Members are reminded that they must declare all relevant pecuniary and non-pecuniary interests relating to any items of business to be discussed at this meeting

BIRMINGHAM CITY COUNCIL

HEALTH, WELLBEING AND THE ENVIRONMENT OVERVIEW AND SCRUTINY COMMITTEE

TUESDAY, 21 FEBRUARY 2017 AT 14:00 HOURS
IN COMMITTEE ROOM 6, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1 **NOTICE OF RECORDING**

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

2 **APOLOGIES**

3 - 14

3 **ACTION NOTES**

To confirm the action notes of the meetings held on 13 December 2016 and 17 January 2017.

4 **DECLARATIONS OF INTERESTS**

15 - 54

5 **WEST MIDLANDS ADASS PEER CHALLENGE AND ACTION PLAN**

Mike Walsh, Intelligence, Strategy & Prioritisation, Commissioning Centre of Excellence.

55 - 130

6 **PROGRESS REPORT ON IMPLEMENTATION: HOMELESS HEALTH**

John Hardy, Commissioning Manager, Commissioning Centre of Excellence.

131 - 136

7 **PROGRESS UPDATE - BIRMINGHAM AND SOLIHULL SUSTAINABILITY AND TRANSFORMATION PLAN (BSOL STP)**

Mark Rogers, STP System Lead and Chief Executive; Councillor Paulette Hamilton, Cabinet Member for Health and Social Care.

137 - 146

8 **WORK PROGRAMME - FEBRUARY 2017**

For discussion.

9 **REQUEST(S) FOR "CALL IN"/COUNCILLOR CALLS FOR ACTION/PETITIONS RECEIVED (IF ANY)**

To consider any request for "call in"/Councillor calls for action/petitions (if received).

10 **OTHER URGENT BUSINESS**

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

11 **AUTHORITY TO CHAIR AND OFFICERS**

Chair to move:-

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

BIRMINGHAM CITY COUNCIL

HEALTH, WELLBEING AND THE ENVIRONMENT O&S COMMITTEE

1000 hours on 13th December 2016, Committee Room 6 – Actions

Present:

Councillor John Cotton (Chair)

Councillors Sue Anderson, Mick Brown, Andrew Hardie, Kath Hartley, Mohammed Idrees, Simon Jevon and Robert Pocock

Also Present:

Elaine Kirwan, Forward Thinking Birmingham, Associate Director of Nursing

Karen Kelly, Forward Thinking Birmingham, Associate Services Director

Anupam Dharma, Forward Thinking Birmingham, Medical Director

Tim Atack, Chief Operating Officer, Birmingham Children's Hospital

Alan Lotinga, Service Director - Health and Wellbeing

Louise Collett, Service Director - Policy and Commissioning

Councillor Paulette Hamilton, Cabinet Member for Health and Social Care

Councillor Lisa Trickett, Cabinet Member for Clean Streets, Recycling and Environment

Rose Kiely, Overview & Scrutiny Manager, Scrutiny Office

Gail Sadler, Research & Policy Officer, Scrutiny Office

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2. APOLOGIES

Councillors Uzma Ahmed, Deirdre Alden, Carole Griffiths and Karen McCarthy.

3. ACTION NOTES/ISSUES ARISING

The action notes of the meeting held on 22nd November 2016 were noted.

4. DECLARATIONS OF INTEREST

Members were reminded that they must declare all relevant interests relating to any items of business to be discussed at the meeting. Councillor Andrew Hardie declared an interest as a registered GP working as a locum in Birmingham.

5. THE PROPOSED BUDGET 2017/18

Alan Lotinga (Service Director – Health and Wellbeing), Louise Collett (Service Director – Policy and Commissioning) were joined by Councillor Paulette Hamilton (Cabinet Member for Health and Social Care) to present the budget proposals for the People Directorate Health and Wellbeing service areas.

Councillor Lisa Trickett (Cabinet Member for Clean Streets, Recycling and Environment) attended to present budget proposals for the Place Directorate Homes and Neighbourhoods service areas that fell within the Environment remit of this committee.

RESOLVED:-

Health and Wellbeing

- A detailed report to be brought back to committee on the Maximising Independence in Adults Programme.
- The new model of day care centres will be shared with the committee once the proposed timeline has been finalised.
- A further report on each of the budget lines with an update on developments to be brought back to committee.
- Further information to be provided on the withdrawal of the Carers Grant and the impact of that.
- Information on the negative cost over the next 10-20 years that is likely to arise from the short term savings on preventative services.
- Further report to committee on the framework agreement for domiciliary care providers which is currently under review.

Homes and Neighbourhoods

- Councillor Trickett to email all Members with the date of her meeting with 'Friends of the Parks' Group.

Feedback from the discussions that have taken place will be shared with Cabinet and officers for consideration when finalising the budget for 2017+.

6. FORWARD THINKING BIRMINGHAM

Elaine Kirwan (Associate Director of Nursing), Karen Kelly (Associate Services Director), Anupam Dharma (Medical Director) of Forward Thinking Birmingham and Tim Atack (Chief Operating Officer) Birmingham Children's Officer presented a report on progress made in the first 6 months of a new contract to provide mental health care for 0-25 year olds.

RESOLVED:-

- Forward Thinking Birmingham to provide data on the footfall at the Pause drop-in centre.
- A further update report to be presented to committee.

7. HEALTH, WELLBEING AND THE ENVIRONMENT OVERVIEW AND SCRUTINY COMMITTEE WORK PROGRAMME 2016-17

The work programme was submitted.

RESOLVED:-

That the work programme be noted.

8. REQUEST(S) FOR CALL IN/COUNCILLOR CALL FOR ACTION/PETITIONS

None

9. OTHER URGENT BUSINESS

None

10. AUTHORITY TO CHAIRMAN AND OFFICERS

RESOLVED:-

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

The meeting ended at 12.19 hours.

BIRMINGHAM CITY COUNCIL

HEALTH, WELLBEING AND THE ENVIRONMENT AND ECONOMY, SKILLS & TRANSPORT O&S COMMITTEES

1000 hours on 17th January 2017, Committee Rooms 3 & 4 – Actions

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Present:

Councillor John Cotton (Chair)

Councillors Uzma Ahmed, Deirdre Alden, Sue Anderson, Mick Brown, Andrew Hardie, Simon Jevon, Carole Griffiths, Mohammed Idrees, Karen McCarthy and Robert Pocock.

Councillor Eva Phillips (am)

Councillors Tim Huxtable and Phil Davies (pm)

Also Present:

Dr Wayne Harrison, Assistant Director of Public Health/Consultant in Public Health

Alec Dobney, Unit Head, Environmental Hazards & Emergencies Department, CRCE, Public Health England

Karen Exley, Senior Environmental Public Health Scientist, Air Pollution & Climate Change Unit, CRCE, Public Health England

Mark Wolstencroft, Air Quality Lead in Environmental Protection

John Newson, Birmingham Friends of the Earth

Libby Harris, Birmingham Friends of the Earth

Jane Harding, Project Manager, and Simon Needle, Birmingham Trees for Life

Councillor Fiona Williams

Paul O'Day, Street Services Manager, BCC

Councillor Lisa Trickett, Lead Cabinet Member for Reducing Air Pollution

Anne Shaw, Assistant Director, Transportation & Connectivity

David Harris, Transport Policy Manager

Adam Harrison, Senior Policy Officer, Transport for West Midlands

Mike Waters, Head of Policy & Strategy, Transport for West Midlands

Dr Chris Chiswell, Consultant in Public Health Medicine, Birmingham Children's Hospital NHS Foundation Trust

Rose Kiely, Overview & Scrutiny Manager, Scrutiny Office

Gail Sadler, Research & Policy Officer, Scrutiny Office

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2. APOLOGIES

Councillors Hartley, Barrie, Donaldson, O'Shea

3. DECLARATIONS OF INTEREST

Councillor Andrew Hardie declared an interest as a GP working in Birmingham.

4. BIRMINGHAM PUBLIC HEALTH/PUBLIC HEALTH ENGLAND

Dr Wayne Harrison (Assistant Director of Public Health, Birmingham Public Health) highlighted the main points in the submission from Birmingham Public Health. The main air pollutants which cause concern in terms of the evidence of their public health impact are Nitrogen oxides, principally NO2 and Particles of different sizes (PM2.5 and PM10 being the regulated size fractions). These are linked to a number of health effects and current estimates are that PM2.5 and NO2 are responsible to 40,000 deaths annually. There is strong evidence for the impact of short and long-term exposure to PM2.5 on cardiovascular health, lung cancer, reduced life expectancy, reduced lung function and heightened severity of symptoms in individuals with asthma, chronic lung disease, ischaemic heart disease and stroke. NO2 has a separate and additional impact on health and high acute levels are associated with respiratory morbidity, hospital admissions and emergency visits for cardiovascular and/or cardiac diagnoses and mortality.

Alec Dobney (Unit Head, Environmental Hazards & Emergencies Department, Public Health England) and Karen Exley (Senior Environmental Public Health Scientist Public Health England) then explained the main points from the Public Health England Report highlighting that within the UK, air pollution is the largest environmental risk linked to deaths every year and that air pollution is associated with much greater public health risk than was understood even a decade ago and more associated adverse health effects are emerging. On average around 80% of oxide of nitrogen (NOx) emissions in areas where the UK is exceeding NO2 limit values is due to transport, although urban and regional background non-transport sources are still considerable. The largest source is emissions from diesel light duty vehicles (cars and vans) and there has been significant growth in vehicle numbers over the last ten years in the UK. Attributing health outcomes from exposure to individual constituent pollutants in emissions is not simple and this supports the need to tackle emissions in general and not necessarily to focus on individual pollutants. For Birmingham, an estimated 5.7% of all-cause mortality is attributable to air pollution.

RESOLVED:-

- Public Health England has commissioned a tool which can be used to estimate the cost to the NHS of pollution which local authorities will be able to use. This will be available in June 2017.
- NICE Guidance on Green Infrastructure is currently out for consultation and due to be published June 2017.

Potential areas for recommendations

Raising Awareness/Public Access to Information

There are a number of services such as Text alert/Airtext that can be used to alert vulnerable people with air quality health advice. Schools should be alerted and aware of the systems but there is no consistency. Explore what BCC can do about raising awareness of air quality alerts, especially for schools?

Green Infrastructure

Can we encourage the building of "living walls" between schools and busy roads?

5. BIRMINGHAM ENVIRONMENTAL HEALTH

Mark Wolstencroft (Air Quality Lead in Environmental Protection) attended to present the submission on behalf of Environmental Health. He provided evidence about the network of air quality monitoring stations which sample the air in real time and provide outputs over a short period. Members were provided with data giving the concentrations for the main pollutants, emission sources, levels and sources of air pollution in Birmingham and in specific pollution hotspots. The evidence included the legislative standards setting out the pollutants for which local authorities have a statutory responsibility to report, the locations of monitoring sites, the position for the West Midlands Urban Area and the UK in relation to compliance with air quality objectives and how these rates compare to other comparable major cities in the UK and Europe. He explained that Environmental Health run their own air quality modelling. In relation to local sources of air pollution, it is known that the primary source of NO2 is from road traffic but that 'source apportionment' on the A38 fronting the Mailbox shows that diesel cars are the primary source of NOx emissions.

RESOLVED:-

That the report be noted

Potential areas for recommendations

Coverage and adequacy of monitoring

The committee queried whether the coverage and location of the real time monitoring stations across the city is adequate?

Local sources of air pollution

It is known that the primary source of NO2 is from road traffic. 'Source apportionment' carried out on the A38 fronting the Mailbox shows clearly that the largest source of emissions is from local sources and the largest contributor to the local sources are diesel cars followed by diesel LGVs.

6. BIRMINGHAM FRIENDS OF THE EARTH

John Newson, Birmingham Friends of the Earth attended to present the submission from Birmingham Friends of the Earth about what would be the most effective ways of implementing and operating a clean air zone, including what should be included, suggested measures and proposals. He was accompanied by Libby Harris, also from Birmingham Friends of the Earth. A variety of measures were proposed including:

- Larger static combustion plants produce a background level of polluted air and should be included in any proposed Clean Air Zone together with all polluting vehicles.
- Reducing traffic flows using a variety of means including provision of Park & Ride, car clubs, halting road widening and red routes that increase traffic flows, promoting active travel such as cycling and walking and promoting the use of fast, clean buses.
- Birmingham City Council planning for a rapid phase out of its own diesel fleet vehicles.
- Any charging in the Clean Air Zone should be proportional to the emissions produced by all vehicles including private cars with any charges collected being ring-fenced and spent on cost effective alternatives to the private car.
- Road space should be reallocated to allow convenient and attractive journeys by tram, bus, taxi and bicycle.
- Electric vehicle charging points should be made an early priority.
- A city-wide approach to clean air is necessary to prevent the diversion of traffic and relocation of the problem to areas outside the city centre.
- A carefully designed scrappage scheme is essential to encourage people to exchange their old diesel vehicles and keep them off the roads.

RESOLVED:-

- BFOE to provide data on air pollution levels which they have measured at various sites using diffusion tubes.
- Queries were raised about the Council's fleet and how many vehicles are diesel which were to be addressed in the evidence to be presented in the afternoon session.

7. BIRMINGHAM TREES FOR LIFE

Jane Harding, Project Manager and Simon Needle from Birmingham Trees for Life attended together with Councillor Fiona Williams to give evidence that tree planting is a valuable part of the overall strategy to alleviate air pollution in cities. It has recently been calculated that Birmingham only has 18% tree canopy cover, compared to an average of 25-30% in other European cities. Maintaining and planting of urban trees can be used to filter out particulate matter and absorb other air pollutants from the atmosphere and improve air quality. In addition the shade cast by trees, in addition to the transpiration of water during photosynthesis can help to reduce air temperatures.

Trees also form part of the wider urban nature network and there is evidence for the beneficial effects of nature on general health and well-being.

RESOLVED:-

That the report be noted.

Potential areas for recommendations

Approach to incorporating appropriate planting within planning permission for new developments

Broad approach to planning for new developments should incorporate appropriate planting of trees of a suitable species in the right place with careful selection of the spaces to be planted, density and placement of the trees, with provision for appropriate maintenance for a period after planting, as a condition of planning for new developments.

Approach to incorporating into planning for transport infrastructure

Need to consider the wider and longer term benefits of keeping mature trees and to incorporate appropriate protection for mature trees into any planning when planning transport infrastructure.

8. TRANSPORTATION AND CONNECTIVITY

Councillor Lisa Trickett (Cabinet Member for Clean Streets, Recycling and Environment) attended to set out the evidence about local road transport, sources of emissions which impact on local air quality and the transport challenge this presents for Birmingham. The city has been mandated by central government to introduce a Category C 'Clean Air Zone' which is currently in the evidence gathering stage. She emphasised the need for shared leadership and ownership of the issue in the city driven by a fundamental right to clean air.

Anne Shaw (Assistant Director, Transportation & Connectivity) and David Harris (Transport Policy Manager) provided evidence about the Birmingham Development Plan, the audit that is currently underway with a view to making the transition to a cleaner fleet, about revising BCC policies in relation to the transport system with a view to keeping vehicles moving, about work with Transport for West Midlands on lower emission vehicles and new technologies and about pursuing a Park and Ride Scheme and work being done to develop a framework across the West Midlands Combined Authority

RESOLVED:-

That the report be noted.

