BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD 20 FEBRUARY 2018

MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON TUESDAY 20 FEBRUARY 2018 AT 1500 HOURS IN COMMITTEE ROOMS 3 AND 4, COUNCIL HOUSE, BIRMINGHAM

PRESENT: - Councillor Paulette Hamilton in the Chair; Councillor Lyn Collin, Graeme Betts, Andy Cave, Dr Andrew Coward, Dr Adrian Phillips, Jonathan Driffill and Stephen Raybould.

ALSO PRESENT:-

Natalie Allen, Programme Director, BVSC
Louise Collett, Service Director Commissioning, BCC
Karen Helliwell, Director of Primary Care and Integration, Birmingham and Solihull CCG
Mark Lobban, Programme Director Service Improvement, BCC
Susan Lowe, Service Manager, Public Health Intelligence
Rebecca Willans, Specialty Public Health Registrar
Errol Wilson, Committee Services, BCC
Dr Zoe Wyrko, STP Clinical Lead for Older People

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APOLOGIES

219 Apologies were submitted on behalf of Councillor Carl Rice and Acting Chief Superintendent Kenny Bell. An apology for non-attendance was also submitted on behalf of Dr Wayne Harrison.

NOTICE OF RECORDING

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

The business of the meeting and all discussions in relation to individual reports was available for public inspection via the web-stream.

DECLARATIONS OF INTERESTS

221 Stephen Raybould declared a non-pecuniary interest in relation to agenda item

No. 10 *Multiple and Complex Needs – Video*. He further declared a pecuniary interest in relation to agenda item No. 11 *Update on Birmingham Better Care Fund Q2 & Q3 and Changes to Commissioning Executive* as BVSC may deliver activity resourced through the Birmingham Better Care Fund.
The Chair then invited the Board members who were present to introduce themselves.

CHANGE TO ORDER OF BUSINESS

222 The Chairman advised that she would take agenda item 4 after the remaining reports.

CHAIR'S UPDATE

223 The Chair gave a brief update on the following: -

- The Birmingham and Solihull Sustainability and Transformation Plan;
- The recent CQC inspection which started on the 4th December 2017 and ended on the 26th January 2018.
- The NHS Winter Crisis Motion to City Council in February.
- Joined up working with Solihull HWB.
- LGA Community Wellbeing Board.
- Thrive Awards
- Female Genital Mutilation
- Domestic Abuse Prevention Strategy

(See document No. 1)

HEALTH AND WELLBEING BOARD MEMBERSHIP AND FREQUENCY OF MEETINGS

The following report was submitted:-

(See document No. 2)

Dr Adrian Phillips, Director of Public Health introduced the report. He highlighted that under the Terms of Reference the meeting was quorate.

Dr Phillips stated that whilst the Board was set up 5 to 6 years ago, in view of all the changes, there was a need to review membership, to look at the law in terms of the legal basis of the Board and to think of the other additional areas that needed to be considered.

He highlighted that the paper was suggesting that they consider not only their purpose, but also who the right people were, in addition to those who were statutory that was required to be on the Board who could help to deliver the strategy and improve health and wellbeing.

In an extensive and wide ranging discussion, the following were amongst issues debated arising from the HWB membership and frequency of meetings:-

a. There was an appetite to participate in this space and a restatement of its function like all of the different changes that had happened around it would be helpful. It would encourage increase participation. There were other opportunities such as the presence of the acutes that would benefit from being on the Board.

b. When things went wrong in the health and wellbeing base the impact was further upstream around the acutes. If there was to be some discussion about transfer into the communities around prevention those people needed to be at the table as it would be of benefit.

c. It was important that they look firstly at the membership and the need for acute representation on the Board. Secondly, the frequency of meetings – in terms of what was happening in the care and health sector generally, but particularly in Birmingham at present. It would be beneficial for the meetings to be held more frequently i.e. monthly so that they could take a better grip on some of the issues and challenges that they face.

d. They needed accountable bodies with the right people around the table they knew could take ownership of what was happening. Things were changing rapidly and they needed to move to monthly Board meetings.

e. They needed to write to the Acute Trusts to have another representative on the Board. A representative from Mental Health was also needed on the Board as a number of the key issues were in this area and they did not have clear ownership.

f. The Chair stated that they had other bodies in and around the system, but at present they did not have the personnel' around the table and they needed to invite these people to sit around the table.

