Complex Lives, Fulfilling Futures

Director of Public Health Annual Report 2019/20

[photo image here that represents MCN + corporate branding]

Contents [Insert page numbers when designed]

FOREWORD

[Insert Justin's photo]

All of us experience challenges at some point in our life, many are short-lived, and we move forward, but for some of us these challenges persist and become baggage that can weigh down our lives and make it hard to achieve our potential.

Some individuals face multiple challenges such as mental health issues, substance misuse and homelessness. Each one is significant, but when added together they magnify the impact making even simple tasks seem overwhelming and unachievable.

Sadly, it is easy to slip into an approach that responds only to the specific need that brought a person to the front door and not see the complexities that surround that individual and challenge them every day.

In my first annual report as a Director of Public Health for Birmingham City Council, I want to highlight the challenges that adults living with multiple and complex needs face and reflect on how we, as a city partnership, can make every adult matter.

The report sets out the data and evidence of the extent multiple and complex needs affect the lives of adults in Birmingham and aims to raise awareness of what really matters when it comes to preventing and tackling many of these problems. Through the shared stories of Bee and Dion, I encourage readers to reflect on how we can help individuals facing multiple complex needs to live fulfilling lives.

I hope that this report inspires action across the city to make every adult matter in Birmingham and support all citizens to thrive.

[Insert Justin's signature]

Dr Justin Varney

Director of Public Health

Birmingham City Council

[Insert Cllr Hamilton's photo]

I am really pleased that this year's Director of Public Health Annual Report focuses on the most vulnerable adults in our city who may have 'fallen through the cracks' of our care system. We need to use this report to reflect on our work in this area and learn how to continue to improve our services to achieve better outcomes for those most at need.

Whilst many of us might experience complex needs at some point of our lives, none of us should struggle on their own. As the Portfolio Holder for Health and Social Care and as the first Mental Health Champion for the City Council, I am keen to ensure that every person who lives in our city has the opportunity to achieve their full potential.

It is important to acknowledge the effort and investment that has already been made to support our citizens with multiple complex needs to transform their lives. We have seen a significant reduction in our rough sleeping population since the previous count through greater partnership work and targeted support and intervention. We are working more closely together across the wider health and care system to prevent crisis through our joint strategies and service models, but we know that more can and must be done.

The challenges of working across a multifaceted system to address complex needs of vulnerable individuals remain considerable. Therefore, it is important that together with all our stakeholders, community and voluntary groups, commissioned services and with health partners we are able to identify issues early on to prevent them from escalating to more complex and significant needs and avoid a high cost to people's health and wellbeing, their lives as well as the public purse.

I hope that this report will provide the opportunity through system partnership to continue to transform and develop a joint upstream action. I hope it will stimulate further a commitment to work collaboratively and act on the Director of Public Health recommendations and work towards turning the complex lives of many of our citizens into fulfilling futures.

[Insert Cllr Hamilton's signature]

Cllr Paulette Hamilton

Chair of the Birmingham Health and Wellbeing Board

Mental Health Champion and Chair of the Creating a Mentally Healthy City Forum

Portfolio Holder for Health and Social Care

Birmingham City Council

1. INTRODUCTION

“The core purpose of the DPH (Director of Public Health) is as independent advocate for the health of the population and system leadership for its improvement and protection” (Association of Directors of Public Health, Faculty of Public Health 2016).

The DPH Annual Report is a way for providing advice and recommendations on population health to both professionals and public, complementing information available within the Joint Strategic Needs Assessment (JSNA) and local health profiles. Its purpose is to influence local policies defining the wider determinants of health.

Findings and recommendations in this report have been based on a thorough study of the journeys of those with multiple complex needs as well as success and gaps in support available across the wider health and care system in Birmingham.

The main focus of the study was the consolidation and analysis of all available statistical and service use data across four main disadvantage domains:

- Homelessness
- Substance misuse
- Mental health
- Offending.

The latter has been based to a large extent on information shared by the probation service, as it has been difficult to obtain the police data within the study’s time constraints. Therefore, it must be acknowledged that whilst the themes and trends that have emerged from analysis may be similar, the findings may be incomplete.

The study is complemented by qualitative research, which includes a wide-ranging literature and policy review as well as findings from three focus groups and a rapid ethnographic research.

The semi-structured focus groups were carried out by the Birmingham Public Health‘s Inequalities Team with three distinctive cohorts of participants to gather city specific insight into multiple complex needs. Focus groups were conducted with:

- Department of Work and Pensions (DWP) job centre front-line staff from across Birmingham in order to determine the challenges they face as a result of an introduction of the Government’s new work and health policy and the Universal Credit. Both place more responsibility on DWP to carry out health and wellbeing assessments and provide tailored wellbeing and coaching support in order to facilitate a much higher number of people with complex needs into becoming economically active;
- female service users with multiple complex needs in order to understand the challenges that specifically women with multiple complex needs face and how their experiences may differ from those of men;
- Peer Mentors from Birmingham Changing Futures programme who provide a lead worker support to the most entrenched individuals experiencing multiple complex needs, including rough sleepers.

The three focus groups were structured by six topics: family composition, common crisis points and vulnerabilities, access to services, service successes, service failures, gaps in service provision. Findings were analysed by the Knowledge, Evidence and Governance

Team (BPH) to identify key themes as well as comparison between the service user and professional perspectives on gaps and needs.

Rapid ethnography was commissioned to develop the insight presented in this report further and to illustrate what daily life and struggle with multiple complex needs is like.

2. UNDERSTANDING MULTIPLE COMPLEX NEEDS

2a. Defining Multiple Complex Needs

'I don't want to live anymore. I don't want to go on anymore. Because everything I care about has been taken away from me. Whether it's through substances, social services, police, you name it – everything I know and care about has gone from me.' (Rough Sleeper in Birmingham) [quote in speech bubbles]

The above quote pretty much defines what life with multiple complex needs, including mental health, substance misuse and homelessness, is like from the perspective of personal experience of the deepest crisis.

Looking through a professional lens, multiple and complex needs (MCN) describe interrelated health and social care needs of disadvantaged individuals which are often enduring and highly problematic, effecting day to day living, life chances and social functioning as well as resulting in economic and social costs where support is inadequate. In many cases the problems develop from trauma and those facing multiple needs often live in poverty and experience stigma and discrimination.

Several terms are used to describe multiple and complex needs in published literature. Terms such as 'Severe and Multiple Disadvantage' (SMD) [1] and 'Multiple and Chronic Exclusion'[2] are also used to describe similar cohorts of individuals, though the main areas of need or disadvantage are broadly consistent. They are most commonly:

- Homelessness
- Mental Ill Health
- Substance Misuse and
- Contact with the Criminal Justice System.

In some cases, this definition is wider as factors of worklessness and mental health can also add to the complexity and challenge of addressing MCN. Also, it is recognised that experience of domestic abuse and violence, separation from children and social inequalities often contribute to women's severe and multiple disadvantage[3].

Multiple complex needs relate to both the multiplicity of need (more than one interconnected need) and depth of need (profound, severe or intense needs)[4].

Making Every Adult Matter (MEAM) Approach[5] details three criteria to identify people facing multiple needs and exclusions:

[1] Lankelly Chase Foundation (2015), Hard Edges: Mapping severe and multiple disadvantage, England.
[2] Fitzpatrick, Bramley, Johnsen (2013), Pathways into multiple exclusion homelessness in seven UK cities. Urban Studies, Jan 2013, 50(1):148-68.
[3] McNeish and Scott (2014), Women and Girls at Risk, Evidence Across the Life Course, DKMS Research.
[4] Rankin and Regan (2004), Meeting Complex Needs: The Future of Social Care, London: Turning Point and IPPR.
[5] Battrick, Hilbery, Holloway (2013), Findings from the Making Every Adult Matter (MEAM) service pilots: a summary paper, Advances in Dual Diagnosis, 2013 May, 17;6(2):66-75.

- Ineffective contact with services: Despite often looking for help, people with multiple needs face challenges when services are designed to only meet one need, or they fail to meet individual service thresholds and no individual organisation takes overall responsibility.
- Chaotic Lives: One need may lead to another and often become a downward spiral especially where they are interlinked, and individuals become trapped in chaotic lives, often since early childhood, and are unsupported.
- Experiencing several problems at the same time: One main need may be complicated by others or multiple lower level needs may become problematic together.

Based on research underpinning the Fulfilling Lives programme and its many evaluations, MCN can be associated with lifelong disadvantage and inequalities that impact on the individual, their interactions with services as well as their interactions with others, often starting from early on in life and escalating throughout the life course up to the point of crisis.

2b. What is the bigger picture?

[Insert an image of a person with MCN in the middle with the logos/ doc covers of the various national strategies and initiatives around, including:
Marmot's Review 2010
Marmot Review 2020 – 10 years on
Social Justice: Transforming Lives 2012
Troubled Families
Homelessness Prevention Act 2017
Everybody In: How to end homelessness in Great Britain
Rough Sleeping Strategy 2018
Lankelly Chace, Hard Edges
Adults Facing Chronic Exclusion programme
Making Every Contact Count
Fulfilling Lives
The Government's Alcohol Strategy 2012 (.gov)
2017 Drug Strategy (.gov)
No health without mental health: A cross-government mental health outcomes strategy for people of all ages 2011
Strategy to end violence against women and girls: 2016 to 2020
Domestic Abuse Bill 2019
Five Year Forward View (NHS)
'Thrive' Mental Health Commission
West Midlands Combined Authority's Radical Prevention
West Midlands Combined Authority's Mental Health Commission]

"The house of children whose parents are addicted to crack-cocaine: Dad has passed out on the mattress in his own vomit, mum is crouched over a table, preparing her fix. What you don't see is the child hidden in the corner crying."

This quote opens the Coalition Government's strategy from 2012, Social Justice: Transforming Lives., developed following the Marmot's Review 2010 and setting out "an

ambitious new vision for supporting the most disadvantaged individuals and families in the UK". That vision was based on two principles: **prevention throughout a person's life**, with carefully designed interventions to stop people falling off track and into difficult circumstances, and **a 'second chance society'** in which anybody who needs a second chance should be able to access the support and tools they need to transform their lives.

Following this strategy, initiatives for families affected by MCN were prioritised with the Troubled Families programme being one of the more successful ones. What appeared to be given less of a priority at the time was the support to single adults without dependents.

Despite a considerable focus on this area of work in the past decade across the UK and in Birmingham, inequalities appear to be increasing. A follow-up report by Sir Marmot has now been published and examines further health inequalities and their cost to the society and to public services. Sadly, it reports that health inequalities in the country are widening and calls for a system-wide action to address inequity of support through effective prevention and early intervention that will reduce future costs[6].

Whilst estimating the scale and true cost of multiple complex needs is difficult; a national study suggests that average public expenditure for a person with MCN is £19,000 (of which £6,020 is welfare benefits) per annum; more than four times the cost of £4,600 for an average individual[7]. [Insert an infographic of coins representing the difference in expenditure:]

COST TO PUBLIC PURSE	
Average benefits claimant	Benefits claimant with MCN
£1	£4

The Lankelly Chase Foundation estimates that over a quarter of a million people in England experience at least two out of three of the homelessness, substance misuse and criminal justice system which equals 4.2 people per one thousand.

[Insert an infographic of proportion of persons experiencing two complex needs using the estimate above (based on ONS population estimates from 2019):

UK population – c 67,000,000; UK population with 2 MCN – c 280,000

England's population – c 54,000,000; England's population with 2 MCN – c 227,000

Birmingham's population – c 1,100,000; Birmingham's population with 2 MCN – c 4,600]

The research also estimates that 1.5 per one thousand people of working age are likely to experience all three of the complex needs.

[Insert an infographic of proportion of persons experiencing three complex needs using the estimate above (based on ONS population estimates from 2019):

UK population – c 67,000,000; UK population with 3 MCN – c 100,000

England's population – c 54,000,000; England's population with 3 MCN – c 81,000

[6] Marmot (2020), Health Equity in England: The Marmot Review 10 Years On.
[7] Lankelly Chase Foundation (2015), Hard Edges: mapping severe and multiple disadvantage, England.

Birmingham's population – c 1,100,000; Birmingham's population with 3 MCN – c 1,650]

The study, which focused predominantly on the rough sleeping population, also found that those experiencing MCN were predominantly white males, aged 25-44 years with history of marginalisation and childhood trauma. Ninety percent of the homeless population are likely to be single homeless rather than family homeless**.** [Reproduce the infographic below using MCN rather than SMD, adding marginalisation and childhood trauma; keep the reference to sex workers]

[9] Though note that street sex work, closely interrelated with some of these more extreme manifestations of SMD, is dominated by women (Fitzpatrick *et al.*, 2013).

Even amongst those with the most complex needs (all three) almost 60% either live with or have ongoing contact with children.

3. THE STORY IN BIRMINGHAM

3a. How do we compare nationally[8]?

According to research carried out by Lankelly Chase Foundation[9], Birmingham belongs to a group of 24 Local Authority areas with the highest prevalence of MCN and takes 18th place in the ranking[10].

[8] Source: Public Health Outcomes Framework, unless stated otherwise.
[9] Lankelly Chase Foundation (2015), Hard Edges: Mapping severe and multiple disadvantage, England.
[10] The ranking is based on three national data sources from 2010-11: Offender Assessment System, National Drug System Monitoring System and the Supporting People Client Record and Outcomes for Short-Term Service data. Other evidence and measures are available which could or could not result in the same ranking.

Table 1: Index of Local Authorities with the highest and lowest prevalence of SMD based on three national data sources for England, 2010/11 (where 100 is the national average)
(a) 24 authorities with highest prevalence

Local Authority (SS)	SP	OASys	NDTMS	Combined
1. Blackpool	378	298	244	306
2. Middlesbrough	152	306	387	281
3. Liverpool	265	200	249	238
4. Rochdale	310	183	184	226
5. Manchester	245	212	217	225
6. Kingston upon Hull	251	191	232	224
7. Bournemouth	266	177	218	220
8. Nottingham	260	199	181	213
9. Stoke-on-Trent	193	215	224	210
10. Newcastle upon Tyne	271	186	167	208
11. Leicester	219	196	187	200
12. Knowsley	179	143	271	197
13. Derby	323	159	110	197
14. North East Lincolnshire	227	140	208	191
15. Blackburn with Darwe	122	235	216	191
16. Camden	239	125	199	188
17. Islington	174	175	205	185
18. Birmingham	171	162	217	183
19. Coventry	216	165	161	181
20. Tower Hamlets	188	140	210	179
21. Westminster	193	96	236	175
22. Plymouth	262	101	162	174
23. South Tyneside	123	157	238	173
24. Bristol	187	159	162	169

Source: Authors' analysis of SP, OASys and NDTMS data and 2011 census

[Highlight or circle Birmingham's data in the table above]

Based on the same research, we would estimate that in Birmingham around 7,100 people meet the criteria of at least one severe multiple disadvantage (multiple complex need) and a mental health issue, and overall, just over 19,700 people have at least one category of SMD.

[Insert 3 infographics:
1) Est. 19,700 people in B'ham have at least one complex need; based on: Lankelly Chase research applied to Birmingham population
2) Est. 7,100 people in B'ham have one complex need and a mental health issue; based on Lankelly Chase research applied to Birmingham Population

Table 1 – Estimates of MCN (referred to SMD) in Birmingham (source: Hard Edges)

Severe Multiple Disadvantage Category	Rate per 1,000 population		Estimated Numbers of People		
	Birmingham	National Average	Overall	With Mental Health Problems	% with Mental Health Problems
SMD1: Homeless Only	5.3	1.9	3,640	480	13%
SMD1: Offender Only	5.8	4.4	3,950	960	24%
SMD1: Substance Misuse Only	6	5.4	4,070	2,350	58%
SMD2: Offender & Substance Misuse	4.8	3	3,290	1,440	44%
SMD2: Homeless & Substance Misuse	2.8	1.4	1,880	590	31%
SMD2: Homeless & Offender	1.4	0.8	960	340	35%
SMD 3 (Based on Supporting People data)	3.6	1.7	2,450	1,150	47%
SMD 3 (Based on Offender Assessment data)	2.1	1.4	1,410	750	53%
SMD 1-3	29	17.4	19,720	7,110	36%

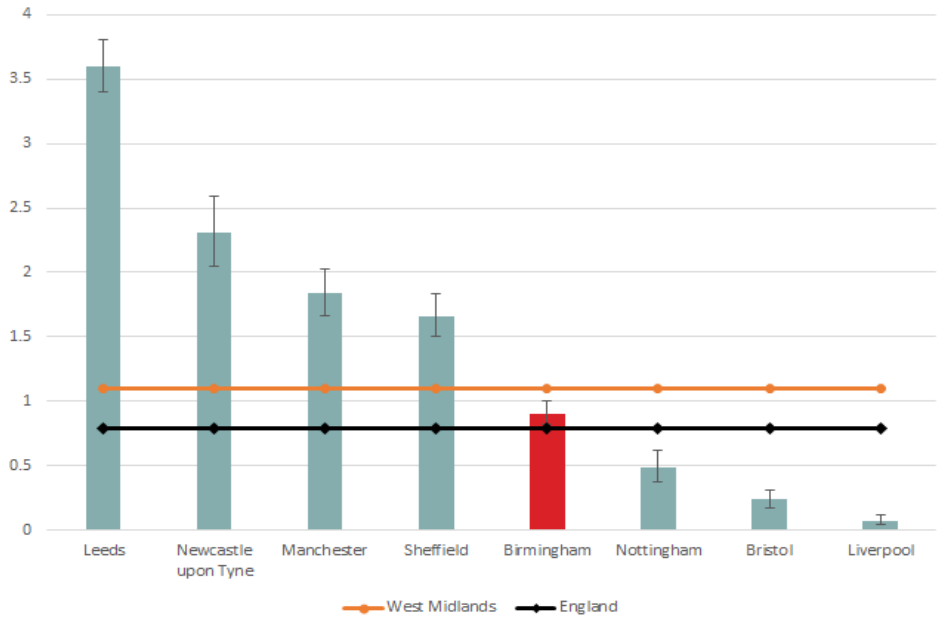
3b. How do we measure locally?

