BIRMINGHAM CITY COUNCIL

HEALTH AND WELLBEING BOARD

TUESDAY, 27 MARCH 2018 AT 15:00 HOURS
IN COMMITTEE ROOMS 3 & 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1 **NOTICE OF RECORDING/WEBCAST**

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

2 **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**

3 - 22

4 **MINUTES AND MATTERS ARISING**

To confirm the minutes of the last meeting.

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

Chair of the Health and Wellbeing Board.

6 **INTRODUCTION TO RICHARD KIRBY (1515 - 1530)**

CEO Birmingham Community Health Care Trust

23 - 48

7 **PROPOSED BIRMINGHAM INTEGRATED HEALTH AND SOCIAL CARE FRAMEWORK FOR OLDER PEOPLE (1530 - 1540)**

Report of Mark Lobban/ Paul Jennings/
Professor Graeme Betts

49 - 58

8 **COMMISSIONING CHANGES IN BIRMINGHAM (1540 - 1555)**

Bsol - Paul Jennings
Impact on Sandwell and West Birmingham (Professor Nick Harding)

59 - 84

9 **HEALTH AND WELLBEING STRATEGY UPDATE (1555 - 1610)**

Dr Wayne Harrison/Carol Herity

10 **CARE QUALITY COMMISSION REVIEW UPDATE (1610 - 1625)**

Professor Graeme Betts

85 - 96

11 **SUSTAINABILITY AND TRANSFORMATION PLAN UPDATE (1625 - 1635)**

Dame Julie Moore

97 - 102

12 **UPDATE OF TOR AND MEMBERSHIP (1635 -1650)**

Dr Adrian Phillips

13 **OTHER URGENT BUSINESS**

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

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.

……..…….
CHAIRPERSON

	Agenda Item: 7
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**27th March 2018**
TITLE:	**PROPOSED BIRMINGHAM INTEGRATED HEALTH AND SOCIAL CARE FRAMEWORK FOR OLDER PEOPLE**
Organisation	**NHS Organisations and Birmingham City Council**
Presenting Officer	**Graeme Betts, Corporate Director** **Mark Lobban, Programme Director – Delayed Transfers Adult Social Care & Health**

Report Type:	**Information**

1. Purpose

To provide assurance to the Health and Wellbeing Board that:

- The future Integrated Health and Social Care Framework for Older People in Birmingham is joined-up and to seek support on the way forward.
- This Framework will sit within a wider comprehensive Joint Strategy for Older People in Birmingham.

2. Implications:

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

3.	**Recommendations**
	The Health and Wellbeing Board is asked to:
3.1	Note the development of a wider comprehensive Joint Strategy for Older People to be discussed at a future meeting of the Health and Wellbeing Board.
3.2	Provide any comments to help further shape the Integrated Health and Social Care Framework.
3.3	Support the work to date being presented to the STP Board on 9th April 2018.

4.	**Background**
4.1	At the Health and Wellbeing Board Meeting on 20th February 2018 the summary of findings from a recent diagnostic to inform improvements to Recovery, Reablement and Rehabilitation was presented and discussed. The Health and Wellbeing Board asked for assurance that this work was joined up with the work on the Placed Based Strategy (that was also considered at the same meeting).
4.2	At the same time the Partners have recognised that a comprehensive Joint Strategy for Older People in Birmingham is required. This Strategy will include the wider corporate actions required to create an age friendly City. A very early draft of this Strategy is being developed. The Integrated Health and Social Care Framework for Older People will be a key strand within this Strategy.
4.3	Therefore to date the most significant work has focussed on developing a draft Integrated Health and Social Care Framework **(Appendix I)** which has been shared with Partners for comment and will be further refined in relation to mental health and urgent/primary care. The Framework breaks our approach down into three interrelated themes which cover the whole range of support provided for older people and their carers. • Prevention • Early Intervention • Personalised Ongoing Support
4.4	A draft proposed Locality Model has also been produced which shows how, through a place based approach, these 3 themes could interrelate at a locality level to wrap appropriate support around an individual. **(Appendix II)**
4.5	In order to drive forward sustainable change at pace and scale and to ensure that improvements are joined up the partners have agreed to establish an ambitious joint transformation programme for integrating health and social care for older people.

4.6	A draft proposal for how the transformation programme might be structured is attached **(Appendix III)** and interim arrangements are now needed to establish the transformation programme.
4.7	An Interim Board of chief officers of BCC and NHS organisations will be formed to oversee the development of this programme (including how we engage with organisations and individuals who can give voice to and articulate the views of older people).

5.	**Compliance Issues**
5.1	***Strategy Implications***
	The Framework is a key strategic development for health and social care
5.2	***Governance & Delivery***
	Regular progress reports to the Health and Wellbeing Board
5.3	***Management Responsibility***
	Board: STP, HWB, Interim Board, Individual organisation governance Day-to-day: Representative Partnership Senior Executive Team

6.	**Risk Analysis**		
Significant reputational and service risks (including financial) if an integrated Framework is not agreed and implemented.			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**

	Appendices
	I. Draft Integrated Health and Social Care Framework II. Draft Locality Model III. Draft Governance

Signatures	
Chair of Health & Wellbeing Board (Councillor Paulette Hamilton)	
Date:	

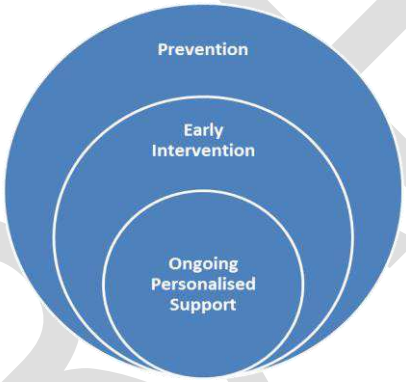
Integrated Health and Social Care Framework for Older People in Birmingham

Older people and their carers shouldn't need to know where the help comes from, just so long as they get it, quickly and when they need it. Our joint vision is for older people to be resilient, live independently whenever possible and exercise choice and control so that they can live good quality lives and enjoy good health and wellbeing. This links to the STP vision 'to help everyone in Birmingham and Solihull to live the healthiest and happiest lives possible'.

It is essential to recognise that in order to support older people to achieve these goals, there is a broad responsibility across a range of partner organisations to provide this support and therefore it is a collective responsibility to make sure we achieve this together

We will provide support that is 'joined-up' across organisations so that older people do not experience duplication of services or delays in accessing support or fall between the gaps. We are open to new ways of doing things and we will make the most of the strengths of all our partner organisations from the public, private, voluntary and community sectors.

Our strategy for older people over the next five years breaks our approach down into **three themes** which cover the whole range of support provided for older people and their carers.



Prevention – A universal wellbeing offer enabling older people to manage their own health and wellbeing, based in local communities and utilising local resources. It will address the issues that lead to older people entering into formal health and care systems, such as social isolation, falls and carer breakdown. Access to good quality information and advice will be the cornerstone of our wellbeing offer, enabling people to identify and access the support that they need in order to maintain living fulfilled lives.

Early Intervention – a range of targeted interventions to promote faster recovery from illness or injury, prevent unnecessary hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living. We will respond quickly, minimise delays and not make decisions about long term care in a hospital setting.

Personalised Ongoing Support – Some older people will need ongoing support to remain living in their own homes and communities. These services aim to maintain individual wellbeing and self-sufficiency, keep older people safe and enable them to be treated with dignity, stay connected to their communities and avoid unnecessary admissions to hospitals or care homes. We will change the way our services are commissioned and delivered to be more focused on achieving better outcomes for older people.

As the three themes overlap we will ensure that support is fully joined up so older people will be able to access ***the right care at the right time in the right place*** in order to be as independent and well as possible at all times.

Prevention

Current models of support fit older people into narrow bands of available services; whereas future support needs to be more personalised to enable older people to achieve the outcomes that matter to them – ***a life not a service***.

For older people to take part in community activities there needs to be a wide range of community opportunities, also known as community assets, which the Council and other organisations should make sure are in place across the City including community centres, leisure centres, parks and gardens. Older people need to feel safe to come out of their homes to enjoy them.

Most older people can undertake active roles in their local community with help and support from their families, friends, neighbours and social groups. However, for some citizens this is only possible with support from public sector organisations or voluntary and community sector organisations.

There are a lot of services and activities that take place in local areas, that aren't always known to everyone who lives there. We want to provide older people with the best advice and guidance on what they might need, when and where they need it with ***no wrong door.*** We also want to help local groups to develop new services and activities, where people have told us they are needed.

Social isolation and loneliness is a huge issue; central to our vision will be developing schemes which help older people connect for mutual support, activity and fun. ***Keeping people connected keeps them well.***

We will be exploring how social prescribing models (e.g. GPs prescribing a course of exercise classes rather than, or as well as, medication) supported by 'guided conversation' techniques help older people think about their needs and get the support they require. We will investigate how we can support older people to plan for later life and be more in control of their care and support needs.

The carers of older people with care and support needs (who might be family, friends or neighbours), play an essential role in the wellbeing of the people they care for and we recognise the important contribution that they make to society. We know that carers can experience significant negative effects on their finances, health (physical, mental and emotional) and employment prospects as a result of their caring role. As part of this strategy we will work in partnership to improve the lives of carers.

Early Intervention

To avoid older people being unnecessarily admitted to hospital we will have a multidisciplinary approach at the front door 7 days a week. The team will specialise in the needs of older people only admitting to an acute bed if clinically indicated. and will organise the appropriate care at home when it is safe to do so, following a **home first** approach. They will be supported to do this by a multidisciplinary quick response intervention that will be linked to the GP and other professionals.

We will ensure that a response can be started within **2 hours** when necessary, identifying a person's ongoing support and make arrangements for these needs to be met. We will ensure

that older people can be seen by expert clinicians, have appropriate tests and investigations if required, and an accurate diagnosis made. **A prompt diagnosis and treatment improves likelihood of a good recovery.**

Although based at the front door of the hospital the multidisciplinary approach supported by a quick response service will be an important component of wider joined-up community support.

Some older people do not need to be in hospital but are not ready to benefit from enablement (support that gives a person the opportunity and confidence to relearn or regain some or all of the skills they may have lost because of poor health). For these people we will provide appropriate short term **(possibly up to 5 days)** support to allow people to recover in their own homes wherever practical. Many older people after a short period of recovery will have no ongoing support needs and for those that need further support to return to their previous level of health and ability we will provide an integrated enablement service (**normally up to but not restricted to 6 weeks**)

Multidisciplinary practitioners within an integrated enablement service will:

- work in partnership with the older person and their carers to find out what they want and need to achieve and understand what motivates them
- focus on a person's own strengths and help them realise their potential to regain independence
- build the person's knowledge, skills, resilience and confidence
- learn to observe and guide and not automatically intervene, even when the person is struggling to perform an activity, such as dressing themselves or preparing a snack
- support positive risk taking

The integrated enablement intervention will be therapy led. We will join-up occupational and physiotherapy services to improve access, optimise services, and remove the risk of duplication and variation in assessment and provision.

We will provide enablement to older people in their own homes wherever practical, making any adjustments, for example equipment or adaptations, needed to make this happen. We will offer enablement as a first option to older people being considered for home support, if it has been assessed that enablement could improve their independence.

We will also provide bed-based enablement within 4 or 5 **specialist centres** across the City for people who are in a sub- acute but stable condition but not fit for safe transfer home with consistent criteria, objectives, and clinical / therapy input. We are aware that if the move to bed-based enablement takes longer than 2 days it is likely to be less successful.

The integrated enablement intervention will be designed to support people with complex needs including those with moving and handling issues and importantly people living with dementia. The service will support people to stay out of hospital and will be aligned to the paramedic service.

The integrated enablement intervention will prevent acute admissions and support timely and effective discharges and will work on the understanding and belief that '***your own bed is best',*** and that in most cases older people are more comfortable in their own homes and therefore recover and regain their independence more quickly if good quality therapeutic support can be provided in their own homes.

Ongoing Personalised Support

We will develop an integrated home support service which brings together home support workers and community nurses (including CPNs) to provide an outcome focussed flexible and responsive service to support older people living at home. This will offer a real opportunity to develop a workforce model that is fit for the future, and which explores the opportunities to train and develop home support workers, health care assistants and nurses to deliver holistic care focused on individual need. For example, this may include training home support workers and carers to carry out medical procedures such as insulin injections for insulin dependent older people in receipt of home support, and who would otherwise require daily nursing visits.

We will provide wrap around holistic support for older people with more complex needs. This will support specific high risk individuals including those with dementia or very unstable long term conditions.

Integrated enablement services and integrated home support services will also provide peripatetic support to care homes in the area; the teams will in reach to local care homes to provide specialist support for residents and to help staff develop skills and confidence.

Developing an integrated workforce strategy is an essential element of our plan. We must ensure that there is a genuine career pathway across a joined-up health and social care system with generic roles and that we encourage young people into careers by supporting them to gain qualifications and skills. Links with local higher education colleges and schools will be improved.

A network of joined-up community support

The 4 or 5 specialist centres across the City will provide the physical space for the right people to form genuinely integrated teams that have a shared ethos of supporting people in their own homes wrapping appropriate support around them.

The integrated community services operating from the care centres will reach into hospitals to ensure that people can go home at the right time with the right type of support (including end of life care). The centres will be part of a wider network of integrated community support. They will support GP practices and be connected to the more local neighbourhood networks as well as community hospitals, care homes and housing providing either specialist or long term support.

We will redefine roles of people working in the community to maximise individual and collective skills. Occupational and physiotherapists will support decision making within enablement approaches. Staff providing enablement will work closely with quick response and paramedic services which GP's will be able to access avoiding unnecessary conveyance to hospital and allowing timely discharge home. Occupational and physiotherapists will also work with nurses and home support workers to ensure older people with ongoing needs have them met in an enabling, personalised way. We will connect our social workers to their local communities and ensure that they have the time to manage complex cases and safeguarding.