g. Over the coming months people would be co-opted to the Board to increase the numbers. It was noted that Dr Phillips will be circulating the membership, restating the terms of reference, re-asking Third Sector organisations whom they were sending to the Board, restating who they needed to sit at the table to assist with decision making.

h. They were moving to having monthly HWB meetings although it had not yet been decided whether they would start in March 2018/April 2018. They will be working with officers to get monthly dates in diaries shortly. They will also be working hard to get the membership moving as it was clear they were the accountable body in the system.

i. The uncomfortable truth was the percentage of health spend in terms of the GDP was decreasing further. In that context, it was tempting for both NHS England and the acute providers to shore up in the short term.

j. The role of the HWB (in terms of the voice of the community, the voice of the citizens was a preventative voice), a democratic accountability. If these things were borne in mind, as the Chair articulated, then putting the HWB front and centre was the right thing.

k. The Chair highlighted that they did not have a vice-chair, but that they will be writing out to see whether there was any interested parties who would be interested in becoming a temporary vice-chair until they had a full complement of members.

It was

224 **RESOLVED:-**

That the Chair review membership of the Health and Wellbeing Board in light of recent changes and circulate a suggested membership and frequency of meetings ahead of the next meeting for comments.

CARE QUALITY COMMISSION REVIEW

225 Professor Graeme Betts, Corporate Director for Adult Social Care and Health, BCC presented the following summary/feedback:-

1) The CQC representatives gave to them on the 26 January 2018 and made the usual general comments that they were pleased with the openness and candour with the people that they had interviewed. They reminded us that this was a review, an inspection and as part of the early exercise, there would be a summit involving SKY which was a social care institute for excellence and other organisations to support us to continue on our improvement journey.

2) The CQC feedback were as followings: -

Vision and leadership

The leadership was highly committed. They acknowledged that there had been relationship issues in the past, competition between sectors and a lack of co-operation in the past. They had identified that there was now an appetite for cultural change and a real shift in Birmingham.

They highlighted that the work being undertaken was a useful one. The nine work-streams that were outlined to them with the opening presentation made a lot of sense and they could see that things were changing in that the system as a whole was committed to addressing the challenge. They identified a new impetus around commissioning, particularly with the formation of a single CCG.

A new leadership in GP leadership, so from the CQC perspective, they could see green shoots of change beginning to show through. They identified that the leaders in the system were driving cultural change, but they raised concerns that much of this was fragile.

They believed that real progress had been made in the last six months, but that the leadership was interim and the changes were not necessarily embedded in the structures underneath. This situation was changing as more people were being appointed into permanent positions.

One of the issues that were raised as a challenge was the lack of embedded multi-agency strategy - no joined up offer, lack of a long-term vision. They stressed the critical role of primary care which they did not feel was always engaged with what they felt it should be. They identified that there was no specific system wide vision for older people.

Governance

They felt that there was work to do here and that we had a vision of what we wanted to do, but that we were uncertain about delivery. There was robust governance, but system wide it was weak.

A lot of energy was focused on the STP, but a lot of the drivers were around the acute bed based care at the expense of the community based facility. However, they were pleased to note recent evidence of greater focus and emphasis on the Place Based agenda and Prevention.

The reminded us that the HWB was mandated, but the question was how the HWB was scrutinising and driving improvements on behalf of the citizens. The HWB had to ensure that the big changes that were being planned was fit for purpose for the people in Birmingham – again emphasising the role of the HWB in the change programme that they were beginning to embark upon.

One criticism the STP was that it lacked a public face - but things were in hand to address that issue. There were a number of specific criticisms around commissioning and around GSNE, personnel strategy, Public Health Directors report, no compelling vision and they could not see a commissioning cycle, nor document with a joint commissioning in it.

Professor Betts stated that once they had seen the detailed report they would probably be minded to challenge some of that as they did not believe Commissioning colleagues would necessarily agree with that analysis.

Partnerships and Relationships

There was a real sense of improvement, but the challenge was at a high level and not moving to the tier below. A high quantity of inadequate services and the CQC provided a pack of information. This was difficult to challenge as inadequate services across the care and health sector, but there were also good ones and ones that were continuing to improve etc. They were pleased that health and social care was conversing and engaging more, but felt that with GPs it was patchy and it was not clear what was happening. There was a challenge here that they needed to address.

They were complimentary about the assets that were available through the voluntary sector in Birmingham. They felt it was genuinely on mind and that there was more that could be done.

