BIRMINGHAM CITY COUNCIL

HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

TUESDAY, 17 MARCH 2020 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) 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.

4 **ACTION NOTES/ISSUES ARISING** **3 - 20**

To confirm the action notes of the meetings held on 11th and 18th February 2020.

5 **PERMISSION TO CONSULT ON THE BIRMINGHAM DRUG AND ALCOHOL STRATEGY** **21 - 50**

Dr Marion Gibbon, Interim Assistant Director, Public Health.

6 **SCOPING OF THE INFANT MORTALITY REVIEW** **51 - 62**

Dr Marion Gibbon, Interim Assistant Director, Public Health

63 - 72

7 **WORK PROGRAMME MARCH 2020**

For discussion.

8 **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).

9 **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.

10 **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 11th February 2020, Committee Room 6 – Actions

Present:

Councillor Rob Pocock (Chair), Mick Brown, Peter Fowler, Mohammed Idrees, Ziaul Islam, Zaheer Khan and Paul Tilsley.

Also Present:

Mark Astbury, Interim Adults Business Partner, Finance.

Mandy Buckley, UNISON.

Ian James, Independent Adviser to HOSC.

Tim Normanton, HR Business Partner, Adult Social Care.

Afsaneh Sabouri, Head of Enablement Service.

Gail Sadler, Scrutiny Officer.

Leslie Smith-Woodman, Team Manager, Enablement Service.

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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**

   Councillor Diane Donaldson and Caroline Johnson, Branch Secretary, UNISON.

4. **ACTION NOTES/ISSUES ARISING**

   The action notes of the meeting held on 21st January 2020 were agreed.

   The following matters have arisen since the committee last met:

   - <u>NHS Long Term Local Plan – Healthwatch Birmingham</u>

     A response to the query regarding the how the number of respondents to the survey compared to other core cities was circulated to members on 31st January 2020.

- Budget Consultation 2020+

  Further information on the home adaptations budget was circulated on 11th February 2020.

- Birmingham Safeguarding Adults Board Annual Report 2018/19

  Cherry Dale provided a response to queries regarding the Forward Carers Hub and a copy of the Non-Regulated Accommodation report.

  It was also noted that next year the committee might look at the health implications for people living in non-regulated accommodation as highlighted in the Safeguarding Report.

Day Opportunities Strategy

Councillor Fowler expressed his disappointment that the informal briefing on the Day Opportunities Strategy for committee members held on 21st January 2020 had been a verbal briefing rather than having the opportunity to view and comment on the written Strategy Report before it was presented to Cabinet. He was also frustrated that today's meeting had been arranged on the same day as the Strategy was being presented to Cabinet.

The Chairman explained that a Scrutiny Committee is not entitled to see documents earlier than the Cabinet. Therefore, the information contained in the Cabinet report was received verbally. The Chairman also assured members that he, along with Scrutiny Officers, had been identifying provisional meeting dates for next year which would potentially avoid clashes with programmed Cabinet meetings.

5. IN-HOUSE ENABLEMENT SERVICE REVIEW – EVIDENCE GATHERING

The Chairman set out the purpose of the evidence gathering session and clarified the status of the Scrutiny Committee in that it does not make decisions and is not an Executive body of the Council and has no authority to commit to any decision on behalf of the Council. As the In-House Enablement Service has been the subject of some contention across the City, the Chair reminded members that nothing that is said in the meeting can be deemed to be consent, amend or agreement in respect of any of the provisions or conditions or working practices within the Enablement Service. The committee will look at options for the In-House Enablement Service but these are not binding to the City Council.

The Chairman also stated that his role confines him to not make any agreement on behalf of Birmingham City Council or the Service or guarantee any outcome which is presented to the committee today.

Advice Note from the Local Government Association and Health Improvement Adviser

Ian James highlighted some of the key themes from his report and linked those with reference to the In-House Enablement Service. He referred to published examples of best practice from the following local authorities: -

- Leeds
- Coventry

- Southwark

Common themes linking best practice included: -

- Focus on Contact Centres providing advice and support to avoid people falling into crisis and requiring formal adult social care support services.
- Building on strong community/voluntary networks.
- A "therapist-led" approach to social care i.e. therapists work with front line workers and providers of care.
- Focus on short-term support with "strengths -based" assessments based on user agreed outcomes to regain or find the right level of independence.
- Formed a provider coalition to create an integrated service under shared management arrangements.

Ian highlighted the challenge of how the skilled and experienced group of staff in the In-House Enablement Service can be integrated into the new way of working in the health and care system. The In-House Enablement Service has in his view continued to work in isolation from some other service developments that are happening in the system and an issue would be to make sure that the In-House Service does not get left behind.

Ian concluded that the work that is being done in Birmingham to improve adult social care as a whole is innovative, pioneering and is in line with best practice elsewhere which others could learn from.

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

- Ian wasn't aware of any local authority comparator across the country where an In-House Enablement Service has successfully been incorporated into a new system around prevention and early intervention. Where In-House Services have been changed their roles have tended to be around reablement for people leaving hospital.
- Addressing comments made in his report regarding "staff may wish to be more involved in prevention and early intervention" and "a risk of the in-house service being 'left behind', Ian said he could see excellent new service developments and a group of staff who were happy and getting job satisfaction from a different way of working which would present an opportunity for some in-house staff. Furthermore, whilst the rest of the service development is moving at pace and good things are happening the in-house service has not yet effectively moved on.
- How other local authorities support culturally diverse communities to care for family members in their own homes may be an element to be included in the final report.
- The City Council could benefit from learning how to manage change effectively across the authority. Examples of how a collaborative approach to

service development through co-production has been used elsewhere would also be helpful in the final report.

Joint Presentation from UNISON/Head of Enablement

Mandy Buckley (Steward, UNISON and Home Care Assistant); Afsaneh Sabouri (Head of Enablement) and Leslie Woodman-Smith (Team Manager, Enablement Service) put forward a collaborative presentation setting out activities which had been undertaken through joint working since the last evidence gathering session in August 2019.

- In 2011 the In-House Enablement Service had circa 800 Enablement Assistants and currently have 225 staff in post.
- The service had recently undergone a CQC inspection and achieved a good rating in all areas.
- In 2018, due to strike action, referrals were only accepted if there was an urgent need or breakdown of care because of an inability to deliver the service. We are now encouraging social workers to send referrals to us for prevention, enablement and long-term service packages and this has been happening better.
- Improving service capacity: -
    - Joint working with UNISON on a self-rostering project in Sutton constituency. Staff working as a team looking at business need, their own work life balance and how they could change their work pattern to even out cover for gaps in shifts.
    - Voluntary redundancy has led to an unbalanced number of staff in the North and South of the city to provide the service. Therefore, following one to one meetings with staff to consider their commitments, we are moving people to their nearest constituency with the aim to create a knock-on effect and get an even number of staff within the constituencies which will be beneficial for the service, staff and provide continuity of care for service users.
- In order to minimise the risk of the In-House Enablement Service being left behind with the evolving health and care system, new initiatives are being explored: -
    - Prevention – Out of Hours

      The Out of Hours Duty Team for adults contact the In-House Enablement Service when service users telephone them for assistance e.g. breakdown of care, domestic issue, and a member or members of staff will go out and support that person. Previously, there was no system in place to deal with this situation and, invariably, a service user would telephone the paramedics.
    - Escorting service to support DTOC

      A patient may be medically fit to leave hospital but need a period of residential care before returning home, but the residential setting

may be in a different part of the city. Enablement staff are providing an escorting service to enable a husband/wife/partner to visit that person. This is a new service and a pathway for referrals is in place. At the moment, it is only available for discharges from the QE Hospital, but it is hoped the service can be offered city-wide.

- Wrap Around

  Sometimes a patient is medically fit for discharge but cannot go home because they may need one or two calls during the night. An OT and social worker would visit the patient's home to assess what equipment/adaptation was needed to have support 24/7 like it would be in a residential home.

- Night Care

  Joint working with colleagues in UNISON. Some staff are moving voluntarily from day shifts to night shifts. The night shift starts at 9.30pm – 7.00am.

- Link to Early Intervention Community Team (EICT)

  EICT is fast pace and if a service user has had a period or enablement or rehabilitation but outcomes have not been achieved upon discharge, the Enablement Service could receive a referral from the Early Intervention Community Team, to continue working with the service user in the community and, if need be, keep that person as a long-term package.

- Future Plans
  - Looking to widen the self-roster across all teams city-wide working 7am-1-2pm and from 4pm-10pm.
  - Exploring how the service can support the role of the customer journey and the prevention approach providing staff with appropriate training to enable them to take up opportunities in other areas should they wish.
  - Exploring the opportunity of creating a bank of staff to cover shortfalls to meet service need across the city.

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

- The In-House Enablement Service is a short-term service which is delivered free of charge regardless of a person's financial position.
- The bank staff would be drawn from existing staff who have indicated they would be available to work on a certain day where they are free and it's their day off. They would get paid for the day as an extra and would be expected to work where needed i.e. anywhere in the city.
- The Commissioning Service within Adults Social Care works very closely with a large network of providers. Sevacare is one of the largest providers to deliver

home care services in the city and there's been a lot of intensive work with them to feedback on performance. There is a recognition that there are times when service standard is not what is expected but the Commissioning Service is working directly with Sevacare to address this.

- The biggest concern raised in the last evidence gathering session was utilisation of time i.e. the time staff are in contact with service users as opposed to downtime. It is anticipated that if self-rostering is implemented across the city contact hours will be improved by 25%, i.e. to reach a total of about 50%.
- Also being factored into the forecast to be realist for staff is staff training, sick leave, annual leave and team meetings.

HR Update

Tim Normanton (HR Business Partner, Adult Social Care) updated the committee on the current workforce position.

- The Early Intervention Community Team (EICT) is a very complex and important undertaking in partnership in a very large-scale system which has taken longer than anticipated and the actual implementation will now be March/April this year.
- There is a joint partnership commissioning programme where BSol CCG and the City Commissioning Service are looking at the whole system market for domiciliary care, enablement and rehabilitation. This work will be carried out over the summer/autumn to understand what the Community Team will do as part of early intervention, where that fits with the intermediate market, where the workforce is and what it is contributing to the system.
- Previous challenges in terms of maximising staffing resource and utilising capacity are now being addressed in partnership with UNISON.
- The next steps are about refining the self-rostering process to get a consistent approach which can be rolled-out city-wide which will enable reallocation of staff across the city – the wave approach. Once this is in place, we will be able to inform the commissioning work about supply and demand across the city/system. This will help to agree the approach moving forwards and will, potentially, have implications for where the workforce is across the partnership.

Finance Update

Mark Astbury (Interim Finance Business Partner, Adult Social Care) updated the committee on two key issues regarding the financial position of the In-House Enablement Service: -

Budget

- The budget for the service this year is £5.3m with an underspend of approximately £900k due to staff vacancies earlier in the year.
- In terms of the base budget for next year, there is a budget for the full establishment as it stands.

- There are no savings targets against the service for next year.

Efficiency of the Service

- The unit cost of the service ranges between £65to£70 per house with a face-to-face contact time of between 26-28%.
- There is no requirement to report on unit costs for reablement and a number of authorities have been unwilling to share that information.
- Where information is available, on average the cost of reablement is between £40-£50 per face-to-face hour based on contact time of 50%. So, the majority of authorities are paying circa £25 per hour for the cost for the service but in terms of actual contact time that is somewhere between £45-£50. If the In-House Enablement Service can increase contact time from the current position to close to 50% that would put it within the bounds of where most authorities have shared their information.
- Afsaneh Sabouri said that at the moment contact time is 25% but by implementing self-rostering city-wide then it is anticipated this would improve by 25% to reach closer to 50%.

Other Issues

- There are some internal operational issues with a small number of staff but are working with another trade union to get this resolved.
- All future planning and new initiatives depend very much on increasing contact time by 25% i.e. to reach the 50% level, but if anything, unforeseen happens then any difficulties/challenges will be shared in an open and transparent manner with stakeholders and politicians

Closing Statement

The Chairman stated that the committee will produce a report to the Cabinet Member for Health and Social Care which will lay out various options for further development and enhancement of the In-House Enablement Service within the broader context of the whole service. A draft report will be presented to the next committee meeting in March. The final report will be sent to the Cabinet Member and any decision lie with the Executive not this committee.

In summary, the Chairman said the day had been helpful and enlightening. Staff had talked through the progress being made to improve the service and a willingness from all parties to achieve a positive result. It had been a fantastic display of collaborative working and he commended all involved on their achievement.

The Chairman also put on record thanks to Ian James for the advice he had provided to the committee.

RESOLVED:

- Tim Normanton to provide diversity data for the In-House Enablement Service workforce.
- A further briefing note is provided to the committee later in the year looking at the service/system as a whole.

- To note 'Adult Social Care – Self Funders' as a possible topic for next year's work programme.

6. WORK PROGRAMME – FEBRUARY 2020

The work programme was noted.

7. REQUEST(S) FOR CALL IN/COUNCILLOR CALL FOR ACTION/PETITIONS RECEIVED (IF ANY)

None.

