There are a lot of initiatives at a District (local) level and it would be useful to itemise and have an outcome against each initiative. More information about contractors delivering a service. For example Districts knowing details of substance misuse contracts. H&WBB should consider having a quarterly newsletter. Speak to the right people face to face rather than using email. Need to establish what we are trying to achieve. Bring sustainability back for local needs and services. Mapping of local assets, health services, District services and networking channels. Need to assess impact and cost of cohort access choice to A&E as could be more cost effective than seeing GPs. Develop a communications strategy. Assess footfall at new walk in centre near City Hospital. Develop H&WB work plan at a local level so Districts can communicate with H&WBB and work collaboratively. More 'joined up' information gathering. Clearer channels of communication, especially from bottom up.

Birmingham Health and Wellbeing Board

Priorities	Issues	What could we do?
Service priorities continued: Access to GP services. (Often A&E services are used instead). Demand led services. Communication.		Common goals, shared ownership and joint opportunities. Find a smart connection between all involved. Ensure the right people sit around the appropriate tables. Invest in shared knowledge. Try to share resources such as data effectively. Feed local issues back to H&WBB. Share good practice. Health to engage with Public Health and Districts on how to use local intelligence and information effectively. Consider CCG representation at a local District level as well as their input. Potential local H&WBBs need to come up with a solution to work together, which could mean joining up with other NHS bodies and other organisations. Develop formal link with H&WBB and Districts in respect of health priorities. Work across boundaries. Listen and learn from each other. Co-ordination of agencies and develop understanding of assets.

The following questions were raised by delegates:

- In terms of Substance Misuse, how are the contracts working?
- What can we do to make the contracts work well?
- How can we make things even better?
- Money is being ring-fenced, but how can we support the Districts?
- How can we extract the money that is available?
- How can we work together to look at the economy of scale and make big things happen?
- What do Districts require from the Health and Wellbeing Board?
- What do Districts expect from the Health and Wellbeing Board?
- Please can we have vulnerable children on the Districts' agendas?
- If the HWBB have priorities, then why are districts not covering these priorities, and vice versa?
- Health and social care scrutiny programme picks up a lot of issues, do districts also add to this?
- How will the H&WBB programme actually function in the wards?
- How do we tap into the Better Care Fund as a partnership?

Birmingham Health and Wellbeing Board

Programme for Health and Wellbeing Board meetings

30th September 2015

Theme	Item	Who	Outcomes and contribution	Purpose	H&WBB Lead
Vulnerable People	Homeless Health Scrutiny Committee Inquiry	John Hardy	Reduce the number of people and families who are statutory homeless.	Information, discussion and decision. *Report*	Cath Gulliver
All	Role of Operations Group	Alan Lotinga	All - Will ensure reports/items at board support themes and outcomes.	Endorsement and decision. *Report*	Chair – Paulette Hamilton
Keep People Healthy	Birmingham Health Protection Forum Annual Report 2014/15	Chris Baggott	Improve management of common and chronic conditions.	Information and endorsement. *Report*	Adrian Philips
Keep People Healthy	Care Act 2014 – Integration, Co-operation and Partnerships	Alan Lotinga	Common NHS and local authority approaches. Improve management of common and chronic conditions.	Information. *Report*	Peter Hay
Vulnerable People	Improving Outcomes for People with Mental Problems – Consultation on Strategy Direction	Adrian Philips	Increase the independence of people with a learning disability or severe mental health problem.	Discussion and endorsement. *Report*	
Vulnerable People	Working Locally (Workshop Outcomes)	Alan Lotinga	Common NHS and local authority approaches. Improve management of common and chronic conditions.	Information and discussion. *Report*	Adrian Philips