In terms of Primary Care and vanguards there were larger organisations that were talking to one another rather than seeing each other as competitors. They identified that progress was being made in that area.

Services

Professor Betts referred to the issues about quality around adult social care and all health services. They pointed out that this meant that citizens were living with inadequate care. They highlighted that we were confident that changes and improvements were being made. If they were a year away, that was still a long time if you were 89. There was a valid point to be made there about the pace in which we move forward.

They highlighted that there were a lot of assets in Primary Care, but variations across them – issues about the quality of care homes and ancillary care that was provided in Birmingham

An issue with processes for people who were difficult to place with complex needs which was an issue we needed to address was highlighted.

Community engagement

There was a lack of awareness of what was available for people and families on their door steps. This links with the point about community assets being non-mind. It was striking when you talk to people about the lack of services in the areas they work and this was something that they needed to address in the system.

The Community Pharmacies needed to be more involved and that there were strong communities in Birmingham. The issue and challenge was how to really engage through the HWB, which again resonate with the points that were made earlier.

Professor Betts advised that the intention was to provide a draft report between mid-February/end of February which would now be unachievable, but it was envisaged that the report will be available in March, which meant that the summit that was originally being intended for the 16th March was unlikely to happen.

It would be better for this to be done in May following the local elections and there was clarity about leadership in the Council, Cabinet Membership etc.

The summit would be chaired and led by Amanda Sutcliffe, CQC Chief Executive. They would expect partners from Social Care and Health etc.to be there, but was awaiting a final date for the summit to be confirmed.

In response to questions and comments Professor Betts made the following statements: -

(i) Professor Betts noted Councillor Lyn Collin enquiry as to whether any documentation was available for Perry Barr and advised that he would wait for the report as his presentation was notes from the feedback.

(ii) They would see the report, but he would expect that some of the comments the CQC made would be change as there were some glaring inaccuracies, but it was not the place to start picking them up.

(iii) They would be engaging people to check the report when it comes back. Originally the report was due mid-February/end of February, but they saw no sign of it emerging. Mid-March would be more realistic for the report to be available.

(iv) Professor Betts noted Dr Coward's enquiry concerning contextualising and advised that the CQC came to look at the care and health system and were particularly focused around people going through and out of hospital.

(v) The focus was on the reviews and they focused on the data they were looking at and did not focus on areas they wanted them to look at. Nonetheless, they could do that when they feedback, they could highlight these areas.

(vi) They were made by people during the interviews who had stressed this point to give this context for the situation they work in, but they did not see it as their role to highlight this point.

The Chair commented that this was a difficult month for staff and they were intense as there were a lot of people going through the whole system. Some of the points they had raised she was in agreement with, but that she had to agree with Professor Betts in relation to the summing up, in that some of the points worried her as they were taken out of context of what was happening in Birmingham.

It was hoped that when they return with the summary, they would see something that were more contextualised so that it was not just taken as an ad hoc scenario. The Chair expressed her thanks to the staff, the service users that were interviewed, and all the partners. Although this was challenging for staff, the CQC was made to feel welcome.

BIRMINGHAM PLACE BASED PLAN

The following report was submitted:-

Professor Graeme Betts, Corporate Director for Adult Social Care and Health, BCC presented the following PowerPoint slides circulated with the agenda papers and drew members' attention to the information contained in the slides. He advised that the focus of the presentation was to put in place the early thinking that was taking place across the care and health system. There were a number of partners who had been working together now to begin to think about what they wanted to see in place when they speak of the *Place Based* agenda.

(See document No. 3)

An extensive discussion took place and the following is a summary of the principal points made:-

a. Councillor Lyn Collin requested that Professor Betts elaborated on what was meant by community catalyst. Professor Betts gave an example of some of the work they were beginning to do. He advised that in terms of community catalyst, they will be working with an organisation which had done work across the country.

b. Basically, they help people set up new and innovative approaches to delivering care and day opportunities etc. This could be a wide range of things – providing meals, friendship, but this was fairly low-level, small enterprise, micro-enterprises. What was important was that if you think of Birmingham's communities, the diversity of its population, some of the bigger companies were delivering to diverse population.

c. By engaging community catalyst you begin to get people of varying local level develop services for their local communities that they were working to keep resources there, it builds up those local communities which was generally good for employment for other social value areas.

