

# **BIRMINGHAM CITY COUNCIL**

## **HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE**

**TUESDAY, 15 OCTOBER 2019 AT 10:00 HOURS**  
**IN COMMITTEE ROOM 6, COUNCIL HOUSE, VICTORIA SQUARE,**  
**BIRMINGHAM, B1 1BB**

### **A G E N D A**

#### **1 NOTICE OF RECORDING/WEBCAST**

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

#### **2 DECLARATIONS OF INTERESTS**

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

#### **3 APOLOGIES**

To receive any apologies.

**3 - 8**

#### **4 ACTION NOTES/ISSUES ARISING**

To confirm the action notes of the meeting held on 17th September 2019.

**9 - 64**

#### **5 BIRMINGHAM DEMENTIA STRATEGY REFRESH**

Zoeta Manning, Senior Integration Manager - Frailty, Birmingham and Solihull CCG and Dr Majid Ali, Clinical Lead Community Services Transformation, Birmingham and Solihull CCG.

**65 - 84**

#### **6 PUBLIC HEALTH GREEN PAPER - CONSULTATION RESPONSE**

Elizabeth Griffiths, Acting Assistant Director of Public Health.

**85 - 152**

7 **BIRMINGHAM SUICIDE PREVENTION STRATEGY**

Elizabeth Griffiths, Acting Assistant Director of Public Health.

**153 - 178**

8 **FUTURE COMMISSIONING OF URGENT TREATMENT CENTRES IN SANDWELL AND WEST BIRMINGHAM**

Hannah Ship, Commissioning Manager, Sandwell & West Birmingham CCG; Dr Sommiya Aslam, Clinical Lead - Urgent Care, SWB CCG; Debra Howls, Senior Commissioning Manager, SWB CCG and Jayne Salter-Scott, Head of Engagement and Communications, SWB CCG.

**179 - 188**

9 **WORK PROGRAMME - OCTOBER 2019**

For discussion.

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

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

11 **OTHER URGENT BUSINESS**

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

12 **AUTHORITY TO CHAIRMAN AND OFFICERS**

Chairman to move:-

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

## BIRMINGHAM CITY COUNCIL

### HEALTH AND SOCIAL CARE O&S COMMITTEE

**1000 hours on 17<sup>th</sup> September 2019, Committee Room 6 – Actions**

**Present:**

Councillor Rob Pocock (Chair), Peter Fowler and Ziaul Islam.

**Also Present:**

Alex Borg, Director of Mental Health Services, Birmingham Women and Children's NHS Foundation Trust

Dr Angela Brady, Clinical Director for Mental Health, BSol CCG

Joanne Carney, Director of Joint Commissioning, BSol CCG

Dr Anupam Dharma, Medical Director, FTB, Birmingham Women and Children's NHS FT

Maria Gavin, Assistant Director, Quality and Improvement, Adult Social Care

Councillor Paulette Hamilton, Cabinet Member for Health and Social Care

Rose Kiely, Overview & Scrutiny Manager, Scrutiny Office

Elaine Kirwan, Deputy Chief Nurse, Mental Health Services, Forward Thinking Birmingham

#### **1. NOTICE OF RECORDING**

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

#### **2. DECLARATIONS OF INTEREST**

None.

#### **3. APOLOGIES**

Councillors Mick Brown, Diane Donaldson, Zaheer Khan and Paul Tilsley.

#### **4. ACTION NOTES/ISSUES ARISING**

The action notes of the meeting held on 13<sup>th</sup> August 2019 were agreed.

The following issues were noted:-

- It was noted that the response from the Cabinet Member for Education, Skills and Culture to the query raised during the 16<sup>th</sup> July evidence gathering as part of the Period Poverty Review, regarding how educational programmes in schools teach children about the menstrual cycle, had still not been received and a response was again requested to be provided by the Cabinet Member as soon as possible.
- In relation to the Adult Social Care Performance Monitoring Scorecard, the further clarification requested on some areas of performance was circulated to members on 15<sup>th</sup> August.
- No further information has been received in response to the further information requested on how many users of the in-house enablement service also have a medical condition and are also being supported by the health service.
- The figure on the current cost per hour for the Enablement Service has been provided and circulated to members but further clarification is being sought.
- The further in-depth work on the experience/potential learning from other local authorities and NHS providers around enablement will be coming to the 29<sup>th</sup> October meeting.
- It was noted that the Scrutiny Office is currently liaising regarding arrangements for a visit to the Community Early Intervention Prototype, dates to be confirmed.
- An update on the BCC Preventive Programme Pilot will be provided by John Williams the new Assistant Director at the 29<sup>th</sup> October meeting and the CCG have also been invited to attend.

## **5. REPORT OF THE CABINET MEMBER FOR HEALTH AND SOCIAL CARE**

Councillor Paulette Hamilton (Cabinet Member for Health and Social Care) presented a report which summarised the key portfolio priorities and provided an update on key areas of work undertaken since last reporting to the committee in November 2018.

The Cabinet Member emphasised the importance of ensuring that adult social care continues to move forward and the central role of partnership working and collaboration in bringing about the necessary shift towards more early intervention and prevention, community based services and place-based planning.

She highlighted the crucial role of the BSol STP in this and the significant developments around Primary Care Networks contributing towards the emergence of Integrated Care Systems.

In discussion, and in response to Members' questions, the following were among the main points raised:

- Public Health has information/data relating to health inequalities across the City which can be broken down to each Ward but each Ward can have

‘hotspots’ of inequality and therefore further work is being undertaken to ‘drill down’ to areas/individuals where there is more significant levels of need and target resources to meet that need.

- Work is being done to educate people about healthy eating in order to tackle the challenge of obesity which will be reported back to committee on a regular basis.
- Following the Day Opportunities Consultation officers will be preparing a Strategy which will be shared with the Cabinet Member in October and the committee will have an opportunity to see that before it goes to Cabinet in November.
- Budget 2018/19 underspend of £10.7m in adult social care has been achieved through modernisation of the service and staff working differently e.g. through Social Workers using the 3 conversations model. The underspend will not be brought forward to 2019/20 but will be used to ease pressures in other directorates.
- Members congratulated the Hall Green Adults Social Work Team for being awarded ‘Outstanding Innovator of the Year’ at the last Chamberlain Awards.
- The Cabinet Member clarified that she was not in support of West Birmingham remaining outside of the Birmingham STP and had contacted NHS England and NHS Improvement concerning this. Systems have been put in place to ensure that residents of West Birmingham, who sit outside the Birmingham and Solihull footprint, get an equal service of the same quality and this is being monitored.
- The Public Health budget has been under a lot of pressure. If central government continue to cut the Public Health budget it will remain under pressure.

**RESOLVED:**

- That the Director of Public Health, when he appears before committee next month, demonstrates the geographical spread on a local level of health inequalities across the City.

**6. FORWARD THINKING BIRMINGHAM**

Elaine Kirwan (Deputy Chief Nurse, Mental Health Services, Forward Thinking Birmingham); Alex Borg (Director of Mental Health Services, Birmingham Women and Children’s NHS Foundation Trust); Dr Angela Brady (Clinical Director of Mental Health, BSol CCG), Joanne Carney (Director of Joint Commissioning, BSol CCG) and Dr Anupam Dharma (Medical Director, Forward Thinking Birmingham) attended to give a presentation which highlighted some of the areas of improvement and actions arising out of the quality improvement since last reporting to committee.

In discussion, and in response to Members’ questions, the following were among the main points raised:

- Reassurance was given that young people that are placed out of area are monitored very closely. There are currently 5 young adults who are placed out of area in acute in-patient beds and try to repatriate those young people as close to home as soon as possible. Reasons for out of area placement include not having a bed locally or a speciality bed being required. In terms of trends, there has been a reduction in those beds. This has been achieved by trying to keep young people as close to home as possible and offer all means to avoid admission in the first place through the Crisis Resolution Treatment Team.
- The CCG commissioned Forward Thinking Birmingham because it covered the 0-25 age group therefore overcoming the gap when transitioning from CAMS to Adult Services.
- There is a lot of variability regarding the waiting list and it is difficult to give a median per se but young people are still waiting too long. There has been progress regarding the waiting list size. The focus has been on the right young people being added to the waiting list and then ensuring that those young people on the waiting list are seen as quickly as possible. Therefore, as a result the median waiting time has got higher because there are a lot more young people who have been waiting 0-1 weeks because they never make it to the waiting list because they access services elsewhere. 35% of young people wait over 18 weeks. The waiting time for an initial assessment has come down, in some areas, to 11 weeks.
- The use of text messaging appointment reminders has led to a reduced number of missed appointments i.e. Did Not Attend (DNA).

**RESOLVED:**

- To provide further data/statistical profiling showing the pattern of waiting times.
- To forward a copy of the CQC report when published.

## **7. ADULT SOCIAL CARE PERFORMANCE MONITORING**

Maria Gavin (Assistant Director, Quality and Improvement, Adult Social Care) presented the quarterly update on the performance of adult social care highlighting the 5 key indicators that are reported to HOSC in detail but also including performance monitoring of all key indicators.

In discussion, and in response to Members' questions, the following were among the main points raised:

- Members commended the ongoing work that is being undertaken to reduce Delayed Transfers of Care which had exceeded the end of year target but noting that the City Council was still in the bottom quartile when benchmarked against other local authorities.

**RESOLVED:**

- The report was noted.

## **8. PUBLIC HEALTH PERFORMANCE MONITORING**

The item was deferred because the data was not available as it had yet to be presented to Cabinet.

### **RESOLVED:**

- Discussion to take place with the Director of Public Health to ascertain how the committee can receive more timely performance data.

## **9. WORK PROGRAMME – SEPTEMBER 2019**

- The Budget Consultation to be added to the work programme in December.

The work programme was noted.

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

None.

## **11. OTHER URGENT BUSINESS**

### **RESOLVED:**

## **12. AUTHORITY TO CHAIRMAN AND OFFICERS**

### **RESOLVED:-**

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

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The meeting ended at 1149 hours.





## **BIRMINGHAM DEMENTIA STRATEGY REFRESH**

### **PROGRESS REPORT – 15<sup>TH</sup> OCTOBER 2019**

#### **FOR BIRMINGHAM HEALTH & SOCIAL CARE OVERVIEW & SCRUTINY COMMITTEE**

#### **1. BACKGROUND AND INTRODUCTION**

The Birmingham and Solihull Dementia Strategy 2014-17 'Give me something to believe in' was adopted by Birmingham City Council, Solihull Metropolitan Borough Council, Birmingham and Solihull CCGs and other partners in 2014. Its overarching purpose was to understand the experiences of people with dementia, to identify what was already in place, and what was required to improve the outcomes for people with dementia and their carers. The strategy was also used as a commissioning framework to support the development of robust pathways for people with dementia and their carers and supports person-centred, integrated care alongside a 'whole pathway' approach to good quality dementia care.

A Strategy Steering Group has been established to support the refresh document with representation from primary care, Birmingham City Council, mental health services, community services, learning disabilities, Alzheimer's Society, Age Concern, Dementia Information and Support for Carers, Crossroads Care, fire service, police service, Birmingham LGBT, Birmingham public health, hospice services and healthcare commissioners.

Stakeholder engagement events were held during July and August 2019 the findings of which will inform the strategy going forward.

In 2015 the Dementia commissioning moved into the Better Care Fund, a national programme where NHS and local government work collaboratively to improve the lives of the most vulnerable people in our society. This arrangement has helped to align and protect budgets for services and ensure a more integrated approach to pathway development for people with dementia and their families and carers.

Dementia now sits under the Ageing Well and Later Life work stream of the Birmingham and Solihull sustainability and transformation partnership (STP) and regular progress reports are provided.

There has been a great deal of progress since the first strategy, but also a recognition that more work is still to be done to further support those living with dementia and their families/carers.

It should be noted that Solihull Metropolitan Borough Council have developed their own refreshed dementia strategy.

## **2. PROGRESS TO DATE**

### **2.1 Pre-Diagnostic / Assessment Pathways**

#### **2.1.1 Learning Disability Health Check Scheme**

People with learning disabilities (LD), particularly those with Down's syndrome are at an increased risk of developing dementia at a younger age. An annual health check can improve people's health by spotting problems earlier.

All practices in the CCG have signed up to the learning disability health check incentive scheme, which includes a review of physical and mental health with referral through the usual practice routes if health problems are identified.

Annual Health Checks can identify undetected health conditions early, ensure the appropriateness of ongoing treatments and establish trust and continuity care. GPs and practice nurses have the much needed generalist skills to help people with LD get timely access to increasing complex health systems.

#### **2.1.2 Memory Assessment Service**

The Memory Assessment Service (MAS) provides assessment and diagnosis for users suspected of developing dementia, when all other causes have been ruled out, including physical, mental health and alcohol. Prior to April 2019, referrals into this service could only be made by GPs. As from 1<sup>st</sup> April 2019, referrals are now accepted from GPs, hospital consultants/nurse consultants, and community matrons/advance nurse practitioners. Although we have limited data, there is evidence that the diagnosis rates of dementia may be increasing across the healthcare economy, although undoubtedly continued effort will be required to achieve nationally aspired levels.

It is anticipated that more patients with suspected dementia will be identified and referred to the MAS, so that they can access the Dementia Navigator Service following diagnosis.

We have worked with our secondary care MAS to develop 'fast track pathways' for 'non-complex' diagnoses aimed at reducing the time from identification to diagnoses and we have increased capacity in MAS to support this.

### **2.2 Post-Diagnostic Pathways**

Birmingham and Solihull CCG has commissioned a Dementia Navigator Service and Dementia Cafes/Activity Groups for Birmingham jointly with Birmingham City Council under the Better Care Fund. It also aims to reduce the number of people who attend hospital who have reached crisis point by focussing on how to prevent the crisis in the first place. The services commenced on 1<sup>st</sup> October 2019.

The Dementia Navigator Service can be accessed following diagnosis at the Memory Assessment Service, and also has a social prescribing element. The person living with dementia and their family/carer will be allocated a dedicated dementia advisor. There is new evidence which shows that the provision of dementia advisors keeps people in the community and the estimates are for every £1 spent, £4 are saved.

The service will operate across the entire span of an individual's dementia journey and will work directly with carers, even when the person with dementia does not desire support or is no longer able to participate in support sessions. The service will provide early intervention / preventative support through:

- A single point of access for information and advice about dementia, information about what support is available pre and post-diagnosis, and how to access this support.
- Signposting to other support services available.
- Practical and low level emotional support to promote greater emotional resilience in service users by creating a sense of safety and an atmosphere of calm.
- Empowering healthier lifestyle choices in local communities (Making Every Contact Count).
- Practical coaching and support to people with dementia and their carers around best strategies and good practice to live well with the condition.
- Advise on and facilitate access to peer-led group support, e.g. dementia cafes and groups.

Solihull Metropolitan Borough Council have also commissioned a Dementia Navigator Service for Solihull which commenced on 1<sup>st</sup> April 2019, thereby creating a consistent service across Birmingham and Solihull STP.

## **2.3 Improving Access to Dementia Services to all Communities**

An independent service evaluation highlighted the need for the Birmingham and Solihull CCG to address its approach to working with Black, Asian and Minority Ethnic (BAME) communities. The evaluation of the dementia support service across Birmingham (March 2018) identified that some communities were not accessing these services, particularly those from BAME communities, and highlighted the fact that it is likely that dementia will be more common among Asian and Black Caribbean older people, because high blood pressure, diabetes, stroke and heart disease, which are risk factors for dementia, are more common in these communities. Some of the key issues in relation to BAME communities include an unfamiliarity with dementia; negative perceptions resulting from poorly translated terms; and stigma.

Another inequality identified related to those with learning disabilities, particularly those with Down's syndrome who are at an increased risk of developing dementia at a younger age. People with learning disabilities will need specific support to understand the changes they are experiencing and to access appropriate services after diagnosis and as dementia progresses.

The CCG is working to bridge these gaps and have subsequently revised the service specifications so that providers of dementia support services engage with these communities in a more proactive way and developed an incentivised quality initiative to improve access to the service to all communities. Other strategies include engaging with primary care networks that have a greater level of diversity.

## **2.4 Engagement Events**

There was a commitment to prioritising engagement with people living with dementia and their families/carers in the refresh of the Birmingham strategy.

Six events were held across Birmingham in July and August 2019 with patients, carers / family members and health and social care professionals. The events were designed to gather their views on how dementia services are provided and understand the performance of services at present.

During the events, participants had the opportunity to share their experiences and give feedback on the following areas:

- Diagnosis
- Access to services
- Ongoing support
- Respite for carers
- Advance care planning/End of life care.

A full copy of the report outlining the findings and recommendations from these events is attached as Appendix 1.

## 2.5 Dementia Education and Training

There is a commitment to provide extra education and training for GPs and practice nurses on the early identification and management of dementia. Early diagnosis is crucial not only to allow early planning for the future but also to allow dementia medication to be commenced at an earlier stage, and allow preservation of existing memory. GPs are the first point of contact for most people suspected with dementia, and so they need to be kept up-to-date with how this should be carried out is essential.

The next education session on 'The Identification of Dementia', is planned for November 2019 and will be delivered by the National Clinical Director for Dementia and Older People's Mental Health at NHS England and NHS Improvement.

## 2.6 Dementia Diagnosis Rate

Birmingham and Solihull CCG wants to achieve a dementia diagnosis rate of 77% by 2022/23. The national dementia target is for at least two thirds of people 65+ with dementia to be diagnosed (66.7%). The current CCG performance as at August 2019 was 67.50%. In order to achieve the CCG target of 77%, it is anticipated that the CCG will maintain a dementia diagnosis rate of 66.7% in 2019/20 and thereafter increase by 5% each year in 2020/21 and 2021/22.

The diagnosis rates for August 2019 are outlined below:

1. Nationally – **67.8%**
2. Regional level:
  - North of England – **North West 73.7% North East & Yorkshire 72.5%**
  - Midlands and East of England - **Midlands 68.7% East of England 66.2%**
  - London - **73.6%**
  - South West of England – **62.5%**
  - South East of England - **65.7%**
3. Birmingham and Solihull CCG - **67.5%**

As at the end of August 2019, the dementia diagnosis rate for Birmingham and Solihull CCG was as follows:

| Population aged 65+ as at April 2019 | Estimated prevalence (Aug 2019) | Target register (66.7%) | Latest diagnosis rate |
|--------------------------------------|---------------------------------|-------------------------|-----------------------|
| 191,777                              | 13,017                          | 8,682                   | 67.50%                |

This commitment to raise the dementia diagnosis rate to an ambitious target, is supported by a robust action plan which started to be implemented across practices in September 2019.

### **3. OTHER PROGRESS**

#### **3.1 Primary Care Networks**

Primary Care Networks are a key part of the NHS Long Term Plan where general practice has become organised into clusters of GP practices, serving a population of 30,000-50,000 patients. These networks are able to deliver a more resilient and responsive service provision compared to the former organisations and will have strong, effective clinical leadership, with each organisation headed by a Primary Care Network Clinical Director. These will allow system partners, including the CCG, to engage with primary care working at scale, and represents a fantastic opportunity to plan and implement health and social care improvements.

#### **3.2 Dementia Drug Prescribing**

Currently in Birmingham and Solihull, dementia drug prescribing is through our local Mental Health Trust. This causes issues for both patients and their carers, as all other medications for such patients will often be through their GP practice, with the exception of these drugs, hence leading to an additional burden upon patients and families to arrange prescription from two different providers. The underlying reasons for this historic arrangement is complex in nature, however, the CCG has been working with system partners for a considerable period of time, and is now very close to finalising agreement on the transfer of dementia drug prescribing to primary care.

#### **3.3 Dementia Advisors for Primary Care Networks**

Birmingham and Solihull CCG has agreed with the provider of the Dementia Navigator Service (Alzheimer's Society) to have a named dementia advisor for each primary care network. This will be notified to all 33 primary care networks across Birmingham and Solihull during October 2019.

#### **3.4 Integrated Dementia Care – Reducing Hospital Admissions and Length of Stay for People with Dementia Through STPs**

Birmingham and Solihull CCG is one of three national pilot sites to work on reducing avoidable hospital admissions; the other two sites are West Yorkshire and Harrogate STP; and North Central London STP. The CCG successfully bid for £183k for an Advance Care Planning Project Manager, and four additional qualified staff for Birmingham and Solihull Mental Health Trust to expand its enablement work in care homes during 2019/20.

- **Advance Care Planning Project Manager**

Commenced in April 2019 and has made good progress in understanding when advance care planning currently commences for people living with dementia and how it is included within training, e.g. safeguarding. There is an STP Advance Care Planning Working Group established to agree advance care planning documentation, which will include all conditions.

- **Enhancing Old Age Mental Health Teams**

Old Age Mental Health Teams are key in providing support to care homes not only for individual clinical advice around dementia and rapid response but also for general learning and support, yet their availability is scanty. Their effect in reducing hospital admissions has been clearly demonstrated but the cost is estimated to be half that of traditional care with a reduction of 50% in hospital admissions. The successful bid will enhance this service by recruiting four additional qualified staff in their community services to enhance admission avoidance work and support to other services.

#### 4. NEXT STEPS

The strategy is currently being refreshed for Birmingham to reflect progress to date and future planning.

The key priorities of the strategy refresh will be:

- Enabling access to a timely diagnosis and post-diagnostic support.
- Information and services that focus on early intervention and prevention.
- Preventing crises and supporting people with dementia within their communities.
- Improving the quality of care for people with dementia and ensuring services are person-centred, integrated across health and social care and fit for purpose.
- Improving advance care planning/end of life care.

A small group is being established to write up the strategy following feedback from the engagement events, and the Strategy Steering Group will be used as a Reference Group during its development. The timetable for this is as follows:

| Task   | Activity   | Oct | Nov | Dec | Jan | Feb | Mar | Apr |
|--|--|-----|-----|-----|-----|-----|-----|-----|
| Strategy Refresh Group   | Establish group to refresh strategy                  |     |     |     |     |     |     |     |
| Gather and Analyse Information   | Analysis of information gained                       |     |     |     |     |     |     |     |
| Formulate Strategy   | Formulate the strategy with Strategy Refresh Group   |     |     |     |     |     |     |     |
| Seek views from Reference Group  | Obtain comments on strategy from Reference Group     |     |     |     |     |     |     |     |
| Finalise strategy  | Finalise strategy following Reference Group comments |     |     |     |     |     |     |     |
| Governance Approval  | Obtain approval from Better Care Fund                |     |     |     |     |     |     |     |
| Update Birmingham Health and Social Care Overview and Scrutiny Committee | Provide update to Committee on strategy              |     |     |     |     |     |     |     |
| Implement Strategy   | Strategy communication and implementation            |     |     |     |     |     |     |     |
| Evaluate and Control   | Review of internal/external issues including targets |     |     |     |     |     |     |     |

The refreshed strategy will also consider the summary and recommendations from the Birmingham Local Dementia Profile (July 2019) produced by the Alzheimer's Society, and Why it's important to review the care of people with dementia (July 2019) produced by Healthwatch.

#### 5. APPENDICES

Appendix 1: Dementia Strategy Review Engagement Report

## **Dementia Strategy Review Engagement - DRAFT**

**Birmingham and Solihull Clinical Commissioning Group**

**Friday, 4 October 2019**

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# 1 Executive summary

## 1.1 Introduction

This report summarises the feedback from engagement events held across Birmingham to inform the development of Birmingham and Solihull CCG's dementia strategy for Birmingham.

### 1.1.1 Background

*This background information is taken from the engagement event presentation.*

The Birmingham and Solihull Dementia Strategy 2014-2017, 'Give me something to believe in', was adopted by Birmingham City Council, Solihull Metropolitan Borough Council, Birmingham and Solihull Clinical Commissioning Group (CCG) and other partners in 2014. Its overarching purpose was to understand the experiences of dementia patients, to identify what was already in place, and what was required to improve the outcomes for patients and their carers. The refreshed strategy will reflect progress to date and future planning requirements.

The key priorities of the strategy refresh will be:

- Enabling access to a timely diagnosis and post-diagnostic support.
- Information and services that focus on early intervention and prevention.
- Preventing crises and supporting people with dementia within their communities.
- Improving the quality of care for people with dementia and ensuring services are person-centred, integrated across health and social care and fit for purpose.

## 1.2 Communications and engagement methodology

Six events were held across Birmingham in July and August 2019 with patients, carers / family members and health and social care professionals. The events were designed to gather their views on how dementia services are provided and understand the performance of services at present.

During the events, participants had the opportunity to share their experiences and give feedback on the following areas:

- Diagnosis
- Access to services
- Ongoing support
- Respite for carers
- End of life care.

The events were structured with a presentation giving background to the strategy, followed by a discussion on each of the five areas.

To facilitate the discussions and ensure everybody had the opportunity to share their views, participants were split into smaller groups. Each group had a facilitator who moderated the discussions and ensured participants stayed on task. Facilitators captured the feedback shared in a facilitator feedback booklet, which followed the same structure as the discussions.

Event participants were also asked to complete a work pack containing demographic profiling questions and questions allowing each participant to rate their experience of each of the five areas:

diagnosis, access to services, ongoing support, respite for carers and end of life care. The findings from the participant work packs have also been presented in this report.

## 1.3 Participant profiling

Overall, there were 88 participants across the six events. 60 participants completed event workbooks, with a summary of the demographic profile of participants provided below:

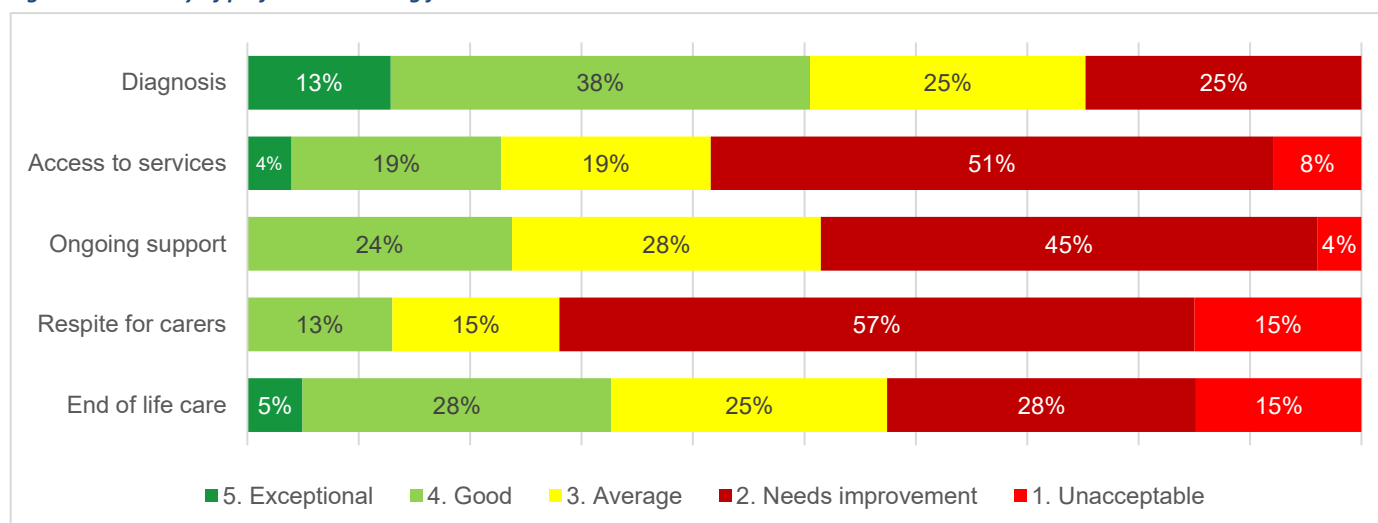
- **Age:** 37 (63%) were aged 65 or over
- **Ethnicity:** 53 (89%) were White British
- **Religion:** 44 (77%) were Christian
- **Sex:** 38 (68%) were female
- **Relationship status:** 40 (72%) were married
- **Health problem or disability:** 23 (43%) had a health problem or disability that limited day-to-day activities
- **Armed services:** 8 (14%) had served in the armed services.

For further information, see Table 2.

## 1.4 Findings

Figure 1 shows performance rating for each area, showing that participants' experiences varied.

Figure 1. Summary of performance rating for each area



Access to services and respite for carers were identified as key areas for improvement

### 1.4.1 Diagnosis

Participants had mixed experiences of the diagnosis process, with 28 (50%) participants rating it as 'exceptional' or 'good'. The experiences of patients suggest that dementia is difficult to diagnose, therefore it can take a long time, which can cause delays in patients accessing services. There was concern that some patients resist seeking a diagnosis for their symptoms, due to social stigma and lack of knowledge around dementia.

Participants identified the following key recommendations:

- Clearer referral pathways to services from GPs and other healthcare professionals

- Increased awareness and training around dementia and dementia services for GPs and other healthcare professionals
- More person-centred approach to diagnosis with assessments at home and less reliance on tests
- Prospective screening at optimal level of functioning for individuals with learning difficulties for future comparison of any changes in global functioning.
- Improved support and information for patients and their carers following diagnosis.

### 1.4.2 Access to services

Participants highlighted issues in accessing services, with provision and access to services varying across the city. Patients and carers commented they were being signposted to many different services, which was causing confusion over who they should contact.

Participants also emphasised a lack of awareness of services, with carers typically finding out information about services via word-of-mouth, increasing the importance of peer support networks like carers' cafes.

Participants identified the following key recommendations:

- A single helpline or point of access to services for clarity over where to access support.
- Increased awareness to support services available, such as dementia cafes, with an updated website of services, but also offline information for those without access to the internet.
- Access to practical support services for carers.
- Greater consistency in access to services and a lack of variation across the city.
- Greater access to dementia nurses for holistic care and continuity of care.
- Shorter waiting times and accessing services sooner.

### 1.4.3 Ongoing support

Participants had mixed experiences of ongoing support, with 12 (24%) of participants rating ongoing support as 'good', compared to 25 (49%) who rated it as 'needs improvement' or 'unacceptable'.

Although participants highlighted positive experiences of support services, such as dementia cafes and DISC, they also recognised support for carers, early intervention services, and access to support in a crisis, as lacking.

Participants identified the following key recommendations:

- Access to support in a crisis 24/7 without calling 999
- Access to early intervention services to prevent crises occurring
- More education and information available for carers – e.g. around practical aspects of dementia
- A greater focus on the health and wellbeing of carers
- Improved communication within services, to make it easier to contact services
- Communication led by health professionals rather than patients and carers; for example, health professionals regularly contacting to check how patients and carers are doing, rather than patients and carers having to contact when there is an issue.
- Increased integration between health and social care.

#### 1.4.4 Respite for carers

Participants highlighted respite for carers as an area in need of improvement. Many carers participating in the events commented that they had a lack of access to respite or had not received any. Financial arrangements around respite were also highlighted as an area of concern; for example, respite care being too expensive. A key consideration was that respite carer should be person-centred and consider the needs of the patient such as the level of dementia they have.

Although some patients and carers accessing respite services commented that the quality of care received was excellent and that the quality of paid carers should be considered in the strategy.

Participants identified the following key recommendations:

- Simplifying the process to access respite with clear guidelines for carers and healthcare professionals
- Improvements to the financial arrangements around respite with carer fees aligning with direct payments
- Improvements to booking respite with care being available at shorter notice and being confirmed earlier
- Increased access to short-term respite care in the home where patients may feel more at ease.

#### 1.4.5 End of life care

Participants recognised that end of life care is a difficult topic to discuss, which was reflected in the low level of response for this area in the events. It was, however, highlighted that it is important to have these discussions when patients have capacity, as well as for carers to make plans for themselves. The need for greater education and awareness around dementia more generally was also highlighted.

Participants identified the following key recommendations:

- Support and information around practical aspects such as Power of Attorney, wills and benefits
- Provision of a checklist or information pack for planning end of life care and arrangements to support patients and carers to make decisions when patients have capacity
- Greater use and awareness of ReSPECT forms.

## 2 Introduction

This report summarises the feedback from the six engagement events held across Birmingham to inform the development of Birmingham and Solihull CCG's dementia strategy for Birmingham. The events took place across July and August 2019.

### 2.1 Report authors

Birmingham and Solihull CCG commissioned NHS Midlands and Lancashire Commissioning Support Unit (MLCSU) Communications and Engagement Service to coordinate the independent analysis of the feedback from the engagement events to produce this report.

### 2.2 Report structure

This report is structured into the following sections:

- **Section 1:** Executive summary
- **Section 2:** Introduction
- **Section 3:** Communications and engagement methodology
- **Section 4:** Respondent profiling
- **Section 5:** Findings
- **Section 6:** List of participants' recommendations

### 2.3 Overview of engagement

Six events were held with patients, carers / family members and health and social care professionals to gather their views on how dementia services are provided and understand the performance of the following key areas:

- Diagnosis
- Access to services
- Ongoing support
- Respite for carers
- End of life care.

The events allowed participants to share their views and experiences and learn more about the revised strategy.

### 2.4 Background

The Birmingham and Solihull Dementia Strategy 2014-2017, '*Give me something to believe in*', was adopted by Birmingham City Council, Solihull Metropolitan Borough Council, Birmingham and Solihull Clinical Commissioning Group (CCG) and other partners in 2014. Its overarching purpose was to understand the experiences of dementia patients, to identify what was already in place, and what was required to improve the outcomes for patients and their carers. The refreshed strategy will reflect progress to date and future planning requirements.

This refreshed strategy is for Birmingham only as Solihull Metropolitan Borough Council developed their own refreshed strategy in 2017.



To support the development of the strategy a steering group has been created consisting of a range of stakeholders including; primary care, Birmingham City Council, mental health services, community services, BCHC Foundation Trust Learning Disability service, Alzheimer's Society, Age Concern, Dementia Information and Support for Carers (DISC), Crossroads Care, fire service, police service, Birmingham LGBT, Birmingham public health, hospice services and healthcare commissioners.