Potential areas for recommendations

Lobbying Central Government

Need to continue to lobby the government about the need to give detailed consideration to developing a diesel scrappage scheme.

9. TRANSPORT FOR WEST MIDLANDS

Adam Harrison (Senior Policy Officer, Transport for West Midlands) and Mike Waters (Head of Policy & Strategy, Transport for West Midlands) attended and gave evidence about the close working relationship between BCC and TfWM and the immediate priority work progressing on a number of sites in relation to Park & Ride and about the regional and national transport activity that is already happening. The M6 Toll is under- utilised against its design capacity and could be better utilised. TfWM are working with other West Midlands local authorities on various projects including traffic optimisation and are trying to get permission from government to enforce traffic management at a local level, on a HS2 connectivity strategy, with Highways England on a key route network approach to manage approximately 600 km of the road network across the metropolitan area which constitutes approximately 7% of the road network but which carries 50% of the traffic.

RESOLVED:-

- A note will be provided for Cllr Tim Huxtable on proposals/progress with the Longbridge Park & Ride.
- Evidence to be provided on data monitoring project currently happening at New Street Station with Network Rail and the University of Birmingham and also about rail electrification plans. (Note – Network Rail subsequently invited to attend March committee meeting to report on both of these.)
- Figures on increased tram usage since the extension opened to be provided.
- Cllr Phil Davies offered to provide some data on New Street Station and information about the number of diesel trains which can be circulated to the other committee members.

<u>Potential areas for recommendations</u>

<u>Lobbying central government</u>

Working with other West Midlands local authorities re traffic management optimisation if, through the West Midlands Combined Authority, could get the power from government to enforce moving traffic infringements at a local level.

<u>Mayoral powers</u> – It may be that one of the powers that comes with the Mayor is the ability to bring in Clean Air Zones which was one of the most popular elements within the Mayoral Consultation.

<u>Pursue the Bus Alliance Partnership to improve bus emissions.</u>

10. BIRMINGHAM CHILDREN'S HOSPITAL NHS TRUST

Dr Chris Chiswell, Consultant in Public Health Medicine, Birmingham Children's Hospital NHS Foundation Trust attended to give evidence about the smoke free zone outside the hospital that is currently voluntary but that the hospital is in discussions with BCC about implementation. Members heard that there is clear evidence of harm to children from poor air quality and about the growing body of literature that

indicates there should be concern about the impact of air quality on the health of children in Birmingham. Members were told that air pollution may contribute towards congenital anomalies, that long term exposure to particulate matter has been linked with overall child mortality and that increased risk was found for post-neonatal infant deaths (between one month and one year) and for deaths from Sudden Infant Death Syndrome. Members were also told about the relationship between childhood exposure to traffic-related air pollution and subsequent risk of developing asthma and that exposure to residential traffic after birth increases the risk of childhood leukaemia.

RESOLVED:-

That the report be noted.

Potential areas for recommendations

Strong Public Health Message

There is a strong public health message about the importance of good air quality and how we value the health of our citizens and especially children that needs to be highlighted with Birmingham citizens.

Smoke Free Zone Initiative

Would like to see the smoke free zone outside the hospital initiative extended to all hospitals and other public facilities, especially where there are children.

11. AUTHORITY TO CHAIRMAN AND OFFICERS

RESOLVED:-

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

_____

The meeting ended at 1600 hours.

Information briefing

Report From: **Strategic Director for People**

Report To: **Health, Wellbeing and the Environment Overview and Scrutiny Committee**

Date: **21 February 2017**

Title: **West Midlands ADASS Peer Challenge and Action Plan**

Summary:

Between 14th and 16th November 2016, Birmingham City Council invited colleagues from across the ADASS network to undertake a peer challenge of Adult Social Care Services with the focus of "maximising the independence of adults in a financially challenged environment."

The remit of the Peer Challenge team was:

"As a Peer Challenge team we want to find out if Birmingham CC have a clear understanding of where they are currently with the quality, management of risk, consistency and value for money of adult social care practice and delivery, to explore what the Directorate, City Council and local NHS partners can do to help them deliver more person-centred, asset-based approaches to help their adult citizens to remain independent, for longer."

In addition to examining whether Birmingham is doing enough to mitigate the financial risk, the team explored:

- social care assessments and care packages;
- care and support planning;
- front line 'joint working' arrangements within health.

The review team was led by Linda Sanders Strategic Director – People at City of Wolverhampton Council and comprised senior officers, elected members and experts by experience from a number of authorities within the region. The team met over 90 people – carers, service users, members and officers - in 30 separate sessions and at 11 different locations in the 3 days they were on site.

At the end of their work they provided detailed feedback highlighting the strengths of the Social Care in Birmingham, as well as some areas to focus on. These are outlined in the attached feedback letter (Appendix 2).

The panel made 6 recommendations:

- Strengthen grip on the financial monitoring and delivery of efficiencies/ savings;
- Strengthen relationship between commissioning and frontline services;
- Increase the pace and scale of transformation required by the Maximising Independence Programme;
- Translate initial thinking into a credible vision for an integrated place based health and care system in Birmingham and outline how relationships with health can be improved at the front door;
- Upscale and maximise the potential offered by an asset based approach with the voluntary and community sector to transform Social work model;
- Strengthen the interface between adult social care and the corporate centre.

A detailed action plan (Appendix 3) with clear lines of accountability has now been developed – aligning specific areas of activity against the above recommendations. The action plan was approved by Cabinet on 24 January 2017. The delivery of the plan will be managed via the Directorate's Maximising Independence of Adults Programme Board. The Peer Challenge team will return later in the year – date to be determined – to review progress against the action plan.

Background information:

Appendix 1 – Peer Challenge Self-Assessment
Appendix 2 – Final Letter from Peer Challenge Team
Appendix 3 – Peer Challenge Action Plan

Contact details:

Mike Walsh
Head of Service – Intelligence, Strategy and Prioritisation, Commissioning Centre of Excellence
Email: Michael.walsh@birmingham.gov.uk
Tel: 4 -2186

West Midlands

Self-Assessment

Incorporating TEASC

Risk Awareness Tool

Birmingham City Council

October 2016

Name of DASS Contact:

Alan Lotinga

Address:

Directorate for People

Birmingham City Council

10 Woodcock Street

Zone 6 - 1st Floor

Birmingham

B7 4BG

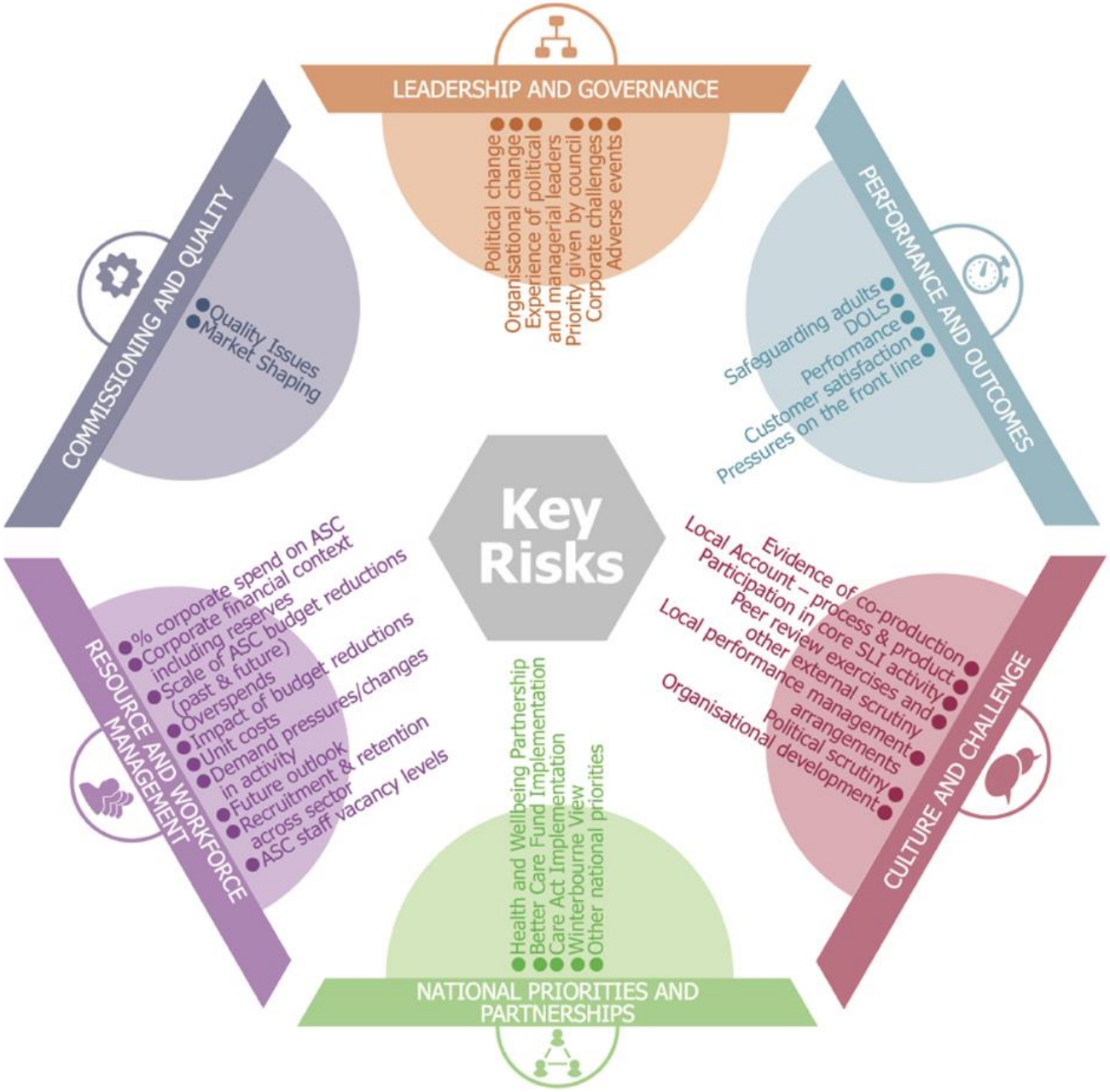
Telephone:

Email:

Narrative on process for completion of this form including who has been involved:

Date self-assessment completed: 31st October 2016

Signed/Agreed on behalf of the Local Authority:


LEADERSHIP AND GOVERNANCE
Political change
Organisational change
Experience of political and managerial leaders
Priority given by council
Corporate challenges
Adverse events
PERFORMANCE AND OUTCOMES
Safeguarding adults
DOLS
Performance
Customer satisfaction
Pressures on the front line
CULTURE AND CHALLENGE
Evidence of co-production
Local Account – process & product
Participation in core SLI activity
Peer review exercises and other external scrutiny
Local performance management arrangements
Organisational development
Political scrutiny
NATIONAL PRIORITIES AND PARTNERSHIPS
Health and Wellbeing Partnership
Better Care Fund Implementation
Care Act Implementation
Winterbourne View
Other national priorities
RESOURCE AND WORKFORCE MANAGEMENT
% corporate spend on ASC
Corporate financial context including reserves
Scale of ASC budget reductions (past & future)
Overspends
Impact of budget reductions
Unit costs
Demand pressures/changes in activity
Future outlook
Recruitment & retention across sector
ASC staff vacancy levels
COMMISSIONING AND QUALITY
Quality Issues
Market Shaping
Key Risks

Birmingham City Council Overview

Population

- Over 1.1 million people live in Birmingham (1,101,360 based on the 2014 mid-year population estimate).
- According to the 2011 Census around 42% of residents were from an ethnic group other than White.
- 46.1% of Birmingham residents said that they were Christian, 21.8% Muslim with 19.3% having no religion.
- 22% of our residents were born outside of the UK, compared with 14% in England and 11% in the West Midlands region.
- The number of births in Birmingham has risen steadily over the last 10 years, now levelling off at around 17,500 births per year.
- Fertility rates are higher in Birmingham than the national average, but have shown a similar trend over recent years.

Households

- Birmingham already has a larger than average household size and a high proportion of overcrowded households than the country as a whole.
- The population is expected to grow by a further 150,000 people by 2031, and it is estimated that the city will need a further 80,000 houses by this time.

Health

- Life expectancy for both men and women is lower than the England average.
- There are significant gaps in life expectancy across Birmingham too – 9 years difference in overall life expectancy between some areas (10 years for men and 7 for women)
- Premature mortality (deaths under age 75) has fallen steadily over the last decade in line with national trends.
- Birmingham has significantly high rates for many disease – for example diabetes rates are significantly higher than average
- Health partners are seeing increasing demand, for example there has been an increase in A & E attendance throughout 2016 across the city's hospitals. In September 2016, A&E attendances were higher at UHB (11%), HEFT (5%) and BCH (13%) than September 2015.

Healthy Lifestyles

- Injuries due to falls in the over 65 cohort are much higher than the average
- Levels of smoking are better than the England average
- Higher proportion of inactive adults
- Adults who feel socially isolated much higher than national average

Performance and Outcomes

Performance

Adult Social Care Service uses a variety of quantitative and qualitative information to monitor its performance, as well as benchmarking performance against other local authorities. This includes the Adult Social Care Outcomes Framework along with local information and statutory surveys.

At the highest level, ASC performance measures are a fundamental part of the Council-wide performance management framework – with 3 key ASC performance measures embedded within the Council Business Plan – measures that were agreed through a wide consultation including with our citizen voice function.

Performance Summary

Strengths and Improvements

- An increasing trend in terms of older adults who now receive care in their own home – a significant reduction in the proportion of older adults admitted into residential or nursing care over the last year;
- Delayed Transfers of Care –performance has stabilised over the last 12 months at a time when the national trend has been negative;
- Good processes for dealing with safeguarding enquiries;
- Improvements to carers perceptions of involvement and in making information more accessible;
- 89% of service users say that the support they receive makes them feel safe;
- Improvements to the proportion and timeliness of reviews;
- Improved performance at the initial point of customer contact – Adults and Communities Access Point.
- Proportion of adults with learning disabilities who live at home;

Areas for Improvement

- Take-up of direct payments remains relatively low;
- Delayed Transfers of Care – although it should be noted that performance has stabilised over the last 12 months at a time when the national trend has been negative;
- Slightly lower proportion of Care Homes classed as Outstanding or Good (63% vs 68% nationally) – with particular issues in the older adult market;
- Customer satisfaction with care and support;
- Better targeting of short term services to maximise independence;
- Social isolation of service users.

Overall ASCOF Position

Analysis of ASCOF data indicates that Birmingham is below average across a number of measures and in terms of a national ranking is one of the poorest performing authorities. Although this should be seen against the context of the city – its size, deprivation and financial challenges- it is clear that there are significant challenges that need to be addressed.