Homelessness

Homeless households often contain some of the most vulnerable people in the city that have higher health and social needs than the general population.
In 2018/19, almost one household in every thousand in the city was not in priority need and therefore not eligible to be housed. Individuals in such households may not present formally to local housing authorities as homeless and having MCN, and as a result have a high risk of rough sleeping and developing associated problems.

The introduction of the Homelessness Reduction Act 2017 provided a further safety net for single homeless who were entitled to have a personal housing plan completed to assist in preventing or relieving their homelessness. The challenge is to create the paradigm shift required to ensure that single homeless with MCN are supported and made aware of their entitlement to receive support around their homelessness when they declare their complex needs. Birmingham has maintained investment in supporting single homeless predominantly through the voluntary and third sector, and the development of the system of joint statutory and third sector support for single homeless is one of the aims of the Birmingham Homelessness Prevention Strategy.

Figure 1 - Statutory homelessness - Eligible homeless people not in priority need 2017/18

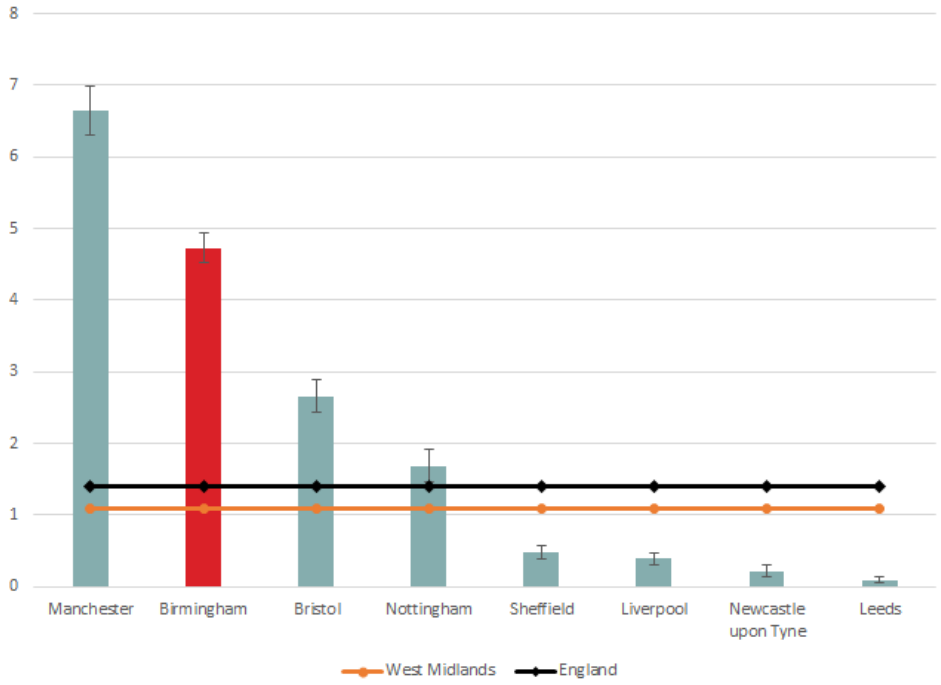


Source: Public Health England[11]

In addition, Birmingham has one of the highest of the core cities number of households in temporary accommodation as a rate per 1,000.

[Insert infographic – 2,058 households in temporary accommodation. source: PHE/Ministry of Housing, Communities & Local Government 2017/18]

Figure 2 Statutory homelessness - households in temporary accommodation (2017/18)



Source: Public Health England & Ministry of Housing, Communities & Local Government[12]

[11] Public Health England. Public Health Profiles. [August 2019] https://fingertips.phe.org.uk © Crown copyright [2019]

[12] Public Health England. Public Health Profiles. [August 2019] https://fingertips.phe.org.uk © Crown copyright [2019]

Between 2009/10 and 2014/15 24,562 persons presented to Birmingham City Council as homeless or at risk of being homeless within the next 8 weeks. The only recording available to indicate whether these persons may have had MCN was the Homeless Priority Reason recorded within their application (it should be noted that only one reason can be recorded and as such this may result in under-recording of additional presenting needs[13]).

The main priority homeless reasons are having dependent children, overall these account for 41% (10,099) of applications.

[Insert infographic: Between 2009-15 over 24,500 persons made a homeless application to Birmingham City Council. 41% of those had dependent children. Source: BCC – Homeless Priority Reason]

Substance misuse accounted for less than 5% of the recorded priority homeless reasons, and mental disability accounted for 4% (970) of the total applications. Again, if these issues are not identified in the homeless applications to the local authority, the individuals are not assessed to have that priority need, and this may result in under-recording of the true prevalence.

Drugs and alcohol are the leading cause of death for people sleeping rough or staying in an emergency accommodation in the city. Between 2013 and 2018 this accounted for 19 deaths[14].

It is worth pointing out that many homeless people may not be visible to the care system. Anawim reported some of their clients who may have not presented as experiencing MCN to the local authority, were using friends' accommodation, or squats.

Substance Misuse

It is estimated that 14 per every 1000 people between ages 15 and 64 in Birmingham are opiate and/ or crack cocaine users.

[Insert infographic – Estimated over 10,500 people aged 15-64 in B'ham are opiate or crack cocaine users; Source: PHE: Public Health Profiles 2016/17]

Opiates refer to heroin and painkillers such as morphine. Around 40% of opiate users are not in treatment and therefore may not have any contact with services. Based on evidence, treatment is completed by around 40% of non-opiate users, but only by 6% of opiate users[15].

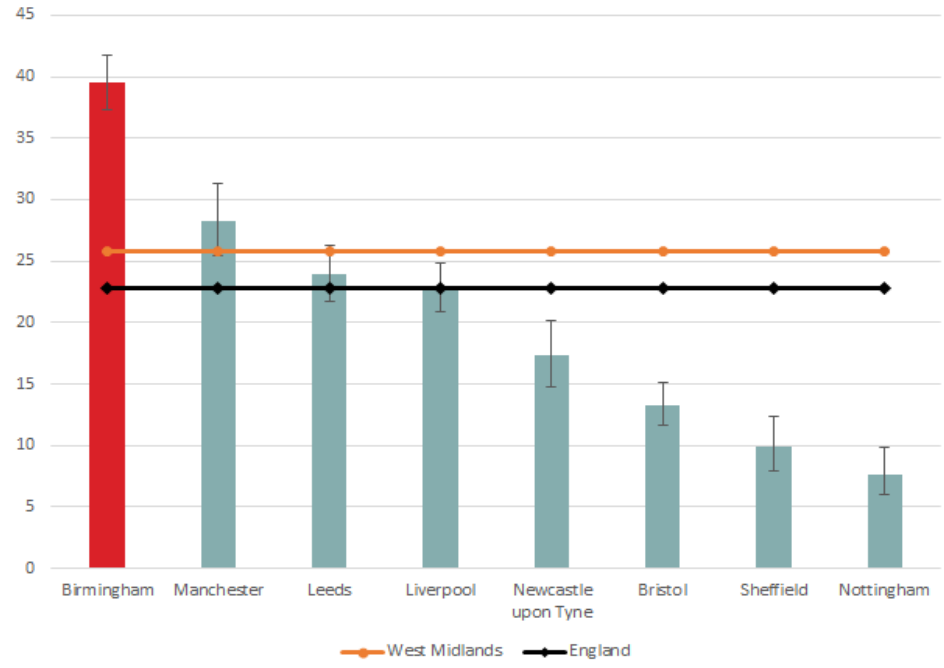
[Insert infographic Around 40% of drug addicts in treatment also receive mental health treatment; Source: PHE/ National Drug Treatment Monitoring System 2016/17]

Around 40% of individuals who entered treatment at a specialist drug misuse service were in receipt of treatment from mental health services for a reason other than substance misuse at the time of assessment which is significantly higher than England, the West Midlands and the other core cities. This may reflect better recording in Birmingham as well as higher prevalence.

[13] Analysis of data recorded by the new HCLIC system, which captures information on those presenting as homeless, needs to be undertaken, as will provide information on wider needs of the homeless population.
[14] ONS - Deaths of homeless people (identified) by underlying cause of death, Birmingham, 2013 to 2018 (bespoke mortality reporting).
[15] Public Health England. Public Health Profiles. [August 2019] https://fingertips.phe.org.uk © Crown copyright [2019]

It is important to note that the prevalence data is only available for opiates and alcohol and it is recognised that substance misuse is much broader and includes other drugs such as cannabis, synthetic cannabinoids, prescription medication, steroids and “club” drugs.

Figure 3 Concurrent contact with mental health services and substance misuse services for drug misuse (%) - 2016/17



Source: Public Health England / National Drug Treatment Monitoring System 2016/17[16]

Alcohol can have equally devastating consequences as drug misuse. There were 25,875 admissions in Birmingham in 2018/19 for alcohol related conditions.

[Insert infographic: 26,000 hospital admissions in B’ham for alcohol related conditions (2017-18); Source: Public Health England]

It is estimated that over 80% of dependent drinkers are not in treatment and only 43% of those entering treatment complete it successfully[17].

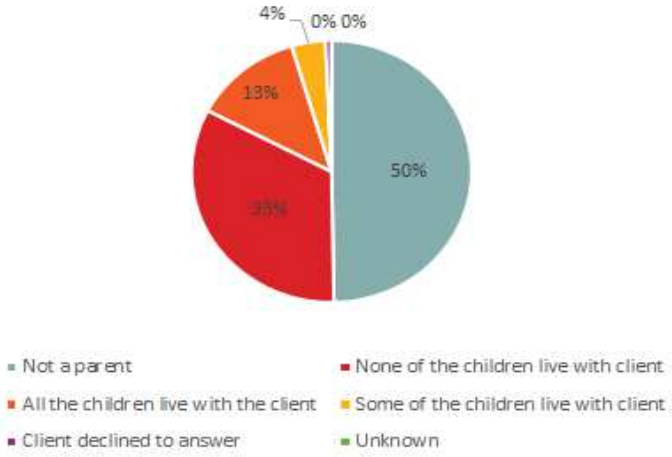
In 2018/19 almost 7,000 assessments were undertaken by the local substance misuse service provider Change Grow Live (CGL). The majority (75%) were for male service users between the ages of 35 and 44 (44%). As a rate per 1,000, the most prevalent ethnic groups were white and mixed (8 per 1,000 for each group). Half of service users did not have children. Of those that had children, the majority did not live with them[18].

Figure 4 – CGL Client Parental Status – 2018/19

[16] Public Health England. Public Health Profiles. [August 2019] https://fingertips.phe.org.uk © Crown copyright [2019]

[17] Public Health England. Public Health Profiles. [August 2019] https://fingertips.phe.org.uk © Crown copyright [2019]

[18] CRiiS, Open Recovery Assessments between 01/04/2018 and 31/03/2019 - data provided by CGL.



In terms of multiple needs, almost 2,000 referrals to CGL came from criminal justice - 35% (may be related to the Criminal Justice System's duty to refer), 19% had housing problems and over a third of people had mental health needs. Though it was not possible to cross-tabulate needs, we can assume that as an absolute minimum around third have at least one need additional to substance misuse problems, though this is likely to be higher. Applying Hard Edges estimates, around 55% would have one additional need (either offending or homelessness).

[insert infographic – 7000 referrals into CGL in 2018/19: 35% from criminal justice, 19% had a housing problem, 34% had mental health issues; Source: CGL]

Mental Health

We know that 1.19% of people in Birmingham have serious mental illness such as schizophrenia, bipolar affective disorder and other psychoses, and 10% are diagnosed with depression.

[Insert 2 infographics: 1) Over 16,000 people (all ages) in Birmingham have serious mental illness; 2) Nearly 100,000 people in Birmingham (18+) have a diagnosis of depression.
Source: QoF- NHS Digital 2018/19]

This only captures those people registered with a GP and with a recorded diagnosis and therefore highlighting again the complexity of capturing data on harder to reach populations such as the homeless and new migrants.

[Insert infographic: Only 64% of adults in contact with secondary mental health services live in stable accommodation in 2018/19 . Source: NHS Digital. Measures from the Adult and Social Care Outcomes Framework]

This is slightly better for females than males and may potentially be linked to family composition or housing eligibility.

In 2018/19 the Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) received 43,337 referrals[19] (including sub-referrals when a patient has been referred to more than one service or team type) for adults aged 18+ living in Birmingham. 51% of

[19] The number of referrals excludes those that were not accepted.

referrals were for female patients and 55% of referrals were for patients from a white ethnic group. The largest groups as a rate were Black/Black British (39 per 1,000) and White/White British (38 per 1,000). 24% of people were 25-34 and 21% were 35-44 years old.

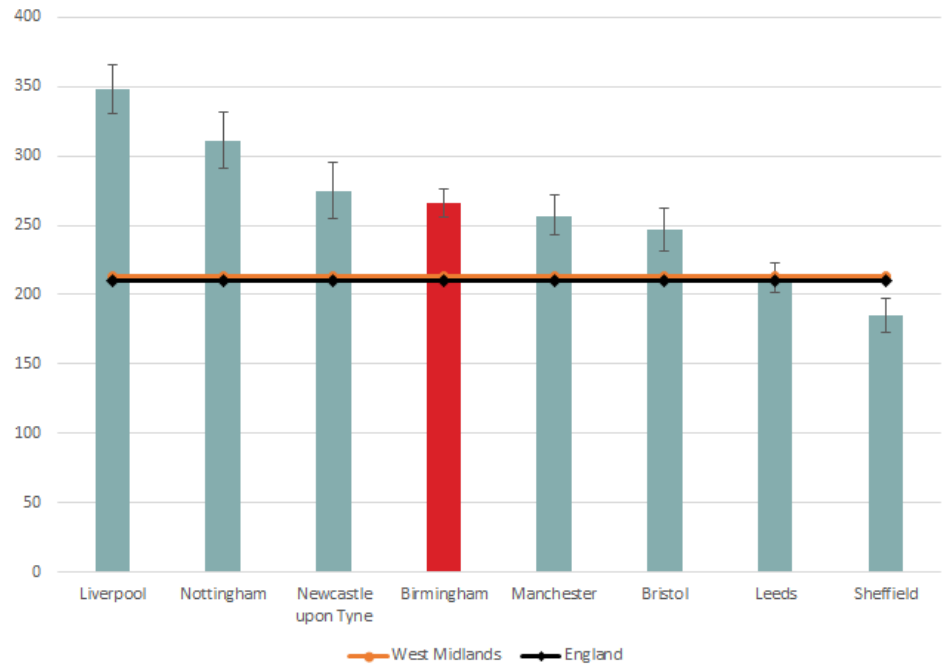
Only around 2% had a recorded substance misuse issue. This has been assessed by commissioners (Adult Social Care and Clinical Commissioning Groups) as very low and a likely underestimation, which may reflect issues with referrals being accepted for clients with dual addiction and mental health diagnosis. Only 3% of BSMHFT patients had a recorded status of non-settled accommodation. It is also important to note there are recognised limitations with data quality in the MHSDS dataset.[20]

Criminal Justice

Offending behaviour is often linked to mental health and substance misuse issues and offenders experience significant health inequalities.

Around 12,000 Offences were recorded in 2017/18 in the city. There were approximately 2,600 first time offenders in 2018 and of all offenders around a third go on to reoffend[21].