Birmingham Health and Wellbeing Board

24th November 2015

Theme	Item	Who	Outcomes and contribution	Purpose	H&WBB Lead
Vulnerable People	Employment and Housing.	Mental health, learning disabilities, physical disabilities, substance misuse, looked after children, homelessness.	Increase the independence of people with a learning disability or severe mental health problem. Reduce the number of people and families who are statutory homeless. Support older people to remain independent.	Information and discussion. *Report?*	
Vulnerable People	Better Care Fund Update.		Support older people to remain independent.	Information. *Report?*	Peter Hay
Vulnerable People	Birmingham Headstart Phase 3 Plans for Lottery Submission. Forward Birmingham – Impact of Service	Karen Helliwell Gavin Ralston Commissioners: children/health. Providers: children/health.	Improve wellbeing of vulnerable children.	Information. *Report* Information. *Report*	
Vulnerable People	Domestic Violence Needs Assessment and Contribution to Strategy.	Paula Harding	Reduce the number of people and families who are statutory homeless.	Information and discussion. ***Verbal***	
Keep People Healthy	Healthy Villages – Update and Next Steps	Councillor Hamilton Dr Andrew Coward Councillor Kennedy	Health and care system in financial balance.	Information and decision. *Report*	Chair – Paulette Hamilton
All	Annual Summary of H&WBB Strategy and Outcome Framework	All.		Information and decision. *Report*	Chair – Paulette Hamilton

Birmingham Health and Wellbeing Board

26th January 2016

Theme	Item	Who	Outcomes and contribution	Purpose	H&WBB Lead
Keep People Healthy.	System Wide Commissioning Plans from Partners.	All partners.	All outcomes.	Information and discussion. *Report*	
	3 CCG Operational Plans/Prospectuses			Information and discussion. *Report*	

Birmingham Health and Wellbeing Board

22nd March 2016

Theme	Item	Who	Outcomes and contribution	Purpose	H&WBB Lead
Child Health	Infant Mortality Annual Report.	Adrian Philips	Reduce infant mortality.	Information. *Report*	Adrian Philips
Vulnerable People	Better Care Fund Update.		Support older people to remain independent.	Information. *Report*	Peter Hay

Birmingham Health and Wellbeing Board

April 2016

Theme	Item	Who	Outcomes and contribution	Purpose	H&WBB Lead
Keep People Healthy.	Pharmaceutical Needs Assessment		Improve management of common and chronic conditions.	Information. *Report*	
All	JSNA – Annual Summary			Information. *Report*	

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD
30 JUNE 2015

MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON TUESDAY 30 JUNE 2015 AT 1500 HOURS IN THE TROPHY SUITE, TALLY HO CONFERENCE AND BANQUETING CENTRE, PERSHORE ROAD, EDGBASTON, BIRMINGHAM B5 7RN

PRESENT: - Dr Gavin Ralston in the Chair; Dr Aqil Chaudary, Dr Andrew Coward, Johnathan Driffil, Cath Gilliver, Peter Hay, Karen Helliwell, Councillor Brigid Jones, Lisa Maxfield, Chief Superintendent Richard Moore and Dr Adrian Phillips.

ALSO PRESENT:-

Margaret Ashton-Gray, Head of City Finance, People Directorate, BCC
Jill Crowe, Development Officer, Housing Strategy Team, BCC
Jenny Drew, Health and Wellbeing Programme Manager, BCC
Karen Helliwell, Director of Performance and Delivery, NHS England (West Midlands)
Paul Holden, Committee Services, BCC
Alan Lotinga, Service Director, Health and Wellbeing, People Directorate, BCC
Candy Perry, Chief Officer (Interim), Healthwatch Birmingham
Anna Robinson, Headstart Programme Manager, The Children's Society
Rob Willoughby, Area Director, The Children's Society

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

The following schedule outlining the functions, terms of reference and membership of the Health and Wellbeing Board agreed by Cabinet on 29 June 2015 was received:-

(See document No. 1)

The Chair placed on record his gratitude to Councillor John Cotton for his work while chairing the Board over the last year and to Andrew Reed (who would soon be taking-up his new role as the Chief Executive of The Royal College of Surgeons) for advice that he had provided to members.

Alan Lotinga, Service Director, Health and Wellbeing, People Directorate, BCC drew members' attention to the additional appointment of Dr Aqil Chawdary as a co-opted member (Lead - Mental Health) on the Board.