	Younger Adult Admissions to Residential / Nursing		Older Adult Admissions to Residential / Nursing		65+ service users still at home 91 days after enablement following hopsital discharge		65+ Reablement after hospital discharge		Delayed transfers of care from hospital		Delayed transfers of care from hospital that are attributable to adult social care		Clients receiving ST Maximise who received no, or lower level, services		Service user satisfaction with care and support		Service Users - ease of accessing advice and information		Service users who feel safe		Service users who say support has made them feel safe	
	2A(1)		2A(2)		2B(1)		2B(2)		2C(1)		2C(2)		2D		3A		3D(1)		4A		4B	
Authority	14-15	15-16	14-15	15-16	14-15	15-16	14-15	15-16	14-15	15-16	14-15	15-16	14-15	15-16	14-15	15-16	14-15	15-16	14-15	15-16	14-15	15-16
Birmingham	16	16.3	781	663	77.3	75.2	3	3.2	20.3	17	11.3	9.9	48.7	51.1	60.5	57.2	69.8	71	70.8	68.2	89.6	89.3
Bolton	13.1	13.7	985	978	79.9	70.1	4.5	2.2	6.9	9.8	2	2.4	80.2	90.7	61.2	62.6	74	69	52.6	61.9	68.3	72.5
Bradford	7	14	718	506	88.8	88.2	2.1	2.8	3.7	3.2	0.6	0.1	54.4	64.8	62.5	63.1	73.3	70.8	70.7	73.2	82.3	84.7
Coventry	13	25.8	706	721	75	81	4.5	1.5	24.2	22.1	11.8	7.3	70	67.2	64.9	61.6	75.3	69.5	75.8	69.8	85.6	86
Derby	2.6	3.2	593	600	90.7	89.5	3.7	3.1	10.7	11.3	1	1.8	71.3	86	65	58.1	71.3	70.2	69.7	67.6	86.2	84.9
Kirklees	11.1	16.4	503	518	94.1	89.1	1.8	1.1	9.8	10.7	1.2	2.6	73.2	78	59.3	62	72.6	72.2	61.7	69.3	75.3	76.2
Leeds	11.1	7.9	764	727	81.3	84.8	4.6	4.4	12.7	15	3.9	4	64.4	69.8	63.2	66	70.4	77.6	67.3	70.9	86.5	83.6
Leicester	13.3	16.3	727	644	84.3	91.5	3.7	3.1	12.9	5.9	4.3	1.7	63	60.5	56.9	61.7	63	61.7	58.3	60.8	75.4	80.7
Liverpool	17.8	14.2	753	774	75	78.6	2.8	3.2	9.2	12.4	3.3	6.1	49.1	64.3	69.5	61.5	75.6	68.5	70.4	68.9	91.8	86.4
Luton	9.2	20.3	306	395	78.9	84.4	3.7	2.9	9.1	5.7	4.1	3.4	66.7	96.3	55.8	59	67.9	66.6	62.1	64	76.6	74.6
Nottingham	24.5	16.2	773	675	80	74.7	0.7	1.6	11.3	15.2	2.5	2.2	49.7	40.5	61.1	68	63.3	75.4	64.5	69.6	79.6	84
Oldham	12.6	15.4	797	859	93.4	89.8	1.6	1.7	4.3	4	0.6	1.1	59.2	84.9	61.2	61	70.5	71	67.5	60.9	83.5	73.7
Sandwell	11.5	14.6	1117	1002	68.6	63.8	3.2	3.2	12.7	7.3	4.7	4.2	63.5	64.7	66.2	70.1	82.2	83.4	77.3	75.6	85.4	90.4
Sheffield	14	21.6	730	988	76.5	76.7	4.9	8.9	15.2	15.7	7.4	7.7	78.5	72.7	59.8	52.3	65.7	66.7	63.6	62.5	81.5	87.2
Walsall	6.8	4.3	480	551	77.2	80.1	4.4	4.3	6.8	9.5	4.1	7.9	77.3	75.7	64.1	62.1	74	68.1	75.5	71.3	91	88.5
Wolverhampton	21.6	15	644	700	80.6	75.6	6.1	3.8	10.5	21.6	4.9	13.4	82.5	80.7	69	65.9	79.1	75	74.8	71.7	84.4	85.5
B'ham Ranking	13	11	13	7	11	13	11	5	15	14	15	15	16	15	12	15	12	6	5	10	3	2
National Avg.	14.2	13.3	669	628	82.1	82.7	3.1	2.9	11.1	12.1	3.7	4.7	74.6	75.8	64.7	64.4	74.5	73.5	68.5	69.2	84.5	85.4

	Service users quality of life		Service user control over daily life		Client Self Directed Support		Carer Self Directed Support		Client Direct Payment		Carer Direct Payment		LD Employment		MH Employment		LD Accommodation		MH Accommodation		Service users with as much social contact as they would like	
	1A		1B		1C(1A)		1C(1B)		1C(2A)		1C(2B)		1E		1F		1G		1H		1I(1)	
Authority	14-15	15-16	14-15	15-16	14-15	15-16	14-15	15-16	14-15	15-16	14-15	15-16	14-15	15-16	14-15	15-16	14-15	15-16	14-15	15-16	14-15	15-16
Birmingham	18.9	18.8	73.5	71.1	100	100	100	97.5	18	19.8	98.7	95.8	1	0.8	5	5.3	35.3	53.9	63.8	69.4	43.5	44.6
Bolton	18.2	18.3	73.7	72.5	97.1	96.7	98.6	94.6	31.4	36.9	29.9	27.7	2	2.1	8	7.2	82.4	93.6	87	79.5	36.4	40.2
Bradford	19.4	19.5	77.8	79.2	79.4	86.8	100	82.5	14.8	17.5	100	81.9	4.9	5.5	7	6.1	84.4	86.3	66.5	69.1	52.2	51.3
Coventry	18.8	19.2	76.2	73.4	82.2	80.2	47	41.9	20.5	21	47	41.9	4.9	3.7	11.1	12.2	81.7	76.3	74.6	70.6	43.1	47.7
Derby	18.9	19.1	79.1	79.5	99.1	100	100	100	38	41.9	100	100	7.1	6.9	7.9	6.9	79.3	81.1	58.4	81.3	42.7	42.2
Kirklees	18.2	18.7	72.7	74	88.9	91.5	-	0.5	40.7	35.2	-	0.5	10.4	10.2	8.1	8.3	83.2	80.3	67	60.5	39.7	42.7
Leeds	18.9	19.2	77.3	73.7	82.3	94.9	73.1	97.4	16.9	18.9	68.8	91.8	7	6.4	10.7	9.9	79.8	65.5	54.2	51.1	44.3	45.2
Leicester	17.9	18.1	67.2	70.5	96.2	98.7	100	100	41.3	44.4	100	100	6.9	5.2	1.8	2.9	69.8	71.8	35.8	62.3	35.6	37.2
Liverpool	19.6	18.8	77.4	73.9	71.8	77.7	100	100	18.3	21.9	40.1	18.6	5.9	5.9	2.7	2.9	89	90.3	68.3	67.7	49.5	49.4
Luton	18.4	19.1	71.6	73.9	88.7	68.6	100	100	34	36.9	100	100	22.9	16.8	7.8	7	69.5	74.8	61.2	55.4	39.3	48.6
Nottingham	18.6	19.1	72.3	77.4	100	100	-	100	30.2	31.7	-	100	1.9	0.3	3.3	6.9	63.6	83.3	41.4	63.6	36.5	46.9
Oldham	18.9	18.3	74.3	69.3	92.8	100	100	100	45.6	37.9	94.1	100	0.5	1	0.7	0.1	78.4	93	15.8	2.5	45.8	37
Sandwell	19.9	19.8	80.4	78.4	92.2	96.1	-	100	33.2	38.5	-	100	3.2	1.3	5.9	5.4	79	80.4	72.3	69.7	51.5	51.4
Sheffield	18.5	18.2	73.9	71.7	71.6	85.4	68.5	100	22.3	37.1	50.5	100	3.6	3.6	5.6	5.3	86.3	84.1	74.4	69.4	41.5	40
Walsall	18.9	18.6	71.2	68.1	82.8	91.3	100	100	29.4	31.1	96.9	97.9	2.8	1.1	6	6	80.8	85.8	77.8	84.2	44.7	43.1
Wolverhampton	19.4	19.5	77.3	75.2	61.5	75.3	33.5	30	22.6	21.5	33.5	30	1.9	1.7	5.3	6.9	67.4	66.1	79.7	79.7	52.6	50.8
B'ham Ranking	5	9	11	13	1	1	1	10	14	14	5	9	15	15	12	12	16	16	10	7	8	9
National Avg.	19.1	19.1	77.3	76.6	83.7	86.9	77.4	77.7	26.3	28.1	66.9	67.4	6	5.8	6.8	6.7	73.3	75.4	59.7	58.6	44.8	45.4

Performance Details

Assessment and Support Planning - Performance Pack Available on request

- In last 12 months 2,234 **Mental Capacity Act Assessments** completed – proxy data suggests that around 90% take place within 72 hours
- We are now collecting more data on **Carers Assessments** and whether they are offered by Social Work teams, than in previous years. In the past 12 months there were around 2,344 assessments across the city (this does not include assessments undertaken by the carers hub).
- **Direct Payments –** Around 20% of eligible clients currently receive a Direct Payment – this figures has remained very static for a number of years.
- **Reviews –** As of September 2016, 80% of clients receiving services have been reviewed, assessed or reassessed in the last 12 months. This is an improvement against 2015. There are large variations between ASP segments – eg. Learning Disability Team is currently at 49%, whilst North Complex Team is at 96%.

Assessment and Support Planning – Hospitals - Performance Pack Available on request

- **Delayed Transfer of Care** – the average number of delayed bed days per 100,000 of the population is 18.5 (August 2016) – above the target for the end of the year (17.8) but a slight reduction compared to 2015/16. The proportion attributed to Social Care delays has slightly increased through 2016 to date;
- Average unplanned/emergency admissions Length of Stay in hospital has reduced across the city over the last 2 years;
- Social Work teams are seeing increasing demand in hospitals - In the previous 12 months to September 2016 there were **6,769 initial assessments** and **2,800 full assessments** completed across the hospitals
- **7 day working** - The chart below shows activity taking place at the weekend. Monthly analysis over 2016 indicates that levels have fluctuated significantly on a monthly basis. This has resulted in 410 discharges since April taking place earlier than would have occurred otherwise.

Adults and Communities Access Point (ACAP) Performance Pack Available on request

- In the 12 months up to September 2016 ACAP First Response Team handled 60,753 calls;
- Over the last year the call abandonment rate has reduced from 35% to 22% (as of September 2016 - 12 month averages)
- Around 54% of cases are closed at second response. This results in reduced demand on social work teams.
- **78%** of those cases referred to a social work team are transferred within 2 weeks of contact. This an improvement from 61% last year.

Customer satisfaction
Users Survey

- In terms of ASCOF 1 Enhancing quality of life for people with care and support needs measure – Birmingham's score is on par with our comparator authorities – although it is below the national average. Younger adults have a slightly better score than older adults, and males over females
- 68% of respondents who use services feel safe, above the comparator group average although a slight fall on last year's levels.
- Almost 90% of people who use services say that those services have made them feel safe and secure.
- In terms of social isolation, 46% of respondents have as much social contact with people as they like – down slightly in the last 12 month but up from 43% in 2012/13. However this is much lower than the national average
- Nearly 72% of users feel information is easy to find – above average and an improvement on last year

Carers Survey

BCC has committed significant resources into improving information and services for carers. Whilst national data is not available for 2015/16 we can review how we are performing as an authority as outlined below :

- 1D Carer-reported quality of life- Index score based upon responses to a range of outcomes.
- 3B Overall satisfaction with social services- percentage of carers who said they were "extremely" or "very" satisfied with the support they and the person they care for have received in the last 12 months
- 3C Carers included in consultation about the person they care for- percentage of carers who said they were "always" or "usually" involved as much as they want in discussions about the support provided to the person they care for
- 3D Ease of finding information- percentage of carers who said they found it "very" or "fairly" easy to find information about support, services or benefits. This includes information from sources other than the council.

Measure	Comparator Ave (2014/15)	Birmingham (2014/15)	Birmingham (latest)
1D	7.7	7.1	7.3
3B	38.2	32.2	28.0
3C	69.7	60.5	63.6
3D	61.5	52.1	58.5

The table shows that there has been a marked improvement in measures 1D, 3C and 3D. This indicates that progress has been made in respect of involving carers in discussions about the person they care for and with regards to making information accessible for carers. However, it is concerning that carers' perceptions of the quality of the service show a negative trend.

Safeguarding adults

In 2015-16, 90% of referrals had an outcome within 28 days. In quarter 1 of 2016-17, following the introduction of a new process in April 2016, in 83% of the completed enquiries the client had been asked to express what outcome they wanted to achieve from the enquiry; this was the second highest % achieved in the 10 West Midland authority areas who reported this information, compared to a West Midlands average of 69%.

Of those enquiries where an outcome was expressed, 91% of these outcomes had been fully or partially met by the end of the enquiry (3rd highest in the region), compared to a West Midlands average of 86%.

The standard of adult safeguarding casework is audited each quarter. This includes checking that the adult has been appropriately placed at the centre of the enquiry in line with the principles of Making Safeguarding Personal.

Audit results consistently show that the standard of 85% of case files indicating good or outstanding work has been exceeded (88.1% over the last 4 quarters, with 89.5% in quarter 2; the target was exceeded through 2015/16)

Deprivation of Liberties Safeguarding

Since the beginning of 2014-15, the number of referrals for Deprivation of Liberties Safeguarding has increased by more than 10 times. While work has been ongoing throughout the period to address this increase, by the end of 2015-16 our backlog stood at 2166 (264 per 100,000 population) – with 68% of those referred in the year still being outstanding. A Best Interest Assessment Team was established to bring together all the qualified Best Interest Assessorts, a Team Manager Authoriser and 20 agency Best interest Assessors. By the end of June 2016, with new systems in place including the use of agency staff to address the backlog, this had reduced to 1689 (206 per 100,000) – with 49% of those referred in the year still outstanding. Early indications is that figures for quarter 2 of this year show even more improvements – All the backlog of requests has now been allocated.

Interface with Healthwatch

Healthwatch Birmingham has experienced some difficulties, but is now entering a phase of stability and consolidation. A permanent CEO, Andrew Cave, has been appointed and is focussed on taking the organisation forward.

In conjunction with Solihull MBC an opportunity was identified to create a joint Healthwatch to align with the Birmingham & Solihull STP. However, this looks unlikely to be taken forward at this stage and the intention is therefore to re-commission Healthwatch Birmingham from 1st April 2017.

The current performance framework seeks to consolidate the organisation; the framework from 1st April, following re-commissioning, will seek to stretch the organisation and build impact.

Leadership and Governance

Political change and context

Councillor John Clancy was elected Leader of the Council in December 2015, replacing Sir Albert Bore who had been leader of the Labour Group for the previous 16 years.

The most recent Council elections were in May 2016 when a total of 40 of the 120 seats were contested. There was no change in political control at this time, with Labour increasing its majority by 2 seats. After the election there were a number of changes in the cabinet structure – although Councillor Paulette Hamilton retained her position as Cabinet Member for Health and Social Care.