## 2.5 The new strategy

The key priorities of the strategy refresh will be:

- Enabling access to a timely diagnosis and post-diagnostic support.
- Information and services that focus on early intervention and prevention.
- Preventing crises and supporting people with dementia within their communities.
- Improving the quality of care for people with dementia and ensuring services are person-centred, integrated across health and social care and fit for purpose.

## 2.6 Next steps

A Dementia Strategy Update will also be provided to the Birmingham Health and Social Care Overview and Scrutiny Committee on 15th October 2019. Copies of this report will also be available for event participants in September 2019.

## 3 Communications and engagement methodology

### 3.1 Engagement events

Table 1 provides an overview of the events that were conducted across the city. Birmingham and Solihull CCG contacted Birmingham Dementia Strategy Steering Group members, community hospital trust and mental health trust to promote the events with their groups. The events were also promoted through GP surgeries and on social media.

*Table 1. Details of engagement events held*

| Date of event | Location | Audience | No. of groups | No. of participants |
|---------------|----------|----------|---------------|---------------------|
|               |          |          |               |                     |
|               |          |          |               |                     |
|               |          |          |               |                     |
|               |          |          |               |                     |
|               |          |          |               |                     |
|               |          |          |               |                     |
|               |          |          |               |                     |

During the events, participants had the opportunity to share their experiences and give feedback on the areas of diagnosis, access to services, ongoing support, respite for carers and end of life care.

To facilitate the discussions and ensure everybody had the opportunity to share their views, participants were split into smaller groups. Each group had a facilitator who moderated the discussions and ensured participants stayed on task. Facilitators also captured the insights that were shared in a facilitator feedback booklet, which followed the same structure as the discussions.

The feedback captured in these feedback booklets has been read and themed and presented in this report of findings. To ensure as much feedback as possible was used in the production of this report, where possible the events were recorded, and the recordings used to supplement the notes captured in the facilitator feedback booklets.

Event participants were also asked to complete a work pack containing demographic profiling questions and questions allowing each participant to rate their experience of each of the five areas: diagnosis, access to services, ongoing support, respite for carers and end of life care. The findings from the participant work packs have also been presented in this report.

# 4 Participant profiling

## 4.1 Participant types

Table 2 shows the different respondent types attending the events. 35 (61%) participants were the carer of a patient.

Table 2. Details of participant types at engagement events

| Respondent type | No. | % |
|-----------------|-----|---|
|                 |     |   |
|                 |     |   |
|                 |     |   |
|                 |     |   |
|                 |     |   |
|                 |     |   |

Table 2 is based on the 57 participants answering this question in the demographic profiling questionnaire. Overall, there were 88 participants across the events, meaning this question was not answered by 31 participants, as a result their respondent type has not been recorded. Some of those not completing the demographic profiling questionnaire could have been social care professionals.

## 4.2 Demographic profile

Table 3 summarises the demographic profile of event participants.

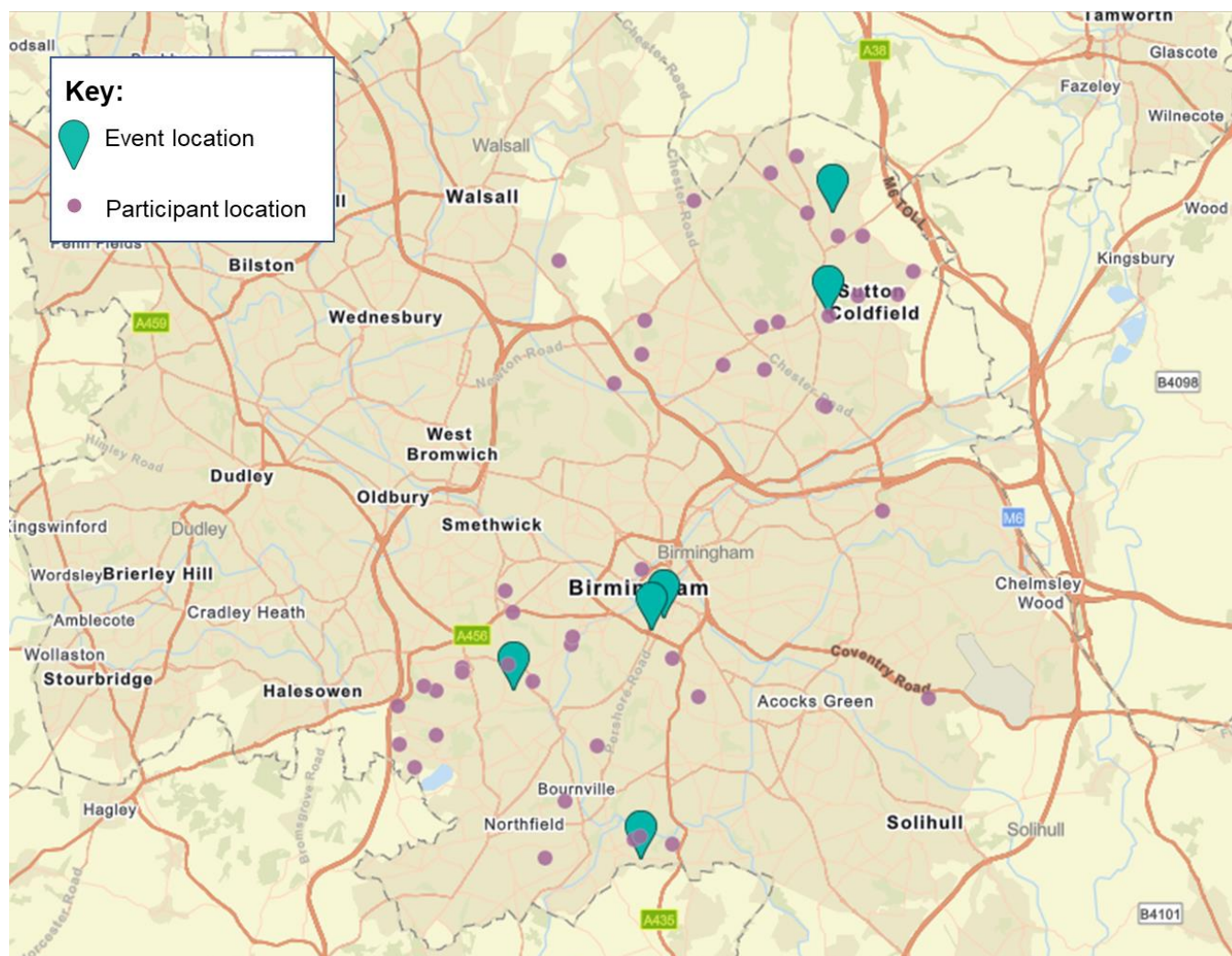
**Table 3. Demographic profile of event participants**

| Ethnicity                        |           |             | Sexual orientation  |           |             |
|----------------------------------|-----------|-------------|---|-----------|-------------|
| White: British                   | 53        | 89%         | Heterosexual  | 51        | 96%         |
| White: Irish                     | 1         | 2%          | Lesbian   | -         | -           |
| White: Gypsy or traveller        | -         | -           | Gay   | -         | -           |
| White: Other                     | -         | -           | Bisexual  | 1         | 2%          |
| Mixed: White and Black Caribbean | -         | -           | Other   | -         | -           |
| Mixed: White and Black African   | -         | -           | Prefer not to say   | 1         | 2%          |
| Mixed: White and Asian           | -         | -           | <b>Base</b>   | <b>53</b> | <b>100%</b> |
| Mixed: Other                     | 1         | 2%          | Relationship status   |           |             |
| Asian/Asian British: Indian      | 2         | 3%          | Married   | 40        | 72%         |
| Asian/Asian British: Pakistani   | 1         | 2%          | Civil partnership   | -         | -           |
| Asian/Asian British: Bangladeshi | -         | -           | Single  | 4         | 7%          |
| Asian/Asian British: Chinese     | -         | -           | Divorced  | 2         | 3%          |
| Asian/Asian British: Other       | -         | -           | Lives with partner  | 2         | 3%          |
| Black/Black British: African     | -         | -           | Separated   | 1         | 2%          |
| Black/Black British: Caribbean   | 1         | 2%          | Widowed   | 7         | 13%         |
| Black/Black British: Other       | -         | -           | Other   | -         | -           |
| Other ethnic group: Arab         | -         | -           | Prefer not to say   | -         | -           |
| Any other ethnic group           | -         | -           | <b>Base</b>   | <b>56</b> | <b>100%</b> |
| <b>Base</b>                      | <b>59</b> | <b>100%</b> | Pregnant currently  |           |             |
| Age category                     |           |             | Yes   | -         | -           |
| 16 - 19                          | -         | -           | No  | 54        | 100%        |
| 20 - 24                          | 1         | 2%          | Prefer not to say   | -         | -           |
| 25 - 29                          | 1         | 2%          | <b>Base</b>   | <b>54</b> | <b>100%</b> |
| 30 - 34                          | 1         | 2%          | Recently given birth  |           |             |
| 35 - 39                          | 2         | 3%          | Yes   | -         | -           |
| 40 - 44                          | 1         | 2%          | No  | 54        | 100%        |
| 45 - 49                          | 4         | 7%          | Prefer not to say   | -         | -           |
| 50 - 54                          | 3         | 5%          | <b>Base</b>   | <b>54</b> | <b>100%</b> |
| 55 - 59                          | 4         | 7%          | Health problem or disability  |           |             |
| 60 - 64                          | 4         | 7%          | Yes, limited a lot  | 12        | 23%         |
| 65 - 69                          | 6         | 10%         | Yes, limited a little   | 11        | 21%         |
| 70 - 74                          | 12        | 20%         | No  | 28        | 53%         |
| 75 - 79                          | 6         | 10%         | Prefer not to say   | 2         | 3%          |
| 80 and over                      | 13        | 22%         | <b>Base</b>   | <b>53</b> | <b>100%</b> |
| Prefer not to say                | 1         | 2%          | Disability  |           |             |
| <b>Base</b>                      | <b>59</b> | <b>100%</b> | Physical disability   | 11        | 32%         |
| Religion                         |           |             | Sensory disability  | 5         | 15%         |
| No religion                      | 9         | 16%         | Mental health need  | 5         | 15%         |
| Christian                        | 44        | 77%         | Learning disability or difficulty   | 1         | 3%          |
| Buddhist                         | -         | -           | Long-term illness   | 6         | 18%         |
| Hindu                            | -         | -           | Other   | 4         | 11%         |
| Jewish                           | -         | -           | Prefer not to say   | 2         | 6%          |
| Muslim                           | 3         | 5%          | <b>Base</b>   | <b>34</b> | <b>100%</b> |
| Sikh                             | -         | -           | Carer   |           |             |
| Any other religion               | 1         | 2%          | Yes - young person(s) aged under 24   | 1         | 2%          |
| Prefer not to say                | -         | -           | Yes - adult(s) aged 25 to 49  | 1         | 2%          |
| <b>Base</b>                      | <b>57</b> | <b>100%</b> | Yes - person(s) aged over 50 years  | 32        | 58%         |
| Sex                              |           |             | No  | 19        | 35%         |
| Male                             | 18        | 32%         | Prefer not to say   | 2         | 3%          |
| Female                           | 38        | 68%         | <b>Base</b>   | <b>55</b> | <b>100%</b> |
| Intersex                         | -         | -           | Gender identity   |           |             |
| Prefer not to say                | -         | -           | Yes*  | 1         | 2%          |
| Other                            | -         | -           | No  | 45        | 94%         |
| <b>Base</b>                      | <b>56</b> | <b>100%</b> | Prefer not to say   | 2         | 4%          |
| Armed services                   |           |             | <b>Base</b>   | <b>48</b> | <b>100%</b> |
| Yes                              | 8         | 14%         | *Have you gone through any part of a process or do you intend to (including thoughts and actions) to bring your physical sex appearance and/or your gender role more in line with your gender identity? (This could include changing your name, your appearance and the way you dress, taking hormones or having gender confirming surgery) |           |             |
| No                               | 48        | 86%         |   |           |             |
| Prefer not to say                | -         | -           |   |           |             |
| <b>Base</b>                      | <b>56</b> | <b>100%</b> |   |           |             |

### 4.3 Mapping of participants

Figure 2 shows the mapping of postcodes for participants, excluding health care professionals. 47 of these participants provided their postcode.

Figure 2. Mapping of respondents and event locations



Postcodes for patients, carers and family or friends have also been mapped according to their Indices of Multiple Deprivation. This is a measure of deprivation of neighbourhoods in England, where 1 represents the 10% most deprived and 10 represents the 10% least deprived areas. Table 4 shows the number of respondents within each deprivation decile.

Table 4. IMD decile of respondents

| IMD Decile | No. of respondents | %   |
|------------|--------------------|-----|
| 1          | 9                  | 20% |
| 2          | 3                  | 7%  |
| 3          | 5                  | 11% |
| 4          | 5                  | 11% |
| 5          | 5                  | 11% |
| 6          | 4                  | 9%  |
| 7          | 5                  | 11% |
| 8          | 3                  | 7%  |
| 9          | 3                  | 7%  |
| 10         | 3                  | 7%  |
| Base       | 45                 |     |

## 5 Findings

This section presents the feedback participants shared at the events on the following areas:

- Diagnosis
- Access to services
- Ongoing support
- Respite care
- End of life care

### 5.1 Reporting and analysis notes

At each of the events, table facilitators made notes on the feedback raised by participants. These notes were then read, with themes identified. These themes formed codes and a coding frame. All responses were read and themes coded against the coding frame. During the coding we have recorded the number of times the theme was mentioned across the six events and which respondent types they were raised by. Appendix A to E presents the results of the coding that was undertaken. The coded data was supplemented with recordings of the events to give further detail around the themes raised.

Event participants were also asked to complete a work pack which consisted of a demographic profiling questionnaire and questions allowing them to rate each of the five service areas and from their experience rate the performance of each of these. These ratings have been used to create the charts shown in the report. The charts show the rating overall and by respondent type. Some respondents provided a rating, but not a respondent type, therefore the total base for the two respondent types may not be the same as the base for all respondents. Percentages may not add up to 100% due to rounding.

Participants could also write comments in the work packs. These have been read and coded and included in the Appendices.

Throughout the findings section of the report we have grouped participants into two types:

- Patients and carers
- Health and social care professionals.

## 5.2 Diagnosis

Figure 3 shows how event participants rated their experience of the diagnosis process. Overall, 28 (50%) participants rated their experience of diagnosis as ‘exceptional’ or ‘good’, compared to 14 (25%) who rated it as ‘needs improvement’. No respondents rated this experience as ‘unacceptable’.

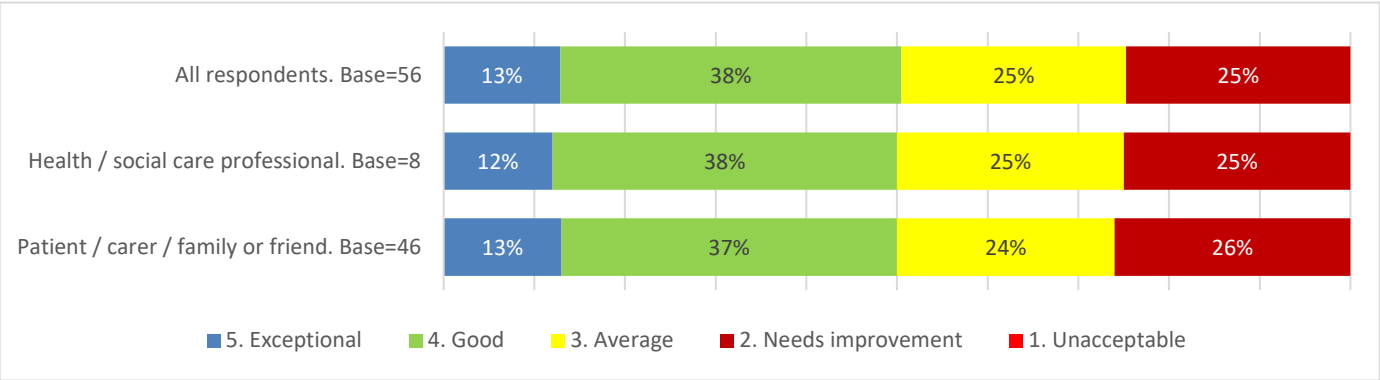


Figure 3. Diagnosis performance rating by respondent type

The following sections present the themes raised around the area of diagnosis during the group discussions. For a detailed breakdown of the themes please refer to Appendix A.

### 5.2.1 The referral processes

Participants highlighted lengthy referral waiting times and being referred to the correct services as areas for improvement. It was commented that GPs may not always identify dementia as the cause of patients’ symptoms, and consequently, may refer patients to the incorrect services.

A healthcare professional said dementia should be considered as the cause of symptoms earlier in the diagnostic process, rather than ruling out other conditions first. However, another healthcare professional highlighted the importance of treating potentially reversible causes which may be overlooked if dementia is considered first.

Both patients and carers and health and social care professionals said there needs to be clearer pathways between GPs and other healthcare professionals who are involved in the diagnosis process, and raising awareness of the available services may help, as it was stated that GPs may be unaware of which services are available that they can refer to.

### 5.2.2 Role of the GP and healthcare staff

Some patients and carers shared positive experiences of GPs supporting them in the diagnosis of dementia. However, others highlighted negative experiences, for example, GPs not asking appropriate questions during their assessments and therefore not being able to diagnose the condition appropriately.

It was commented by patients and carers that GPs should have increased awareness and better training in dementia. Additionally, both patients and carers and health and social care professionals stated the need for staff other than the GP to specialise in or have knowledge of dementia and its corresponding care requirements.

The need for more staff in the Memory Assessment Service was also emphasised by patients and carers.



### 5.2.3 Communication

Participants raised communication as an area for improvement. Carers of dementia patients said family members should also be able to raise concerns with a healthcare professional without the patient being present. This is because dementia is a sensitive subject and often patients will say they are 'fine' to appease the GP.

Both patients and carers and health and social care professionals commented that communications need to be tailored to each individual.

### 5.2.4 Diagnostic process

Participants highlighted the diagnosis process and the initial tests as an area for improvement. Participants reported that some patients resisted diagnostic tests, and other symptoms, behavioural changes and the effects of medication should be taken into consideration.

Participants commented that the diagnostic test is ineffective and does not identify whether patients have impaired memory capability. There was some polarisation between participants when discussing the questions GPs asked patients during the initial assessment. While some participants stated that questions were too difficult, others felt they were too easy. Those who felt the questions were too easy said patients were able to provide appropriate responses, which meant GPs were not referring them for additional tests leading to a delay in the diagnosis. Those stating the questions were too difficult said the questions were too hard, even for those not experiencing impaired memory.

Participants also commented that assessments taking place at home where the patient is most at ease would avoid the stress of travel.

A health and social care professional suggested that rather than relying on tests, a more person-centred approach is required utilising a variety of assessment methods, over a specific period to gain a longitudinal overview of a patient's behaviour.

The importance of completing physical health checks was raised and the difficulties with reasonable adjustments being made in primary care for individuals with learning difficulties to get relevant health checks specifically blood tests. Therefore, there is a need for Health Facilitation Nurses to strengthen those links between services.

Learning Disability Improvement Standards Compliance with NHSI standards is monitored to ensure Trusts respond to the needs of people with learning difficulties, their families and carers specifically making reasonable adjustments.

Some participants stated dementia diagnosis can take a long time, leading to delays in accessing treatment causing stress and tension for families. This delay in diagnosis also delays patients and carers access to support services. However, it was acknowledged by patients and carers and health and social care professionals that dementia is difficult to diagnose. One health and social care professional said that sometimes the illness needs to unfold before a diagnosis is possible.

*'Once you get the diagnosis, it just seems like everything falls into place.  
It's just the time it takes to get the diagnosis'*

**Carer, Event 5**



### 5.2.5 Existing conditions

Participants found that patients with multiple conditions often find that diagnosis takes longer because other conditions may affect their symptoms, making dementia harder to diagnose.

Participants also highlighted that dementia is difficult to diagnose in patients with learning difficulties due to changes in functioning often being associated with the learning disability rather than other causes and other comorbidities. Therefore, an increase in education about dementia and learning difficulties for carers and family are required to ensure early recognition. In addition, an MDT approach to diagnosis is needed to ensure a holistic assessment and support throughout a patient's journey of care. This links to the Learning Disability Mortality Review (LeDeR).

### 5.2.6 Seeking support from a healthcare professional

Participants reported a number of barriers to accessing support. Both patients and carers and health and social care professionals commented that there is a stigma around mental health and dementia, which can be a barrier to patients seeking support from healthcare professionals. For example, patients may avoid discussing symptoms with their GP because they are afraid of being labelled as having dementia, and how this could negatively impact people's perceptions of them.

Healthcare professionals identified the Dementia Friends initiative and the Dementia Engagement and Empowerment Project as helping to tackle the stigma and lack of education around dementia.

Patients and carers found that it can be difficult to recognise the cause of symptoms and there should be consideration for patients who do not have family to assist in identifying symptoms or to help care for them.

### 5.2.7 Support and information

Patients and carers commented that information and services available for other conditions is better than those available for dementia.

Patients and carers experienced different levels of information support following initial diagnosis: some were not provided with anything, while others felt they were given too much and almost bombarded. This lack of consistency in approach included signposting to services with some receiving little navigational support compared to others.

As a result, there is a need for clarity in the information patients and their carers are provided following diagnosis. The importance of accessible information about growing older and dementia for individuals with learning difficulties, their carers and family was also discussed, specifically regarding pre and post diagnostic counselling.

### 5.2.8 Summary and participants' recommendations

Participants had mixed experiences of the diagnosis process, with 28 (50%) participants rating it as 'exceptional' or 'good'. The experiences of patients suggest that dementia is difficult to diagnose, therefore it can take a long time, which can cause delays in patients accessing services. There was concern that some patients resist seeking a diagnosis for their symptoms, due to social stigma and lack of knowledge around dementia.

Participants identified the following key recommendations:

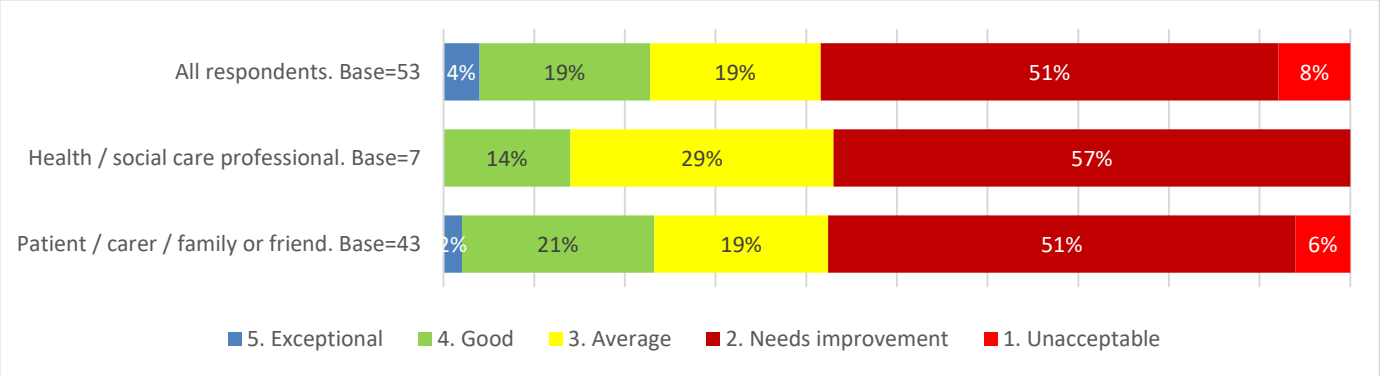
- Clearer referral pathways to services from GPs and other healthcare professionals

- Increased awareness and training around dementia and dementia services for GPs and other healthcare professionals
- More person-centred approach to diagnosis with assessments at home and less reliance on tests
- Prospective screening for patients with learning difficulties to provide a reliable baseline of premorbid functioning to compare any future changes in global functioning.
- Improved support and information for patients and their carers following diagnosis.

5.3 Access to services

Figure 4 shows how event participants rated their experience of access to services. Overall, 12 (23%) participants rated their experience of accessing services as ‘exceptional’ or ‘good’, compared to 31 (58%) who rated it as ‘needs improvement’ or ‘unacceptable’.

Figure 4. Access to services performance rating by respondent type



The following sections present the key themes raised around access to services during the group discussions. For a detailed breakdown of the themes please refer to Appendix B.

5.3.1 Signposting and navigating services

Participants highlighted service navigation as an area requiring improvement. Both patients and carers and health and social care professionals commented that patients and carers may be signposted to a variety of services, which can be confusing. As a solution, patients and carers suggested that more support is required to assist in navigating these services. This could be facilitated through a single point of contact, such as one telephone number, where carers can access the appropriate service.

*‘It’s great that there’s all these organisations, but when you’re given a list like that and there’s a problem, I’m thinking, ‘right, who do I phone?’ There’s not just one, central phoneline that can be diverted’*

**Carer, Event 6**

5.3.2 Accessing support for carers

Patients and carers discussed a lack of access to support following diagnosis, with some participants finding this to vary by area causing some to describe it as a ‘postcode lottery’. Patients and carers also suggested: dementia care should be integrated into other services; more resources are required for support in social care and that provision should be person centred as a one size fits all approach does not work for everyone.

The availability of support services for families and carers to help with the practical aspects of care, including; getting a driving license revoked, obtaining a Power of Attorney, registering for the carers allowance and dealing with challenging behaviour was also raised as a concern.

Patients and carers felt that carers need access to training and education, so they can provide suitable care for the patient. Additionally, health and social care professionals commented that NHS staff need training in dementia, such as occupational therapists.

However, as raised by a health and social care professional, consideration needs to be made for working carers, who cannot attend carers' cafes and access peer support.

Another health and social care professional commented there are limitations on which services patients can be referred to and there needs to be improved access to early intervention services.

*"Once diagnosis is made I think the carer should be provided with the details of all the help they can get, like the attendance allowance, or the tax relief plus where they can take their husbands for day care."*

**Carer, Event 6**

### 5.3.3 Accessing support services and assessments

Long waiting times for support and assessments was a reoccurring theme raised by patients and carers.

Patients and carers also commented the criteria to access services is too strict. Patients need to have access to services sooner and more regular assessments are needed.

*"It's practical help I want. When you're at your lowest, that's when you can't get the service. It's ludicrous. That's when they should be jumping in and giving you the help you need"*

**Carer, Event 5**

### 5.3.4 Services for patients with learning difficulties

Both patients and carers and health and social care professionals commented on the perceived limited availability of services such as dementia cafes and day centres tailored for individuals with a learning disability and dementia. This is because their needs are different; for example, they are likely to be younger than other dementia patients. Although there are Growing Older with Learning Disabilities and Dementia (GOLDD) day provision within BCC the provision is not equitable across Birmingham due to the closure of centres in the South of the city. Therefore, there is a need to ensure services make reasonable adjustments for individuals with a learning disability and environments are dementia friendly was also raised.

A carer of a patient highlighted the need for those caring for people with learning difficulties and dementia to access peer support groups which carers in mainstream services have access to. The accessibility of resources specifically for individuals with learning difficulties created by Growing Older with Learning Disabilities in Birmingham (GOLD) group was highlighted as a concern. However, health care professionals highlighted that resources were available from BCHC Learning Disability service and on the internet.

A health and social care professional said that there is a lack of funding to provide training in dementia and learning difficulties at day centres.

*'We've got a dementia café half a mile away from us and we've been invited and been a few times. They're absolutely lovely, there's no two ways about it, but they're for very, very old people and the things they do are for very old people. Not one single one is a person with learning disabilities, not one of them'*

### 5.3.5 Dementia nurses

Dementia nurses were highly regarded due to the excellent service they provide. However, participants said there is a need for improved awareness and access to Admiral Nurses / dementia nurses. One health and social care professional suggested that dementia care needs the same level of service provision as cancer services. Another added there should be more dementia nurses, so everyone with dementia has access to a dementia nurse for holistic care.

Improving the continuity of care was an issue raised by both patients and carers and health and social care professionals.

### 5.3.6 Awareness of services

Finding out about services was highlighted as an issue by participants. Patients and carers commented that they find out about services through peers or word-of-mouth. Consequently, peer support networks like carers' cafes and dementia cafes are important. During one of the events a carer said they found out about the Attendance Allowance through the Alzheimer's Society at a dementia café.

Health and social care professionals commented that an updated website of contacts and services is required. However, there is also a need for information that is available offline as some patients and carers do not have internet access.

*"You don't know what you don't know. There has to be some way to say in your area there is this, this, this and this."*

Social care professional, Event 4

### 5.3.7 Other themes raised around accessing services

Patients and carers highlighted the location of services as being an issue. It was commented that appointments and services can be too far from patients' homes, making it difficult to arrange transport and travel to them.

*"The memory clinic do tell you about places, but I don't drive and my husband can't drive anymore. The kind of places they were suggested I wouldn't get to. Here was convenient for me to come by bus."*

Carer, Event 6

Considerations were raised about the quality of care provided by paid carers.

Patients and carers highlighted effective care received from community nurses and GPs.

### 5.3.8 Summary and participants' recommendations

Participants highlighted issues in accessing services, with provision and access to services varying across the city. Patients and carers commented they were being signposted to many different services, which was causing confusion over who they should contact.

Participants also emphasised a lack of awareness of services, with carers typically finding out information about services via word-of-mouth, increasing the importance of peer support networks like carers' cafes.

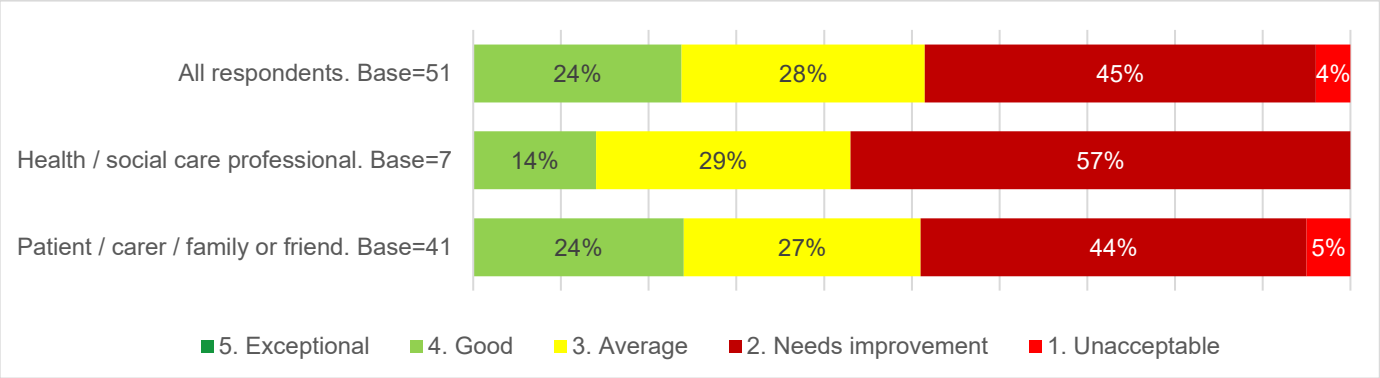
Participants identified the following key recommendations:

- A single helpline or point of access to services for clarity over where to access support.
- Increased awareness to support services available, such as dementia cafes, with an updated website of services, but also offline information for those without access to the internet.
- Access to practical support services for carers.
- Greater consistency in access to services and a lack of variation across the city.
- Greater access to dementia nurses for holistic care and continuity of care.
- Shorter waiting times and accessing services sooner.

## 5.4 Ongoing support

Figure 5 shows how event participants rated their experience of ongoing support. Overall, 12 (24%) of participants rated ongoing support as ‘good’, compared to 25 (49%) who rated it as ‘needs improvement’ or ‘unacceptable’.

Figure 5. Ongoing support performance rating by respondent type



The following sections present the key themes raised around the area of ongoing support during the group discussions. For a detailed breakdown of the themes please refer to Appendix C.

### 5.4.1 Crisis care

Participants found that services are designed for those in a crisis, rather than supporting early intervention to prevent crises, which would provide better care for patients and reduce costs.

Participants suggested that a single point of contact is required who can be called during a crisis, because currently carers are calling 999. Participants also state this care should be available 24 hours a day, seven days a week.

Both Patients and carers and health and social care professionals commented that it may take a crisis, such as an unplanned hospital admission, to access services.

*“What we find is that referrals are coming through far too late in a lot of respects where people are really at risk of breakdown and managing for themselves at home. Whereas I think there is a gap between when people are diagnosed and that cognitive rehab work in order to help people maintain their skills”*

**Healthcare professional, Event 4**

### 5.4.2 Support for carers

Participants said there is a lack of education and information available to support carers. Patients and carers found there is insufficient assistance and support for carers and a lack of awareness on what they are entitled to. The focus is on the patient, not the carers and there is a need to consider the emotional wellbeing and health of carers.

A carer at one of the events described being placed on a six-week course which gave them an overview of dementia and allowed them to meet other carers. However, in hindsight the carer stated the course needed to provide support around the practical aspects and skills required once the condition progresses, such as showering patients and getting them into and out of the bed.

Another theme raised by patients and carers was the lack of counselling services. Peer support was highlighted as important, as well as access to respite care and offline resources for carers who do not use the internet.

A discussion within the learning disability focus group covered the needs of older carers supporting their child who has a diagnosis of dementia. In contrast to mainstream services health care professionals working within this area work with many individuals with learning difficulties living with dementia who are supported by their parents. This is a different relationship dynamic where elderly parents are experiencing their own health conditions whilst caring for their child living with dementia.