8. OTHER URGENT BUSINESS

None.

9. 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.

The meeting ended at 1144 hours.

BIRMINGHAM CITY COUNCIL

HEALTH AND SOCIAL CARE O&S COMMITTEE

1000 hours on 18th February 2020, Committee Rooms 3 & 4 – Actions

Present:

Councillor Rob Pocock (Chair), Mick Brown, Diane Donaldson, Peter Fowler, Mohammed Idrees, Ziaul Islam and Paul Tilsley.

Also Present:

Karl Beese, Commissioning Manager, Adult Public Health Commissioning.

Councillor Matt Bennett.

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

Professor Graeme Betts, Director Adult Social Care.

Elizabeth Griffiths, Assistant Director, Public Health.

Councillor Paulette Hamilton, Cabinet Member for Health and Social Care.

Rose Kiely, Overview & Scrutiny Manager, Scrutiny Office.

Sandra Orton, Divisional Director of Operations, Division 6, University Hospitals Birmingham NHS Foundation Trust.

Gail Sadler, Scrutiny Officer.

Natalie Slayman-Broom, Umbrella General Manager – Sexual Health Service.

Max Vaughan, Head of Service, Adult Public Health Commissioning.

John Williams, Assistant Director, Adult Social Care.

Councillor Alex Yip.

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2. DECLARATIONS OF INTEREST

None.

3. APOLOGIES

Councillor Zaheer Khan.

4. REQUEST FOR CALL IN: ADULT SOCIAL CARE – DRAFT DAY OPPORTUNITIES STRATEGY

Councillors Matt Bennett and Alex Yip had requested the call in as they felt it met the following criteria: -

4 – the Executive appears to have failed to consult relevant stakeholders or other interested persons before arriving at its decision.

5 – the Executive appears to have overlooked some relevant consideration in arriving at its decision.

6 – the decision has already generated particular controversy amongst those likely to be affected by it or, in the opinion of the Overview and Scrutiny Committee, it is likely to do so.

8 – there is a substantial lack of clarity, material inaccuracy or insufficient information provided in the report to allow the Overview and Scrutiny Committee to hold the Executive to account and/or add value to the work of the Council.

9 – the decision appears to give rise to significant legal, financial or property issues.

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

- It was acknowledged that some responses to the consultation exercise had been omitted from the pack that was available to the Executive.
- It was suggested that responses to the consultation had had no impact on the proposals put forward and it appeared the document was unchanged.
- The consultation process is not clear about the future of Day Care Centres which is at the very heart of the issue for service users and carers.
- The Cabinet Member said 960 completed consultation questionnaires had been received; over 700 questions submitted; over 3000 comments made; and 2476 people attended over 248 consultation meetings. The Council was listening to the voice of the public and working in a co-production way would produce a strategy that the majority of citizens would agree with.
- Greater community involvement through the transfer of community assets to the voluntary sector to support day opportunities was being considered. To date a mapping exercise had taken place and the next stage would be co-production.
- It was clarified that only one consultation had taken place. In response to a legal challenge the period of consultation was extended and because the period of consultation ended in early August a further extension for written submissions was given until the end of August.
- There were some communication issues with people with disabilities and those whose first language wasn't English. To address these issues an easy read version of the documentation was produced; engaged closely with Centre staff who knew how best to communicate with their service users and

family members were encouraged to attend events to support individuals so their views could be heard.

- Feedback from the consultation had raised concerns about the use of personal budgets and direct payments. Service users and their carers need reassurance that if using direct payments does not work for them, they do not have to continue to use them. It's about choice and what is best for an individual.
- The Cabinet Member: -
    - Apologised for the omission of the responses but confirmed they would be presented to Cabinet at the March meeting. She also confirmed that the Executive had made the decision of 11th February 2020 in the full knowledge of that information.
    - Assured members that the decision taken by Cabinet on 11th February had not predetermined the future of Day Centres.
    - The decision regarding the Day Centres would not be made until the implementation plan was presented to the Executive in January 2021 and then would need to go through a further consultation.
- There appeared to be miscommunication between senior officers and frontline staff on the interpretation of the policy for referrals into Day Centres. Social workers outline a range of options available and Day Centre provision is only one of them.
- Going forward, the recommendation being proposed by senior officers is that, for transparency, the co-production work is led by an independent, nationally recognised organisation. Officers will support that organisation. The City Council will be a stakeholder along with citizens, carers and providers in the decision-making process.

RESOLVED:

That the decision made by Cabinet on 11th February 2020 was not 'called-in' (by 6 votes to 1 i.e. Councillors Islam, Idrees, Donaldson, Brown, Tilsley and Pocock rejected the call-in; Councillor Fowler voted for the call-in). However, upon the chair's suggestion, a letter would be sent to the Cabinet Member highlighting the following issues that had been discussed, and asking that these be considered by the Executive in the course of the next Implementation Plan stage: -

- This Scrutiny Committee should be involved in the next stage of the co-production design process.
- Reassurance was sought from the Cabinet Member that people who choose Day Care Centre provision will continue to be entitled to do so.
- That there should be no direct or implicit coercion to pressure service users to opt out of Day Centre care.
- That Day Care Centres should be closely integrated into wider day opportunities within the community.

- There was concern that direct payments may not always be appropriate for an individual as a way of funding the mechanism for day opportunities or day centre support and should only be used when appropriate to do so.
- This Scrutiny Committee would want to contribute to an early working draft of the implementation plan.
- Concern was raised that messages from senior officers are not being accurately communicated to service users and carers by frontline staff.
- Concern about the ability of the third sector to effectively deliver day opportunities in the community.

Councillor Fowler expressed his disappointment that only one carer had been allowed to speak to members before the call-in meeting commenced and would have welcomed the opportunity for other service users/carers to do so.

Councillor Brown asked that the committee be provided with a copy of the timeline and protocol staff were given in terms of discussions with families regarding future Day Care provision.

5. ACTION NOTES/ISSUES ARISING

The action notes for the meeting held on 11th February 2020 will be available at the 17th March 2020 meeting.

6. PUBLIC HEALTH PROFILE DATA – SEXUAL AND REPRODUCTIVE HEALTH CONTEXTUAL DATA

Elizabeth Griffiths (Assistant Director, Public Health) provided a contextual report on sexual and reproductive health in the city by drawing on publicly available data on the Public Health England fingertips website. The information provided data on sexually transmitted infections, HIV, reproductive health and teenage pregnancies and supporting documents explained what each of the indicators mean, how they have been calculated and what should be considered when reflecting on them. The information was useful in identifying which areas of the city and which populations may need specific interventions.

RESOLVED:

The report was noted.

7. SEXUAL HEALTH: TESTING AND TREATMENT SERVICE IN BIRMINGHAM – UMBRELLA

Max Vaughan (Head of Service, Adult Public Health Commissioning); Natalie Slayman-Broom (Umbrella General Manager – Sexual Health Service); Sandra Orton (Divisional Director of Operations, Division 6, University Hospitals Birmingham NHS Foundation Trust) and Karl Beese (Commissioning Manager, Adult Public Health Commissioning) attended to give a presentation from the commissioners and providers perspective. Max provided a brief overview of the commissioning arrangements with Umbrella, which has been led by UHB NHS Foundation Trust

since August 2015. Natalie gave a summary of the service highlighting areas which the service is doing well and where improvement is needed.

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

- The non-return of online STI kits was highlighted as an issue but the return rate of 59-60% is much higher than the national average of around 40%. Work is being undertaken to try and address this.
- The instructions in the kit are pictorial to make it easy for everyone to understand. Foreign language interpreting services are available upon request at clinics.
- The Freshers campaign was very successful. It was carried out in September and the results for October were the highest the service had ever had.
- Any person residing in Birmingham or Solihull can access the service and order an online kit. If under 16 years of age attendance at a clinic is required.
- Plans for 2020 include upgrading T1 pharmacies to T2 which will be carried out through a procurement process. If a T1 pharmacy does not want to become a T2 pharmacy, they will not be commissioned going forwards.
- Used local outcomes data to identify potential gaps in provision and identified pharmacies in those areas, which are currently part of the Umbrella network, and invited them to tender.
- If someone attends clinic who is not a resident from Birmingham or Solihull the service is legally obliged to see them as it is an open access service. Cross charging another authority is generally accepted but some local authorities are asking for additional information which be difficult to get and if not provided won't pay. The out of area caseload is approximately 20%.
- Birmingham's funding for the service is slightly above average per population compared to other core cities.
- There is a Research and Development Team at Whittall Street and the service is part of an impact study which is a national project. The service is involved in clinical trials.
- One of the weakness of the service is the chlamydia diagnostic rate but the national target is very high which is why there is also a national average.

RESOLVED:

Natalie to provide further information on the clinical trials that Umbrella are involved with.

The next update report to include Chlamydia geographical data across the wards in Birmingham. Councillors would be interested in the data for their own ward and may be able to play an active part in promoting screening.

The chair conveyed the thanks of the committee to Natalie for her inputs to the Committee over recent years and wished her well in her future career.

8. ADULT SOCIAL CARE PERFORMANCE MONITORING – MONTH 8

Maria Gavin (Assistant Director, Quality & 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:

- There is a lot of proactive work to promote Shared Lives. Recruiting carers and providing training to support people with learning difficulties takes time and there is a lag between a successful advertising campaign and carers being matched with clients.
- Clarification about how the figure for delayed transfers of care was sought which tends to be described as bed days. The figure for November was 11.09 per 100,000 population 18+.
- The PURE Project which assists people with learning disabilities to access employment is a multi-million-pound European funded joint initiative for 3 years. It will not be affected by Brexit and, therefore, funding will be maintained for that period.

RESOLVED:

Maria to provide clarification on the number of beds inappropriately occupied across the whole of the estate i.e. each hospital.

Councillor Pocock suggested that a more detailed consideration of the factors affecting Delayed Transfers of Care and where it is more prevalent across the system e.g. early intervention, hospital by hospital, intermediate care should be added to the 2020/21 work programme.

9. WORK PROGRAMME – FEBRUARY 2020

The work programme was noted.

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

None.

11. OTHER URGENT BUSINESS

None.

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.

The meeting ended at 1226 hours.

BIRMINGHAM CITY COUNCIL
Councillor Rob Pocock
Scrutiny Chair
Health & Social Care
Overview and Scrutiny Committee

The Council House
Victoria Square
Birmingham B1 1BB
Telephone: 0121 464 4419

Our Ref: RP/rk

5th March 2020

Councillor Paulette Hamilton,
Cabinet Member Health & Social Care,
Room M83, Ground Floor,
Council House

Dear Cllr Hamilton,

Request for Call in: Adult Social Care – Draft Day Opportunities Strategy

I am writing to you as agreed, following the meeting on Tuesday 18th February which you attended and where the Health and Social Care Overview & Scrutiny Committee considered the Request for Call In relating to the Adult Social Care Draft Day Opportunities Strategy, which was lodged by Cllrs Matt Bennett and Alex Yip.

You will remember that wide-ranging concerns were raised in the course of the discussion. We noted, however, your assurance that no decision has yet been made on the future of day services in Birmingham and that there is no 'pre-determination' of the final decisions in the report of 11th February. We welcome your assurance that the next stage of the process anticipates a considerable amount of co-production work being done with all stakeholders on the future of day services which will be happening over the next nine months before the strategy comes back to Cabinet in January 2021, when you have advised that a decision will be taken by Cabinet on the future of day opportunities. If at that point any closures are being considered, then we note your assurance that a further consultation will need to take place.

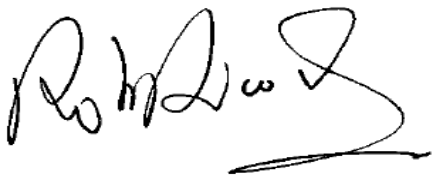
In the circumstances, the members of the committee decided not to call-in the decision. However, in the light of the important issues raised in the course of the debate, the members decided that their serious concerns needed to be put on record and raised with you in the form of a letter, in order that these can be fully considered by the Executive during the next stage of the co-production process on the Implementation Plan.

Eight main areas of concern were raised by the Committee during the meeting.

1. This Scrutiny Committee needs to be included in part of the co-design process happening between now and when the strategy goes back to Cabinet in January 2021.
2. The Committee sought reassurance that individuals who choose to use the services provided by Day Centres can continue to exercise their entitlement to make that choice.
3. That there should be no coercion or no appearance of coercion to pressure people to opt out of Day Centre care where this is their preferred day care option.
4. Day Centres need to be integrated into the wider community and with wider day opportunities as closely and as quickly as possible.
5. Direct Payments may not always be the most appropriate solution for people. They need to be carefully explained to people/reassurance provided so that people understand how to use them.
6. An initial working draft of the co-produced strategy/implementation plan should be brought to the HOSC at the earliest opportunity for our consideration and comment
7. There needs to be greater clarity of communication about current policy between the leadership level and how that is communicated to people on the ground at the front line - both workers and service users. We are concerned to hear that the approach being taken at senior level which does not presume closure of centres, may not be accurately reflected by staff on the front line.
8. We have some concerns over the capacity and ability of voluntary and third sector organisations to play an effective role in the provision of day opportunities. As day opportunities develop, there needs to be investment in voluntary and third sector organisations and in making community asset transfers work and in supporting people in local communities.