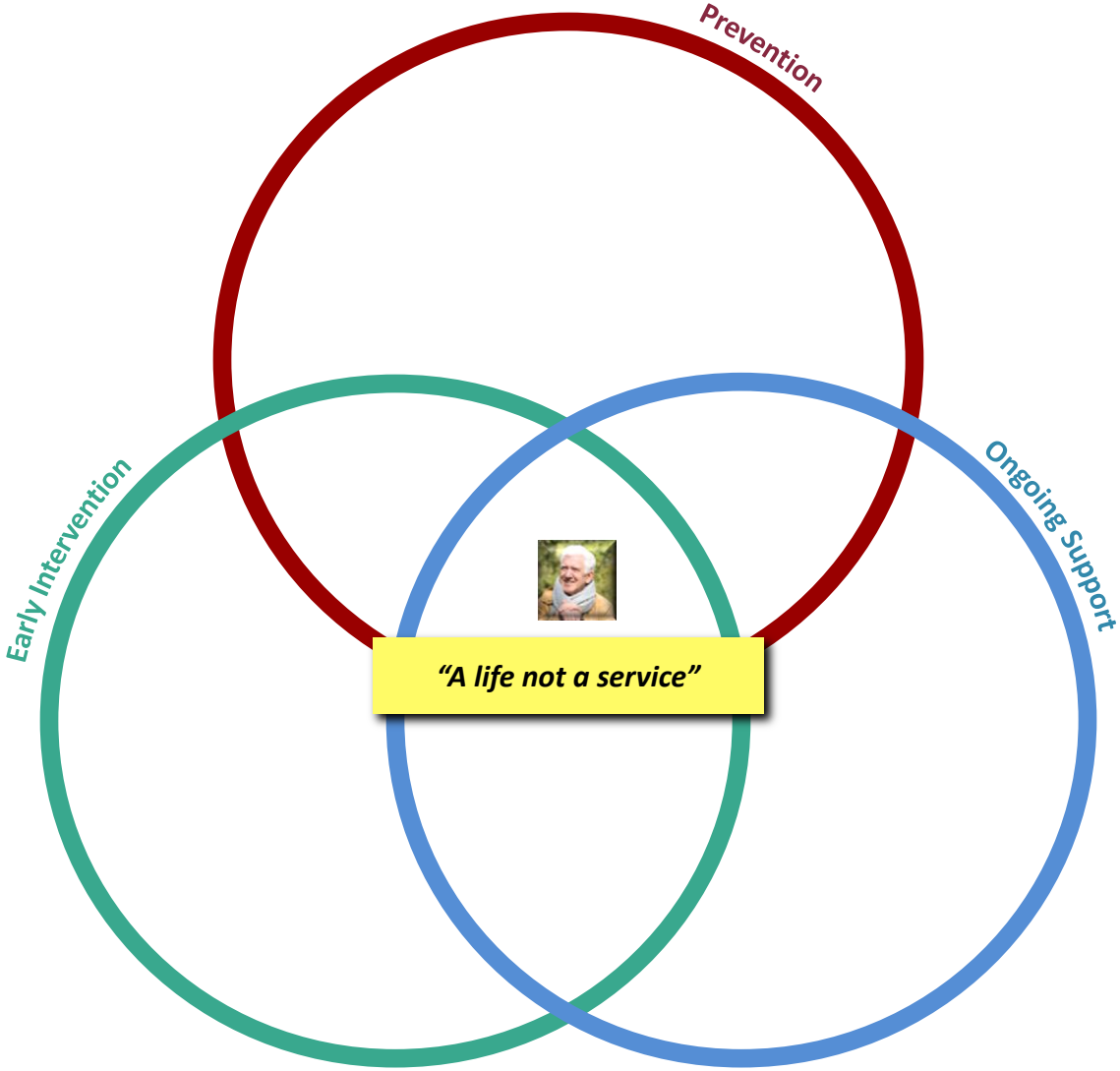
We will review access arrangements within the wider joined-up network making the best use of information and communication technology. The networks will have a digital catalogue of care, support and activities so that everyone within a local community knows what is available to keep people as active and well as possible. People co-ordinating or providing direct support will have timely access to shared electronic records.

Appendix II

Draft Proposed Locality Model

– A placed based approach

Proposed Locality Model - A place based approach

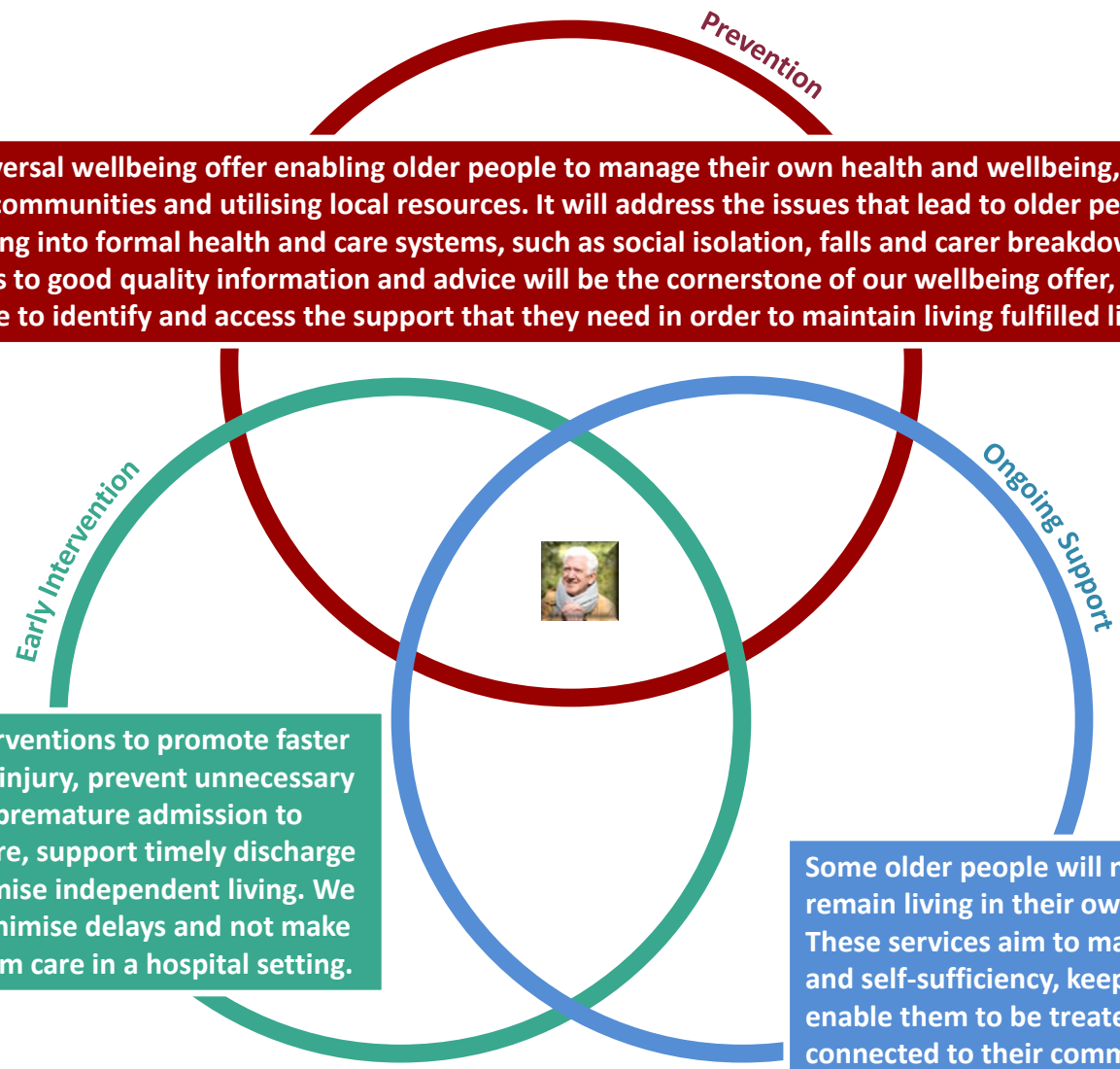


Birmingham City Council

NHS

We will ensure that support is fully joined up around the person so that they can access ***the right support at the right time in the right place*** in order to be as independent and well as possible at all times

Proposed Locality Model - A place based approach



Prevention

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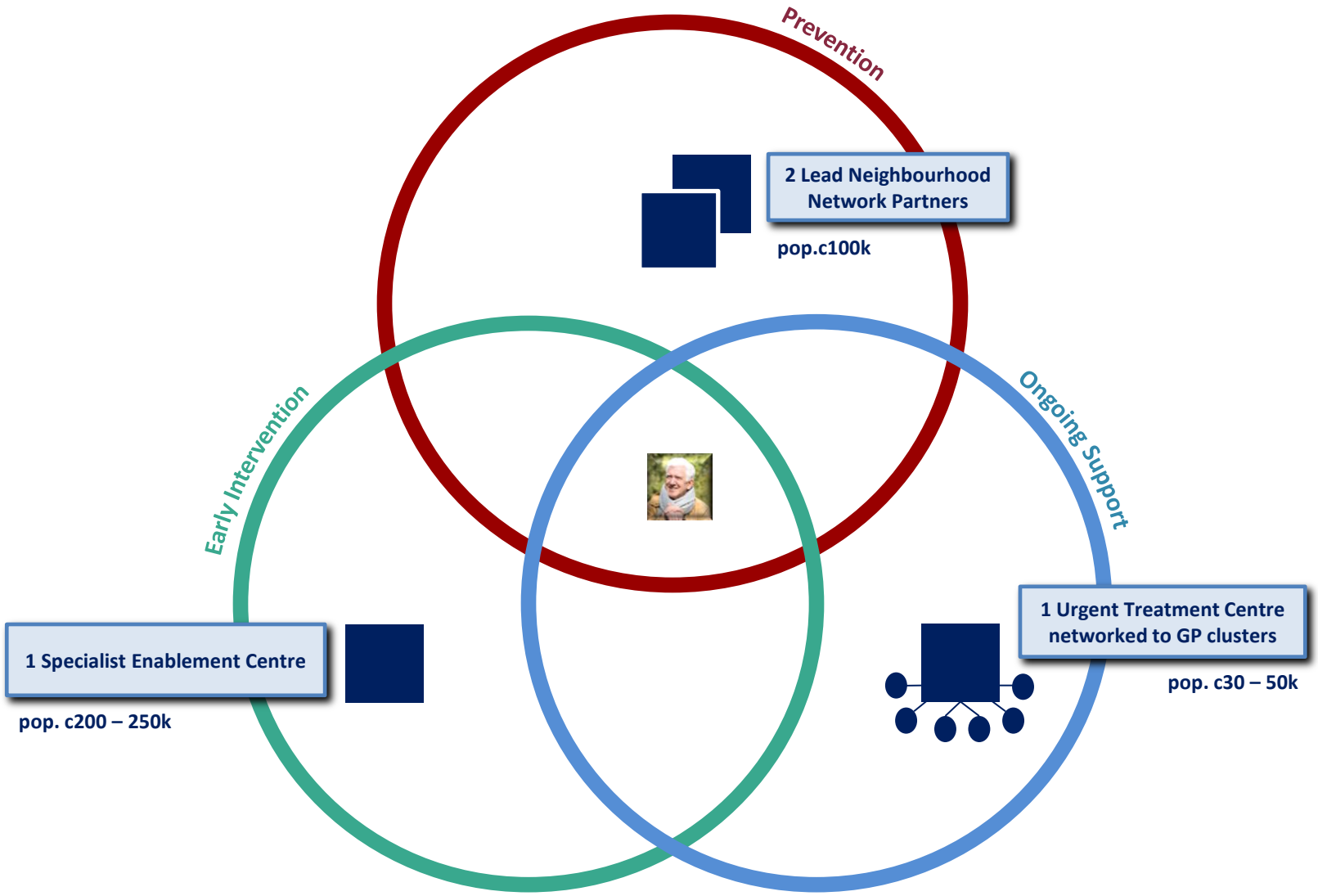
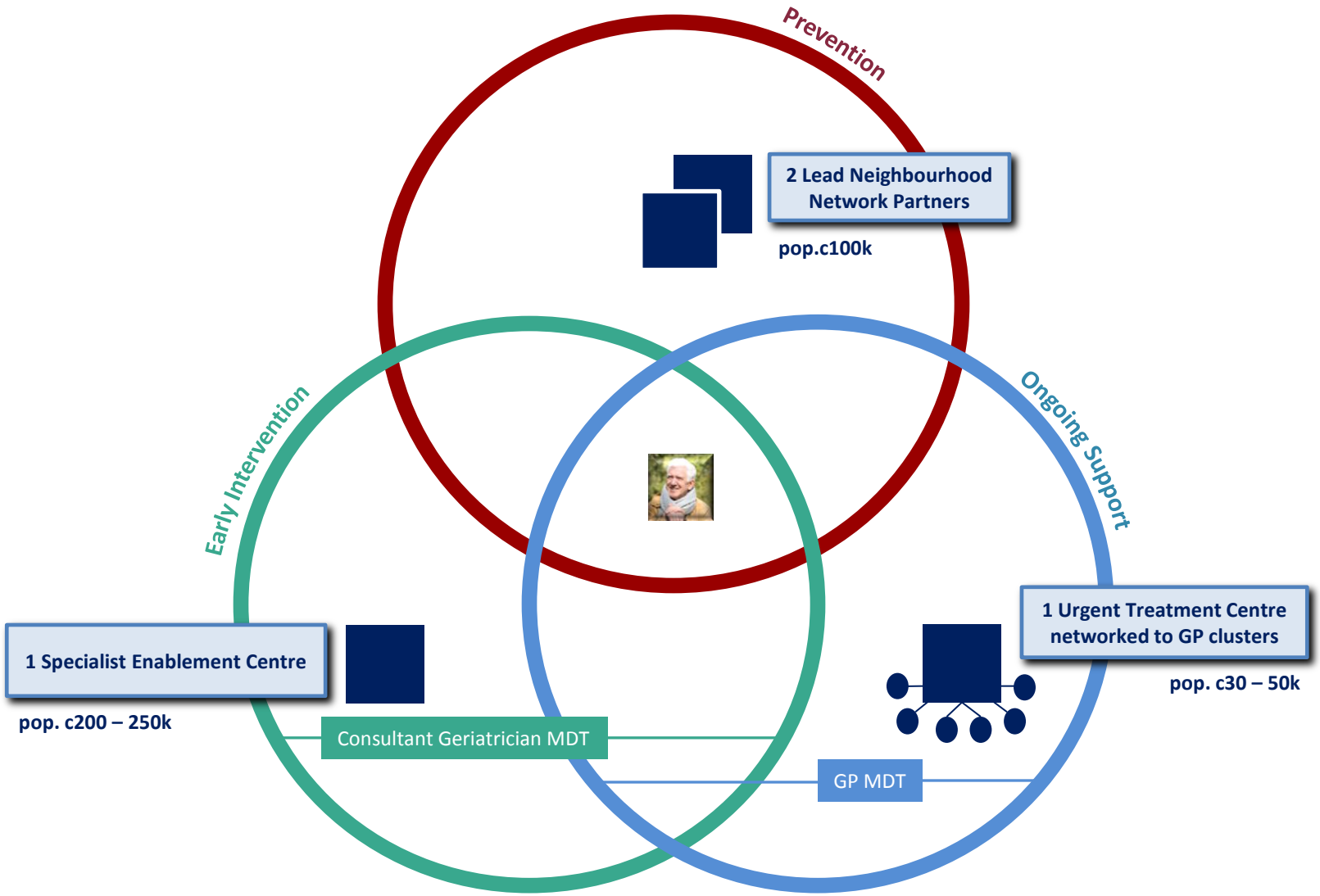
Proposed Locality Model - A place based approach