d. Louise Collett stated that locality based multi-disciplinary Hubs were about the aspiration to have locations where they could work in a far more integrated way around the community. This links to the aspiration to move away from acute care, preventing people from going into hospital and help people make a good transition out of hospital. It was noted that

this was still in design stage at present as they needed to ensure that what was put in place was right and fit for purpose.

e. The Chair commented that they were looking at August/October 2018, but that the dates were slipping slightly as she was briefed about this last week.

f. Dr Coward commented that Public Health Wales had just published a report on Adverse Childhood Experiences and was something that he could share with the Board. It was adverse childhood experiences that fuelled criminality and pre-disposition to physical mental health problems.

g. A lot of the report highlights the need for community resilience and how community resilience mitigated the effects of toxic stress, particularly the involvement of responsible adults in a child's life and sports. Reading that report might help us build on this. Our priority groups needed to involve children and young people and some of the concept in this room was not inconsistent which needed to be done to mitigate toxic stress.

h. In terms of how the document came across, one thing that was found in the healthy villages work was not dissimilar from the Place Based approach was the concept of citizen activation. If the report was just read, it might appear that the citizen, vulnerable and frail individual was sitting in the middle of these services in quite a depressive fashion. What was found was when these frail, vulnerable, elderly people received more holistic person services that helped them in terms of some of the outcome that was referenced in the presentation, which 50% of them wanted to give something back.

i. Andy Cave stated that central to all of this Place Based was how staff listened to the individuals and understand what was going on in their lives to understand what connections they have in their lives to build services around them. It was an offer from Healthwatch Birmingham, to be more involved and thinking through how they could develop those processes and to understand what the needs of the local communities and the needs of individuals to build those services around them.

j. In terms of personalisation, Mr Cave highlighted that they were currently doing an inquiry into direct payments in particular looking at the experience of people in receipt of direct payments and the choice of services that they have available to them. Some of that learning when they publish the report would be useful to feed into this strategy.

k. Stephen Raybould enquired whether anything had been done around transition. He added that there was a great deal of support for this especially with the city moving into the same … The NHS and voluntary and … encountered some difficulties in how to set themselves up. From the point of view of the community sector, it supports what's being done and it would be transformative.

l. There was a challenge around voluntary sector provision as historically it was provided thematically so that the transition aspect was in areas of multiple complex needs or in areas where there had been a requirement for delivery across the city. There needed to be some thought about the impact on capacity. There was a risk that some of the capacity would be lost if organisations had to engage at a constituency level, rather than a citywide level.

m. Professor Betts in noting the last point stated that they were keen to work at all the different levels as it was recognised that some organisation worked at a citywide level whilst others were local. The approach they had taken to commissioning was trying to reflect that approach so they could get the maximum benefit from the organisation they were engaging with.

n. A more general point was that helpful was the issue concerning community resilience and they needed to stress and strengthen that when they revised it. People were not *passive little souls* waiting for them to come along and make them better again. They manage well for the vast bulk of their lives where no one helps them. They needed to look at how they support this and how they maximise this without taking control and were keen to work with partners in taking these point forward.

o. The Chair commented that going forward this was something the HWB would be helpful in helping to shape

The Chair thanked Professor Betts for reporting to the meeting and it was

226 **RESOLVED:-**

That the Board noted the contents of the report and presentation for information and early sight on the development of the Place Based Strategy.

PROPOSED BIRMINGHAM INTEGRATED HEALTH AND SOCIAL CARE MODEL FOR OLDER PEOPLE

The following report was submitted:-

(See document No. 4)

Mark Lobban, Programme Director, Service Improvement, BCC and Dr Zoe Wyrko, STP Clinical Lead for Older People presented the item.

Mr Lobban drew the attention of the members to the information in the report and the recent production of *Phyllis.* He commented that they needed to build a system around the individual and there was a propensity to use sticking plasters. They had undertaken a dynastic i.e. holding a mirror to the situation so the partnership working with an external organisation called *Newton* had a track record in this area.

In response to questions from members, Dr Zoe Wyrko and Mark Labban made the following statements:-

- Due to the context of work and the type of people they needed to look at, that were predominantly the older people with frailty, where their most predominant mental health conditions were dementia.
- They had people who have had longer term psychiatric conditions when they had been younger called *burnt out.* They had their long term sequelae and depression that was dementia.