We look forward to your assurance that due consideration will be give to our concerns during the next phase of this work.

Yours sincerely,



Councillor Rob Pocock
Scrutiny Chair
Health & Social Care Overview and Scrutiny Committee

DRAFT FOR CONSULTATION

Triple Zero City Strategy

Birmingham

2020-2030

DRAFT

Our Shared Ambition

We want Birmingham to be a city where drugs and alcohol addiction do not cause preventable deaths and damage lives through overdose and crime.

We want Birmingham to be a city where young people grow up without addiction and where adults who are living with addiction to substances can access treatment and support and regain control of their lives.

Outcomes

We have three key ambitious outcomes we want to achieve through working in partnership across the city:

- Zero deaths due to drugs or alcohol addiction
- Zero overdoses due to drug or alcohol addiction
- Zero people living with addiction to drugs or alcohol not receiving support to manage and overcome their addiction

These are deliberately ambitious as we need to keep pace and focus to drive change at scale and truly impact on the challenge of drug and alcohol addiction in the city.

Key Objectives

These three outcomes are underpinned by a series of objectives which allow us to monitor progress towards these three longer term goals:

- Reduce access to, and the affordability of, illegal drugs in Birmingham
- Reduce the proportion of young people trying illegal drugs
- Reduce the number of harmful and hazardous drinkers
- Increase the proportion of people with drug and alcohol addiction in treatment
- Explore new models of treatment, care and support to minimise the risk of overdose and death
- Improve access to Naloxone and other interventions that can improve outcomes of overdose
- Improve access to employment support for people accessing treatment and support for drug and alcohol addiction
- Improve access to healthcare services for people accessing treatment support for drug and alcohol addiction
- Work in partnership with citizens, businesses, and organisations across the city to achieve our shared ambition to achieve the triple zero targets

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Context

Birmingham is a diverse, global, vibrant city with over a million citizens, however too many of our citizens lives are being damaged by addiction to alcohol or drugs.

Addiction to drugs comes in many forms and the landscape of drugs has evolved significantly over the last twenty years. The Triple Zero strategy will address a broad definition of drug addiction including novel psychoactive substances, steroid abuse, club drugs and prescription drug addiction as well as the more traditional opioid-based drug addiction models.

Alcohol addiction is often described in the context of harmful and hazardous drinking. The National Institute for Health and Care Excellence (NICE) defines harmful drinking as a pattern of alcohol consumption that causes health problems, including psychological problems such as depression, alcohol-related accidents or physical illness such as acute pancreatitis. Harmful drinkers can become alcohol dependent, which NICE defines as characterised by craving, tolerance, a preoccupation with alcohol and continued drinking despite harmful consequences.

Tackling alcohol and drug addiction and the harm that it causes needs us to work in partnership across the city. Preventing addiction requires action across the life-course to improve mental wellbeing, reduce access, reduce demand and give people other pathways to managing life challenges. Supporting those living with addiction to reduce the risk of death and overdose requires early identification, brief interventions as well as, for some, longer-term treatment and support. Enabling those living with addiction to manage and overcome their addiction and regain balance means working with educators and employers, as well as health and social care providers, to provide opportunities for individuals to achieve a healthy and productive life.

Led by Birmingham City Council in partnership with the West Midlands Police and Crime Commissioner, the Triple Zero Strategy sets out a refreshed approach to creating a healthier and safer city for all the residents of Birmingham.

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Definitions

Drugs

In the UK illegal drugs are classified into three main categories, A, B and C, with class A drugs attracting the most serious punishments and crimes (Table 1). The drugs are classified as controlled by the Misuse of Drugs Act (1971) and the class is allocated based on the level of harm the drug is thought to cause. Under the Act it is illegal for individuals to possess the drug, supply it or sell it, or allow it to be used in premises they own.

Table 1: Drug Classifications

Class	Drug
A	Crack cocaine, cocaine, ecstasy (MDMA), heroin, LSD, magic mushrooms, methadone, methamphetamine (crystal meth)
B	Amphetamines, barbiturates, cannabis, codeine, ketamine, methylphenidate (Ritalin), synthetic cannabinoids, synthetic cathinones (for example mephedrone, methoxetamine)
C	Anabolic steroids, benzodiazepines (diazepam), gamma hydroxybutyrate (GHB), gamma-butyrolactone (GBL), piperazines (BZP), khat
Temporary class drugs (The government can ban new drugs for 1 year under a 'temporary banning order' while they decide how the drugs should be classified.)	Some methylphenidate substances (ethylphenidate, 3,4-dichloromethylphenidate (3,4-DCMP), methylnaphthidate (HDMP-28), isopropylphenidate (IPP or IPPD), 4-methylmethylphenidate, ethylnaphthidate, propylphenidate) and their simple derivatives

There are a range of other words used in relation to drugs and alcohol which we have included definitions of here:

Opioids is a term used to describe a group of psychoactive substances derived from the poppy plant, including opium, morphine and codeine, as well as their semi-synthetic counterparts, including heroin (World Health Organisation, 2004).

Novel Psychoactive Substances describes a group of new drugs that have been designed to replicate some of the effects of other drugs like cannabis, cocaine and ecstasy while remaining legal which is why they are sometimes called 'legal highs'. The effects of NPS vary significantly from drug to drug and, compared to more traditional drugs, we have relatively little information on them. However, there is a growing body of evidence to demonstrate the potential short and long-term harms associated with their use.

Club Drugs is a term used to describe a group of drugs that are associated with use in parties and club nights. This includes drugs like MDMA (Ecstasy), GHB, Rohypnol, Ketamine, Methamphetamine, and LSD. Club drugs carry significant health risks and can cause serious harm and death with the risk often increased through contamination with other substances.

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ChemSex Drugs describes drugs that are predominantly used in association with sexual activity, the most common drug in this group is Methamphetamine, more commonly known as Crystal Meth, Tina, Glass or Yaba. Chemsex drugs carry health risks as drugs but also associated with higher sexual risk taking.

Steroids, in the context of steroid abuse, describes anabolic steroids which are often used illegally to increase muscle mass, decrease fat and enhance athletic performance. Steroids have significant health risks in both the shorter and longer term.

Prescription and over the counter drug abuse is the use of a prescription or over the counter medication in a way not intended by the prescribing doctor or dispensing pharmacist, this can be as a result of addiction or criminal activity. The most commonly abused drugs include opioids like codeine, antidepressants, ADHD medication and anti-anxiety medication.

Alcohol

Unlike most drugs in this policy alcohol is legal for adults to drink. The Chief Medical Officer recommends that adults drink no more than 14 units of alcohol a week. A unit of alcohol is about half a pint of normal strength beer or cider or a single shot, a small glass of wine is about 1.5 units.

There are two main terms used in the context of alcohol misuse:

Harmful drinking

The definition of harmful alcohol use in this guideline is that of the World Health Organisation‘s International Classification of Diseases, 10th Revision [The ICD-10 Classification of Mental and Behavioural Disorders] (ICD-10; WHO, 1992):

> “a pattern of psychoactive substance use that is causing damage to health. The damage may be physical (e.g. hepatitis) or mental (e.g. depressive episodes secondary to heavy alcohol intake). Harmful use commonly, but not invariably, has adverse social consequences; social consequences in themselves, however, are not sufficient to justify a diagnosis of harmful use."

Hazardous drinking

The term ‘hazardous use’ appeared in the draft version of ICD-10 to indicate a pattern of substance use that increases the risk of harmful consequences for the user. This is not a current diagnostic term within ICD-10. Nevertheless, it continues to be used by WHO in its public health programme (WHO, 2010a; 2010b).

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Policy Context

There is significant variation in policy on drug and alcohol misuse across the world. As a global city we have developed the strategy for Birmingham drawing on policy and practice from both UK and international policy.

As a city our citizens experience the impact of drugs and alcohol misuse at an individual, family, community and city-wide level. Cities often face additional challenges in relation to organized crime and being a hub for transport and migration. Cities also face tensions between the desire for economic growth linked to the night-time economy and the interconnection between this economy and drug and alcohol misuse. There is some evidence that cities are at often at the forefront of tackling the challenges of drug and alcohol because they have the immediate responsibilities for responding to the impact of these challenges such as violence, disorder, crime and inequality.

National & International Drug Policy Overview

The Home Office Drug Strategy 2017 sets out an approach based largely on reducing demand and supply, with a mention of rehabilitation and co-operation in action to reduce overall global supply of Class A drugs.

National policy places the responsibility for the commissioning of drug treatment services as part of the recommended services commissioned through the local authority public health grant, however it is not a statutory service. Local authorities have responsibilities with regards to the NHS Constitution under the 2012 legislation to delivery drug and alcohol recovery services and are required to fund appropriate interventions as recommended by National Institute of Clinical Excellence (NICE).

NICE have published guidelines on drug treatment and also made recommendations about interventions at a system level that can influence drug misuse but these are not government policy.

The World Health Organisation (WHO) identifies the world drug problem as both a public health issue and a safety and security issue, with different countries responding with their own balance between these two domains. The WHO recommends that drug use disorders are managed within the public health system, as the evidence shows this is what works best. In certain countries the idea of including treatment of drug use disorders still meets resistance – *"partly owing to a delay in transferring science to policy and ultimately to the implementation of evidence-based clinical practices".* The WHO advocates for a life course approach to prevention on the basis that intervention in the early years has most impact.

In international terms, the UK has taken a less liberal approach to drug criminalisation[i] than some other countries although in general this is restricted to liberalisation relating to Cannabis. There are some areas where there has been significant innovation internationally, especially in relation to heroin assisted treatment such as "safer injecting facilities". In some countries drug consumption

rooms, where illicit drugs can be used under the supervision of trained staff, have been operating for the last three decades and are now found in 10 countries. The benefits of providing supervised drug consumption facilities may include improvements in safe, hygienic drug use, especially among regular clients, increased access to health and social services, and reduced public drug use and associated nuisance. There is no evidence to suggest that the availability of safer injecting facilities increases drug use or frequency of injecting. These services facilitate rather than delay treatment entry and do not result in higher rates of local drug-related crime.

National and International Alcohol Policy Overview

The WHO provides a Global Status Report on Alcohol Policy. The mechanism by which this works is through the Global Alcohol Policy Alliance. A report was produced for the World Health Assembly in 2019 to report on the implementation of the WHO's global strategy to reduce the harmful use of alcohol during the first decade of its endorsement. A conference will be held in Dublin in March 2020.

National policy on Alcohol was produced by PHE in 2018: "Alcohol: applying All Our Health". This focuses on work to reduce alcohol harm in professional practice and action that can be taken by front-line health and care professionals. It also outlines actions that can be taken by both management and strategic leaders. The primary measures of the impact of alcohol harm are found in the Public Health Outcomes Framework Indicators (alcohol-related admissions to hospital and successful completion of alcohol treatment). There is an Everday Interactions measuring impact toolkit that can be used by health care professionals and an alcohol impact pathway. NICE PH24 provides guidance on prevention of alcohol use disorders.

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The context of drugs in Birmingham

The Drug market in Birmingham

The majority of organised crime groups (OCG) in the West Midlands are heavily involved in the drugs trade. In 2017, there were 84 OCGs being tracked by West Midlands Police, of these 31 were primarily involved in drug related criminality. OCGs involved in the drugs trade are likely to have an international client base; The National Crime Agency (NCA) has reported Birmingham as one of the three main exporting areas of drugs in the UK, alongside London and Liverpool. Of the 84 OCGs tracked, 27 were known to have an international footprint. Organised criminals in the West Midlands are profiting from a drug market worth approximately £188m.

One of the eight drug policy recommendations from the West Midlands Police and Crime Commissioner is to seize the money from organised criminals including across the drug market and put this towards improving drug services. Those who have previously been benefiting from the drug market will instead be paying for drug services to help those suffering with a drug addiction and to reduce the number of drug-related deaths. Between 2012 and 2017, West Midlands Police seized more than £17 million from offenders under the Proceeds of Crime Act (POCA).

Drug Misuse in Birmingham

Estimated prevalence of opiate and/or crack cocaine use in Birmingham residents (5-64 years old) has been nearly twice the national rate in recent years. In 2011/12 the rate was 15.2 per 1000 population (England 8.4). In 2016/17 Birmingham's rate decreased to 14.2 and the national has increased to 8.9 per 1,000 population.

The city's recorded number of drug users (opiate and/or crack cocaine use measured by various organizations, including drug treatment, probation, police and prison data) fluctuates over time: with cases at a peak of 10,743 (2011/12), then decreasing to 9,705 (2014/15) and rising again to 10,525 (2016/17).