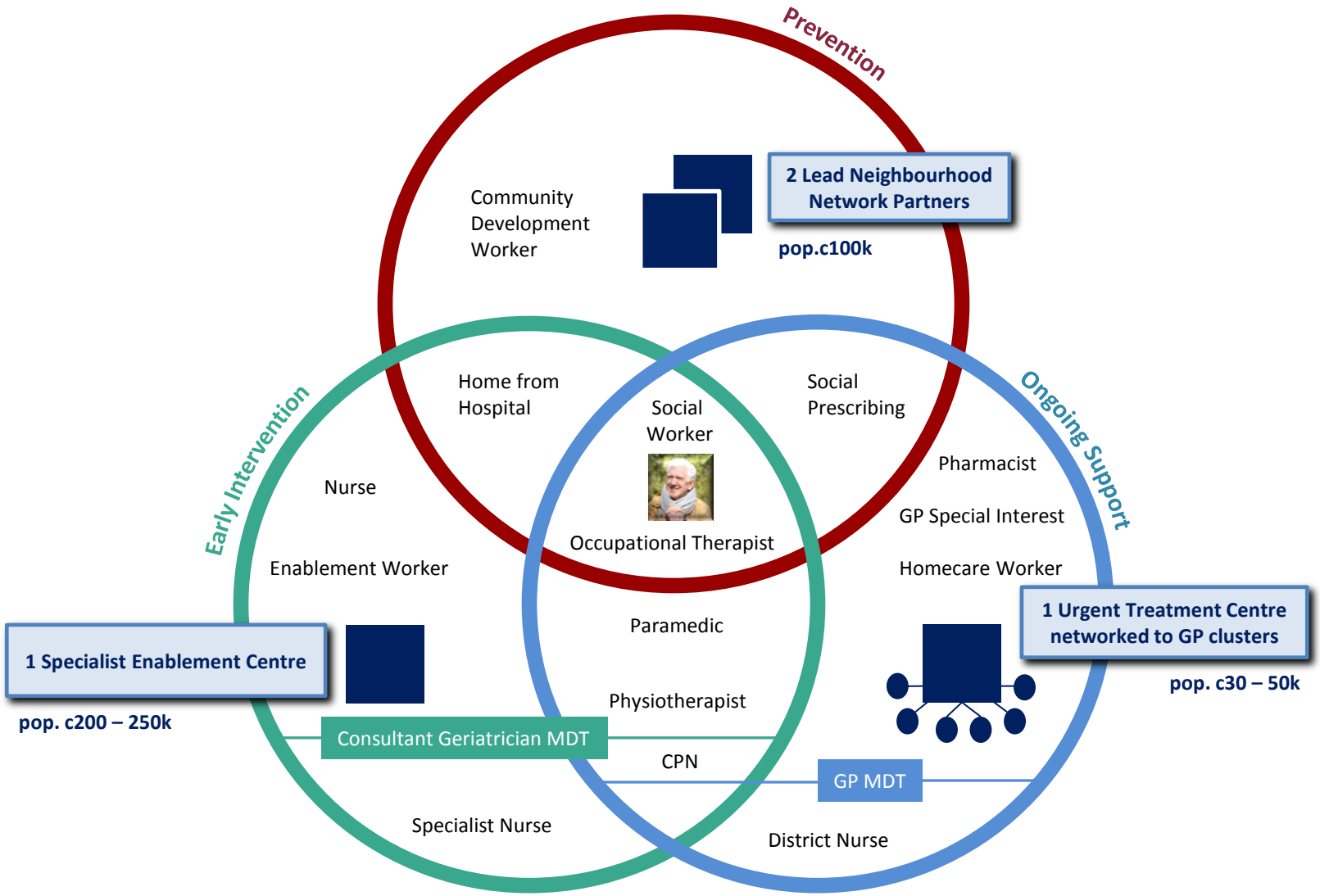
Efficient distribution of resources to layers of population within a locality

Proposed Locality Model - A place based approach



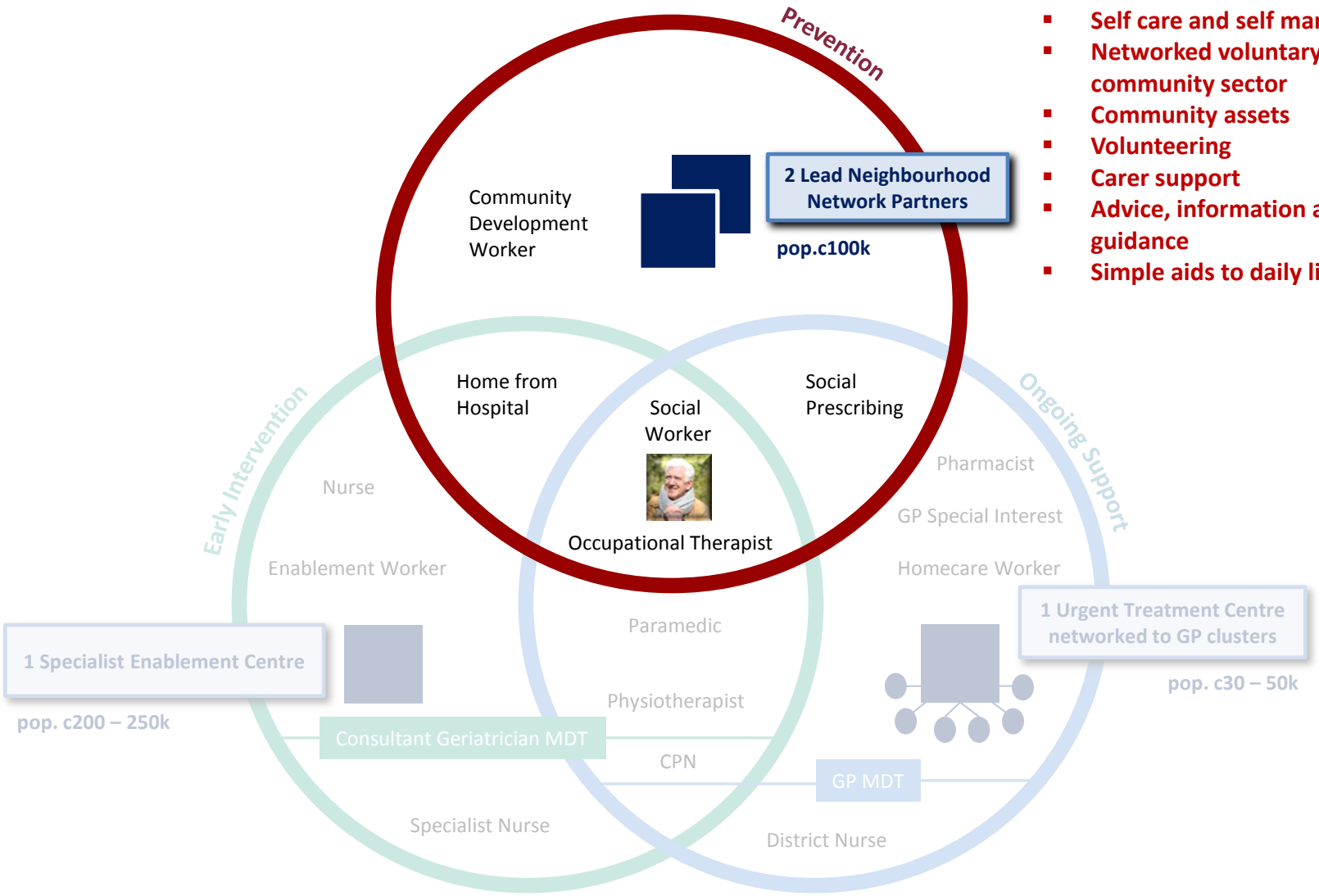
GPs and consultant geriatricians working together to oversee clinical aspects of the pathway and champion the **'home first'** ethos

Proposed Locality Model - A place based approach



Clearly defined roles of people working in the community to maximise individual and collective skills and capacity

Proposed Locality Model - A place based approach



- Self care and self management
- Networked voluntary & community sector
- Community assets
- Volunteering
- Carer support
- Advice, information and guidance
- Simple aids to daily living

Birmingham City Council

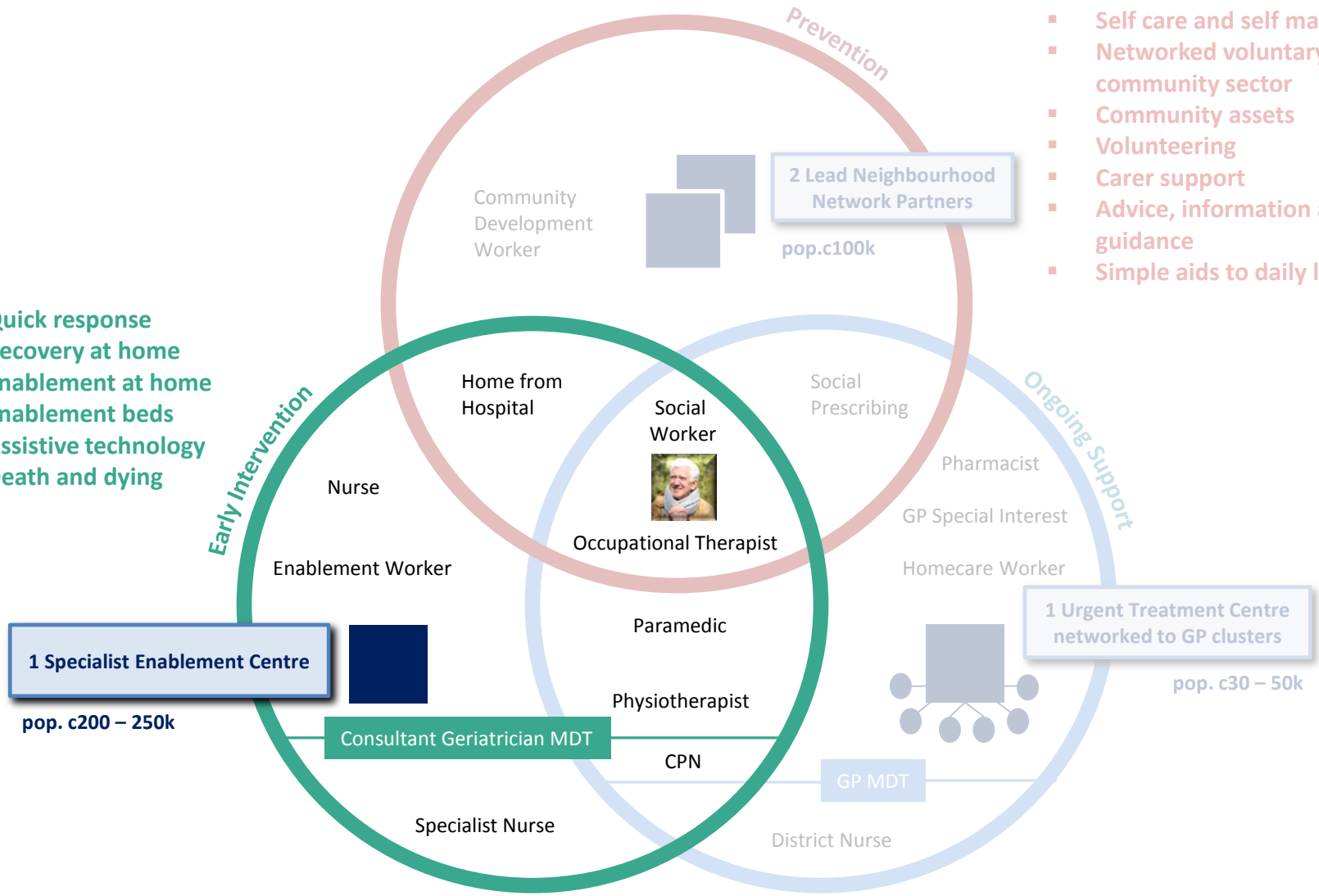
NHS

"Keeping people connected keeps them well"

Proposed Locality Model - A place based approach

- Self care and self management
- Networked voluntary & community sector
- Community assets
- Volunteering
- Carer support
- Advice, information and guidance
- Simple aids to daily living

- Quick response
- Recovery at home
- Enablement at home
- Enablement beds
- Assistive technology
- Death and dying



Birmingham City Council

NHS

"Your own bed is best"