Figure 5 Rate of first-time offenders based on recorded (via Police National Computer) crime data per 100,000 population (2018) aged 10+



Source: Public Health England /Ministry of Justice[22]

West Midlands Police estimate that approximately 95% of referrals to the Vulnerability Team received through the online portal were for people with Multiple Complex Needs living in Birmingham. This system captures cases where concerns around the vulnerability of individuals are reported by other departments of the police force or members of the public.

[20] The latest national Data Quality Maturity Index (DQMI) score for MHSDS was 71.9%, hence there are still data quality issues with the dataset.

[21] Public Health England. Public Health Profiles. [August 2019] https://fingertips.phe.org.uk © Crown copyright [2019]

[22] Public Health England. Public Health Profiles. [August 2019] https://fingertips.phe.org.uk © Crown copyright [2019]

This equates to almost 4,950 out of 5,200 referrals in 2019 and does not include incidents reported through alternative referral methods. Data relates to those who gave consent to be referred into a Support based Partner Organisation.

[Insert infographic: 4,950 referrals received through the West Mids. Police online portal in 2019 were for adults with MCN. Source: WMP]

There were 1,185 cases managed by the National Probation Service Birmingham Local Delivery Unit as at 7 January 2020[23]. These consist of offenders in three categories: (a) Community – an individual with Community Order or Suspended Sentence Order; (b) Post-release – offenders on licence; (c) Pre-release – offenders currently in custody.

Of the 1,185 records 36% (421) had a Register Description of Mental Health Issues and/or Mentally Disordered Offender. An additional field indicated that 9% (111) persons were recorded as having No Fixed Abode.

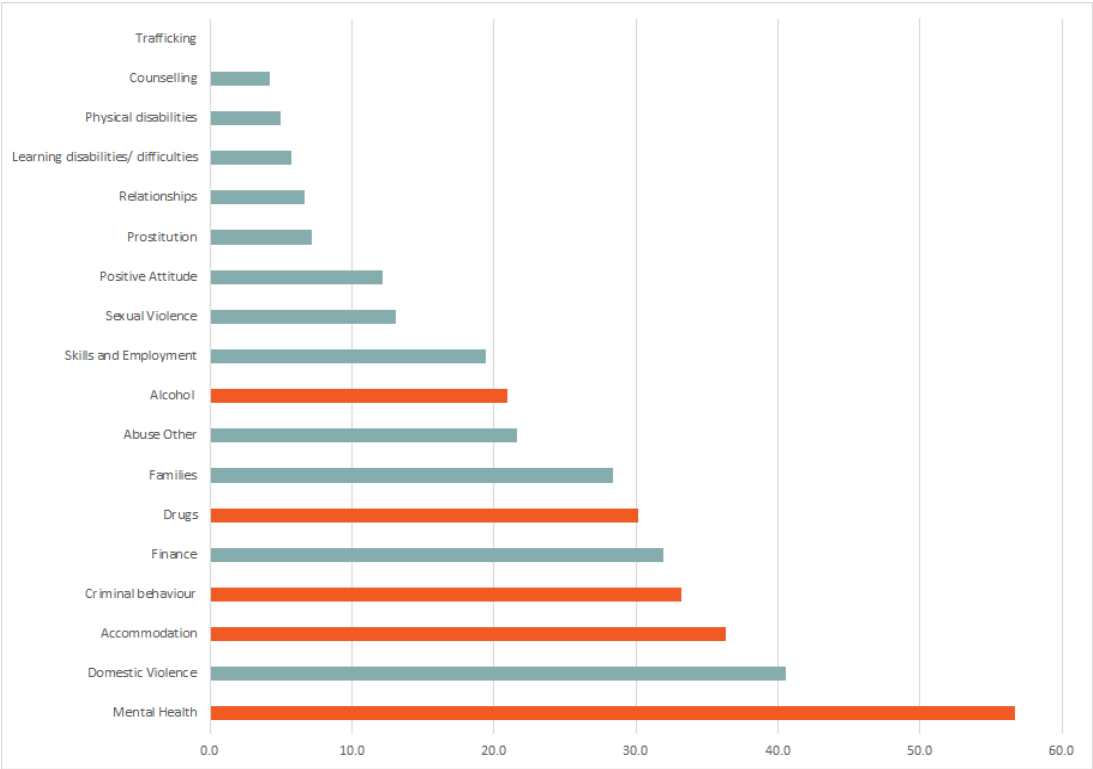
Multiple Complex Needs specific service data

In 2019, Anawim (a third sector organisation providing support to women with MCN) had 1,025 referrals. They estimate that 76% of women referred to their service presented with five needs or more, with 39% presenting with 7-10 needs each. Anawim use more need categories than the standard definition including domestic violence amongst others with the most common need being mental health. Around 42% of their service users have children and around a quarter of those who stated their ethnicity were White British. The majority of Anawim service users were 26-35 (31%) followed by 36-45 years of age (27%)[24].

[insert infographic – 1,025 referrals into Anawim in 2019, 76% of referred women presenting 5 or more complex needs. Source: Anawim]

Figure 6 – Percentage of Service Users by Need – 12 Months to November 2019

[23] Data provided by National Probation Service Birmingham Local Delivery Unit.
[24] Data provided by ANAWIM.



Data provided by the Changing Futures Together Programme run by the Birmingham Voluntary Service Council (BVSC) as part of the national Fulfilling Lives initiative[25] suggests there is a higher level of MCN in Birmingham than anticipated by them originally. It was estimated that 156 of the most entrenched individuals (with three or more of homelessness, problematic substance misuse, reoffending and mental ill health) would receive support from the programme between December 2014 and June 2019. This figure was exceeded in the first 2 years and continues to grow.

2018/19 data from their Lead Worker Peer Mentor Programme (LWPM) which provides a one to one support by a trained mentor with lived experience shows that 130 people accessed the service. Of these 64% of service users were male. The largest proportion of service users were 35 to 44 years old (34%), followed by 25 to 34-year-olds (20%), and majority of service users were of white ethnicity.

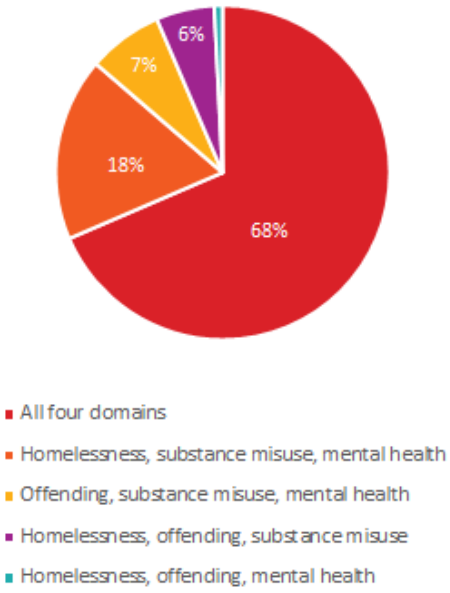
[insert infographic: profile of service users – 64% male, 34% 35 – 44 years old. Source: BVSC – Changing Futures Together]

Changing Futures specifically captures data on need domains. Over two thirds of service users had needs in all four domains. Though this was more common in males than females, with 74% of males having needs in all four areas compared to 57% for females. This suggests a potentially different pattern of need and intervention required for different genders which is supported by published research[26].

[25] Data extract from Birmingham Changing Futures LWPM cost benefit report 2018/19.

[26] Agenda, AVA and Burrow Cadbury Trust (2014), Mapping The Maze: Services for women experiencing multiple disadvantage in England and Wales.

Figure 7 – Birmingham Changing Futures Service Users by Need Category



Hospital Episodes Statistics data collected during an inpatient visit for 2018/19 shows we had 6,845 admissions of Birmingham residents with MCN (classified in this instance as two or more of mental ill health, homelessness or substance misuse recorded in any of the diagnosis fields within the data – offending not being recorded as part of the admission records) out of a total of 391,172 general admissions – which equates to 1.7%. The multiple complex rate has been mostly static over the last 10 years running at a 1.6 or 1.7%. Such recording would in some instances be reliant on the person declaring these diagnoses or them being relevant to the admission in question.

[Insert infographic: Almost 7,000 hospital admissions of patients with MCN in Birmingham in 2018/19. Source: NHS Digital – Hospital Episode Statistics]

4. MEET BEE AND DION

To complement the findings from data analysis and develop a greater understanding of what life of a person experiencing multiple complex needs living in Birmingham looks like, two case studies have been developed using an ethnographic study.

In January 2020, an experienced ethnographer worked with two people in Birmingham who fell into the category of having MCN. Below are the written accounts of that work. The stories have been anonymised as far as is possible whilst retaining the critical features of the places in which the work was carried out. While reading them, it is worth remembering that no individual story need match a macro picture, and that no individual will perfectly reflect statistical trends. Furthermore, ethnographic work like this can yield rich pictures, but also coarse ones. For that we make no apology.

It is also worth remembering that these two accounts, alone, should not be used as evidencing the full extent of a 'system' or of any particular service, or a population of certain kinds of people. In the sense that they rely to some extent on self-reporting, and on self-confessed unreliable witnesses, they should also not be seen as being unfailingly

‘true’. What they are, are honest accounts of a day in the life of two people living and trying to get on, in Birmingham.

Bee, 45 years old

“It’s like they *wish* I was being abused!” “What do you mean?” “It’s like if I was being abused they would know which form to pull out. They don’t want to hear that I’m fine. I’m in a relationship. With a man. And he doesn’t abuse me.” Bee is talking about a women’s outreach centre that she has been attending for years.

But Bee *has* been abused. She has worked in the sex industry where abuse, she says, was the norm: “When other women [who did the work she did] tell me they’ve been raped. I just tell them to get over it. Get on with it. That’s what I did. Move on. It’s normal. You can’t let it get you down.”

The abuse that Bee has suffered isn’t the root cause of all the problems she now faces. It doesn’t dictate all the decisions, good and bad, that she makes. It is a bit part in a life of peaks and troughs; one of many traumas that may one day be properly dealt with, or may not. Bee is also often fierce like this: about other people that can’t keep up with her, about services that she feels don’t properly listen, about the ‘nana heads’ on [the] road, and with herself and her own struggles with addiction and the legacies of bad choices and bad luck.

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Bee drinks. She starts early in the day with a can of beer and then drinks slowly throughout. Sometimes she will be out of her house early, on others she may never leave, spending the day laying on her sofa and watching Netflix. When the weather is cold, she says, there are fewer people out (‘on road’). There’s less going on. Less happening.

Nonetheless, today, cold though it is, she has a doctor’s appointment. “Pills are easy. I always get lots of pills. I have manic dep… [correcting herself] bi-polar. They changed the name, but it’s the same.” The clinic she attends is clean and welcoming, a friendly, if institutional, space. The only sign that this is not an everyday GP’s surgery is the prominent security guard sitting behind a desk at the entrance. The staff are friendly even as Bee barks requests and instructions to them from the back of a short queue. It’s 10 minutes before the start of her appointment: “Am I early? Don’t say I am early. I can’t wait. I can’t wait in here.” Bee is visibly uncomfortable. She sits. Stands. Sits again. The staff say that the doctor won’t be a moment. It’s too much for Bee. She walks out. It’s not the place specifically, she says, it’s all queues. She tells a story about how she had been physically forced to leave a shop only the day before because she looked like she was going to hit someone in a queue. She says she wouldn’t have.

On the way back to her house, she stops to buy a second can of beer from a grocer’s. There is a man standing outside. She knows him. He is impassive as she asks him if he is ok or needs her help. On her way out she gives him enough money to buy a can for himself. He thanks her and goes in behind her. “I used to drink with his brother. I loved him. But he died last year.”

Her home is not far away but she opts to ride the bus. After a stop or two, another woman gets on, close in age to Bee but her clothes are shabby compared to Bee’s ostentatious long-coat and beads, and her mouth is toothless when she smiles, unlike Bee’s confident

grin. They know each other. The new passenger sits on the opposite side of the aisle and loudly recounts lurid tales of a couple, each heroin addicts, that she and Bee both know. Some other passengers turn their heads away pretending not to hear. Bee joins in the banter, but later confides that she seems to attract 'all the crazies' and that the woman on the bus shouldn't be considered a friend. She also, privately, confides that she herself has bit of an addiction problem beyond drink, but to keep this quiet, as the people around her in her life don't know.

Back at her house, Bee introduces her housemates. They drink too. Bee gives them some money for beers and they go out. Bee thinks that one of them sometimes steals from her when she is not there and points to padlocks crudely fixed to her kitchen cupboards. But she also cares for them. She is better with money, and better at avoiding trouble, and this puts her in a slightly authoritative role: "Queen Bee". She tries to settle down when they have gone, but she is antsy. Today is not one of her 'staying in' days. She wants to get back on the street, to 'hustle', and she has a plan to go and see a friend.

The plan is convoluted. Bee has a friend who helps her out. He's older and retired and has time for her. Bee has asked him to come round in his car and to take her to see another friend, Alice, which he happily agrees to. The plan involves going in to a formal place of work, so Bee stashes her fresh beer can under her coat. At the front desk reception, she listens with wide eyes to the directions she is given to find Alice. It quickly becomes apparent that she couldn't take them in and has to ask almost everyone she passes for more directions ("I have such a bad memory you know. I'm not even joking. It was the drugs. Before."). She has to journey through the building in small increments. Eventually she gives up and calls Alice on her phone. Alice emerges from a corridor and rushes over to greet Bee. Bee gives her a £5 note and asks if Alice will cook dinner for her the next day. Alice agrees with a smile and rushes back to work. The whole encounter is over in seconds. And then Bee turns to try and find her way out of the labyrinth, and back to the car that is waiting for her in a no-parking zone…

On the way home, Bee asks to be dropped on the main road instead. She wants to find people. She warns that some of them could be dangerous. Not too long ago she had received a number of death threat letters to her home, though is not sure why, or who they might have been from. In the event, she finds lots of people. The road, a busy shopping street packed with charity shops, takeaway restaurants, cheap supermarkets and newsagents, is full of people that call out to her. None of them are using the shops and services. They are all drinkers, and many are also addicts, she says. They are just moving up and down the street, as if on conveyor belts, finding each other and looking for *opportunities*. Bee exchanges pleasantries, sometimes ostentatiously, sometimes cautiously. But she is looking for another kind of person, someone who might have just got 'paid' in fact. Someone from whom she might be able to call in a favour: a bit of money, or a drink. This is 'hustling'.

Avoiding a pub that she sometimes goes to because there is no one in there she knows she can trust, she moves to find somewhere quieter and emptier. Eventually she tries a bar near the 'drinker's park' ("I know we shouldn't drink in a park. It's for kids isn't it? But then look. What kids would come here? There's no playground or anything. Some nights the whole place is just covered in bottles and cans."). She thinks some of her better acquaintances might come in to the bar on their way there. The staff know her and turn a blind eye to the can of beer she is already carrying. Once in the bar there is little else for

her to do. Bee slumps and waits, but the bar is empty and it's not clear exactly what she is waiting for.

She is also getting tired. The previous night had been disturbed when a 'gang of kids' broke into the house opposite her own. Bee and her housemates suspected that it had been to do with drugs and claimed to have seen this with their own eyes ("The police never even came! They still haven't come." "Did any of you call the police?" "No way!"). Certainly, there was plenty of evidence for what had happened visible to the naked eye, but Bee says that the gangs are dangerous. She points out several places in the streets near her house where they seem to act with impunity and warns not to take pictures. She tells a story of a friend who was stabbed and almost died, 'for nothing', when he was just walking past them on his way home, and then, shockingly, of how she and another friend of hers had recently been car-jacked by some young boys with a machete. The gang had taken the car and left her and her friend shivering with fright in the street.

Despite all of this, Bee insists that her life is not currently at a low ebb. In fact, she has the opportunity to move to a new home, which she will do initially on her own. She has plans to make it how she wants it before inviting anyone else (including her boyfriend) to come and stay with her. She has been desperate to escape from the area she currently lives in ("It's not safe!"), so this chance is a good one. She is also reasonably stable mentally, she says, and has been able to rekindle some relationships with family members, and maintain friendships with people like Alice, who live 'like normal'. She has a plan to kick her more recent drug addiction too and has already told a local service provider about it in order to start this process off ("… but they need to give me respite. I've had it before. It's amazing! I need to be sent away for like a couple of weeks and use, you know, the substitute. To get it together and then get on …").

The troughs were worse. Bee says that she had been good at school, outgoing and reasonably successful, but at 16 had suffered a mental breakdown: "That's when things started going wrong." Since then, she says, she has suffered some 15 or 16 similar breakdowns. Each one has involved significant memory loss, long stays in hospital, and some kind of traumatic consequence. It is the breakdowns, she says, that ruin everything. In the past, such breakdowns have led to her having a child removed from her (and from whom she is now permanently estranged), a trauma from which she says she cannot entirely recover. She has lost housing because of things she has done during breakdowns. And she has lost work (which she would love to get back to, but recognises that this seems a long shot now).