We have limited local data on patterns of drug and alcohol misuse but there are national prevalence estimates from the Crime Survey for England and Wales from which we can estimate the potential burden of misuse in Birmingham (Table 2). This modelling estimates that in the last month over 8,900 adults in Birmingham have used a class A drug (this is an under estimation as this will not include hostels, students and anyone else with temporary addresses. Over the last year over 1,370 have used anabolic steroids and 43,870 used non-prescribed prescription-only painkillers. However, it is important to note that there is significant variation in use frequency e.g. only 5.9% of adults using powder cocaine in the last month were using daily compared to 25.4% of cannabis users using daily.

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Table 2: Estimated number of adults using drugs based on national and regional prevalence data from the Crime Survey for England and Wales 2018/19[ii] (based on est. pop of 16-59yr of 685,603)

Data from Crime Survey for England and Wales 2018/19	Adults 16-59yrs who used drug ever in their lifetime		Adults 16-59yrs who used drug ever in the last year			Adults 16-59yrs who used drug in the last month	
	% national	Est. pop. In B'ham	% national	% West Midlands	Est. pop. In B'ham	% national	Est. Pop in B'ham
Class A							
Any cocaine	10.80%	74,045	2.90%	N/A	19,882	1.10%	7,542
Powder cocaine	10.70%	73,360	2.90%	2.10%	14,398	1.10%	7,542
Crack Cocaine	0.80%	5,485	0.10%	N/A	686	0.00%	0
Ecstasy	9.90%	67,875	1.60%	0.70%	4,799	0.30%	2,057
Hallucinogens	8.50%	58,276	0.70%	0.50%	3,428	0.10%	686
LSD	5.00%	34,280	0.40%	N/A	2,742	0.00%	0
Magic mushrooms	6.90%	47,307	0.50%	N/A	3,428	0.10%	686
Opiates	0.70%	4,799	0.10%	N/A	686	0.10%	686
Heroin	0.50%	3,428	0.10%	N/A	686	0.00%	0
Methadone	0.40%	2,742	0.10%	N/A	686	0.00%	0
Class A/B							
Any amphetamine	8.90%	61,019	0.60%	N/A	4,114	0.10%	686
Amphetamines	8.80%	60,333	0.60%	0.40%	2,742	0.10%	686
Methamphetamine	0.50%	3,428	0.00%	N/A	0	0.00%	0
Class B							
Cannabis	30.20%	207,052	7.60%	6.30%	43,193	4.00%	27,424
Ketamine	3.10%	21,254	0.80%	N/A	5,485	0.30%	2,057
Mephedrone	1.70%	11,655	0.00%	N/A	0	0.00%	0
Class B/C							
Tranquillisers	2.80%	19,197	0.40%	N/A	2,742	0.20%	1,371
Class C							
Anabolic steroids	1.10%	7,542	0.20%	N/A	1,371	0.10%	686
New psychoactive substances	2.50%	17,140	0.50%	N/A	3,428	N/A	N/A
Nitrous Oxide	N/A	N/A	2.30%	N/A	15,769	N/A	N/A
Non-prescribed prescription only painkillers	N/A	N/A	6.40%	N/A	43,879	N/A	N/A
Any Class A drug	16.00%	109,696	3.70%	2.50%	17,140	1.30%	8,913
Any drug	34.20%	234,476	9.40%	7.90%	54,163	5.00%	34,280

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There is some variation in patterns of use between different age cohorts for example younger adults are more likely to be using nitrous oxide than the overall adult population (8.7% compared to 2.3%) and this may mean the true picture for Birmingham is slightly different given our larger proportion of young adults.

There is also variation in drug use patterns in different ethnic groups (Table 3), in general drug use is highest in mixed ethnicity groups and white ethnicity groups within the population. Given Birmingham's significant diversity this reinforces the need for local approaches to consider cultural identity in the provision of services and support.

Table 3: Proportion of 16 to 59-year olds reporting use of illicit drugs by ethnic group in 2018/19[iii]

	Class A Drugs			Class B Drugs		Any Drug
	Any Class A	Powder Cocaine	Ecstasy	Amphetamines	Cannabis	
ALL ADULTS AGED 16 to 59	**3.7**	**2.9**	**1.6**	**0.6**	**7.6**	**9.4**
Ethnic group						
White	4.1	3.3	1.7	0.7	8.0	9.9
Non-White	1.9	1.1	1.0	0.1	5.9	6.7
Mixed	10.5	6.2	4.7	0.6	18.5	23.4
Asian or Asian British	0.5	0.3	0.3	0.1	2.8	3.0
Black or Black British	1.1	0.6	0.6	0.0	6.7	6.8
Chinese or other	1.7	0.6	1.2	0.0	7.5	8.4

The lesbian, gay, bisexual and transgender (LGBT) community has a higher than average reported use of recreational drugs and different patterns of drug misuse. A 2011 survey highlighted that 50% of respondents had used drugs for recreational purposes.

At a national level, communities that are most deprived have nearly three times the prevalence rate than the least deprived areas for opiate and/or crack cocaine use.

Steroid abuse is most commonly associated with male body builders; however, the use has spread to female body builders as well as into the recreational gym scene[iv]. One study in South Wales found over 70% of recreational gym users reported using anabolic steroids[v]. There is also reported use alongside the street drug scene where steroids can be used to counteract some of the anorexic effects of other drug addictions.

Treatment and Support

The main national focus of treatment and support commissioning guidance is on opioid drug addiction and harmful alcohol addiction. There is limited national emphasis on treatment of club drugs, steroid abuse or NPS. This trend might be the result of individuals who tend to access treatment tend to be opiate users rather than anyone using any other type of substance, therefore the data available is likely to be opiate heavy. Provision of treatment and support services is not a statutory

requirement but is a recommended service for commissioning through the local authority public health grant.

In 2020 it is estimated that 43% of opiate users in the City are engaged in treatment services. Those opiate users in treatment and new to treatment tend to have a relatively high level of multiple complexities compared to similar areas nationally and are an ageing cohort which is generating new areas of health and social care need.

In 2020 Birmingham City Council invested £14.8m on drug and alcohol treatment and support for all ages funded by the public health grant. A single system with a matrix of partnership providers has been commissioned to deliver these services. GP and pharmacy primary care, as well as the third sector are part of the provider matrix led in 2020 by Change, Grow, Live (CGL). There are a range of service responses provided through this partnership including specific service elements focused on mental health, prison release, employment, criminal justice, blood borne viruses, domestic abuse, acute sector, child protection and homelessness.

In 2018/19 5,399 people accessed treatment, 76% of these were male and 24% female, the largest age group was aged 30-39yrs but it is important to note that 13% of clients were over 50yrs old. Over 90% of people were in treatment for opioid drug addiction, with a much smaller number being treated for alcohol addiction or alcohol and non-opioid addiction. 1,757 people were new presentations to treatment, over 60% of these were White British, 7% were Pakistani and 5% Caribbean and just under 90% were UK nationals. Although most new presentations reported no religion, 18% were of a Christian faith and 8% were Muslim. At the time of presentation 2% reported a lesbian, gay or bisexual sexual orientation and 27% of clients had at least one disability recorded.

At presentation 8% of clients reported use of prescription-only medicines or over-the-counter medicines and 8% of clients reported use of club drugs.

99% of clients had an initial wait of less than three weeks to start treatment which is in line with the national average and unplanned exit from treatment were slightly lower than the national average (17% compared to 18%).

The local service compares well to the national picture in terms of opiate treatment with 47% completing treatment in under two years and 38% of opiate users achieving abstinence at six-month review and 24% reporting significant reduction in use.

Treatment outcomes are tracked nationally through the Treatment Outcomes Profile which reviews outcomes for different drug types at six months in terms of abstinence, significantly reduced use and injecting use. Across most drug types the profile for Birmingham on abstinence at six months is not as strong as nationally, however it is more positive for significant reduction in use. A similar proportion of clients are no longer injecting at 6 months.

Successful completion of treatment by clients who do not re-present to treatment in Birmingham is slightly lower for Opiates than nationally (5.4% compared to 5.8%) but higher for Non-Opiates (37.9% compared to 34.4%).

In line with the national policy focus the current service provision has primarily an opiate user focus although there is some service provision for alcohol addiction and other forms of drug addiction.

The commissioned system has a primary focus on treatment although the nationally funded individual placement support pilot has strengthened the approach to employment support for people in treatment. The focus on prevention, early intervention and longer-term recovery is an area that needs further development in the future.

Alongside the commissioned drug and alcohol treatment services there are a range of voluntary and community sector providers including peer to peer support groups and organisations like Alcoholics Anonymous, Cocaine Anonymous and Narcotics Anonymous and charitable provision of residential rehabilitation support.

Drug overdose

Drug overdose is monitored at a national level as hospital admissions related to drug poisoning. As well as being a key issue to be addressed in themselves, poisoning admissions can be an indicator of future deaths. People who experience non-fatal overdoses are more likely to suffer a future fatal overdose.

Drug overdose is reported as a crude rate per 100,000 people. The most recent published data for 2018-19 suggests the rate in Birmingham is higher than the national average (Table 3).

Table 4: Crude rate of hospital admissions for drug poisoning (2018/19)

Indicator	Birmingham	England
Hospital admissions for drug poisoning (primary or secondary diagnosis) All persons, crude rate per 100,000	65.2	56.2

Deaths related to drug misuse

Drug related deaths in the UK are at a record high and have been increasing for the last four years. More specifically within the West Midlands, every three days someone dies from a drug poisoning; nationally over 54% of deaths involved opiates. There has been an increase in the number of overdose deaths due to the impact of fentanyl mixed with heroin in the UK drugs market. This highlights the importance of focusing on preventing these deaths and educating the public on the effects of drugs. The latest available data (2016-18)[vi] shows that the rate of deaths from drug use in Birmingham is 6.3 (per 100,000 population) and this is significantly higher than the England and West Midlands rates that are both 4.5. Birmingham has the second highest rate in the region behind Stoke-on-Trent and are the 6th lowest of the 8 Core Cities.

The context of alcohol in Birmingham

There is in general more limited data on the scale of alcohol misuse and the impact in terms of crime and health services when compared to drug misuse.

The alcohol economy in Birmingham

In our city alcohol is often part of socialising and celebration and the hospitality and recreation sector is an important and valued part of Birmingham's economy, especially the vibrant night-time economy. Across the city there are over 170 supermarkets selling alcohol, with many more shops, bars and pubs with an alcohol licence.

In England we spend on average £16.30 per week on alcoholic drinks, of this about £8.10 per week is spent on alcoholic drinks away from home[vii]. The average spend per household in the West Midlands is slightly lower at £14.60 per week, however the proportion of this spend for at home consumption is higher than the national average (53% compared to 51%). Nationally the average household spend on alcohol has fallen over the last decade, especially in relation to the spend on alcoholic drinks away from home. This has been reflected in over 11,000 pubs closing over the last decade in the UK, although in the same period employment in pubs and bars has increased by 6%[viii].

In Birmingham there are about 2.8 pubs per 10,000 people which is lower than the UK average of 5.8 pubs per 10,000. There are now about 220 fewer pubs in Birmingham than in 2001, a fall from 545 pubs in 2001 to 325 pubs in 2018. Approximately 5,000 people have jobs in Birmingham's pubs and bars, although this has fallen by 28.6% since 2001[ix]. Birmingham is also home to several breweries and distilleries which are important parts of our local economy.

In 2010, £42.1 billion was spent on alcohol in England and Wales alone. Alcohol is often heavily discounted so that it is now possible to buy a can of lager for as little as 20p or a two litre bottle of cider for £1.69[x]. The pricing of alcohol is a national issue, but it is also a local issue in terms of business responsibility as well.

Much like healthy food the approach has to balance the practicalities of business, the importance of jobs and economic growth alongside the potential health impacts and risks of harm from alcohol misuse and addiction. We have to work constructively with businesses and communities to support responsible drinking across the city.

Alcohol misuse in Birmingham

Alcohol-related harm is largely determined by the volume of alcohol consumed and the frequency of drinking occasions.

In January 2016 the Chief Medical Officer (CMO) issued revised guidance on alcohol consumption, which advises that in order to keep to a low level of risk of alcohol-related harm, adults should drink no more than 14 units of alcohol a week. The 2011-2014 Health Survey for England found that almost double the proportion of adults in

Birmingham abstain from alcohol compared to the national average (30.9% compared to 15.5%), and although the proportion of adults drinking more than 14 units of alcohol a week is lower in Birmingham than the national average it is still significant (18.9% compared to 25.7%).

Based on national prevalence rates it was estimated that there are approximately 12,667 adults in Birmingham with alcohol dependence in need of specialist treatment.

National data has highlighted there are variations in rates of harmful drinking in different ethnic groups, rates are highest in White British ethnic communities (Table 5).

Table 5: The percentage of adults nationally, by ethnic group, who drink at harmful or dependent levels (2014)

Ethnicity	**% of adults drinking at harmful or dependent levels**
White British	5.2%
White other	1.9%
Asian	1.0%
Mixed	3.9%
Black	3.5%

There is also variation depending on deprivation; 2.1% adults in the most deprived decile were dependant drinkers, compared to 0.9% in the least deprived.