*“They should be focussing on carers. Patients with dementia are following a pathway. The carers seem to wear out quicker than the people with dementia. There is no support for the carers and they ought to be looking at what they are doing for carers they are the people that are virtually carrying the system.”*

**Carer, Event 6**

### **5.4.3 Support services**

Patients and carers highlighted positive experiences of support services such as DISC (Dementia Information and Support for Carers) and dementia cafes and there is a need for greater funding for these voluntary groups. Other themes raised included the need for continuity of care and paid carers / dementia nurses to provide dementia care.

### **5.4.4 Communication**

Patients and carers stated they found it difficult to contact some services, such as social services and district nurses. Carers highlighted the district nurse service needs better communication and co-ordination to fit around patients' needs.

It was also commented that contact should be led more by health professionals rather than patients and carers. For instance, healthcare professionals should regularly contact patients and carers to check on their wellbeing and provide advice on support, rather than patients and carers having to call them when there is a problem and they are too busy living with the condition.

### **5.4.5 Integrating services**

Participants commented there needs to be greater integration between health and social care. Health and social care professionals commented there needs to be increased access to dementia services from learning disability services.

### **5.4.6 Other themes raised around ongoing support**

Patients and carers commented they need to have ongoing access to Admiral Nurses, as they provide excellent support; health and social care staff need to have more training in dementia; the financial aspect of care needs to be considered and the requirement for personalised care and support needs to be provided that considers the different types and stages of dementia.



### 5.4.7 Summary and participants' recommendations

Participants had mixed experiences of ongoing support, with 12 (24%) of participants rating ongoing support as 'good', compared to 25 (49%) who rated it as 'needs improvement' or 'unacceptable'.

Although participants highlighted positive experiences of support services, such as dementia cafes and DISC, they also recognised support for carers, early intervention services, and access to support in a crisis, as lacking.

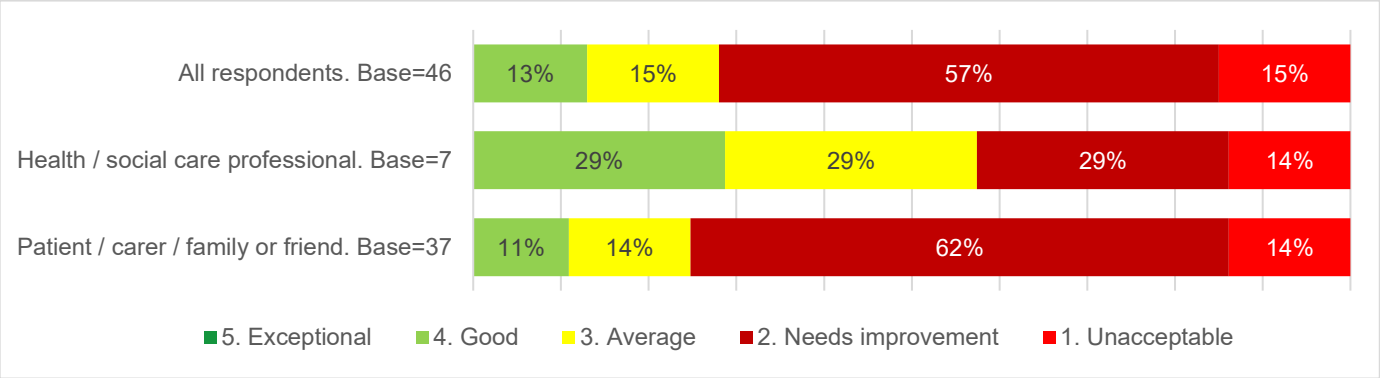
Participants identified the following key recommendations:

- Access to support in a crisis 24/7 without calling 999
- Access to early intervention services to prevent crises occurring
- More education and information available for carers – e.g. around practical aspects of dementia
- A greater focus on the health and wellbeing of carers
- Improved communication within services, to make it easier to contact services
- Communication led by health professionals rather than patients and carers; for example, health professionals regularly contacting to check how patients and carers are doing, rather than patients and carers having to contact when there is an issue
- Increased integration between health and social care.

5.5 Respite for carers

Figure 6 shows how event participants rated their experience of respite for carers. Overall, 6 (13%) participants rated respite for carers as good, compared to 33 (72%) who rated it as ‘needs improvement’ or ‘unacceptable’.

Figure 6. Respite for carers performance rating by respondent type



The following sections present the key themes raised around respite for carers during the group discussions. For a detailed breakdown of the themes please refer to Appendix D.

5.5.1 Financial support

Concerns about financial support were discussed by participants. Specific concerns raised included, respite care being too expensive, and direct payments not always aligning with care fees. This makes accessing respite more difficult.

Patients and carers said that accessing financial support payments is complicated and needs to be to be simplified. Some patients and carers argued that it is unfair that they are self-funding their care.

5.5.2 Access to respite

Accessing respite was an area of concern for participants. Participants commented that the process to access respite care is complicated and requires simplification, although it is considered easier to access in times of crisis. Many carers participating in the events noted difficulty in accessing respite or had not been offered any.

Concerns raised by carers included limited access to short-term respite care and qualified carers to provide this service. Carers would like better access to respite care at home, because many patients do not want to go to a care home and are more at ease when cared for in their own home. The need for access to live-in carers was also highlighted for this reason.

Patient and carers identified problems booking respite. A carer commented that respite care not being confirmed until a week before it was required, making planning difficult. The requirement for respite care to be available seven days a week, including over holiday periods was highlighted.

Health and social care professionals commented that care must be booked too far in advance. It was also highlighted that criteria to access respite depends on care packages. A social care professional commented that there are no clear guidelines on accessing respite, which means patients may be referred to multiple professionals, who feel that they cannot help. It was also

commented that there is a lack of choice in respite care, apart from residential institutions, which may be unsuitable for younger people with dementia.

### 5.5.3 Patient needs and wellbeing

Participants commented the level of dementia a patient has should be considered when offering these services. Patients and carers commented patients may not want to go into care homes and become confused or distressed in respite care. They also commented respite care should be patient centred.

### 5.5.4 Other themes

Some patients and carers accessing respite services commented that the quality of care received was excellent and that the quality of paid carers should be considered in the strategy. They further commented that a review system is needed for care homes; the emotional impact on carers should be considered, as carers may feel guilty about respite care, and day hospice services should be utilised, as they allow those with various conditions to come together.

### 5.5.5 Summary and participants' recommendations

Participants highlighted respite for carers as an area in need of improvement. Many carers participating in the events commented that they had a lack of access to respite or had not received any. Financial arrangements around respite were also highlighted as an area of concern; for example, respite care being too expensive. A key consideration was that respite carer should be person-centred and consider the needs of the patient such as the level of dementia they have.

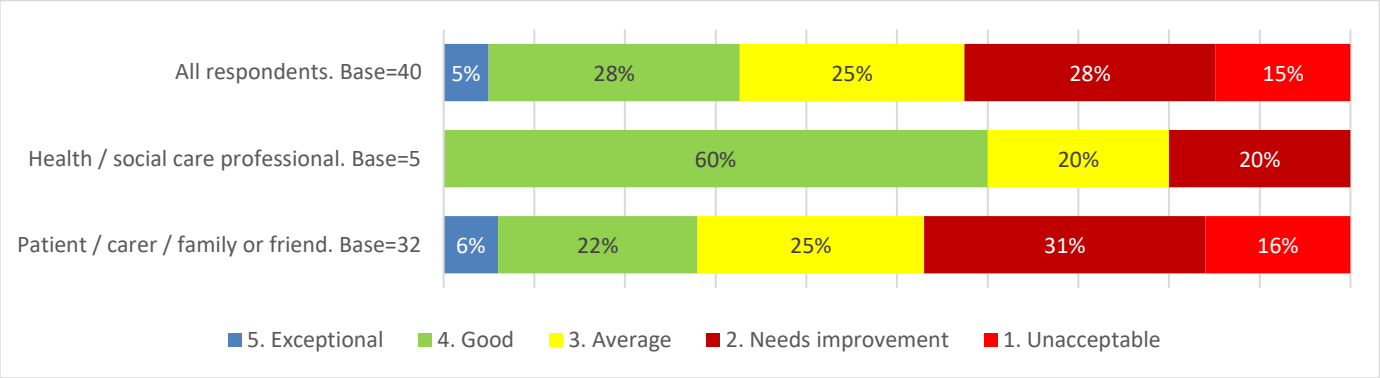
Participants identified the following key recommendations:

- Simplifying the process to access respite with clear guidelines for carers and healthcare professionals
- Improvements to the financial arrangements around respite with carer fees aligning with direct payments
- Improvements to booking respite with care being available at shorter notice and being confirmed earlier
- Increased access to short-term respite care in the home where patients may feel more at ease.

## 5.6 End of life care

Figure 7 shows how event participants rated their experiences of end of life care. Overall, 13 (33%) participants rated end of life and advance planning as exceptional or good, compared to 17 (43%) who rated it as ‘needs improvement’ or ‘unacceptable’.

Figure 7. Planning in advance performance rating by respondent type



The following sections present the key themes raised around the area of end of life care during the group discussions. For a detailed breakdown of the themes please refer to Appendix E.

### 5.6.1 Approaching the topic

Participants observed that end of life care is a difficult topic to talk about and individual wishes need to be respected if people do not wish to talk about it.

Some patients and carers said that end of life care needs to be addressed within the family.

### 5.6.2 Carers’ future planning

A key theme raised by respondents was the need for carers to make future arrangements as well as the patient; for example, if a carer dies before the patient.

### 5.6.3 Patient capacity

Patients and carers commented that decisions should be made when patients have capacity to be involved in these discussions, with some patients and carers saying that staff should make the decision if patients lack capacity.

### 5.6.4 Practical support

Patients and carers reported that more support, guidance and information is required around the financial implications and practicalities around elements such as Power of Attorney, wills and benefits. Patient and carers commented that they had made plans without support.

It was also commented that practical support is available from the Alzheimer’s Society.

Participants commented a checklist or information pack is needed for planning end of life care and arrangements. The ‘Planning for the Future’ booklet was highlighted as offering useful support.

### 5.6.5 Dementia in society

Participants commented dementia should be classed as a disease and there is a need for wider public awareness and education around dementia.

### 5.6.6 Other themes

Other themes raised by patients around end of life care include; patients may not want to go to hospices due to culture or religion, as hospices may be perceived to be Christian and ReSPECT forms need to be used, but there is a lack of awareness around them which needs to be changed. It was also highlighted that it is important for care homes to be aware of patients' wishes.

### 5.6.7 Summary and participants' recommendations

Participants recognised that end of life care is a difficult topic to discuss, which was reflected in the low level of response for this area in the events. It was, however, highlighted that it is important to have these discussions when patients have capacity, as well as for carers to make plans for themselves. The need for greater education and awareness around dementia more generally was also highlighted.

Participants identified the following key recommendations:

- Support and information around practical aspects such as Power of Attorney, wills and benefits
- Provision of a checklist or information pack for planning end of life care and arrangements to support patients and carers to make decisions when patients have capacity
- Greater use and awareness of ReSPECT forms.

## 6 List of participants' recommendations

### Diagnosis:

- Clearer referral pathways to services from GPs and other healthcare professionals
- Increased awareness and training around dementia and dementia services among GPs and other healthcare professionals
- More person-centred approach to diagnosis with assessments at home and less reliance on tests
- Prospective screening for patients with learning difficulties to provide a reliable baseline of premorbid functioning to compare any future changes in global functioning.
- Clearer support and information for patients and their carers following diagnosis.

### Access to services

- A single helpline or point of access to services for clarity over where to access support.
- Increased awareness of support services available, such as dementia cafes, with an updated website of services, but also offline information for those without access to the internet.
- Access to practical support services for carers.
- Greater consistency in access to services and a lack of variation across the city.
- Greater access to dementia nurses for holistic care and continuity of care.
- Shorter waiting times and accessing services sooner.

### Ongoing support

- Access to support in a crisis 24/7 without calling 999
- Access to early intervention services to prevent crises occurring
- More education and information available for carers – e.g. around practical aspects of dementia
- A greater focus on the health and wellbeing of carers
- Improved communication within services, to make it easier to contact services
- Communication led by health professionals rather than patients and carers; for example, health professionals regularly contacting to check how patients and carers are doing, rather than patients and carers having to contact when there is an issue.
- Increased integration between health and social care.

### Respite for carers

- Simplifying the process to access respite with clear guidelines for carers and healthcare professionals
- Improvements to the financial arrangements around respite with carer fees aligning with direct payments
- Improvements to booking respite with care being available at shorter notice and being confirmed earlier
- Increased access to short-term respite care in the home where patients may feel more at ease.

### End of life care:

- Support and information around practical aspects such as Power of Attorney, wills and benefits
- Provision of a checklist or information pack for planning end of life care and arrangements to support patients and carers to make decisions when patients have capacity
- Greater use and awareness of ReSPECT forms.

## 7 Appendices

### Appendix A: Diagnosis

#### Themes raised by event

|  | Total mentions | Total tables mentioning themes |         |         |         |         |
|--|----------------|--------------------------------|---------|---------|---------|---------|
|  |                | Event 1                        | Event 3 | Event 4 | Event 5 | Event 6 |
| Diagnosis takes a long time  | 7              | 1                              | 1       | 1       | 1       | 3       |
| GP supported the diagnosis of dementia   | 4              | 2                              | -       | 1       | -       | 1       |
| Communication / support needs to be tailored to each individual                        | 4              | 2                              | -       | 2       | -       | -       |
| Medication may alter symptoms / cause confusion  | 3              | -                              | 1       | -       | -       | 2       |
| No support provided following diagnosis  | 3              | 1                              | -       | 1       | -       | 1       |
| Diagnostic test asks the wrong questions / is ineffective                              | 3              | 1                              | 1       | 1       | -       | -       |
| Need more awareness of dementia cafes  | 2              | -                              | -       | -       | -       | 2       |
| Assessments should take place at home  | 2              | -                              | 1       | 1       | -       | -       |
| GP may not ask the right questions   | 2              | 1                              | 1       | -       | -       | -       |
| GP could not diagnose the problem  | 2              | -                              | -       | 2       | -       | -       |
| Consider the stigma around mental health and dementia (e.g. in different cultures)     | 2              | -                              | -       | 2       | -       | -       |
| Lack of support / information for families and carers at diagnosis                     | 2              | 1                              | -       | -       | -       | 1       |
| Families need to be able to speak to healthcare professional without patient present   | 2              | 2                              | -       | -       | -       | -       |
| Patients with other conditions may have issues with diagnosis                          | 2              | 1                              | -       | -       | 1       | -       |
| Need GPs to be more aware / specialised in dementia (e.g. Specialist in each practice) | 2              | -                              | -       | 2       | -       | -       |
| Difficult to recognise the issue   | 1              | -                              | 1       | -       | -       | -       |
| Signposted to lots of services following diagnosis                                     | 1              | -                              | -       | -       | -       | 1       |
| Difficult to navigate services and support   | 1              | -                              | -       | -       | -       | 1       |
| Need to consider symptoms over a period of time  | 1              | -                              | 1       | -       | -       | -       |
| Consider patients without family to care for them / identify symptoms                  | 1              | -                              | -       | 1       | -       | -       |
| Need access to dementia nurses   | 1              | -                              | -       | -       | 1       | -       |
| Long waiting times for referrals   | 1              | 1                              | -       | -       | -       | -       |
| Diagnosis was quick  | 1              | -                              | -       | -       | -       | 1       |
| Lack of staff in Memory Assessment Service   | 1              | 1                              | -       | -       | -       | -       |
| Staff other than GPs in surgery should specialise in dementia care                     | 1              | -                              | 1       | -       | -       | -       |
| Need to be referred to the correct service   | 1              | 1                              | -       | -       | -       | -       |
| Too much information provided at diagnosis   | 1              | 1                              | -       | -       | -       | -       |
| Consider learning from other areas (e.g. Devon)  | 1              | -                              | -       | 1       | -       | -       |
| Need updated website of contacts and services  | 1              | -                              | -       | 1       | -       | -       |
| Difficult to diagnose in patients with learning difficulties                           | 1              | -                              | -       | -       | 1       | -       |
| Need a baseline for learning difficulty patients                                       | 1              | -                              | -       | -       | 1       | -       |
| Need support for learning disability patients  | 1              | -                              | -       | -       | 1       | -       |
| Need to consider that patients will resist diagnostic tests                            | 1              | 1                              | -       | -       | -       | -       |
| Need to considerer dementia earlier in the diagnostic process                          | 1              | -                              | -       | -       | 1       | -       |
| Need to consider all symptoms, not just memory and tests                               | 1              | 1                              | -       | -       | -       | -       |
| Base (total number of groups/tables at each event)                                     |                | 3                              | 1       | 2       | 1       | 3       |

The figures represent the number of groups/tables mentioning the theme in the events. For example, 2 means the theme was mentioned by 2 of the groups/ tables during the event. Event 2 is not shown in the table because no participants attended.



## Themes raised by respondent type

|  | Total mentions | Themes raised by Patients and carers/ family members |         |         |         |         | Themes raised by health and social care professionals |         |         |         |         | Themes raised by both sets of respondent types on the same table |         |         |         |         |
|--|----------------|--|---------|---------|---------|---------|---|---------|---------|---------|---------|--|---------|---------|---------|---------|
|  |                | Event 1  | Event 3 | Event 4 | Event 5 | Event 6 | Event 1   | Event 3 | Event 4 | Event 5 | Event 6 | Event 1  | Event 3 | Event 4 | Event 5 | Event 6 |
| Diagnosis takes a long time  | 7              | 1  | 1       | 1       | 1       | 3       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| GP supported the diagnosis of dementia   | 4              | 2  | -       | 1       | -       | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Communication / support needs to be tailored to each individual                        | 4              | 2  | -       | 1       | -       | -       | -   | -       | -       | -       | -       | -  | -       | 1       | -       | -       |
| Medication may alter symptoms / cause confusion  | 3              | -  | 1       | -       | -       | 2       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| No support provided following diagnosis  | 3              | 1  | -       | 1       | -       | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Diagnostic test asks the wrong questions / is ineffective                              | 3              | 1  | -       | 1       | -       | -       | -   | -       | -       | -       | -       | -  | 1       | -       | -       | -       |
| Need more awareness of dementia cafes  | 2              | -  | -       | -       | -       | 2       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Assessments should take place at home  | 2              | -  | -       | 1       | -       | -       | -   | -       | -       | -       | -       | -  | 1       | -       | -       | -       |
| GP may not ask the right questions   | 2              | 1  | 1       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| GP could not diagnose the problem  | 2              | -  | -       | 2       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Consider the stigma around mental health and dementia (e.g. in different cultures)     | 2              | -  | -       | 1       | -       | -       | -   | -       | 1       | -       | -       | -  | -       | -       | -       | -       |
| Lack of support / information for families and carers at diagnosis                     | 2              | 1  | -       | -       | -       | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Families need to be able to speak to healthcare professional without patient present   | 2              | 2  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Patients with other conditions may have issues with diagnosis                          | 2              | 1  | -       | -       | 1       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need GPs to be more aware / specialised in dementia (e.g. Specialist in each practice) | 2              | -  | -       | 2       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Difficult to recognise the issue   | 1              | -  | 1       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Signposted to lots of services following diagnosis                                     | 1              | -  | -       | -       | -       | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Difficult to navigate services and support   | 1              | -  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | 1       |
| Need to consider symptoms over a period of time  | 1              | -  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | 1       | -       | -       | -       |
| Consider patients without family to care for them / identify symptoms                  | 1              | -  | -       | 1       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need access to dementia nurses   | 1              | -  | -       | -       | 1       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Long waiting times for referrals   | 1              | 1  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Diagnosis was quick  | 1              | -  | -       | -       | -       | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Lack of staff in Memory Assessment Service   | 1              | 1  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Staff other than GPs in surgery should specialise in dementia care                     | 1              | -  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | 1       | -       | -       | -       |
| Need to be referred to the correct service   | 1              | 1  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Too much information provided at diagnosis   | 1              | 1  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Consider learning from other areas (e.g. Devon)  | 1              | -  | -       | -       | -       | -       | -   | -       | 1       | -       | -       | -  | -       | -       | -       | -       |
| Need updated website of contacts and services  | 1              | -  | -       | -       | -       | -       | -   | -       | 1       | -       | -       | -  | -       | -       | -       | -       |
| Difficult to diagnose in patients with learning difficulties                           | 1              | -  | -       | -       | 1       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need a baseline for learning difficulty patients                                       | 1              | -  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | 1       | -       |
| Need support for learning disability patients  | 1              | -  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | 1       | -       |
| Need to consider that patients will resist diagnostic tests                            | 1              | 1  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need to consider dementia earlier in the diagnostic process                            | 1              | -  | -       | -       | 1       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need to consider all symptoms, not just memory and tests                               | 1              | 1  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| <i>Base (total number of groups/tables at each event)</i>                              | 1              | 3  | 1       | 2       | 1       |         | 3   | 1       | 2       | 1       |         | 3  | 1       | 2       | 1       |         |

The figures represent the number of groups/tables mentioning the theme in the events. For example, 2 means the theme was mentioned by 2 of the groups/tables during the event. Event 2 is not shown in the table because no participants attended.

## Themes raised in participant work packs

|   | Total     | Patients and carers/<br>family members | Health and social<br>care professionals |
|---|-----------|--|---|
| General comment regarding needing improvement                         | 1         | 1                                      | -                                       |
| GP supported the diagnosis of dementia                                | 1         | 1                                      | -                                       |
| Need a baseline for learning difficulty patients                      | 2         | -                                      | 2                                       |
| Long waiting times for referrals                                      | 1         | 1                                      | -                                       |
| Consider patients without family to care for them / identify symptoms | 1         | -                                      | 1                                       |
| Need support for learning disability patients                         | 1         | 1                                      | -                                       |
| Received good support following diagnosis                             | 1         | 1                                      | -                                       |
| More support to access health checks required                         | 1         | -                                      | 1                                       |
| Ensure that LD patients can access blood tests                        | 1         | -                                      | 1                                       |
| Signposted to assessment quickly                                      | 1         | 1                                      | -                                       |
| Lack of support / information for families and carers at diagnosis    | 1         | -                                      | 1                                       |
| Other   | 1         | -                                      | 1                                       |
| <i>Base</i>   | <i>11</i> | <i>6</i>                               | <i>5</i>                                |

## Appendix B: Access to services

### Themes raised by event

|  | Total mentions | Total tables mentioning themes |         |         |         |         |
|--|----------------|--------------------------------|---------|---------|---------|---------|
|  |                | Event 1                        | Event 3 | Event 4 | Event 5 | Event 6 |
| Signposting to lots of services / need to support with navigating services / single helpline | 6              | 2                              | 1       | 1       | -       | 2       |
| Waiting times are too long for support   | 4              | 3                              | 1       | -       | -       | -       |
| Lack of access to support following diagnosis  | 4              | -                              | -       | 1       | 1       | 2       |
| Lack of support for families and carers  | 4              | 2                              | -       | 1       | -       | 1       |
| Find out about services through peers / word of mouth  | 3              | -                              | -       | -       | -       | 3       |
| Need access to training and education for carers   | 2              | -                              | 1       | 1       | -       | -       |
| Need more awareness of Admiral Nurses  | 2              | -                              | 1       | -       | 1       | -       |
| Consider that one size does not fit all / need to be person-centred                          | 2              | -                              | -       | 1       | -       | 1       |
| Appointments / services too far from patient's home / transport difficult                    | 2              | 1                              | -       | -       | -       | 1       |
| Need support with practicalities e.g. Power of attorney, driving                             | 2              | 1                              | -       | -       | -       | 1       |
| Need access to support in a crisis (without calling 999)                                     | 2              | 1                              | 1       | -       | -       | -       |
| Consider quality of paid carers  | 2              | 1                              | -       | 1       | -       | -       |
| Accessibility is variable / hit and miss / postcode lottery                                  | 2              | -                              | -       | -       | -       | 2       |
| Need more up-to-date information about services  | 1              | -                              | -       | -       | -       | 1       |
| NHS staff need training in dementia (e.g. occupational therapists)                           | 1              | -                              | -       | 1       | -       | -       |
| Need access to early intervention services   | 1              | -                              | -       | 1       | -       | -       |
| Community nurses are effective   | 1              | 1                              | -       | -       | -       | -       |
| Limitations on services patients can be referred to  | 1              | -                              | 1       | -       | -       | -       |
| GPs are effective  | 1              | -                              | -       | -       | -       | -       |
| Need support with challenging behaviour  | 1              | 1                              | -       | -       | -       | -       |
| Dementia cafes provide excellent peer support  | 1              | -                              | -       | 1       | -       | -       |
| Need to integrate dementia into other services   | 1              | -                              | -       | 1       | -       | -       |
| Carers Allowance is not enough   | 1              | 1                              | -       | -       | -       | -       |
| Need time to accept diagnosis  | 1              | -                              | -       | 1       | -       | -       |
| Need access to day centres / dementia cafes for younger patients with learning difficulties  | 1              | -                              | -       | -       | 1       | -       |
| Need more resources for support in social care   | 1              | -                              | -       | -       | -       | 1       |
| Consider support for working carers (e.g. can't attend carers cafes)                         | 1              | -                              | -       | -       | -       | 1       |
| Need provision like in cancer services   | 1              | -                              | -       | -       | -       | 1       |
| <i>Base (total number of groups/tables at each event)</i>                                    |                | 3                              | 1       | 2       | 1       | 3       |

The figures represent the number of groups/tables mentioning the theme in the events. For example, 2 means the theme was mentioned by 2 of the groups/tables during the event. Event 2 is not shown in the table because no participants attended.

## Themes raised by respondent type

|  | Total mentions | Themes raised by Patients and carers/ family members |         |         |         |         | Themes raised by health and social care professionals |         |         |         |         | Themes raised by both sets of respondent types on the same table |         |         |         |         |
|--|----------------|--|---------|---------|---------|---------|---|---------|---------|---------|---------|--|---------|---------|---------|---------|
|  |                | Event 1  | Event 3 | Event 4 | Event 5 | Event 6 | Event 1   | Event 3 | Event 4 | Event 5 | Event 6 | Event 1  | Event 3 | Event 4 | Event 5 | Event 6 |
| Signposting to lots of services / need to support with navigating services / single helpline | 6              | 2  | -       | 1       | -       | 2       | -   | -       | -       | -       | -       | -  | 1       | -       | -       | -       |
| Waiting times are too long for support   | 4              | 3  | 1       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Lack of access to support following diagnosis  | 4              | -  | -       | 1       | 1       | 2       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Lack of support for families and carers  | 4              | 2  | -       | 1       |         | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Find out about services through peers / word of mouth  | 3              | -  | -       | -       | -       | 3       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need access to training and education for carers   | 2              | -  | 1       | -       | -       | -       | -   | -       | 1       | -       | -       | -  | -       | -       | -       | -       |
| Need more awareness of Admiral Nurses  | 2              | -  | -       | -       | 1       | -       | -   | -       | -       | -       | -       | -  | 1       | -       | -       | -       |
| Consider that one size does not fit all / need to be person-centred                          | 2              | -  | -       | -       | -       | 1       | -   | -       | -       | -       | -       | -  | -       | 1       | -       | -       |
| Appointments / services too far from patient's home / transport difficult                    | 2              | 1  | -       | -       | -       | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need support with practicalities e.g. Power of attorney, driving                             | 2              | 1  | -       | -       | -       | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need access to support in a crisis (without calling 999)                                     | 2              | 1  | 1       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Consider quality of paid carers  | 2              | 1  |         | 1       |         |         | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Accessibility is variable / hit and miss / postcode lottery                                  | 2              | -  | -       | -       | -       | 2       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need more up-to-date information about services  | 1              | -  | -       | -       | -       | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| NHS staff need training in dementia (e.g. occupational therapists)                           | 1              | -  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | 1       | -       | -       |
| Need access to early intervention services   | 1              | -  | -       | -       | -       | -       | -   | -       | 1       | -       | -       | -  | -       | -       | -       | -       |
| Community nurses are effective   | 1              | 1  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Limitations on services patients can be referred to  | 1              |  | -       | -       | -       | -       | -   | 1       | -       | -       | -       | -  | -       | -       | -       | -       |
| GPs are effective  | 1              | 1  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need support with challenging behaviour  | 1              | 1  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Dementia cafes provide excellent peer support  | 1              | -  | -       | 1       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need to integrate dementia into other services   | 1              | -  | -       | 1       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Carers Allowance is not enough   | 1              | 1  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need time to accept diagnosis  | 1              | -  | -       | -       | -       | -       | -   | -       | 1       | -       | -       | -  | -       | -       | -       | -       |
| Need access to day centres / dementia cafes for younger patients with learning difficulties  | 1              | -  | -       | -       | 1       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need more resources for support in social care   | 1              | -  | -       | -       | -       | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Consider support for working carers (e.g. can't attend carers cafes)                         | 1              | -  | -       | -       | -       | -       | -   | -       | -       | -       | 1       | -  | -       | -       | -       | -       |
| Need provision like in cancer services   | 1              | -  | -       | -       | -       | -       | -   | -       | -       | -       | 1       | -  | -       | -       | -       | -       |
| Base (total number of groups/tables at each event)   | 1              | 3  | 1       | 2       | 1       | 3       | 3   | 1       | 2       | 1       | 3       | 3  | 1       | 2       | 1       | 3       |

The figures represent the number of groups/tables mentioning the theme in the events. For example, 2 means the theme was mentioned by 2 of the groups/tables during the event. Event 2 is not shown in the table because no participants attended.

## Themes raised in participant work packs

|  | Total     | Patients and carers/<br>family members | Health and social<br>care professionals |
|--|-----------|--|---|
| Need access to services (e.g. day centres) for younger patients with learning difficulties | 4         | -                                      | 4                                       |
| General negative comment   | 2         | 2                                      | -                                       |
| General positive comment   | 1         | 1                                      | -                                       |
| Accessibility is variable / hit and miss / postcode lottery                                | 1         | -                                      | 1                                       |
| Need to increase awareness of services   | 1         | 1                                      | -                                       |
| Need access to training and education for carers   | 1         | 1                                      | -                                       |
| Lack of support for families and carers  | 1         | -                                      | 1                                       |
| Need funding to support voluntary groups   | 1         | -                                      | 1                                       |
| Need access to 24/7 support  | 1         | 1                                      | -                                       |
| Need to integrate dementia into other services (e.g. learning disability)                  | 1         | -                                      | 1                                       |
| Waiting times are too long for support   | 1         | -                                      | 1                                       |
| Need more training in learning difficulties for dementia professionals                     | 1         | -                                      | 1                                       |
| <i>Base</i>  | <i>11</i> | <i>6</i>                               | <i>5</i>                                |

## Appendix C: Ongoing support

### Themes raised by event

|   | Total mentions | Total tables mentioning themes |         |         |         |         |
|---|----------------|--------------------------------|---------|---------|---------|---------|
|   |                | Event 1                        | Event 3 | Event 4 | Event 5 | Event 6 |
| No-one to contact in an emergency apart from 999 / need crisis care                         | 4              | 2                              | -       | 1       | -       | 1       |
| Lack of access to assistance for carers   | 4              |                                |         | 1       | 1       | 2       |
| Lack of education and information to support carers   | 4              | 1                              | 1       | 1       | -       | 1       |
| Focus is on patient, not carers / need to consider emotional wellbeing and health of carers | 3              | 2                              | -       | -       | -       | 1       |
| DISC provides excellent support   | 2              | 2                              | -       | -       | -       | -       |
| Need access to 24/7 support   | 2              |                                | 1       | -       | 1       | -       |
| Need to have access to Admiral nurses   | 2              | 2                              | -       | -       | -       | -       |
| Health and social care staff need to have training in dementia                              | 2              | 1                              | -       | 1       | -       | -       |
| Criteria to access services is too strict   | 2              | 2                              | -       | -       | -       | -       |
| Need to have access to services sooner  | 2              | -                              | -       | 2       | -       | -       |
| Need more integration between health and social care  | 2              | -                              | -       | 1       | -       | 1       |
| Admiral Nurses provide excellent support  | 1              | 1                              | -       | -       | -       | -       |
| Lack of counselling services  | 1              | 1                              | -       | -       | -       | -       |
| Need funding to support voluntary groups  | 1              | 1                              | -       | -       | -       | -       |
| Long waiting times for assessments  | 1              | 1                              | -       | -       | -       | -       |
| Need to have continuity of care   | 1              | 1                              | -       | -       | -       | -       |
| Need access to respite  | 1              | -                              | 1       | -       | -       | -       |
| Consider financial aspect of care   | 1              | -                              | -       | -       |         | 1       |
| Need to have regular assessments  | 1              | -                              | -       | 1       | -       | -       |
| Services are geared around those in crisis  | 1              | -                              | -       | 1       | -       | -       |
| Peer support is important   | 1              | -                              | -       | 1       | -       | -       |
| Need to consider different types of dementia  | 1              | -                              | -       | 1       | -       | -       |
| Need access to dementia services from LD services   | 1              | -                              | -       | -       | 1       | -       |
| Need access to offline resources for carers who don't use the internet                      | 1              | -                              | -       | -       | 1       | -       |
| Need paid carers / dementia nurses to provide personal care                                 | 1              | 1                              | -       | -       | -       | -       |
| <b>Base (total number of groups/tables at each event)</b>                                   |                | 3                              | 1       | 2       | 1       | 3       |

The figures represent the number of groups/tables mentioning the theme in the events. For example, 2 means the theme was mentioned by 2 of the groups/tables during the event. Event 2 is not shown in the table because no participants attended.