114 **RESOLVED:-**

That the re-appointment of the Health and Wellbeing Board with the functions, terms of reference and membership as outlined in the schedule / referred to above be noted and approved, as appropriate.

DECLARATIONS OF INTERESTS

115 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.

HEALTH AND WELLBEING BOARD SUPPORT

116 Members noted the arrangements for the following City Council officers to support the Board as outlined on the agenda:-

Alan Lotinga	Service Director, Health and Wellbeing, BCC
Jenny Drew	Health and Wellbeing Programme Manager, BCC
Paul Holden	Committee Services

The Chair also welcomed Jill Crowe, Development Officer, Housing Strategy Team, BCC who would be offering additional research analyst support to the Board and Operational Group.

APOLOGIES

117 Apologies for absence were submitted on behalf of ACC Marcus Beale, Brian Carr, Councillor Lyn Collin, Councillor Paulette Hamilton and Dr Nick Harding.

DATES OF MEETINGS

Members were advised that further consultation needed to take place on the suggested dates.

118 **RESOLVED:-**

That the following proposed dates for future meetings of the Board be noted, pending further consultation: 1500 hours on Tuesday 22 September 2015; Tuesday 24 November 2015; Tuesday 26 January 2016; Tuesday 29 March 2016.

CHAIR'S UPDATE

119 The Chair advised the meeting that he was delighted to report that bikes and accompanying helmets and locks were currently being delivered to 4000 Birmingham residents that made successful applications as part of the City Council's Big Birmingham Bikes initiative. He highlighted that, as many members would be aware, the initiative was part of the £60million Birmingham Cycle Revolution project that aimed to make cycling an everyday form of transport over the next 20 years.

All the successful applicants would be required to complete a cycle riding course and undertake bike maintenance training as part of the scheme. Furthermore all the bikes would be GPS tracked with individuals needing to show that they had used their bikes at least once a week for the first six months to permanently keep the bikes.

The Big Birmingham Bikes initiative would also see another 2000 bikes being made available for all residents to hire for free at twenty-two specially equipped cycle hubs around the City. A number of bikes at the hubs would be set aside for community access or loaned out to individuals or groups. The GPS tracking would provide details of how often the bikes were used and therefore valuable data on the impact of an individual having a new bike. The Chair extended his praise to all the team and the citizens involved in this innovative scheme.

The Chair raised some Healthwatch items, as follows:-

(a) He was pleased to report that Healthwatch Birmingham was one of two local Healthwatch organisations invited to join a National Working Group looking at improving Patient and Public Involvement in Primary Care; this would inform Healthwatch's strategic work and also provide an opportunity to showcase good practice from across this region.

(b) Healthwatch Birmingham had facilitated a co-design event on 18 June 2015 which initiated strategic, systems-wide work which aimed to establish, support and ultimately ensure patients, the public, carers and service providers were at the heart of all changes made in the name of service improvement. Further workshops were planned to co-design the actions needed at a whole systems level to overcome obstacles currently preventing patients and the public being at the heart of decision-making. The work would broaden involvement from Health and Social Care commissioners, providers and members of the public. Health and Wellbeing Board members would be asked to scrutinise obstacles and solutions identified from the work once the outputs from workshops were issued. The contact for the work was Candy Perry, Chief Officer (Interim), Healthwatch Birmingham.

The Chair also referred to a letter that members had received from Councillor Paulette Hamilton as Chair of the Health and Wellbeing Board reconfirming her commitment to the Midland Metropolitan Hospital in Smethwick and the work of the Right Care Right Here programme which involved significant partnership development across primary, secondary and tertiary provision. The work was

key to the future of health and social care services for the local population and driving forward the focus on helping and supporting the prevention agenda, early intervention and delivering wellbeing in key local settings - with access to expert acute care when necessary. Members indicated their support for the scheme.

In concluding, the Chair also referred to Your Care Connected. He advised the meeting that the electronic information system which allowed doctors and nurses outside a GP Practice to view information from GP records was currently at a proof of concept trial stage.

REVIEW OF DOMESTIC VIOLENCE STRATEGY

The following report was submitted:-

(See document No. 2)

Alan Lotinga, Service Director, Health and Wellbeing, People Directorate, BCC introduced the information contained in the reports.