- The dementia services were not what they were meant to be at present. They had meetings with colleagues from the Mental HealthTrust, so whilst there were some pathways in place for people who present and in an organised type that they may go along to their GPs with memory problems being referred onto the memory services, there was a pathway for that to happen.
- There were some issues with follow up, but that pathway was always there. Where they struggle was if they were presenting in much more of the crisis point even if their first presentation was not yet to the acute hospital.
- With the mental health crisis they had been building up to that and speaking with colleagues, that service was not fully commissioned in the way it needed to be.
- The reason mental health was not mentioned discreetly on every slide was because for this group of people, you could not often separate out mental and physical health.
- The service was new and innovative for Birmingham, but not new and innovative as they had colleagues elsewhere in the country where this sort of service exist and it was simply a support service on a discharge, but this was after a crisis encounter.
- It may be an attendance where they could put some physical support under quick response/rapid response into someone's house; they could get some activation of member health service to that person. That maybe what they needed to do to get them over an episode of delivery.
- This was a problem and may work via physical illness or change of medication due to bereavement etc. Being able to support them through it so that a diagnosis or assessment could be at the right place for the person.
- It was wrong to diagnose dementia in an acute care bed as they would be disadvantaging people and making assumption. They had to give them the best chance to recover before they say what the problem was and this was what they could do about it.
- This was like a bridging service but this sounds temporary. This was what was missing, something to fit in the gap between the acute hospital or the acute contact for when that person was well and at their best again.

Members then made the following comments: -

1. Reassurance was needed that they were joining up the Board between Professor Betts thinking and the Place Based Plan. The emphasis was not more on non-statutory services but about community resilience and the work they were doing highlights more the role of statutory services. If they were going to make any differences, they had to have that unique fusion between the citizen non-statutory service and the statutory services.
2. In the model, the aspect that seemed most developed was the on-going personal support and the aspect that seemed least developed was the space around prevention in the slides. This was consistent across all of the strategic documentation in the space that the areas of familiarity for the institutions.

3. A lot of thought was put into them and the space which was the space about community resilience and the space that would deliver the substantial change which would quell demand was never articulated. The question was what work was going to take place so that that prevention space was articulated better.
4. STP had been discussed for a while and it was stated that they were not just going to look at the symptoms, but they would look at how they could work with partners to give somebody a quality of life. This include where they live, how they were supported within the home, before they get to absolute nursing care. However, nothing was mentioned about joined up work.
5. Work was being done in Birmingham around prevention, but this was not identified in the strategy, so if they got the repetition over and over again, it just shows that the gradual thinking that needed to be done had not worked its way in.

   Mark Labban then stated that:-

   - He was in agreement with the comments made. At the moment he did not think that they were as joined up as they would like it to be.
   - There was a good explanation for that; there was a focus on prevention building the community capacity the asset which was for all citizens.
   - It was also about other things other than prevention such as direct payments, but the initial focus in thinking was around that preventative space.
   - Similarly, they had started this work based upon the work that they did in the assessment that he had mentioned earlier whilst focussing on that path hospital interface, decisions in hospital, the rapid response, avoid people going in at A&E, getting people home and think about what they could do.
   - What they realised was that they could not look at those things in isolation. There needed to be that overarching vision that binds all of this together.
6. What came through clearly with *Phyllis* was the lack of communication which highlighted how this could be built into the system. The quicker people leaves hospital, the more you had to communicate with what was happening to people.
7. The model was successfully used in terms of the young person's pathway and the housing organisations were actively involved.

   Mark Labban further stated –

   - That in terms of engagement, consultation and co-production, at present, the assessment speaks for itself as there were huge gaps in the service offering the CQC had stated in some of their comments.
   - That one of the slides sums up what intermediary care was and at the bottom there was a little document called halfway home. This document was originally published in 2001, but was republished in 2011 and was stressed around mental health.

- Whilst there were well performing intermediary care services around the country, none of the focus was on mental health. The guidance was there for some time and a lot of the text in there was from the NICE Guidance.
- To a certain extent they should not have to consult whether they should have intermediary care services. How they developed and how they deliver locally, they needed to be talking to people to make sure they do what they needed to do.
- At this stage this was just putting together what the components of a good integrated care and social model should look like. They needed to work out how they do this in the best way taking all the issues on board that had been discussed.

The Chair thanked Mark Lobban and Dr Zoe Wyrko for attending the meeting and presenting the information. It was

227 **RESOLVED:-**

(i) That the Health and Wellbeing Board be asked to provide any initial comments to help further shape the model; and
(ii) To provide direction on how progress will be reported to the Health and Wellbeing Board.