## Themes raised by respondent type

|   | Total mentions | Themes raised by Patients and carers/ family members |          |          |          |          | Themes raised by health and social care professionals |          |          |          |          | Themes raised by both sets of respondent types on the same table |          |          |          |          |
|---|----------------|--|----------|----------|----------|----------|---|----------|----------|----------|----------|--|----------|----------|----------|----------|
|   |                | Event 1  | Event 3  | Event 4  | Event 5  | Event 6  | Event 1   | Event 3  | Event 4  | Event 5  | Event 6  | Event 1  | Event 3  | Event 4  | Event 5  | Event 6  |
| No-one to contact in an emergency apart from 999 / need crisis care                         | 4              | 2  | -        | 1        |          |          | -   | -        | -        | -        | 1        | -  | -        | -        | -        | -        |
| Lack of access to assistance for carers   | 4              |  | -        | 1        | 1        | 2        | -   | -        | -        | -        | -        | -  | -        | -        | -        | -        |
| Lack of education and information to support carers   | 4              | 1  | -        | 1        |          | 1        | -   | -        | -        | -        | -        | -  | 1        | -        | -        | -        |
| Focus is on patient, not carers / need to consider emotional wellbeing and health of carers | 3              | 2  | -        | -        |          | 1        | -   | -        | -        | -        | -        | -  | -        | -        | -        | -        |
| DISC provides excellent support   | 2              | 2  | -        | -        |          |          | -   | -        | -        | -        | -        | -  | -        | -        | -        | -        |
| Need access to 24/7 support   | 2              | -  | 1        | -        | 1        |          | -   | -        | -        | -        | -        | -  | -        | -        | -        | -        |
| Need to have access to Admiral nurses   | 2              | 2  |          | -        | -        | -        | -   | -        | -        | -        | -        | -  | -        | -        | -        | -        |
| Health and social care staff need to have training in dementia                              | 2              | 1  | -        | 1        | -        | -        | -   | -        | -        | -        | -        | -  | -        | -        | -        | -        |
| Criteria to access services is too strict   | 2              | 2  | -        | -        | -        | -        | -   | -        | -        | -        | -        | -  | -        | -        | -        | -        |
| Need to have access to services sooner  | 2              | -  | -        | 2        | -        | -        | -   | -        | -        | -        | -        | -  | -        | -        | -        | -        |
| Need more integration between health and social care  | 2              | -  | -        | 1        | -        | -        | -   | -        | -        | -        | -        | -  | -        | -        | -        | 1        |
| Admiral Nurses provide excellent support  | 1              | 1  | -        | -        | -        | -        | -   | -        | -        | -        | -        | -  | -        | -        | -        | -        |
| Lack of counselling services  | 1              | 1  | -        | -        | -        | -        | -   | -        | -        | -        | -        | -  | -        | -        | -        | -        |
| Need funding to support voluntary groups  | 1              | 1  | -        | -        | -        | -        | -   | -        | -        | -        | -        | -  | -        | -        | -        | -        |
| Long waiting times for assessments  | 1              | 1  | -        | -        | -        | -        | -   | -        | -        | -        | -        | -  | -        | -        | -        | -        |
| Need to have continuity of care   | 1              | 1  | -        | -        | -        | -        | -   | -        | -        | -        | -        | -  | -        | -        | -        | -        |
| Need access to respite  | 1              | -  | 1        | -        | -        | -        | -   | -        | -        | -        | -        | -  | -        | -        | -        | -        |
| Consider financial aspect of care   | 1              | -  | -        | -        | -        | 1        | -   | -        | -        | -        | -        | -  | -        | -        | -        | -        |
| Need to have regular assessments  | 1              | -  | -        | -        | -        | -        | -   | -        | -        | -        | -        | -  | -        | 1        |          | -        |
| Services are geared around those in crisis  | 1              | -  | -        | -        | -        | -        | -   | -        | 1        | -        | -        | -  | -        | -        | -        | -        |
| Peer support is important   | 1              | -  | -        | 1        | -        | -        | -   | -        | -        | -        | -        | -  | -        | -        | -        | -        |
| Need to consider different types of dementia  | 1              | -  | -        | 1        | -        | -        | -   | -        | -        | -        | -        | -  | -        | -        | -        | -        |
| Need access to dementia services from LD services   | 1              | -  | -        | -        | -        | -        | -   | -        | -        | 1        | -        | -  | -        | -        | -        | -        |
| Need access to offline resources for carers who don't use the internet                      | 1              | -  | -        | -        | 1        | -        | -   | -        | -        | -        | -        | -  | -        | -        | -        | -        |
| Need paid carers / dementia nurses to provide personal care                                 | 1              | 1  | -        | -        | -        | -        | -   | -        | -        | -        | -        | -  | -        | -        | -        | -        |
| <i>Base (total number of groups/tables at each event)</i>                                   | <i>1</i>       | <i>3</i>   | <i>1</i> | <i>2</i> | <i>1</i> | <i>3</i> | <i>3</i>  | <i>1</i> | <i>2</i> | <i>1</i> | <i>3</i> | <i>3</i>   | <i>1</i> | <i>2</i> | <i>1</i> | <i>3</i> |

The figures represent the number of groups/tables mentioning the theme in the events. For example, 2 means the theme was mentioned by 2 of the groups/tables during the event. Event 2 is not shown in the table because no participants attended.

## Themes raised in participant work packs

|   | Total     | Patients and carers/ family members | Health and social care professionals |
|---|-----------|-------------------------------------|--------------------------------------|
| DISC provides excellent support   | 6         | 6                                   | -                                    |
| Lack of access to assistance for carers                                   | 2         | -                                   | 2                                    |
| Need to have continuity of care   | 2         | 1                                   | 1                                    |
| Need to integrate dementia into other services (e.g. learning disability) | 2         | -                                   | 2                                    |
| Admiral Nurses provide excellent support                                  | 1         | 1                                   | -                                    |
| General negative comment  | 1         | 1                                   | -                                    |
| Need to ensure new service offer is clear and patients/carers are aware   | 1         | -                                   | 1                                    |
| Lack of education and information to support carers                       | 1         | -                                   | 1                                    |
| Need access to services sooner  | 1         | 1                                   | -                                    |
| Need more training in learning difficulties for dementia professionals    | 1         | -                                   | 1                                    |
| Other   | 2         | 2                                   | -                                    |
| <i>Base</i>   | <i>17</i> | <i>12</i>                           | <i>5</i>                             |



## Appendix D: Respite care

### Themes raised by event

|  | Total mentions | Total tables mentioning themes |         |         |         |         |
|--|----------------|--------------------------------|---------|---------|---------|---------|
|  |                | Event 1                        | Event 3 | Event 4 | Event 5 | Event 6 |
| Respite care is too expensive                              | 5              | 2                              | -       | 1       | -       | 2       |
| Process to access respite care is too complicated          | 5              | 1                              | 1       | 1       | -       | 2       |
| Lack of access to respite / not been offered respite       | 4              | -                              | -       | 2       | -       | 2       |
| Patients do not want to go into care homes                 | 2              | 1                              | -       | -       | -       | -       |
| Patients can become confused / distressed in respite       | 2              | 1                              | -       | 1       | -       | -       |
| Carers may feel guilty / emotional impact on carers        | 2              | 1                              | -       | 1       | -       | -       |
| More assistance is required in the home                    | 2              | 1                              | 1       | -       | -       | -       |
| Access to respite is easier in a crisis                    | 2              | -                              | -       | 2       | -       | -       |
| Respite care received is excellent                         | 2              | -                              | -       | -       | 1       | 1       |
| Consider quality of paid carers                            | 2              | 2                              | -       | -       | -       | -       |
| Direct payments and care fees do not align                 | 1              | 1                              | -       | -       | -       | -       |
| Direct payments are too restricted / need to be simplified | 1              | 1                              | -       | -       | -       | -       |
| Need a review system for care homes                        | 1              | -                              | 1       | -       | -       | -       |
| Need to consider the level of dementia the patient has     | 1              | -                              | 1       | -       | -       | -       |
| Need to ensure care is patient-centred                     | 1              | -                              | 1       | -       | -       | -       |
| Can't get respite confirmed until a week before            | 1              | -                              | -       | -       | -       | 1       |
| Care has to be booked far in advance                       | 1              | -                              | -       | -       | -       | -       |
| Criteria to access respite depends on care package         | 1              | -                              | 1       | -       | -       | -       |
| Need access to live-in carers                              | 1              | -                              | -       | 1       | -       | -       |
| Consider utilising day hospice services                    | 1              | -                              | -       | 1       | -       | -       |
| Care home will accommodate the dates required              | 1              | -                              | -       | -       | 1       | -       |
| Need access to personal care                               | 1              | -                              | -       | -       | -       | 1       |
| <i>Base (total number of groups/tables at each event)</i>  |                | 3                              | 1       | 2       | -       | 3       |

The figures represent the number of groups/tables mentioning the theme in the events. For example, 2 means the theme was mentioned by 2 of the groups/tables during the event. Event 2 is not shown in the table because no participants attended.

## Themes raised by respondent type

|  | Total mentions | Themes raised by Patients and carers/ family members |         |         |         |         | Themes raised by health and social care professionals |         |         |         |         | Themes raised by both sets of respondent types on the same table |         |         |         |         |
|--|----------------|--|---------|---------|---------|---------|---|---------|---------|---------|---------|--|---------|---------|---------|---------|
|  |                | Event 1  | Event 3 | Event 4 | Event 5 | Event 6 | Event 1   | Event 3 | Event 4 | Event 5 | Event 6 | Event 1  | Event 3 | Event 4 | Event 5 | Event 6 |
| Respite care is too expensive                              | 5              | 2  | -       | -       | -       | 2       | -   | -       | 1       | -       | -       | -  | -       | -       | -       | -       |
| Process to access respite care is too complicated          | 5              | 1  | -       | -       | -       | 2       | -   | -       | -       | -       | -       | -  | 1       | 1       | -       | -       |
| Lack of access to respite / not been offered respite       | 4              | -  | -       | 2       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Patients do not want to go into care homes                 | 2              | 1  | 1       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Patients can become confused / distressed in respite       | 2              | 1  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Carers may feel guilty / emotional impact on carers        | 2              | 1  | -       | 1       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| More assistance is required in the home                    | 2              | 1  | 1       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Access to respite is easier in a crisis                    | 2              | -  | -       | 1       | -       | -       | -   | -       | 1       | -       | -       | -  | -       | -       | -       | -       |
| Respite care received is excellent                         | 2              | -  | -       | -       | 1       | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Consider quality of paid carers                            | 2              | 2  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Direct payments and care fees do not align                 | 1              | 1  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Direct payments are too restricted / need to be simplified | 1              | 1  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need a review system for care homes                        | 1              | -  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need to consider the level of dementia the patient has     | 1              | -  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | 1       | -       | -       | -       |
| Need to ensure care is patient-centred                     | 1              | -  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | 1       | -       | -       | -       |
| Can't get respite confirmed until a week before            | 1              | -  | -       | -       | -       | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Care has to be booked far in advance                       | 1              | -  | -       | -       | -       | -       | -   | 1       | -       | -       | -       | -  | -       | -       | -       | -       |
| Criteria to access respite depends on care package         | 1              | -  | -       | -       | -       | -       | -   | 1       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need access to live-in carers                              | 1              | -  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Consider utilising day hospice services                    | 1              | -  | -       | -       | -       | -       | -   | -       | 1       | -       | -       | -  | -       | -       | -       | -       |
| Care home will accommodate the dates required              | 1              | -  | -       | -       | 1       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need access to personal care                               | 1              | -  | -       | -       | -       | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Base (total number of groups/tables at each event)         |                | 3  | 1       | 2       | 1       | 3       | 3   | 1       | 2       | 1       | 3       | 3  | 1       | 2       | 1       | 3       |

The figures represent the number of groups/tables mentioning the theme in the events. For example, 2 means the theme was mentioned by 2 of the groups/tables during the event. Event 2 is not shown in the table because no participants attended.

## Themes raised in participant work packs

|   | Total | Patients and carers/ family members | Health and social care professionals |
|---|-------|-------------------------------------|--------------------------------------|
| Care has to be booked far in advance  | 1     | -                                   | 1                                    |
| Respite care received is excellent  | 2     | 1                                   | 1                                    |
| More information and awareness required                                     | 3     | 1                                   | 2                                    |
| Would like carers groups at respite home                                    | 1     | 1                                   | -                                    |
| Respite care is too expensive   | 1     | 1                                   | -                                    |
| Lack of access to respite / not been offered respite / more access required | 4     | 2                                   | 2                                    |
| Respite is important / need access to respite                               | 1     | 1                                   | -                                    |
| Other (no comment / don't know / can't comment)                             | 5     | 5                                   | -                                    |
| Base  | 14    | 10                                  | 4                                    |

## Appendix E: End of life care

### Themes raised by event

|   | Total mentions | Total tables mentioning themes |         |         |         |         |
|---|----------------|--------------------------------|---------|---------|---------|---------|
|   |                | Event 1                        | Event 3 | Event 4 | Event 5 | Event 6 |
| Need to consider that death is a difficult topic  | 4              | 3                              | 1       | -       | -       | -       |
| Consider the need for future arrangements for carers (e.g. if a carer dies first)                 | 3              | -                              | -       | 1       | 1       | 1       |
| Decision should be made when patients have capacity   | 2              | 2                              | -       | -       | -       | -       |
| Need support with financial implications / practicalities e.g. Power of Attorney, wills, benefits | 2              | 1                              | -       | -       | 1       | -       |
| Need to respect individual wishes   | 2              | -                              | 1       | 1       | -       | -       |
| Need to be addressed within the family  | 2              | -                              | 1       | -       | -       | 1       |
| Staff should make decision if patients lack capacity  | 2              | 2                              | -       | -       | -       | -       |
| Planning for the Future' booklet offers useful support  | 2              | -                              | -       | 2       | -       | -       |
| Have made plans without support   | 2              | -                              | -       | 1       | -       | 1       |
| Need to use RESPECT forms   | 1              | -                              | -       | -       | -       | 1       |
| Dementia should be classed as a disease   | 1              | -                              | 1       | -       | -       | -       |
| Need information pack   | 1              | -                              | -       | -       | -       | 1       |
| Need for wider public awareness of dementia   | 1              | -                              | -       | -       | -       | 1       |
| Received practical support from Alzheimer's Society   | 1              | -                              | -       | -       | -       | 1       |
| Lack of awareness of Respect forms  | 1              | 1                              | -       | -       | -       | -       |
| Patients may not want to go to hospices due to culture / religion (e.g. seen as Christian)        | 1              | -                              | -       | 1       | -       | -       |
| <i>Base (total number of groups/tables at each event)</i>   |                | 3                              | 1       | 2       | 1       | 3       |

The figures represent the number of groups/tables mentioning the theme in the events. For example, 2 means the theme was mentioned by 2 of the groups/tables during the event. Event 2 is not shown in the table because no participants attended.

## Themes raised by respondent type

|   | Total mentions | Themes raised by Patients and carers/ family members |         |         |         |         | Themes raised by health and social care professionals |         |         |         |         | Themes raised by both sets of respondent types on the same table |         |         |         |         |
|---|----------------|--|---------|---------|---------|---------|---|---------|---------|---------|---------|--|---------|---------|---------|---------|
|   |                | Event 1  | Event 3 | Event 4 | Event 5 | Event 6 | Event 1   | Event 3 | Event 4 | Event 5 | Event 6 | Event 1  | Event 3 | Event 4 | Event 5 | Event 6 |
| Need to consider that death is a difficult topic  | 4              | 3  | -       | -       | -       | -       | -   | 1       | -       | -       | -       | -  | -       | -       | -       | -       |
| Consider the need for future arrangements for carers (e.g. if a carer dies first)                 | 3              | -  | -       | 1       | 1       | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Decision should be made when patients have capacity   | 2              | 2  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need support with financial implications / practicalities e.g. Power of Attorney, wills, benefits | 2              | 1  | -       | -       | 1       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need to respect individual wishes   | 2              | -  | -       | 1       | -       | -       | -   | -       | -       | -       | -       | -  | 1       | -       | -       | -       |
| Need to be addressed within the family  | 2              | -  | 1       | -       | -       | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Staff should make decision if patients lack capacity  | 2              | 2  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Planning for the Future' booklet offers useful support  | 2              | -  | -       | 1       | -       | -       | -   | -       | -       | -       | -       | -  | -       | 1       |         |         |
| Have made plans without support   | 2              | -  | -       | 1       | -       | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need to use RESPECT forms   | 1              | -  | -       | -       | -       | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Dementia should be classed as a disease   | 1              | -  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | 1       | -       | -       | -       |
| Need information pack   | 1              | -  | -       | -       | -       | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Need for wider public awareness of dementia   | 1              | -  | -       | -       | -       | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Received practical support from Alzheimer's Society   | 1              | -  | -       | -       | -       | 1       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Lack of awareness of Respect forms  | 1              | 1  | -       | -       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| Patients may not want to go to hospices due to culture / religion (e.g. seen as Christian)        | 1              | -  | -       | 1       | -       | -       | -   | -       | -       | -       | -       | -  | -       | -       | -       | -       |
| <i>Base (total number of groups/tables at each event)</i>   | 1              | 3  | 1       | 2       | 1       | 3       | 3   | 1       | 2       | 1       | 3       | 3  | 1       | 2       | 1       | 3       |

The figures represent the number of groups/tables mentioning the theme in the events. For example, 2 means the theme was mentioned by 2 of the groups/tables during the event. Event 2 is not shown in the table because no participants attended.

## Themes raised in participant work packs

|   | Total | Patients and carers/ family members | Health and social care professionals |
|---|-------|-------------------------------------|--------------------------------------|
| Consider different needs of learning disability patients                          | 3     | -                                   | 3                                    |
| Consider the need for future arrangements for carers (e.g. if a carer dies first) | 1     | -                                   | 1                                    |
| Need further information  | 1     | 1                                   | -                                    |
| Needs to be discussed when appropriate  | 1     | 1                                   | -                                    |
| Need access to dementia nurses  | 1     | -                                   | 1                                    |
| Need to consider that death is a difficult topic                                  | 1     | -                                   | 1                                    |
| Other   | 6     | 6                                   | -                                    |
| <i>Base</i>   | 12    | 8                                   | 4                                    |









|                           |  |
|---------------------------|--|
| <b>Report to:</b>         | <b>Birmingham Health and Social Care Overview and Scrutiny Committee</b> |
| <b>Date:</b>              | <b>15 October 2019</b>   |
| <b>TITLE:</b>             | <b>PUBLIC HEALTH GREEN PAPER - CONSULTATION RESPONSE</b>                 |
| <b>Presenting Officer</b> | <b>Elizabeth Griffiths, Acting Assistant Director of Public Health</b>   |

|                     |                           |
|---------------------|---------------------------|
| <b>Report Type:</b> | <b>Information report</b> |
|---------------------|---------------------------|

|   |
|---|
| <b>1. Purpose:</b>  |
| To inform the Committee of the findings of the Public Health Green Paper consultation and the mechanisms by which the issues raised will be progressed. |

|   |
|---|
| <b>2. Recommendation</b>  |
| <p>The Health and Social Care Overview and Scrutiny Committee is asked to note:</p> <ul style="list-style-type: none"> <li>• The findings from the Public Health Green Paper public consultation as summarised in this report and Appendices A-C.</li> <li>• The mechanisms by which the issues raised will be progressed.</li> </ul> |

|  |
|--|
| <b>3. Report Body</b>  |
| <p><b>4.1 Executive Summary</b></p> <p>4.1.1 In March-May 2019 the Public Health Division ran a public consultation exercise on its Public Health Green Paper. The aim of the Green Paper was to initiate a conversation with the public on key areas of inequality and need observed within the City.</p> <p>4.1.2. The public consultation process comprised community based focus groups and ward forum presentations; an on-line questionnaire hosted on the Council's Be Heard website; and, hard copy questionnaires made available in a number of community locations such as GP practices and ward forum venues.</p> <p>4.1.3 In total 447 consultation responses were received and the views of approximately 600 members of public were gathered at ward forums and community based focus groups.</p> <p>4.1.4 The headline responses from the public consultation were as follows:</p> <ul style="list-style-type: none"> <li>• Strong support for the overarching theme of reducing health inequalities and significant support for work to reduce rates of infant mortality.</li> <li>• A gap was identified around a specific public health focus on mental health and wellbeing.</li> <li>• A need to better articulate the health and wellbeing benefits of the Commonwealth Games to the population. Although it is important to note that the consultation pre-dates the public launch in August and the development of the legacy work-stream on physical activity and wellbeing which will help bring these benefits out more clearly.</li> </ul> <p>4.1.5 As a result of the consultation responses the Health and Wellbeing Board has established four new sub-forums to accelerate partnership action on health inequalities in the city, this includes a new forum focused on mental health and wellbeing.</p> <p>4.1.6 In addition to the work of the sub-forums there are a wide range of work programmes in place across Birmingham Public Health to progress the findings of the Green Paper consultation including the Joint Strategic Needs Assessment and the Director of Public Health's Annual Report.</p> <p><b>4.2 Consultation</b></p> <p>4.2.1 In March-May 2019 the Public Health Division ran a public consultation exercise on its Public Health Green Paper. The aim of the Green Paper was to initiate a conversation with the public on key areas of inequality and need observed within the City.</p> <p>4.2.2 The public consultation process comprised community based focus groups and ward forum presentations; an on-line questionnaire hosted on the Council's Be Heard website; and, hard copy questionnaires made available in</p> |

a number of community locations such as GP practices and ward forum venues.

- 4.2.3 The Public Health Division attended 21 ward forums to discuss the consultation and commissioned a number of local community organisations to deliver targeted engagement activities to strengthen participation from under-represented groups through an open tender process. The Division also commissioned BeatFreaks to develop an interactive prioritisation installation that was used in community settings to engage citizens in a different way about the priorities.
- 4.2.4 The consultation was supported with a suite of consultation products such as infographics and detailed presentations on the proposed priority areas of need identified within the consultation.
- 4.2.5 In total 447 consultation responses were received and the views of approximately 600 members of public were gathered at ward forums and community based focus groups.
- 4.2.6 The headline responses from the public consultation were as follows:
- Strong support for the overarching theme of reducing health inequalities and significant support for work to reduce rates of infant mortality.
  - A gap was identified around specific public health focus on mental health and wellbeing.
  - A need to better articulate the health and wellbeing benefits of the Commonwealth Games to the population. Although it is important to note that the consultation pre-dates the public launch in August and the development of the legacy work-stream on physical activity and wellbeing which will help bring these benefits out more clearly.
- 4.2.7 The consultation approach highlights some key lessons to improve future consultations, these include:
- Recognising the long lead in time to gain inclusion in ward forum agendas.
  - The use of real-time demographic analysis of responses was useful to be able to commission additional targeted engagement activity to address under-representation.
  - There is a need to develop easy read resources as part of the consultation materials to improve participation and access for people with learning disabilities and low levels of English reading skills.
  - Specific consideration is needed to improve meaningful consultation and engagement with children and young people and to enable children's voice in complex consultations, similar consideration is needed for other protected characteristic groups, especially those with learning disabilities.
- 4.2.9 The consultation findings are available in Appendices A-C.

### **4.3 Next Steps / Delivery**

- 4.3.1 As a result of the responses received, the Health and Wellbeing Board has five sub-groups to oversee development and delivery of shared action to drive City-wide improvement in the following areas:

- Creating a Mentally Healthy City Forum
  - Creating a Healthy Food Forum
  - Creating an Active City Forum
  - Creating a City without Inequality Forum
  - Health Protection Forum (already established)
- 4.3.2 These Forums will be chaired by Cabinet Members and will involve cross party representation as well as key strategic partners from across the City and region to accelerate action. They will strengthen the connection between the Health and Wellbeing Board and other City and regional partnership bodies. These Forums will hold their initial meetings in October 2019. Each will report progress to the Health and Wellbeing Board on an annual rotational basis.
- 4.3.3 To better monitor the needs of Birmingham's vulnerable population, the Birmingham Joint Strategic Needs Assessment (JSNA) is being refreshed to ensure that city level data is presented across the life course from pregnancy, birth and early years through to end of life. The 2019 core dataset will be available in Autumn 2019; the 2020 and 2021 core datasets will have a stronger focus on inequalities observed between communities in the City.
- 4.3.4 The JSNA includes a four year programme of deep dive reviews focusing on particular populations within the City. The Deep Dive reviews scheduled for 2019/20 are the Health and Wellbeing of Veterans; Death and Dying in Birmingham; the Health and Wellbeing of the Public Sector Workforce; and Mobility Impairment.
- 4.3.5 The Director of Public Health's annual report for 2019/20 will focus on the health needs of vulnerable adults. The report, titled Making Every Adult Matter, is currently at the planning and scoping stage. The Project Brief is available in Appendix D.
- 4.3.6 Action on addressing infant mortality will be taken forward through the existing Birmingham United Maternity Partnership (BUMP) and through the Child Death Overview Panel. The consultation reinforced many of the recommendations set out in the 2018 Director of Public Health Annual Report: Fulfilling Lives for Under Fives and this links into the Children's health transformation work being led by Birmingham and Solihull Clinical Commissioning Group.
- 4.3.7 Work to increase the understanding and visibility of the health and wellbeing benefits of the Commonwealth Games is being taken forward by the Director of Public Health (DPH), who is the lead DPH for the West Midlands Association of Directors of Public Health for the Games and is part of the leadership group developing the physical activity and wellbeing legacy workstream.
- 4.3.8 Feedback on the consultation findings and our response will be through a public "We Asked, You Said, We Did" document and where requested the Public Health Division will return to Ward Forums that participated in the consultation to feedback in person.
- 4.3.9 The Director of Public Health has been commissioned by the Health and

Wellbeing Board to write a Creating a Healthy City Framework which will provide an overarching framework for the Health and Wellbeing Board's shared ambition to protect and improve the health and wellbeing of the citizens of Birmingham. The Framework approach will identify the actions led through a matrix of strategies and action plans across the Council and its partners to deliver change. This will be developed over the Winter/Spring 2019/20.

#### **Appendices**

**Appendix A: Public Health Green Paper Consultation 2019 Summary Feedback**  
**Appendix B: Public Health Green Paper Demographic profile of respondents**  
**Appendix C: Focus Group feedback**  
**Appendix D: Director of Public Health Annual Report Project Plan**

## **Appendix A: Public Health Green Paper Consultation 2019 Summary Feedback**

### **1 Public Health Green Paper Consultation Summary Feedback**

The tables referred to in this summary can be found in Appendix B.

#### **Respondents**

There were 477 responses to the public consultation and approximately 600 views were collected from community engagements events, presentations to ward forums and targeted focus groups.

People from a wide range of ages (from 20-79 years) responded to the written and on-line consultation; the largest amount of responses received were from those aged 50-59 years. Table 1 shows that there was an under-representation in responses from children and those aged under 30. To address this gap BeatFreaks were commissioned to develop an interactive prioritisation installation that was used in community settings to engage children and young people in a different way about the priorities.

166 responses (37%) were from people reporting to have a physical or mental health condition; this was marginally lower than would have been expected.

302 responses were received from heterosexual or straight respondents, 21 from people identifying as gay or lesbian, 10 from those identifying as bisexual, 12 as other and 102 who preferred not to say or who declined to answer the question. Table 5 suggests that there was a good response from the LGBT community as the proportion of respondents to the survey identifying as LGBT exceeded what would have been expected compared to the proportion of the Birmingham population identifying as LGBT.

179 respondents identified as Christian, 19 Muslim, 10 Sikh, 142 with no religion and 10 as other. 87 people preferred not to say or declined to answer the question. Table 6 suggests that the Muslim, Hindu and Sikh populations were under represented in questionnaire respondents therefore faith based focus groups with the Muslim, Hindu and Sikh population were commissioned from community providers.

#### **Overarching priority: Health Inequalities**

- 1.1 85% of respondents agreed with the Public Health vision and core values as laid out in the Public Health Green Paper. 94% of

respondents to the consultation questionnaire agreed or strongly agreed that health inequalities should be considered across our work.

### **Priority 1: Child Health**

- 1.2 90% of respondents to the questionnaire agreed or strongly agreed that Child Health should be one of the priorities.
- 1.3 In addition there was consensus by the faith based focus groups that the three themes were the right themes to focus on in the strategy for child health.
- 1.4 Reducing infant mortality was the highest supported priority within the Child Health area; 91% of respondents agreed or strongly agreed that this should be a priority.
- 1.5 Taking a whole systems approach to childhood obesity was supported by 88% of respondents to the questionnaire. This topic provoked the most interest from the faith base focus groups; participants were surprised by the increase in the rates of obesity in Birmingham from reception to Year 6.
- 1.6 Supporting the mental health of our most vulnerable children was supported 87% of respondents to the questionnaire; however there was support that this should be extended so that support for mental health and wellbeing was a priority for all, not just those in vulnerable groups.

### **Priority 2: Working age adults**

- 1.7 Support for the working age adult theme was also high with 87% of respondents agreeing or strongly agreeing that this should be a priority. Responses from the interactive prioritisation installation run by Beatbreaks to seek the views of young people (those under 30 years) rated working age adults as the highest priority for support as they were seen as the centre of support for both children and the elderly and as such ranked the highest for both priority and potential impact.
- 1.8 Supporting workplaces to improve their employee wellbeing offer was supported by 84% of respondents; addressing the cumulative impact of unhealthy behaviours was supported by 85% and supporting the mental and physical health of our most vulnerable adults was supported by 91% of respondents.
- 1.9 Feedback from the Muslim focus groups suggested that these priorities broadly focussed on the right things yet it was felt that there

should be a greater focus on men's health, and in particular men's mental health.

### **Priority 3: Older adults**

- 1.10 92% of respondents supported that older adults should be one of our priority areas. The highest levels of support were for supporting the mental and physical health of our most vulnerable older people, which was supported by 93% of respondents, reducing social isolation which was supported by 92% of respondents and developing community assets which was supported by 90% of respondents. Providing system wide information and support received the lowest levels of support at 84% of respondents to the questionnaire.

In the Muslim Focus Group, the conversation focused on how significant the group felt the impact of isolation was in older people. Linked to the Child Health priority, participants discussed that there could be a perception that isolation is less of an issue in the Asian community as there are "large families and you look after your elders", however, the group all agreed that feeling lonely and isolated is not always about whether there are people around you. Some of the group also suggested that this can actually add to isolation in older people. There was an agreement that it was not just vulnerable older adults, but older adults more generally that were at risk of social isolation.

### **Priority 4: Healthy environment**

- 1.11 Whilst the overarching priority of healthy environment was supported by 91% of respondents, the themes within this priority received varying levels of support. Improving air quality was supported by 88% of respondents; increasing the health gains of new developments received support from 83% of respondents and health protection assurance and response including screening, immunisations and vaccinations received support from 90% of respondents.

### **Maximising the health gains from hosting the Commonwealth Games**

- 1.12 Of all the priorities proposed within the Green Paper, maximising the public health gains of the Commonwealth Games received the lowest levels of support, 60% of respondents to the survey agreed or strongly agreed that this should be a priority with 18% of respondents disagreeing or strongly disagreeing.



- 1.13 The faith based focus groups felt that the Commonwealth Games could really help to get children and parents interested in sport but that there would need to be opportunity for them act upon this interest and funding for community level sport. There was also a view that the Games was a good opportunity to get rid of bad or old buildings and lead to new assets that stay for the communities after the games. Overall the groups were very positive and excited about the Games coming to Birmingham.