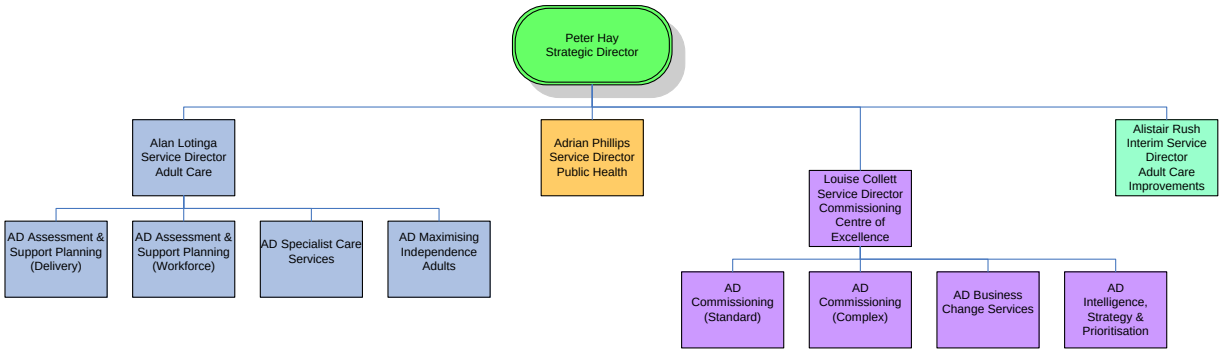
Over the next few years there is likely to be a significant change in the political makeup and structure of the Council. As a result of the "Kerslake Review" into the corporate governance of Birmingham City Council, a Boundary Commission review of Birmingham political wards was undertaken. The Commission recommended changing the number of wards from 40 to 69, with the city being represented by 101 rather than 120 members. The final recommendations of the Local Government Boundary Commission for England were published after much consultation in September 2016. To facilitate the implementation of this, all-out elections will take place in 2018.

System and organisational change and context, incl. system wide ASC focus

The Council is structured into three Strategic Directorates – People, Economy and Place. Adult Social Care forms part of the People Directorate. The other principal elements of the People Directorate are Children's Services and Education. In addition, People Directorate contains Public Health and the Commissioning Centre of Excellence. Both of these services work across all elements of the People Directorate.

The Directorate Leadership Team (DLT) meets weekly and brings together the Strategic Director, Service Directors for Adult Care, Education, Children's, Commissioning and the Director for Public Health.

The chart below shows the current structure of Adult Social Care alongside Public Health and the Commissioning Centre of Excellence.



The leadership capacity of the Adult Social Care function has recently been expanded by the appointment of an Interim Service Director for Adult Care Improvements and an Assistant Director to lead on delivery of the Maximising Independence of Adults programme.

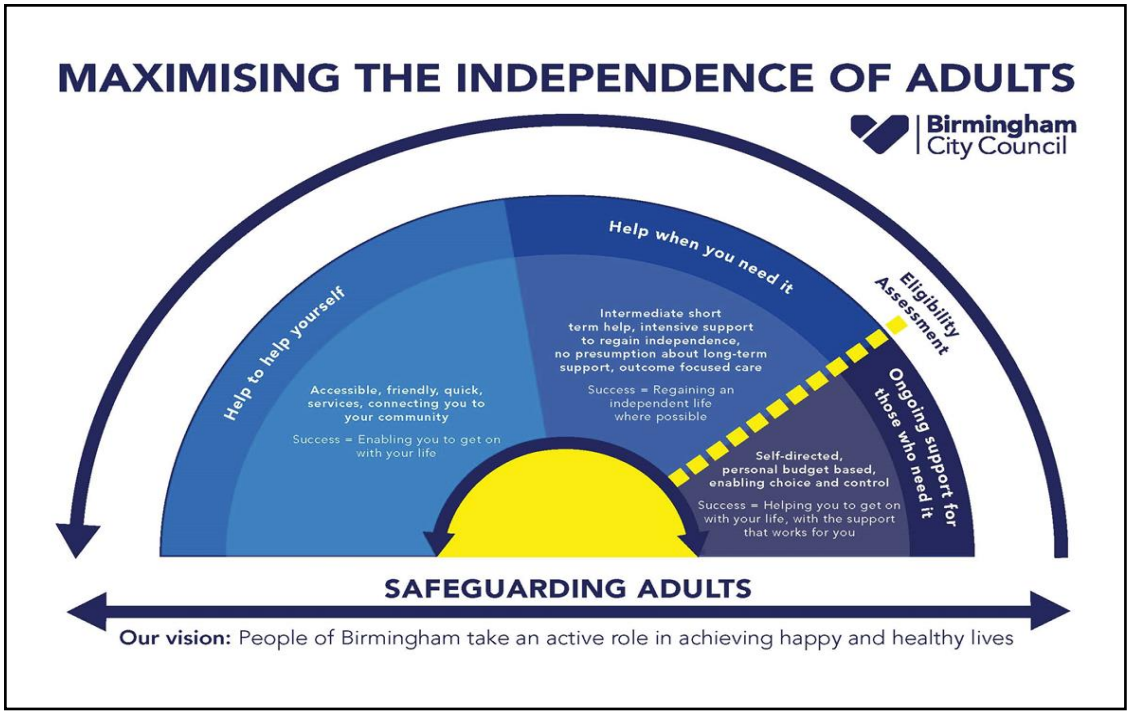
Adult Social Care is 8 years into a fundamental 10-year transformation programme. We have reviewed this programme and are considering the future operating models for Assessment and Support Planning (ASP) and Specialist Care Services (SCS).

In order to deliver its future vision for Adult Social Care and to deliver its savings target the Council has established the Maximising the Independence of Adults Programme. This builds upon the 10-year programme but reflects the wide range of new, demanding responsibilities arising from the Care Act 2014 and a number of other key national requirements and expectations. Three priorities have been identified to meet the challenge.

- Improving the Customer Journey
- Shaping the market (Service Transformation)
- Prevention

To deliver the programme we have established robust project and programme management arrangements, setting clear priorities, managing interdependencies and delivering at a pace projects which deliver benefits while minimising risk.

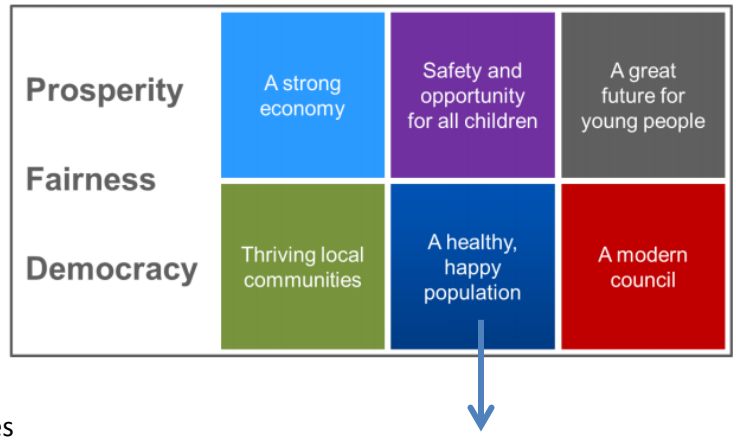
The Maximising Independence of Adults vision and approach is encapsulated in the diagram below.



Priority given by the Council to Adult Social Care

Adult Social Care is clearly visible within the council at a senior level – with the Strategic Director for People a member of the Council's Corporate Leadership Team. Given the significant financial challenge around ASC – the Council and Directorate has implemented robust measures to tackle the financial challenge through fortnightly budget meetings held with the Chief Executive, Deputy Leader and the Cabinet Member.

Adult Social Care is fully embedded in the Current Birmingham City Council Plan. There are two clear sub-outcomes relating to ASC within the "Healthy Happy Population" outcome.



Sub-outcomes

- *A seamless health and social care provision so people can get the service they require or the correct information and advice in one place, with people who need services able to access the services they need irrespective of who the provider is*
- *Citizens having greater control and independence and making informed choices about who they want to provide the care and support they require and where they want it provided; with all citizens who have an assessed, eligible care need having access to either a direct payment or individual budget.*

The Council is currently developing a new vision –"Birmingham: a city of growth where every child, citizen and place matters". This is supported by four priorities:

- Children;
- Housing;
- Jobs and Skills;
- Health.

Of these, the Council is explicit that Children are the key priority. This reflects the young profile of the City and the issues relating to failures to protect vulnerable children that the City has experienced.

The Health theme will incorporate measures relating to Adult Social Care as part of a life-course outcomes framework.

The over-riding priority to ensure that vulnerable children are properly protected has resulted in a decision to establish a Children's Trust to deliver the Council's social care responsibilities for children. The creation of the Trust will clearly impact on the structure of the People Directorate, particularly with regard to leadership capacity and support services. Similarly the landscape for Education is changing with a greater emphasis on delivery of local authority functions through the Birmingham Education Partnership. In this context the future shape of the People Directorate will need to evolve; for Adult Social Care the direction of travel is towards greater integration with Health.

Commissioning and Quality

The importance of managing risk and quality in the market through a commissioning-led approach has been recognised with the establishing of the Commissioning Centre of Excellence (CCoE) in 2015. The CCoE has responsibility for commissioning care packages for citizens from providers, managing contracts and undertaking market shaping activity with the purpose of achieving the best outcomes for citizens whilst ensuring value for money.

The Council currently commissions adult social care for approximately 7,000 citizens at any point in time from over 800 care settings in the independent care sector. These services are principally commissioned under a framework contract with mini-competition for each package of care. We also have a number of strategic block contracts for residential homes, nursing homes and Extracare services.

We employ a quality rating system for providers registered on our framework contract which is a key part of the mini-competition process. Scoring takes into account a provider self-assessment, CQC ratings and any contractual interventions undertaken by the Council, giving each provider a quality rating which is published quarterly. Quality ratings vary across sectors but by way of an example, we currently have 72.4% of home support providers rated as 'good', 20.5% 'requiring improvement' and 7.1% rated as 'inadequate'.

The Council has recently agreed to extend its framework contract which started in 2012, whilst we conduct a review of how these services are commissioned.

Market Shaping

Over summer 2016 the CCoE has engaged with the adult social care provider market to explore the following three themes:

- Defining quality;
- A Fair Price for Care; and
- Brokerage

This work is to support the re-commissioning of the adult social care framework contracts from 1st October 2017. A key element of this activity has been working with the market to begin to define a quality framework in Birmingham which proposes to remove the poorest performing providers (which fail to improve) from the new framework. This in turn could give rise to potential issues re: capacity. A further part of this work is to try and address longstanding concerns about the price Birmingham pays for adult social care and to develop an approach which the market are engaged with and that ensures the market is sustainable.

In terms of market gaps, there is evidence to suggest that complex nursing and dementia needs are increasingly being expected to be delivered in community settings. Further work is underway to review the Council's Dementia Strategy which will be fed into revised Market Position Statements at the appropriate time. Close working relationships have been developed with Clinical Commissioning Groups across Birmingham, to work with nursing homes to achieve improvements in clinical quality and enable more complex nursing needs to be met in these settings.

Work is underway with health to take a much more coordinated approach to managing providers and consideration is being given to joint contracting arrangements. A working group has been established with Clinical Commissioning Group's to look at Continuing Health Care (CHC) commissioning and whether this could be conducted under a revised joint contract. This is

particularly important when addressing issues of quality and price with providers and to ensure a consistent message about the standards expected and what the wider health and social care system is prepared to pay for these services.

The 2016/17 Council Business Plan has a target of achieving at least "72% of service users living in a care home (incl nursing home) or receiving home support placed with providers meeting the 'Good' quality standard (average of quarterly scores)". As at the end of quarter one (2016/17) only 62.3% of citizens were placed at providers rated good by the Self-Assessment process, compared to 65.1% in 2015/16. There are variations within this figure with home support providers having a higher average rating than bed-based providers. Within the latter the performance of the older adults market is of concern with just over 40% of providers meeting the required standard.

Quality Issues

Since 2014 the ASC service a Data Quality and Standards Team lead by a Group Manager has been in place with the aim on improving social work practice. This team has led on the development of quality standards and guidance, developed audit tools and undertaken benchmarking exercises. They have led on the redesign of the assessment tools used.

There has been great emphasis on the quality of work completed by setting clear standards and expectations set about work undertaken across ASP. The introduction of the assessment audit checklist has ensured that SPDs audit assessments against a given standard. This approach has introduced the concept of the competency based self-authorisation to embed professional autonomy for social workers who can evidence their level of competency via these audits. We have completed customer telephone audits which have shown a 90+% satisfaction rate with the quality of social workers interventions.

Quality of Care Planning - This is not reported on through care first so no data is available however work is being carried out by the ASP quality team to audit individual cases on a rota basis there is also a pro forma being developed to demonstrate best practice for completing standard and complex cases. These are in their infancy at present and would require at least 3 months to acquire meaningful data.

In terms of quality of commissioned services, a robust process is in place for home support services and older adults' bed based services. This is based on a quality rating system as described above. For nursing homes there is a joint process for managing quality issues which has been used within the 41 homes managed by Cross City CCG since June 2016. We are also working towards a joint Serious Incident process in Nursing Homes to enable quality concerns to be investigated in the most appropriate place.

The Council is currently taking action with a number of providers in relation to quality concerns which includes suspensions and improvement plans.

Market Position Statement

The Council's Market Positon Statement is published and can be found on the Council's website here: http://www.birmingham.gov.uk/marketpositionstatement

As the MIA programme progresses the MPS will be up-dated and will reflect the framework Terms & Conditions as issued post consultation.

Capacity/True Cost of care

In recent months Birmingham was impacted by the closure of a number of nursing homes, home support agencies and supported living providers . A joint protocol has been agreed with health to ensure a consistent approach to closures and appropriate prioritisation of citizens across health and social care. The re-assessment of citizens was undertaken very effectively although this did exacerbate capacity issues in terms of finding alternative provision. On a positive note Birmingham is seeing construction of new residential and nursing provision which will increase available capacity. Issues to be considered over the coming months are the continued use of a large volume of Enhanced Assessment Beds, commissioned by CCG partners.

With regards to the true cost of care/fair price of care, this has been the subject of close working with providers over the summer, following the publication of the latest KPMG open book process. Taking a regional and core cities view we have identified a potential issue regarding home support which we are discussing with providers.

Obviously any conversation regarding fees has to be cognisant of the City Council's complex financial position and the commitment to the Birmingham Care Wage.

Value for money of care packages – the use of a tendering process through Sproc.net provides assurance in terms of the value for money of care packages by combining the BCC self-assessment questionnaire, CQC ratings and a financial element to find the most suitable provider for support packages. The allocation of packages and the scoring of bids includes a specific element which identifies the extent to which providers can meet the citizen's outcomes.

With the recent introduction of New Deal we may be able to identify if support plans effectively meet the outcomes of Users – further work needs to be completed on this to identify validity.

National priorities and partnerships

Health and Wellbeing Partnership & Partnership Boards

The membership of the health and well-being board has been revised and strengthened. The Board now includes representatives from the CCG (Vice Chair) and also the housing and independent sector. We have moved away from holding meetings only at Council offices to help open up the discussion and we have more thematic workshops where other key individuals as well as board members are invited. The health and well-being strategy is being rewritten and a clearer role for the Health and Wellbeing operations group is being developed.

Adults Safeguarding Board

In preparation and since the implementation of the Care Act 2014 the BSAB governance and membership, the Board's plan (now far more strategic and looking over 3 years), risk register and its annual report have been fundamentally revised and moved on from previous years. There has also been a significant increase in investment in infrastructure support to the Board, linked Groups and to promote better joint work with other partnership boards on common top priorities eg domestic violence, mental health/DOLS, oversight of unregulated care settings, etc. There has been a particular emphasis placed on getting more effective and relevant joint working/co-production with the voluntary and community sector and citizens who have experienced the safeguarding system. We are aiming to appoint a new Independent Chair of the Board in the near future.