MULTIPLE COMPLEX NEEDS

The following report was submitted:-

(See document No.5)

Dr Adrian Phillips, Director of Public Health, BCC and Natalie Allen, Programme Director, Birmingham Voluntary Service Council presented the item.

Following a brief introduction of the item, Dr Adrian Phillips invited Natalie Allen to present the item who made the following statements: -

a) The Birmingham Changing Futures Together was funded by the Big Lottery Funds and was a partnership of organisations within Birmingham, who were currently working together, to have a specific focus on this client group and to look at approaches that they could pioneer and learn from in the hope that they may eventually become on mainstream to stop the most complex individuals in the city falling through the gaps.

b) There were lots of different pieces of work that they were doing, but it was important to recognise the scale of the issue here in Birmingham.

c) In terms of multiple and complex needs they were two to three times the national average in terms of the prevalence ratio within the city. There was significant social and physical cost associated with their needs. A lot of this was due to the use of crisis service, because the prevention approach to this group was not working.

d) People turning up at A&E were being arrested as further on in that pathway the system was failing them. It was found from working with service users, that just accessing services and engaging with services for a lot of reasons this was difficult for them. This pressure should not be placed on them as the pressure should be on us to adopt what we were doing to make it work for them.

e) It was demonstrated through some of the approaches that they were doing particularly in using individuals with experience in frontline work. They had ring-fenced post for individuals who have had themselves multiple and complex needs who were acting as peer mentors for this client group.

f) It was noticed that in every area and outcomes where those individuals had access to a peer mentor, their outcomes had significantly improved as well as their engagements rates and their engagement within services. There were things that they were now learning about this group they know work and through this Board they had taken some of these things forward and it was becoming part of the more mainstream work that they do.

At this juncture, the Board was shown a video clip of the client group who had explained what had worked for them in terms of service delivery, individuals and culture change, individual services and sustaining recovery.

g) One of the things they had learnt was that services were pulled out too early. They were good at putting short term intervention into place and hoping that that would be sufficient. When we look at these complex individuals, this was not the case. This was about a long term approach and outcomes to ensure a sustained recovery.

A general discussion then ensued and members made the following statements: -

- They could do some simple things that could make a difference, not just to this group, but more importantly to their children.

- It was important to break the cycle and they would send out the Lankelly Chase Foundation which showed that this was generational. There were some simple things like the Adverse Childhood Experiences (ACEs) that they may not so affect, but make people more resilient.

- There were some simple things that they could do like peer mentorship, community assets etc. Employment was also important – work experience getting the reference and social value. It was important that they look at things such as the Social Value Act (Birmingham Business Charter) as they could do some amazing things.

- This was where the revolution begins and Changing Futures was a big part of that. The desire of a lot of people was to make Birmingham the first trauma informed city in England. At its heart was not what was wrong with you, the question was what had happened to you.

- This was a good example of service user involvement at the heart of what they shout about as a city and a gold standard of how to involve service users to the design deliver and employment of services.

- There needed to be a change in the way that commissioners looked at the whole system and commission together so that the local authority, health and Police look at the whole system of commissioning including the HWB.

- The City Council sits in a position of considerable authority in relation to this area, partly because a lot of the work that was commissioned around homelessness, substance misuse and the wider housing policy sits within its scope and remit.

- Revisiting the way the contracts for providers were constructed to ensure that they could provide for people with multiple complexes would make a difference.

- The reality was that they were not necessarily complex, but the working across the different agencies takes time and some resource and if they had to hit a huge number of generically themed people, sometimes that works against the people in multiple complex needs to be prioritised. There was a substantial need to make a difference.

The Chair thanked Dr Phillips and Natalie Allen for reporting to the meeting. It was

228 **RESOLVED:-**

(i) Agreed that the Health and Wellbeing Board:

- Identifies individuals with Multiple Complex Needs as a priority group due to their disproportionately poor outcomes and effect on future generations;

- Supports the work of Changing Futures;

- Engages partner organisations to simplify their offer, support appropriate work placements especially through the STP process;

- Works with housing partners in terms of stable accommodation; and

- Adopts targets from the Changing Futures programme in the interim.

(ii) In addition the Board is invited to "walk the Frontline with Birmingham Changing Futures" and experience life at first hand for this group and use the experience and learning to challenge policy, partner organisations etc. and promote systems change within their position of influence.