## Appendix B: Public Health Green Paper Demographic profile of respondents

Table 1: Public Health Green Paper consultation respondents by age.

| Age Group                          | Number of respondents* | % of those responding | % of total Birmingham population |
|------------------------------------|------------------------|-----------------------|----------------------------------|
| Under 19                           | 0                      | 0%                    | 28%                              |
| 20 -24                             | 10                     | 2%                    | 9%                               |
| 25 -29                             | 13                     | 3%                    | 8%                               |
| 30 -34                             | 24                     | 5%                    | 7%                               |
| 35 - 39                            | 27                     | 6%                    | 7%                               |
| 40- 44                             | 37                     | 8%                    | 6%                               |
| 45- 49                             | 49                     | 11%                   | 6%                               |
| 50 - 54                            | 63                     | 14%                   | 6%                               |
| 55- 59                             | 79                     | 18%                   | 5%                               |
| 60 - 64                            | 43                     | 10%                   | 4%                               |
| 65 - 69                            | 33                     | 8%                    | 4%                               |
| 70 - 74                            | 30                     | 7%                    | 3%                               |
| 75 - 79                            | 15                     | 3%                    | 2%                               |
| 80 - 84                            | 0                      | 0%                    | 2%                               |
| 85+                                | 0                      | 0%                    | 2%                               |
| Prefer not to say                  | 17                     | 4%                    | N/A                              |
| <b>Supressed Total Respondents</b> | <b>440</b>             | <b>100%</b>           | <b>N/A</b>                       |

\*Answers less than 4 suppressed to 0 and answers between 5 and 10 suppressed to 10, Total counts below, do not match the total responses due to suppressing responses

Source: ONS 2018 mid-year population estimates

**Table 2: Public Health Green Paper Consultation respondents by Gender.**

| <b>Gender</b>                      | <b>Number of respondents*</b> | <b>% of those responding</b> | <b>% of total Birmingham population</b> |
|------------------------------------|-------------------------------|------------------------------|---|
| Male                               | 168                           | 38%                          | <b>49.5%</b>                            |
| Female                             | 244                           | 55%                          | <b>50.5%</b>                            |
| Other                              | 0                             | 0%                           | <b>0%</b>                               |
| Prefer not to say                  | 28                            | 6%                           | <b>0%</b>                               |
| <b>Supressed Total Respondents</b> | <b>440</b>                    | <b>100%</b>                  | <b>N/A</b>                              |

\*Answers less than 4 supressed to 0 and answers between 5 and 10 supressed to 10, Total counts below, do not match the total responses due to suppressing responses

**Table 3: Public Health Green Paper Consultation respondents by physical or mental health condition.**

| <b>Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?</b>      | <b>Number of respondents*</b> | <b>% of those responding</b> | <b>% of total England population</b> |
|--|-------------------------------|------------------------------|--------------------------------------|
| Yes  | 158                           | 36%                          | <b>38.9%</b>                         |
| No   | 245                           | 56%                          | <b>61.1%</b>                         |
| Prefer not to say  | 31                            | 7%                           |                                      |
| <b>Supressed Total Respondents</b>   | <b>440</b>                    | <b>100%</b>                  | <b>N/A</b>                           |
| <b>Actual Total Respondents</b>  | <b>447</b>                    | <b>N/A</b>                   | <b>N/A</b>                           |
| <i>Those that answered yes :</i><br><b>Affected by the following long-term physical or mental health conditions or illnesses</b> | <b>Number of respondents*</b> | <b>% of those responding</b> |                                      |
| Physical or mental conditions  | 138                           | 31%                          |                                      |
| Vision   | 0                             | 0%                           |                                      |
| Hearing  | 28                            | 6%                           |                                      |
| Mobility   | 0                             | 0%                           |                                      |
| Dexterity  | 0                             | 0%                           |                                      |
| Learning or understanding or concentrating   | 0                             | 0%                           |                                      |
| Memory   | 0                             | 0%                           |                                      |
| Mental Health  | 4                             | 1%                           |                                      |
| Stamina, breathing or fatigue  | 0                             | 0%                           |                                      |
| Socially or behaviourally  | 0                             | 0%                           |                                      |
| Other (please specify)   | 0                             | 0%                           |                                      |

\*Answers less than 4 suppressed to 0 and answers between 5 and 10 suppressed to 10, Total counts below, do not match the total responses due to suppressing responses

**Table 4: Public Health Green Paper Consultation respondents by Ethnicity.**

| <b>Ethnicity</b>  | <b>Number of respondents*</b> | <b>% of those responding</b> | <b>% of total Birmingham population</b> |
|---|-------------------------------|------------------------------|---|
| White/White British / White European / White Other      | 352                           | 82%                          | 57.9%                                   |
| Mixed/multiple ethnic Groups                            | 12                            | 3%                           | 4.4%                                    |
| Black / Black British / Black African / Black Caribbean | 30                            | 7%                           | 8.9%                                    |
| Asian/Asian British                                     | 35                            | 8%                           | 26.6%                                   |
| Other   |                               |                              | 2.2%                                    |
| Prefer not to say                                       | 15                            |                              | N/A                                     |
| <b>Supressed Total Respondents</b>                      | <b>444</b>                    |                              | <b>N/A</b>                              |

\*Answers less than 4 suppressed to 0 and answers between 5 and 10 suppressed to 10, Total counts below, do not match the total responses due to suppressing responses

**Table 5: Public Health Green Paper Consultation respondents by Sexual Orientation**

| <b>Sexual orientation</b>          | <b>Number of respondents*</b> | <b>% of those responding</b> | <b>% of total Birmingham population**</b> |
|------------------------------------|-------------------------------|------------------------------|---|
| Heterosexual or straight           | 302                           | 74%                          | } ~97.5-96.1%<br>2.5-3.9%                 |
| Bisexual                           | 10                            | 2%                           |   |
| Gay or Lesbian                     | 21                            | 5%                           |   |
| Other                              | 12                            | 3%                           |   |
| Prefer not to say                  | 65                            | 16%                          |   |
| <b>Supressed Total Respondents</b> | <b>410</b>                    | <b>100%</b>                  | <b>N/A</b>                                |

\*Answers less than 4 suppressed to 0 and answers between 5 and 10 suppressed to 10, Total counts below, do not match the total responses due to suppressing responses

\*\*Source: Birmingham PH Division, estimates derived from NHS GP Patient Survey (2017). IPSOS Mori. <https://gp-patient.co.uk/surveysandreports2017>

**Table 6: Public Health Green Paper Consultation respondents by Religion or Belief**

| <b>Sexual orientation</b>          | <b>Number of respondents*</b> | <b>% of those responding</b> | <b>% of total Birmingham population</b> |
|------------------------------------|-------------------------------|------------------------------|---|
| Christian                          | 179                           | 43%                          | 46.1%                                   |
| Buddhist                           | 0                             | 0%                           | 0.4%                                    |
| Hindu                              | 0                             | 0%                           | 2.1%                                    |
| Jewish                             | 0                             | 0%                           | 0.2%                                    |
| Muslim                             | 19                            | 5%                           | 21.8%                                   |
| Sikh                               | 10                            | 2%                           | 3.0%                                    |
| No religion                        | 142                           | 34%                          | 19.3%                                   |
| Any other religion                 | 10                            | 2%                           | 0.5%                                    |
| Prefer not to say                  | 61                            | 14%                          | 6.5%                                    |
| <b>Supressed Total Respondents</b> | <b>421</b>                    | <b>100%</b>                  | <b>N/A</b>                              |

\*Answers less than 4 supressed to 0 and answers between 5 and 10 supressed to 10, Total counts below, do not match the total responses due to suppressing responses

## **Appendix C: Focus Group feedback**

### **Focus Group Feedback**

Real-time demographic analysis of responses allowed the Public Health Division to commission additional targeted engagement activity to address under-representation in the following areas: children and young people, the Muslim, Hindu and Sikh communities and BAME (black and minority ethnic) groups.

Three local organisations were commissioned to undertake targeted participation activities. This summary details the feedback received.

#### **Doink, Beatfreaks collective**

Population: Children and Young People

Opportunistic sampling at Asda Bordesley Green and Sparkhill Swimming Pool

The Beatfreaks research centred around three questions –

- Which priorities need action first?
- Which priorities have the biggest impact?
- What does your community need to action these priorities?

#### **Key findings:**

Working aged people were seen as the centre of support for both children and the elderly and as such ranked the highest in priority and in impact. This was despite people showing greater concern for the plight of children and the elderly in our city. Suggested support for working age adults including access to training and employment to tackle joblessness (which was perceived to be a root cause of many other issues) and carer services. It was felt that engaging with schools, faith centres and workplaces are key to connecting with this demographic.

Many respondents, particularly those of faith-based communities felt that problems surrounding drug or alcohol misuse were not issues that affected “their communities”; similarly loneliness in older adults were not seen to be issues as many people in that part of the city live in multi-generational households.

A need to identify a different approach to engaging women, especially homemakers was raised. It was felt that engagement could focus around schools.

The environment was ranked lowest in priority and was seen to affect people personally the least. However through discussion people made links between a healthier environment and the health of Birmingham’s citizens.

## **The Active Wellbeing Society**

Population: Adults from faith communities; Muslim, Hindu and Sikh women

Number of Focus Group participants: 23 (2 sessions)

Total number of participants: 23

### **Key findings:**

#### **Priority 1: Child Health**

There was consensus by both groups that the three themes - based on a discussion around the statistics and contributory risk factors – were the right themes to focus on in the strategy for child health.

The theme that both groups particularly focussed their attention and interest on was the childhood obesity theme, and participants were surprised by the increase in the rates of obesity from primary school entry (11.3%), to exit (25.6%). This provoked much discussion around the opportunities – where interventions and education should be provided and at what age should we be focusing efforts. Pregnancy and postnatal were identified as high-risk times for Muslim women in terms of mental and physical wellbeing. The Muslim Focus Group agreed that parenting support and support in pregnancy (i.e. education and information giving) was important to ensure a happy mum and happy baby

#### **Priority 2: Working Age Adults**

Overall, both groups felt that the themes were broadly focused on the right things. However, the Muslim Focus Group commented that there is nothing specific on men's health, something that they felt needed attention and particularly men's mental health.

#### **Priority 3: Ageing Well/Older adults**

The discussion around ageing well – the risks, what Public Health can influence and opportunities to tackle it very much crossed over all three themes in this priority for both focus groups. Participants also felt that this priority very much linked to the previous themes about the importance of providing opportunities for people to be socially and physically active.

In the Muslim Focus Group, the conversation quickly focused on how significant the group felt the impact of isolation was in older people. Linked to the Child Health priority, participants discussed that there can be a perception that isolation is less of an issue in the Asian community as there are "large families and you look after your elders", however, the group all agreed that feeling lonely and isolated is not always about whether there are people around you. Some of the group also suggested that this can actually add to isolation in older people.

There was a view that we need to have more older people's activities – social and physical that tackle isolation. Comments were that there should be activities that stimulate conversations, peer support, spending time with others outside the family. There was an agreement that we need to look after not just vulnerable older adults, but older adults more generally to stop them sliding into this category.



#### Priority 4: Healthy Environment – main findings

Whilst there were some discussions about air quality in the Hindu/Sikh Focus Groups, both groups focused their discussions on health protection, particularly vaccinations.

#### Commonwealth Games

In terms of impact, there was a view that it could really help to get children and parents interested in sport but that there would need to opportunity to them act upon this interest and funding for community level sport. There was also a view that the CWG is a good opportunity to get rid of bad or old buildings and lead to new assets that stay for the communities after the games, such as Perry Barr train station and the extension of the nearby cycle lane, and that it could bring new equipment. Overall, the groups were very positive and excited about the CWG coming to Birmingham.

#### **Smart Women CIC**

Population: Sparkbrook B11 area; participants recruited from local organisations: Ashiana Community Project, Bosnia House, Fallows Road Resident Association, ISRA, Muath Trust, Narthex Sparkhill, Yemeni Community Foundation

Number of Focus Group participants: 192 (12 sessions)

Participants invited to review and evaluate findings: 106

Questionnaires processed: 242

Total number of participants: 450

Key findings: the main concerns raised within participants were around access to information, and access to health and community services to enable behavioural change such as weight loss, and the self-management of conditions such as Type 2 Diabetes.



## DPH ANNUAL REPORT 2020 – MULTIPLE COMPLEX NEEDS PROJECT BRIEF

### Purpose

The overarching purpose of the report is to present an objective professional statement about the health and wellbeing of people (particularly single men) with multiple complex needs (MCN) in Birmingham through:

- Consolidating the evidence and providing an insight into the health and wellbeing of the population of interest
- Highlighting the importance of the place as a setting for health improvement and prevention
- Highlighting the opportunities for health improvement and prevention.

### Key outcomes

- Create an insight
- Present a compelling story backed up by evidence
- Present a statement with recommendations

### Scope

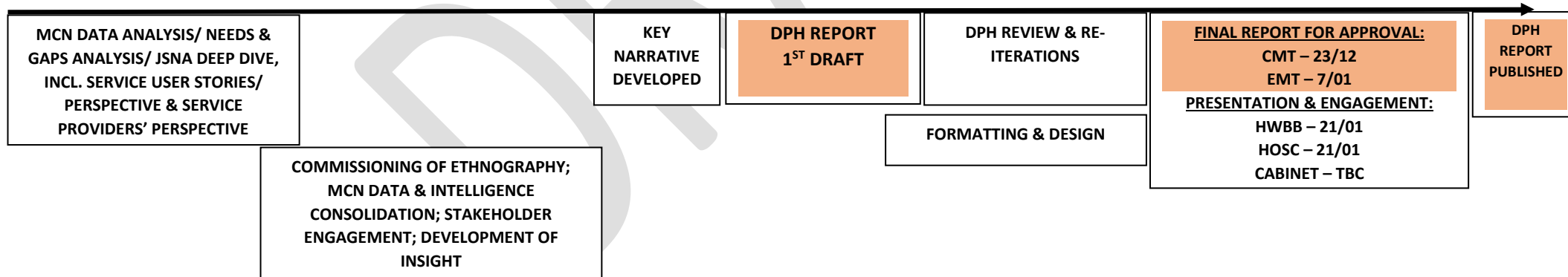
- Consolidation and analysis of relevant data and intelligence about MCN in Birmingham/ JSNA deep dive to create an insight and a greater understanding of needs, gaps and what works:
  - o Definition of MCN (MEAM)
  - o target cohort – single men in the context of wider MCN group
  - o in analysis - age as a specific dimension after gender
  - o focus on those who are not engaged with services/ fallen through the gaps
  - o route causes and contributing factors of ill health and wellbeing/ preventable deaths/ suicide deaths
- Ethnographic research – a life of one or two individuals whose story and journey to be presented through their own eyes/ voice that will form a core element of the report and its recommendations (research to be commissioned)
- Draft report
- Approval process and final report
- Video format (summary report)
- Design and artwork
- Publication and promotional activity

## Key content/ headings

- Definition and characteristics of MCN
- Background, incl. needs and gaps analysis
- The compelling story – key lines of enquiry:
  - o What are the health and wellbeing issues?
  - o When and why did the issues start to occur?
  - o What would have prevented them (if the clock could have been turned back...)?
  - o What support was/ wasn't available at the time?
  - o What has led to crisis (definition of crisis)?
  - o Did I ask for help? If not, why? If yes, was it made available and did it meet all my needs?
  - o What do I need now?
  - o Am I in a position to ask for/ access help? Etc.
  - o What are my aspirations, should the help I need be made available?
- Conclusions/ the case for change
- Opportunities and the next steps

## Timeline

| WK 1 | WK 2 | WK 3 | WK 4 | WK 5 | WK 6 | WK 7  | WK 8  | WK 9  | WK 10 | WK 11 | WK 12 | WK 13 | WK 14 | WK 15 | WK 16 | WK 17 | WK 18 | WK 19 | WK 20 | WK 21 |
|------|------|------|------|------|------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 2/9  | 9/9  | 16/9 | 23/9 | 30/9 | 7/10 | 14/10 | 21/10 | 28/10 | 4/11  | 11/11 | 18/11 | 25/11 | 2/12  | 9/12  | 16/12 | 23/12 | 30/12 | 6/01  | 13/01 | 20/01 |



|                           |  |
|---------------------------|--|
| <b>Report to:</b>         | <b>Birmingham Health and Social Care Overview and Scrutiny Committee</b> |
| <b>Date:</b>              | <b>15 October 2019</b>   |
| <b>TITLE:</b>             | <b>BIRMINGHAM SUICIDE PREVENTION STRATEGY</b>                            |
| <b>Presenting Officer</b> | <b>Elizabeth Griffiths, Acting Assistant Director of Public Health</b>   |

|                     |                           |
|---------------------|---------------------------|
| <b>Report Type:</b> | <b>Information report</b> |
|---------------------|---------------------------|

### **1. Purpose:**

1.1 The attached report (**Appendix 1**) follows an agreement at Full Council on the 06/11/2018 that a suicide prevention strategy would be developed.

1.2 The strategy sets out the priorities for action and a shared ambition for the city to reduce deaths from suicide, as part of the wider ambition to become a mentally healthy city.

### **2. Recommendation**

The Health and Social Care Overview and Scrutiny Committee is asked to note the update on the implementation of the Birmingham multi-agency Suicide Prevention Strategy, the contents of the Strategy (Appendix 1) and the draft action plan (Appendix 2).

### **3. Report Body**

#### **3.1 Context**

Suicide is preventable.

The latest figures indicate suicide rates in Birmingham are significantly lower than the England average and are the lowest of all the core cities. Birmingham's ambition is to maintain the lowest and reduce the number of suicides in the City.

The Five Year Forward View for Mental Health set the ambition that by 2020/21 the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels. This included the development and delivery of local multi-agency suicide prevention and action plans. The NHS Long Term plan also contains suicide prevention and reduction ambitions, including bereavement support for families and staff bereaved by suicide and a new longer-term management of self-harm.

Birmingham City Council has a partnership approach to suicide prevention and has worked with NHS England / Public Health England to develop this strategy. An Equality Impact Assessment has been undertaken – the strategy considers all the protected characteristics.

### **3.2 Current Circumstance**

The draft Birmingham Suicide Prevention Strategy has been through internal council approval process and was agreed and supported by the Birmingham Health and Wellbeing Board at its meeting on 24 September 2019; the Strategy is due to be presented to Full Council.

The multi-agency suicide prevention partnership, chaired by Justin Varney the Director of Public Health, will support the implementation of the Action Plan.

### **3.3 Next Steps / Delivery**

The Birmingham Suicide Prevention Working Party will be the driving partnership group that will enable and oversee delivery of the action plan that underpins these priorities and report to the Birmingham Health and Wellbeing Board's Creating a Mentally Healthy City Sub-Forum.

Significant ongoing work continues to take place ensuring the Action Plan is robust and timely. It will require long term support and commitment from many partners to achieve its ambition for a zero suicide. Much effort is being taken to enable meaningful data is captured from real time surveillance, data sharing agreements and close partnership working with the Birmingham Coroner, NHS England, Public Health England and WM Police.

The Creating a Health Mentally Healthy City Forum will be responsible for oversight of the Birmingham Suicide Prevention Strategy and Action Plan (draft action plan available in Appendix 2).

The Creating a Mentally Healthy City Forum will provide a link between the Health and Wellbeing Board, the NHS Mental Health Pathways Programme Board and the NHS Mental Health Partnership Stakeholder Board.

## **Appendices**

Appendix 1: Birmingham Suicide Prevention Strategy  
Appendix 2: Draft Action Plan

# BIRMINGHAM SUICIDE PREVENTION STRATEGY

2019-2024

FINAL DRAFT V12







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# EXECUTIVE SUMMARY

Death through suicide reflects the ultimate loss of hope and leaves a significant and lasting impact on families, communities, employers and society.

Prevention suicide requires partnership working across the breadth of society and building on the 2012 national strategy this strategy has been developed through a co-production partnership between the Council and a wide range of organisations as a shared approach to reducing deaths through suicide.

Although in Birmingham the rate of suicide is low compared to other cities, and the national rates, there is a shared ambition to maintain the lowest rate of suicide of any of the core cities in England and continue to reduce deaths through suicide in the City over the next decade through a Zero Suicide approach.

The Birmingham Suicide Prevention Strategy is a co-produced strategy that sits alongside national strategy and is based on a combination of local and national evidence and data. In Birmingham in addition to the nationally recognized high risk groups we also have higher rates of suicide among individuals working in skilled trade occupations like construction and among citizens born in Poland and Eastern European countries.

The Strategy sets out a series of key priority areas for action across the partnership under six core areas:

Reducing the risk of suicide in high-risk groups

Improving mental health in specific groups

Reducing access to means of suicide

Provide better information and support to those bereaved or affected by suicide

Support the media in delivering sensitive approaches to suicide and suicidal behaviour

Support research, data collection and monitoring

The Birmingham Suicide Prevention Working Party that will be the driving partnership group that will enable and oversee delivery of the action plan that underpins these priorities and will report into the Health and Wellbeing Board through the Director of Public Health.

We are confident through the shared action of partners, communities and citizens Birmingham will achieve its ambition to reduce the rate of suicide in the city to zero.



# BIRMINGHAM

## WORKING TOWARDS A SUICIDE FREE CITY



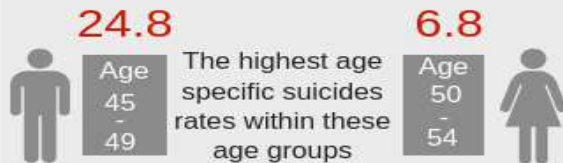
Public Health, July 2019  
Not to be used without permission.  
Numbers have been rounded

### THE NATIONAL PICTURE

In 2017 there were  
**5,821**  
suicides registered  
in the UK, an age  
standardised rate of  
**10.1**  
deaths per 100,000

Male Suicide Rate  
**15.5**  
deaths per 100,000  
Female Suicide Rate  
**4.9**  
deaths per 100,000

### AGE SPECIFIC RATES



### ACCESS TO SERVICES

**two thirds**  
of people who die  
through suicide  
have been in  
contact with  
Services

**one third**

of people have had  
no contact - **young men** are the most  
likely to be among  
this third.

### THE LOCAL PICTURE

In 2015/17 there were  
**205**  
suicides registered  
in Birmingham,  
which equates to  
**70**  
deaths per year

Male Suicide Rate  
**11.3**  
deaths per 100,000  
Female Suicide Rate  
**4.1**  
deaths per 100,000

**53%**  
of suicides in  
Birmingham over  
the last 10 years  
have taken place  
in the **home**

**76%** of  
suicides in  
Birmingham  
are men  
residents born in  
**Poland** and **Eastern Europe** have a higher  
rate of suicide.

**30.5**  
deaths per 10,000  
occur in the  
**Skilled Trades Occupations**  
**42,000** people in  
Birmingham work in  
this sector

**3,700**  
mental health in-  
patient admissions  
during 2017/18

### AT RISK & VULNERABLE

**Men** have a...  
**3x**  
greater risk of  
suicide than  
women

**4.7**  
households per  
1,000 households  
are in temporary  
accommodation

**Self-harm**  
is the single  
biggest indicator  
of suicide risk

in Birmingham  
**1,977**  
individuals  
presented to  
A&E with self-  
harm in 2017/18

Nationally...  
**45%** of suicides  
involved patients  
with a history of  
alcohol misuse and  
**33%** had a history  
of drug misuse.

There is growing  
evidence of  
increased rates of  
mental health  
problems, self-harm,  
and suicidal  
thoughts among  
**LGBT** people.

Data sourced from: Birmingham Suicide Prevention Strategy 2019 - 2024; Graphics: Canva; The Noun Project



# INTRODUCTION

Every suicide is one too many.

The death of someone by suicide has devastating effects on families, friends, workplaces and communities. For each person that dies this way at least 10 people are affected and only 1 in 3 who take their life are known to Mental Health Services<sup>1</sup>.

Suicide is one of the leading causes of years of life lost (YLL)<sup>2</sup>; in Birmingham as well as across England and in terms of absolute numbers suicide is 4<sup>th</sup> highest cause of YLL (2014-2016), behind infant mortality, coronary heart disease and lung cancer.

There is an associated economic cost and the average cost per suicide for those of working age is £1.7 million in England<sup>3</sup>, which includes intangible costs (loss of life to the individual, the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and funerals<sup>4</sup>. But above all, suicide is preventable and by working together we can reduce this tragic loss of life and provide better support for those left behind.

In 2012, the UK Government published a national strategy 'Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives' which set out overall objectives of:

- A reduction in suicide rate in the general population in England
- Better support for those bereaved or affected by suicide

The Birmingham Suicide Prevention Strategy builds on this to set out priorities for action and a shared ambition for the city to reduce deaths through suicide, as part of our wider ambition to become a mentally healthy city.

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<sup>1</sup> Local Suicide Prevention Planning

<sup>2</sup> Preventing Suicide in England: a cross-government outcomes strategy to save lives 2012: <https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england>

<sup>3</sup>No health without mental health: A cross-Government mental health outcomes strategy for people of all ages [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/215808/dh\\_123993.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215808/dh_123993.pdf).

<sup>4</sup> Knapp, Martin and McDaid, David and Parsonage, Michael (2011) Mental health promotion and mental illness prevention: the economic case. 15972. Department of Health, London, UK.

The Strategy is a collaboration between organisations, communities and citizens to take collective and individual action over the next five years to significantly reduce the rate of suicide in the city, address inequalities in suicide by focusing on those in highest risk groups, and improve care and support for those affected by suicide.

## CONTEXT OF SUICIDE AND SUICIDE PREVENTION

The context of suicide and suicide prevention is set out in terms of policy at local and national levels as well as the picture from the data and research nationally and the evidence from cities.

### Policy Context

The Five Year Forward View for Mental Health set the ambition that by 2020/21 the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels. This included development and delivery of local multi-agency suicide prevention plans.

In 2012 the Department of Health released its national suicide prevention strategy Preventing Suicide in England. The National Strategy identified six key areas for action to support delivery of objectives. These six areas provide the themes for our local approach and are being used as the basis for the Birmingham suicide prevention action plan which accompanies this strategy.

The NHS Long Term Plan <sup>5</sup> contains suicide prevention & reduction ambitions including the following;

- Suicide reduction will remain a NHS priority
- Full coverage across the country of the existing suicide reduction programme
- Design and roll out of a Mental Health Safety Improvement Programme with a focus on suicide prevention and reduction for mental health inpatients
- Use of decision support tools to increase our ability to deliver personalised care and predict future behaviour, such as risk of self-harm or suicide.
- Bereavement support for families and staff bereaved by suicide , who are likely to have experienced extreme trauma and are at heightened risk of crisis themselves, which will be rolled out to all areas of the country.
- A new approach to the longer term management of self-harm

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<sup>5</sup> <https://www.longtermplan.nhs.uk/online-version/>



There have been a number of other national publications to support this strategy; such as:

- Preventing suicide in England: Third progress report (2017)<sup>6</sup>
- Public Health England's Local suicide prevention planning practical resource (2016)<sup>7</sup>
- National Confidential Inquiry into Suicide and Homicide Report: Suicide by children and young people (2017) <sup>8</sup>
- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2017) <sup>9</sup>
- Public Health England: Support after a suicide: A guide to providing local services: National Suicide Prevention Alliance (2017)<sup>10</sup>

These publications, alongside stakeholder engagement and the local data have informed the development of this strategy. This local strategy will in time align with the wider action plan to support a Mentally Healthy City and the Health Inequalities Framework for Birmingham which will be developed over 2019/20.

## The Picture of Suicide

The picture of suicide in England is limited because the data is drawn from death certification.

For many years the coroner has had to be certain beyond reasonable doubt that the death was through suicide before confirming this on the death certificate, this has probably led to an under-estimate of the scale of suicide. However in 2017/18 the guidance for coroners changed to allow 'death through suicide' to be based on reasonable judgement and this is likely to see an increase in the number of deaths attributed to suicide.

It is important to also recognise that although there may be a link between self-harm and suicide, the data on self-harm reflects a larger group of people, some of who have no intention of dying.

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<sup>6</sup> Department of Health (England). Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives. 2017.

<sup>7</sup> Public Health England Local suicide prevention planning: A Practice resource: <https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan>

<sup>8</sup> Suicide by children and young people in England. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2017.

<sup>9</sup>The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report: England, Northern Ireland, Scotland and Wales. October 2017. University of Manchester

<sup>10</sup> Public Health England: Support after a suicide: A guide to providing local services: National Suicide Prevention Alliance <https://www.gov.uk/government/publications/support-after-a-suicide-a-guide-to-providing-local-services>

## The National Picture

Suicides have seen an overall decreasing trend since time series began. However male suicides remain significantly higher than females. Suicide rates are higher among specific groups of occupation as well as specific population groups such as lesbian, gay, bisexual and trans people, ethnic minority people and refugee and asylum seekers.

The highest rates regionally are seen in the North of England. With the West Midlands close to the England average. The lowest rates are in London.

In 2017<sup>11</sup> there were 5,821 suicides registered in the UK, an age-standardised rate of 10.1 deaths per 100,000 population. The UK male suicide rate of 15.5 deaths per 100,000 was the lowest since time-series began in 1981; for females, the UK rate was 4.9 deaths per 100,000, this remains consistent with the rates seen in the last 10 years. Males accounted for three-quarters of suicides registered in 2017 (4,382 deaths), which has been the case since the mid-1990s. Suicide is currently the most significant cause of death among Males below the age of 50 and young people aged 5 to 19<sup>12</sup>.

The highest age-specific suicide rate was 24.8 deaths per 100,000 among males aged 45 to 49 years; for females, the age group with the highest rate was 50 to 54 years, at 6.8 deaths per 100,000.

A third of people who die through suicide have been in contact with mental health services before their death, a further third have been in contact with primary care services but the remaining third have had no contact with services. Young men are the most likely to be among the third with no contact with services before their death. In 2017 hanging or strangulation was the most common method for suicide followed by poisoning.

Data is lacking on how many suicide attempts are among those previously bereaved by suicide, but research suggests around 1 in 10 bereaved people have made an attempt<sup>13</sup>.

Non-fatal self-harm is one the strongest risk factors for subsequent suicide. The data on self-harm is based on clinical data from presentation to healthcare services, so is likely to be an underestimate of the actual number of people affected. Evidence suggests that the UK has one of the highest rates of self-harm in Europe<sup>14</sup> and for all

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<sup>11</sup><https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2017registrations>

<sup>12</sup> ONS: Deaths Registered in England and Wales (series DR): 2017

<sup>13</sup> Pitman AL, Osborn DP, Rantell K, King MB. Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults. *BMJ open*. 2016 Jan 1;6(1):e009948.

<sup>14</sup> Horrocks, J., House, A. & Owens, D. (2002). Attendances in the accident and emergency department following self-harm; a descriptive study. University of Leeds, Academic Unit of Psychiatry and Behavioural Sciences.

age groups the annual prevalence is approximately 0.5%<sup>15</sup> of the population experience self-harm.

Self-harm is most common among young people with the highest rates of hospital admissions due to self-harm in the 15-19 age group. (648.6 admissions per 100,000 in 2017/18<sup>16</sup>).

Research also shows us that girls are twice as likely to self-harm than boys<sup>17</sup> and admission rates for girls almost doubled in two decades, from 7,327 in 1997 to 13,463 in 2017.

## The Local Picture

The latest figures in Birmingham indicate the suicide rate to be significantly lower than the England average<sup>18</sup>.(fig 1)

The number of death registrations for suicide and injuries of undetermined intent in 2015-17 was 205<sup>19</sup> which equates to around 70 per year. Rates for Birmingham are similar to some of nearest statistical neighbours<sup>20</sup>, but lower than most.

Fig 1: Age standardised rate of suicide (all persons) per 100,000 population 2015-17 (3yr average) Source: PHE Fingertips



<sup>15</sup> NICE (2003). "Self-harm in over 8s: long term management." Clinical Guideline 133. Available at:

<https://www.nice.org.uk/guidance/cg133/resources/selfharm-in-over-8s-longterm-management-35109508689349>

<sup>16</sup><https://fingertips.phe.org.uk/search/self%20harm#page/3/gid/1/pat/6/par/E12000005/ati/102/are/E08000025/iid/92796/age/6/sex/4>

<sup>17</sup> Morgan C, Webb RT, Carr MJ, Kontopantelis E, Green J, Chew-Graham CA, Kapur N, Ashcroft DM. Incidence, clinical management, and mortality risk following self harm among children and adolescents: cohort study in primary care. *bmj*. 2017 Oct 18;359:j4351.

<sup>18</sup> <https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/0/gid/1938132828/pat/6/par/E12000005/ati/102/are/E08000025>

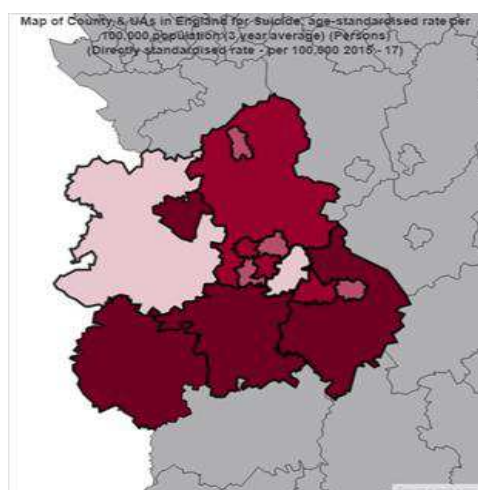
<sup>19</sup> Public Health Outcomes Framework indicator 4.10.

<sup>20</sup> CIPFA nearest neighbours - <https://www.cipfa.org/policy-and-guidance/publications/n/nearest-neighbour-model-england>

There has been some fluctuation in the 3 year rate for Birmingham as in 2014 due to a backlog of coroners cases being processed within a single year, however this has now rebalanced and the current trend is in line with the previous 3yr rate.

Compared to the rest of the West Midlands, Core cities group and the CIPFA comparator group, the 3 year rate of suicide in the city is one of the lowest, (fig 2). However it is important to note that because of the size of the city the overall count of suicides across the three years is second highest and in one year, on average, there are more deaths through suicide in Birmingham than across the whole three year period in Solihull.

**Fig 2: Comparison map and table of Age standardised rate of suicide (all persons) per 100,000 population 2015-2017 (3yr average) across the West Midlands region**



|                | Count | Rate |
|----------------|-------|------|
| Birmingham     | 205   | 7.6  |
| Shropshire     | 67    | 8.0  |
| Coventry       | 76    | 8.8  |
| Walsall        | 65    | 9.1  |
| Dudley         | 77    | 9.4  |
| Solihull       | 52    | 9.5  |
| Staffordshire  | 225   | 9.7  |
| Wolverhampton  | 66    | 9.9  |
| Sandwell       | 86    | 10.4 |
| Worcestershire | 165   | 10.8 |
| Warwickshire   | 169   | 11.3 |
| Herefordshire  | 59    | 11.7 |

Source: Fingertips, Public Health England

Compared to the Core Cities group Birmingham currently has the lowest rate of suicide and across the CIPFA comparison group (a group of demographically matched areas) the 3yr rate of suicide in the city is one of the lowest, (fig 3).

**Fig 3: Comparison tables of Age standardised rate of suicide (all persons) per 100,000 population 2015-2017 (3yr average) across the Core Cities and the CIPFA nearest neighbours group for Birmingham**

|                          | Rate        |
|--------------------------|-------------|
| <b>Core City Average</b> | <b>11.8</b> |
| Leeds                    | 11.8        |
| Bristol                  | 10.6        |
| Liverpool                | 9.9         |
| Manchester               | 9.3         |
| Nottingham               | 9.2         |
| Sheffield                | 7.7         |
| <b>Birmingham</b>        | <b>7.6</b>  |

|                      | Rate        |                   | Rate       |
|----------------------|-------------|-------------------|------------|
| <b>CIPFA Average</b> | <b>10.8</b> |                   |            |
| Salford              | 12.3        | Nottingham        | 9.2        |
| Bolton               | 11.9        | Walsall           | 9.1        |
| Leeds                | 11.8        | Bradford          | 9.0        |
| Bristol              | 10.6        | Leicester         | 8.9        |
| Sandwell             | 10.4        | Coventry          | 8.8        |
| Liverpool            | 9.9         | Sheffield         | 7.7        |
| Wolverhampton        | 9.9         | <b>Birmingham</b> | <b>7.6</b> |
| Kirklees             | 9.4         | Derby             | 7.3        |

Public Health England's suicide prevention profile<sup>18</sup> highlights that Birmingham has high levels of some of the recognised risk factors for suicide but despite this has lower overall rates of suicide than other areas in the West Midlands and Core Cities.