She has also lived on the streets, including a long period living behind some industrial bins with a partner she had met ("having a man can keep you safer you know?"). This relationship kept her out of housing for a long time as she felt she couldn't leave him even when she was offered more permanent accommodation. It also meant that she prolonged an addiction to crack cocaine ("That's bad stuff. I have no memory anymore. I can forget things that have only just happened"). Living on the streets, she says, was the worst time of her life.

This is Bee: peaks and troughs. As the day draws to a close, she reflects on her own personality. Is it a good thing that she is such a character? That everyone knows her? Does that attract trouble? Or does it keep her safe, and give her a network to draw on? Probably both, she decides, but she also knows that it means that every day is unpredictable. Staying at home is safe, but not realistic. And the more she is out, the more

she accumulates colourful pieces in her jigsaw life. Her parting remarks reflect the danger: “You should have visited me in the summer. There is so much more going on then. [She winks] It would have been like an all-day party!”

Dion

Dion is frustrated. He lost his phone a week ago and it is beginning to cause him problems. He has a new phone, but it has a new number, and he has lost his contacts. He explains that he had lent his previous phone to a friend, another homeless man in Birmingham, and had been due to get it back a couple of days later. Unfortunately, the other man had committed a serious crime the very night that Dion had lent him the phone, and had been taken away by the police, with Dion’s phone. Dion didn’t expect to get it back.

Not having his phone means that there are a couple of trips, outside of his usual routine, that he must make. He is dressed for the cold weather: a thick winter jacket, tightly-woven trousers with multiple pockets, a woollen hat, and a good pair of boots. He is in his late 50s, and still physically strong, though his face attests to the ageing properties of too much alcohol and years of living outdoors, and he has underlying health problems that are likely to become more visible in the near future than they are today.

At around the same time that he lost his phone, Dion had managed to secure a bed in a small house run by a registered social landlord. There is a spare room at the house and the landlord has given Dion a week to find someone to fill it before he finds someone else (a potential risk for Dion who has had bad experiences with unexpected housemates in the past). Dion has told a friend about it, but that friend now has the wrong phone number, so Dion must go and find him where he lives in supported housing. Dion describes his friend as a ‘couple of slices short of a loaf’, but he’s also ‘safe’, and Dion has known him a long time.

The building where his friend lives has a reception desk and Dion is told that he can’t go in, and that they can’t tell Dion if his friend is in or out. So, Dion leaves a note with his new phone number and a message asking his friend to call him back or to meet him at his ‘pitch’.

His ‘pitch’ is the place where Dion stands to sell copies of the Big Issue magazine. It’s in the centre of Birmingham, in a good spot. The walk from the dilapidated supported accommodation building and Big Issue distribution office to the centre of the city is marked by a jarring shift in wealth and affluence with each road crossed. Dion’s demeanour changes as he transitions from safe anonymity in one, to interloper in another. As soon as he approaches the city centre, Dion becomes animated and witty. He needs to be a cheery vendor working the crowds to entice a sale. He has a ready quip for almost every passer-by, some are stock (“Buy a Big Issue? No? A small one for half the price?”) others are off-the-cuff. Dion is alcoholic but describes himself as a friendly and mellow drunk (“I get funnier throughout the day.”).

At his pitch, it is clear that Dion occupies the space in a different way to the shoppers and business people passing by. Whilst most offer smiles as Dion offers his magazines, or chat on phones and in groups whilst on the move, Dion’s world is more permanent. A constant cast of characters who also live on the streets come past. They all know Dion and Dion

knows them all. One man comes by struggling with crutches and a cast. Another man, bare-chested despite the cold, and with a constant patter about Scottish football clubs, stands and talks at Dion for 10 minutes. A young girl with a hooded jacket tight round her face and carrying a massive backpack trudges up. Dion offers a wave and a smile and explains that she is only recently arrived, homeless and from London ("She needs help now or she'll get stuck."). A street musician whom Dion likes comes over to see how he is doing. Dion offers the spare room in his house to the man (in case his other friend never gets his note), and this prompts a flurry of phone calls to the landlord, but it won't work because the musician does not have the security of a state provided income. And finally, a man and a woman with some news. They know where Dion's phone is. The friend he had lent it to hadn't taken it with him to the police station. Dion can go and collect it from the woman's mother's house later that day. It was a complicated story.

All the while Dion breaks up the time with trips away from the busy shopping street (first carefully removing his red Big Issue bib), down side alleys or behind bins for a piss ("The shops often don't let me in"), or to take a drink from a bottle of vodka that he has secreted in one of his deep jacket pockets. At 3 o'clock Dion can also make a trip to a nearby food van where they will give him a free sandwich. He had once gone to them at the end of a long cold day around Christmas and had begged for some food, and they had taken pity. Now it's a regular thing. For the most part however, Dion does not eat in the day ("It gets in the way of my drinking"), which is strange, he reflects, since he is a fully trained chef.

When he was young, still a teenager, Dion had joined the army as a way of getting out of a rough South London life. He served two tours. He doesn't want to recall everything he did or what it was like, but he is clear that the time left him scarred mentally ("How can anybody see those things and be ok?"). When he left, he determined to do something different and studied catering at a college in the North of England, during which time he met a woman with whom he had a child. When she was still young however, he says that out of the blue he was sent a letter by a lawyer saying that his girlfriend and daughter had left him and never wanted to see him again. It pains him now to recount this, and tears are visible as he says definitively that his life fell apart that day. In retrospect, of course, he had already faced a great many difficulties before then: violence on the streets of London, a children's home, active duty in the army, and of course, drinking had already become a habit. But on that day, he says, he suffered a breakdown. He doesn't remember exactly what happened, but he woke up in hospital a week later, and has taken prescribed medication to pacify and calm his mind ever since.

From then on, he says, he used the skills that the army taught him to survive. He claims to have travelled all over Europe, taking jobs in restaurants or living wild in forests whilst taking odd building jobs. Sure enough, he demonstrates that he is near fluent in Italian and can get by in German. He is proud, he says, that he can live anywhere. He can build shelters, skin animals, make a fire ("Survival. That's what I am good at. As long as I have a mission. And I have one right now!" "What is your mission?" "Survival!"). This is not to say that he always made good choices of course. He met another woman, and had another child, but he no longer knows where they are. He spent time in prison after getting caught up in the midst of some deals that went wrong and that had turned violent. And all of the time, he was drinking.

When he came back to England, he reunited with family, from whom he was long 'ex-communicated', and who now lived in the North of England. But the relationships broke down acrimoniously, and he was soon on the streets again. He says that he has since

slept in every doorway, carpark and alley that homeless people sleep in, along with finding beds in “every proverbial shithole that some people call ‘housing’”. That’s how he knows everybody on the streets.

But he is beginning to feel his age. His body is slowing down. In fact, his body is *breaking* down. He missed his last doctor’s appointment that was arranged for him at the Homeless Men’s Health Exchange, but he knows there is something seriously wrong. He has lost strength in one of his arms, and he shakes involuntarily. He rejects help though insisting that he has the skills to look after himself, and besides, he says, he can’t handle structure. “You mean like AA? No way. I don’t like that. Meetings. God. And anyway, I don’t want to stop.” “Veterans stuff? Yeah, they have offered me help now and then. But there’s too many rules. I don’t need that. I know how to survive.” “Even the Big Issue is a bit like that. So many rules. But at least I can make some money.”

Today, he says, is “like Groundhog Day … but not in a bad way. I get up, have my ‘breakfast’ [beer], maybe go and get some Big Issues if I have run out. Make some money – I can survive on a tenner – then go to Tesco, buy some food, my vodka – it calms my mind – and something for ‘breakfast’ – then start it all again.” The vodka, he says, calms his mind enough to leave the house: “Without it, I wouldn’t leave. The medication makes me confused and forget things. But the vodka gets me out of the house and I need to get out to get the money.” He also tops up with his income from ESA, which he has recently used to buy a computer. The landlord has also agreed to provide internet in the house. And this is important, because with his contacts back and an internet connection, he can get back in contact with his mother. His mother lives separately from the rest of his family, but also far away from Birmingham. She is old, and confused, he says, and probably doesn’t have long to live. But he wants to speak to her still, until she dies.

As he leaves, Dion reminds me “I’m sorted now. I have a good landlord. A house. I am getting the internet. I can survive.” He has been in this new situation for ten days.

5. WHAT MATTERS

Whilst the ethnographic study highlights the uniqueness of the life journey, experiences and choices of each of the individuals experiencing MCN, focus group discussions with those with lived experience as well as front-line practitioners helped us develop an understanding of the feelings and perceptions that are frequently reported or may be common to the most vulnerable people in the city. Below is a summary of what, in general, matters most to people with MCN, particularly when it comes to accessing support.

5a. What people with multiple complex needs think

“The easiest thing to give in my opinion is love and care, but it’s the hardest thing that they find.” (Anawim service user about statutory sector provision) [this speech bubble at the top – distinguished from others]

“I will pick the phone up to ring to put a complaint in about housing or mental health or even just to access some help with it. And they just read a script, there is no humanity there anymore.”

“In the mental health now, a few do care. But the majority of them, it’s just, onto the next one, onto the next one. No understanding, no compassion, none of it.”

“If we could see people when they are younger and help them and explain things to them because we have been through it and we have got understanding, I think they might not get to where we are now. They might be helped before they get to this age.”

“Yeah so every time it’s been a huge amount of time. But it’s priceless. It’s 24-26 weeks whereas I think now, the way they treat you, you get six weeks mate. If you’re lucky I will give you an extra three. If you’re lucky, you know what I mean? And you better be fixed by then, get back to work.”

[Quotes in speech bubbles coming from a group of people in the middle etc.]

To develop a good understanding of what really matters to individuals experiencing multiple complex needs to be able to transform their lives and what the common drivers for the inequality they face are, we talked to them through a series of focus groups. Here is what they value most when it comes to contact with services:

- Understanding, compassion and humanity from professionals responding to requests for help or providing support;
- “Personal touch” when providing support, such as a follow up letter or telephone call;
- Opportunity to build trust and relationships with key workers to be able to fully engage with treatment and therapy without the fear of the possibility of being abandoned or let down later;
- Tenacity of professionals who will persistently encourage engagement with services and offer support all the way through;
- Being seen or provided support immediately or shortly after a referral, so that the window of opportunity is not missed, and the daily chaos does not hinder the chance to transform their lives;
- Prevention and early intervention, starting from early childhood when neglect, abandonment and abuse are first being experienced;
- Same easy access to support regardless of age, gender, disability or family circumstances (I.e. marital status and dependents);
- Knowledge of where to find appropriate services and support;
- Continuity of key worker;
- Time to recover before support is abruptly ended when it reaches the maximum target time;
- Peer support throughout the journey.

5b. What professionals think

There is a strong perception amongst the professionals that the escalation of complex needs is associated with limited, insufficient or no access to welfare support. We chose to interview a group of job centre front-line staff from across Birmingham who, according to the latest state of welfare reports produced by the Department of Work and Pensions (DWP), routinely come into contact and support individuals with multiple complex needs, many of whom are single and without dependents with them.

“We get a lot of homeless people, people which are in supported accommodation. Majority of those tend to be ex-offenders, things like that. So, if there are single people with children then they are usually not with the parents that we see.” [speech bubble]

Here are the things that the practitioners stated they believed were of the greatest importance for their clients who experience multiple complex needs:

- Stable and safe environment (I.e. being away from the relatives and networks who had previously a negative impact on their lives, or caused harm);
- Stable and suitable accommodation (e.g. appropriate support, guidance, presence of support workers in supported accommodation);
- Presence of role models or mentors who genuinely have the best interest of the individual seeking support at heart;
- Front-line staff being appropriately trained to be able to provide support more effectively;
- Trust to encourage engagement with the service followed by the service being able to provide the help required for the duration that is needed in order to secure the long term best possible outcome;
- Planned upstream provision for those at risk of having multiple complex needs or their escalation, e.g. planned prison releases into appropriate accommodation and/ or treatment;
- Communication and robust handovers between services and organisations for wrap around seamless support;
- Multi-agency working and co-location of services for easy access and timely provision.

"That is the critical issue. The type of housing. If they are in a more stable environment a lot of this wouldn't be able to happen. They would be safer and less exposed to the wrong kind of people."

"You'll find a lot of these landlords take up these properties just so they can take the vulnerable people in and go mishap with them" (about unregulated supported accommodation).

"We keep using the word supported accommodation, but it is only supported financially, there is no such thing as workers and guidance."

"In an ideal world, they should be some sort of plan where we are moving you to this cos you've just come out of prison or you were homeless, this is our plan with you over the next 6 months. We are going to do this in a phased way and if you meet these criteria we are going to do (next phase), there is none of that. So, you're asking people to fix multiple aspects of their life in one go. It is too much for anyone, no one can do that."

"It's important that we have more access to each other's services at the right level, so we know where one finishes and the next one starts."

[Quotes in speech bubbles with a group of professionals in the middle]

6. WHAT WORKS

Successful interventions save the public purse significant sums:

"The research identified three broad categories of experience in women with multiple needs using the women's centres[27], with varying levels of support need. The model shows that a successful intervention, costing between £1,151 and £2,302 per woman per year can save the public purse between £47,000 and £264,000 per woman over five years, depending upon the level of support needed" (Revolving Doors Agency, 2011).

Below is a compilation of best practice when working with people with complex needs based on available research literature and evaluation of local, national and international initiatives.

The National Institute for Health and Care Excellence (NICE) recommends that people with mental illness and substance misuse problems should not be excluded from secondary mental health services because of their substance misuse, and should have a coordinator to support with social care, housing, physical and mental health needs, as well as their substance misuse problems[28]. In addition, there is a need for effective identification, assessment, coordination and delivery of care for all people with a mental health problem in contact with the criminal justice system, including those on probation[29].

The Advisory Council on the Misuse of Drugs[30] provided advice to the government on the factors that make the homeless population vulnerable to substance misuse harms and how these can reduce. It recommended amongst others that:

1. Housing policies, strategies and plans should specifically address the needs of people who use drugs and are experiencing homelessness.

2. Services at a local level must be tailored to meet the specific needs of substance users who are currently experiencing, or have recently experienced, homelessness and need to consider people who are experiencing multiple and complex needs.

3. Substance use, mental health and homelessness services should use evidence-based approaches such as integrated and targeted services, outreach, and peer mentors to engage and retain homeless people in proven treatments such as opiate substitution treatment.

The guidelines above are incorporated into the Birmingham Homelessness Prevention Strategy and the commissioning strategies for substance misuse. Dual diagnosis services have also been established, but there are still challenges to be addressed in order to ensure their full capability.

Research generated by the third sector organisations working with people with MCN focuses more on the individual experiences of those with MCN and best approaches to their recovery and transforming their complex lives, and sets out 10 principles for effective services[31]. They also reflect findings from many evaluations of national and local schemes, such as Anawim and Changing Futures Together.

[27] Centres or hubs where support was provided specifically to women experiencing complex needs that were subject of the study carried out by the Revolving Doors Agency in 2011 - Counting the Cost – Findings from women-specific Financial Analysis model.
[28] National Institute for Health and Care Excellence (2016), Coexisting severe mental illness and substance misuse: community health and social care services. NICE guideline [NG58].
[29] NICE (2017), Mental health of adults in contact with the criminal justice system guideline [NG66].
[30] Advisory Council on the Misuse of Drugs (2019), Drug-related Harms in Homeless Populations.
[31] These principles are based on a combination of desistance and recovery theory as well as Revolving Doors Agency's research: Comprehensive Services for Complex Needs: A summary of the evidence, Adding Value? Reflections on payment by results for people with multiple complex needs.

Here are the 10 principles[32] for effective complex needs services:

11. **'Someone on your side'**: Opportunity to build consistent, positive and trusting relationships.
12. **Assertive and persistent**: An assertive and persistent approach to engagement that does not give up on people. Continuous and consistent support over a prolonged period, responding positively and constructively to setbacks.
13. **Tailored**: A personalised approach which addresses the full gambit of an individuals' needs and is culturally sensitive to particular needs of specific groups including women, people of black and minority ethnic backgrounds and young adults.
14. **Building on strengths**: Supports the client to recognise and develop personal strengths, recognising more than a 'bundle of needs and problems'.
15. **Coordinated and seamless**: Understands and links with other services, pulls services together around the client, helps clients to access and coordinate support through brokerage and advocacy. Ensures continuous support across key transitions, avoiding gaps in care.
16. **Flexible and responsive**: Flexible approach to support and an ability to react quickly in a crisis.
17. '**No wrong door**': If a service cannot provide support, they take responsibility for connecting the client with someone who can.
18. **Trauma informed**: Understands the emotional and behavioural impact of traumatic childhood and life experiences on clients and vicarious trauma on staff, avoids re-traumatisation, facilitates reflective practice, builds resilience and supports recovery.
19. **Co-produced**: Designed in partnership with service users.
20. **Strategically supported**: Has the buy-in of senior, strategic stakeholders and is adequately resourced.