Treatment and support for alcohol misuse

In 2017/18, Birmingham had 1,617 dependent drinkers in alcohol treatment of which males were estimated to be 13% of those estimated to be in need, compared to 18% nationally. Treatment for alcohol misuse is part of the CGL commissioned service.

Analysis by Public Health England of clients in alcohol treatment in 2018-19 reported that 64% were male and 36% female which is comparable to the national gender balance. The largest proportion of clients in treatment were aged 40-49yrs and 50-59yrs, and it is important to note that 11% of clients in treatment were aged over 60yrs.

Analysis of clients presenting new to treatment in 2018-19 in Birmingham highlights that most clients are White British (66%) followed by Indian (5%) and Pakistani (4%) ethnicities. 89% of those presenting for treatment have a UK nationality and after no religion (45%), Christianity (23%) and Islam (4%) and Sikh (3%) are the most common faiths.

3% of clients presenting new to treatment had a gay, lesbian or bisexual sexual orientation and 35% of clients had at least one disability.

100% of clients waited less than three weeks to start the first intervention for alcohol treatment. The service had a lower proportion of unplanned exits from treatment (11%) than the national average (14%).

It is important to highlight that the case load of clients in Birmingham appears to have a higher proportion of severely dependent drinkers (32% of male and 26% of female clients) compared to the national profile (18% male and 15% female), however there are a higher proportion of clients nationally where this profile is unknown.

The NICE Clinical Guidelines on treatment recommend that harmful and mildly dependent drinkers receive a three-month treatment intervention and for those with moderate and severe dependence this should be for a minimum of six months. In Birmingham the average time in treatment is 180 days compared to 186 days nationally, however only 27% of clients leave treatment before 3 months compared to 35% nationally.

There are two key measures of in-treatment success, abstinence rates at planned exit and days of drinking change between start and planned exit. Birmingham had a lower proportion of individuals achieving abstinence at exit (49%) than nationally (51%), however the service achieved a great change in number of drinking days dropping from 22.2 at entry to 9.6 at exit, compared to 20.7 and 11.5 days nationally.

Successful treatment is measured in the context of completion of treatment and the client not returning to alcohol within 6 months. Birmingham is achieving a slightly higher level of successful treatment against this indicator in 2018 (40%) than the national average (38%).

Alcohol overdose

Alcohol overdose is described in the context of admission episodes for intentional self-poisoning by and exposure to alcohol condition, it is reported as a directly standardised rate by gender of clients (Table 6). The rate of alcohol overdose is lower in Birmingham than nationally, especially for women.

Table 6: Directly standardised alcohol overdose rates for Birmingham and England (2017/18)

2017/18	Birmingham Per 100,000 adults	National rate Per 100,000 adults
Male	38.8	39.5
Female	47.7	53.0

Impact of alcohol misuse

Alcohol consumption is a contributing factor to hospital admissions and deaths from a wide range of conditions which costs the NHS about £3.5 billion per year and society £21 billion annually.

Whilst the overall drinking rates in England have decreased from 2011 to 2016 (from 34% to 31% for males and 18% to 16% of women), Birmingham's (2017/18) hospital admissions for alcohol related conditions are significantly higher than England. For male admissions it was 3,553 per 100,000 (England 3,051) and for females 1,762 (England 1,513) (Table 7).

The Birmingham rate for alcohol specific and alcohol related mortality is significantly higher than the England average and has been over recent years. The latest period 2015/17, has the alcohol specific mortality rate for Birmingham at 14.4 deaths per 100,000 population (England, 10.6 deaths). Similarly, the 2015/17 alcohol related mortality rate for Birmingham is 53.3 deaths compared to the England rate of 46.2 deaths per 100,000 population.

Table 7: Hospital admissions counts and rates for alcohol-related conditions for Birmingham, West Midlands and England

Indicator	Period	Birmingham		West Midlands	England
		Count	Rate/100,000	Rate/100,000	Rate/100,000
Admission episodes for alcohol-specific conditions - <18yrs	2016/17-18/19	140	16.2	26.1	31.6
Admission episodes for alcohol-related conditions (narrow)	2018/19	6,748	706	739	664

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Drug and alcohol misuse amongst Young People and their parents in Birmingham

Birmingham has a larger proportion of children and young people than the UK average and if we are going to address drug and alcohol misuse fully we have to explicitly consider how to work with them to change the city.

Drug and alcohol misuse impacts on children and young people in many ways, either because they are themselves using alcohol or drugs, or their parents or other family members are, or because they are pawns in organised crime or victims of crime.

Although the number of young people who are using drugs and alcohol is much smaller than adults this is a highly vulnerable group. A Substance Misuse Needs Assessment for Children and Young People, was carried out in August 2018, shows:

Table 8: What About Youth (WAY) Survey 2014/15 (age 15): Birmingham results

Getting drunk in the last 4 weeks	Rates were lower in Birmingham than in England (5.9% vs 14.3%) Within Birmingham, rates were higher for girls than boys; highest for white ethnicity amongst girls and mixed ethnicity amongst boys
Ever trying cannabis	A lower proportion of Birmingham children reported ever trying cannabis (6.5%) than in England (10.5%) Within Birmingham, mixed ethnicity had the highest rates
Taking cannabis in the last month	A lower proportion of Birmingham children reported taking cannabis in the last month (2.0%) than in England (4.55). Within Birmingham, rates were highest for black boys and mixed ethnicity girls
Ever trying drugs other than cannabis	A lower proportion of Birmingham children reported ever trying drugs other than cannabis (1.4%) than in England (2.4%) Within Birmingham, rates were higher for girls; highest for white girls and black boys
Taking drugs other than cannabis in the last month	A very low proportion of Birmingham children reported taking drugs other than cannabis in the last month (0.2% vs 0.8% in England)

Young people receiving interventions for substance misuse have a range of vulnerabilities that require specialist support and intervention. Those in treatment often say they:

- are/were victims of domestic violence
- have contracted a sexually transmitted infection
- have experienced sexual exploitation

And are more likely to:

- not be in education, employment or training and
- be in contact with the youth justice systems

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Table 9: Numbers affected in Birmingham: 11-15 year olds

	National Prevalence %	Estimated B'ham Prevalence (ethnicity adjusted) %	Est. number in B'ham population aged 11-15yrs N=73,252 (2016)
Ever taken drugs	23.9	26.0	19,000
Taken drugs in the last month	17.4	18.2	13,300
Taken drugs in the last month	9.7	9.8	7,200
Ever drunk alcohol	45.3	30.4	22,300
Drunk alcohol in the last week	10.3	5.7	4,200
Ever smoked	19.0	16.3	12,000
Current smokers	6.3	5.0	3,600
Regular smokers	2.7	2.0	1,500

Table 10: Number affected in Birmingham: 16-24 year olds

	National Prevalence %	Estimated numbers in Birmingham population aged 16-24 N=169,046 (2016)
Infrequent drug users (once or twice a year)	46	77,800
Frequent drug users (>once a month)	4.1	7,000
Taken NPS in the last year	1.2	2,000
Number drinking >8/6 units on heaviest drinking day	20.4	34,500

Source: Smoking, drinking and drug use among young people, 2016

Young people in treatment 2019/20

Young People's substance misuse treatment services in Birmingham offer support to anyone under 18 years who has a substance misuse problem, or who are affected by parental (or guardian) substance misuse.

This support is delivered by means of a service offering brief interventions and advice, comprehensive assessment and care planning and 1:1 structured interventions. The current contract for the service was awarded to Aquarius Action Projects in October 2019 for a period of 2 years with an option to extend for a further two years (e.g. 2 + 1 + 1) subject to available funding and satisfactory performance.

At 31st December 2019 there were:

- 350 under 18s in treatment (up 5% compared to previous rolling year)
- 56 in secure estate
- 0 over 18s in YP services
- 93% wait less than 3 weeks
- 80% had planned exits (England 82%)
- 30% drug free (England 33%)
- Main substances: cannabis (95%), alcohol (44%), nicotine (3%), cocaine (3%) and Solvent (4%)

Parental Substance Misuse

Dependent parental alcohol and drug use has an adverse impact on children, particularly regarding their physical health, psychosocial wellbeing and personal alcohol and drug use.

There is increasing evidence that adverse childhood experiences (ACEs) such as living in a household with problem alcohol use can contribute to long term harms. If a child experiences four or more risk factors during childhood they have a substantially higher risk of developing health-harming behaviours, such as smoking, heavy drinking and cannabis use.

A report by the Children's Commissioner produced in July 2018 showed:

- 30,000 children and young people aged under 18 in Birmingham are living with an adult who has reported substance misuse
- Of these, over 11,000 are living with an adult dependent on drugs or alcohol
- Of these, 2,500 are living with an adult who also has severe mental health problems and has experienced DV

The Quarter 2 Diagnostic Outcomes Monitoring Executive Summary 2019/20 shows:

- There are 1,564 adults currently accessing treatment who live with children (this represents 22.6% of all adults accessing treatment)
- 19.3% of all adults starting treatment in quarter 2 were adults living with children
- 8.9% of children were on Child Protection Plans (higher than the national average of 7%)
- 2.9% of children were looked after (national average of 2.9%)

Although a small number of pregnant women present each year for treatment for drug or alcohol misuse these are an important group and our local maternity providers have specialist midwives who are trained to work with these women and support them through pregnancy and work with treatment providers to achieve positive outcomes for bother mother and baby.

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Our Framework for Action

The Framework for Action is focused on delivery through six themed workstreams that will work together to create a safer, healthier city.

The six themed workstreams are:

1. Prevention
2. Early intervention
3. Treatment, Support & Recovery
4. Children and young people
5. Additional challenges
6. Data and Evidence

Through the six workstreams there a five ‘golden threads’ which weave across all of the Forum frameworks for action:

Citizen First
We will put the citizen at the heart of our approach, working with citizens across the city to help co-produce a healthy, sustainable, economically viable environment that is accessible to everyone.

Regulation & Enforcement
We want to support businesses to be financially and environmentally sustainable and make the most of the everyday contact between regulation and enforcement authorities in the city and the region to support businesses to work towards our shared ambition of a city in which people enjoy alcohol responsibly and without it causing harm.

Diversity & Inclusion
We know that there are significantly different relationships with drugs and alcohol in different cultures and communities across the city and as we progress this work we want to work with these communities to find solutions and approaches that work in the context of celebrating this diversity.

Scale & Pace
Birmingham is a large city with a diverse community and it is important that we keep a focus on moving at pace and scaling to reach every part of Birmingham with our work, building on success and finding ways to scale across the whole city to ensure every citizen benefits.

Learning & Listening
We also know we need to listen and be humble in our approach, learning in true partnership with cities, in the UK and across the world, learning from research and practice-based evidence and from our citizens. We will be open and honest in our conversations about the challenges as well as the opportunities and successes.

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Workstreams of Action

Through the development of the action plan that will deliver this strategy we will review the evidence and take an action-learning approach to the action plan to move at pace to address the drivers of addiction as well as support those whose lives are blighted by the impact.

The six workstreams of action will create a framework for delivering the vision and ambition of the strategy.

Prevention

Prevention requires action on multiple levels across the city to reduce the supply of drugs and saturation of alcohol as well as reducing demand. Action on prevention may include:

- Disrupt and close-down organised crime that underpins the drug trade
- Challenge the saturation of low-cost alcohol sales
- Education and awareness raising, especially with communities most at risk
- Exploring opportunities to tackle sales of steroids and nitrous oxide in the city
- Targeted social marketing and awareness work with communities at highest risk
- Medicine monitoring and support in healthcare settings to tackle prescription and over the counter medicine misuse
- Work with key settings such as workplaces, schools and universities to support organisational approaches to reducing drug and alcohol misuse

Early intervention

Early intervention is about providing support to prevent addiction forming and providing alternative ways of managing the stress and pressures that are pushing people towards misuse. Action on early intervention may include:

- Promoting access to peer support and self-care early interventions
- Increasing training and awareness among professionals working with communities most at risk
- Work with community and performance gyms to raise awareness of steroid abuse risks and impacts
- Continue to strengthen the collaboration between homelessness, mental health and substance misuse services
- Explore how to better support family and friends to enable peer early intervention and support

Treatment, Support & Recovery

Treatment aims to help people to manage their addiction, ideally with the ambition to achieve a life free of drugs or alcohol misuse, or where this is not possible to achieve a level of maintenance which enables them to actively participate in society. Action on treatment, support and recovery may include:

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- Continue to support drug and alcohol treatment services in line with national commissioning guidelines and national provided funding resources
- Continue to review the models of care provided against the emerging pattern of usage
- Employment support for people accessing drug or alcohol treatment services and work with employers to encourage provision of job opportunities
- Increase connectivity between commissioned professional treatment services and community based mutual aid groups such as Alcoholics Anonymous, Cocaine Anonymous and Narcotics Anonymous
- Explore innovative models of risk minimisation in treatment such as heroin assisted treatment and safer injecting facilities

Children and Young People

The impact of drugs and alcohol on children and young people can last a lifetime and it is important that we have a specific focus on their needs and issues as well as engage them in active solutions for the city. Action on children and young people may include:

- Address youth gang violence and crime and particularly tackle organised crime's use of children and young people in drug trafficking
- Integrate drug and alcohol prevention and early intervention into other services concerned with reducing risky behaviours in children and young people such as sexual health or truancy
- Support schools to deliver high quality evidence-based education on personal resilience in all educational settings including schools, and universities
- Promote access for young people to accurate information about drugs to allow them to make informed choices
- Increased screening and referral of young people at risk of substance misuse through mainstream services working with higher risk groups
- Ensure that drug and alcohol treatment services have strong relationships with social care and safeguarding support to ensure children and young people in families where there is substance misuse are safe and protected
- Ensure that support for children and young people is closely joined up to support for adults so that young people get the support they need as they get older and transition between services.