**Fig 4: Some of the Suicide Prevention Risk Factors - Birmingham**



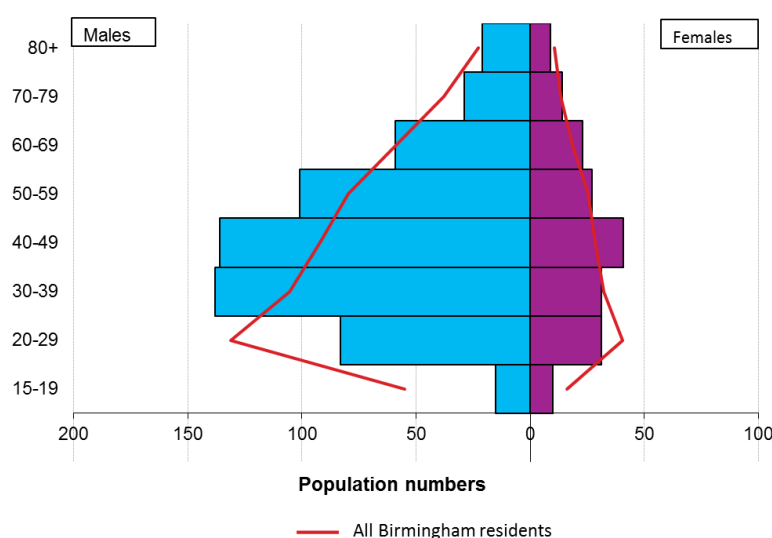
When we explore the detail of the deaths through suicide in Birmingham it highlights some important differences:

- 76% of suicides in Birmingham are men and they most commonly occur in ages 30-49, for women the largest age group is 40-49. (fig 5)
- Birmingham residents born in Poland and Eastern Europe have a higher rate of suicide compared to people born in the UK; however this may not account for recent migration trends and is likely to be a reflection of the larger numbers of working age males in the denominator population. (fig 6)
- 53% of suicides in the last 10 years have taken place at home. Other common locations were other residential properties (6%), public green spaces (4%), canals or rivers (4%), railways (4%). Hospitals were recorded as place of death in 16% of suicides, with no further information on where the suicide took place

Methods of suicide were similar to national rates, with hanging or suffocation accounting for 63% of male and 44% of female suicides since 2007; poisoning was more common for females than males (31% vs 15%)

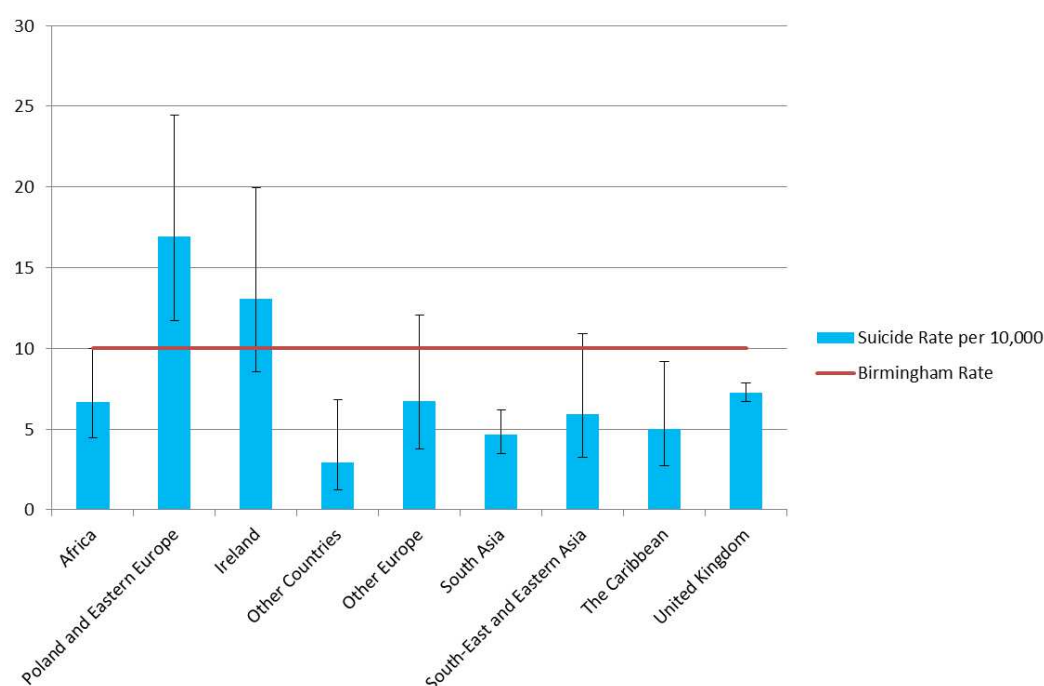
- Similar to national patterns, occupations with higher numbers of suicides in Birmingham were skilled trades, process plant and machine operatives and elementary occupations. (fig 7)
- Nationally, students had a lower rate of suicides than the general population. This appears to also be true for Birmingham according to local analysis

**Figure 5: Population pyramid showing age and sex distribution of deaths due to suicide and undermined injury, Birmingham residents, 2007-2017**



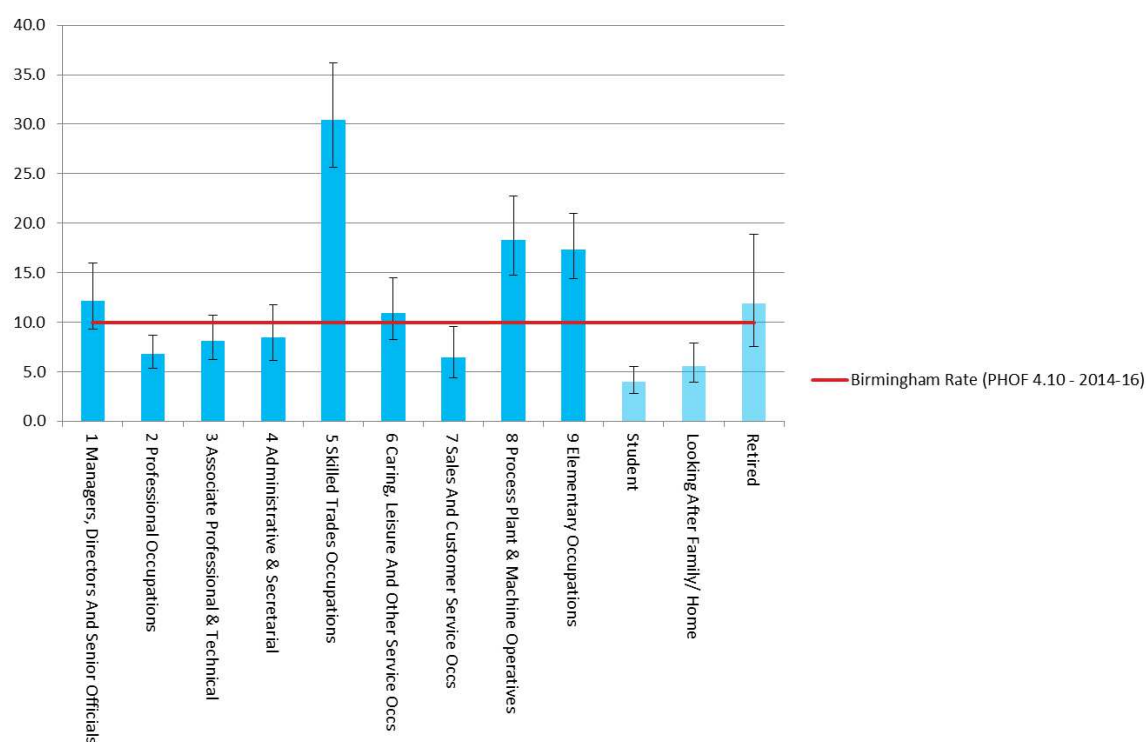
Source: Primary Care Mortality Data, NHS Digital

**Figure 6: Crude suicide rate by country of birth, Birmingham residents, 2007-2017**



Denominator Source: ONS Detailed Country of Birth Analysis from the 2011 Census

**Figure 7: Crude suicide rate by occupation group (males and females), Birmingham residents, 2007-2017**



Denominator Source: NOMIS annual population Survey Employment by occupation Apr 17 to Mar 18, and Economic inactivity table

<https://www.nomisweb.co.uk/reports/lmp/la/1946157186/report.aspx#tabjobs>

# OUR SUICIDE PREVENTION AMBITION

Our ambition for this strategy is to **maintain the lowest rate of suicide of any of the core cities<sup>21</sup> in England and continue to reduce deaths through suicide in the City over the next decade through a Zero Suicide approach**

We will achieve this ambition through collaboration and working together at every level of the city and in every community, family and workplace, focusing our efforts in six key areas (building on the National Suicide Prevention Strategy):

- 1. Reduce the risk of suicide in key high-risk groups**
- 2. Tailor approaches to improve mental health in specific groups**
- 3. Reduce access to the means of suicide**
- 4. Provide better information and support to those bereaved or affected by suicide**
- 5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour**
- 6. Support research, data collection and monitoring**

We can achieve a step change in suicide prevention and mental wellbeing but only if we all step up to act. It is important that we take action across all six areas simultaneously in order to effect change.

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<sup>21</sup> Major cities are defined as being the 'Core City Group' reflecting the largest cities in England. This allows us to benchmark progress against comparable populations and urban context.



# OUR PRIORITIES

## Priority One: Reduce the risk of suicide in key high-risk groups

The inclusion of specific high risk groups within this strategy is underpinned by findings of the National Confidential Inquiry<sup>22</sup>, National Strategy and local intelligence.

- **Men**

Men have a 3 times greater risk of suicide than women, in Birmingham this risk is highest among working age men between 30-49yrs.

In Birmingham there are an estimated 414,319 men<sup>23</sup>, the current 3yr average rate of suicide in men in the city is 11.3/100,000, meaning over the last three years and estimated 47 men have died through suicide.

Men are a large and diverse group of the population. However focusing on raising awareness of mental health issues and suicide amongst men and reducing the stigma on men talking about their mental health can be effective interventions.

- **People with a history of self-harm**

Self-harm, including attempted suicide, is the single biggest indicator of suicide risk.

In Birmingham in 2017/18 1,977 individuals presented to A&E with self-harm.

There is already NICE guidance on the treatment of self-harm which includes psychosocial assessment and mental health liaison support in the emergency department. Psychiatric Liaison service is specialist multidisciplinary mental health service, working within all acute hospitals in Birmingham for people that present at A&E.

Alongside this important provision it is important that clinical commissioners ensure that good local data is driving service improvement to minimise the risk for this group when they present in the emergency department or in primary care.

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<sup>22</sup> The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report: England, Northern Ireland, Scotland and Wales.

<sup>23</sup> ONS Mid-Year population Estimates 2017 – Males aged 18+

- **People with alcohol and drug-related problems**

Nationally 45% of suicides involved patients with a history of alcohol misuse, 33% had a history of drug misuse.

13.6%<sup>24</sup> of adults in Birmingham are binge drinkers of alcohol, and while this is lower than the national average it still represents approximately 115,469 adults in the city. A further 1.66% are dependent drinkers, approximately 14,094 adults.

There are around 6,666 individuals in treatment for drug use<sup>25</sup>.

There is existing NICE guidance on dual diagnosis, i.e. substance misuse and mental health issues, and it is important that our drug and alcohol support services and mental health services are working closely together to support individuals and reduce the risk of suicide through the care pathway.

- **People in the Care of Mental Health Services (including in-patients)**

Around 60-70 inpatients die by suicide per year nationally. Of all patients who died through suicide in the first week after discharge in 2017, the highest number occurred on the second (19%) and third (21%) day.

There were 3,700 mental health in-patient admissions during 2017/18 in Birmingham<sup>26</sup>, although some of these represent readmission of the same individuals, each admission is an opportunity to intervene and prevent suicide after discharge.

The national campaign for all mental health trusts to achieve Zero suicides provides an excellent framework for action and Birmingham Mental Health Trust will need to work with partners across primary and secondary care to achieve this and reduce the risk for in-patients and patients supported by community services.

In addition local data indicates two specific high-risk groups identified by place of birth and occupation:

- **Birmingham residents born in Poland and Eastern Europe**

According to the last census there were approximately 16,562 Birmingham residents born in Poland and Eastern Europe and this figure is likely to be higher today. This group has the highest suicide rate by country of Birth and is two thirds higher than the City's population as a whole

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<sup>24</sup> PHE Local Alcohol Profiles for England

<sup>25</sup> PHE Public Health Profiles : Adults in treatment at specialist drug misuse services

<sup>26</sup> Hospital Episode Statistics (ICD10 codes F00-F99)

By the nature of being a thriving city there is some churn in the population with people moving into the city and leaving the city but there is a growing population who have moved into Birmingham from Poland and Eastern Europe. We need to work with these communities and the groups that are most engaged with them as well as with service providers to ensure mental health and wellbeing services are culturally appropriate.

- **People in skilled trades occupations (e.g. construction industry)**

In Birmingham the rate of suicide among men and women in skilled trade occupations, like construction, is three times the average for the city.

It is estimated that 42,000 people in Birmingham work in a skilled trade<sup>27</sup>.

Birmingham is a city with a significant amount of construction and building development, providing jobs for local people as well as attracting transient trades people from outside the city. We have to work with employers, developers and trade professional bodies to raise awareness of suicide and reduce the risks associated with the workplace.

Although these are in many ways broad categories of individuals, by addressing them in a focused way there is likely to be a positive impact on the general mental wellbeing of the city and reduce the risk of suicide.

## **Priority Two: Tailor approaches to improve mental health in specific groups**

As well as targeting high-risk groups, another way to reduce suicide is to improve the mental health of the population. For this whole population approach to reach all those who might need it, the national strategy recommends tailored measures to improve the mental health of groups with particular vulnerabilities or problems with access to services.

The groups highlighted in the national strategy are:

- **Children and young people, specifically looked after children, care leavers and children and young people in the youth justice system**

Children and young people have an important place in the strategy. Too many children are developing poor mental well-being and the risk of suicide is greater when children have mental health issues. Looked after children and care leavers are between four and five times more likely to self-harm in adulthood.

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<sup>27</sup> NOMIS Annual Population Survey by SOC2010 2017/18

In Birmingham when we focus on the highest risk groups of children and young people, this is the scale of the population in 2017:

1,838 Looked after children<sup>28</sup>

726 Care Leavers<sup>29</sup>

870 Children and young people in the youth justice system

Focusing our efforts on preventing suicide among these children and young people who are at highest risk will have a broader positive impact on the wider population of children and young people.

- **Survivors of abuse or violence, including sexual abuse**

There is a strong link between individuals experiencing violence and abuse and suicide, which is why it is important that there are coherent and evidence based services of support for people enduring violence and abuse.

We know from the research into adverse childhood events (ACE) that the impact of abuse, neglect and violence can play out across a lifetime. While there is no routinely collected data on the distribution of those with defined ACES in Childhood, commissioned surveys<sup>30 31</sup> suggest that almost half (47%) of Adults (aged 18-69) had at least one of these experiences in childhood. In Birmingham this could potentially equate to almost 350,000 adults.

Over 40,000<sup>32</sup> individuals experience domestic abuse in the City and it is important that all of our specialist support services are actively thinking about the mental health and wellbeing of clients.

There are also 31,692 people affected by violent crime in the city in 2017/18<sup>33</sup> and as well as considering the physical impact of this violence it is essential

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<sup>28</sup> DfE Children Looked After in England Local Authority Tables 2017

<sup>29</sup> DfE Children Looked After in England Local Authority Tables 2017 - Number of children who ceased to be looked after during the year

<sup>30</sup> ACES in Blackburn with Darwin Council –with Liverpool John Moores University 2014

<https://www.blackburn.gov.uk/Pages/aces.aspx>

<sup>31</sup> Hughes K et al. Relationships between adverse childhood experiences and adult mental well-being: results from an English national household survey. BMC public health. 2016

<sup>32</sup> Birmingham Domestic Abuse Prevention Strategy 2018 – 2023

[https://www.birmingham.gov.uk/downloads/file/10086/domestic\\_abuse\\_prevention\\_strategy\\_2018\\_-\\_2023](https://www.birmingham.gov.uk/downloads/file/10086/domestic_abuse_prevention_strategy_2018_-_2023)

<sup>33</sup> Police.UK – Reported Violence and Sexual Offences 2017/18 (to September) Extrapolated from published rate using ONS mid-year population data

that commissioners and service providers address the short and long term psychological impact.

- **Veterans**

In Birmingham there are an estimated 93,000 veterans<sup>34</sup>.

The Council and many partner organisations are signatories to the Armed Forces Community Covenant which sets out a commitment to address the needs of veterans and provides an important opportunity to specifically think about the needs of this group of individuals.

- **People living with long-term conditions and disability**

There is a strong evidence of an association between long-term health conditions and poor mental health.

In Birmingham approximately 198,000 people are living with a long-term health condition or disability<sup>35</sup>. Nationally two thirds of people with a long term physical health condition also have a co-morbid mental health problem, mostly anxiety and depression. Therefore we would estimate at least 130,680 people are living with mental health problems and long term health conditions. It is important that we consider the mental health and wellbeing of individuals with long term conditions, especially chronic pain, and clinical and social care professionals are actively talking about mental health issues, especially where physical health is deteriorating.

- **People with untreated depression**

People who have untreated depression are at increased risk of suicide and self-harm and around half of all completed suicides are related to depressive and other mood disorders (ICD-10 F3)<sup>36</sup>. Only around 1 in 3 people with depression receive treatment, and there are inequalities in treatment seeking behaviour and receipt of treatment.<sup>37</sup> With around 55,000<sup>38</sup> adults on the primary care depression registers of Birmingham GPs, there may potentially an additional 110,000 people who are not in receipt of treatment and at higher risk of suicide than those receiving help.

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<sup>34</sup> 2011 Census (ONS) estimates 11% – applied to Birmingham Population

<sup>35</sup> <https://www.nomisweb.co.uk/census/2011> (table KS301EW)

<sup>36</sup> Bachmann S. Epidemiology of suicide and the psychiatric perspective. International journal of environmental research and public health. 2018 Jul;15(7):1425.

<sup>37</sup> Adult Psychiatric Morbidity Survey 2014: NHS Digital

<sup>38</sup> Quality and Outcomes Framework 2017-18 Recorded Disease Prevalence Table 2: Depression

We need to increase awareness of the signs and symptoms of depression and ensure that people are aware of the support available and how to access it themselves or to signpost others.

- **People who are especially vulnerable due to social and economic circumstances**

There are strong links between mental ill-health and social factors like unemployment, debt, social isolation, family breakdown and bereavement. Adults aged between 16 and 59 who live alone for example are significantly more likely to have common mental disorders (CMD) than those who live with others. There are also marked differences in CMD prevalence among labour market cohorts. Using age-standardised figures, the CMD rate in employed people is 15.2% (aged 18-64) compared to 28.8% in the unemployed and 33% among people who are economically inactive<sup>39</sup>. Birmingham's claimant rate is the highest of all of the core cities at 7.3%, and economic data shows around 37,000 are unemployed and seeking work with an additional 217,000 people economically inactive<sup>39</sup>. Between these two cohorts there may be around 82,000 in a vulnerable position suffering with CMD.

We need to work to improve the advice and support available to people who are more vulnerable due to their circumstances. This means delivering mental health support together with practical advice in front line services (such as debt, benefits and housing), with mental health awareness embedded within service delivery.

- **Lesbian, gay, bisexual and transgender people**

Between 2-5%<sup>40</sup> of the population nationally identify as lesbian, gay, bisexual and/or trans, however data from the GP patient survey in 2017<sup>41</sup> would suggest in Birmingham the figure is between 2.5- 3.9% .

Nationally and internationally there is evidence of increased rates of mental health problems, self-harm and suicidal thoughts among LGBT people, especially LGBT young people<sup>42</sup>.

In Birmingham, it is estimated, that between 17,563 and 43,908<sup>43</sup> identify as LGBT based on the national estimates.

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<sup>39</sup> Economically Inactive – includes full time students, looking after family and those unable to work for health reasons

<sup>40</sup> Annual Population Survey (2017 data), Office for National Statistics

<sup>41</sup> NHS GP Patient Survey (2017). IPSOS Mori. <https://gp-patient.co.uk/surveysandreports2017>

<sup>42</sup> NIESR Report: Inequality among lesbian, gay bisexual and transgender groups in the UK 2016

<sup>43</sup> Calculated on Birmingham Population 16 and over

Addressing these issues requires action across the whole system and is as much about ensuring that mental health services are accessible and culturally competent to support LGBT people as tackling the discrimination and harassment that add to the burden of mental ill health.

- **Black, Asian and minority ethnic groups**

People from Black, Asian and minority ethnic groups often face cultural stigma around mental health problems and there are inequalities in access to health services. Research suggests that Black Adults for example have the lowest treatment rate of any ethnic group<sup>44</sup> but have higher rates of serious mental illness such as psychosis<sup>45</sup>. There is also evidence that some immigrant groups may be at higher risk of suicide. In a review Non-European immigrant women (including Black African and South Asian) were at the highest risk for suicide attempts. Risk factors among migrants and ethnic minorities were found to be: language barriers, worrying about family back home, and separation from family<sup>46</sup>.

42% of the population of Birmingham come from a non-white British ethnic background<sup>47</sup>; in some parts of the city non-white ethnic groups are becoming the majority population, however there remain issues with culturally competent services and issues of stigma and discrimination around mental health within some ethnic minority communities.

We need to work with communities to reduce stigma around mental health and suicide as well as bridge the gap between service providers and communities to ensure individuals in need are able to access support.

- **Refugees and asylum seekers.**

People who are refugees and asylum seekers may require additional support as a result of trauma that they may have experienced in their country of origin or during their journey to the UK

There are approximately 1,800 asylum seekers in Birmingham, though this figure fluctuates during the year being accommodated by the government and awaiting a decision on their asylum claim. This is in addition to people who have already been granted refugee status (or some other leave to remain)

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<sup>44</sup> Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital

<sup>45</sup> Kirkbride, J et al. Psychoses, ethnicity and socio-economic status. *The British Journal of Psychiatry*, 2006 193(1), 18–24

<sup>46</sup> Forte A et al. Suicide risk among immigrants and ethnic minorities: a literature overview. *International journal of environmental research and public health*. 2018

<sup>47</sup> ONS Census 2011: KS201

and have settled within the City... Support for refugee communities is inconsistent but delivered through a range of voluntary, community and public sector agencies and services.

The Home Office and its contracted providers (Serco and Migrant Help from September 2019) are responsible for the welfare of asylum seekers they are accommodating and supporting. Once people leave that accommodation those duties come to an end and it is the responsibility of mainstream public sector services to identify, engage with and support refugee communities who may be experiencing crisis or at risk of crisis. Mental health is a consistent concern – including awareness and self-help, cultural sensitivities, visibility in and engagement with the health system, as well as specific and relevant services for refugee communities and it is vital that we maintain this focus.

- **People in Contact with the Criminal Justice System**

People who come into contact with the criminal justice system are high risk of for suicidal behaviour and self-harm<sup>48</sup> and experience many of the risk factors associated with these behaviours such as mental illness, adverse life events, drug and alcohol misuse and relationship breakdown as well as the effects of incarceration, and adjustment to life after release. We need to ensure an efficient and consistent approach across all partner organisations involved in the Criminal Justice System, to recognise and support poor mental health and other risks.

## **Priority Three: Reduce access to the means of suicide**

Restricting access to the means of suicide is an important component of this strategy. It is a well evidenced and effective area of suicide prevention particularly in cases of impulsive suicide, where if the means are not easily available at the time of crisis the suicidal impulse may pass<sup>49 50</sup>.

The most common methods of suicide in both Birmingham and England are hanging, suffocation and poisoning.

Addressing access requires action at many different levels, including:

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<sup>48</sup> Borschmann R, Young JT, Moran PA, et al. Self-harm in the criminal justice system: A public health opportunity. *The Lancet Public Health*. 2018 Jan 1;3(1):e10-1.

<sup>49</sup> Florentine JB and Crane C (2010) Suicide prevention by limiting access to methods: a review of theory and practice. *Social Science & Medicine* 70(10): 1626–1632

<sup>50</sup> HM Government: Preventing Suicide in England; A cross-government outcomes strategy to save lives



- Considering risk of suicide in the planning, design and refurbishment of housing and public spaces and facilities (e.g. car parks) for both new and change of use facilities for vulnerable people near to high risk locations.
- Mapping potential high risk sites through reviewing self-harm data and reports from health and police services and take action to reduce risk e.g. barriers, signage.
- Increase awareness of suicide risk, and steps to intervene, in staff working in high risk areas e.g. park wardens, traffic wardens.
- Reduce the risk of medication stockpiling through safer prescribing practice, especially for patients in high risk groups.
- Support retailers and vendors to consider suicide risk in the sale of potentially fatal gases and liquids.

Reducing access in many ways is one of the simplest steps that we can take but because of the variety of ways in which individuals die through suicide it is an area which requires continual review and collaboration between partners as things progress.

## **Priority Four: Provide better information and support to those bereaved or affected by suicide**

For those bereaved by suicide the impact is severe.

Families and friends who are bereaved are at highest risk of mental health problems but it can have also have a profound effect on the local community or on the workplace/school or college where the individual was.

For every life lost at least 10 people are affected, with research suggesting that this could be as high as 135<sup>51</sup> people in need of support. Based on the number of suicides in Birmingham we would estimate that between 700 and 9,500 people affected by suicide are in need of support annually.

There is no national specialist service for those bereaved by suicide in the NHS but there are many charities which provide support and advice to bereaved individuals.

It is important that all organisations in the city think about how they can support individuals who are bereaved, including when that bereavement is through suicide, this includes:

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<sup>51</sup> Cerel, Julie, et al. "How many people are exposed to suicide? Not six." Suicide and Life-Threatening Behaviour (2018).

- Employers utilising the evidence based toolkits in suicide post-vention from Public Health England and Business in the Community
- Promoting the 'Help at Hand' resource to relatives when a death occurs alongside the 'Waiting Room Resource Key' to support signposting to help.
- Working between public sector and third sector partners to ensure an appropriate bereavement support service that recognises the specific aspects of death through suicide with consideration of capacity, real time referral and data sharing requirements.
- Considering public awareness campaigns to raise awareness of the support available for individuals affected by a death through suicide.

## **Priority Five: Support the Media in delivering sensitive approaches to suicide and suicidal behaviour**

How the media portrays suicide and what is reported can have a significant influence on behaviours and attitudes.

The way in which the UK media has reported suicide has changed fundamentally over the years – in part due to charities, like Samaritans working in the area of suicide prevention.

Ultimately, we can only reduce the numbers of suicides each year if we continue to talk about the issue and the media has an important role in educating the public on suicide prevention and are able to utilise mass readership and viewing to publicise sources of help and support available. However inappropriate reporting may put vulnerable individuals at risk, effect the bereaved and may lead to imitative behaviour.

Research consistently demonstrates that risk significantly increases if details of suicide methods are reported, or if the coverage is extensive or sensationalised.

The media need to continue to cover this important topic but this need to be done without putting vulnerable people at risk.

We need to work with local and regional media, especially considering media focused on high-risk communities, to increase awareness of national guidelines on responsible reporting of deaths through suicide and promoting a positive and culturally sensitive discussion in the media about mental health issues.

## **Priority Six: Support research, data collection and monitoring**

Accurate and timely data on suicides statistics is vital for understanding patterns and behaviours, reducing risk and informing action to prevent future suicides. Such intelligence will also provide some of the measures of success for this strategy.

Currently there is a limited source of information and intelligence regarding local suicides to inform prevention activity in the city. However there are future opportunities to develop a system of real time surveillance with partners.

We have to work together across the partnership supporting this strategy to develop more a coherent and robust picture of suicide and self-harm and the related risk factors in the city to support service planning and monitor the impact of this strategy on outcomes and risk reduction.

## **MOVING INTO ACTION**

### **Governance & Accountability**

Tackling suicide requires major action from a wide range of organisations working in partnership.

We recognise that our NHS commissioning and provider partners have geographies which extend beyond the geographical boundary of the city, most often with Solihull.

Ultimately there is shared responsibility between the NHS and the Council for delivery of this strategy. This shared responsibility comes together through the statutory Health and Wellbeing Boards and the Mentally Healthy City sub-board that is being established in 2019/20. The Mentally Healthy City sub-board will link with the NHS STP Mental Health Delivery Board which reports up through the NHS governance framework and both will draw on the external stakeholder Mental Health Partnership Group.

The Suicide Prevention Working Group will oversee the delivery of the action plan and monitor progress against the plan. This group will report to the Mental Health Programme Delivery Board and the Health and Wellbeing Board through the Mentally Healthy City Sub-Board. Annex 2 sets out the current terms of reference.

The Suicide Prevention Working Group will oversee delivery of an annual action plan that will be signed off by the Director of Public Health on behalf of the Health and Wellbeing Board and the Clinical Commissioning Group.

## Measuring Success

Fortunately suicide is still a relatively infrequent occurrence, however we will track progress for this strategy through metrics linked to our ambition.

Our ambition is to maintain the lowest suicide rate of the core cities in England and achieve a zero deaths through suicide ambition over the next decade; these will be monitored through the national indicators on 3yr rolling rates and counts published by PHE.

Alongside these indicators we are also developing through the action plan for 2019/20 a suite of metrics to track progress against the priority areas for action.

## Principles for Action

Across the implementation of this strategy we have agreed a set of core principles which are shared across the partnership, these are:

1. We are open to share and learn as we implement action to move forward the strategy in the city.
2. We recognise the inequalities in mental health and self-harm that sit behind the picture of suicide and will work collectively to address these.
3. We understand that the implementation of this strategy will require action by all partner organisations, by communities and by citizens working together.
4. We are committed to keeping citizens at the centre of what we do.

## Action Plan Development

The Suicide Prevention Working Group will be responsible for co-developing an annual action plan which will be approved by the Director of Public Health for Birmingham City Council, in consultation with the chairs of Health and Wellbeing Board and STP/CCG Boards.

## Keeping Citizens at the centre

We are committed to keep Citizens at the centre of what we do as we move forward this work and therefore the final section of this strategy is dedicated to the voices of citizens affected by suicide and self-harm.

*'When I look back over the period of time leading up to my suicide attempt, I realise I actually hit all the 'high risk' markers. A holistic approach is needed rather than a 'tick box' one. If a person is saying no to thinking of acting on suicidal thoughts, yet all the indicators point to significant risk factors, such as recent abuse or assault, significant depression, a major life circumstance, a history of self-harm including drug misuse, every effort should be made to ensure safety of that individual. My own personal experience is that I would have benefitted from Increased input from a community mental health team, a link between mental health and drug misuse teams, my doctor not supplying large quantities of medication on prescription at once and retailers being giving training to be made aware of potentially fatal means being sold.'*

*'My life took a desperate turn when I lost my job and got into debt. I couldn't face life failing my family. I had enough medication from my Doctor to end it. They would be better without me. If I hadn't been found as soon as I was, my children would have been growing up without their Daddy and this haunts me every day. I was scared to tell anyone how I felt because I thought my children would be taken into care. Looking back, I wasn't a danger to anyone, only myself. Maybe I wouldn't have got that far if it wasn't such a stupidly scary thing to talk about or if people could talk to me without being scared themselves. People are too scared to even say the word.'*

## ANNEXES

1. Membership of the Suicide Prevention Working Group
2. Suicide Prevention Working Group TOR
3. 2019/20 Draft Action Plan

## ANNEX 1 – Suicide Prevention Working Group Membership<sup>52</sup>

| Name             | Organisation                    |
|------------------|---------------------------------|
| Justin Varney    | Director of Public Health - BCC |
| Duncan Vernon    | Public Health - BCC             |
| Amanda Lambert   | Public Health - BCC             |
| Dennis Wilkes    | Public Health - BCC             |
| Jenny Riley      | Public Health - BCC             |
| Mo Philips       | Public Health - BCC             |
| Elaine Woodward  | NHS England                     |
| Helen Wadley     | Birmingham MIND                 |
| Paul Sanderson   | PHE                             |
| Kerry Webb       | BSMHFT                          |
| Joanne Carney    | BSOL CCG                        |
| Gemma Coldicott  | BSOL CCG                        |
| Jennifer Weigham | BSOL CCG                        |
| Dario Silverstro | BSOL CCG                        |
| Clare Walker     | Solihull MBC                    |
| Elaine Kirwan    | BWC NHS FT                      |
| Lisa McGowan     | BWC NHS FT                      |
| Sean Russell     | WMCA                            |
| Karen Edwards    | NHS England                     |
| Dave Brown       | PAPYRUS                         |
| Lesley Hales     | CRUSE Birmingham                |

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<sup>52</sup> As at May 2019

## **ANNEX 2 – Suicide Prevention Working Group Terms of Reference**

Terms of reference Birmingham Suicide Prevention Working Group

### **1. Aim**

The Birmingham Suicide Prevention Working Group aims:

- to reduce the rate of suicide and self-harm within Birmingham
- to provide a forum for successful multi-agency partnership working at strategic and operational level
- to work across STP area Birmingham and Solihull

### **2. Objectives**

To facilitate and promote joined up partnership arrangements where appropriate in ensuring effective working to reduce suicide rates across STP area

### **3. Responsibilities**

- to develop and agree a multi-agency suicide prevention strategy and action plan for Birmingham (and work across/with Solihull's strategy and plan)
- to monitor the implementation of the suicide prevention strategy
- to review and update the strategy as appropriate
- to inform and influence commissioning of specific projects and initiatives to meet the aims of the suicide prevention strategy over and above routine MH commissioning by CCGs
- to commission and analyse an annual statistical and intelligence update
- to publicise ongoing work and recent developments
- to facilitate partnership working between organisations represented on the Working Group
- to influence the work of all agencies and individuals who could help prevent suicide and self-harm, including those with lived experience.