Proposed Locality Model - A place based approach

- Self care and self management
- Networked voluntary & community sector
- Community assets
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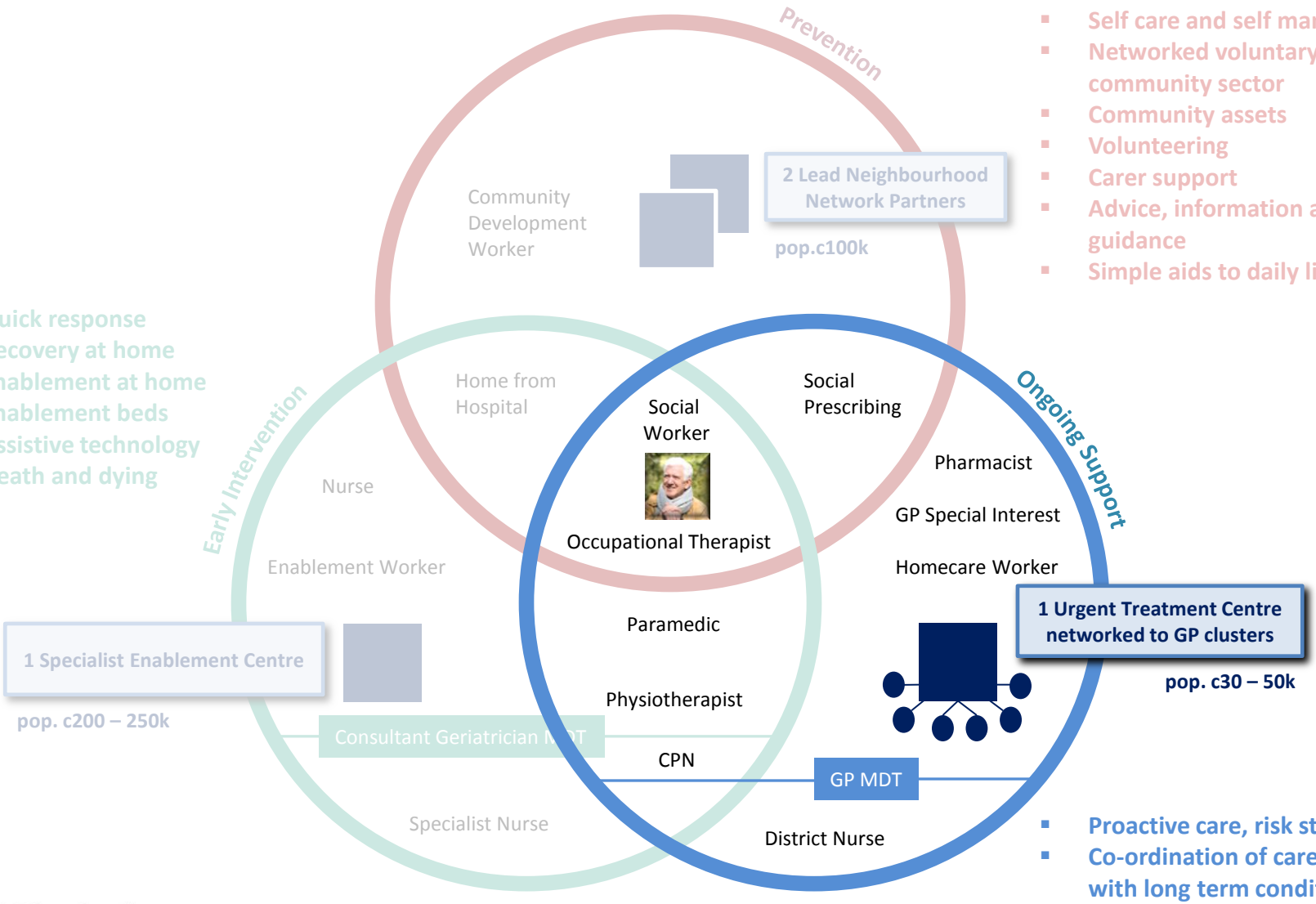


- Proactive care, risk stratification
- Co-ordination of care for people with long term conditions
- Outcome focussed home support
- Direct payments and personal health budgets
- Support to care homes

Birmingham City Council

NHS

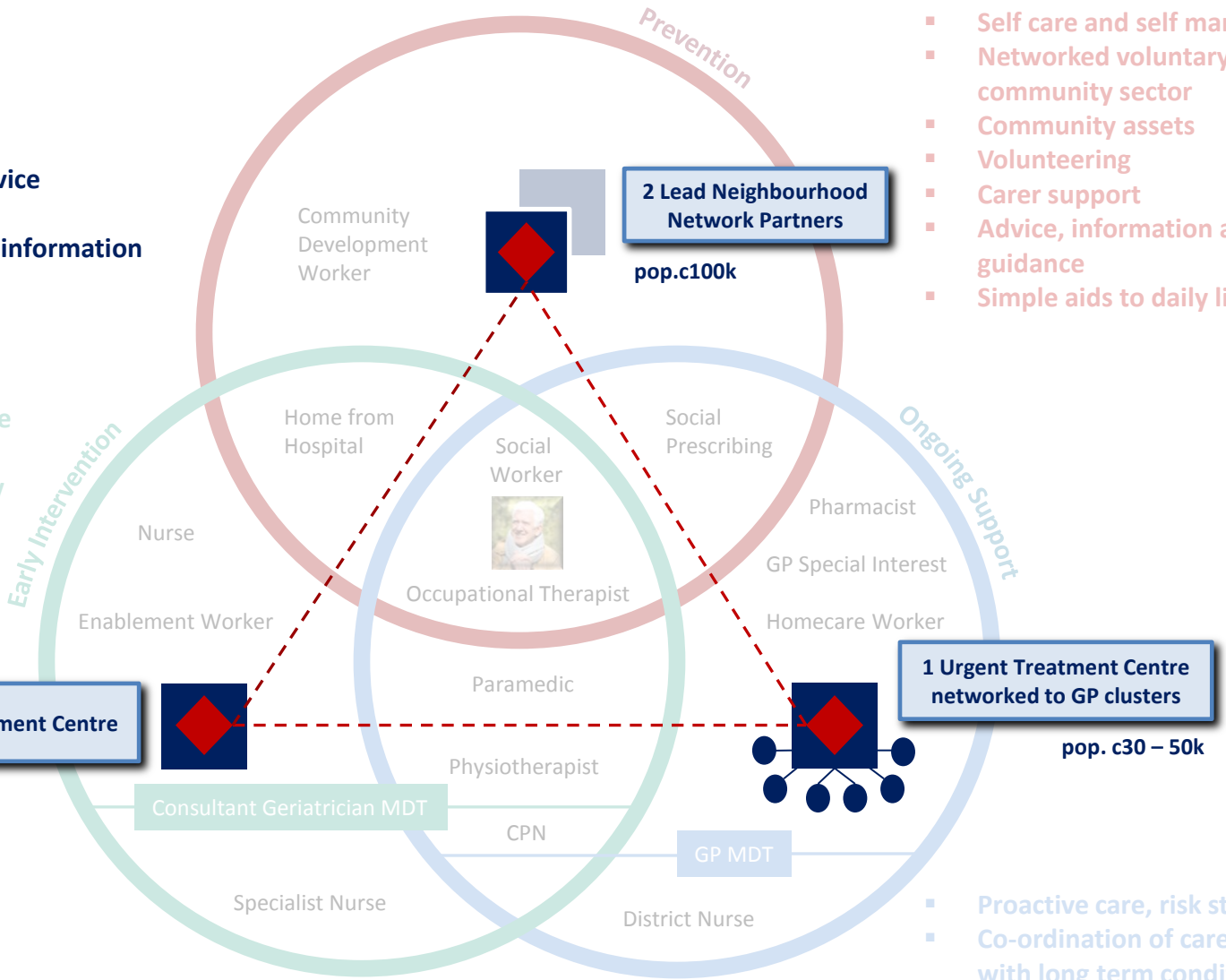
Choice and control

Proposed Locality Model - A place based approach

Contact

- **Digital menu of service**
- **Shared care record**
- **Whole system flow information**

- Quick response
- Recovery at home
- Enablement at home
- Enablement beds
- Assistive technology
- Death and dying



- Self care and self management
- Networked voluntary & community sector
- Community assets
- Volunteering
- Carer support
- Advice, information and guidance
- Simple aids to daily living

- Proactive care, risk stratification
- Co-ordination of care for people with long term conditions
- Outcome focussed home support
- Direct payments and personal health budgets
- Support to care homes

Birmingham City Council

NHS

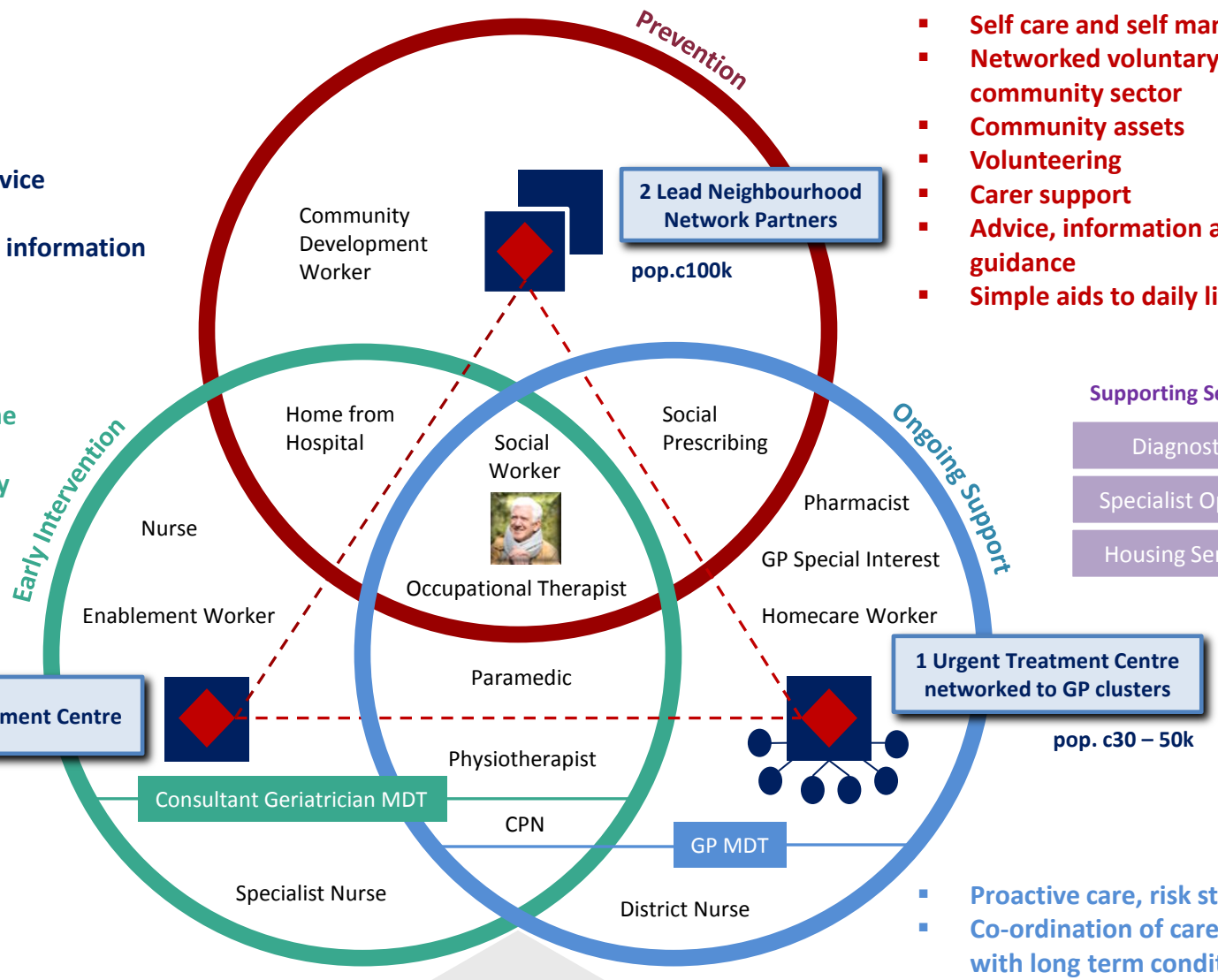
"No wrong door"

Proposed Locality Model - A place based approach

Contact

- Digital menu of service
- Shared care record
- Whole system flow information

- Quick response
- Recovery at home
- Enablement at home
- Enablement beds
- Assistive technology
- Death and dying



- Self care and self management
- Networked voluntary & community sector
- Community assets
- Volunteering
- Carer support
- Advice, information and guidance
- Simple aids to daily living

Supporting Services

- Diagnostics
- Specialist Opinion
- Housing Services

- Proactive care, risk stratification
- Co-ordination of care for people with long term conditions
- Outcome focussed home support
- Direct payments and personal health budgets
- Support to care homes