The following were amongst the issues raised and responses to questions:-

1) Members highlighted that there were many “hidden voices” and stressed that it was essential that a wide ranging preventative agenda was pursued.
2) Dr Andrew Coward considered that addressing domestic violence an absolute top priority and in making reference to the need for victims to be provided with long-term support asked that members consider visiting the Allens Croft Project.
3) Superintendent Richard Moore referred to work the Police carried out in tackling and managing offenders and cited the provision of early help services where the Police, Social Care, Education and Health all worked together, as the way forward.
4) In referring to research (Hard Edges, Heriot-Watt University), Dr Adrian Phillips commented on the high correlation between a person suffering domestic violence and being homeless / an ex-offender / a substance misuser.
5) Reference was made by Dr Andrew Coward to data showing that over ninety per cent of women with a mental health condition were victims of domestic abuse.
6) Cath Gillver informed members that domestic violence was not explicitly mentioned in the Birmingham Changing Futures Programme and undertook to pursue this matter.
7) The Service Director undertook to ensure that men as well as women and children were referenced in documentation.
8) Further to comments made, Candy Perry, Chief Officer (Interim), Healthwatch Birmingham considered that data for the region should be compared with other parts of the country on the frequency of characteristics of victims of domestic abuse. The matter was identified as

an issue to be raised with Paula Harding, Senior Service Manager Equalities, BCC.

9) The members of the Board agreed to take all opportunity to engage in and also engage key others in the review of the City's Domestic Violence Strategy over the coming months.

120 **RESOLVED:-**

That, subject to the above, the contents of the report be noted.

HEALTHWATCH BIRMINGHAM

The following report was submitted:-

(See document No. 3)

Candy Perry, Chief Officer (Interim), Healthwatch Birmingham in introducing the paper reported on the strategy of the organisation going forward.

In the course of the discussion the Chief Officer (Interim) sought consent to report further on the proposed mainstream adoption of the Healthwatch Birmingham's Patient Experience Platform ("Widget") referred to on page 7 of the document. Alan Lotinga, Service Director, Health and Wellbeing responded on this issue and in putting forward a proposal highlighted that the Operations Group would look at the details.

121 **RESOLVED:-**

(a) That the contents of the report be noted;

(b) that the Chief Officer (Interim) of Healthwatch Birmingham be requested to report back as soon as possible via the Board's Operations Group with specific proposals / a business case to show how the mainstream adoption of Healthwatch Birmingham's Patient Experience Platform ("Widget") by all relevant Birmingham health and care commissioners and providers would operate.

BIRMINGHAM HEADSTART DEVELOPMENT

The following report was submitted:-

(See document No. 4)

Anna Robinson, Headstart Programme Manager, The Children's Society introduced the information contained in the report.

The following were amongst the issues raised and responses to questions:-

1) In referring to the Stage 3 application mentioned in the report, Rob Willoughby, Area Director, The Children's Society highlighted that the Big

Lottery was closely monitoring work taking place to assess the extent of strategic partnership working and level of system change that could be achieved going forward.

2) Members were advised that it was proposed to submit a further report to the Board in the autumn on the Stage 3 application.

3) The current Stage 2 work was achieving the lowest level of young people behavioural problems over the last five years in the three schools identified in the report and the tools being used therefore appeared to be making a difference. However, the challenge now was how this could be done on a much wider scale.

4) The partnership looked to use a range of tools but PATHS did appear to be achieving outcomes for young people that others were not.

5) Members were advised that there was alignment with City Council programmes; that links had been made with Police and School Panels; and that there were plans to hold a number of community conferences.

122 **RESOLVED:-**

(a) That the contents of the report be noted;

(b) that this Board continues to endorse Headstart and supports the strategic partnership to achieve system change.