Research on multiple complex needs is wide in scope and much of the published evidence comes from evaluations of specific interventions, or research around the benefits of prevention and early intervention. There are several approaches and models, which, through evaluation and review, seem to be showing positive results[33].

Prevention and early intervention

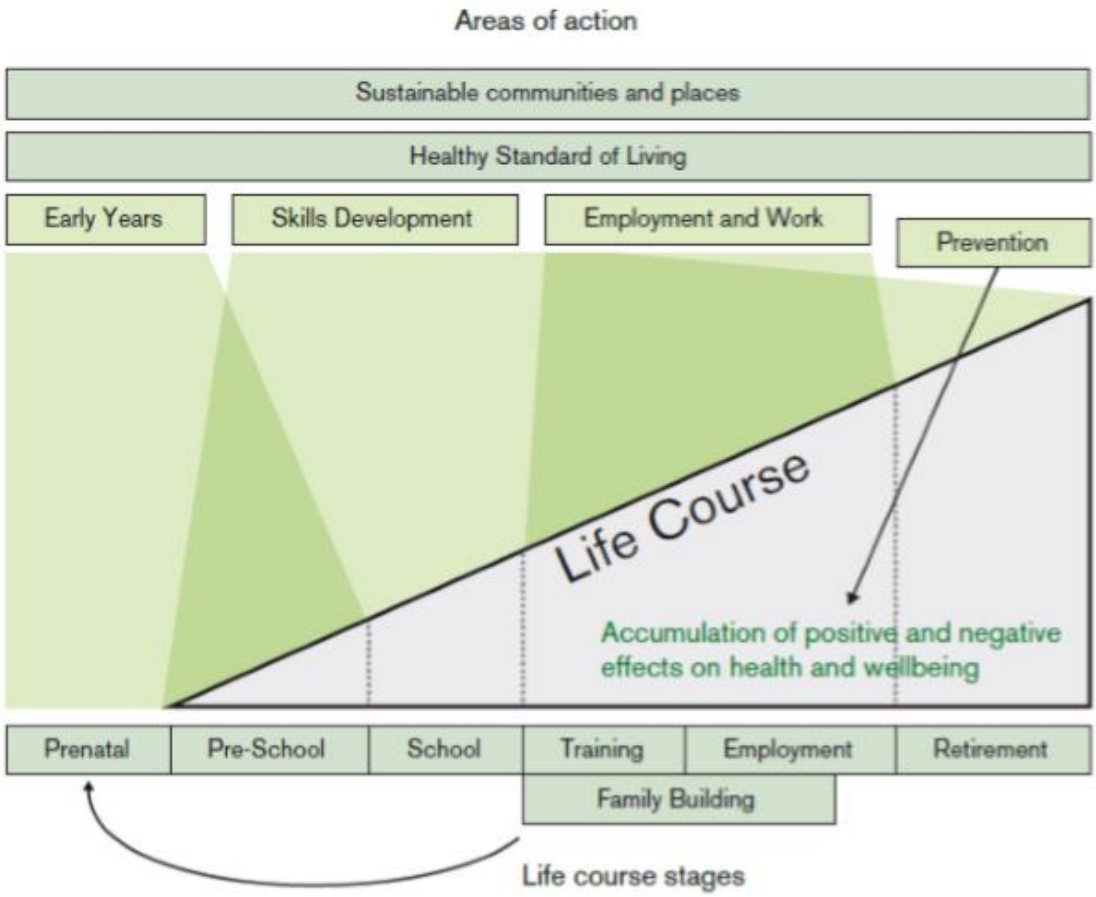
"Why should you have to get to the rock bottom before someone comes in? if they catch you then, then you won't hit there." *Focus group participant* [speech bubbles]
"Effective early intervention works to prevent problems occurring, or to tackle them head-on when they do, before problems get worse. It also helps to foster a whole set of personal strengths and skills that prepare a child for adult life. We have a good understanding of the risk actors that can threaten children's development, limit future social and economic opportunities, and increase the likelihood of mental and physical health problems, criminal involvement, substance misuse, or exploitation or abuse in later life." (Early Intervention Foundation)

[32] http://www.russellwebster.com/10-principles-for-working-with-people-with-complex-needs/
[33] *Revolving Doors Agency (2015), Comprehensive services for complex needs: assessing the evidence for three approaches.*

Figure 9. Factors impacting on child's life (Early Intervention Foundation)

Adverse childhood experiences (ACEs) are an indicator of the child being at risk of developing multiple complex needs later in life, if not supported effectively. These risk factors cannot tell us exactly which child or young person will need help, but they can help us identify children who are vulnerable and who may need extra support. Studies show that early intervention works best when it is made available based on pre-identified risks.

This links with Prof. Michael Marmot's Life Course Approach to tackling health inequalities through prevention.



Source: Fair Society, Healthy Lives. The Marmot review. Strategic Review of Health Inequalities in England post-2010.

Social isolation is also one of the risk factors that may lead to the escalation of need and developing MCN. The new Marmot Review highlights the huge impact it has on people declining. In some cases, **reduction of social isolation** could prevent complex needs.

Not all complex needs can be prevented, but there are interventions and approaches that can be put in place to prevent their escalation and crisis. Those, for example, include:

- **Multisystemic Therapy**[34] - an intensive psychological treatment programme which takes place in the family home. Therapists work closely with young people and their families to address the different areas which influence behaviour.

- **Wraparound**[35] - a process of co-ordinating professional and community-based support for young people, underpinned by a focus on family strengths and the 'voice and choice' of young people and their families.

- **Comprehensive leaving care plans and interventions** for young people, including life skills training and preparedness for independent living and adulthood, starting well in advance of leaving care. One of many such interventions is f the

[34] Revolving Doors Agency (2015), Comprehensive Services for Complex Needs: A summary of evidence.
[35] Revolving Doors Agency (2015), Comprehensive Services for Complex Needs: A summary of evidence.

House Project[36], but there are other opportunities much earlier on in the child's journey through care.

- **Support for veterans** experiencing complex needs, such as substance misuse, post-traumatic stress, family breakdown, right from the start of leaving service or medical care through fast-tracking into appropriate local services and support.

- **Planned prison releases** where a **coordinated plan and care** are established and available from the moment of release. For example, the Through the Gate Resettlement Service being provided by the Probation Service theoretically is such intervention, but we know from evaluations that all service objectives are being met appropriately across the country[37]. An improved model is being introduced by the Community Rehabilitation Company operating in Birmingham.

- **Planned hospital discharge** where a coordinated plan and care are in place and available from the moment of discharge. Birmingham's Adult Social Care commissioners are exploring a partnership pilot including a multi-disciplinary team within the University Hospitals Birmingham (UHB) with a plan to replicate within the Sandwell and West Birmingham NHS Trust in a trial to ensure that nobody is discharged into homelessness.

Recovery and transformation

Many people with MCN struggle to recover and transform their lives through support from mainstream services. They may be excluded for disruptive behaviour or they do not meet rigid and complicated thresholds for access. This means they often disengage and come into contact with the system at crisis point, and so repeatedly attend A&E or end up in custody. Many are repeatedly imprisoned for short periods of time; many are unable to sustain stable housing and end up homeless. Families with complex needs and a chaotic environment often have their children taken into care.

Here is a list of those interventions that have proved to be effective when it comes to recovery and transformation:

- **Lead or Link Workers and Service Navigators.** The model aims to provide support from a worker to help people who are not receiving the support they need, through linking them in with services, providing advocacy and emotional support, providing consistency and stability. The evidence base is limited and largely from consultancy evaluations such as Fulfilling Lives and Revolving Doors and is for the most part qualitative. However, evaluations show promising results in terms of outcomes for service users such as reductions in hospital admissions and criminal behaviour.

- **Peer mentoring** is a form of mentorship between a person who has lived through a specific experience and a person who is relatively new to that experience. Peer mentors can be role models to show that change is possible. The peer mentor role also provides positive development and opportunity for the mentors themselves.

[36] https://thehouseproject.org/a-local-house-project/
[37] https://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2016/09/Through-the-Gate.pdf

Evidence behind the effectiveness of peer mentoring specifically for MCN is still emerging. This type of model has an RCT evidence base in other support areas such as HIV, substance misuse and parenting. However, local evaluations show the value of this type of support in transforming people's lives and securing longer term outcomes.

- **Psychologically informed / trauma informed environments** are services where the day-to-day running has been designed around psychological theory or grounded in complete understanding of the effects of trauma exposure, considering the psychological and emotional needs of people with vulnerabilities and trauma history. There is an absence of RCT evidence though findings from the Liverpool Wavers of Hope service indicates that their psychologically informed accommodation service had a much higher rate of successful move-on (93 per cent) compared to general accommodation services.[38]

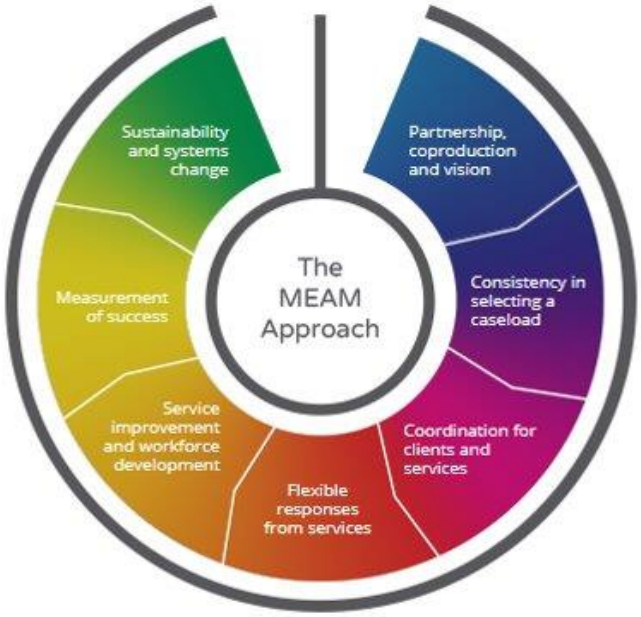
- **Housing First** is designed to help people who need a home, but also need extra help to address their complex needs. The model is intended to provide suitable housing solutions quickly to those in need and crucially is not conditional on abstinence from alcohol or drugs. There are established Housing First projects in North America and Scandinavia, but the model is relatively new in the UK and has been promoted by the Government through the national Rough Sleeping Strategy 2018. This approach has been quite successful abroad and there are a number of evaluations available to support this. The evidence in the UK is still limited, however it is being reported that people in the Housing First intervention groups experience significantly fewer episodes of hospitalisation and shorter hospital stays are more likely to remain housed at 18-24 months compared to the rest of the population experiencing rough sleeping.

- **Coordination and integration.** The Making Every Adult Matter (MEAM) coalition supported three pilots in Cambridgeshire, Derby and Somerset in 2011 to coordinate and integrate the delivery of existing local services for people facing multiple complex needs and exclusions. Each pilot area employed a coordinator to engage with clients and ensure the best possible route through services, for example by helping clients to gain access to housing, treatment for substance misuse, or mental health assessments in a timely manner that best works for the client to sustain their recovery. The findings [39] showed statistically significant improvements in wellbeing for nearly all clients across all quantitative measures (The NDT Assessment, The Warwick-Edinburgh Mental Well-Being Scale, The Outcomes Star). Some of the associated costs to local services decreased in the first year of the pilot. Cambridgeshire saw a 31% reduction in crime costs (£100,000 or 31 percent). Other services experienced a temporary surge in usage as access to them has been enabled through the coordinators.

[38] Liverpool Waves of Hope (2017), Accommodation Based Service: Lessons from a Psychologically Informed Approach.
[39] Battrick, Hilbery, Holloway (2013), Findings from the Making Every Adult Matter (MEAM) service pilots: a summary paper. Advances in Dual Diagnosis. May 2013 17;6(2):66-75.).

The MEAM Approach helps local areas design and deliver better coordinated services for people experiencing multiple disadvantage. It's currently being used by partnerships of statutory and voluntary agencies in 27 local areas across England.

MEAM Approach areas consider seven principles, which they adapt to local needs and circumstances. We provide hands-on support to the local partnerships as part of this process.

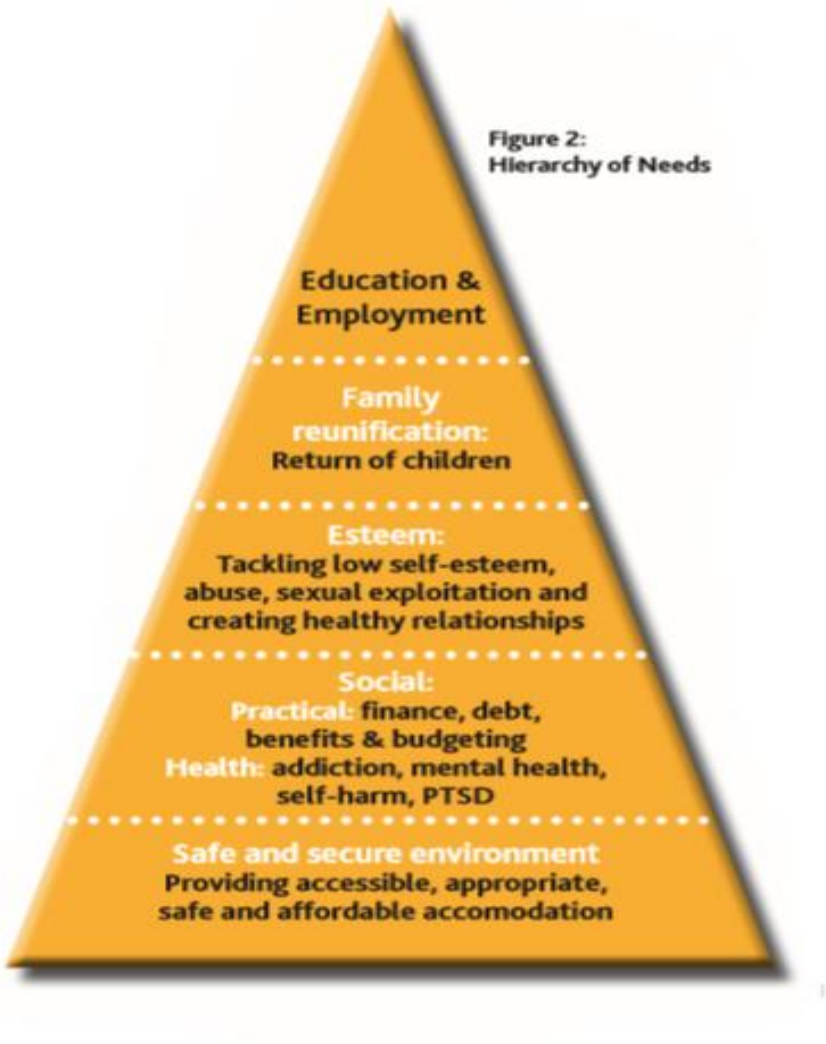


- **Bespoke person-centred solutions.** Fulfilling Lives is a national £112 million investment over 8 years via the Big Lottery Community Fund supporting people who are experiencing some of the most entrenched multiple and complex needs. It funds voluntary sector-led partnerships in12 areas of England, of which Birmingham's Changing Futures is one. They are working to provide person-centered and coordinated services for people with MCN, engaging individuals who are not currently engaged with services and are routinely excluded from other support. An independent evaluation of 12 of the Fulfilling Lives partnerships carried out by CFE Research and the University of Sheffield showed that up to the end of September 2017, almost 3,000 people had used the programme of which a large number were found to have at least three of the four needs (95 per cent) and just over half (51 per cent) had all four. Individuals who remained engaged with the programme for approximately two years showed a clear reduction in risk and need though people with the most complex needs may require extended periods of engagement with services (12 months or more) in order to build trust[40].

- **A stepped approach to addressing complex needs** which locally has been used by Anawim, has proved to be effective when addressing multiple complex needs of women. It is based on the Maslow's theory of the Hierarchy of Needs and demonstrates how safe and secure accommodation facilitates the process of engagement with services and that it is crucial before a woman is able to address her health and social needs[41]. We also know that being able to make own choices and being in control of our lives has a positive impact on recovery, so access to accommodation in itself may not be lead to addressing MCN, but access to suitable accommodation of **choice** may be more helpful.