UPDATE ON BIRMINGHAM BETTER CARE FUND QUARTER 2 AND QUARTER 3 AND CHANGES to COMMISSIONING EXECUTIVE

The following reports were submitted:-

(See documents Nos.6 - 8)

Louise Collett, Service Director Commissioning, Adult Social Care and Health and Karen Helliwell, Director of Primary Care and Integration, Birmingham and Solihull CCG introduced the information contained in the report.

Louise Collett advised that at the last HWB meeting a draft of the Better Care Plan was submitted to the Board. She highlighted that this had now been formally approved by NHS England and at the same time they had also confirmed that our performance around delayed transfers were such that they would not be penalised in anyway by having the Better Care Funding removed next year.

They had taken the opportunity to review and refresh their governance arrangements, both to take account of the changes in the various organisations, but also allow them to have a strong focus on the joint commissioning approach, particularly for those areas with big system wide impact. In the past the Better Care funds existed separately from the wider system which was something that they wanted to change

Karen Helliwell commented that she had endorsed Louise Collet's statements and that a lot of the reports they had heard today needed integrated and joint commissioning arrangements. The changes to their terms of reference and governance reflected that and this include West Birmingham.

Ms Collett advised that they had started to pull together a joint and they have identified some joint arrangements one of which was how they manage care homes and that it was important to have a clear and strong relationship market. It was important looking at the regular reporting that they had to do on the Better Care Fund, the issues which stand out which they needed to keep a focus on were the ones that came up repeatedly.

It was about people in hospital and people leaving hospital, transfers of care and also about enablement. There was a real sense of collective ownership and understanding what needed to be changed.

The Chair commented that it had not been an easy winter and the delayed transfers of care they were looking at that *under the barrel of a gun.* They had reported to the Board last year that they had been given and additional £27m plus which was given to them in April.

By September, they were then told that because they wanted them to spend the money in a certain area, if this money was not shown that they were improving destock out of hospital, some authority were told that the money would be removed. Had this happened in this system they would have gone under, but with the hard work of the staff and joined up work with the NHS, social care and some of the detailed work that had taken place over Christmas, NHS England had written to say that they would not lose their funding. The Chair expressed thanks to all for their hard work concerning the issue.

Louise Collect noted Andy Cave query and advised that they already sort to expand and broaden the membership as previously it was the City Council and the CCGs. They had now invited a representative from the NHS providers to add their expertise to the discussions and this was something they wanted to keep under review.

It was:-

229 **RESOLVED:-**

That the contents of the reports be noted.

NHS BIRMINGHAM AND SOLIHULL CCG TRANSITION UPDATE - PRESENTATION

The following report was submitted:-

(See document No.9)

Karen Helliwell advised that the presentation in the pack gave an overview of the progress that had been made around the merger of the three CCGs. She highlighted the following: -

a. They had made excellent progress in the time that they had and a lot of hard work had been undertaken across all three CCGs. They had developing organisational strategy, governance arrangements and they were into recruitment.

b. That Dr Peter Ingham, who was in attendance at the meeting, was appointed the new Chair of Birmingham and Solihull CCG. They had also appointed a full time Chief Executive Paul Jennings who was now their substantive Chief Executive of the CCG. He was the Interim Chief Executive for the last 6 months and they were now pleased for his appointment again.

c. All of their executive team were in place and most importantly, their structure identifies the localities. – 5 for Birmingham which replicates the two constituency models for local authorities. A lot of the work they had spoken about today was going to be easier for them to work in partnership with their stakeholders. They had identified the GP Leads for each local area.

d. In terms of the locality development, some of the place based work that they talked about would be key in taking forward for the future. Importantly for West Birmingham, they now had a formal agreement between the two CCGs, how they were going to work together and build upon the good work that they had already undertaken to date.

e. They had agreed a memorandum of understanding and there was a joint Board with an independent lay member as Chair and they were working with both CCGs, clinical and other representatives going forward with clear delegation that they would work through over time. They had a

workshop coming up shortly to work through some of the details of that. They were pleased that they had that in place as part of their merger.

It was:-

230 **RESOLVED:-**

That the presentation and contents of the report be noted.

BIRMINGHAM PHARMACEUTICAL NEEDS ASSESSMENT 2018 PRESENTATION

The following report was submitted:-

(See document No.10)

Rebecca Willans, Speciality Public Health Registrar and Susan Lowe, Service Manager, Public Health Intelligence presented the report.