Additional Challenges

Many individuals who are struggling with addiction face additional challenges, these include those who are homeless or have insecure housing, people living with mental health issues or people experiencing violence, coercion, abuse or involved in the criminal justice system.

In 2018/19 the drug treatment service identified 35% of new presentation clients had a mental health condition, in alcohol treatment this was higher at 40%, of these 72%

of those in drug treatment and 80% of those in alcohol treatment were receiving active mental health treatment from their GP or the Community Mental Health team. In the same cohort 17% of those with drug issues and 10% of those with alcohol issues presented with a housing problem or no fixed abode at the start of treatment.

14% of newly presenting clients for drug treatment and 18% of those presenting for alcohol treatment in 2018-19 were living with children and a further 35% in drug treatment and 25% in alcohol treatment are parents but not living with children. It is important that through our approach we consider the additional challenges of drugs and alcohol not just on individuals but also on their families, especially their children. We will make sure that children living in families and households where adults use drugs and alcohol are safe and supported.

In the same year 3% of women presenting for drug treatment, and 2% presenting for alcohol treatment, were pregnant, although this is a small number, these are a particularly high-risk group to consider.

It is important that we specifically consider the needs of these individuals in developing our approach generally and also consider where explicit intervention is needed. Action on people with additional challenges may include:

- Additional targeted training and awareness to support engagement and referral for people accessing mental health or housing services
- Specific work with the Birmingham Children's Trust to strengthen links and support for families where a parent or family member is misusing alcohol or drugs
- Specific work with Birmingham United Maternity Partnership (BUMP) to ensure interconnected pathways of care and support for mothers with addiction issues
- Specific work with the criminal justice health system to address drug and alcohol issues within custody and through probation and youth justice services

Data and Evidence

Through the work to deliver this strategy we aim to increase the understanding of the picture of drug and alcohol misuse and addiction in the city and strengthen the evidence base for what works. Action on data and evidence may include:

- Developing a more detailed local data set of indicators to track progress and impact
- Explore potential for economic indicators and metrics to look at impact of low cost alcohol
- Research into steroid, nitrous oxide, club drug and NPA to better understand patterns of use and supply chains
- Research to better understand the cultural context of alcohol and substance misuse and the inequalities within the city

Measuring Success

The triple zero has three headline objectives:

- Zero deaths due to drugs or alcohol addiction
- Zero overdoses due to drug or alcohol addiction
- Zero people living with addiction to drugs or alcohol not receiving support to manage their addiction

The baseline data for these three objectives are:

Deaths attributable to Alcohol
Deaths from alcohol misuse are measured through two nationally reported indicators (Table 11):

Alcohol-Specific Mortality - Deaths from alcohol-specific conditions, all ages, directly age-standardised rate per 100,000 population. Reported annually by Public Health England.

Alcohol-Related Mortality - Deaths from alcohol-related conditions, all ages, directly age-standardised rate per 100,000 population. This includes deaths of children where parental alcohol use was a significant contributing factor such as foetal alcohol syndrome causing infant mortality. Reported as a 3yr average rate.

Table 11: Birmingham deaths attributable to alcohol

		2016-18	**2015-17**	**2014-16**	**2013-15**	**2012-14**
Alcohol-Specific Mortality	*Persons*	15.0	14.4	14.3	14.2	13.9
	Males	22.3	21.7	21.9	21.6	21.2
	Females	8.1	7.7	7.3	7.2	6.9
		2018	**2017**	**2016**	**2015**	**2014**
Alcohol-Related Mortality	*Persons*	57.4	53.2	53.0	51.9	59.2
	Males	83.1	79.2	79.8	77.5	92.0
	Females	35.2	31.4	30.1	30.4	30.9

Drugs attributable to Drug misuse
Deaths from drug misuse are measured through one nationally reported indicator (Table 12):

Deaths in drug treatment, mortality ratio - The indicator is calculated as a three-year rolling average expressed per 100,000 population and is published by Office of National Statistics (ONS). ONS data is based on the current National Statistics definition of deaths related to drug poisoning by both legal and illegal drugs and includes accidents, suicides and assaults involving drug poisoning, as well as deaths from drug misuse and drug dependence. From these a smaller number of cases are selected that satisfy a definition of drug misuse deaths (a) deaths where the underlying cause is drug abuse or drug dependence or (b) deaths where the

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underlying cause is drug poisoning and where any of the substances controlled under the Misuse of Drugs Act (1971) are involved.

Table 12: Birmingham deaths attributable to drugs

		2014/15 - 16/17	2013/14 - 15/16
Deaths in drug treatment	*Count*	122	102
	Mortality Ratio/100,000	0.77	0.70

Overdose

For alcohol we are using the following indicators as metrics to measure impact:

Admission episodes for intentional self-poisoning by and exposure to alcohol
Admissions to hospital where the secondary diagnoses is an alcohol-attributable intentional self-poisoning by and exposure to alcohol code on the hospital record system. It is reported each financial year as sex-specific annual average rates calculated per 100,000 population (Table 13).

Table 13: Admission episodes for alcohol poisoning and exposure in Birmingham

		2017-18	2016-17	2015-16	2015-14	2014-13
Admission episodes for intentional self-poisoning by and exposure to alcohol	*Persons*	43.2	49.0	53.7	50.9	49.8
	Males	38.8	47.5	46.7	46.9	47.7
	Females	47.7	50.7	60.7	54.8	51.8

Admission episodes with a primary diagnosis of poisoning by drug misuse
Admissions to hospital where the primary diagnosis is poisoning by drug misuse as coded on the hospital record system. It is reported each financial year as annual average sex specific rates calculated per 100,000 population (Table 14).

Table 14: Admission episodes with a primary diagnosis of drug misuse poisoning in Birmingham

		2017-18	2016-17	2015-16	2015-14	2014-13
Admission episodes with primary diagnosis of poisoning by drug misuse	*Persons*	37	26	28	27	23
	Males	40	31	32	33	26
	Females	34	21	24	22	21

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People Not Receiving Treatment/Support

Alcohol

For alcohol we are using the following indicators as metrics to measure the proportion of people not accessing treatment and support for alcohol (Table 15):

Number in treatment at specialist alcohol misuse services – Total number of individuals who received treatment at a specialist alcohol misuse service. Reported annually in financial years.

Proportion of people waiting more than 3 weeks for alcohol treatment - Proportion of first alcohol treatment interventions where the person waited over 3 weeks to commence treatment. Reported annually in financial years.

Proportion of dependent drinkers not in treatment - The estimated proportion of alcohol dependent adults in the given year who were not in contact with alcohol treatment services in that year. Reported annually in financial years.

Table 15: Number in alcohol treatment indicators for Birmingham

	2017/18	**2016/17**	**2015/16**	**2014/15**
Number in treatment at specialist misuse services (persons)	1413	1,895	1,824	2,105
Proportion waiting more than 3 wks for alcohol treatment (persons)	1.0%	1.4%	5.8%	10.5%
Proportion of dependent drinkers not in treatment (%)	N/A	81.1%	82.3%	79.3%

Drugs

For drugs we are using the following indicators as metrics to measure the proportion of people not accessing treatment and support for opioid drugs (Table 16):

Proportion of opioid users not in treatment – The estimated proportion of the local opiate users in the given year who were not in contact with drug treatment services for an opiate problem in that year. Reported for adults aged 15-64yrs, annually in financial years.

Proportion of people waiting more than 3 weeks for opioid drug treatment - Proportion of first opioid drug treatment interventions where the person waited over 3 weeks to commence treatment. Reported annually in financial years and this measure has evolved in the way this is reported due to providers recording this incorrectly in the past.

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Table 16: Number in drug treatment indicators for Birmingham

		2016/17	2015/16	2014/15
Proportion of opioid users not in treatment (persons)	Count	3,159	3,325	3,228
	%	38.4%	40.4%	39.2%
Proportion waiting more than 3 wks for opioid drug treatment (persons)	Count	13	52	112
	%	0.4%	1.7%	3.7%

We will develop a further matrix of proxy metrics based on local service data which will enable us to monitor the implementation and impact of the strategy.

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Governance

The Triple Zero Strategy will be overseen by the Health and Wellbeing Board, as a statutory committee of Cabinet.

The Framework for Action workstreams will be delivered through the Creating a City Without Inequality Forum, which reports to the Health and Wellbeing Board, under the leadership of the Cabinet Member for Inequalities and Community Cohesion.

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	Agenda Item: x
Report to:	**Overview and Scrutiny**
Date:	**17 March 2020**
TITLE:	**PRE-CONCEPTION CONVERSATION**
Organisation	**Public Health, Birmingham City Council**
Presenting Officer	**Marion Gibbon. Acting Assistant Director, Public Health**

Report Type:	**Presentation**

1. Purpose:

The purpose of this paper is to inform you of the intention to initiate some work on pre-conception for the city of Birmingham.

2. Recommendation

2.1 That the board agrees to the initiation of a piece of work focusing on pre-conception particularly amongst seldom heard communities.

3. Report Body

3.1 Context

Nationally the rate of infant mortality has been declining steadily since the 2001/03 period. This has not been the trend in Birmingham where the infant mortality rate has not been consistently decreasing. In the period 2014-16 it rose to 7.9 per 1,000 and the period 2016 -18 it decreased to 369 per 1,000. This is not a significant difference however; the rate is consistently above that of England.

The number of infants who die between 28 days and less than one year. Infant mortality is an indicator of the general health of an entire population. It is felt that there should be a focus on pre-conception in order to improve infant mortality. Work has been undertaken on implementing, 'just one question' in relation to whether a woman is intending to get pregnant in the proceeding year. This then is able to be used as a stimulus for a conversation that focuses on possible interventions that could be undertaken.

4. Compliance Issues

5.1 Overview and Scrutiny Responsibility and Committee Update
1) Undertake in-depth analysis to underpin the development of a Birmingham Infant Mortality Strategy 2) Review the provision of clinical genetics, genetic testing and counselling for families 3) Liaise with other regions in England such as Bradford, Sheffield and Tower Hamlets, that have implemented an approach to respond to the increased genetic risk associated with consanguineous marriage 4) Work with community leaders to agree how to explore the public/ community perspective of consanguinity and service needs with a culturally sensitive approach 5) Report back to the committee once work is undertaken
5.2 Management Responsibility
Marion Gibbon, Interim Assistant Director of Public health

6. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Challenges arising from the sensitive nature of this initiative	Medium	Medium	Ensuring that the system is agreeable to a focus on pre-conception in order to improve infant mortality in Birmingham
Capacity within the public health team	Medium	Medium	Ensure that pre-conception remains priority within the team and that capacity is sourced quickly upon staff turnover.

Appendices
Pre conception report

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

Dr Marion Gibbon, Interim Assistant Director of Public Health
Jeanette Davis, Officer, Public Health
Karen Saunders, Public Health England

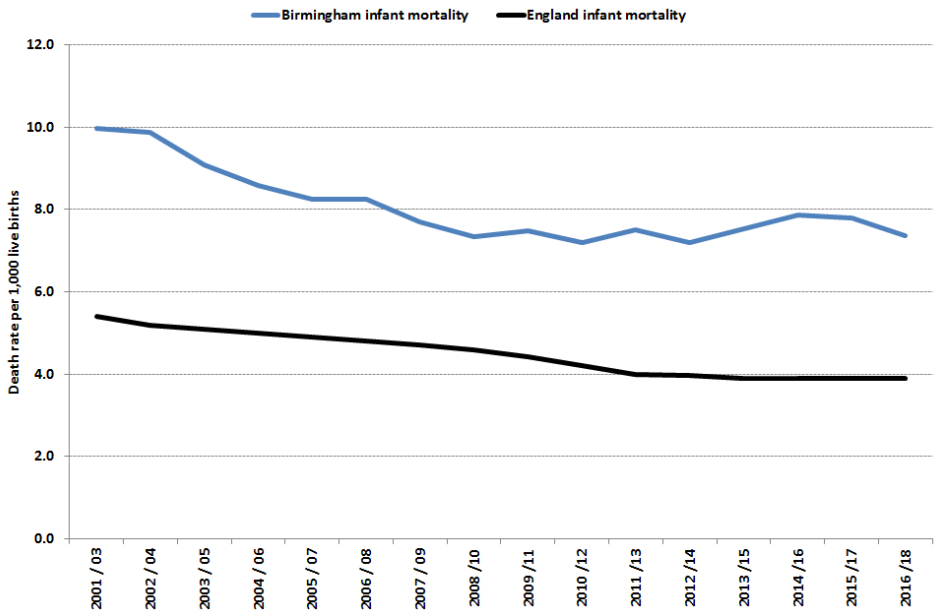
Briefing on Infant Mortality (deaths under the age of 1 year)

Introduction

Infant mortality is defined as death before the child reaches the age of one year. Infant mortality rate is the number of deaths under one year of age occurring among the live births in a given geographical area during a given year, per 1,000 live births. It represents a particularly distressing category of premature death and is an indicator of the general health of an entire population. The reason for the focus on infant mortality in Birmingham is due to Birmingham having consistently high rates that exceed that of England

Summary

In the three years between 2016 and 2018 there were 369 infant deaths in Birmingham (an average of 123 per year), representing an infant mortality rate of 7.4 per 1,000 live births. The infant mortality rate in Birmingham is significantly above the national average of 3.9 per 1,000 live births. Infant deaths account for around 88% of all deaths of children and young people in Birmingham (0-19).