Birmingham City Council

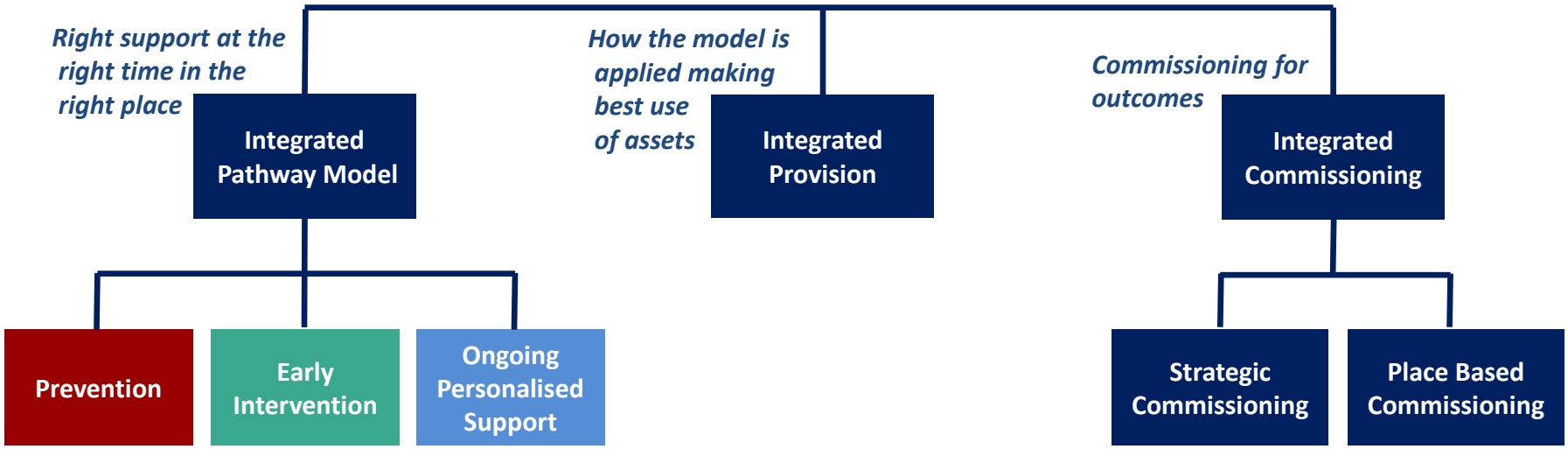
NHS

Appendix III

Draft Proposed Governance

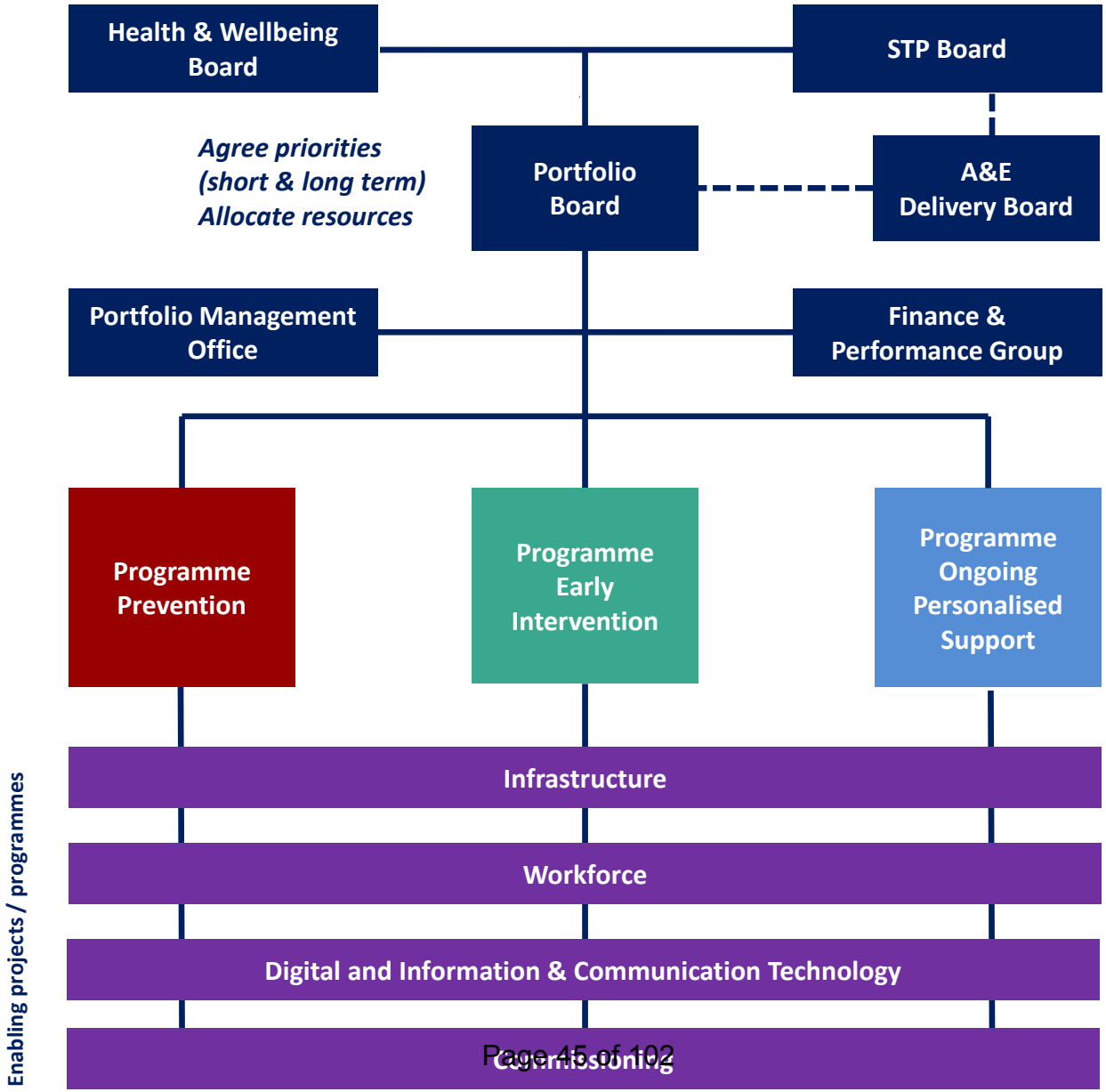
– A single bounded change programme

Components of Integration



Appropriate focus must be given to each component of integration

Portfolio Governance – Integrated Health and Social Care



Potential Projects

Programme
Prevention

Potential Projects

- **Project**

Programme
Early Intervention

Potential Projects

- **Project**

Programme
Ongoing Personalised Support

Potential Projects

- **Project**

Agreeing the Locality Model will allow us to populate the projects under each programme

Interdependencies

Potential Enabling Programmes / Projects

Infrastructure

- **Project**

Workforce

- **Project**

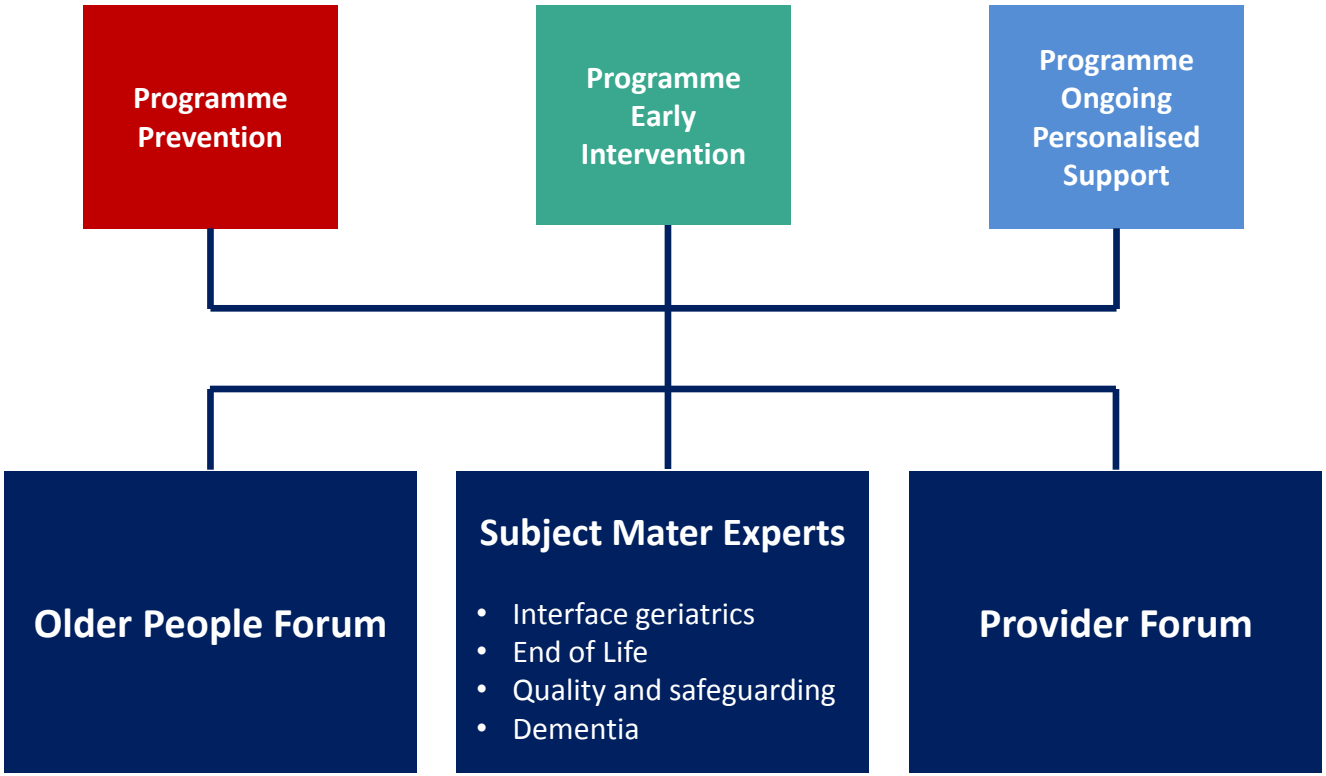
Digital and Information & Communication Technology

- **Project**

Commissioning

- **Project**

Co-production



NHS Birmingham and Solihull Clinical Commissioning Groups

Paul Jennings, Chief Executive Officer

Birmingham Health and Wellbeing Board, 27 March 2018

Vision and values

We have a great opportunity to make a real difference to the lives of local people.

Working together, we can deliver the best possible health outcomes for patients across the whole of Birmingham and Solihull, by commissioning the best and most responsive services for local people, based on their needs.

This is challenging, but having a single commissioning voice, gives us a far better opportunity to make the impact we want and need to.

The core values of the NHS will drive what we do locally, and we rightly have a clear focus on reducing health inequalities and improving health outcomes for all, whilst ensuring a sustainable health service for the long-term.

We will also expect the services we commission to also uphold these values.

Organisational development

The CCG's organisational development strategy and constitution were submitted for NHS England's approval on 13 February.

Approval was received on 7 March from NHS England, with authorisation to proceed with the creation of the new CCG, with no conditions.

Paul Jennings formally confirmed in post by Simon Stevens.

Solihull CCG directions formally lifted within six months.

The management of change for CCG staff process is almost complete.

Immediate priorities

The newly formed NHS Birmingham and Solihull CCG will have two clear areas of focus:

1) Commissioning services that deliver the aims, objectives and service improvements included in the STP, contracts with providers and the Operational Plan; and

2) Developing as strategic commissioner, strengthening place based commissioning and provision, as well as developing and implementing the STP operating model.

This will be delivered through a clinically-led organisation, with clear priorities and measurements of success, which demonstrate closer working to deliver high quality, integrated services.

The new organisation will develop strategic and financial plans for the next 3-5 years, over the next six months.

We believe that it is vital that this is developed by, rather than presented to, the new organisation.

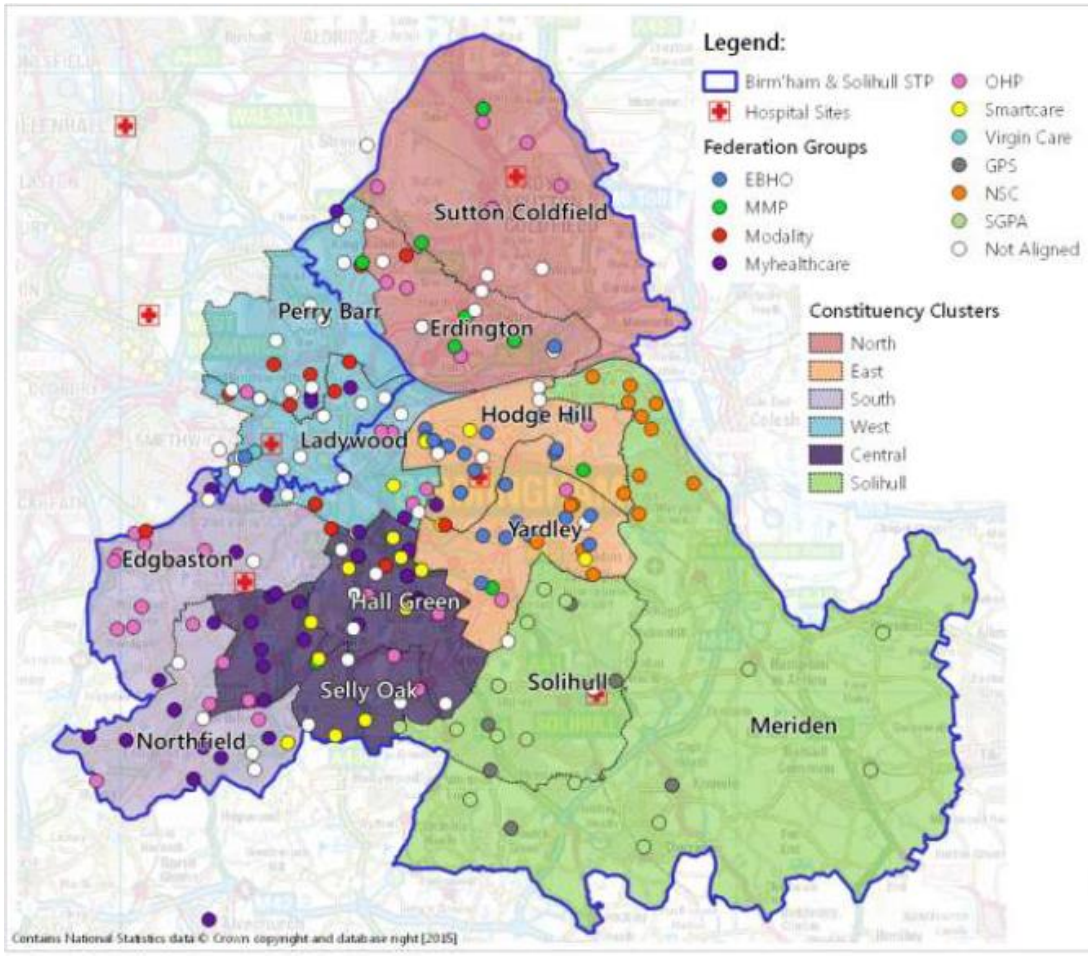
CCG organisational model

Birmingham and Solihull system:
Single financial plan;
Single strategic and operational plan and locality assurance;
Birmingham and Solihull level commissioning (regional JSNA); and
Executive and clinical leadership team.