PRIMARY CARE: (A) PRIMARY CARE STRATEGY AND COMMISSIONING OF PRIMARY CARE; (B) THE ESTABLISHMENT OF PRIMARY CARE COMMITTTEES

The following reports from Karen Helliwell, Director of Performance and Delivery, NHS England (West Midlands) and Dr Gavin Ralston, Chair of the Birmingham CrossCity Clinical Commissioning Group were presented to the Board:-

(See document No. 5 and 6)

The following were amongst the issues raised and responses to questions:-

1) Dr Adrian Phillips raised the issue of whether there were principles that the Board would wish to seek to apply across primary care and made reference to holding workshop sessions in this regard.

2) Candy Perry, Chief Officer (Interim), Healthwatch Birmingham suggested that one of the principles that could be adopted by the Board was a standard for public and patient involvement.

3) Dr Andrew Coward stressed the need for new modes of care to be developed as part of transferring resources from secondary care to primary and social care to address projected NHS funding shortfall by 2020.

4) Peter Hay highlighted the importance of identifying opportunities for innovation and testing out different approaches.

5) Alan Lotinga, Service Director, Health and Wellbeing, People Directorate, BCC reported that there was an opportunity for a representative of the Board to serve on the Sandwell and West Birmingham Primary Care Committee and undertook to contact members in this regard.

123 **RESOLVED:-**

That the contents of the reports be noted.

PROPOSALS IN RESPONSE TO THE UNIVERSITY OF BIRMINGHAM'S HEALTH SERVICES MANAGEMENT CENTRE'S (HSMC) REVIEW: (A) REVIEW OF THE HEALTH AND WELLBEING BOARD - PROGRESS (B) PROPOSED BOARD VALUES AND PRINCIPLES

The following reports were submitted:-

(See document No. 7 and 8)

Alan Lotinga, Service Director, Health and Wellbeing, People Directorate, BCC introduced the information contained in the reports. Further to Appendix 1 of the first report he highlighted that a workshop on mental health was planned but that it had now been decided not to proceed with the proposed session relating to Extra Care Villages, as this issue required further consideration. Nonetheless, it was highlighted that a meeting on working locally was scheduled for 16 July 2015 at which the matter could be discussed - reference being made by other members to the need for a wider piece of work covering health and housing. The Service Director also highlighted that primary care was a potential priority area for a workshop session.

124 **RESOLVED:-**

(a) That the reports be noted;

(b) that the suggested values and principles for the Health and Wellbeing Board's work set out in paragraph 4.5 of the second report be agreed and this Board commits to adopting these in all work.

BETTER CARE FUND (BCF) UPDATE

The following report was submitted:-

(See document No. 9)

Margaret Ashton-Gray, Head of City Finance, People Directorate, BCC introduced and expanded on the information contained in the report.

Alan Lotinga, Service Director, Health and Wellbeing, People Directorate, BCC offered to forward to all members of the Board a summary of the current governance and project support in the Better Care programme.

125 **RESOLVED:-**

That the following be noted:-

(a) Cabinet approval has been given for Birmingham City Council to act as host for the BCF pooled budget under the provision of Section 75(2) of the National Health Service Act 2006 and that agreement has been given for the detailed work to be completed by delegated officers regarding the Section 75 agreement and the pooled budget arrangements - the delegated officers are Peter Hay, Strategic Director, People Directorate; Alan Lotinga as Service Director, Health and Wellbeing; Louise Collett, Service Director, Commissioning; and Margaret Ashton-Gray, Head of Finance as Pooled Budget Manager;

(b) the delegated authority for the Strategic Director for People in consultation with the Director of Legal and Democratic Services and the delegations to the Accountable Officers from each of the Clinical Commissioning Groups to continue to negotiate, execute and complete all necessary documents to give effect to the BCF and pooled budget arrangements;

(c) that further updates will be submitted for Board consideration in November 2015 and March 2016.

MINUTES

126 The Minutes of the Board meeting held on 24 March 2015 were confirmed and signed by the Chair.

Dr Adrian Phillips reported that further to resolution No 108(c), the Birmingham South Central Clinical Commissioning Group was helping to progress the infant mortality audit work. He also informed members that they were likely to see deterioration in respect of the 2014 figures highlighting that these related to when deaths were signed-off, not when they happened.

The meeting ended at 1646 hours.

……..…….
CHAIRPERSON