[40] CFE Research (2017), Fulfilling Lives: supporting people with multiple needs. Annual report 2017 - Key insights from the past year.
[41] McDonald et al (2014), Women with Multiple Needs: Breaking the Cycle- Summary Report.

[Reproduce the diagram]



7. WHAT'S ON OFFER

7a. Local strategies and approaches

[images of front pages/ logos of the local strategies and approaches with an image of a person in the middle]

Below is a list of key local strategies and approaches developed to address specific complex needs of the most vulnerable residents of Birmingham. Those stem from, are linked to, or complement the sub-regional and regional work being undertaken by:

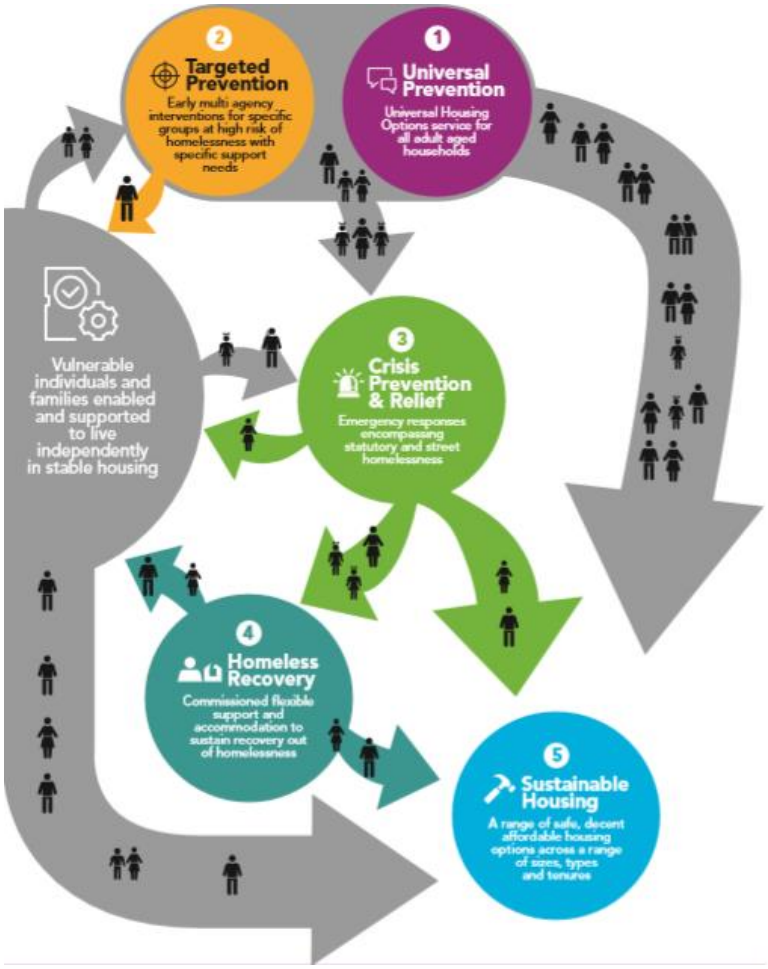
- The West Midlands Combined Authority's Homelessness Taskforce
- The West Midlands Combined Authority's Public Sector Reform Board
- The Birmingham and Solihull Sustainability and Transformation Partnership
- The Black Country and West Birmingham Sustainability and Transformation Partnership and other.

Birmingham Homelessness Prevention Strategy 2017+

This multi-sector multi-agency strategy focuses on preventing people from becoming homeless in the first place and supporting those who are homeless to build a more positive future in good health, sustainable accommodation and long-lasting employment. It aims to

do so by implementing a robust pathway from prevention, through early intervention to recovery.

[The Positive Pathway image]



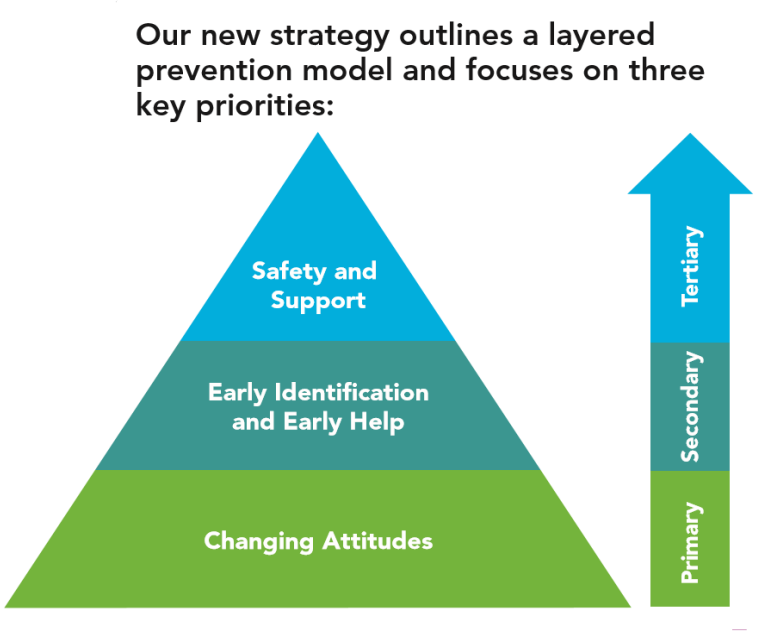
Birmingham Domestic Abuse Prevention Strategy 2018-2023

In 2017 domestic abuse was the second highest reason for homelessness in Birmingham. Whilst 90% of victims who applied for housing as homeless were accepted, only 32% of women and children seeking refuge in an emergency were able to access accommodation. The impact of domestic abuse on the mental health of victims, including children is severe; dealing emotionally with the abuse and trauma they have experienced often results in depression, anxiety and post-traumatic stress disorders. Women experiencing significant domestic abuse are more than twice as likely to have an alcohol problem and eight times more likely to be drug dependent than others. Children being exposed to or witnessing domestic abuse experience it, too. So, they too need appropriate support to prevent them developing MCN in the future.

For perpetrators of domestic abuse that are held accountable through the justice system, the resulting impacts can be of the breakdown of family connections and often wider diminishing community networks of support as well as the ending of relationships and loss of a place to live in. These in combination can result in a spiralling complexity of health, financial and social decline and disadvantage; leading to multiple complex needs, i.e. poor mental & physical health, having no fixed abode, rough sleeping.

Therefore, the Birmingham Domestic Abuse Prevention Strategy focuses on adults (predominantly women), children and young people experiencing domestic abuse, children that are exposed to or witness domestic abuse as well as domestic abuse perpetrators.

[Insert a proper image of the prevention triangle]



Birmingham Armed Forces Community Covenant

In Birmingham there are an estimated 93,000[42] veterans, many of whom are at risk or experiencing multiple complex needs, including mental health issues which are often associated with service- related trauma and may lead to substance misuse and homelessness.

The Council and many partner organisations are signatories to the Armed Forces Community Covenant which sets out a commitment to support veterans and presents an opportunity to specifically focus on complex issues affecting their lives.

It is important to note that very few ex armed forces personnel in Birmingham are amongst the known service users with MCN. Also, service user experience suggests that many of the existing support agencies for veterans struggle to deal with MCN and the support available focuses mainly on immediate discharge form service.

Creating a Mentally Healthy City

The Birmingham Health and Wellbeing Board created a sub-forum that focuses specifically on mental health and wellbeing. The forum is a partnership of strategic stakeholders who are committed to making Birmingham a Mentally Healthy City. There is ongoing work to improve access to Mental Health services for the most vulnerable and disadvantaged groups through the Joint Strategic Needs Assessment work and our recent Suicide Prevention Strategy, as well as emerging work towards Creating a City without Inequalities. There is a commitment to develop a comprehensive public health approach aimed at reducing the burden and impact of mental ill health and to measure our achievement in reaching disadvantaged and vulnerable people and effectiveness of work

[42] 2011 Census estimate (ONS).

with these communities; such as those from Black and Minority Ethnic groups (African, Caribbean, South Asian, Chinese; Polish and Eastern Europeans); people that identify as LGBT; other migrant groups; and people that are homeless.

Birmingham Suicide Prevention Strategy 2019-2024

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

Individuals experiencing MCN are at a higher risk of suicide. Preventing or tackling MCN leads to preventing suicide deaths.

7b. Local services

There is a wide range of services, both statutory and non-statutory, and support available in Birmingham for those experiencing complex needs. Most of them focus on intervention and recovery through a series of carefully designed criteria and pathways.

This report highlights the main provision and acknowledges that the list is not exhaustive.

[Include organisations/ service logos]

Prevention & Early Intervention

There are several universal and early intervention services being commissioned by Public Health and the Children's Trust that aim to prevent and tackle the early indicators of complex needs in children and young people. The key services are:

- Health visiting and early years provision
- School health and wellbeing service
- Early Help and Family Support.

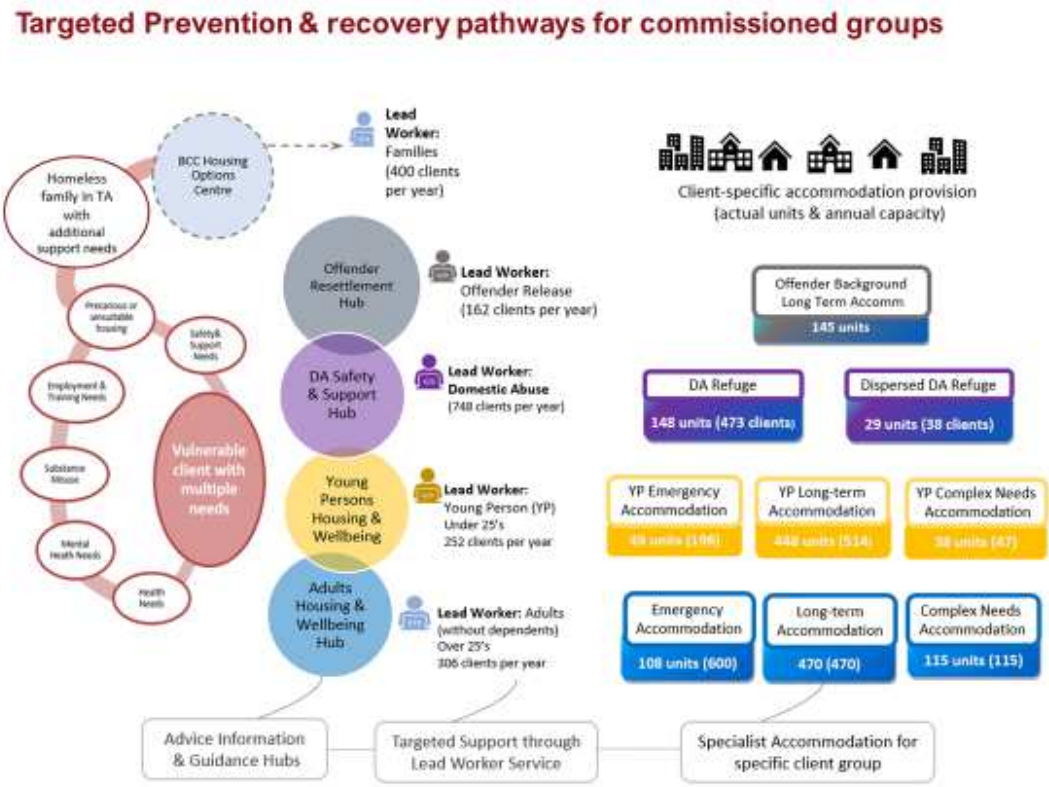
Birmingham's **Think Family Strategy** complements and provides a response to families with additional needs captured within the **Right Service Right Time framework** and the **Early Help Strategy** for the city. Both Early Help and Right Service, Right Time were adopted by Birmingham Children's Safeguarding Board in March 2015.

The Family Support service have trained a number of staff in the **Adverse Childhood Experiences (ACE) recovery toolkit** and the Children's Trust now deliver citywide the toolkit to both parents and children. The Trust are also looking to provide Trauma-Informed approaches and are exploring what this may look like operationally in line with their **Relationship-Based Practice Model**.

There are other services in the city that already use such approaches which may also be known as Psychologically Informed Environment models (e.g. BSMHFT, Women's Aid), or are working towards their implementation (e.g. Housing).

Homelessness

Birmingham City Council commissions a variety of services for rough sleepers as part of its new **Street Intervention Model** which, since recently, is coordinated by the **Trident Outreach Service**.



The stakeholders and partner organisations meet regularly and decide on user centred approaches that can include single and joint organisational contact depending on level and complexity of presenting need. **The Housing First** service accepts referrals from the Street Intervention Model and provides a named system navigator for those who require more intense support and are known to be rough sleepers or at risk of becoming a rough sleeper. Housing First **i**nitiative has been funded since 2018 via a £9.6 million central government's grant and represents a new in the UK approach to addressing homelessness with Birmingham one of the first in the West Midlands to trial this over 3 years. It relies on joint working between the council, housing associations, private rented sector accommodation and a variety of support groups to help and support rough sleepers to break the cycle of decline and multiple deprivation that has led them to living on the streets. It starts by putting homeless people into a home, before building a support network around them. Housing First provides wraparound support for the multiple needs of the persons referred and this support continues even if they are rehoused.

In terms of the substance misuse offer, the interface with CGL supports persons who are rough sleeping, those in homeless hostels and ensures an effective bridge between those who are homeless and in treatment, and their ongoing community-based treatment, should they find accommodation. Working in partnership with the Birmingham Voluntary Service Council, CGL also offer rapid on street opiate substitute prescribing as part of the national Rough Sleeping Initiative.

Health Xchange is Birmingham and Solihull Mental Health Foundation Trust's Primary Care Service specifically for the homeless population. They offer a full general practice service to those who are homeless or vulnerably housed aged 16 and over and not

pregnant. As well as GP access, nurse prescribing drop-ins are provided and nurse clinics offering a range of provision i.e. sexual health, screening, chronic illness support and blood and HIV testing. A counselling service is provided by community psychiatric nurses who triage a person's mental health problems and will refer to secondary services where appropriate.

Mental Health

The Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) provides a range of community based, day, inpatient and specialist mental health services.

The Community mental health team for homeless people is the statutory mental health NHS services in Birmingham and Solihull for people who are homeless and experiencing mental health problems. The service provides assessment and treatment of mental health problems, management of complex psychological and social needs, risk assessment, community nursing support, physical health monitoring, social assessment, access to vocational training and occupational activity and resettlement advice. It is a city wide service and see people with mental health problems that are sleeping rough, living in squats, hostels or otherwise homeless. This includes patients that are not registered with a GP.

In January 2020, a new Street Psychology service was commissioned for five years to explicitly support homeless persons with mental health issues. They undertake street-based assessments and link rough sleepers with appropriate services, and in any instance where the person(s) are housed there is a handover to the community Mental Health Team to ensure continuity of care.

The NHS Veterans' Mental Health Complex Treatment Service (VMH CTS) is a specialist community mental health service for armed forces veterans. It is for those experiencing complex mental illness related to their time in the military and to help veterans regardless of when they left the armed forces.

BSMHFT also provides low and medium secure mental health services for adults, as well as forensic services for children and young people, addictions services and dual diagnosis.

Substance Misuse

Change Grow Live (CGL) supports all persons with substance misuse issues over the age of 18 through a variety of services.

CGL's core approach to working alongside vulnerable people includes delivering treatment and recovery actions that integrate with the city's wider multi-agency approach to tackling substance misuse and commonly associated conditions, such as homelessness and mental health.

The CGL homeless offer was rated as an outstanding area of practice by the Care Quality Commission in April 2019 and is delivered in partnership with the Street Intervention Model and incorporates the agreed protocol for the mental health co-provision as detailed below.

In terms of offenders, CGL work to the requirements of the Probation National Standards in order to provide Drug Rehabilitation Requirements and Alcohol Treatment Requirements where these are set out as terms of probation. Such work is undertaken in partnership with probation service providers and the Integrated Offender Management

system to identify and work with offenders including those categorised as PPOs (prolific and priority offenders).

Dual diagnosis approach

CGL has an agreed protocol with Birmingham Solihull Mental Health Trust that details the treatment pathway for those with co-existing mental health and substance misuse problems. When a referral received fits the pathway criteria then a joint assessment should be completed within one week, and a care plan co-produced with input from the service user that includes details of all relevant partner agencies.

Offending

In addition to the interfaces laid out above as well as other provision available through the Vulnerable Adults Housing and Wellbeing Support, there is number of hubs across the city, including one specifically focused on ex-offenders. The other hubs are focused on young people aged between 18 and 24, single adults, childless couples and victims of domestic abuse.

The work of all these hubs is likely to bring them into contact and provide services to persons with MCN. They concentrate on coordinating and networking services in a person-centred manner by providing a named lead worker to facilitate such multi- agency working for a period of two years. This is especially relevant in terms of ex-offenders with MCN, as they can have up to five appointments in the first day of being released from prison with the aim to avoid re-incarceration, aid reintegration into society, and speed up recovery.