Locality:
Notional locality budgets, QIPP delivery and performance accountability;
Place based delivery plans and teams (local JSNA);
Integrated budgets and teams;
Governance model and interface with HOSC/HWBB; and
Health and care partnerships (including primary care).

Neighbourhood:
GP provider and community asset network development; and
Neighbourhood care model development.

Localities



Parliamentary Constituency	Resident Population (MYE 2015)	Constituency Group	Resident Population (MYE 2015)	Registered population (2017)*
Sutton Coldfield	94,661	NORTH: Sutton Coldfield & Erdington	195,615	258,803
Erdington	100,954			
Hodge Hill	127,751	EAST: Hodge Hill & Yardley	238,959	222,860
Yardley	111,208			
Edgbaston	101,633	SOUTH: Edgbaston & Northfield	204,562	283,571
Northfield	102,929			
Perry Barr	109,312	WEST: Perry Barr & Ladywood	247,337	275,501
Ladywood	138,025			
Selly Oak	106,288	CENTRAL: Selly Oak & Hall Green	224,834	257,471
Hall Green	118,546			
Solihull	100,622	SOLIHULL: Solihull & Meriden	210,445	237,357
Meriden	109,823			
Total	**1,321,752**	**Total**	**1,321,752**	**1,535,563**

The Strategy Unit

** of patients registered to the practices aligned to each constituency cluster*

Locality development

The CCGs' locality model is intended to be fluid.

During the course of this year, we will be able to start describing our plans for how we want to work going forward, which we will develop in partnership with our patients and other stakeholders.

We are proposing to have an open dialogue to reflect the needs of each of the localities.

We are also proposing a core function with variation, as agreed with key partners, that will respond to the maturity of plans in the respective places.

Locality challenges

They are large localities; a clear focus is required on the interface with general practice, providers and the STP.

Move towards more strategic commissioning.

A joint commissioning strategy for West Birmingham.

Ensure Solihull is supported, with a strong interface with Local Authority.

Ensure Birmingham challenges are met e.g. East Birmingham/North Solihull, Good Hope etc.

There has been a lot of work to date with Sandwell and West Birmingham CCG, including a development workshop on 21 March to progress the terms of reference, memorandum of understanding, delegation agreement and other key areas of business, such as committee arrangements.

Key areas of progress to date include:

- A memorandum of understanding in place, setting agreed strategic direction;

- Delegation agreement and a terms of reference in final draft;

- Agreed approach regarding joint committee working;

- Elected GP representatives engaged across West Birmingham; and

- Joint committee will be operational within Q1.

	Agenda Item: 9
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**27th March 2018**
TITLE:	**HEALTH & WELLBEING STRATEGY UPDATE**
Organisation	**Birmingham City Council**
Presenting Officer	**Adrian Phillips / Carol Herity**

Report Type:	**Information**

1. Purpose:

1.1 To update the Health and Wellbeing Board of progress in developing and establishing potential indicators and targets and accountable groups across the health and social care economy that have the lead on delivering the ambitions in the Health & Wellbeing Strategy.

1.2 To identify issues that may hinder progress delivering the ambitions of the strategy.

2. Implications:

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

	Improving stable and independent accommodation for those learning disability	Y
	Improve the wellbeing of those with multiple complex needs	Y
	Improve air quality	Y
	Increased mental wellbeing in the workplace	Y
Joint Strategic Needs Assessment		Y
Joint Commissioning and Service Integration		Y
Maximising transfer of Public Health functions		N
Financial		Y
Patient and Public Involvement		Y
Early Intervention		Y
Prevention		Y

3. Recommendations

3.1 The Board to note the developments related to the Strategy.

3.2 The Board members agree to provide specific leadership to individual objectives.

3.3 The Board has a programme of receiving more detailed updates from each of the priority leads as a rolling programme over 12 months.

4. Background

4.1 The Health and Social Care Act 2012 required Local Authorities in England to have a Health and Wellbeing Board (HWBB). Boards should ensure that local health needs drive local decision-making, bringing together partners to improve health. A refreshed Health and Wellbeing Strategy (HWBS) was adopted in January 2017.

4.2 At the July HWBB it was agreed that the Operations Group should look to identify individuals from each area to lead priority areas of the strategy. The Operations Group were tasked with identifying potential indicators, targets and key delivery groups, including areas where gaps existed, and to report back to the HWBB.

4.3 The mechanisms that can be used to progress meaningful actions to improve outcomes in these areas need to be identified.

4.4 Targets

Appendix 1 outlines updated strategy in linking objectives with targets, source etc. Difficulties have been encountered in focussing on targets and agreement of sources etc. It is proposed that the Board will provide leadership in developing this further.

4.5 Board Member Involvement

The strategy must be owned by the Board. It is recommended that Members of the Board consider "leading" the objectives. This would involve relevant Board Members receiving updates on key issues and developments related to the objectives. This would enable them to update at meetings as needed.

4.6 Next Steps

- The Health and wellbeing Board Operations Group continue to work with partners to ensure plans are in place to deliver the ambitions within the strategy.
- The Operations Group to report on continued progress against targets once they have been established.

5. Compliance Issues

5.1 Strategy Implications

This paper concerns development of the strategy.

5.2	***Governance & Delivery***
	To be overseen by the Health and Wellbeing Board
5.3	***Management Responsibility***
	The Health and Wellbeing Board

6.	**Risk Analysis**		
	A risk assessment cannot be completed until the draft strategy has been agreed		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
#	#	#	#

Appendices	
1.	Health and Wellbeing Strategy Update

Signatures	
Chair of Health & Wellbeing Board (Councillor Paulette Hamilton)	
Date:	

Health & Wellbeing Strategy Update

Background

In January 2017 the HWBB agree to a set of updated priorities for the HWS. Subsequently the HWBB has asked the Operations Group to identify potential indicators and targets and accountable groups across the health and social care economy that have the lead on delivering these ambitions.

An overview of this work is shown in the table below.

Ambition	Target	Key links/external bodies	Board Lead	Operations Lead
Detect and Prevent Adverse Childhood Experiences	tbc	Birmingham Early Help and Safeguarding Partnership	tbc	Dennis Wilkes BCC
All children in permanent housing	All children in permanent housing	Housing Birmingham	Jonathan Driffill	Kalvinder Kohli BCC
Increase the control of individuals over their care through Integrated Personal Commissioning (Personal Health Budgets and Direct Payments)	To be agreed with NHSE BCC target 25% by 31/3/18	Integrated Personalised Commissioning Board	tbc	Anita Holbrook CCG Tapshum Pattni / Chris MacAdams BCC
Increasing employment/ meaningful activity and stable accommodation for those with mental health problems	8.9% patients with on CPA in paid employment by 2020/21 Accommodation tbc	Mental Health System Strategy Board Adult Social Care and Health Directorate Leadership	tbc	Jo Carney CCG Melanie Brooks BCC

Ambition	Target	Key links/external bodies	Board Lead	Operations Lead
Improving stable and independent accommodation for those learning disability	tbc	Adult Social Care and Health Directorate Leadership	tbc	Melanie Brooks BCC
Improve the wellbeing of those with multiple complex needs	tbc	West Midlands Combined Authority	Stephen Raybould	Natalie Allen/Ruby Dillon BVSC
Improve air quality	Halve air pollution attributable mortality by 2030	BCC Air Quality Steering Group	Adrian Phillips	Wayne Harrison BCC
Increased mental wellbeing in the workplace	tbc	West Midlands Combined Authority	tbc	tbc

Further details on the indicators, baseline performance and required trajectories, along with an overview of current plans to achieve the ambitions that have been identified are given in attached summaries.

Current position

System-wide work on each of the priorities still seems to be at different stages of development. From the information supplied to the Health & Wellbeing Operations Group each if the areas of the strategy can be categorised as below.

Identified indicators, targets and plans for delivery

- All children in permanent housing
- Increasing employment /meaningful activity for those with mental health problems
- Improving air quality
- Integrated Personal Commissioning

There are established work streams for each of these priorities with proposed and/or agreed targets. For the mental health and employment priority BCC integration with the NHS needs to be better understood.

Plans being developed but targets not yet determined

- Improving stable and independent accommodation for those learning disability
- Increasing stable accommodation for those with mental health problems
- Improve the wellbeing of those with multiple complex needs
- Detect and Prevent Adverse Childhood Experiences

Limited nationally published indicators are available for each of these areas. However, it has been recognised that there are gaps in these areas.

Indicators, targets and plans not yet determined

- Mental wellbeing in the workplace

Next steps

Agree the accountable group and targets for:

- Improving stable and independent accommodation for those learning disability
- Increasing stable accommodation for those with mental health problems
- Improve the wellbeing of those with multiple complex needs

Establish Birmingham indicators, targets and plans for:

- Mental wellbeing in the workplace
- Detect and Prevent Adverse Childhood Experiences

Detect and Prevent Adverse Childhood Experiences

Please provide a brief update on your agreed targets /indicators.

The suite of indicators being used by the Birmingham Early Help and Safeguarding Partnership have been adopted as being the most sensitive to changes in the impact of our local experiences in childhood. Changes due to the prevention of adverse experiences will, however, take time to be measureable.

A more formal assessment of the timeframe for measureable impact will need to be undertaken.

Current progress/developments?

The groups to develop our local responses to the opportunities for secondary and tertiary prevention are being formed to meet in December and report back to the Early Help and Safeguarding Partnership in Quarter 4 of 2017/18.

The Birmingham Child Poverty Action Forum is evaluating its next steps in Q4 of 2017/18

How can the board support you?

Continued support by Board members in their organisations and partnerships.

Seeking opportunities to support the development of a Strategic Partnership approach to developing the common culture and language of adverse experience being developed by the Chairs of the Birmingham Community Safety Partnership, Birmingham Adult Safeguarding Board, and the Birmingham Safeguarding Children Board.

Support for the Birmingham Child Poverty Action Forum in partnership with the Children's and the Equalities Overview and Scrutiny Committees.

Who is the Board Lead?

No one identified

All members have expressed a commitment.

Andrew Coward and Adrian Phillips have been personally involved in the Task & Finish group and ongoing developments

All children in permanent housing

Please provide a brief update on your agreed targets /indicators.

- The Homelessness Prevention Strategy 2017 + was presented at Cabinet December 2017 and City Council January 2018.
- The Pathway domain work is progressing, the first cut of excellence across the five domains - Universal, targeted, crisis, recovery and sustainable housing was presented at the Homelessness Partnership Board November 29th 2017. The next task is to establish audit tools to identify how far off excellence existing services are currently, gaps and best practice.
- The intention is to develop a kite mark for excellence which all agencies and learning institutions sign up to in terms of delivering excellent services in preventing homelessness.

Current progress/developments?

There are a number of new legislative changes which will support this target:

All local authorities are currently preparing for the implementation of the Homeless Reduction Act 2017 which places a much stronger duty on prevention people from becoming homeless. The Local Authority Legal duties covers three key areas:

1) Duty to provide advisory services – Free information and advice on preventing and relieving homelessness, including information tailored to the needs of particular vulnerable groups.

2) An enhanced prevention duty - requiring local authorities to intervene earlier to prevent homelessness (from 28 days to 56 days).

3) A new duty towards those who are already homeless requiring local authorities to work with them for 56 days to help secure accommodation to relieve their homelessness. It is clear that there is a firm expectation that local authorities reduce the numbers of households placed within temporary accommodation as a result of this new legislation.

To support this process, the Supporting People and Homeless Prevention Grant commissioned providers may be asked to closer align some of their service area activity to support the preventative duties as set out within the Act.

The local authority has also been provided with some new burdens monies to support them to put in place the changes required to support the implementation of the new legislation. This includes changes to back office systems, staff training, additional staff, IT infrastructure and potentially some external commissioning.

With regards to young people leaving Care – The new Children and Social Work Act 2017 requires local authorities to put in place a local offer that may assist care leavers in preparing for adulthood and independent living. This includes services relating to health and well-being, relationships, education and training, employment, accommodation and participation in society.

Work is currently underway with the Children's Trust (Shadow) to establish the housing and support requirements associated with this new duty.

The draft Code of Guidance on the Homeless Reduction Act also makes specific reference to the role of housing authorities in working with children services and consult care leavers to ensure the advice and information is i) designed in an appropriate format for the age of the client group; ii) available through communication channels which care leavers are most likely to access iii) understood by children's services authority staff.

A Care leavers Accommodation and Support Framework has been in development for a number of months and this will support the specific requirements with regards to young people leaving care. This will include sustainable, affordable and suitable housing options for young people as they prepare of independent living.

Work is also under way between the Children's Trust (Shadow) and the Place Directorate in order to secure 1 Bed Flats for Care Leavers as a means of more settled accommodation with Support.

Development of the Youth Housing Offer for Birmingham is being progressed through the Housing Birmingham Workstreams with partner agencies. This will include shared living options, pre tenancy support, live and work schemes and employment and training.

Birmingham is also represented on the regional mayoral work streams which include support to families and young people.

How can the board support you?

1) The development and implementation of a homelessness positive pathway for Birmingham requires a systems leadership/systems change approach to be successful. One area that requires specific attention is the contribution of health partners along the different domains of the pathway. This may be very different to what is currently provided. The Board may wish to consider offering some systems change support. Discussions are currently underway with Public Health to see if this can be resourced. Board may also wish to retain some oversight of this specific work stream.

2) The recommendation within the Cabinet Report is that the implementation of the Pathway will report to the Health and Wellbeing Board. Therefore there are boarder issues relating to homelessness and its impact upon the life course on different cohorts of vulnerable groups which are at greater risk of homelessness:

- Victims of domestic abuse
- care leavers
- Mental Health, learning, physical and sensory disabilities
- People leaving prison or with offending backgrounds

The Board may wish to consider boarding its interest to support the development and commissioning activity to respond to the above using the Positive Pathway approach

3) As part of the Homelessness Reduction Act there will be a Duty upon Public Authorities from October 2018 to refer service users who they may think may be homeless or threatened with homelessness to a housing authority. There is a view amongst stakeholders that this wording could be voluntary strengthened by key stakeholder agencies to a voluntary Duty to collaborate and this would be within the spirit of the Homelessness Positive Pathway. The Board may wish to give some consideration as to how this could be agreed as a starting point by agencies represented on the Health and Wellbeing Board?