Children's Safeguarding board/Community Safety Partnerships

Work is progressing with the Children's Safeguarding Board , Community Safety Partnership and Health and Wellbeing Board to work together more on appropriate priorities and support mechanisms eg in relation to domestic violence , child sex exploitation and female genital mutilation. The new Domestic Abuse Prevention Strategy 2017-2020 is currently out for consultation.

Better Care Fund

The City's second BCF plan effective from April 2016 was fully approved, without conditions, by NHS England. In all important respects the local health and care system is currently in the process of fusing/merging relevant BCF projects and support capacity into STP workstreams and governance, whilst respecting the fact that BCF delivery and reporting, of course, remain mandatory requirements nationally.

Care Act Implementation

The most recent regional Care Act stocktake report highlighted the positive progress Birmingham was making around the Care Act, including the working in revising the Customer Journey, more effective work with partners, and better support for Social Care Staff. The findings of the regional work are as follows:

The regional position

- Across the region the proportion of people assessed as eligible has increased.
- Council's will wish to ensure that they are meeting their statutory duties towards carers.
- Preparation for adulthood is in its early stages of development
- Confidence in the ability to recruit and train the local Social Care workforce has declined since the previous stocktake.
- Costs have mostly increased as expected with some higher than predicted costs in safeguarding and preparation for adulthood.
- Widespread feedback across the region that councils are partially able to understand and shape the local care market.

Birmingham's variation from regional position

- A significant overall increase in activity (assessments, eligibility, carers, information and advice). Need to ensure data is accurate/validated.
- Prevention is developing but not fully effective. 11 of the 14 council's in the region are more confident in meeting these duties.
- Information and advice also developing but not fully effective.
- Birmingham's confidence in the ability to recruit and train the Social Care workforce has increased since the last stocktake. This is against the regional picture where overall there is a decline in confidence.
- The financial picture shows some consistencies with the region with impact being felt on a large scale

In summary the strengths and areas for improvements highlighted in the stocktake are summarised in the table below.

Strengths	Improvements
We are confident that we have embedded the statutory requirement plus the 'spirit' of Care Act 2014.	Performance/Monitoring and evaluation- is an area requiring further work
Learning & development - The Learning & Development Service (tlds) has also developed and commissioned a programme re. Meeting CQC Inspections. This too, has been very popular amongst providers.	Advice & information - Birmingham is at present looking to improve joint commissioning and provision of information with other parts of the Council.
Market shaping & Commissioning - BCC are very effective n regard to shaping the market and mitigating provider failure.	Prevention – developed but not yet fully effective
Prisons & custodial setting – Engagement with Winson Green Prion staff. Pathway for prisons has been completed.	Carers offer - yet to determine
Deferred payments – well established	Assessment process – are we applying this in a manor that is consistent. I.e. whole family approach
	Personal budgets – The Council has no clear approach in how it intends to meet section 26 of the Act giving the right to a personal budget for this eligible for care and support.

Winterbourne View/Transforming Care

The Directorate and the three Birmingham CCGs have operated a Section 75 agreement for joint commissioning of services for adults with Learning Disabilities and Mental Health issues since 2010. This arrangement remains in place though the governance arrangements have changed to ensure greater focus on each service area.

The joint Integrated Commissioning Board has been replaced by two separate interim boards whilst the future Governance arrangements are reconsidered within the scope of the commissioning reform work stream within the Sustainable Transformation Plan. The mental health system strategy board has been in place for over a year and provides strategic direction for Mental Health Services.

An extended Transforming Care Board is also now in place to provide governance around the development of services to adults with Learning Disabilities. The agenda of these boards has recently been revised to ensure all partners remain sighted to the financial position with regards to jointly commissioned services.

System Wide Transformation

The City Council been working in partnership with the NHS and Solihull Metropolitan Borough Council to develop a Sustainability and Transformation Plan (STP) to improve the health and wellbeing of people living in Birmingham and Solihull. Mark Rogers – Chief Executive of Birmingham City Council is the Footprint lead for Birmingham and Solihull area.

The STP was made public on October 24th – the first area in the country to do so. The Plan identifies 3 areas for change:

- Insufficient system wide focus on use of resources
- Too much care that can be delivered elsewhere is provided in a hospital setting
- Variation in clinical services

And 3 clear objectives:

- Creating efficient organisations and infrastructure
- Transformed primary, social and community care
- Fit for future

Resource and workforce management

Financial Context

Like the majority of local authorities within the region, Birmingham is experiencing a growth in demand for services whilst facing severe reductions in the funding that is available for care.

Since 2011, funding for Adult Social Care in Birmingham has reduced by a cumulative total of £152m.

A Transformation Programme agreed in 2008 set out a 10 year £200m+ savings programme that was subsequently stretched to £400m+. However, even if this was fully delivered it would not be sufficient to meet the actual savings that are now required.

There has been a failure to realise all of the savings identified in the 2008 plan. In particular, there have been shortfalls against the projected 30%+ savings for younger adults care packages. There have also been major changes to the operating environment since 2008. The Care Act, in particular, has led to changes in responsibilities and demand.

Service reviews and demand management initiatives have delivered mixed successes. "Underspends" in early years of the programme turned to a large overspend of £9m in 2015/16 that has continued to grow. Consequently there is increasing reliance on reserves and balances from the NHS – some of which have not been properly agreed.

Large movements in forecasts, especially for placements, have been experienced in the current financial year. At present a £50m shortfall is projected. £28m of this is due to the non-delivery of NHS resources through the Better Care Fund and the Sustainable Transformation Plan. Although included within the financial plan for the year, this is now unlikely to be made available.

There are a number of factors that have resulted in the current financial situation including a failure to realise unrealistic programmed savings, poor financial management that has not been closely enough aligned to forecasts, use of reserves that has obscured underlying issues, £6m per annum unfunded demographic pressures, other external pressures such as DoLs, large increases in long-term care packages directly from hospitals and EABs and failure of the care market.

The Directorate has implemented robust measures to tackle the financial challenge. Fortnightly budget meetings are held with the Deputy Leader, Chief Executive and the Cabinet Member. Whilst Adult Social Care is the most prominent issue, there is a clear recognition that all parts of the Council need to contribute to mitigate budget pressures. The Maximising Independence of Adults programme has been launched with a clear remit to stretch the resources that are available and to deliver savings. A key area for action is the need to manage and reduce demand within the system. Our relationship with the NHS is crucial; we need to ensure that commissioning and funding arrangements, for example those relating to Continuing Health Care and Enhanced Assessment Beds, are appropriate and that we are co-ordinating efforts to manage demand.

We recognise that further action is required to address the scale of the challenge. We need to focus on sound, practical action to reduce the overspend and to make sure that this activity is properly project-managed and fully implemented; we need to develop a better understanding of our interactions with the NHS to enable us to have clear, evidence-based conversations about roles, responsibilities and funding; we need to make sure that social work practice is consistent with policy and that we are truly doing asset-based assessments so that the limited resources that we do have are properly and fairly utilised; we need to implement a clearer strategy for the provision of Specialist Care Services and stronger commissioning, procurement and brokering process and

systems. Above all we must urgently define a new Adult Social Care function and structure and, therefore, a new "offer" in the community and in hospitals.

With respect to the Peer Challenge process we have already identified many issues and have action plans in place. We do not want these to be duplicated. However, within the scope of the Peer Challenge there would be value in exploring consistency of practice and whether our social work practice is stretching the resources we have. In addition, we are seeking input from the review team on managing the relationship with colleagues in the NHS.

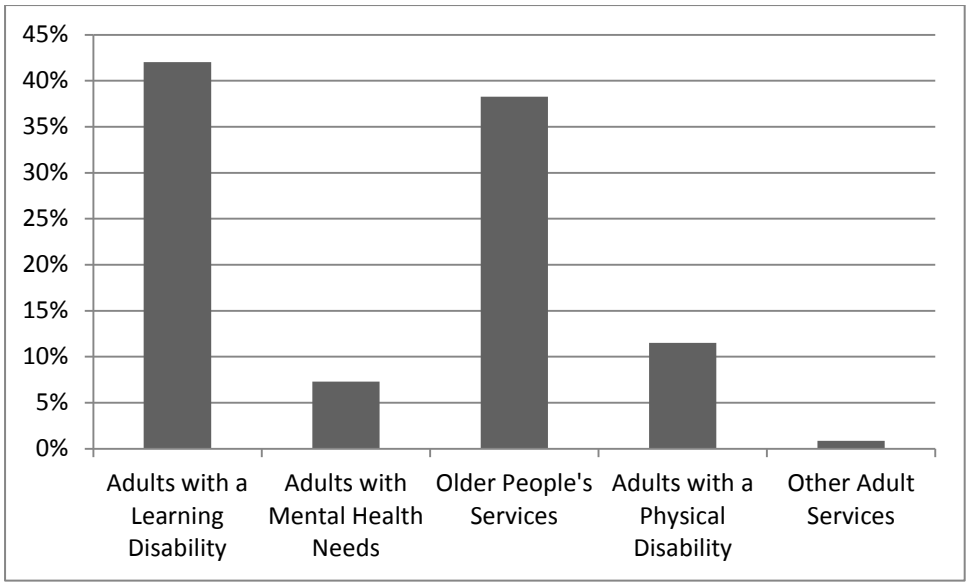
% corporate spend on ASC

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Adults Social Care	287,834	276,885	263,298	232,556	216,255	226,867
Council Spend excluding Education	941,989	937,806	902,590	862,812	823,953	812,320
%	31%	30%	29%	27%	26%	28%

% spend on residential care

52% of the total spend (net of client contributions) on care packages is spent on residential care.

Expenditure (net of client contributions) on care packages by client group



Workforce, vacancies and recruitment

There are currently 924 [878.5 FTE] staff members within the Assessment and Support Planning (ASP) function. Of these, 405 (44%) are social workers. This includes 68 [62.9 FTE] GR5 Social Workers and 337 [321.1FTE] GR4 Social Workers

There are 11 (FTE) vacant Grade 5 and 21.5 (FTE) vacant Grade 4 social work posts that are being covered by agency staff at present. This is equivalent to 8.5% of the current social worker cohort.

Recruitment and selection is currently taking place for all vacant post across ASP.

Specialist Care Services are working through a service redesign to include re-provision of some services and decommissioning of other services. This is being carried out in consultation with service users and staff. Commissioning officers are assessing the capacity and quality of alternative providers within in the market.

As a result of the service redesign process, SCS is subject to a section 188 notice at present. This places restrictions on recruitment although there is flexibility to utilise agency staff if there is a critical business need. Similarly recruitment can also take place where there is a sound business case, for example where specialist skills are required.

The workforce delivery model was redesigned in 2011 in response to the Munro review of Social Work in England as well as existing budget pressures. Adult Social Work was restructured which resulted in a reduction in the management tiers and management numbers. It also introduced the organisational split between Workforce and Delivery. Management tiers were reduced to Director, Assistant Director, Group Manager, Team Manager and Senior Practitioner Workforce/Delivery. The Assistant Team Manager post was deleted. New roles of Senior Practitioner Delivery (SPD) and Senior Practitioner Workforce (SPW) were created.

A matrix management structure was introduced. Delivery held the responsibility for the flow of the work and the management of the delivery of assessments and support planning. Workforce was responsible for the management and supervision of the staff as well as any HR issues. The separation of the workforce in this way was to address the concern that in the management of pressured and challenging work environments it is staff support and supervision that suffers. It is this which the Munro report highlighted that can lead to demotivated staff, poor staff retention and a reduction in the quality of the work undertaken by social workers. The SPWs are managed by Group Managers Workforce. This ensures that decision making is consistent across the organisation. SPW are, as far as possible, linked to one team and work closely with the Team Manager and SPDs to address any issue which arise about the performance of the staff group.

The Workforce /Delivery split has enabled us to be sure that we have our workforce at work, in the correct teams, undertaking the level of assessment which matches their skill set. The commitment to creating a learning environment can be seen by the development of clear career pathways and a commitment to the ongoing appraisal of workers.

Due to the innovative nature of this approach the model has been externally reviewed in 2012 by Jon Glasby from the University of Birmingham. This review recognised the value and strength of working in this way.

One of the key drivers for this change was to strengthen our management approach while reducing the tiers and numbers of managers. The savings achieved by this restructure was £5.2 million.

There is clear evidence of the positive impact of this approach in the Birmingham Reform Board Summary 2016 and the internal evaluation of workforce complete June 2016. However as with all approaches we are committed to review the workforce / delivery balance.

One of the very important recommendation of the Maria Gibbs review of social work was that in order to improve the morale and motivation of the staff they needed to be given consistent and proper supervision. The workforce delivery model provides ,every social worker with 10 supervision per year to look at all their training, development and career progression. They also receive case work supervision from senior practitioner delivery.

Culture and challenge

Local Account – process and product

The 2015/16 Local Account document is currently being prepared in light of the release of the latest ASCOF benchmarking information. Findings from this self-assessment and peer review process will also help inform this process. Previous years versions are available and published on the City Council's website.

Participation in core SLI activity & Peer review exercises

The directorate team fully embrace Sector Led Improvement – Peter Hay and other senior staff participate in the WM Peer Challenges of other WM Adult Social Care Departments, supporting them to develop and bringing learning back to Birmingham to further develop our services, we actively lead on both regional and national priorities and key issues – Peter is co-chair of WMADASS, Alan Lotinga is the lead officer for DASS safeguarding, Carl Griffiths chairs the deputies/AD's Group and Safina Mistry is the lead for Carers, we are also very active on the regional finance and legal networks.

Peter and Alan also give national presentations and joint panels on hot topics to promote the Adult Social Care View and issue, the most recent of these was evidence given to the National Carers Commission, Birmingham featured prominently in their report launched from the House of Commons.

Local performance management arrangements

Performance Management is integral to the delivery of Adult Social Services. At the highest level, ASC performance measures are a fundamental part of the Council-wide performance management framework – with 3 key ASC performance measures embedded within the Council Business Plan – measures that were agreed through a wide consultation including with our citizen voice function.

Through the work of the Maximise Independence of Adults a new Adults Performance Framework is currently being developed – which will address system wide performance.

The Commissioning Centre of Excellence Intelligence and Analysis team also supports the service in providing a number of dedicated Business Intelligence and Management Information reports around the following areas:

- Assessment and Support Planning (broken down by areas and teams)
- Assessment and Support Planning in Hospitals
- Adults and Communities Access Point (ACAP)
- Safeguarding
- Specialist Care Services

As well as this to support improvement in social work standards - In 2014 we developed a Data Quality and Standards Team lead by a Group Manager. This team has led on the development of quality standards and guidance, developed audit tools and undertaken benchmarking exercises. They have led on the redesign of the assessment tools used. A key part of their work is to drill down into the IT systems, identifying errors in recording and providing the teams with the information so these can be resolved.

Political Scrutiny and Overview

Birmingham has a strong political challenge through the Health, Wellbeing and the Environment Overview and Scrutiny Committee whose members was finalised after the May 2016 election.

Ongoing programme of scrutiny involvement in relation to adult social care during municipal year since April 2016 has included.