Rebecca Willans requested that given the time that the skip through to the recommendations of the report. The Chair agreed with the request. Rebecca Willans advised that they were here to seek endorsement from the HWB on the conclusions and recommendations of the Birmingham Pharmaceutical Needs Assessment (PNA) 2018 due to be published at the end of March 2018. This was the second refresh of the PNA since responsibility was transferred to the HWB.

Susan Lowe advised that the take home message from the PNA was good and that there was good pharmacy coverage throughout the city. There were high levels of access to pharmacy services and these were well distributed about the city.

Dr Phillips stated that putting this into context, pharmacies will need assessment was used by NHS England and where appropriate delegate the CCGs in terms of commissioning pharmacy services. This was the reason it was one of the legal mandate of the HWB to deliver the PNA.
Rebecca Willans noted Dr Coward's query concerning NHS England's publication of a paper 18 months ago describing the decommissioning of a significant amount of community based pharmacies and advised that this was raised with the Local Pharmaceutical Community (LPC) team who were part of the PNA Steering Group and they had undertaken a strategy assessment as part of the needs assessment to look at risk.

The PNA must be refreshed every three years as a minimum. They had scope that for Birmingham in the next three years was this work likely to impact on the PNA commissioning in Birmingham and LPC had assured them that they did not have any information at this stage.

The HWB must look at the PNA a minimum of every three years unless there had been some significant new information or policy changes. If this happened they would asked their LPC colleagues to raise this with the Board as it would need to be looked at again.

Ms Willans noted Stephen Raybould's enquiry concerning the forward view specifically in relation to the digital market place and stated that they had looked at online providers, distance selling pharmacies and community pharmacies, but at the moment there was not a trend towards closure of community based pharmacies and the core services they provide.

There had been a slight increase in the number of distant selling pharmacies which would shape the way that community pharmacies may operate as there could be some online access and using websites. This was due for publishing in March 2018 and they could request the help of their LPC to check with their members to ascertain whether there were any plans that they were not aware of in the preparation of the report regarding online access.

The Chairman informed the Board that Dr Jeff Blakely who was in attendance chairs the Local Pharmaceutical Group. She welcomed him to the meeting and advised that she wanted to do the same for Dr Peter Ingham; but that Karen Helliwell had already done so.

Dr Jeff Blakely stated that the work that Karen and her team had done for community pharmacy was great and that the findings were comprehensive. He stated that there was a recommendation that needed to be considered around minor ailments as there were a lot of people that might struggle to access a commissioned service from NHS England that had been decommissioned at the end of May 2018 with the commissioning moving if chosen to do so by the CCGs. There were a lot of people that were in deprived communities of Birmingham that currently access some minor ailment treatments through community pharmacies and if nothing changes this will stop at the end of May 2018.

Dr Phillips advised that the document was for NHS England who was not in attendance today. He suggested that a letter from the Chair be sent to NHS England if the HWB agreed the report pointing out the particular issue that was raised.
It was:-

231 **RESOLVED:-**

That the Health and Wellbeing Board (HWB) was asked to endorse the conclusions and recommendations set out in the 2018 Birmingham PNA.

The conclusions were:

I. Evidence in the 2018 PNA indicates that there is good coverage of provision for pharmaceutical services in Birmingham.

II. Some advanced and enhanced services may require examination by the relevant commissioners to assess whether a pharmaceutical service offer could enhance provision.

III. There are high levels of access to locally commissioned services, which are well geographically distributed.

The recommendations were:

(i) The HWB may wish to consider whether the Medicine Use Review service and Minor Ailments Service should now be listed as essential services in the Birmingham PNA.

(ii) Commissioners of services related to management of minor ailments, appliances and palliative care should consider whether pharmacy provision would improve access in their area.

(iii) All commissioners and providers should ensure that information regarding patient and public involvement and engagement is collated and made accessible to inform local commissioning decisions. The PNA steering group should further peruse collated information from NHS choices (e.g. multilingual staff, facilities) and results of the Community Pharmacy Patient Questionnaire 2016/17).

MINUTES

232 The Minutes of the Board meeting held on 3 October 2018 were confirmed and signed by the Chair.

Dr Adrian Phillips commented that it might be useful for the minutes of this meeting to note that they did not meet on Tuesday 16 January 2018 as the meeting was deferred until Tuesday 20 February 2018.

The Chair thanked everyone for attending and highlighted that the next meeting was scheduled for Tuesday 27 March 2018.

The meeting ended at 1706 hours.

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CHAIRPERSON