Who is the Board Lead?

Jonathan Driffill

Increase the control of individuals over their care through Integrated Personal Commissioning – Personal Health Budgets

Please provide a brief update on your agreed targets /indicators.

No update received

Current progress/developments?

No update received

How can the board support you?

No update received

Who is the Board Lead?

No one identified

Increase the control of individuals over their care through Integrated Personal Commissioning - Direct Payments

Please provide a brief update on your agreed targets /indicators.

Indicator: Proportion of clients for whom a Social Care Individual Budget is being taken in the form of a Direct Payment.

Target: 25% by 31/3/18

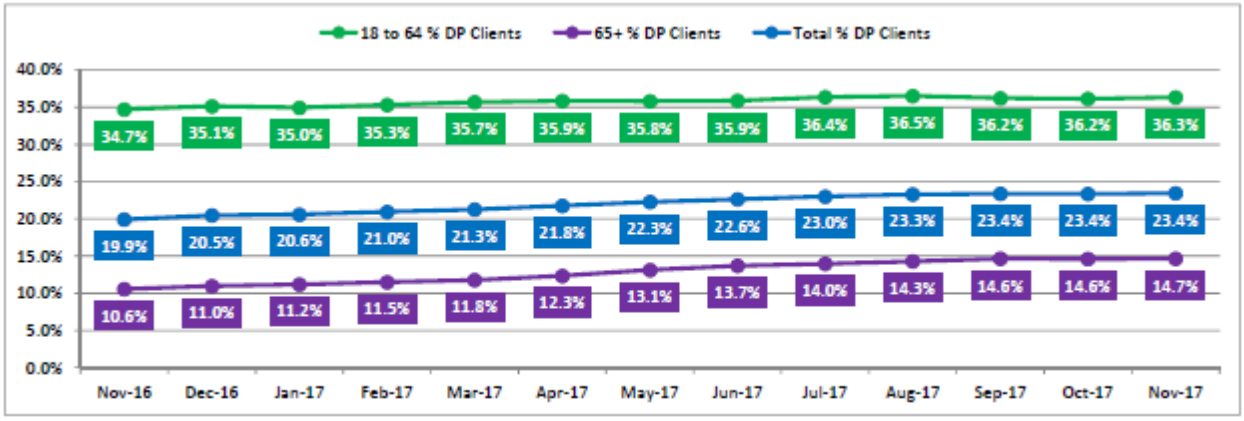
Current progress/developments?

Direct Payments

Showing the number of clients (not carers) receiving a service which is eligible for Self Directed Support (e.g. Direct Payments or Individual Budgets) and the number / proportion of clients who receive this, in whole or in part, as a Direct Payment.

Figures shown as a series of snapshots at the end of each month and on the date of the latest available data

		Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	06/11/2017
18 to 64	Eligible clients	3182	3178	3210	3235	3247	3265	3284	3291	3298	3321	3340	3363	3358
	Clients with DP	1105	1117	1122	1143	1159	1171	1176	1181	1200	1213	1210	1216	1220
	% DP Clients	**34.7%**	**35.1%**	**35.0%**	**35.3%**	**35.7%**	**35.9%**	**35.8%**	**35.9%**	**36.4%**	**36.5%**	**36.2%**	**36.2%**	**36.3%**
65+	Eligible clients	5038	4907	4908	4922	4944	4883	4867	4885	4871	4879	4908	4928	4926
	Clients with DP	532	538	549	566	582	603	639	669	680	697	719	720	722
	% DP Clients	**10.6%**	**11.0%**	**11.2%**	**11.5%**	**11.8%**	**12.3%**	**13.1%**	**13.7%**	**14.0%**	**14.3%**	**14.6%**	**14.6%**	**14.7%**
Total	Eligible clients	8220	8085	8118	8157	8191	8148	8151	8176	8169	8200	8248	8291	8284
	Clients with DP	1637	1655	1671	1709	1741	1774	1815	1850	1880	1910	1929	1936	1942
	% DP Clients	**19.9%**	**20.5%**	**20.6%**	**21.0%**	**21.3%**	**21.8%**	**22.3%**	**22.6%**	**23.0%**	**23.3%**	**23.4%**	**23.4%**	**23.4%**



How can the board support you?

No support required from the board at this time.

Who is the Board Lead?

No one identified

Increasing employment/ meaningful activity for those with mental health problems

Please provide a brief update on your agreed targets /indicators.

Birmingham CCGs have recommissioned Mental Health 'day services' and learning and work services to provide a redesigned integrated recovery and employment service for people receiving secondary care mental health services. Employment support will be provided with fidelity to the Individual Placement Support (IPS) model.

Individual Placement Support is an evidence based model which has been proven to achieve higher numbers of people entering and sustaining employment. IPS workers are integrated into community mental health services and provide open ended support to both employee and employer.

The IPS service will fulfil full fidelity principles outlined by the Centre for Mental Health. The commissioned service must therefore exceed 8 quality outcomes, these are:

- To ensure that no service user is excluded from the service
- Employment support and treatment are integrated
- Job search is rapid and intensive
- Only minimal pre-work training is offered and that the focus should be on obtaining sustained employment.
- Service users are offered a personalised job search.
- IPS work with employers to develop links and support.
- Long term support in work, both before, during and after employment.
- Access to welfare and benefits advice.

The Employment and Recovery service will:

Ensure more mental health service users in contact with secondary care services in employment as a result of the introduction of the fidelity Individual Placement Support model.

Increase the number of people with mental health problems preparing for employment by building their work capacity and skills for looking for work.

- Increase the number of people with mental health problems in sustainable employment.

Targets:

Engagement in IPS Service.	Number of people engaged in IPS service	2018/19 – 504 2019/20 – 672 2020/21 – 672
Paid Job Outcomes	Service Users in paid employment (reported under/over 16 hours per week and sustained for 13 weeks)	2018/19 – 120 2019/20 – 190 2020/21 – 190
Job Retention	Number of people in existing paid employment who retain their employment	2018/19 – 12 2019/20 – 19 2020/21 – 19

Current progress/developments?

A tendering process for Mental Health Recovery and Employment Services has been undertaken and a contract has now been awarded to a consortium of providers – Better Pathways, MIND and Creative Support. Better Pathways will be delivering the IPS functions from April 2018.

Plans for mobilisation remain on track for the new service to commence at the start of April.

How can the board support you?

To advise of any opportunities to encourage the Local Authority and other employers to engage with IPS workers.

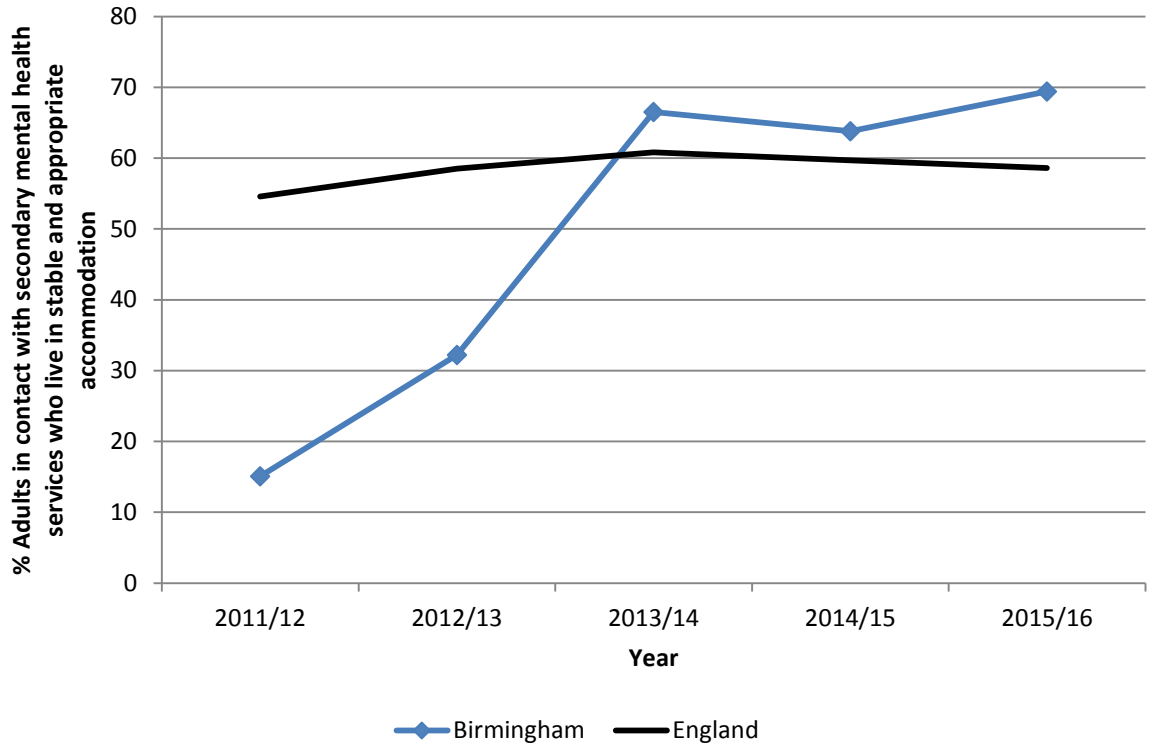
Who is the Board Lead?

No one identified

Increasing stable accommodation for those with mental health problems

Indicator: Adults in contact with secondary mental health services who live in stable and appropriate accommodation (PHOF)

Target: tba



Current plans to achieve ambition

This target is published annually and it is difficult in-year to track and demonstrate progress. It is recommended that the Health and Wellbeing Board consider for 2018-19 a data set that can be measured monthly and that will give assurance that work is delivering progress. It is recommended that Health and Wellbeing Board commission a baseline exercise to understand:

- Number of Adults within Adult Social Care with a Mental Health Problem a Shared Life living arrangement, and number of Adults supported in Support Living

- Number of Adults with a Learning Disability supported within general needs Housing.

- From BSMHT the number of Adults on CPA within stable accommodation.

There are three main pieces of work which will support work in this area:

- **Specialist Impact Team** – This team brings together Social Work, commissioning and family support to target reviews for vulnerable adults with a focus on providing support in the least restrictive setting maximising independence. Alongside the new Commissioning Framework, work will take place with providers to develop their approach to supporting move on plans with the aim of supporting move to independent living.

  The team will prioritise work with the most vulnerable adults whilst working to support better utilisation of supported living schemes in the City. The team will be recruited by January 2018 and impact on performance will be seen from March 2018.

  The recruitment of carers in Shared Lives will provide a greater range of housing options and opportunities for Adults. A specific action plan will be developed to build Shared Lives scheme capacity for Mental Health.

- **Supported living framework and utilisation –** as part of the Commissioning framework the approach to supported living is being reviewed. Work will take place to address the high level of scheme voids, and providers will be supported to adapt or decommission schemes which are not relevant to the needs of individuals.

- **Homeless and housing strategy –** closer links are being made to support the housing strategy work to address the needs of vulnerable adults. Clear actions are not yet in place but will be agreed by January 2018. This will need to include specific actions for BCC, the CCG and BSMHFT.

Council and Mental Health Trust representatives are meeting to look at developing meaningful measures linked to two key objectives:

- How we support individuals to access settled accommodation (cohort to be identified)?
- Individuals living in settled accommodation how do we support them to maintain the accommodation and avoid unnecessary move-on/eviction/abandonment?

Accountable Group

Adult Social Care and Health Directorate Leadership Team and Joint Commissioning Team within the CCG.

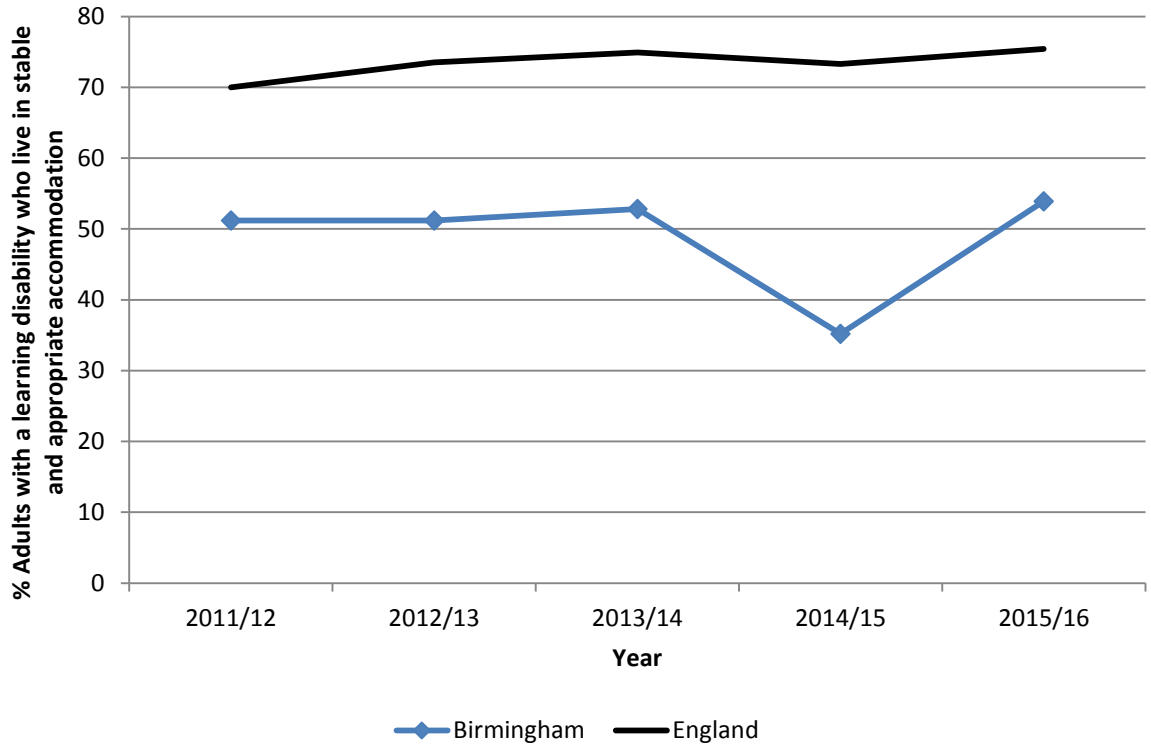
Who is the Board Lead?