Source: ONS Births and Deaths

Infant mortality rates have been declining steadily across the United Kingdon since the 2001/03 period. This has not been the trend in Birmingham where the infant mortality rate has not been consistently decreasing. In the period 2014-16 it rose to 7.9 per 1,000 and the period 2016 -18 it

decreased to 369 per 1,000. This is not a significant difference however; the rate is consistently above that of England.

The infant mortality rate consists of three components:

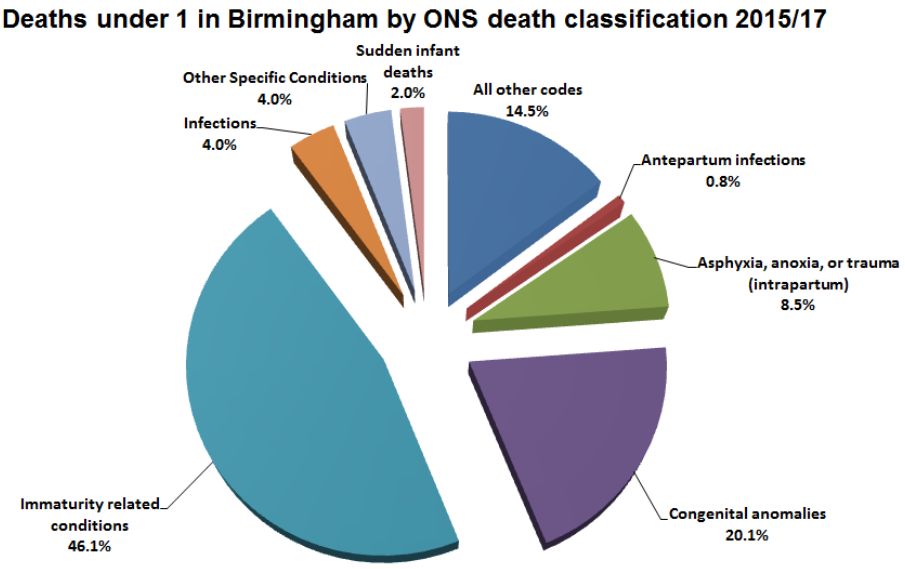
1. Early neonatal – the first 0 to 6 days after birth
2. Late neonatal – 7 to 28 days after birth
3. Post-neonatal morality rate: The number of infants who die between 28 days and less than one year

Influences on Health and Wellbeing

Infant mortality is an indicator of the general health of an entire population. The rate reflects the relationship between the wider determinants of population health such as economic, social and environmental conditions and the immediate causes of infant mortality. Deaths occurring during the first 28 days of life (neonatal period) are considered to reflect the health and care of both mother and newborn. There is a recognised correlation between higher infant mortality rates and deprivation. Reducing infant mortality overall and the gap between the richest and poorest groups are part of the Government's strategy for public health.

Consanguinity

Consanguineous marriage is a union between couples related as second cousins or closer. Globally, 10.4% of the population are married to a blood relative or a child of such a relationship.[i] While there are potential social, economic, and genetic advantages to consanguineous marriages, there is also a significant association between consanguinity and increased risk of child mortality, disability and other conditions linked to autosomal recessive inheritance. An analysis of the impact of consanguinity locally and of current service provision in terms of genetic testing and counselling was undertaken in response to reports that consanguinity may be a contributory factor to some cases of child disability and death.



A number of areas in the UK where there is a high prevalence of consanguinity have implemented interventions to respond to the increased genetic risk associated with consanguineous marriage and further work needs to be undertaken to consider if such an approach should be undertaken in Birmingham. However, it is important to acknowledge that the challenge in tackling this potential risk can be complicated by cultural sensitivities, preconceptions and misconceptions around consanguinity.

A number of social and economic advantages of consanguineous marriage are have been identified including:[ii]

- Assurance of marrying within the family and the strengthening of family and societal ties
- Assurance of knowing one's spouse before marriage
- Reduced chances of maltreatment or desertion
- Simplified premarital negotiations, with conditions and arrangement agreed in late childhood or early teens
- Greater social compatibility of the bride with her husband's family, in particular her mother-in-law who also is a relative
- Reduced dowry
- Maintenance of land holdings

However, a significant association has been consistently demonstrated between consanguinity and the risk of mortality and morbidity resulting from congenital defects arising from autosomal recessive inheritance. [iii]3 The decline in overall infant mortality to very low rates in England has revealed the contribution of severe recessive disorders to childhood mortality and morbidity.[iv]

Child Health Burden of Consanguinity[v]

Cousin marriage impacts almost exclusively on inherited conditions which are controlled by genes that are inherited from both parents i.e. recessive and does not influence chromosomal abnormalities that are sex-linked or dominantly inherited conditions. However, the range of autosomal (linked to a chromosome that is not a sex-linked) recessive conditions is extremely wide and not clearly defined. A preliminary survey in Blackburn found that the incidence of autosomal recessive disorders in childhood was 12 times greater in the Asian population than in North European with 83 different recessive disorders being identified.

[vi]However, accurate estimates of the increased genetic risk associated with consanguinity are hampered by poor data availability.[vii] A prospective study in Birmingham reported that among a sample of over 2,000 North European babies the birth prevalence of all congenital disorders was 4.3% (with 0.28% being identified as possible recessive disorders), compared to 7.9% (with around 3% being recessives) among the 956 British Pakistani babies in the study. It is estimated that of around 2,300 children born annually in the UK with a severe recessive disorder at least 630 (30%) are from parents of Pakistani origin (who contribute just 3.4% of all births).[viii]

Confounding factors that are non-genetic variables are known to influence childhood health including social conditions, maternal age and education, birth order, and birth intervals. However, mean maternal age at marriage and at first birth is generally lower in consanguineous unions and there also is evidence that women in consanguineous unions continue to bear children at later ages. It is therefore extremely important to consider the following confounding variables when considering the impact of consanguinity on child health:

- Gender (disability prevalence higher in boys)
- Age (cohort effects)
- Socioeconomic status
- Maternal age and education
- Birth order and birth intervals
- Reproductive behavioural factors including longer reproductive span (younger maternal age and bear children up to later ages)

Rates of Foetal Loss

- The evidence is not clear to date of the relationship between consanguinity and foetal loss. The majority of studies do not indicate a higher rate of foetal loss for consanguineous couples but these studies tend to focus on losses later in pregnancy and losses due to genetic disorders / other causes may occur earlier in pregnancy.

Birth outcomes

- Stillbirths are in excess of 1.5% deaths at first cousin level
- Evidence is not clear on the relationship between consanguinity and birth weight

Deaths in neonatal period and infancy

Excess of 1.1% deaths in first cousin progeny both in the neonatal period and in infancy but confounders are often not accounted for in studies

Birth defects

Congenital anomaly

- A recent study in Bradford found that consanguinity was associated with a doubling of risk for congenital anomaly and that 31% of all anomalies in children of Pakistani origin could be attributed to consanguinity. The authors conclude that consanguinity is a major risk factor for congenital anomaly.[ix]

Deafness

- Increased incidence of both syndromic and non-syndromic deafness with consanguinity

Visual impairment

- Consanguinity-associated blindness is less frequent than deafness but retinitis pigmentosa and congenital cataracts have been associated with consanguinity

Congenital heart disease

- Elevated rates of consanguinity have been consistently reported for congenital heart defects such as atrial septal defects and ventricular septal defects.
- There are variable reports of other congenital cardiac abnormalities including transposition of the great arteries, coarctation, pulmonary atresia and Tetralogy of Fallot.

Other defects

- Neural tube defects are suggested to be more common but this could be related to confounding variables
- There may be a genetic explanation for an association between Down syndrome and consanguinity but there is insufficient evidence of this to date

Single gene autosomal recessive diseases

Genetics suggest that consanguinity is much higher in rare metabolic conditions e.g. lysosomal storage disorders and cerebral lipoidoses.

Blood disorders

Increased prevalence's of α- and ß- thalassemias, rare complex haemoglobinopathies and other haematological disorders are seen with consanguinity Developmental delay Mild and severe intellectual and developmental disability present in higher prevalence in consanguineous unions

An over-emphasis on the contributory role of consanguinity alone to ill-health has led to misconceptions and caused unease and upset in communities which traditionally have favoured consanguineous marriage. It should be noted that consanguineous marriage is not restricted to specific religions or population groups10 and also that:

- Consanguinity facilitates expression of rare recessive disease genes but does not cause genetic disease.
- Consanguinity can have favourable as well as unfavourable biological effects.
- In populations which favour consanguineous marriage, the circle of family members who can act as successful tissue donors also is significantly extended.

- Many rare recessive disorders are transmitted by healthy parents who carry one gene variant for the disorder. The harmful recessive gene mutations tend to cluster within extended family groups, but even when both parents carry the same abnormal recessive gene, the chance of each pregnancy being affected by that condition is 1 in 4. Therefore, most babies born to cousin couples are healthy.

Legal Considerations

First cousin and other more remote categories of consanguineous marriage are permissible under civil legislation virtually throughout the world, with the notable exception of the USA (restrictive laws in 31 states).

National Policy

The Department of Health does not provide general guidance to the public on cousin marriage, but it supports NHS initiatives among communities with a higher prevalence of cousin marriage on a number of issues. In particular, DH supports the need to work with communities to increase the understanding of genetic risk and raise awareness of the availability of genetics services that can provide advice and support for at risk families.

The Department of Health published the Implementation Plan for Reducing Health Inequalities in Infant Mortality: A Good Practice Guide in 2007.

Other national policy documents include guidance that is relevant to this issue without specific mention of consanguinity. These include:

1) The National Service Framework (NSF) for Children, Young People and Maternity Services Standard 814:

Marker of Good Practice 3: Early identification and intervention are provided through clinical diagnosis and the Framework for the Assessment of Children in Need and their Families. Interventions support optimal physical, cognitive and social development, and are provided as early as possible with minimum waiting times.

This is of particular relevance as there is the potential that many children are known to have developmental delay, possibly caused by an autosomal recessive condition, but without a definitive clinical diagnosis. Genetic testing, particularly in the context of parental consanguinity, could enable earlier diagnosis and intervention and informed future reproductive behaviour decision-making.

2) Maternity Matters (2007):

Policy commitment to maternity services:

“1.2 The aim of health reform in England is “to develop a patient-led NHS that uses available resources as effectively and fairly as possible to promote health, reduce health inequalities and deliver the best and safest healthcare”. For maternity services this means providing high quality, safe and accessible services that are both women-focused and family-centred. Services should be accessible to all women and be designed to take full account of their individual needs,

including different language, cultural, religious and social needs or particular needs related to disability, including learning disability."

3) NICE Clinical Guideline 62

Guideline 62 covers Antenatal care states that areas outside the remit of the guideline include when there is a family history of genetic disorder, or women who have had recurrent miscarriage, a stillbirth or neonatal death. There is no explicit mention of consanguinity at its potential impact as it was largely outside the remit of this guideline.

4) Community genetics services in low- and middle-income countries: Report of a WHO Consultation (WHO 2011)

This WHO consultation considered genetics in countries outside the UK, however, some of the issues and recommendations are relevant.

5) Pregnancy and early life: reducing stillbirth and infant death (2019):

A planning tool that examines factors that influence stillbirth and infant death at population level, rather than in individual clinical care.

6) NHS England Saving Babies' Lives: A care bundle for reducing stillbirth (2019):

Guidance that enables acute trusts to examine factors that influence stillbirth and develop actions to mitigate them.

Local policy

There is a systematic multiagency process for gathering data after every childhood death known as a Child Death Review. The Child Death Overview Panel gathers comprehensive information on the factors that contribute to a child death in order to make recommendations on appropriate changes in practice that are needed. In Birmingham, Child Death Reviews are carried out by the Birmingham Child Death Overview Board which reports to the Birmingham Safeguarding Children's Board.