- Involvement of Better Care Fund/STP leads in initial informal meeting in June 2016 to brief members and plan scrutiny work programme.
- Report to HOSC in July on the use of Enhanced Assessment Beds including capacity in Care Centres which was followed by a visit to two Care Centres by HOSC Chair and another HOSC Member. This will be followed by a further report scheduled to come to the November meeting to update Members on the latest position.
- Attendance by Cabinet Member for Health and Social Care at September HOSC meeting for progress report and questioning by HOSC Members on all aspects of portfolio.
- The December HOSC meeting will be devoted to scrutinising the 2015/2016 Local Performance Account Report and the West Midlands Challenge of Birmingham Adult Care.
- In addition the members have been and will continue to scrutinise changes to End of Life Care Services in Sandwell and West Birmingham through the Joint Birmingham/Sandwell HOSC .

Complaints

The Citizen Voice Team is part of the Commissioning Centre of Excellence responsible for the management of the statutory complaints function for adult social care and for promoting and facilitating Citizen Engagement activity throughout the commissioning cycle.

The Citizen Voice Team has increased the number of staff managing complaints over the past year and started to review the complaints process to allow the service to grow and develop to ensure the Citizen receives the best customer care service possible.

We are scoping new ways of involving Citizens to assist the team in ensuring measureable quality standards are set, embedded and monitored.

The Annual Report 2015-2016 has highlighted the following:-

- 147 statutory complaints were received during this reporting period, a reduction on the previous two years;
- 11 complaints were withdrawn during the process;
- 628 individual statutory complaint elements investigated;
- 391 complaint elements not upheld, 142 elements upheld, 54 elements partially upheld, 40 elements inconclusive, 1 element where no finding could be made;
- Assessment and Support Planning again received the largest number of complaints (92) compared to (129) for the same service area last financial year;
- The Statutory timeframe for responding to a complaint is six months: 131 complaints were responded to within that timeframe;
- Staff Behaviour was the highest overall reason for complaints received with 32;
- 6 Local Government Ombudsman Complaints in respect of statutory complaints were registered for the reporting period in respect of statutory complaints received;
- A further 146 pieces of information received not competent for the statutory complaints process including 58 Corporate ‘Your Views’ Complaints were managed by the team.

- Early resolution for Citizens by processing and managing information received with their agreement as requests for service rather than complaints.

Organisational Development

We are proud of our workforce. The quality of social work in the city has been recognised at a national level. For the past 3 years Birmingham ASP has had an increasing numbers of finalists and winners at the National Social Work Awards. We have won the Adult Social Worker of the Year for the past 2 years (2014 and 2015) as well as Adult Team Leader 2014, Assessed and Supported Year in Employment (ASYE) 2015 and the award for Creative and Innovative practice for our Post-hospital Discharge Team in 2015. This year we have 7 successful finalists. We have also been recognised by our partners as providing quality intervention and support – winning the National HSJ Health Care Award for hospital discharge work in 2014. Our partnership work with Birmingham City University has also been recognised; this year (2016) we have won 2 awards for the support given to student social workers, one for the SPEd Team, nominated by the university tutors, and one for an individual SPEd nominated by the student.

We celebrate the achievements the work that social workers do locally too, holding various events to celebrate their achievements – including presentation of certificates and small mementos. Social Workers are frequently nominated and win in the directorate awards (Shining Stars) and Council-wide awards (Chamberlain Awards).

The success we have achieved demonstrates that adult social work practice in Birmingham is recognised as being of high quality. However, we are not complacent and recognise that we need to ensure that the very best practice is consistently to be found in all areas of adult social work. In particular, we need to embrace the challenges identified in the Peer Review File Audit and continue to build on the quality of our social work interventions.

We recognise the need for continuous learning and development to ensure that the workforce has the knowledge and skills to meet the demands of a changing operating environment and we are committed to the learning and development of all our staff. We are committed to the development of a Learning Unit for students and ASYE. It is important to us to invest in workers at the start of their career and so embed the knowledge and skills required to develop skilled practitioners. This involves not only investing in new workers but also the skills and knowledge of assessors. We have developed 2 specialist practitioner roles, Senior Practitioner Education, who work closely with universities, directly support 8 students and support the wider practice educator role and the Senior Practitioner Workforce ASYE who work with the External Moderation Partnership and provide direct support to ASYEs via workshops and action learning sets.

Managers and staff are being encouraged recognise their own strengths as well as to identify the skills and expertise of their supervisees. Some of the more experienced and confident members of staff with the right skills have been invited to facilitate sessions within and across teams. This approach has been taken with some the direct payments ‘refresh’.

SCS has been included in terms of briefing sessions to managers who will cascade the information to workers who are can act as promoters of direct payments, fulfil a signposting role – e.g., OTs, Home Carers, Day Centre workers etc.

Value based training is being delivered to Social Care Facilitators, plus, Referral and Advice Officers.

Work is being undertaken with CCoE colleagues to develop standards within Home Support Provider services - Meeting Quality Standards in Social Care – a 2 day programme for Home Support proprietors and registered managers.

Care Act '14, outcomes focused related training has been commissioned for people who have been recruited to ASP during 2016 and Care Act '14 e-learning programmes are available to all staff in ASP.

Learning and development for newly qualified social workers (NQSWs) continues and qualifications related programme/refresher programmes continue to be offered, eg., in relation to mental health work etc. Best Interest Assessors, Approved Mental Health Practitioners. Mental Capacity and Deprivation of Liberty Safeguards training contuse to be rolled out.

All ASP managers' programmes have been refreshed (Team Managers, SPDs/SPWs). A programme for senior managers (AD, GM etc.) has been developed.

Safeguarding for Managers has been developed and added to the existing suite of programmes, which have each been updated to ensure that they are compliant with the CA14.

Continuing Health Care training for social workers has been developed and is mandatory.

X3 Social Care Apprentices are being recruited in late '16. A local FE provider will deliver the training.

A seminar with partners across local CCG partners and BCC to discuss apprenticeships across the health and social care economy, workforce planning and development is due to take place in Dec '16.

Support continues to be given to SCS regarding day-to-day running of services, refresher training to ensure compliance with regulatory requirements etc. additional training can be provided in house or purchased in if there is a statutory requirement as identified by the Care Quality Commission.

Specific learning and development programmes have been commissioned to assist staff where services are being closed e.g., managing change, resilience etc.

Service User/Carer Voice and co design

Since the autumn of 2015 we have established a new model for engaging with citizens entitled "Citizen Voice". The aim of this model is to ensure the voice of the citizen influences our practice at all stages of the commissioning cycle.

This approach moves away from the previous model of a small numbers of citizens involved in an ad hoc way, to the 'sign up' of a much larger numbers of citizens to work with us to co-produce service standards and have input into service design, monitoring and evaluation.

To be able to offer citizens of all ages, interests and experience opportunities as and when they arise within commissioning teams.
Developing the infrastructure to be able to manage this new model has involved developing:

- a new staff team

- Publicity campaign – to encourage citizens of all ages, interests and experiences to volunteer some time to get involved through a new 'Menu of Involvement' Leaflet, posters, Web content and staff going out to speak to citizens
- Internal communications campaign / workforce development for staff, including staff briefings, drop in sessions and surveys
- Building a new database to enable citizens to 'sign up' electronically to a range of citizens of all ages opportunities based on their interest
- Governance – the setting up of a new Citizen Governance Board to scrutinise and provide quality assurance regarding citizen voice activity

Challenges:

The main challenge is ensuring that all commissioning project plans consider how and when they will involve and engage a representative range of citizens, service users and carers to inform design, delivery, monitoring and evaluation of services from a citizen perspective.

Making it Real - We have completed two full cycles of Making it Real action plans but we were not in a position to sign up to a further cycle in 2015/16 due to major restructure across commissioning. However, we have been successfully building on previous MIR activity by using that learning to inform current work under the Direct Payment Project Board. Members of staff from the Citizen Voice team and citizens who use Direct Payments have worked together to co-produce a strategic communications and engagement plan, as well as being involved in developing new ways of sharing their story to promote Direct Payments.

CITY OF WOLVERHAMPTON COUNCIL

02 December 2016

Peter Hay
Strategic Director for People
Birmingham City Council
PO Box 16466
B2 2DP

Dear Peter

Birmingham City Council Adult Social Care Peer Challenge – 14th -16th November 2016

I write to give you formal feedback following the peer challenge on **Maximising the independence of adults in a financially challenged environment**. This builds on the provisional feedback we shared with you on 16th November 2016. (A copy of our presentation is attached as an appendix).

I was pleased to lead the peer challenge and I was joined by Pete Jackson, programme manager, Anne Clarke (assistant director Worcestershire County Council), Paul Smith (commissioning manager Wolverhampton City Council), Kerrie Allward (assistant director Walsall Council), Steve Corton Better Care Fund manager West Midlands), Keymn Whervin (expert by experience), Councillor Ken Meeson (Cabinet member and chair Solihull health and wellbeing board) and Mark Taylor (director of finance City of Wolverhampton Council) . The team met over 90 people in 30 separate sessions and at 11 different locations in the 3 days we were on site.

The process also included a case file audit and this was led by Mark Godfrey for Improvement & Efficiency West Midlands, and undertaken by members of the West Midlands Principal Social Worker Network.

I would like to thank you for putting Birmingham forward to host this peer challenge at a time when you like many other councils face large challenges and pressures. Specifically, your strong recognition of the value of sector led improvement as a process for improving performance and outcomes. The flexibility the council demonstrated in responding to requests for additional information and also the quality and breadth of the data that was provided ahead of the visit was also very much appreciated

I would also like to thank all the people who use services, carers, staff and partners, the leader of the council, cabinet member for adults, and scrutiny members who participated in the challenge. We were made welcome and our thanks go to Mike Walsh and Mary Grant and the administrative team in your office for their organisation before and during our visit.

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There were many positive areas of good practice and policy that we will take away from our visit and in particular the commitment and enthusiasm of staff at all levels in the organisation to provide great care for the citizens of Birmingham.

Ahead of the peer challenge you provided a detailed self-assessment and a focused set of documents that assisted the team in understanding the position of adult social care in Birmingham. This demonstrated a high degree of self-awareness of the challenges that you face. We felt that your use of the 6 domains of risk was particularly helpful in providing an overview and the team used this throughout the challenge to check alignment between your self-assessment and the evidence and commentary that we saw on site. I have attached a summary of our reflections on these areas in the appendix attached.

You asked for the peer challenge to focus on "Maximising the independence of adults in a financially challenged environment" and in particular to help your social care staff to best maximise the independence of adults.
In particular, to look at the effectiveness of your: -

- social care assessments and care packages
- care and support planning
- front line 'joint working' arrangements within health

Additionally, given the issues highlighted in your self-assessment, you requested that the team review: - whether Birmingham adult social care is facing a severe financial risk and if you are doing enough to mitigate this risk?

Starting with the financial risk the team identified this as the key challenge facing Birmingham 's adult social care services and the scale of financial challenge can be summarised in your self-assessment: -

"Since 2011 ASC budget has reduced by a cumulative total of £152m, the Transformation programme agreed in 2008 – 10 year saving of £200m has now stretched to £400m, there has been a reliance on reserves to balance the budget and the transfer of funding from health of £50m has a shortfall for 2016/17 of £28m, and there has been a failure to deliver previous budget targets."

To mitigate these risks, you have instigated: -

- Fortnightly budget meetings with the CEO to monitor monthly trends and spend,
- Work to better understand the financial interactions with health
- The development of a clearer strategy for the provision of specialist care services
- The development of the Maximising Independence for adults' programme
- A review of value for money of in-house provision
- A review of financial controls, including panels and resource allocation system
- A Finance and Operational Management Audit Report which makes key recommendations such as:
    - Better availability of budget information for budget holders
    - Engagement with finance and operational management
    - Care package forecasting
    - Expenditure reports

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What else should you be considering?

- The importance of getting an overall grasp of the financial challenges faced is urgent and the forthcoming Local Government Association Stress Test will require detailed work to be undertaken to present a credible narrative of the financial position.
- There is an urgent need to align financial monitoring systems between adult social care and corporate finance.
- The lack of ownership of budget savings at team and group manager level and the availability of accurate budget monitoring information is severely hampering the ability of front line staff to contribute to efficiencies and savings.
- There is a need for corporate 'ownership' of the adult social care budget targets – and a much better collective view of where they sit in the list of overall council savings priorities.

Social care planning, assessments and care packages
Strengths

- Responsiveness of the Standard service.
- Access to enablement.
- Use of telephone assessment.
- Strengths identified in the case file audit included:
- Self-authorisation of assessments
- Quality of case recording
- Good learning and development through reflection.

Social care planning, assessments and care packages
Areas for consideration

- Extent to which an asset based approach is embedded in all teams.
- Consistent practice in process for agreement for personal budgets.
- Consideration for options for support planning other than being social work led.
- Additional areas for consideration identified in the case file audit included:
- Extent to which strengths based work is embedded in all teams
- Having a stronger focus with regard to complying with the Care Act duty around promoting wellbeing
- Reviewing the approach to managing risk and reliance on institutional care.

Front line 'joint working' arrangements within health –
Strengths

- Strong strategic commitment across partners.
- Degree of progress in the last 12 months.
- Growing understanding of the interface between health and social care.
- Actively engaged in the Sustainability and Transformation Plan (STP) process.
- Good frontline working relationships between health and social care.
- Growing joint working on pathways and shared protocols.

Frontline 'joint working' arrangements within health -

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Areas for Consideration

- Separate budgets and relationships across health and social care impacts on ability for partners to work and commission collaboratively.
- Better Care Fund programme is not central to health and social care partnerships and is seen as a 'Health Plan'.
- Reviewing the potential for risk and benefit share arrangements.
- Increased use of data and intelligence to inform decision making.
- Vision for future integrated health and social care front door services not clear.

Given the breadth of the feedback that the team has provided I believe it would be helpful to highlight 6 areas where we recommend that you focus attention in your own planning and improvement processes. We have posed these as objectives in the expectation that you will wish to translate them into an action plan to respond to the areas we have suggested that you consider.

Areas recommended for further action: -

1. strengthen your grip on the financial monitoring and delivery of efficiencies / savings requirement given the scale and urgency of the budget challenges faced.
    a. work closely with corporate finance on the current and future savings proposals to ensure deliverability and that the implications of any saving proposals put forward are fully owned by the service and the corporate centre
    b. implement the findings of the recent Finance and Management Audit report
2. strengthen the relationship between the commissioning for excellence unit & with your delivery of frontline services and improve their engagement with stakeholders including carers
3. increase the pace and scale of transformation required by the Maximising Independence Programme to have a much stronger focus on the delivery of improved outcomes for service users
4. translate your initial thinking into a credible vision for an integrated place based health and care system in Birmingham and outline how relationships with health can be improved at the front door
5. upscale and maximise the potential offered by an asset based approach with the voluntary and community sector to transform your traditional Social work model placing a particular emphasis on your narrative and your actions in relation to prevention
6. strengthen the interface between adult social care and the corporate centre to realise the ambition for Birmingham to become "a city that cares" and a great city to grow old in.