No one identified

Improving stable and independent accommodation for those learning disability

Indicator: Adults with a learning disability who live in stable and appropriate accommodation (PHOF)

Target: tbc



Current plans to achieve ambition

This target is published annually and it is difficult in-year to track and demonstrate progress. It is recommended that the Health and Wellbeing Board consider for 2018-19 a data set that can be measured monthly and that will give assurance that work is delivering progress. It is recommended that Health and Wellbeing Board commission a baseline exercise to understand:

- Number of Adults within Adult Social Care with a Learning Disability placed within Residential Care/Specialist Placement, number of Adults within a Shared Life living arrangement, and number of Adults supported in Support Living

- Number of Adults with a Learning Disability supported within general needs Housing.

There are three main pieces of work which will support work in this area:

- **Specialist Impact Team** – This team brings together Social Work, commissioning and family support to target reviews for vulnerable adults with a focus on providing support in the least restrictive setting maximising independence. Alongside the new Commissioning Framework, work will take place with providers to develop their approach to supporting move on plans with the aim of deescalating care or supporting move to independent living.

  The team will prioritise work with the most vulnerable adults whilst working to support better utilisation of supported living schemes in the City. The team will be recruited by January 2018 and impact on performance will be seen from March 2018.

  The recruitment of carers in Shared Lives will provide a greater range of housing options and opportunities for Adults.

- **Supported living framework and utilisation –** as part of the Commissioning framework the approach to supported living is being reviewed. Work will take place to address the high level of scheme voids, and providers will be supported to adapt or decommission schemes which are not relevant to the needs of individuals.

- **Homeless and housing strategy –** closer links are being made to support the housing strategy work to address the needs of vulnerable adults. Clear actions are not yet in place but will be agreed by January 2018.

Learning Disability and Employment

Work is also being undertaken to address issues around learning disability and employment, we are addressing this through the Day Opportunities Strategy and we have established links with the apprentice scheme; the economies commissioned services and are planning an employment challenge for 10 of our day centre service users.

Accountable Group

Adult Social Care and Health Directorate Leadership Team.

Who is the Board Lead?

No one identified

Improve the wellbeing of those with multiple complex needs

A separate paper is being prepared for the Board

Who is the Board Lead?

Stephen Raybould

Improve Air Quality

Please provide a brief update on your agreed targets /indicators.

No updates available for the air quality indicators.

Current progress/developments?

The Clean Air Zone (CAZ) feasibility study is progressing. An outline business case for the CAZ has been presented to DEFRA by the DPH. An integrated impact assessment has also been developed.

Plans are progressing to provide NO_2 monitoring equipment and air pollution educational tools to schools throughout Birmingham to improve data collection and raise awareness.

The Health & Wellbeing Board Operations Group discussed the "Health Outcomes of Travel Tool" that has been developed by the NHS Sustainable Development Unit. The tool helps NHS organisations measure the impact their travel and transport has in environmental, financial and health terms to allow the creation of a plan and targeted initiatives to reduce the NHS's impact from travel and transport.

https://www.sduhealth.org.uk/delivery/measure/health-outcomes-travel-tool.aspx

How can the board support you?

Members of the Board are encouraged to respond to the air quality policy consultation when launched and promote it within their networks.

NHS bodies should consider the use of the Health Outcomes of Travel Tool to explore reducing their impact on air pollution. Other partners should work to similarly reduce their contribution to air pollution within the city.

Who is the Board Lead?

Adrian Phillips

Increased mental wellbeing in the workplace

The WMCA Mental Health Commission has developed a 'West Midlands Workplace Wellbeing Commitment' where public and private sector employers sign up to demonstrate their commitment to the mental health and wellbeing of their staff.

The Commission has also committed to work with the Government to trial an innovative 'Wellbeing Premium' - a tax incentive that rewards employers demonstrating their commitment to staff wellbeing. The trial will reveal if such a financial incentive, accompanied by an employer action plan, reduces staff sickness absence, improves productivity and prevents people leaving work due to ill health.

Improving wellbeing in the workplace is also a work stream for the Birmingham & Solihull STP.

Monitor Deloitte have recently published an Independent Review of Mental Health and Employers to understand how employers can better support all individuals currently in employment (including those with poor mental health or wellbeing) to remain in, and thrive through work.

https://www2.deloitte.com/uk/en/pages/public-sector/articles/mental-health-employers-review.html

It is proposed that the Health & Wellbeing Board hold a workshop based around this report to consider the implication of mental wellbeing in the workplace for Birmingham

Who is the Board Lead?

No one identified

One Care Partnership

REFRESHING THE STRATEGY

MARCH 2018

Our challenges and opportunities

With the pressures of…

Ageing + Chronic diseases + Technology + Inequality

…how will we make high quality care for everyone sustainable now and for future generations?

Our resources

The overall challenge of making high quality care sustainable now and for future generations relies on major actions locally and nationally.

Local actions

- Prevention
- Work
- Right care, right place
- Reducing variation
- Harnessing technology
- Economies of scale

National actions

- Adult social care Green Paper
- NHS funding settlement
- Devolution of powers
- Alignment of regulation with placed based approach
- Realism on timescales

Our strengths

The centre of the nation

- Second biggest UK metro economy
- Youngest core city in Europe
- Over a hundred languages spoken
- Legacy and future of sporting excellence

- Six universities in one city
- New transport connectivity
- Great place to live
- Creativity and culture

A place of limitless ambition

Co-production

GPS Healthcare
General Practice Solihull

myhealthcare

Our Health Partnership
OHP A healthy future for patients and practices

mmp
TAKING CARE
MIDLANDS MEDICAL PARTNERSHIP

Birmingham City Council

Solihull Metropolitan Borough Council

NHS
Solihull
Clinical Commissioning Group

West Midlands Ambulance Service NHS Trust

NHS
Birmingham South Central
Clinical Commissioning Group

NHS
Birmingham CrossCity
Clinical Commissioning Group

NHS
Birmingham Community Healthcare
NHS Foundation Trust

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

WEST MIDLANDS COMBINED AUTHORITY

NHS
Heart of England
NHS Foundation Trust

NHS
University Hospitals Birmingham
NHS Foundation Trust

NHS
Birmingham Women's and Children's
NHS Foundation Trust

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Birmingham Health Partners

One Care Partnership
Birmingham and Solihull
Helping us to be healthier and happier

Our vision

"Our vision is to help everyone in Birmingham and Solihull to live the healthiest and happiest lives possible."

One Care Partnership
Birmingham and Solihull
Helping us to be healthier and happier

Core aspirations

- Independence and resilience
- Equity, equality and inclusion
- Integration and simplification
- Promoting prosperity
- Social value





Our approach

A true **partnership** that operates on the basis of **place** rather than institutional silos

That **engages** broadly with our citizens and acts on the best **evidence**

This would be **transformational**

One Care Partnership
Birmingham and Solihull
Helping us to be healthier and happier

Our approach

Life course:

Born well

Grow well

Live well

Age well

Die well

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Our approach

Closing the gaps:

Health *and* social care

Mind *and* body

Primary *and* secondary

Citizen *and* service

Advantaged *and* disadvantaged

One Care Partnership
Birmingham and Solihull
Helping us to be healthier and happier

Our priorities

1 Childhood and adolescence

- A healthy start in life
- Local maternity system
- Improving mental health for children and young people

2 Adulthood and work

- Promoting health and well being, and managing chronic disease
- Staff health and well being
- Promoting skills and prosperity
- Breaking the cycle of deprivation

3 Ageing and later life

- Ageing well and improving health and care services for older people
- Creating a better experience at the end of life

4 Enablers

- Improving air quality for a healthier environment
- Broadening access to urgent care
- Digital innovation and integration
- Making the best use of the public estate

One Care Partnership
Birmingham and Solihull
Helping us to be healthier and happier

Proposed next steps

- Agree strategy proposals across partner organisations (March 2018)
- Take to STP Board and revise after feedback, including prioritisation (April 2018)
- Take to H&WB Boards and revise after feedback, including prioritisation (April 2018)
- Set up citizen and patient focus groups (April/May 2018)
- Prepare public facing communications (May 2018)
- Commission academic evidence review (April 2018)
- Wider public engagement programme (summer 2018)
- Revise governance/sub-groups and resource plan to be set up to deliver priorities (May 2018)
- Work up or revise more detailed plans for each of the priorities and work-streams (May/June 2018)
- Begin implementation of obvious priorities (summer 2018 onwards)
- Finalise strategy after public feedback (September 2018)
- Publish academic evidence base for priorities (September 2018)
- Ongoing implementation with quarterly stocktakes on progress (ongoing)

	Agenda Item: 12
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**27th March 2018**
TITLE:	**HEALTH & WELLBEING BOARD MEMBERSHIP - REVIEW**
Organisation	**Birmingham City Council**
Presenting Officer	**Adrian Phillips**

Report Type:	**Discussion**

1. Purpose:
1.1 To propose changes to the membership of The Health and Wellbeing Board as outlined in 4.5 and 4.6.

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

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

3. Recommendation
3.1 The Board to agree changes to its composition

4. Background
4.1 A previous meeting agreed that the Membership of the Board should be reviewed (as well as increasing the frequency of meetings).
4.2 The purpose of the Board is laid in Statute is to
a) promote the reduction in Health Inequalities across the City through the commissioning decisions of member organisations
b) report on progress with reducing health inequalities to the Cabinet and the various Clinical Commissioning Group Boards
c) be the responsible body for delivering the Joint Strategic Needs Assessment for Birmingham (including the Pharmaceutical Needs Assessment)
d) deliver and implement the Joint Health and Wellbeing Strategy for Birmingham
e) participate in the annual assessment process to support Clinical Commissioning Group authorisation
f) identify opportunities for effective joint commissioning arrangements

and pooled budget arrangements

g) provide a forum to promote greater service integration across health and social care

4.3 Terms of Reference

Under the Health and Social Care Act 2012 the composition of Board must include:-

- The Leader of the Council or their nominated representative to act as Chair of the Board
- The Corporate Director for Adult Social Care and Health Directorate
- The Corporate Director for Children and Young People Directorate
- Nominated Representatives of each Clinical Commissioning Group in Birmingham
- The Director of Public Health
- Nominated Representative of Healthwatch Birmingham

Each Local Authority may appoint additional Board Members as agreed by the Leader of the Council or their nominated representative. If additional appointments are made these will be reported to Cabinet by the Chair of the Board.

For the Board to be quorate at least one third of Board Members and at least one Elected Member must be present

Members of the Board will be able to send deputies with prior agreement of the Chair. It is assumed that they have the decision-making authority of that Board Member.

4.4 Membership 2018/19

The current City Council Appointments to the Health and Wellbeing Board are:

- Cabinet Member for Health and Social Care as Chair
- Cabinet Member for Children, Families and Schools
- Opposition Spokesperson on Health and Social Care
- Corporate Director for Adult Social Care and Health Directorate
- Corporate Director for Children and Young People Directorate
- Director of Public Health

External Appointments to the Health and Wellbeing Board are:

- Representative of Healthwatch Birmingham
- Representative of Birmingham CrossCity Clinical Commissioning Group

- Representative of Birmingham South Central Clinical Commissioning Group
- Representative of Sandwell and West Birmingham Clinical Commissioning Group
- Representative of Third Sector Assembly
- Representative of NHS England Local Area Team
- Chair of the Birmingham Community Safety Partnership
- 1 local NHS Provider representative
- Member of the Birmingham Social Housing Partnership

4.5 Changes to Board Membership

Since the membership of the Board was last reviewed in June 2017, there have been significant changes in both personnel and organisational structures in the Council, CCGs and NHS Providers as well as in the strategic environment in which the Board operates. It is not proposed to alter the City Council membership.

It is proposed to:

Invite 2 representatives from the new Birmingham and Solihull CCG. This would nominally be Chair and Accountable Officer, subject to the deputising arrangements as above.

Continue with a representative from Sandwell and West Birmingham Clinical Commissioning Group – nominally the Chair.

Continue with representatives from the Birmingham Community Safety Partnership and the Birmingham Social Housing Partnership (nominally the Chair as above).

Invite Birmingham Voluntary Sector Council to consider appropriate representation from that sector (and until that time act as that representative).

Invite the Birmingham and Solihull STP lead to be a member of the Board in place of the provider representative.

Invite a representative of the Department of Work and Pensions (DWP) nominally the Service Leader, Birmingham and Solihull District. The rationale is that a number of strategic aims are linked to employment in specific groups.

Remove the NHSE representative from the Board as many of their functions have been delegated to CCGs.

4.6 Other Proposals

It is also proposed that:

The Vice-Chair continues to be a CCG representative, namely the Chair of the Birmingham and Solihull CCG.

There is a programme of joint meetings with the Solihull Health & Wellbeing Board.

That other representatives are co-opted as the work of the Board dictates. For example consideration should be given to inviting a member of the Children's Trust.

In addition, we propose to change the Health and Wellbeing Board report template to meet the current priorities within the Strategy.

5.	**Compliance Issues**
5.1	***Strategy Implications***
	This paper concerns development of the Board.
5.2	***Governance & Delivery***
	To be overseen by the Health and Wellbeing Board
5.3	***Management Responsibility***
	The Health and Wellbeing Board

6.	**Risk Analysis**		
A risk assessment cannot be completed until the draft strategy has been agreed			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
#	#	#	#

Appendices

Signatures	
Chair of Health & Wellbeing Board (Councillor Paulette Hamilton)	
Date:	