Voluntary sector

[Include organisation/ service logos]

BVSC: Birmingham Changing Futures Together is one of twelve Fulfilling Lives sites: Supporting people with Multiple Complex Needs (MCN's). The National Lottery Community Fund has invested £9,950,000 in this Birmingham project to support adults with multiple and complex needs. The project started June 2014.

At the heart of the project is a strong focus on working in partnership with "experts by experience", the project aims to improve the collaboration and integration of agencies to improve the service user journey. It focuses on long-term service and system change to support individuals that are *leading complex lives to lead fulfilling lives* and to ensure new ways of working are embedded in; striving to ensure:

- Seamless and integrated services through better signposting and referral pathways
- Earlier identification and diagnosis of complex needs to ensure a response is triggered sooner
- Tracking and monitoring of progress and outcomes
- Data sharing between providers so that service users are not repeatedly required to "tell their story"
- Intensive and more 'guided' support for service users and working partners support and development too
- Service users are leading the way in service design and integral to any system change.

It has several work streams ranging from a *Virtual Hub* that provides information, data and expertise to the programme and specific streams of work; ***Lead Workers and Peer Mentors*** helping those people with MCN's to navigate services to access appropriate recovery and support, ensuring collaborative working through a network of organisations, so that there is ***No Wrong Door*** for individuals seeking help. The services are supported further through the use of an ***Intelligent Common Assessment Tool (iCAT)*** which enables sharing information and records between agencies, and by strengthening professional practice with training and supervision towards ***Psychologically Informed Environments.*** Changing Futures also enables the development and support for those that are experts by experience through ***Every Step of the Way*** ensuring service users are involved and integral towards designing, developing and monitoring the programme. The programme provides ***Improved Outreach/In- reach and Beyond the Basics*** support towards connections with friendship groups for building resilience and sustaining recovery, and ultimately breaking the cycle of intense service use.

Anawim based in Birmingham; provides a holistic service through caseworker and criminal justice solutions to women with MCN (over 18) and their children and anyone that identifies as a woman resident in Birmingham. The work aims to:

- Increase self-worth, keep families together (where appropriate)
- Empower each woman and child towards independence, regular employment and dignity
- To raise each woman's self-awareness, trust and responsibility towards herself, her children and the wider community
- To ensure the wider community are better informed about issues affecting this client group.

They work with other agencies specifically supporting those vulnerable to exploitation including prostitution and substance misuse; early Interventions for women who may have offended and those vulnerable to crime as well as victims of domestic violence. Anawim offer intervention, support, rehabilitation, prison In-reach, drop-ins and outreach in the community, including to homeless women and street workers.

Shelter helps people struggling with bad housing or homelessness through advice, support and legal services. They offer face to face; online advice, legal support and a national helpline and provide advice on a range of topics around homelessness.

SIFA Fireside is a charity enabling homeless and vulnerable people to take control towards achieving healthier, fulfilling lives. They work to provide inclusion, engagement and equal access to services for people that are disadvantaged or experiencing homelessness, aiming to reduce homelessness and offending, increase social inclusion and life skills, improving health and employment potential.

Partnership agencies work alongside the staff to provide health and well-being services to clients. The access point for all services is their Drop-in Centre. They also deliver the Adult Support Hub aimed at early intervention for individuals with multiple needs living in precarious housing.

St. Basil's works with young people to enable them to find and keep a home, grow their confidence, develop skills, increase opportunities and prevent homelessness.

They aim to:

- Meet the needs and raise the aspirations of young people through provision of good quality accommodation
- Prevention and support services which meet the diverse needs of young people
- Ensure young people are involved in setting standards, identifying priorities and monitoring services
- Challenge discrimination and promote diversity and cohesion through employment, service delivery and community engagement.

Birmingham Mind is part of a national mental health charity providing services in and beyond Birmingham's boundaries increasing service provision to those most affected by poor mental health as well as increasing preventative and community-based services.

Other services and initiatives

The PURE (Placing vulnerable Urban Residents into Employment) project is part-funded by the European Social Fund and delivered by Birmingham City Council's Adult Social Care. It brings together a range of coordinated interventions which assist the needs of citizens with barriers into the employment market. The project participants gain an intensive level of support to address their complex needs to be able to access either employment or training.

Preventing Crisis Project is an initiative developed and delivered by Birmingham City Council and voluntary sector partners, including ASIRT, Refugee and Migrant Centre and Central England Law Centre, which is working with organisations supporting individuals with MCN, such as Women's Aid and SIFA to provide them with legal, immigration and welfare advice.

8. GAPS AND BARRIERS

8a. Lived experience perspective

"I just think if I knocked on the door of services and I just said I had two kids and a disability I would get more". (Focus group participant with MCN)

The research that was conducted to underpin this report through a series of focus groups and a rapid ethnography suggests that **not having dependents** poses a significant barrier to accessing the right services at the right time. Not having dependents and **being in a relationship** can further hinder the opportunity to receive support.

Through past experiences, many individuals with complex needs are unable to manage relationships whether at a family, personal level or with professionals. This effects engagement as well as coping mechanisms. The peer mentors from one of the focus groups reported that most people they see are single, though a small minority are in unhealthy relationships, and confirmed that it is easier for the single people to get support.

"I think it's actually easier for a single person to get help. Because they are only focusing on themselves. We see it so often, people… if you looked at like growing up, they are just looking for a fix. They are just looking for somebody to validate them."

Substance misuse was discussed a major complicating factor in accessing services such as mental health assessments or accommodation.

“So, it’s like a vicious cycle, it’s like trying to get accommodation but you also need to get quick to get them straight into other services to get them on scripts, to get their mental health looked at. They can’t, you can’t, treat mental health when there is substance misuse happening.”

In addition, **substance misuse treatment was considered too limited** in terms of capacity and a scope of substances, with perceived absence of a pathway for new psychoactive substances which are a big problem.

Most experiences that were shared with us were around how difficult it is to access services due to **lack of IT skills** as well as the **high thresholds, rigidity of eligibility and complicated pathways into services** posing a significant barrier. The service users felt that they have to repeatedly expose the worst and most painful parts of themselves in order to be considered for support, which in itself can make them more vulnerable.

“Just down to the simplest thing like filling in forms, that you won’t just have to do that once, you have to keep on doing it, so you have to really dig, cos, I try my best to be the bit that presents well, that isn’t making people uncomfortable. But you have to dig deep to find that bit to go oh, right that’s the bit that’s going to say, I’m going to get that access to that service.”

“One barrier is lack of awareness, lack of knowledge. Some people don’t know how to get, to go on the internet and navigate the web to find services necessarily. You have to be quite savvy to do that.”

Additionally, comments were made that the services themselves can discourage people from engaging, even where there is a valid need for support.

“Also, some people when they knock on the service door the first answer they get is no, which is naturally. They take the first no and never go back again. You have to be persistent.”

[quotes in speech bubbles]

The theme of humanity (or lack thereof) in persons delivering services was revisited, and a **perceived lack of care from professionals**. It was apparent that the group took this quite personally and felt that improvements in this were important but also difficult to achieve. There was some concession made that **the burden of need on services** was driving this due to **professionals being under pressure** to deliver quick services, and the resultant sacrifice of quality of service.

“I think it is within the mental health, the nurses and psychiatrists, I think they are overwhelmed with the amount of people that are having problems and don’t know, But it’s like you are on a conveyer belt – next please. No compassion.”

The **waiting times and time limited aspect of mental health services** was criticised as those waiting for services can sometimes deteriorate, and those within services are sometimes not fully recovered when treatment ends.

It would be fair to say that one of the gaps and barriers that the focus groups’ participants felt most passionately about was **the suitability of temporary supported accommodation**. While it was viewed as relatively straightforward to find someone

somewhere to stay, specific criticism was pointed at the non-commissioned exempt supported housing sector viewed as inappropriate and unsafe, as not regulated or monitored in terms of standards. It was stressed that people often feel safer in the streets rather than in that accommodation.

“Rather than put them somewhere where they’re going to focus on change, you [the council] put them in somewhere where it’s full of like mental health, abuse and addiction.”

Often supported accommodation can be more detrimental and was seen as wasted money when alternative types of support would be better.

“I’ve got somebody a place. He wants to get off the streets and stuff like that, he wants to get off the gear. And he’s gone there and then getting worse. Because the people there, you know, are worse than he is.”

“The city council are spending millions and it’s all wasted. They could be putting it into another service that actually helps.”

The evaluation of the service user experience conducted by the Changing Futures Together programme confirms that majority of those who reported trying access support (housing and rehabilitation) complained that short term /temporary accommodation put them at risk and or led to relapse. Many did not re-engage with specific services if they had a poor experience.

All of the above can lead to another frequently fed back barrier to engagement with services and support: **mistrust of services**.

“A lot of people, they don’t trust services. I didn’t trust services, I wanted to do everything on my own. So yeah. But I think on the plus side if you do keep an open mind the support is there.’

8b. Service perspective

Our research suggests that professionals view **lack of services and specifically those services concerned with financial support,** creating or exacerbating other pre-existing conditions and pushing people to crisis point.

“And when universal credit came in, that’s what it did to them. It threw money at them and left them out there. And now they are in crisis, they are coming back for help but there are not that many places we can send them for help cos everywhere is shutting down, closing down.”

Other issues seemed to be centred on there being a **lack of coordinated or integrated services or the inappropriateness of services relative to the needs of clients.** There were barriers identified in reference to being unable to refer on behalf of clients and a **lack of a feedback mechanism or information sharing** around services that are suggested to clients.

“Everyone is so scared of GDPR.”

“What you are saying is you get people at crisis point, whether they are suicidal, and you get people who have some mental health and anxiety issues who could do with some support and they are either one or two. But where is the middle?”

“And we can’t hand off to anyone. So, you know, we can’t ring up a GP surgery and go look Mr X has got this issue, I think he needs to be seen by somebody. We don’t have that authority to do that. We, and when I say we, I mean collectively as all the agencies we work together, I think there needs to be something along those lines, something that we can feed into.”

There were concerns that **lack of education and skills within the client group** meant they were unable to access some of the support services available or seek employment in a meaningful way. It was felt that clients would potentially not be receptive to training if it were made available, mostly due to peer groups and employer **attitudes towards criminal history**.

“They don’t want to go back to school to learn their reading and writing to get an office job, them and their friends and the areas they are from, people go and work in construction, or you come out of prison and go and work in construction. There is no point applying to work in a shop or office, cos you have got a criminal record.”

Two particular client groups were perceived as being failed by the current systems more than others; ex-offenders and more specifically **those subject to multi-agency public protection arrangements (MAPPAs)** to ensure the successful management of violent and sexual offenders. It was highlighted that these persons are often vulnerable and likely to have been a victim of similar offences themselves but are only treated as perpetrators often experiencing a limited access to appropriate support and services.

“So this is customers, yeah the MAPPAs, where they have had, you know they have restrictions placed on them for whatever – it tends to be sex offenders and things like that but you know, they automatically get, you know, if that is one of those customers they get exited from our programme- they can’t be sent to things, they can’t do, because of those restrictions.... They are just as vulnerable as everybody else, as it has been proven 9 times out of 10 that if they have done it, it’s happened to them at some point and things like that.”

Particular problems were highlighted with the **need for self-advocacy** (which some clients struggle with), **continuity of contact with named persons within services, and communication between services**.

“People establishing a good rapport with a probation officer but then because of circumstances leaving prison and being put in touch with probation in another area, which staggers the appointments – you lose the contact, you lose the continuity.”

[All quotations in speech bubbles]

Practitioners we spoke to also mentioned the risk that No Recourse to Public Funds (NRPF) poses when it comes to developing MCN and how it may hinder their recovery and transformation. Although the study that underpins this report did not come into a direct contact with individuals with NRPF, we are aware through reports from a range of services that there are perceived significant gaps in understanding the eligibility for support and stressed the importance of free and competent legal advice to enable access to appropriate level of support.

9. A CASE FOR CHANGE

People with multiple complex needs often suffer from physical and mental health problems, unemployment, family breakdown and exclusion. These are the common symptoms of multiple complex needs, but the pathways that lead to developing those needs are unique to each person. It is important to recognise the number and range of services and innovative approaches serving the most vulnerable citizens in Birmingham. In fact, the scale of the statutory and non-statutory provision landscape is significant. However, current services are organised to respond to the common symptoms well, but they are not flexible enough to adapt and support the complex needs and unique journeys of vulnerable people, leading to unfulfilled lives and high service and social costs. Finding a balance between equity and equality is not easy.

We know that problems of multiple complex needs start young and require early intervention. By the time we start identifying, assessing and planning interventions we are often years too late increasing significantly the cost to society and economy.

As the cost of late intervention increases, there is less chance for a positive outcome. Extrapolated across Birmingham and Solihull, an expenditure of over £127 million per annum for people with at least two needs out of homelessness, offending and substance misuse. There is a high overlap between people in this cohort and those who are unemployed; about only 6% of those with three MCN's are currently employed (60% are unemployed).

As can be seen from the stories of Bee and Dion as well as our focus groups' participants, the diversity of organisations required to support people with MCN may work in separate divisions, but people do not. Dealing with mental health issues, substance misuse, homelessness and offending involves contact through numerous different departments and teams. These can collectively contribute and represent the daily trials and tribulations of one person with several needs. When services are not working together effectively to provide a wraparound care, people don't just slip through the cracks, organisations are then perceived to be out of touch with the real complexity of people's lives.

The data, research and feedback from those affected by MCN tell us that much more can and should be done to improve the life chances of children and young people in Birmingham and help those already experiencing crisis to transform their lives. This is with a full acknowledgement that Birmingham has already built solid foundations and public services are working in times of financial constraint but when working well in true collaboration, they are able to serve as a pillar and a guide, removing barriers and bridging many gaps.

10. WORKING TOGETHER

This report has highlighted many examples of good practice and collaboration when it comes to tackling some of the most complex needs and inequalities in Birmingham. But there are still significant gaps and as a City Partnership, working alongside the national policy and locally with the Health and Wellbeing Board, Adults and Children Safeguarding Boards and the Housing Birmingham Board, we have the potential to do more.

Through genuine commitment to work together we can develop:

1) a clear offer of support that is evidence based, coherent, cost-effective and sustainable; this includes an offer of safe and suitable supported accommodation;

2) a system that is prevention and early intervention driven through understanding where the critical intervention points are and acting upon them quickly;

3) recovery and transformation mainstream support that is timely and flexible enough to meet the unique support needs of individuals with complex lives, where they can build on their strengths in an environment of trust and do not experience any unintended consequences of the rigidity of the system;

4) a coordinated approach to the management and delivery of multiagency support and robust information recording and sharing, to ensure a seamless provision without duplication and delay.

We must ensure that:

1) Support is person centred, trauma informed, culturally sensitive and accessible to all when it is needed most;

2) Support is holistic and MCN are not approached in isolation from key risk factors such as adverse childhood experiences and poverty;

3) Activity of all front-line professionals working with people with MCN is underpinned by the principles of Making Every Contact Count (MECC) and Making Every Adult Matter (MEAM);

4) We share best practice and learn from individuals with lived experience of MCN and design services together.

To enable change, system leaders are asked to:

1) Endorse the principles of the MEAM Approach across the health and care system in Birmingham;

2) Consider MCN in partner work programmes to develop a shared understanding and ownership of the problems with the current system and a clear vision and action for change;

3) Provide strategic support to develop integrated data sharing and intelligence around those who have MCN that cuts across organisational boundaries;

4) Support a sustainable system and culture change that will enable a greater flexibility and better coordination of services for those with multiple complex needs and create more opportunities for prevention and early intervention;

5) Influence partner organisations to ensure their commitment, shared responsibility and accountability.

By working together with energy and purpose, we can influence change across the system for people like ***Bee*** and ***Dion***, to support and empower them and many others in our city to build fulfilling futures.

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GLOSSARY

Adverse Childhood Experiences: ACEs are stressful events occurring in childhood including domestic violence, parental abandonment through separation or divorce, being the victim of abuse or neglect, a member of the household being in prison.

Commissioned services: It means care, support or supervision that has been arranged and paid for on a client's behalf by a public authority such as: In the case of personal care, a local authority adult social care department.

Core Cities: The Core Cities Group is a self-selected advocacy group of large regional cities in the United Kingdom and outside Greater London. It is a partnership of eight city councils: Birmingham, Bristol, Leeds, Liverpool, Manchester, Newcastle, Nottingham, and Sheffield.

Early intervention: It means identifying and providing effective early support to children and young people who are at risk of poor outcomes. Effective early intervention works to prevent problems occurring, or to tackle them head-on when they do, before problems get worse.