Conclusions

The team recognised the significant work the council has been undertaking and scale of the challenges that are faced given the size of the population, the levels of deprivation and the external attention that the council has received following the Kerslake review. We were very impressed by the commitment demonstrated by frontline staff and the determination of the council leadership team and politicians to move forward in a planned way to improve the independence overall of citizens and in particular the outcomes for those growing old in the city as part of the council's vision and plan for 2026.

Finally, we have sought to make the findings of the peer challenge constructive and helpful to the council and also to strike an appropriate balance between support and challenge. In line

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with the west midlands peer challenge approach, we would ask that the council considers the recommendations, develops an action plan in response, and in March 2017 a review of progress takes place through a discussion between the Lead Director of Adult Social Care (DASS) and myself. It is also agreed in the West Midlands that councils will publish their peer challenge final letter and subsequent action plan to demonstrate its commitment to sector led improvement.

We hope that you regard the comments and recommendations the Team has made as being constructive and helpful. The regional Improvement manager Pete Jackson and Ian James the care and health improvement advisor for the LGA are resources that are available to support councils to develop action plans to drive change as a result of a peer challenge. We have learnt from the process ourselves and we have really appreciated the opportunity to take away some good examples of care and support that we can share with councils across the West Midlands.

On behalf of the Team, I would like to thank you for hosting this peer challenge and for working so positively with us. I hope that you will agree this has resulted in a helpful and constructive outcome and if you have any points that you would like clarifying please do not hesitate to contact me

Yours sincerely

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CC Mark Rogers, Cllr Paulette Hamilton, Martin Samuels, Ian James, Peer Challenge team

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Appendix 1
Birmingham City council self-assessment

Leadership
Strengths

- Strategic Director of People is seen to be approachable and credible with a strong strategic vision.
- Cabinet member is seen as a committed and positive leader with visible leadership of the Maximising Independence of Adults Programme Board.
- Leader and Scrutiny Chair see Health & Social Care as a priority - "Care is what this City does".
- Chief Executive has demonstrated strong system leadership on behalf of the Sustainability and Transformation Plan (STP).
- A new city vision and plan has Older People as one of the four priorities - "A great city to grow old in".

Leadership
Areas for consideration

- Encourage a whole council approach to the Adult Social Care agenda – aligning objectives and effort.
- Maximise opportunities for evidence based learning and encourage staff to review best practice elsewhere.
- Systematic approach to prevention.
- Strengthen the system leadership narrative and forum for integration – focus on outcomes.
- Need to develop a shared understanding of the challenges, opportunities and motivation to further develop trust in partnerships.

Performance and outcomes
Strengths

- Impressive performance recovery on Deprivation of Liberty Standards back log (2500 March 15 - 150 November 16) excellent use of risk register.
- Clear programme management approach with political leadership for the Maximising Independence of Adults programme.

Performance and outcomes
Areas for consideration

- High use of institutional care. Consider personalisation and empowerment through the use of direct payments.
- Delayed transfers of care – the position has been described as 'stabilised' but what are the current trends and could the Better Care Fund be used as a vehicle for partnership innovation?
- The performance in relation to the Adults Social Care Outcomes Framework does not benchmark well against regional and national comparators and represents a reputational issue for the council.
- Adults Community and Access Point – review demand management in relation to reablement and resilience/capacity (turnover/gaps through training & volume).

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- Need fundamental review of interface with Carers and their engagement in co-production of services.
- Increase visibility and transparency of performance information to demonstrate and monitor progress and drive change.

Commissioning and quality
Strengths

- Well-resourced team with capacity and capability to support the transformation of Adult Social Care
- Direct Payments Board Communications Strategy fully co-produced with service users
- Integrated and recovery based single system recommissioned re substance misuse services well aligned with social care and with good outcomes
- Scope for harnessing Public Health intelligence and expertise in Adult Social Care commissioning

Commissioning and quality
Areas for consideration

- Clear disconnect between commissioning and delivery.
- Birmingham Care Wage may be unaffordable.
- Review outcomes delivered and value for money of internally provided services.
- Review the Adult Social Care profile of expenditure to match the aspiration in MIA.
- Development of a commissioning strategy to invigorate the third sector to support the MIA programme and reduce dependency on traditional services.
- Care Act was soundly implemented in 2013 but council may wish to consider current compliance with broader duties particularly carers, wellbeing and Market Shaping.

National priorities and partnerships
Strengths

- Excellent Extra Care scheme independently evaluated by Aston University in 2015
- "Feels like the partnerships are coming together" BCF/HWBB/STP
- 'No wrong door' an excellent example of partnership led by BVCS to help support people with complex needs
- Leadership of the Health & Wellbeing Board and its clear strategic priorities
- Better Care Fund plan regarded as a good plan, approved with no conditions
- Transforming Care Board good governance established

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National priorities and partnerships
Areas for consideration

- "relationships with carers, regarded as being good two years ago have been neglected and as a result we feel undervalued, under supported and underserved"
- Long way to go towards co-production, review if structures are in place to support
- Need to understand the evaluation of the Shred Life Plus programme undertaken in 2015 and implement lessons as part of MIA programme
- Market sustainability - maintain focus given the ongoing fragility of the market

Workforce management
Strengths

- Staff that we met were positive, enthusiastic, knowledgeable in their field and open to scrutiny and challenge
- The case file audit found:
    - Social Workers are generally positive about working in Birmingham.
    - Good support for students and the Assisted Supported Year in Employment Programme.
    - Philosophy of investment in people.
    - Well-resourced development programmes.

Workforce management
Areas for consideration

- Workforce delivery split – clarity of accountability/affordability.
- How well are the costs understood for in house services?
- The case file audit found:
    - Review make safeguarding personal
    - Focus on developing asset based approach

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Appendix 3 – Adult Social Care Peer Challenge Action Plan

Recommendation	Activity	Start Date	Completion date	Lead
A. Strengthen your grip on the financial monitoring and delivery of efficiencies/savings requirements				
a. Work closely with corporate finance on the current and future savings proposals to ensure deliverability and that the implications of any saving proposals put forward are fully owned by the service and the corporate centre	A1. i. Establish Directorate Savings Programme Board ii. Review effectiveness of the Board prior to Peer Challenge 6 month visit	Dec-16	i. Dec-16 ii. Apr-17	Peter Hay, Strategic Director for People
	A2. i. Develop Implementation Plans for savings proposals ii. Develop Benefits Cards for each budget savings line	Dec-16	Jan-17	i. Programme Leads ii. David Moran – Interim Assistant Director Finance
b. Implement the findings of the recent Finance and Management Audit report	A3. Implement audit recommendations: i. Business Process Review - Care First to Voyager ii. Consultation with stakeholders iii. Review of Cost Centre structure and associated control totals/hierarchies iv. Improve data quality v. Placement Panel Impact vi. System Redesign & Implementation	Jan-17	i. Jan-17 ii. Mar-17 iii. Feb-17 iv. Mar-17 v. Mar-17 vi. Apr-17	Peter Hay, Strategic Director for People

Recommendation	Activity	Start Date	Completion date	Lead
B. Strengthen the relationship between the commissioning for excellence unit & with your delivery of frontline services	B1. Development of a strategy for Commissioned Adult Social Care including changes to processes, systems and interfaces between Commissioning and Social Work teams	Dec-16	Jul-17	John Denley, Assistant Director - Commissioning
	B2. Improve information sharing: reporting of commissioning activity to social work management teams; involve commissioning managers in budget panel meetings	Dec-16	Jan-17	Maria Gavin, Assistant Director - Commissioning /Carl Griffiths, Assistant Director - ASC
	B3. Improve visibility of safeguarding information to commissioning managers	Dec-16	Jan-17	John Denley, Assistant Director - Commissioning
C. Improve engagement with stakeholders including carers	C1. Develop new model of engagement and co-production with citizens including carers	Dec-16	Jan-17	Pat Merrick, Assistant Director - Commissioning
	C2. Key consultation: Adult Social Care Budget Proposals	Jan-17	Mar-17	Pat Merrick, Assistant Director - Commissioning
	C3. Key consultation: Adult Social Care External Commissioning strategy & framework	Mar-17	May-17	Maria Gavin, Assistant Director - Commissioning

Appendix 3 – Adult Social Care Peer Challenge Action Plan

Recommendation	Activity	Start Date	Completion date	Lead
D. Increase the pace and scale of transformation required by the Maximising Independence Programme to have a much stronger focus on the delivery of improved outcomes for service users	D1. Direct Payments - delivery of Engagement and Communication Strategy to increase rate of take-up	Dec-16	Jul-17	Carl Griffiths, Assistant Director - ASC
	D2. Enablement - Develop and implement an effective in-house enablement service and realise savings of £4m	Oct-16	Jun-17	Geoff Sherlock, Interim Assistant Director - ASC
	D3. ACAP - Develop future operating model	Jan-17	Mar-17	Tapshum Pattni, Assistant Director - ASC
	D4. Single-handed Care - Implement Pilot Project and evaluate outcomes	Dec-16	Feb-17	Carl Griffiths, Assistant Director - ASC
	D5. Make better use of intelligence to support adult improvement programme and drive change	Dec-16	May-17	John Denley, Assistant Director - Commissioning
E. Translate your initial thinking into a credible vision for an integrated place based health and care system in Birmingham and outline how relationships with health can be improved at the front door	E1. Developing a vision for integrated social care with primary health care.	Nov-16	Apr-17	Peter Hay, Strategic Director - People

Appendix 3 – Adult Social Care Peer Challenge Action Plan

Recommendation	Activity	Start Date	Completion date	Lead
F. Upscale and maximise the potential offered by an asset based approach with the voluntary and community sector to transform your traditional Social work model placing a particular emphasis on your narrative and your actions in relation to prevention	F1. Develop model for future social work with an associated workforce plan and undertake consultation with citizens and stakeholders	Jan-17	May-17	Carl Griffiths/ Tapshum Pattni, Assistant Directors - ASC
G. Strengthen the interface between adult social care and the corporate centre to realise the ambition for Birmingham to become “a city that cares” and a great city to grow old in.	G1. Embed key adult social care measures of personal independence and quality care within the health outcome of the Council Plan	Dec-16	Apr-17	Peter Hay, Strategic Director - People
	G2. Develop and Deliver Council of the Future Operating Model; embedding key social care outcomes within an integrated commissioning model	Jan-17	TBC	Mark Rogers, Chief Executive

Information briefing

Report From: **Strategic Director for People**

Report To: **Health, Wellbeing and the Environment Overview and Scrutiny Committee**

Date: **21 February 2017**

Title: **Homeless Health**

Summary:

The Homeless Health report from Overview and Scrutiny was published in July 2015 and since then the homeless landscape has significantly changed.

Homelessness has continued to rise nationally, regionally and locally. Priority homelessness continues to increase and the recent release of the National Rough Sleeping Statistics has seen further significant rises in the numbers of people rough sleeping. Birmingham's rough sleeping figure for 2016 was 55, a 53% increase on the previous year in line with national trends.

Health inequalities amongst people experiencing homelessness, and in particular those sleeping rough, continues to be an area of concern.

Based upon self-disclosed information obtained by the Outreach Service

- 72% of rough sleepers have a substance misuse issue
- 44% of rough sleepers have a mental health issue
- 19% of rough sleepers have a physical health issue

The growth in the use of legal highs over the last 3 years has also exacerbated the situation.

Homelessness and its impact is societal and requires a societal response.

Recent Activities

- A homeless review has been completed that is informing change..

- A homeless summit was held with key partners and stakeholders in October .

- A homelessness transformation programme has been introduced to deliver a comprehensive change to preventing and tackling homelessness in Birmingham. This programme is multi-agency and sets out to deliver the shared vision for Birmingham –"In Birmingham we will work together to eradicate homelessness."

- A rough sleeping review has been undertaken by Housing and Homes Overview and Scrutiny.

- Birmingham has been successful in two bids to DCLG drawing in £2.1 million towards tackling rough sleeping and homeless prevention.

Future Work

- Undertaking a mapping exercise of health services and surgeries available for rough sleepers.

- Update the Homelessness Health Needs Audit

- Develop the new Homelessness Strategy 2017-2022

- Strengthen the links with the Health and Wellbeing Board

- Need to define how the STP can respond and inform health responses to homelessness as part of the Homelessness Strategy development.

Background information:

Appendix 1 – Overview and Scrutiny Homeless Health Report
Appendix 2 - Recommendations Updates
Appendix 3 – Homeless Welfare Service Performance report

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Homeless Health

A report from Overview & Scrutiny

Contents

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Reports that have been submitted to Council can be downloaded from www.birmingham.gov.uk/scrutiny.

Preface

By Councillor Sharon Thompson

Member, Health and Social Care Overview & Scrutiny Committee

As many of you will be aware, homelessness is a topic in which I have a considerable personal interest and to which I have a great personal commitment. I am very grateful to the previous Chair of the Health and Social Care Overview and Scrutiny Committee for allowing me the opportunity to present this report on a topic about which I feel very passionate.

I know from personal experience that being homeless is physically and mentally difficult and that homeless people are among the most vulnerable in our society. They suffer worse health than those living in settled accommodation and yet despite suffering worse health than the general population, they often struggle to access healthcare services. This is starkly illustrated by the fact that, in spite of improvements in the health of the general population over the last 15 years, the average age of death for homeless people is just 47 years old with the average age for homeless women being even lower at just 43. This compares to 77 for the general population. This is a truly shocking statistic and we need to take action now to ensure that homeless people are able to access to the healthcare services they need.

I would like to thank members of the Health and Social Care Overview & Scrutiny Committee together with health partners and a wide range of organisations from across the City who have given their time and effort to contribute to this Inquiry. I would also like to say a particular thank you to the small group of rough sleepers who agreed to participate in the inquiry and who made a considerable impact on the members who listened to their experiences with the result that the recommendations emerging form the Inquiry have tended to focus mainly, but not exclusively, on aspects of the health and housing needs of the single homeless who find themselves sleeping rough. I make no apologies for this.

A Scrutiny Committee Inquiry alone cannot hope to solve the problems of homeless people in the City. However the committee can and have made recommendations for improvements which I sincerely hope will go some way towards highlighting some of the areas where action needs to be taken to ensure that help is available to homeless people where and when they need it and that no one if left in the position of having to sleep rough. I hope that these recommendations will go some way towards starting to improve the lives of homeless people in the City.