The Birmingham and Solihull United Maternity and Newborn Partnership (BUMP) is a collection of local NHS Acute Trusts who provide maternity care, that have come together under one vision:

'To deliver a consistent world class holistic service that empowers women and families to make informed choices, enabling them to access high quality care from a range of providers that is most suited to their personal choice and clinical need.'

BUMP aims to introduce:

- A single point of access for all maternity referrals making sure you have access to the right care from day one, through your dedicated midwife
- Dedicated Community hubs – bringing midwifery and specialist care to convenient locations and

- A host of additional services, including online antenatal courses and much more.

The local situation

Local services that address this issue

The acute trusts provide an assessment service for parents at risk of genetic abnormalities due to recessive autosomal conditions. Once the results are known they are referred for appropriate genetic counselling if required.

There is not a programme of pro-active awareness raising about consanguinity across relevant communities in Birmingham.

What is the perspective of the public support available?

It is extremely important that cultural sensitivity is taken to ascertain what local communities feel about the support offered to them. Currently little is known and an evaluation is being planned to ascertain what communities feel about some of the themes covered within this report and what they consider can be implemented.

Recommendations

1) Undertake in-depth analysis to underpin the development of a Birmingham Infant Mortality Strategy

2) Review the provision of clinical genetics, genetic testing and counselling for families

3) Liaise with other regions in England such as Bradford, Sheffield and Tower Hamlets, that have implemented an approach to respond to the increased genetic risk associated with consanguineous marriage.

4) Work with community leaders to agree how to explore the public/ community perspective of consanguinity and service needs with a culturally sensitive approach

5) Hold a workshop with community/genetics/antenatal services to discuss and agree approach

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[i] Bittles and Black, 2010. The impact of consanguinity on neonatal and infant health. Early Human Development 86 (2010) 737–741
[ii] Saggar, A.K. and Bittles, A.H. (2008) Consanguinity and child health. Paediatrics and Child Health, 18 (5) pp. 244-249
[iii] Bittles and Black (2010)
[iv] Aamra Darr (2010) HGSG Briefing Paper Consanguineous Marriage and Inherited Disorders
[v] Bittles and Black (2010)
[vi] Khan et al 2010 J Community Genet June; 1(2): 73–81. Developing and evaluating a culturally appropriate genetic service for consanguineous South Asian families

[vii] Salway et al (2012). Responding to increased genetic risk associated with consanguineous marriage: A formative review of current service approaches in England. Available at http://clahrcsy.nihr.ac.uk/images/health%20inequalities/resources/Responding%20to%20increased%20genetic%20risk.pdf

[viii] Darr et al, 2010

[ix] Sheridan et al, 2013 (in press) Lancet. Risk factors for congenital anomaly in a multiethnic birth cohort: an analysis of the Born in Bradford study

Health and Social Care Overview & Scrutiny Committee 2019/20
Work Programme

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

15th Oct 2019 Send out: 3rd Oct 2019	Dementia Strategy (new) Public Health Green Paper – Feedback from consultation Suicide Prevention Strategy – Action Plan Urgent Treatment Centres	Dr Majid Ali, Clinical Lead, Community Services Transformation, BSol CCG; Zoeta Manning, Senior Integration Manager – Frailty, BSol CCG Elizabeth Griffiths, Interim AD, Public Health Jayne Salter-Scott, SWB CCG
15th Oct 2019 Informal meeting	Period Poverty Report – Post 8 day rule.	Cllr Rob Pocock
19th Nov 2019 Send out: 7th Nov 2019	Public Health Profile Data Birmingham Substance Misuse Recovery System (CGL) Healthwatch Update:- • Contract/New Structure • Healthwatch Strategy/Direction of Travel • Update on previous and current investigations The Impact of Poor Air Quality on Health – Tracking Report Adult Social Care Performance Monitoring	Elizabeth Griffiths, Interim AD, Public Health. Max Vaughan, Head of Service, Universal and Prevention – Commissioning Andy Cave, Chief Executive, Healthwatch Birmingham Mark Wolstencroft, Operations Manager, Environmental Protection. Maria Gavin, AD, Quality & Improvement, Adult Social Care; David Rose, Performance Management Officer.
26th November 2019 – **TO BE RESCHEDULED**	Enablement Review – Evidence Gathering	

17th Dec 2019 Send out: 5th Dec 2019	NHS Long Term Local Plan – Healthwatch Birmingham Budget Consultation: • Adult Social Care • Public Health Public Health Budget	Andy Cave, Chief Executive, Healthwatch Birmingham Councillor Paulette Hamilton, Cabinet Member for Health & Social Care; Professor Graeme Betts, Director Adult Social Care; Dr Justin Varney, Director of Public Health. Dr Justin Varney, Director of Public Health
21st Jan 2020 Send out: 9th Jan 2020	Birmingham Safeguarding Adults Board Annual Report Early Intervention Programme Birmingham Community Healthcare NHS Foundation Trust Draft Quality Accounts 19/20 - Briefing	Cherry Dale, Independent Chair of the Birmingham Safeguarding Adults Board. Mike Walsh, Service Lead – Commissioning; Andrew McKirgan, Director of Partnerships. Colin Graham, Associate Director, Clinical Governance, BCHC.
11th Feb 2020 Send out: 30th Jan 2020	In-House Enablement Service Review – Evidence Gathering	
18th Feb 2020 Send out: 6th Feb 2020	Public Health Performance Monitoring – Sexual and Reproductive Health Profiles Birmingham Sexual Health Services – Umbrella (UHB) Adult Social Care Performance Monitoring	Elizabeth Griffiths, Assistant Director, Public Health. Max Vaughan, Head of Service, Universal and Prevention – Commissioning Maria Gavin, AD, Quality & Improvement, Adult Social Care; David Rose, Performance Management Officer.

17th March 2020 Send out: 5th March 2020	Permission to Consult on the Birmingham Drug and Alcohol Strategy Scoping of the Infant Mortality Review	Marion Gibbon, Interim Assistant Director, Public Health Marion Gibbon, Interim Assistant Director, Public Health
17th March 2020 Informal Meeting	In-House Enablement Service Review – Draft Report	Councillor Rob Pocock
21st April 2020 Send out: 9th April 2020	Integrated Care Systems Primary Care Networks Briefing Annual Report of the Director of Public Health 2019/20 Infant Mortality Review – Terms of Reference	Rachel O'Connor, Assistant Chief Executive of the STP Pip Mayo, Locality Director, BSol CCG Dr Justin Varney, Director of Public Health Councillor Rob Pocock

Items to be scheduled in Work Programme

- Adult Social Care Commissioning Strategy (Graeme Betts)
- Ageing Well Programme (Graeme Betts)
- Shared Lives Service Re-design (Graeme Betts)
- Neighbourhood Networks Programme (Graeme Betts)
- Immunisation and Screening
- Blood Donor Service

MUNICIPAL YEAR 2020/21	Mental Health Strategy Update Childhood Obesity – Stocktake Report Birmingham Dementia Strategy Refresh (October 2020) BCHC Public Health Contracts (Autumn 2020) Creating a Healthy Food Environment	Joanne Carney, Director of Joint Commissioning, BSol CCG Dr Justin Varney, Director of Public Health Zoeta Manning, Senior Integration Manager – Frailty, BSol CCG.

CHAIR & COMMITTEE VISITS		
Date	**Organisation**	**Contact**
23rd July 2019	Day Centre Visits	Sonia Mais-Rose
22nd October 2019	Community Early Intervention Prototype	Pauline Mugridge
28th November 2019	One Team One City – Early Intervention Event	Afsaneh Sabouri

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	Sport and Leisure Transformation: Wellbeing Service	21 April 2020
005920/2019	Adult Social Care and Health – Draft Day Opportunity Strategy	11 February 2020

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	

Joint Birmingham & Sandwell Health Scrutiny Committee Work		
Members	Cllrs Rob Pocock, Mick Brown, Peter Fowler, Ziaul Islam, Paul Tilsley	
Meeting Date	**Key Topics**	**Contacts**
24th July 2019 @ 2.00pm Birmingham	• Update on Review of Solid Tumour Oncology Cancer Services • Update on Recommissioning of Gynae-oncology Services. • Further update on the Midland Metropolitan Hospital • Further update on Measures to Reduce A&E Waiting times at Sandwell and West Birmingham Hospitals	Scott Hancock, Project Lead, Head of Operational Performance and Business Management Support, UHB; Cherry West, Chief Transformation Officer, UHB; Toby Lewis, Chief Executive, Sandwell & West Birmingham NHS Trust; Jessamy Kinghorn, Head of Communications & Engagement – Specialised Commissioning, NHS England (Midlands & East of England). Toby Lewis, Chief Executive, Sandwell & West Birmingham NHS Trust.
12th September 2019 @ 2.00pm Sandwell	• Update on Review of Solid Tumour Oncology Cancer Services • Update on Recommissioning of Gynae-oncology Services. • Further update on the Midland Metropolitan Hospital • Further update on Measures to Reduce A&E Waiting times at Sandwell and West Birmingham Hospitals	Cherry West, Chief Transformation Officer, UHB; Toby Lewis, Chief Executive, Sandwell & West Birmingham NHS Trust; Jessamy Kinghorn, Head of Communications & Engagement – Specialised Commissioning, NHS England (Midlands & East of England). Toby Lewis, Chief Executive, Sandwell & West Birmingham NHS Trust.

13th February 2020 @ 2.00pm (Birmingham)	• Primary Care Networks • Further update on the Midland Metropolitan Hospital • Update on Recommissioning of Gynae-oncology Services. • Update on Review of Solid Tumour Oncology Cancer Services	Carla Evans, Head of Primary Care, SWBCCG. Toby Lewis, Chief Executive, Sandwell & West Birmingham NHS Trust. Cherry West, Chief Transformation Officer, UHB; Andrew Clements, Divisional Director of Operations, UHB; Toby Lewis, Chief Executive, Sandwell & West Birmingham NHS Trust; Kieran Caldwell, Commissioning Manager, West Midlands Specialised Commissioning Unit; Sarah Makin, NHS Arden & Greater East Midlands CSU.

Joint Birmingham & Solihull Health Scrutiny Committee Work		
Members	Cllrs Rob Pocock, Diane Donaldson, Peter Fowler, Zaheer Khan, Paul Tilsley	
Meeting Date	**Key Topics**	**Contacts**

26th June 2019 @ 6.00pm (Solihull)	• Financial Savings Plan 2019/20 including:-
	  ○ Service Redesign Projects -
	  ▪ What has been reviewed and what is the outcome of that through cost savings?
	
	• UHB - Update on UHB Merger including potential changes to trauma, orthopaedic and gynaecology services
		Phil Johns, Chief Finance Officer, BSol CCG
		
		Fiona Alexander, Director of Communications UHB; Harvir Lawrence, Director of Planning and Performance, BSol CCG

5th September 2019 @ 5.00pm (Birmingham)	• UHB - Potential changes to trauma and orthopaedic and gynaecology services - Update
	
	• Urgent Primary Care Service Model
	  ○ JHOSC to be consulted on draft Service Model
	  ○ Impact of UTC communications campaign in Solihull
	
	• Clinical Treatment Policies – Evidence based policy harmonisation programme – Phase 3
		Fiona Alexander, Director of Communications UHB; Jonathan Brotherton, Chief Operating Officer UHB; Pratima Gupta and Panayiotis Makridesh, Clinical Leads UHB; Harvir Lawrence, Director of Planning and Performance, BSol CCG
		
		Phil Johns, Deputy CEO; Helen Kelly, Associate Director of Urgent Care and Community, BSol CCG
		
		Neil Walker, Associate Director of Right Care and Planned Care, BSol CCG; Katherine Drysdale and Andrea Clark, AGEM CSU

23rd January 2020 @ 6.00pm (Solihull)	• Clinical Treatment Policies – Evidence based policy harmonisation programme – Phase 3 – Feedback from Consultation.	Neil Walker, Associate Director of Right Care and Planned Care, BSol CCG; Katherine Drysdale and Andrea Clark, AGEM CSU
	• BSol CCG Financial Plans ○ Update on risk to delivery of savings and the impact of this on 2020/21.	Paul Athey, Chief Finance Officer, BSol CCG
	• Boots Walk in Centre Engagement Plan	Jennifer Weigham, BSol CCG
TO BE SCHEDULED	• Birmingham and Solihull Mental Health NHS Foundation Trust including:- ○ Introduction to new Chief Executive ○ Improvements made since CQC inspection carried out in November 2018. (Report published April 2019).	Roisin Fallon-Williams, Chief Executive, BSMHFT.
	• Role of the STP across the Birmingham and Solihull footprint	Paul Jennings, System Lead, BSol STP
	• Birmingham and Solihull STP – Joint Public Health Priorities / role STP across Birmingham and Solihull – evidence of impact and effectiveness	Dr Justin Varney, DPH Birmingham and Ruth Tennant DPH Solihull.
	• Disinvestment on Savings Plan	Paul Athey, Chief Finance Officer, BSol CCG
	• NHS England and NHS Improvement Redesign Work for Community Dental Services	Howard Thompson, Supplier Manager – Dental, NHS England and NHS Improvement – Midlands.