#### **4. Membership**

To ensure that as many people and organisations are aware of, and involved in, suicide prevention this group has two types of members:

- those that regularly attend the meetings of the working group
- those who don't regularly attend the meetings, but are on the circulation list and may attend the meetings on an ad-hoc basis.

[regular attenders must include one representative from each of the Task and Finish groups; member from each political party; DPH, PHE/NHSE, Solihull, CCG, MH Trust, VCSE]

[Others who are to be included in the circulation list who may attend on an ad hoc basis include emergency services; police; fire; CJS; railways]

#### **5. Accountability**

This group will report to the local Health and Wellbeing Board, the appropriate STP board, and Health Committees within the Council.

#### **6. Administrative support**

Public Health will provide the Chair and the admin support for the Group initially until further review.

#### **7. TOR approval and review date**

Terms of reference will be reviewed every two years. The next review date will be Feb 2021.

#### **8. Frequency of Meetings**

Meetings of the working group will be held quarterly (unless otherwise agreed by the working group). Where possible, meetings will be held in different venues across Birmingham.

## **ANNEX 3 – Draft Action Plan**

The Action Plan will be fully worked up with Partners at the Suicide Prevention Working Party meetings.

Costs associated with partners will be paid by those organisations.

It is felt that only sundry expenses and Officer time will be associated with Birmingham City Council and those will be met from the Public Health Grant.

## Action Plan

|   |                  | Initial Actions   | Detail   | Lead | Partners | Timescale |
|---|------------------|---|--|------|----------|-----------|
| <b>Priority 1: Reduce the risk of suicide in key high-risk groups</b> |                  |   |  |      |          |           |
| 1   | <b>Men</b>       | <p>Raise awareness among men of the support available</p> <p>Reduce stigma among men including finding different language to use and not presuming that men don't want to talk.</p> <p>Consider community leaders/ faith leaders as ambassadors.</p> <p>Develop health promotion initiatives which are targeted at men and delivered in locations frequented by men (job centres, youth centres, sports venues, barbers, tattoo artists, music venues, pubs and clubs.</p> <p>Safe space for men to talk.</p> | <p>Learn from other areas e.g. wave 1 SP sites and trailblazer sites. For example- sports focussed programme; men only programmes; campaigns</p> <p>Detail to be agreed</p>  |      |          |           |
| 2   | <b>Self-Harm</b> | <p>Implement NICE guidance on the treatment of self-harm , including assessments at Emergency Department, including psychosocial assessments and mental health liaison services</p> <p>Improve local monitoring of people who present with self-harm</p> <p>Ensure services in place for those who self-harm</p> <p>Serial presentations of self-harm should be red-flagged as a high suicide risk.</p> <p>Raise awareness with schools/ Children's Trust regarding self-harm and serial self-harmers.</p>    | <p>Work with local CCG commissioners/psychiatric liaison to ensure evidence is collected towards the Public Health Outcome Framework measurement of people presenting with self-harm.</p> <p>Make the local Emergency Care Data Set as robust as possible and raise awareness of the NHS</p> |      |          |           |

|   |                               | Initial Actions  | Detail   | Lead        | Partners | Timescale |
|---|-------------------------------|--|--|-------------|----------|-----------|
|   |                               |  | CQUIN for people who frequently attend Emergency Department having self-harmed<br><br>Detail to be agreed  |             |          |           |
| 3 | <b>Substance Misuse</b>       | <p>Ensure that Mental Health and Substance Misuse services are implementing the NICE Dual Diagnosis guidance</p> <p>Ensure greater focus on alcohol and drug misuse is as a key component of risk management in mental health care</p> <p>Dual diagnosis pathways to be reviewed and embedded to enable the most effective partnership working (Substance Misuse/ Mental Health).</p> <p>More joined up care required as D&amp;A Programmes often exclude people from mental care.</p> | <p>Contact:<br/> <a href="mailto:adele.flannegan@aquarius.org.uk">adele.flannegan@aquarius.org.uk</a> </p> |             |          |           |
| 4 | <b>Mental health patients</b> | <p><u>MH Inpatients</u><br/> NHSE to support/challenge all MHT zero suicide ambition inpatient plans to include:<br/> - Assessment and risk management based on best practice.<br/> - SI process/learning<br/> - Safety plans</p> <p><u>Primary care/IAPT service</u><br/><br/> Suicide prevention training for all GP's.</p>  | <p>Online programmes to be</p>   | NHS England |          |           |

|    |   | Initial Actions  | Detail   | Lead  | Partners | Timescale |
|----|---|--|--|---|----------|-----------|
|    |   | Ensure IAPT providers do not include self-harm/suicide risk as an exclusion criteria   | sent (Dr Cave).<br><br>For all GP's provide training and materials – in identifying patients at risk of death by suicide.  |   |          |           |
| 5. | <b>Birmingham Residents Born in Poland and Eastern Europe</b> | <p>Work with Polish and Eastern European communities and the groups that are most engaged with them as well as with service providers to ensure mental health and wellbeing services are culturally appropriate/ sensitive.</p> <p>Learn from other areas with existing focused services in place</p> <p>DWP – work psychology specific sessions with interpreters.</p> <p>Work with Polish and Eastern Europe ex-pats to know where communities are.</p> <p>Highlight suicide and mental wellbeing through community events.</p> <p>Develop champions (P&amp;EE).</p> <p>Undertake training for P&amp;EE for translators.</p> <p>Campaign to reduce stigma in Polish/ EE communities.</p> | <p>Link with CEO of the Polish Ex Pats Association and Director of Health Policy in Warsaw</p> <p>Michelle &amp; Stephen Handsworth JCP – find out if this has been done or if this is volunteering.</p> <p>TWR/ PH/ Barney Thorne</p> | <p>DPH/ Birmingham Public Health</p> <p>DWP</p> |          |           |
| 6. | <b>People in Skilled Trade Occupations</b>                    | <p>Work with employers, developers and trade professional bodies to raise awareness of suicide and reduce the risks associated with the workplace. Thrive at Work – link to PHE toolkit for employers.</p> <p>Promote the Zero Suicide Alliance training with SME's and Construction Companies.</p>  | <p>Mates in Mind Mental Health First Aiders.</p> <p>Greater Birmingham Chamber of Commerce/</p>  | <p>DPH/ Birmingham Public Health</p>            |          |           |

|  |  | Initial Actions  | Detail  | Lead | Partners | Timescale |
|--|--|--|---|------|----------|-----------|
|  |  | <p>Need a safe space for men to talk.</p> <p>Skilled trades – hidden population of self-employed plumbers, electricians, roofers, builders, etc.</p> <p>Aquarius Life – delivering introduction to Mental Health to skilled trade apprentice programmes.</p> | <p>Birmingham City Council Procurement Team.</p> <p>Specialist regulatory body i.e. Corgi etc.</p> <p>Contact:<br/> <a href="mailto:adele.flannegan@aquarius.org.uk">adele.flannegan@aquarius.org.uk</a> </p> |      |          |           |

|  |   | Action | Detail | Lead | Partners | Timescale |
|--|---|--------|--------|------|----------|-----------|
|  | <b>Priority 2 Tailor approaches to improve mental health in specific groups</b> |        |        |      |          |           |

|   |   |   |   |  |  |  |
|---|---|---|---|--|--|--|
| 7 | <b>Those in prison or facing a custodial sentence</b> | Engage the Criminal Justice System in a way that will ensure those most vulnerable are identified and supported across organisational boundaries.   | Develop new approaches to support those in crisis in the CJS (pre and post prison)  |  |  |  |
| 8 | <b>Children and Young People</b>                      | <p>Work with schools and youth services to raise awareness and reduce the risks and promote anti bullying and to tackle self-harm. Schools to work with parents to have conversations regarding mental health resilience.</p> <p>All families with a child under 5 have a named Health Visitor; ensure all Health Visitors have suicide awareness training as standard.</p> <p>Build emotional resilience in primary school age children.</p> <p>Work with Looked After Children Care Leavers Team to raise awareness of personal resilience and mental wellbeing.</p> <p>Birmingham Children's Trust already work in partnership with Education, Forward Thinking Birmingham, BCT/ Health regarding safety plans for suicide and self-harm.</p> <p>Early support and prevention – support risk factors for children with Autism/ SEN.</p> <p>Ensure Children's Homes are a safe environment.</p> <p>Schools to have staff trained in Mental Health Awareness</p> | <p>BCC School Support/ lead practitioner for MH.</p> <p>Training to be included in Specialist Community Public Health Nursing - Health Visiting (SCPHN - HV).</p> |  |  |  |

|   |   |   |  |  |  |  |
|---|---|---|--|--|--|--|
|   |   | and MH First Aid.   | Link, learn, and share.                            |  |  |  |
|   |   |   | Custody Cells – good practice.                     | Police<br><br>BCC/<br>schools/<br>colleges<br>/ unis |  |  |
| 9 | <b>Survivors of abuse or violence, including sexual abuse</b> | Survivors of Modern Day Slavery.<br><br>Mental Health Awareness training for BHAROSA support staff. | Link with David Grey<br>Adult Social Care/ Police. | Public Health  |  |  |



|    |  |  |  |                              |  |  |
|----|--|--|--|------------------------------|--|--|
| 10 | <b>Veterans</b>  | Dishonourably discharged – minimal or no support for them.<br><br>JSNA Deep Dive – this will reveal actions.   | Details to be agreed.  | Elizabeth Griffiths – BCCPH. |  |  |
| 11 | <b>People with Long Term Health Conditions</b>                         | Utilise Commonwealth Games to promote volunteer opportunities.<br><br>SEN/ Autism and their families – nature of disability puts this group at risk of social isolation etc.   | Undertake Autism Research – high risk group.   |                              |  |  |
| 12 | <b>People with untreated depression</b>                                | Increase awareness of the signs and symptoms of depression and ensure that people are aware of the support available and how to access it themselves or to signpost others.  |  |                              |  |  |
| 13 | <b>People who are especially vulnerable due to social and economic</b> | Financial and debt advice, homelessness services for vulnerable people...develop a local debt pathway.<br><br>Suicide awareness training to frontline service providers across education, housing, employment and others | Ensure that the staffing in these services are trained in either MHFA, Assist or the new Suicide First Aid so that people can identify and speak to people about suicide and |                              |  |  |

|     |  |   |                                |  |  |  |
|-----|--|---|--------------------------------|--|--|--|
|     | <b>circumstances</b>   |   | signpost people appropriately. |  |  |  |
| 14  | <b>Lesbian, gay, bisexual and transgender people</b>                       | <p>Ensure that mental health services are accessible and culturally competent to support LGBT people.</p> <p>Tackling the discrimination and harassment that add to the burden of mental ill health. (How)</p>  |                                |  |  |  |
| 15. | <b>Black, Asian and minority ethnic groups</b>                             | <p>Work with communities to reduce stigma around mental health and suicide.</p> <p>Bridge the gap between service providers and communities to ensure individuals in need are able to access support.</p> <p>Consider safe hubs in faith communities.</p> |                                |  |  |  |
| 16. | <b>Refugees and asylum seekers.</b>  |   |                                |  |  |  |
| 17  | <b>Develop/spread best practice in supporting families and communities</b> | <p>Learn from the services actively supporting bereaved families and communities.</p> <p>Collate best practice examples from 3<sup>rd</sup> Sector</p>  |                                |  |  |  |

|    |                          |  |  |                              |  |  |
|----|--------------------------|--|--|------------------------------|--|--|
|    | <b>S.</b>                |  |  |                              |  |  |
| 18 | <b>Raising Awareness</b> | <p>Community based awareness campaign to reduce stigma and discrimination against Mental Health Disorders and Suicide.</p> <p>Encourage commissioners to ensure all programmes are accessible and appropriate for disabled people.</p> <p>Suicide prevention training for housing providers and benefit teams.</p> <p>Accommodation Providers to single men/ refugees need to be aware that middle-aged single men are part of the high-risk group.</p> <p>Mental health first aid training for food bank and union staff.</p> <p>Peer Support Programmes consider growing a Brum Survivors Network of Peer Support Champions from suicide survivors.</p> <p>Undergraduate and postgraduate training at universities.</p> <p>Promote local support groups/ networks for those bereaved by suicide.</p> <p>Coordinate with PHE on campaigns.</p> <p>GBCC – promote Zero Suicide Alliance and Mental Health First Aiders with SME's.</p> | <p>Engage with faith groups, respected leaders/ elders, and community groups.</p> <p>Commissioning Managers</p> <p>Raise awareness of housing officers and lettings staff.</p> | Homeless Partners hip Board. |  |  |

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|  |  |  | BCU |  |  |  |
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|    |   | Action  | Detail   | Lead        | Partners | Timescale |
|----|---|---|--|-------------|----------|-----------|
|    | <b>Priority 3 - Reduce access to the means of suicide</b> |   |  |             |          |           |
| 19 | Planning and Building Design                              | <p>High Risk Environments – amends the developer’s toolkit to reflect suicide prevention measures when reviewing planning applications.</p> <p>Mapping potential high risk sites through reviewing self-harm data and reports from health and police services and take action to reduce risk e.g. barriers, signage.</p> <p>Children’s Homes should be included in safe environment with reduced risks.</p> <p>All new buildings have HIA and put prevention points into new HIA’s i.e. Custody Suites.</p> | <p>Work with the Local Authority Property and Housing team to include suicide risk in building design considerations for major refurbishments and upgrading of social housing stock and corporate assets</p> <p>Work with planning and developers to include suicide risk in new building design considerations, especially in relation to multi-storey car parks, bridges and high rise buildings that may offer suicide opportunities.</p> | Kyle Stott. |          |           |
| 20 | Suicide Prevention Training                               | <p>Increase awareness of suicide risk, and steps to intervene, in staff working in high risk areas e.g. park wardens, traffic wardens.</p> <p>Develop Suicide Prevention Training Strategy.</p> <p>Training and awareness of how to</p>   | <p>Map suicide training provided across the city. To include online resources</p> <p>Identify good practice in suicide prevention training<br/>Develop and resource a local training plan</p> <p>Police have a checklist for</p>   |             |          |           |

|    |   |   |  |  |  |  |
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|    |   | <p>manage home environments. (children's homes, residential homes, PD/LD).</p> <p>Make suicide prevention training a part of the contract with providers who work with vulnerable adults such as CGL.</p> <p>Work with DWP as advisers often get 'journal' messages mentioning suicidal thoughts.</p> <p>Map training offer in West Midlands</p>  | <p>custody cells – good practice.</p> <p>Follow up with PHE</p>  |  |  |  |
| 21 | Identification and reduction of Hotspot risk.                     | <p>PH to coordinate a multi-agency response once areas have been identified. These agencies might include Transport Police, Network Rail and private landlords in addition to the usual agencies. Specific action plans for specific hotspots should be identified in a timely manner, taking care not to draw attention to them in the process.'</p> <p>Raise awareness with Housing Officers/ Social Workers.</p> | <p>Mapping the location of confirmed and possible suicides and self-harm locations to identify "hot spot" locations.</p> <p>Informing partner agencies and those that have responsibility for buildings/land used for suicide to raise awareness and target training.</p> <p>Establish a process for alerting train station staff if someone with high suicide risk goes missing from acute care. - Take action to reduce risk (i.e. install signage, barriers) in line with evidence base</p> |  |  |  |
| 22 | Identification and removal of potential risk points within public | Ensure robust risk assessment procedures for all areas where  |  |  |  |  |

|    |                     |  |   |  |  |  |
|----|---------------------|--|---|--|--|--|
| .  | services buildings. | <p>suicide could occur</p> <p>Hospital, prisons, care centres to review ligature points and potential high risk areas</p>  |   |  |  |  |
| 23 | Safer Prescribing   | <p>Reduce the risk of medication stockpiling through safer prescribing practice, especially for patients in high risk groups.</p> <p>Promote NICE guidelines on the appropriate use of drug treatments for depression.</p> <p>Promote safe prescribing of painkillers and antidepressants, including through the following: -<br/>Provide information to the CCG, GPs and hospital prescribers on deaths caused by prescription drugs, with recommendations. -</p> <p>Undertake a needs assessment for people addicted to prescribed medication.</p> | Establish a time limited working group to oversee needs assessment and make recommendations |  |  |  |

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| 24 | Control of Gases and Liquids | <ul style="list-style-type: none"> <li>Support retailers and vendors to consider suicide risk in the sale of potentially fatal gases and liquids.</li> </ul> | Develop and co-ordinate an engagement strategy with retailers . |  |  |  |



|    | Issue  | Action  | Detail   | Lead         | Partners | Timescale |
|----|--|---|--|--------------|----------|-----------|
|    | <b>Priority 4: Provide better information and support to those bereaved or affected by suicide</b> |   |  |              |          |           |
| 25 | Support Resources  | <ul style="list-style-type: none"> <li>• Ensure that the 'Help is at Hand' booklet is promoted and suggested to relatives by Police/funeral directors/first responders etc.</li> <li>• Ensure that the Waiting Room Resource Key is available for all professionals (this will enable prevention as well as it helps to signpost people to the right service).</li> <li>• Research best practice i.e. Start a Conversation campaign (Barney Thorne – Leics Police).</li> <li>• Research Norfolk Police/ Public Health.</li> <li>• A bereaved person needs to have the consistency of just speaking to one person to prevent repeated re-telling of events.</li> </ul> | Any service with linkage to bereaved relatives who should have a copy – make the handbook local by adding in specific local telephone numbers. | Police (FDS) |          |           |
| 26 | Investment in Services   | <ul style="list-style-type: none"> <li>• Investment in services</li> </ul>  |  | PHE          |          |           |

|    |  |   |                             |  |  |  |
|----|--|---|-----------------------------|--|--|--|
|    |  | <p>supporting those bereaved by suicide – in particular young people. (CRUSE has some really good data that can help with quantifying this). Ensure services are consistent with PHE guidelines.</p> <ul style="list-style-type: none"> <li>• What are the Commissioning Gaps – the early help that's working.</li> </ul>   | Austin Rodriguez and Dario? | NHS Trust<br>CRUSE<br>(CCG currently fund CRUSE) |  |  |
| 27 | Raising Awareness of Available Support | <ul style="list-style-type: none"> <li>• Public awareness campaigns to raise awareness of the support available for individuals affected by a death through possible suicide.</li> <li>• Create an App to give advice, animated short clips, signposts help, sometimes it's better to see than read information.</li> </ul> |                             | Police/ LA<br><br>Natasha McLeish (BHC)          |  |  |
| 27 | Postvention Support                    | <ul style="list-style-type: none"> <li>• Support easier accessible suicide bereavement services e.g. improve communication between mental health/crisis services and families- create Postvention service</li> </ul>  |                             |  |  |  |

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|  |  | <p>development in Birmingham (i.e. postvention suicide group support sessions, individual family support counselling etc.)</p> <ul style="list-style-type: none"> <li>• Reduce the impact of suicide - Standardise proactive approach to offering services/support to those bereaved by suicide. (Minimal waiting list required as support in needed THEN).</li> <li>• Support Employers utilising the evidence based toolkits in suicide postvention from Public Health England and Business in the Community</li> <li>• Prevention awareness HS2 by bridges.</li> </ul> |  |  |  |  |
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|    | Issue   | Action   | Detail  | Lead | Partners | Timescale |
|----|---|--|---|------|----------|-----------|
|    | <b>Priority 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour</b> |  |   |      |          |           |
|    |   | Action   | Detail  | Lead | Partners | Timescale |
| 28 | Promotion of expert guidelines  | <p>Work with local and regional media, especially considering media focused on high-risk communities to increase awareness of well-developed expert guides such as by The Samaritans<br/> <a href="https://www.samaritans.org/media-centre/media-guidelines-reporting-suicide">https://www.samaritans.org/media-centre/media-guidelines-reporting-suicide</a>)</p> <p>Utilise Social Media in a positive way to promote/ manage mental wellbeing, suicide, and death.</p> <p>Manipulation of media i.e. teenage myth-busting (Momo challenge).</p> | Incorporate into wider CCG and BCC communications plans |      |          |           |

| Priority 6 Support research, data collection and monitoring |                       |   |  |                                 |  |  |
|---|-----------------------|---|--|---------------------------------|--|--|
| 29  | Increase Intelligence | <p>Utilise real time surveillance to start to identify trends and hot-spots.</p> <p>Real time surveillance regarding individuals presenting at A&amp;E with self-harm, especially serial presentations.</p> <p>Develop a systematic approach to local intelligence gathering and partnership dissemination (including ethnicity).</p> <p>Explore alternative sources of data and intelligence which identifies populations of interest and informs an agile local partnership response to suicide prevention needs in the city.</p> <p>Identify suicides of non-Birmingham residents that take place within Birmingham.</p> <p>Need to understand BAME cultures to help services engage parents on behalf of children</p> | <p>Sudden death form.</p> <p>Work with the Coroner, WM Police, WM Ambulance Service, Network Rail and BTP to define enhanced, timely and systematic intelligence monitoring.</p> <p>Intelligence to be shared with the Birmingham SP Partnership; enabling an informed response to suicide clusters and drives a proactive response to post-suicide bereavement support.</p> <p>Develop a clear intelligence group to support the aims of the Board</p> <p>Produce a report for the steering group based on currently available data</p> <p>Steering group to identify intelligence needs for future</p> | <p>WM Police</p> <p>Papyrus</p> | <p><i>Solihull, B&amp;S Coroner, WMP, WMCA</i></p> |  |

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|  |  | <p>(Papyrus have done this).</p> <p>An audit of companies undertaking mental health first aider training to see the spread and types of businesses interested.</p> <p>Triangulation of data to include research and local knowledge.</p> <p>Commission a piece of work to get better data around the reasons people decide to take their own life.</p> | <p>development of strategy</p> <p>Approach PHE/ONS for suicide data based on place of death within Birmingham</p> <p>Develop a methodology to identify similar events</p> <p>Use Wave 1 sites as benchmark especially autism work.</p> |  |  |  |
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## Draft Action Plan

| Initial Actions   |                         |  | Lead                      | Partners | Timescale |
|---|-------------------------|--|---------------------------|----------|-----------|
| <b>Priority 1: Reduce the risk of suicide in key high-risk groups</b> |                         |  |                           |          |           |
| 1   | <b>Men</b>              | <p>Raise awareness among men of the support available and work with and through partners with specific focus on men's engagement to reduce the stigma among men to discuss mental health and suicidal thoughts.</p> <p>Focus opportunities for awareness raising and health promotion in locations frequented by men (job centres, youth centres, sports venues, barbers, tattoo artists, music venues, pubs and clubs) drawing on existing good practice.</p> | Cruse<br><br>Common Unity |          |           |
| 2   | <b>Self-Harm</b>        | Implement NICE guidance on the treatment of self-harm, including assessments at Emergency Department, including psychosocial assessments and mental health liaison services with appropriate follow-up support and care, and ensuring that serial presentations of self-harm should be red-flagged as a high suicide risk.   | CGL                       |          |           |
| 3   | <b>Substance Misuse</b> | Ensure that Mental Health and Substance Misuse services are working collaboratively to implement the NICE Dual Diagnosis guidance and establish coherent dual diagnosis pathways of care.  | CGL                       |          |           |

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| 4  | <b>Mental health patients</b>                                 | <p><u>Mental Health Inpatient Settings:</u><br/>Ensure through commissioning levers and proactive support that all mental health in-patient providers have 'zero suicide ambition in-patient action plans' in place that are being implemented and are demonstrating progress.</p> <p><u>IAPT &amp; Community Mental Health Services:</u><br/>Ensure that the commissioning of IAPT and community mental health services does not create referral or exclusion barriers for treatment for individuals with a history of self-harm or suicidal intent.</p> <p><u>Primary care:</u><br/>Ensure through commissioning and service improvement levers that all primary care clinical staff and front line administrative staff have suicide awareness and prevention training.<br/>Suicide prevention training for all GP's.</p> | CCG: Dario Silvestro            |  |  |
| 5. | <b>Birmingham Residents Born in Poland and Eastern Europe</b> | <p>Work with Polish and Eastern European communities, and the groups that are most engaged with them, as well as with service providers to ensure mental health and wellbeing services are culturally appropriate/ sensitive.</p> <p>Through the partnership with Warsaw, develop a shared learning approach to suicide prevention with Polish and Eastern European communities.</p>   | BCC Public Health – Mo Phillips |  |  |



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| 6. | <b>People in Skilled Trade Occupations</b> | Work with employers, developers and trade professional bodies to raise awareness of suicide and reduce the risks associated with the workplace. | BCC Public Health –<br>Mo Phillips<br><br>Cruse<br><br>Samaritans |  |  |
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| Action   |   |   | Lead  | Partners | Timescale |
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| <b>Priority 2: Tailor approaches to improve mental health in specific groups</b> |   |   |   |          |           |
| 7  | <b>Those in prison or facing a custodial sentence</b> | Engage the Criminal Justice System in a way that will ensure those most vulnerable are identified and supported across organisational boundaries.   | Common Unity<br><br>NHE-Regional Lead         |          |           |
| 8  | <b>Children and Young People</b>                      | <p>Work with partners to improve the awareness of suicide risk and prevention for children, young people and parents across the 0-19yr workforce. i.e. midwives, health visitors, teachers, youth workers, community sport coaches, etc.</p> <p>Work with schools and youth services to raise awareness and reduce the risks and promote anti bullying, promote mental wellbeing and tackle self-harm.</p> <p>Support schools to work with parents to have conversations regarding mental health resilience.</p> <p>Support staff and settings working with young people facing</p> | Forward Thinking<br>Birmingham<br><br>PAPYRUS |          |           |

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|    |   | multiple challenges that might put them at greater risk to have appropriate training and awareness of how to prevent suicide e.g. looked after children, young offenders, children with special educational needs, LGBT youth. |   |  |  |
| 9  | <b>Survivors of abuse or violence, including sexual abuse</b> | Ensure that pathways of care and support for victims of violence and abuse consider mental health support and suicide prevention explicitly in risk assessment and through staff training.                                     | Women's Aid   |  |  |
| 10 | <b>Veterans</b>   | Work with partners in the armed forces to consider how best to support veterans and reduce risk of suicide, especially among those who are dishonourably discharged.   | BCC Public Health – Mo Phillips                     |  |  |
| 11 | <b>People with Long Term Health Conditions</b>                | Work with NHS partners to embed mental health awareness and suicide prevention and risk assessment into chronic disease care and support pathways through direct commissioning and staff training.                             | CCG: Dario Silvestro<br><br>STP – Care Pathway Work |  |  |
| 12 | <b>People with untreated depression</b>                       | Increase general awareness of the signs and symptoms of depression and ensure that people are aware of the support available and how to access it themselves or to signpost others.  | Year 2<br><br>Linked to Men – Priority One          |  |  |

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| 13 | <b>People who are especially vulnerable due to social and economic circumstances</b> | Consider how in the welfare support pathways, especially around financial and debt advice, homelessness and bereavement there is active integration of suicide awareness and prevention alongside training of frontline providers.   | Review Year 2<br>PH Commissioning<br>Citizens Advise<br>Welfare Benefits<br>Neighbourhood Team<br>Academic Loan Sharks |                                 |  |
| 14 | <b>Lesbian, gay, bisexual and transgender people</b>                                 | <p>Work with providers and frontline services to increase awareness of suicide risk and mental health inequalities affecting LGBT people, especially young LGBT people, those with disabilities, from BAME communities and the elderly.</p> <p>Ensure that mental health services are accessible and culturally competent to support LGBT people.</p> <p>Work with the Community Cohesion and PREVENT team to amplify and support work to reduce homophobic, transphobic and biphobic hate crime and discrimination which may contribute to suicide and self-harm.</p> | Charity - Mental Health Unlocked   | BCC Public Health – Mo Phillips |  |
| 15 | <b>Black, Asian and minority ethnic groups</b>                                       | <p>Work with communities and front –line organisations to reduce stigma around mental health and suicide.</p> <p>Bridge the gap between service providers and communities to</p>   | Charity - Mental Health Unlocked   | BCC Public Health –             |  |

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|    |                                     | <p>ensure individuals in need are able to access support and that services can provide culturally relevant and competent services.</p> <p>Work with faith leaders and communities to support positive and constructive approaches to suicide prevention and improving mental wellbeing.</p> |   | Mo Phillips |  |
| 16 | <b>Refugees and asylum seekers.</b> | Work to ensure active consideration of suicide prevention and risk assessment in refugee and asylum seeker care and support pathways and that there is access to appropriate mental health support and care when required.  | <p>Austin Rodriguez<br/>(Refugees &amp; Asylum Seekers Working Group)<br/>BCC Public Health –<br/>Monika Rosanski</p> |             |  |

| Action   |                                     |   | Lead   | Partners | Timescale |
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| <b>Priority 3: Reduce access to the means of suicide</b> |                                     |   |  |          |           |
| 17   | <b>Planning and Building Design</b> | <p>High Risk Environments – amends the Birmingham developer’s toolkit to reflect suicide prevention measures when reviewing planning applications.</p> <p>Work with the Local Authority Property and Housing team to include suicide risk in building design considerations for major refurbishments and upgrading of social housing stock and corporate assets and as an active consideration for ‘high rise buildings’ such as multi-storey car parks.</p> <p>Mapping potential high risk sites through reviewing self-harm data and reports from health and police services and take action to</p> | <p>BCC Public Health – Kyle Stott</p> <p>Network Rail – Richard Godwin</p> |          |           |

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|     |  | reduce risk e.g. barriers, signage.   |  |  |  |
| 18  | <b>Suicide Prevention Training for those working in high risk settings</b> | Increase awareness of suicide risk, and steps to intervene, in staff working in high risk areas e.g. park wardens, traffic wardens.   | WMCA – Sean Russell  |  |  |
| 19. | <b>Identification and reduction of Hotspot risk.</b>                       | Establish an epidemiological and evidence based process to identify suicide environmental 'hot spots' and a risk reduction protocol.  | BCC Public Health – Kyle Stott<br><br>Natalie Stewart<br>(Geographical Surveillance/Trends)<br><br>Network Rail – Richard Godwin |  |  |
| 20  | <b>Safer Prescribing</b>   | Reduce the risk of medication stockpiling through safer prescribing practice, especially for patients in high risk groups and with high risk medication such as painkillers and anti-depressants through the NHS Medicines Management Programme | CCG: Dario Silvestro   |  |  |
| 21  | <b>Control of Gases and Liquids</b>  | Support retailers and vendors to consider suicide risk in the sale of potentially fatal gases and liquids.  | BCC Trading Standards  |  |  |

| Action   |                          |  | Lead                  | Partners | Timescale |
|--|--------------------------|--|-----------------------|----------|-----------|
| <b>Priority 4: Provide better information and support to those bereaved or affected by suicide</b> |                          |  |                       |          |           |
| 22   | <b>Support Resources</b> | Increase visibility of signposting resources such as 'Help is at Hand' and Waiting Room Resource Key through front line professionals working with individuals who are affected by suicide.  | Samaritans            |          |           |
| 23   | <b>Support Services</b>  | <p>Work with commissioners across the city partnership to review the provision of bereavement support, including specialist support for bereavement through suicide.</p> <p>Work with service providers and commissioners and front line services to develop a more coherent post-vention pathway for individuals affected by suicide.</p> <p>Encourage employers to use the Business in the Community/PHE suicide prevention and post-vention toolkits.</p> | Cruse<br>Common Unity |          |           |

| Action  |                                       |  | Lead   | Partners | Timescale |
|---|---------------------------------------|--|--|----------|-----------|
| <b>Priority 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour</b> |                                       |  |  |          |           |
| 24  | <b>Promotion of expert guidelines</b> | Work with local and regional media, especially considering media focused on high-risk communities, to increase awareness of well-developed expert guides for journalists such as by The Samaritans ( <a href="https://www.samaritans.org/media-centre/media-guidelines-reporting-suicide">https://www.samaritans.org/media-centre/media-guidelines-reporting-suicide</a> ) | Samaritans<br>BCC<br>CGL<br>BEP (Birmingham Education Partnership) |          |           |

| Action  |                              |   | Lead   | Partners | Timescale |
|---|------------------------------|---|--|----------|-----------|
| <b>Priority 6: Support research, data collection and monitoring</b> |                              |   |  |          |           |
| 25  | <b>Increase Intelligence</b> | <p>Work with partners across the West Midlands to develop the approach to real time surveillance to start to identify trends and hot-spots across the region – recognising that this is more effective than a single city approach due to the small numbers.</p> <p>Consider additional research into the reasons people decide to take their own life, especially in the context of high risk groups.</p> <p>Consider work to consolidate an ongoing focus on best practice evidence base as future work emerges as part of the annual refresh of the action plan.</p> | <p>PHE – Institute of Mental Health – Task &amp; finish Working Group</p> <p>BCC Public Health – Ralph Smith</p> <p>CCG: Dario Silvestro</p> |          |           |

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Sandwell and  
West Birmingham  
Clinical Commissioning Group

# Future Commissioning of Urgent Treatment Centres in Sandwell and West Birmingham



# Future Commissioning of UTCs in Sandwell and West Birmingham CCG

Focus on:

- Previous engagement work
- Moving Forward
- Preferred Options for Sandwell and West Birmingham
- Consultation Approach
- Next Steps

# National Context:

- NHS Long Term Plan Requirements for Urgent Care
  - The national vision for the future of Urgent and Emergency Care services is, for those people with urgent but non-life threatening needs to receive responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to peoples' homes as possible, minimising disruption and inconvenience for patients and their families.
  - With regards to pre-hospital urgent care the NHS Plan states that:
    - the Urgent Treatment Centre model will be embedded by autumn 2020 so that all localities have a consistent offer for out-of-hospital urgent care, with the option of appointments booked through a call to NHS 111
    - patients will be supported to navigate the optimal service 'channel', there is an ambition to embed a single multidisciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP out of hours services from 2019/20.
- GP Forward View Ambitions include:
  - Workforce: increasing GP numbers, introducing new roles, portfolio careers, measures to reduce GP burnout
  - Workload: including workflow optimisation, introducing new ways of working, new consultation types, at scale working to create efficiency
  - Care Redesign: Pathway redesign in place, development of PCNs,
  - Infrastructure: Estates refresh, new digital and technologies to manage workload and efficiency in general practice
  - Investment: Increased investment year on year

# Local Context:

- The demand for walk in centres has increased significantly alongside increased demand across the whole of the urgent care system. This has occurred despite a deliberate increase in general practice access.
- Patients want ease of access that suits their personal circumstances
- There is waste in the system, duplication of access
- There is a cohort of patients attending walk in centres/primary care/ A&E that could either self-care or be seen by another primary care professional
- The principles of a placed based integrated model is right for the future model of care
- The offer needs to
  - Maintain patient choice
  - Continue to promote personalisation, self-care and patient activation.
  - Meet the national requirements for urgent treatment centres
  - Provide opportunities for future integration of services
  - Deliver the ability to 'walk in' as patients have told us they value this.