Ethnography: It is an in-depth qualitative research method based on the recording and analysis of a culture, society, or a population group, usually involving participant-observation and resulting in a written account.

Focus group: It is a qualitative research method which involves gathering of deliberately selected people who participate in a facilitated discussion intended to elicit perceptions about a particular subject matter or issue.

General Data Protection Regulation: GDPR is EU law on data protection and privacy.

Health Inequalities: These are differences in health status or in the distribution of health determinants between different population groups, for example, differences in mortality rates between people from different social classes.

iCAT (Intelligent Common Assessment Tool): iCAT is all-in-one database, referral and case management tool for supporting clients with MCN, providing a platform for easy communication and information sharing across many specialist services.

Joint Strategic Needs Assessment: A Joint Strategic Needs Assessment (JSNA) looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area.

Making Every Adult Matter: MEAM is a coalition of national charities representing over 1,300 frontline organisations across England. Working together they support local areas across the country to develop effective, coordinated services that directly improve the lives of people facing multiple disadvantage.

Making Every Contact Count: MECC is an approach to behaviour change that uses day to day interactions that organisations and people have with other people to support them in making positive changes to their physical and mental health and wellbeing.

Maslow Hierarchy of Needs: It is a motivational theory in psychology comprising a five-tier model of human needs, often depicted as hierarchical levels within a pyramid. Needs lower down in the hierarchy must be satisfied before individuals can attend to needs higher up. From the bottom of the hierarchy upwards, the needs are: physiological, safety, love and belonging, esteem, and self-actualization.

Multi-Agency Public Protection Arrangements: In the jurisdiction of England and Wales, a Multi-Agency Public Protection Arrangement (MAPPA) is an arrangement for the "responsible authorities" tasked with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public.

Multiple Complex Needs: MCN are persistent, problematic and interrelated health and social care needs which impact an individual's life and their ability to function in society. They are likely to include: homelessness, mental, psychological and physical health problems, drug and/or alcohol dependency, and offending behaviour.

No Recourse to Public Funds: NRPF is a condition imposed on someone due to their immigration status. Section 115 Immigration and Asylum Act 1999 states that a person will have no recourse to public funds if they are subject to immigration control. This prohibition only applies to certain specified public funds, so a person with this condition is not prevented from accessing other publically funded services, including support from social care.

Outcomes Star: It describes a family of evidence-based tools for measuring and supporting change when working with people.

Prevention: It is an action of stopping something (in the context of this report – health inequalities, multiple complex needs or crisis) from happening.

Randomised Controlled Trial: RCT is a quantitative study in which people are allocated at random to receive one of several clinical interventions to measure and compare their outcomes. RCTs are quantitative, comparative, controlled experiments in which investigators study two or more interventions.

Social determinants of health: These are conditions in which people are born, grow, live, work and age, and which are shaped by the distribution of money, power and resources at global, national and local levels.

Statistical neighbours: These are local authorities with similar demographic characteristics, e.g. age distribution, levels of deprivation.

Statutorily homeless: These are households or individuals whom the local authority has a legal duty to assist on the basis that they are unintentionally homeless and fall within a specified priority need group.

Supported housing: It describes is any housing scheme where housing, support and sometimes care services are provided as an integrated package. Supported housing services include homelessness hostels, refuges, sheltered housing and long-term accommodation for people with ongoing support needs.

Warwickshire-Edinburgh Wellbeing Scale: These were developed to enable the measuring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing. The 14-item scale WEMWBS has 5 response categories, summed to provide a single score. The items are all worded positively and cover both feeling and functioning aspects of mental wellbeing, thereby making the concept more accessible. The scale has been widely used nationally and internationally for monitoring, evaluating projects and programmes and investigating the determinants of mental wellbeing.

APPENDIX I

Update on actions recommended in the Director of Public Health Annual Report 2018: Fulfilling Lives for Under Fives.

	Recommendations	Progress to date	What next
1. Overarching – fulfilling lives for under fives	1. Commissioners and providers of Early Years services within Birmingham take account of the demographic makeup and distribution of the under fives population across the city (specifically in Central and Eastern areas) and target efforts and resources accordingly.	Birmingham Forward Steps (BFS) is contracted to provide a City wide service which meet the needs of different parts of the city e.g. children's centres remain operational in areas where the need is considered to be greater.	Continue to support the provider to implement this approach. Ensure that the findings in the CYP JSNA chapter help to inform this approach.
	2. Commissioners and providers have in place robust data collection systems to monitor health needs and outcomes for children under five and their families, including the Ages and Stages Questionnaire and breastfeeding rates.	KPIs for BFS contract include ASQ and breastfeeding rates, they are robust and monitored monthly via contract review meeting. PHE, BCC commissioners and BCHC providers have worked closely to improve data collection systems to ensure they meet data quality requirements.	Continue to support the provider to deliver robust data collection and reporting systems.
	3. Local Sustainable Transformation Partnerships across the city encourage commissioners and service providers to strengthen the prevention offer from preconception through to early years for the citizens of Birmingham, particularly through the Local Maternity System and Birmingham Forward Steps.	BSol STP has a children and maternity portfolio. A subgroup of this is CHIP (children's health improvement programme), this is where work is being done to improve the prevention offer with a particular focus on the LMS and BFS.	Develop and implement specific action plans for prevention under the STP. This currently includes increasing uptake of children's vaccinations
	4. Inclusive growth and economic development programmes across the city and those led by the West Midlands Combined Authority, maximise opportunities to promote the wellbeing of young children and their families, particularly those in poverty in greatest need.	The city has been successful in being part of the LGA Childhood Obesity Trailblazer programme which is focused on upstream interventions to improve the food environment for families	Continued implementation of Childhood Obesity Trailblazer programme
	5. The Birmingham Health and Wellbeing Board encourages and facilitates strong strategic partnership working and ensures robust governance arrangements	Five forums have been created which report to the HWBB: a physically active city, a mentally healthy city, a city without inequality, a healthy food city and	The CYP chapter of the JSNA is currently being finalised for sign off by the HWBB.

	are in place between statutory and non-statutory bodies to monitor and promote the health and wellbeing of under five year olds.	health protection - 0-5 year olds are included in all of these delivery forums.	
2. Conception, pregnancy, neonatal	1. The Birmingham and Solihull United Maternity Programme, as it develops into the Local Maternity System, must be explicit about the arrangements for supporting women with additional needs described in this section.	Current work on supporting women with additional needs is being undertaken. Health Visitor recruitment and retention is an issue. A consideration of managing capacity and demand is being reviewed in Birmingham and Solihull.	Qualitative work on pre-conception.
	2. The Birmingham and Solihull United Maternity Programme, as it develops into the Local Maternity System, must be explicit about the arrangements for identifying women who smoke, motivating them to stop, and the referral arrangements with the Birmingham and Solihull Smoking Cessation providers.	The ante-natal smoking cessation model is delivered by 2 trained midwifery support workers in Erdington community midwifery team, offering specialists clinics embedded into maternity services. The pilot has proved to be successful leading to higher patient engagement and chances of quitting smoking.	The BUMP programme board has extended the model to prevent a gap in provision, until a similar model can be rolled out to Birmingham maternity services.
	3. The Birmingham and Solihull United Maternity Programme, as it develops into the Local Maternity System, must ensure robust delivery of the NHS Saving Babies' Lives Care Bundle	The BUMP programme is focusing on the delivery of the NHS Saving Babies Lives Care Bundle and progress is overseen through the programme board. Over the last year that has been significant progress including a new pathway for the management of pre-term labour, a joint peer to peer perinatal mortality review process and successful pilot of a Single Point of Access model across 16 GP surgeries. Funding has been secured from HEE to support a roll out of a Saving Babies Lives training programme that launches in 2020.	The BUMP programme will continue to progress delivery of NHS Saving Babies Lives Care Bundle to complete implementation in line with national guidelines.
	4. Birmingham Forward Steps must establish a systematic approach to supporting women's nutrition and physical activity in the postnatal period, particularly those who are overweight or obese.	BFS are commissioned to deliver the healthy child programme, which includes providing lifestyles advice to women in the post-natal period.	Outcomes to be monitored.
3a.	1. The work on increasing the uptake and use of the Healthy	The baseline uptake of healthy start vouchers in Mar 2018 was	We are now working to sign up the extra people

Early years health and care: Health service use	Start vouchers should continue and report to the Health and Wellbeing Board and Overview and Scrutiny committee on progress and impact in June 2019.	70%. Through a programme of targeted action working with agencies we increased the uptake to 75% and maintained the uptake at 75% through to February 2019. In Feb 2019 the DWP and NHS adjusted their databases of eligible beneficiaries and uncovered a significant number of people who were eligible for HSV that were previously unknown. This resulted in all local authority uptake rates dropping, in Birmingham it dropped to 60% in Mar 2019 as we had an additional 2,824 extra beneficiaries.	and have increased our rate to 62%. As well as front line health visiting and children centre staff we are working with: • Early years education • community groups • debt advice agencies • GPs and primary care to try and identify the additional eligible beneficiaries. We are also starting work with DWP to ascertain the previously unknown extra beneficiaries.
	2. The Birmingham and Solihull United Maternity Programme, as it develops into the Local Maternity System, should collaborate with the City Forward Steps to establish a robust and sustainable offer of breast feeding support to improve breastfeeding rates at initiation, 6-8 weeks and beyond.	The infant feeding sub-group of the BUMP includes representation from maternity service providers and Birmingham Forward Steps. The aim of this group is to develop a robust, consistent, systematic offer across the early years system to increase breastfeeding initiation and duration rates.	Continue to develop the offer and monitor outcomes.
	3. Birmingham City Council should work with the commissioned Early Years' Service – Birmingham Forward Steps (BFS) to address data quality issues, particularly in relation to breastfeeding rates.	BCC has worked with BFS and Public Health England colleagues to improve Breastfeeding data quality. BFS data collection Systems are being modified to ensure that data generated in future meets quality criteria.	Continue to monitor and evaluate the data.
	4. Birmingham City Council and partner organisations should develop an offer of enhanced nutritional and physical activity opportunities to optimise weight and fitness for life based on a whole systems approach to obesity.	BCC is working with partners through the HWBB forums (physically active city and healthy food city) on a whole systems approach to obesity which involves re-focusing work upstream.	Strategies to be developed through the Creating a Physically Active City Forum and the Creating a Healthy Food City Forum.
3b. Early years health and	1. NHS England works with partners to develop action plans in areas, communities or populations with low uptake to	BSol STP has identified improving childhood vaccination uptake as a priority, and action plans are being developed with stakeholders,	MMR tail-gunning planned for Birmingham and Coventry from April 2020

care: Vaccinations	deliver increased uptake. This will reduce levels of inequality in uptake. 2. NHS England and Clinical Commissioning Groups to produce and implement plans to target the lowest performing 10% of GPs and deliver increased uptake in Practices with the very lowest performance.	including NHSE, to take this forward. West Midlands Immunisation Partnership meetings are in place for planning between NHSE, LAs and CCGs NHSE and CCG leads worked together on flu vaccine ordering and performance	Discussions underway for Health inequalities hub for Birmingham and Solihull from April 2020 subject to negotiations
3c. Early years health and care: Oral health	1. Public Health England to publish the results of Children's Oral Health Needs Assessment to identify areas or communities with the worst oral health inequalities. 2. Birmingham Forward Steps to adopt NICE and Public Health England oral health improvement recommendations.	BFS have worked with PHE colleagues to adopt best practice in relation to oral health improvement recommendations.	Currently awaiting publication of 2019 survey of 5 year olds by PHE
4. Early years education and development	1. Birmingham Forward Steps should develop locality links with the local private, voluntary, or independent providers of Early Years Education to enhance and enable the uptake of the Early Years 2-2.5 year assessment and educational entitlement offers.	Education and Development BFS representatives engage in regular early years forum meetings which provides an opportunity to develop links with early years education providers in the private, independent and voluntary sectors. Children's centre staff in particular are working to develop good links with early education providers.	Continue to develop collaborations and monitor impact of joint action.
	2. Birmingham Forward Steps and Birmingham City Council should work together to address data quality issues identified in relation to the Ages and Stages questionnaire (ASQ-3) collected at the 2-2.5 year health visitor assessment.	BFS, BCC and PHE colleagues have worked closely together to address data issues in relation to the Ages and Stages Questionnaire collected at the 2-2.5 year health visitor assessment, this has included an early years improvement board which focussed on understanding this issue. BFS systems have now been adapted to incorporate necessary changes and anticipate seeing considerable improvements in data quality within the current financial year.	Monitor and evaluate the data.
5a.	1. The reduction in the impact of family poverty on children should	Birmingham's Child Poverty Action Forum (CPAF) has identified	A cross-sector group, led by the Council, has

Family and social environment	become the outcome measure for the economic developments in the City by all partners collectively. The principles of the Inclusive Growth Commission and WMCA Inclusive Growth Unit should be explicitly explored for their implications in Birmingham by Birmingham Financial Inclusion Partnership and Birmingham Child Poverty Action Forum.	inclusive growth as a key policy areas of focus. The CPAF is supporting cross-sector plans to make Birmingham a living wage city.	been established. This group is working up plans to submit to the Living Wage Foundation.
	2. The poor health of deprived areas is a symptom of, and barrier to, inclusive growth. The Joint Strategic Needs Assessment (JSNA) must describe these patterns of impacts and should be used to support decisions to reduce family poverty by Birmingham Health and Wellbeing Board and Birmingham Financial Inclusion Partnership.	The CYP chapter of the JSNA includes patterns of deprivation and its impact on outcomes. This will be used to inform the work of the fora set up under the HWB Board, including the Creating a City Without Inequality Forum .	Joint upstream action to be developed as part of the Creating a City without Inequality Forum's and the Financial Inclusion Partnership's work.
	3. Evaluation of schemes using 106 funding in Longbridge should be shared widely with recommendations and next steps to start further innovative schemes along these principles by Birmingham Health and Wellbeing Board and Child Poverty Action Forum.	The Longbridge scheme has not been evaluated. As part of the Longbridge project, a RCT was conducted on Run a Mile. Findings were published. https://research.birmingham.ac.uk/portal/files/46440038/Breheny_et_al_Cluster_Randomised_BMC_Public_Health.pdf	
5b. Adverse Childhood Experiences	1. Opportunities for Tertiary Prevention should be developed with adult Mental Health clients (including personality disorder, complex family presentations), children's social care (Child Protection and Child In Need) and Primary Care. 2. Opportunities for Secondary Prevention should be developed into an Early Emotional Help system framework for Primary schools. This should be a partnership of schools, the voluntary sector and NHS, which responds to children with difficult and concerning behaviour. This should include the introduction of enquiry into the adverse	Opportunities to develop an ACES informed approach across the system, at a strategic level, are being explored by senior Public Health staff. This will provide an opportunity to build on the existing Framework of Preventing the Impact of ACES in Childhood in Birmingham at primary, secondary and tertiary levels. Commissioners and providers with an interest in emotional health and well being regularly meet as part of the Education Emotional Well Being Steering Group and help to shape emotional health and well being services around schools	Continue to develop a joint action in collaboration with partners, taking a public health approach to addressing ACEs and their impact.

	experiences in the child and family. 3. Opportunities for Primary Prevention should be sought in sharing the understanding of impacts of adverse experiences with parents during the antenatal period by the Local Maternity System and Forward Thinking Birmingham.	through links with the CYP Local Mental Health Transformation Board. Enquiry into adverse childhood experiences is an implicit aspect of this work. Primary prevention opportunities arise across the LMS and early years settings providers.	
	4. Opportunities to develop locality understanding and responses in wider linked communities such as extended families, faith or social groups and neighbourhoods to the evidence of harmful impact of these experiences should build upon the experiences of the pilots in Castle Vale and Kings Norton (Dr Andrew Coward, Area Early Help Hubs and Forward Thinking Birmingham).	At the time of producing the report the West Midlands Combined Authority Adverse Childhood Experiences lead, Dr Andrew Coward, was proposing a community based development of awareness of the impact of these experiences in Castle Vale and Kings Norton. This would, of course, be evaluated before more widespread adoption.	Public Health Communities team are developing community profiles to help with greater understanding of different communities in Birmingham. This specific piece of work is not currently progressing due to staff changes
5c. Child homelessness	1. The Joint Strategic Needs Assessment should focus on supporting the evaluation of the Birmingham Homelessness Prevention Strategy by Adult Social Care, Birmingham Public Health, and Birmingham Forward Steps.	The 2019/20 JSNA children and young people's chapter includes a specific section on homelessness and how it affects children and young people to help inform the local approach.	In 2020 working with the Birmingham and Solihull CCG the Council is collaborating on a specific focused action group to look at how to improve support to children and young people living in temporary accommodation.