# Patient Voice

- Pre Consultation Engagement
  - In 2018 the CCG held a sequence of conversations with our patients (including groups identified as high volume users of walk in services e.g. parents of children under 5s, students) and local partners.
- The aims were to:
  - Gain views on existing services – what works well and what doesn't work so well
  - Gather information on how they would like service to be delivered in future to make their experience of accessing urgent care services better.
- Engagement undertaken by 2 independent consultation partners
- The engagement activities were informed by the Equality Impact Assessment (EQIA)
- The report from the listening exercise engagement has been made available and key messages are summarised on the following slides.

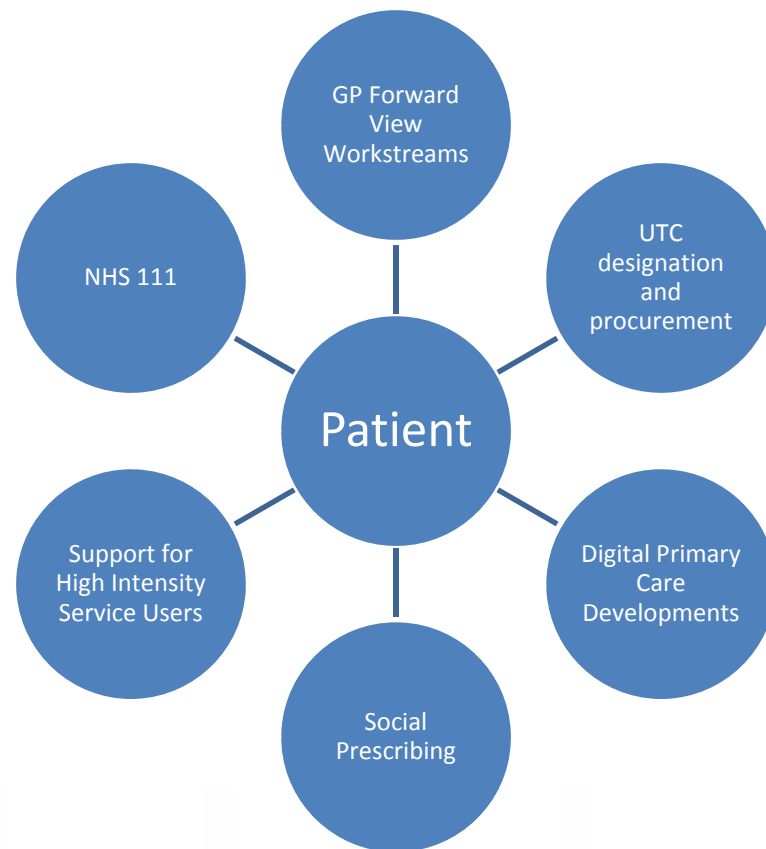
# Patient/ Public Perspective

- Real or perceived inability to book a same day or a timely routine appointment with their General Practice (GP)
- Frustration with GP booking processes
- They liked the simplicity of a walk in service in terms of just turning up as and when they needed to in the knowledge they would be seen
- Unaware of the extended service offer available in GP
- Majority of patients would be happy to attend an appointment at either their own GP or an alternative GP led service nearby.
- NHS 111 service was useful and had directed some people to the walk in service
- For unregistered patients this is their route (other than A & E) to care

# Clinical/ General Practice Perspective

- Primary care networks are not yet fully matured.
- New provider partnerships are emerging
- This is an opportunity to implement change in the system
- Important to ensure continuity of care through sharing patient records
- Recognition that patients want different types of access including some walk in capability
- There is a need to provide an offer for unregistered patients and encourage them to register
- GP workforce challenges, needs greater skill mix for the future
- There was an appetite to design and deliver a new model
- The full potential of NHS 111 has not yet been fully realised and it could be a more integrated part of the system

# Addressing the challenges and supporting patients to get to the right service first time





# Moving Forward

- Digital Primary Care

- The NHS Long Term Plan commits that every patient will have the right to be offered digital-first primary care by 2023/24.
  - The new five-year framework for GP contract reform describes the areas in which we expect early progress to be made in general practice including:
    - By April 2020 all patients should have online access to their full record
    - By April 2021 all patients should have the right to online and video consultations.
- Following a procurement exercise 10 practices within SWB CCG are undertaking a proof of concept of Substrakt Health's PatientPak platform which provides a local online care navigation system including video consultation capability.
- Discussions are currently ongoing to assess how the system could benefit work around social prescribing and the prevention strategy moving forward.
- Implementation is underway with a full evaluation of findings expected to be available in May 2020

# Moving Forward

- GP Forward View

- As a CCG we are actively working to implement the GP Forward view by focusing efforts on achieving the 10 High Impact Actions:

1. Active signposting: Provides patients with a first point of contact which directs them to the most appropriate source of help and includes web and app-based portals.
2. New consultation types: Introduce new communication methods for some consultations, such as phone and email, improving continuity and convenience for the patient, and reducing clinical contact time
3. Reduce Did Not Attend (DNAs):
4. Develop the team: Broaden the workforce in order to reduce demand for GP time and connect the patient directly with the most appropriate professional.
5. Productive work flows: Introduce new ways of working which enable staff to work smarter, not harder.
6. Personal productivity: Support staff to develop their personal resilience and learn specific skills that enable them to work in the most efficient way possible.
7. Partnership working: Create partnerships and collaborations with other practices and providers in the local health and social care system.
8. Social prescribing: Use referral and signposting to non-medical services in the community that increase wellbeing and independence.
9. Support self care: Take every opportunity to support people to play a greater role in their own health and care with methods of signposting patients to sources of information, advice and support in the community.
10. Develop QI expertise: Develop a specialist team of facilitators to support service redesign and continuous quality improvement.

# Moving Forward

- Urgent Treatment Centres
  - Existing services at Parsonage Street and Summerfield to be designated as Urgent Treatment Centres by end December 2019
  - Current contracts for both services will end on 31 March 2021
  - CCG considering options for service provision from 1 April 2021 taking into account the following:
    - Delivery of a place based solution in line with CCGs in Black Country and West Birmingham STP
    - Sandwell Urgent Treatment Centre will be mobilised in Spring 2022 alongside the opening of the Midland Metropolitan Hospital and will also meet the UTC standards published by NHS England in June 2017. This will be a fixed point in the system.
    - Maintenance of some system stability in light of service reconfiguration taking place within Sandwell and West Birmingham Hospitals Trust and the service review being undertaken in relation to the Birmingham NHS Walk in Centre (Boots)
    - Digital offer being rolled out across the CCG
    - Potential to integrate services e.g. Out of Hours in the future.

# Moving Forward

- Supporting High Intensity Users
  - Newly commissioned service provided by British Red Cross to support individuals who frequently call 999, attend A+E or both
  - Service based on the following key principles:
    - Person Centred Approach
    - De-medicalised model
    - Practical and emotional support
    - Multi-disciplinary working
    - Resilience not reliance

# Moving Forward

- Social Prescribing



# Moving Forward

- Place Based Proposal (Preferred Option) - Sandwell
  - Current contract with Malling Health will end on 31 March 2021.
  - Lease on Parsonage St building also ends on 31 March 2021 and will not be renewed.
  - As part of the Midland Metropolitan Hospital business case the Sandwell Urgent Treatment Centre will open in the Sandwell A+E site in Spring 2022.
  - Commissioners plan to work collaboratively with system partners to find a suitable and pragmatic route from our current system configuration to the proposed future state, pending the outcome of the consultation. This would be undertaken in a staged approach with timescales aligned to the business case and revised schedule for Midland Metropolitan Hospital

# Moving Forward

- Place Based Proposal (Preferred Option) - West Birmingham
  - Current contract with Virgin Care expires on 31 March 2021
  - New UTC service would need to be procured
  - Proposal for 5 year contract with 5 year option to extend
  - A full procurement process would therefore be undertaken and market engagement would be part of this to encourage the provider market to respond.
  - Summerfield is a secure tenure until around 2030 therefore the location would remain the same.
  - We are aware of the need to ensure a joined up approach across Birmingham and therefore meet regularly with BSol colleagues to discuss developments.
  - We are actively engaged in the BSol led service review group focused on Birmingham WIC (Boots)



# Benefits

- Benefits of proposed options
  - Provides like for like service
  - In line with patient insight this option is likely to be favoured by patients
  - Opportunity to test the market
  - Provides additional capacity and support in the future urgent care system
  - Supports place based approach which is consistent with the Black Country and West Birmingham STP model (I.e. each place has an UTC)
  - Will be in line with NHS guidance on UTCs.
  - Provides an opportunity to explore further simplification of the urgent care system in future
  - CCG have an opportunity to influence the service and workforce model for Sandwell UTC if we engage with the provider at an early stage
  - Offers stability within an already pressured urgent care system whilst other service reconfigurations and reviews take place



# Consultation/ Engagement Approach

- In line with the 'The Gunning Principles', using the insight from the pre consultation engagement to develop our consultation and engagement plans. These will be:
  - Informed by EQIA, previous engagement work, Walk-in Centre data and stakeholder analysis
  - Delivered by an independent consultation partner recruited as per pre-consultation engagement phase
  - Place based
    - Sandwell – formal consultation as will involve a change in location due to land at Parsonage St no longer being available
    - West Birmingham – engagement as no significant change to the service

## Next Steps

- SWB CCG intends to commence the next phase of engagement and consultation in early November 2019
- SWB CCG therefore requests that members of the Joint Health Overview and Scrutiny Committee endorse the place-based approach to enable this next phase of work to take place.

# Questions?





# Same Day Access Engagement

## 16 November to 20 December 2018

## Background

Sandwell and West Birmingham Clinical Commissioning Group undertook an initial phase of engagement (phase 1) from Friday 20 April to Friday 1 June 2018 to understand from stakeholders, patients and the public how they felt same day access services currently in place were working for them, and to gain views on same day access services to inform future development.

The feedback from the phase 1 engagement told the CCG:

- There was limited awareness among parents of children aged 0-5 that children in this age group could be referred for a clinical assessment within 24 hours.
- Only 13 out of 43 respondents were aware that this was available, this was triangulated by conversations heard during the outreach engagement
- There is a need for further patient education particularly among refugees and asylum seekers on how to access same day services. Language barriers have a significant impact on information available being understood.
- 90% of white respondents were registered with a GP compared to 21% of BME respondents.
- 45% of respondents were not aware that weekend appointments were now available.
- 61% of respondents were aware that appointments with a GP (or another health care professional) were available from 8am to 8pm during the week.
- 74% of respondents to the patient and public survey said they would be willing to accept a same day appointment at a different GP practice if a GP appointment was unavailable on the same day at their own GP surgery.
- Due to busy work schedules and a short engagement period of six weeks it is understandable that response to the clinical questionnaire was low. Therefore, further clinical feedback opportunities should be considered over the next few months.

Commissioners considered the feedback from phase 1 of the engagement to inform a proposed model for Same Day Access services in the future. This focused on a decentralised model, with a smaller acute hospital and more services being provided closer to home through general practice.

## Introduction

Sandwell and West Birmingham decided to undertake further engagement with stakeholders, patients and the public to find out if the people of Sandwell and West Birmingham shared the CCG vision for the future of Same Day Access Services and to gather feedback on the proposed service model. The engagement took place from 16 November to 20 December 2018.

## Methodology

Engagement Officers conducted face to face interviews at 13 engagement opportunities with community groups and at the Summerfield and Parsonage Street walk in centres. Engagement officers attended seven engagement opportunities in Sandwell and six in West Birmingham. Two of the thirteen engagement opportunities were held as drop-in events, one in Sandwell and one in West Birmingham. The other 11 events included engagement with:

- Patients visiting the two walk in centres at various times of the day.
- Parents of children under 5.
- Adults under 35.
- Older people.
- BME groups.
- New migrants, refugees, asylum seekers and homeless people.
- People with a disability.
- Young Carers.
- Carers of those with dementia.

## Outcomes of the engagement

One hundred and fifty conversations took place during the engagement period. To reach a wider audience, a press release was issued and information posted on social media and the CCG website. This led to 87 hits on the website, five Tweets with 640 total Impressions, eight total engagements and seven link clicks.

## Support for the Same Day Access Service model

Overall people supported the proposed model for same day access and particularly liked the following:

- Same day access - Most people told us they were happy to see a GP or appropriate health care professional at an alternative GP practice close to where they live if it meant they could be seen on the same day. This aspect of the proposed model was very well received.

- **Same day referral** - People liked the proposal for direct referral into another service if required (eg mental health)
- People were pleased to see digital communication as part of the same day access proposed model. It was important to them that they would not have to give the same information repeatedly and that an up to date medical history, including medicines prescribed, would be available to professionals at any same day access appointment

### **Concerns to be considered**

Overall people supported the proposed model for same day access but some shared the following concerns:

- **Waiting times** - some people were concerned that the proposed model could still result in long waiting times.
- **Transport and travel** – even though the new model will offer an appointment on the same day at a GP practice closer to home, some people felt the geographic area covered by Primary Care Hubs may still lead to transport and/or travel difficulties for some.
- **Workforce** – concern was expressed around the workforce capacity needed for the proposed model. One of the most consistent concerns raised about the current service was the inability or difficulty in getting a GP appointment
- **Finance** – people wanted to be assured that the Same Day Access model was affordable and sustainable
- **Concerns around communication barriers** such as language and disability eg visual impairment (see more detail on pages 4 and 5)

### **Additional points raised by certain groups:**

#### **Dementia Support and Information for Carers:**

- Some patients may still want to see their own doctor
- There was concern that a doctor who did not know the patient may not be as caring

#### **Sandwell Visually Impaired group:**

- The group felt there was insufficient provision in place for visually impaired people. For example in their experience, doctors won't



do home visits and online bookings don't work because there isn't any sound assistance.

- The group said there needed to be more in place for people who are visually impaired. One solution people mentioned was more Visually Impaired specific training for receptionists.
- Information on services available in braille may be useful
- Travel to appointments was a concern for members of the group due to their reliance on carers, family and friends to attend appointments

### **Young Carers:**

- Like the NHS app
- Face to face is the best way to see a doctor/nurse
- As a young carer I would like to see doctor/nurse I already know
- Walk in centres are important because if you need some prescriptions for medicine you don't have to book an appointment (where else to access)
- A badge or card would be useful. It would have your picture, name, age, I'm a young carer; and the person you care for to allow you to pick up the medication for your family.
- A young carer's hot line would be good.

### **Conclusion and Recommendations**

- The majority of people who fed back their views on the proposed model for Same Day Access services supported the model
- As Primary Care Hubs are further established an integrated impact assessment is recommended to enable the CCG to consider, understand and explore possible solutions to address perceived travel and transport concerns raised during the engagement
- If a decision to go to public consultation is made the consultation document needs to include an explanation of how the proposed model will be financed.
- Should the CCG decide to proceed to public consultation a full workforce analysis could provide reassurance and evidence to mitigate concerns raised in the engagement on how the future workforce will support the proposed model.

- **People will need explanation and reassurance that the new model will improve waiting times when accessing a same day appointment**
- **Further engagement with disabled groups such as the visually impaired will be needed, to understand how they would like to be communicated with.**



## Health and Social Care Overview & Scrutiny Committee Work Programme

2019/20

**Committee Members:** Chair: Cllr Rob Pocock

Cllr Mick Brown  
Cllr Diane Donaldson  
Cllr Peter Fowler  
Cllr Mohammed Idrees

Cllr Zaheer Khan  
Cllr Ziaul Islam  
Cllr Paul Tilsley

### Committee Support:

Scrutiny Team: Rose Kiely (303 1730) / Gail Sadler (303 1901)

Committee Manager: Errol Wilson (675 0955)

### Schedule of Work

| Meeting Date   | Committee Agenda Items   | Officers  |
|--|--|---|
| 4 <sup>th</sup> June 2019<br>(Informal)                  | Work Programme Workshop <ul style="list-style-type: none"> <li>Public Health Performance Indicators</li> <li>Adult Social Care Performance Indicators</li> <li>Draft Quality Accounts</li> </ul> | Dr Justin Varney, Director of Public Health; Rebecca Bowley, Head of Business Improvement and Support (Adult Social Care); Maria Gavin, AD, Quality & Improvement, Adult Social Care; David Rose, Performance Management Officer (Adult Social Care); Max Vaughan, Behaviour Service Integration Manager; Adult Social Care; Carol Herbert, Clinical Quality Assurance Programme Manager, BCHC. |
| 18th June 2019<br>Send out:<br>6 <sup>th</sup> June 2019 | Appointments to Deputy Chair and JHOSCs<br><br>Minor Surgery and Non Obstetric Ultrasound Services (NOUS) Listening Exercise   | Angela Poulton, Deputy Chief Officer – Strategic Commissioning & Redesign; Kally Judge, Commissioning Engagement Officer, Sandwell and West Birmingham CCG.   |



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| 18 <sup>th</sup> June 2019<br>Send out:<br>6 <sup>th</sup> June 2019     | Period Poverty – Evidence Gathering   | Neelam Heera, Founder of the Charity Organisation 'Cysters'  |
| 16 <sup>th</sup> July 2019<br>Send out:<br>4 <sup>th</sup> July 2019     | <p>Period Poverty – Evidence Gathering</p> <p>Adult Social Care Performance Monitoring Scorecard – End of Year 18/19</p> <p>Draft Response to the Day Care Opportunities Consultation Strategy – For comment</p> <p>Enablement Review – Draft Scoping Paper</p> | <p>Councillor John Cotton, Cabinet Member for Social Inclusion, Community Safety and Equalities.</p> <p>Dr Justin Varney, Director of Public Health.</p> <p>Soulla Yiasouma, Joint Head of Youth Services.</p> <p>Maria Gavin, AD, Quality &amp; Improvement, Adult Social Care; David Rose, Performance Management Officer.</p> <p>Cllr Rob Pocock</p> <p>Cllr Rob Pocock</p> |
| 13 <sup>th</sup> August 2019<br>Send out:<br>2 <sup>nd</sup> August 2019 | Enablement Review – Evidence Gathering  |  |
| 17 <sup>th</sup> Sept 2019<br>Send out:<br>5 <sup>th</sup> Sept 2019     | <p>Cabinet Member for Health and Social Care Update Report</p> <p>Forward Thinking Birmingham</p> <p>Adult Social Care Performance Monitoring</p> <p>Public Health Performance Monitoring</p>   | <p>Councillor Paulette Hamilton; Suman McCartney, Cabinet Support Officer.</p> <p>Elaine Kirwan, Associate Director of Nursing.</p> <p>Maria Gavin, AD, Quality &amp; Improvement, Adult Social Care; David Rose, Performance Management Officer.</p> <p>Elizabeth Griffiths, Interim AD, Public Health</p>  |
| 17 <sup>th</sup> Sept 2019<br>Informal meeting                           | Period Poverty – Draft Report   | Cllr Rob Pocock  |



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| 15 <sup>th</sup> Oct 2019<br>Send out:<br>3 <sup>rd</sup> Oct 2019      | <p>Dementia Strategy (new)</p> <p>Public Health Green Paper – Feedback from consultation</p> <p>Suicide Prevention Strategy – Action Plan</p> <p>Urgent Treatment Centres</p>  | <p>Dr Majid Ali, Clinical Lead, Community Services Transformation, BSol CCG; Zoeta Manning, Senior Integration Manager – Frailty, BSol CCG</p> <p>Elizabeth Griffiths, Interim AD, Public Health</p> <p>Jayne Salter-Scott, SWB CCG</p>  |
| 15 <sup>th</sup> Oct 2019<br>Informal meeting                           | Period Poverty Report – Post 8 day rule.   | Cllr Rob Pocock  |
| 29 <sup>th</sup> October 2019<br>Send out:<br>17 <sup>th</sup> Oct 2019 | Enablement Review – Evidence Gathering   |  |
| 19 <sup>th</sup> Nov 2019<br>Send out:<br>7 <sup>th</sup> Nov 2019      | <p>The Impact of Poor Air Quality on Health – Tracking Report</p> <p>Birmingham Substance Misuse Recovery System (CGL)</p> <p>Healthwatch Update:-</p> <ul style="list-style-type: none"> <li>Contract/New Structure</li> <li>Healthwatch Strategy/Direction of Travel</li> <li>Update on previous and current investigations</li> </ul> <p>Adult Social Care Performance Monitoring</p> <p>Public Health Performance Monitoring</p> | <p>Mark Wolstencroft, Operations Manager, Environmental Protection.</p> <p>Max Vaughan, Head of Service, Universal and Prevention – Commissioning</p> <p>Andy Cave, Chief Executive, Healthwatch Birmingham</p> <p>Maria Gavin, AD, Quality &amp; Improvement, Adult Social Care; David Rose, Performance Management Officer.</p> <p>Elizabeth Griffiths, Interim AD, Public Health.</p> |



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| 17 <sup>th</sup> Dec 2019<br>Send out:<br>5 <sup>th</sup> Dec 2019     | <p>Budget Consultation:</p> <ul style="list-style-type: none"> <li>• Adult Social Care</li> <li>• Public Health</li> </ul> <p>Birmingham Safeguarding Adults Board Annual Report</p> <p>Transformation of Services through Early Intervention</p> <p>NHS Long Term Local Plan – Healthwatch Birmingham</p> | <p>Councillor Paulette Hamilton, Cabinet Member for Health &amp; Social Care; Dr Justin Varney, Director of Public Health.</p> <p>Cherry Dale, Independent Chair of the Birmingham Safeguarding Adults Board.</p> <p>Balwinder Kaur, AD, Adult Social Care; Pauline Mugridge, AD, Adult Social Care</p> <p>Andy Cave, Chief Executive, Healthwatch Birmingham</p> |
| 17 <sup>th</sup> Dec 2019<br>Informal meeting                          | Enablement Review – Draft Report   | Councillor Rob Pocock   |
| 21 <sup>st</sup> Jan 2020<br>Send out:<br>9 <sup>th</sup> Jan 2020     | <p>Birmingham Community Healthcare NHS Foundation Trust Draft Quality Accounts 19/20 - Briefing</p> <p>Primary Care Networks Briefing</p>  | <p>Colin Graham, Associate Director, Clinical Governance, BCHC.</p> <p>(Paul Sherriff? TBC)</p>   |
| 18 <sup>th</sup> Feb 2020<br>Send out:<br>6 <sup>th</sup> Feb 2020     | <p>Director of Public Health Annual Report</p> <p>Birmingham Sexual Health Services – Umbrella (UHB)</p> <p>Adult Social Care Performance Monitoring</p> <p>Public Health Performance Monitoring</p>   | <p>Dr Justin Varney, Director of Public Health</p> <p>Max Vaughan, Head of Service, Universal and Prevention – Commissioning</p> <p>Maria Gavin, AD, Quality &amp; Improvement, Adult Social Care; David Rose, Performance Management Officer.</p> <p>Elizabeth Griffiths, Interim AD, Public Health.</p>   |
| 17 <sup>th</sup> March 2020<br>Send out:<br>5 <sup>th</sup> March 2020 |  |   |



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| 21 <sup>st</sup> April 2020<br>Send out:<br>9 <sup>th</sup> April 2020 |  |  |
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| <b>MUNICIPAL<br/>YEAR 2020/21</b> | Mental Health Strategy Update                  | Joanne Carney, Director<br>of Joint Commissioning,<br>BSol CCG           |
|                                   | Childhood Obesity – Stocktake Report           | Dr Justin Varney,<br>Director of Public<br>Health                        |
|                                   | Update on 'The Effects of Pollution on Health' | Mark Wolstencroft,<br>Operations Manager,<br>Environmental<br>Protection |

| <b>Items to be scheduled in Work Programme</b>  |  |
|---|--|
| <ul style="list-style-type: none"> <li>• Adult Social Care Commissioning Strategy (Graeme Betts)</li> <li>• Ageing Well Programme (Graeme Betts)</li> <li>• Shared Lives Service Re-design (Graeme Betts)</li> <li>• Neighbourhood Networks Programme (Graeme Betts)</li> <li>• Tracking of the Suicide Prevention Action Plan.</li> <li>• GP Practice Delivery – (Late 2019) <ul style="list-style-type: none"> <li>◦ Partnerships (e.g. Modality)</li> <li>◦ Universal Patient Offer (Karen Helliwell)</li> </ul> </li> <li>• STP Strategy – Post Engagement Report (Rachel O'Connor)</li> <li>• Update on the New Social Work Model in Birmingham (Pauline Mugridge) (Early new municipal year)</li> <li>• Immunisation and Screening</li> <li>• Infant Mortality</li> <li>• Joint Strategic Needs Analysis (JSNA) – Elizabeth Griffiths to advise date.</li> <li>• Integrated Care Systems – Paul Jennings</li> </ul> |  |

| <b>CHAIR &amp; COMMITTEE VISITS</b> |  |                  |
|-------------------------------------|--|------------------|
| <b>Date</b>                         | <b>Organisation</b>                    | <b>Contact</b>   |
| 23 <sup>rd</sup> July 2019          | Day Centre Visits                      | Sonia Mais-Rose  |
| TBA                                 | Community Early Intervention Prototype | Pauline Mugridge |



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

| Item no.    | Item Name   | Proposed date    |
|-------------|---|------------------|
| 005730/2018 | A Sustainable Solution for the Future of Wellbeing Services and Hubs                                | 26 November 2019 |
| 005920/2019 | Adult Social Care and Health – Draft Day Opportunity Strategy                                       | 26 November 2019 |
| 006656/2019 | Public Health Budget  | 26 November 2019 |
| 007017/2019 | Approval of Section 75 Agreements for Adult Social Care and Health Integrated Commissioning 2019/20 | 26 November 2019 |

### INQUIRY:

|                     |   |
|---------------------|---|
| Key Question:       | How can a sustainable supply of free sanitary products be made available to females in educational establishments and council run buildings and, through engagement with our partners, more widely in buildings/venues across the City? |
| Lead Member:        | Councillor Rob Pocock   |
| Lead Officer:       | Rose Kiely / Gail Sadler  |
| Inquiry Members:    | Councillors Brennan, Brown, Fowler, Islam, Rashid, Tilsley and Webb   |
| Evidence Gathering: | June and July 2019  |
| Drafting of Report: | August/September 2019   |
| Report to Council:  | November 2019   |

### Councillor Call for Action requests

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| <b>Joint Birmingham &amp; Sandwell Health Scrutiny Committee Work</b> |  |   |
|---|--|---|
| <b>Members</b>  | Cllrs Rob Pocock, Mick Brown, Peter Fowler, Ziaul Islam, Paul Tilsley  |   |
| <b>Meeting Date</b>   | <b>Key Topics</b>  | <b>Contacts</b>   |
| 24 <sup>th</sup> July 2019 @ 2.00pm<br>Birmingham                     | <ul style="list-style-type: none"> <li>Update on Review of Solid Tumour Oncology Cancer Services</li> <li>Update on Recommissioning of Gynae-oncology Services.</li> </ul> | <p>Scott Hancock, Project Lead, Head of Operational Performance and Business Management Support, UHB; Cherry West, Chief Transformation Officer, UHB; Toby Lewis, Chief Executive, Sandwell &amp; West Birmingham NHS Trust; Jessamy Kinghorn, Head of Communications &amp; Engagement – Specialised Commissioning, NHS England (Midlands &amp; East of England).</p> <p>Toby Lewis, Chief Executive, Sandwell &amp; West Birmingham NHS Trust.</p> |
| 12th September 2019 @ 2.00pm<br>Sandwell                              | <ul style="list-style-type: none"> <li>Update on Review of Solid Tumour Oncology Cancer Services</li> <li>Update on Recommissioning of Gynae-oncology Services.</li> </ul> | <p>Cherry West, Chief Transformation Officer, UHB; Toby Lewis, Chief Executive, Sandwell &amp; West Birmingham NHS Trust; Jessamy Kinghorn, Head of Communications &amp; Engagement – Specialised Commissioning, NHS England (Midlands &amp; East of England).</p> <p>Toby Lewis, Chief Executive, Sandwell &amp; West Birmingham NHS Trust.</p>  |



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| 12th December 2019 @ 2.00pm<br>Birmingham | <ul style="list-style-type: none"><li>• Further update on the Midland Metropolitan Hospital</li><li>• Update on Review of Solid Tumour Oncology Cancer Services</li><li>• Update on Recommissioning of Gynae-oncology Services.</li></ul> | <p>Toby Lewis, Chief Executive, Sandwell &amp; West Birmingham NHS Trust.</p> <p>Cherry West, Chief Transformation Officer, UHB; Toby Lewis, Chief Executive, Sandwell &amp; West Birmingham NHS Trust; Jessamy Kinghorn, Head of Communications &amp; Engagement – Specialised Commissioning, NHS England (Midlands &amp; East of England).</p> |
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| <b>Joint Birmingham &amp; Solihull Health Scrutiny Committee Work</b> |   |   |
|---|---|---|
| <b>Members</b>  | Cllrs Rob Pocock, Diane Donaldson, Peter Fowler, Zaheer Khan, Paul Tilsley  |   |
| <b>Meeting Date</b>   | <b>Key Topics</b>   | <b>Contacts</b>   |
| 26 <sup>th</sup> June 2019<br>@ 6.00pm<br>(Solihull)                  | <ul style="list-style-type: none"> <li>Financial Savings Plan 2019/20 including:-               <ul style="list-style-type: none"> <li>Service Redesign Projects -                   <ul style="list-style-type: none"> <li>What has been reviewed and what is the outcome of that through cost savings?</li> </ul> </li> </ul> </li> <li>UHB - Update on UHB Merger including potential changes to trauma, orthopaedic and gynaecology services</li> </ul> | <p>Phil Johns, Chief Finance Officer, BSol CCG</p> <p>Fiona Alexander, Director of Communications UHB; Harvir Lawrence, Director of Planning and Performance, BSol CCG</p>  |
| 5 <sup>th</sup> September 2019 @ 5.00pm<br>(Birmingham)               | <ul style="list-style-type: none"> <li>UHB - Potential changes to trauma and orthopaedic and gynaecology services - Update</li> <li>Urgent Primary Care Service Model               <ul style="list-style-type: none"> <li>JHOSC to be consulted on draft Service Model</li> <li>Impact of UTC communications campaign in Solihull</li> </ul> </li> <li>Clinical Treatment Policies – Evidence based policy harmonisation programme – Phase 3</li> </ul>    | <p>Fiona Alexander, Director of Communications UHB; Jonathan Brotherton, Chief Operating Officer UHB; Pratima Gupta and Panayiotis Makrides, Clinical Leads UHB; Harvir Lawrence, Director of Planning and Performance, BSol CCG</p> <p>Phil Johns, Deputy CEO; Helen Kelly, Associate Director of Urgent Care and Community, BSol CCG</p> <p>Neil Walker, Associate Director of Right Care and Planned Care, BSol CCG; Katherine Drysdale and Andrea Clark, AGEM CSU</p> |



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|-----------------------------|---|---|
| December 2019<br>(Solihull) | <ul style="list-style-type: none"> <li>Clinical Treatment Policies – Evidence based policy harmonisation programme – Phase 3 – Feedback from Consultation.</li> <li>Birmingham and Solihull Mental Health NHS Foundation Trust including:- <ul style="list-style-type: none"> <li>Introduction to new Chief Executive</li> <li>Improvements made since CQC inspection carried out in November 2018. (Report published April 2019).</li> </ul> </li> <li>BSol CCG Financial Plans <ul style="list-style-type: none"> <li>Update on risk to delivery of savings and the impact of this on 2020/21.</li> </ul> </li> <li>Role of the STP across the Birmingham and Solihull footprint</li> </ul> | <p>Neil Walker, Associate Director of Right Care and Planned Care, BSol CCG; Katherine Drysdale and Andrea Clark, AGEM CSU</p> <p>Roisin Fallon-Williams, Chief Executive, BSMHFT.</p> <p>Paul Athey, Chief Finance Officer, BSol CCG</p> <p>Paul Jennings, System Lead, BSol STP</p> |
| March 2020<br>(Birmingham)  | <ul style="list-style-type: none"> <li>Birmingham and Solihull STP – Joint Public Health Priorities / role STP across Birmingham and Solihull – evidence of impact and effectiveness</li> </ul>   | Dr Justin Varney, DPH Birmingham and Ruth Tennant DPH Solihull.   |
| <b>TO BE SCHEDULED</b>      | <ul style="list-style-type: none"> <li>Disinvestment on Savings Plan</li> </ul>   | Paul Athey, Chief Finance Officer, BSol CCG   |
|                             | <ul style="list-style-type: none"> <li>NHS England and NHS Improvement Redesign Work for Community Dental Services</li> </ul>   | Howard Thompson, Supplier Manager – Dental, NHS England and NHS Improvement – Midlands.   |