Councillor Sharon Thompson

Summary of Recommendations

	Recommendation	Responsibility	Completion Date
R01	That potential locations in the city centre be explored to find the most suitable venue which can be made available to be used as a central point where homeless people can go to access information, advice and support on accommodation, benefits (including accessing a computer to start the process of registering to make a claim) and be referred to available health services without needing to make an appointment or travel to one of the customer service centres.	Cabinet Member for Neighbourhood Management and Homes Cabinet Member for Health and Social Care as Chair of the Health and Wellbeing Board	30 September 2015 for final version of Welfare Specification and new service to start 1 April 2016. 31 July 2015 for remodelled Housing Advice Centre Options
R02	That the three Birmingham Clinical Commissioning Groups should explore: 1. How they can make it easier for homeless people to register with a GP even if they are only temporarily residing in an area and have a permanent address elsewhere or have no permanent address. 2. How homeless people can be facilitated to maintain registration on a GP list once they have registered even if, due to the transient nature of their lifestyle, they subsequently move out of that area.	Birmingham Cross City, Birmingham South Central and Sandwell and West Birmingham Clinical Commissioning Groups	31 March 2016 Health and Wellbeing Board Agenda 13 October 2015
R03	That the multi-agency working that is already starting to happen to tackle the housing and health problems of people sleeping rough in the city centre by connecting rough sleepers to local support and services is strengthened. Groups already in existence need to be reviewed to establish whether they are working together effectively with a view to building on the existing protocol and the work already being done by the StreetLink multi-agency working group, to ensure that relevant agencies are alerted before major regeneration work starts, to provide an opportunity to support homeless people squatting or sleeping rough in the area.	Cabinet Member for Neighbourhood Management and Homes Cabinet Member for Health and Social Care	31 October 2015
R04	That services should be commissioned in a joined up way wherever possible, specifically when commissioning services for people with a	Cabinet Member for Health and Social Care	31 January 2016

	dual diagnosis of either: 1. mental health and substance misuse or 2. people with alcohol problems who also suffer from dementia, where there is currently a gap in service provision.		
R05	That wherever possible services for homeless people should be designed to reach out to homeless groups who need them by moving away from a silo culture and exploring options for placing statutory services where homeless people already attend, such as the Homeless Health Exchange or SIFA Fireside, along the lines of the Inclusion Healthcare Social Enterprise Model	Cabinet Member for Health and Social Care Cabinet Member for Neighbourhood Management and Homes	31 October 2015
R06	That a forum or other appropriate mechanism be established between HM Prison Birmingham and Birmingham City Council to facilitate more joined up working with prisons and the probation services to provide improved pathways between prison and the general community with a view to: 1. Linking prison healthcare provision better to wider community healthcare services on release from prison in particular for prisoners with serious mental health, drug and/or alcohol problems; 2. Supporting prisoners into appropriate accommodation before and after discharge from prison; 3. Prioritising appropriate accommodation for homeless women in contact with the criminal justice system. 4. Supporting prisoners to link into the benefit system before and after release from prison. 5. Providing/sharing information about services available in the community to facilitate improved pathways between prison and the general community.	Cabinet Member for Health and Social Care Cabinet Member for Neighbourhood Management and Homes	31 March 2016
R07	That the Joint Commissioning Team should examine the feasibility of commissioning an emergency and/or out of hours specialist homeless primary care service for the city.	Cabinet Member for Health and Social Care Birmingham and Solihull Mental Health NHS	31 December 2015

		Foundation Trust Cabinet Member for Neighbourhood Management and Homes	
R08	That the best way to provide a direct line of communication between the City Council and people sleeping rough in the city centre who have a problem or a complaint, for example through advice surgeries in the city centre, be explored.	Cabinet Member for Neighbourhood Management and Homes	Already commenced Progress Update 31 October 2015
R09	That an assessment of progress against the recommendations made in this report be presented to the Health and Social Care O&S Committee.	Cabinet Member for Neighbourhood Management and Homes	31 October 2015

1 Introduction

1.1 What is homelessness?

1.1.1 Not having a home damages people's lives and there are thousands of people who don't have the right accommodation to allow them to lead healthy and fulfilling lives. A lack of commitment to ending homelessness just increases the costs to the public purse and postpones the problems associated with homelessness to be dealt with in the future.

1.1.2 The wider definition of homelessness covers a multitude of situations and includes people sleeping rough, single homeless people living in hostels, shelters and temporary supported accommodation as well as statutory homeless households. Statutorily homeless households are households who seek housing assistance from local authorities on the grounds of being currently or imminently without accommodation. The term also includes the 'hidden homeless' households. That is people who may be considered homeless but whose situation is not 'visible' either on the streets or in official statistics. This would include households living in very overcrowded conditions, squatters and people who are 'sofa-surfing' with friends or relatives.

1.1.3 Homelessness is about so much more than just not having suitable accomodation.

> Homelessness is about more than rooflessness. A home is not just a physical space, it also has a legal and social dimension. A home provides roots, identity, a sense of belonging and a place of emotional wellbeing. Homelessness is about the loss of all of these. It is an isolating and destructive experience and homeless people are some of the most vulnerable and socially excluded in our society.[1]

1.2 Focus of Inquiry

1.2.1 This Inquiry into homelessness set out to explore how health outcomes for homeless households differ from the wider population and what can be done to close the gap. The aim was to develop a clear understanding of the health issues experienced by vulnerable and excluded homeless households in terms of outcomes and service provision with a view to informing the future commissioning of health services, whether by the local authority or health commissioners, for this group of people.

1.2.2 The scope was initially defined in terms of the cohort of households whose health outcomes are worse than the wider population with a likely focus on vulnerable and excluded single person and couple households for whom the local authority does not have a statutory duty to accommodate.

[1] Crisis

Typically this would include those living in insecure accommodation, 'sofa-surfing', squatting and sleeping rough.

1.2.3 Although evidence was presented about homelessness in the wider sense and much of this has been included in this report, as the evidence gathering progressed it became increasingly clear that the recommendations emerging from the Inquiry were likely to be more narrowly focused. Much of the evidence was around the health and housing needs of a group of single homeless who have slipped through the net and find themselves sleeping rough and about the services that are available to them and their use of and access to those services. Members were mindful that there are other important aspects of homelessness which would merit closer examination and scrutiny which may be covered in a future scrutiny inquiry.

1.3 Impact of homelessness on health

1.3.1 Homelessness and health are inextricably intertwined. Being homeless is physically and mentally difficult and homelessness has significant negative consequences on health with the result that people who are homeless experience some of the worst health problems in our society. They are vulnerable to illness, poor mental health and drug and alcohol problems and are more likely than the general population to have multiple and complex physical and mental health needs.

1.3.2 Those who experience homelessness are also more likely to have unhealthy lifestyles which can cause long-term health problems or exacerbate existing issues. Analysis of the latest data found that 77% of homeless people smoke, 35% do not eat at least two meals a day and two-thirds consume more than the recommended amount of alcohol each time they drink.[2]

1.4 Barriers to accessing healthcare

1.4.1 In spite of suffering worse health than the general population, homeless people often struggle to access healthcare services. There are many reasons for this which need to be understood if inequalities in service access are to be addressed.

1.4.2 Some of the barriers include difficulty in accessing primary care such as the inability to register with a GP. This is often due to lack of proof of identity or inability to prove permanent residence in the catchment area or to provide other documentation required to register with a GP.

1.4.3 Health services are designed to treat one condition at a time but homeless people often experience multiple and complex health problems. This means that support needs to be accessed through different parts of the health system which can be difficult to navigate for people who are often leading chaotic lifestyles and dealing with issues relating to mental health and substance misuse and who may also not trust and not understand the system.

[2] Homeless Link Report "The unhealthy state of homelessness: Health audit results 2014"

1.4.4 Undiagnosed or untreated mental health problems can also be a barrier to seeking help as can fear and denial of ill health, difficulty communicating health needs and fear of stigmatisation or of being labelled. People with complex problems can often find it difficult to comply with treatment and fail to attend appointments which can then lead to them being excluded from services.

1.4.5 In order to improve the healthcare that homeless people receive staff need to be able to identify and understand and work with homeless patients. Sometimes healthcare staff remain unaware that a patient is homeless, either because the patient has not been asked or because they are afraid of admitting to being homeless and sometimes staff may lack the skills to deal with people who are exhibiting challenging behaviour.

1.4.6 Homeless people are often living more transient lives than other people which can make it difficult to maintain engagement with health services especially where staff may not have had the opportunity or time to be able to build up a trusting relationship with a homeless patient.

1.5 The financial cost

1.5.1 The combined effect of the factors mentioned above, means that health problems frequently go untreated until they have escalated to a point where they become critical. This failure to improve health at an early stage can often mean that problems have become more serious and are therefore likely to require more intensive and more expensive treatment due to the delay in accessing treatment. This has cost implications for the NHS. The Department of Health estimated that the annual cost of hospital treatment alone for homeless people is at least £85 million a year. This means costs of more than £2,100 compared to £525 per person among the general population[3]

1.5.2 Failure to support homeless people to access the healthcare they need before they need urgent hospital treatment also leads to more reliance on treatment at Accident and Emergency (A&E) leading to avoidable emergency admissions to hospital or to homeless people presenting at primary health services with multiple and entrenched problems. Homeless Link found that homeless people report an average of 1.66 A&E visits a year, compared to 0.38 among the general population. The latest data from Homeless Link indicates that the number of A&E visits and hospital admissions is four times higher for homeless people than for the general public.[4]

1.6 Health Inequalities

1.6.1 In addition to suffering worse health than those living in settled accommodation, homeless people face significant inequalities in accessing health services. This is starkly illustrated by the shocking fact that, in spite of recent improvements in the health of the general population, the average age

[3] McCormick B (2010) Healthcare for single homeless people, Office of the Chief Analyst, Department of Health
[4] Homeless Link Report "The unhealthy state of homelessness: Health audit results 2014"

of death for homeless people is just 47 years old with the average age for homeless women being even lower at just 43, compared to 77 for the general population.[5]

1.6.2 The Health and Social Care Act 2012 introduced duties to improve health and reduce health inequalities. The Act gives responsibility for public health to local authorities and requires them to take appropriate steps to improve the health of people in the area and to provide assistance to individuals to help them to minimise any risks to health arising from their accommodation or environment.[6] Local authorities are also required to produce an assessment of local health needs which should identify the needs of all people in the local area. These Joint Strategic Needs Assessments (JSNAs) should identify the health needs of homeless people, including single homeless people and the gaps in current services.

1.6.3 Health and Wellbeing Boards have a duty to act to improve the health of all local people and Clinical Commissioning Groups (CCGs) have a duty to reduce health inequalities in health outcomes and in access to health services. In order to improve the poor health experienced by homeless people services need to be designed to overcome the barriers to accessing healthcare experienced by people who are homeless.

[5] Crisis study on mortality amongst homeless people "Homelessness: A silent killer"
[6] Health and Social Care Act 2012 Section 2B

2 Homelessness in Birmingham

2.1 The Birmingham context

2.1.1 In his evidence to the committee, the Birmingham Cabinet Member for Health and Wellbeing who also chairs the Health and Wellbeing Board (HWBB) acknowledged that homelessness is a major issue for the city and that the links between homelessness and health inequalities are clear and stark. What not many people realise however is that Birmingham has actually grown by 10% in the last 10 years. That means approximately 100,000 extra people living in Birmingham in the last 10 years, which puts homelessness into an even sharper context. The city has seen an increase in homeless applications and increases in the numbers of rough sleepers in the city.

2.1.2 Although there have been improvements in the health of the general population over the past 15 years the statistics relating to the health of homeless people remain unacceptably poor compared with the general population.

2.1.3 In order to design effective services the local HWBB need to ensure that data is collected about local health needs, including the health needs of homeless people and they do this through the JSNA. The Birmingham Director of Public Health gave evidence that homelessness is a key indicator of how good public health is and, until recently, there was no other local authority with more statutory homelessness of households per thousand population than Birmingham. Statutory homelessness has since been prioritised by the HWBB and improvements in outcomes are starting to be made and, although Birmingham is still towards the bottom, it no longer takes the most applications in the country.

2.1.4 As a first step towards demonstrating commitment to improve the health of homeless people, the Birmingham HWBB have signed St Mungo's Broadway Charter for Homeless Health (Appendix A). This commits the HWBB to:

- **Identify Need**: identifying and including the health needs of homeless people in the JSNA. This includes people who are sleeping rough, people living in supported accommodation and people who are hidden homeless.
- **Provide leadership**: providing leadership on addressing homeless health. The Director of Public Health has a key leadership role to play in tackling health inequalities and will lead in promoting integrated responses and identifying opportunities for cross-boundary working.
- **Commission for Inclusion**: the local authority working with the CCGs to ensure that local health services meet the needs of people who are homeless and that the services are welcoming and easily accessible.

2.2 Identify Need: Birmingham Homeless Health Needs Audit

2.2.1 With a view to gathering more accurate data on the health needs of homeless people, a Homeless Health Needs Audit was carried out in Birmingham during 2014. The intention was to review a sample of homeless people and to use their views when designing services. This took the form of a survey distributed to homeless shelters, housing support agencies and related services during 2014 with a view to reviewing the health needs of a random sample of those with priority housing needs or homeless to establish a picture of the current health and mental well-being and of the service provision for this group. A pilot survey ran during May 2014 with a further survey from July to 31 October 2014.

2.2.2 A total of 342 responses were received. Of the responses:

- 77% were aged 25 years or under, the male female split was approximately 60:40 overall but with a majority of females under 25 years.
- 56% were white or other white ethnicity with the under 25 years being 42% white, 18% black and 15% Asian. Of the over 25s 68% were white, 10% black and 3% Asian.
- 18% had a mental health disorder.

2.2.3 **General Health** - Overall health was OK (34%) or good (34%), their living situation appeared to be stable (40% in hostels, 14% in accommodation) and many did not abuse drugs to cope with their situation (83%). But 16% rated their health as poor.

- Diet and nutrition seemed to fare reasonably well with the majority eating regular meals and having access to fruit and vegetables.
- However only 75% were registered with a GP, 60% were registered with a dentist with the over 25 group less likely to have registered with a dentist.

2.2.4 **Mental Health** - Both groups had significant mental health issues, with higher representation for the over 25 groups.

- Both groups suffered anxiety, depression and stress (20%) overall.
- The under 25s experienced suicidal thoughts (30%) and ADHD.
- The over 25s exhibited more violent behaviour/anger (2% of survey cohort; 18% of over 25 age group) and schizophrenia.

2.2.5 **Well-being -** The under 25 age group stated that friends and environment have a positive effect on their lifestyle, with friends providing financial and health support.

- The over 25 age group highlighted family as having a negative effect on their well-being, which supports data given on housing application acceptances where family breakdown is one of the main reasons given.
- Over 25s rate unhappier with all the environmental and personal influences.

- There is good general awareness of sexual health services, with 52% having had a sexual health check in the past 12 months.

2.2.6 **Support** – There was a higher number of rough sleepers in the older group; twice as many as under 25s sleeping on sofas.

- Under 25s receive more financial support from family and friends; over 25s mostly rely on benefits.
- Under 25s receive more help from family and friends regarding health.

2.2.7 **Vaccinations/screening** – There is some confusion regarding vaccinations, screening and tests, especially around hepatitis. Many are not sure if they have had tests or what tests they were. Screening, vaccinations and subsequent treatment received a low response and it is unclear whether this is due to the respondents not suffering from these conditions or not having been appropriately signposted.

2.2.8 **Substance Use** – Alcohol use was high although the majority stated that they did not drink every day (95%) and did not consider themselves to have a drinking problem (93%). Alcohol consumption was greater in the older group, although it was significant in both groups. The over 25s had higher drug use across all drugs, but significantly more Class A. The under 25s have higher cannabis use.

2.2.9 **General** - 26% state they have a disability, half mental health, a quarter have a learning disability.

10% on bail, recently left prison or under probation

6% left care in the last 12 months

6% actively in drug treatment, 8% in recovery from drug misuse, 18% taking drugs

9% used legal highs in the last month.

2.3 Provide leadership: What is being done in Birmingham?

Tackling homelessness is a key priority for Birmingham City Council[7]

2.3.1 The Cabinet Member gave evidence that the Birmingham HWBB are actively prioritising homelessness and will be taking the data gleaned from the Homeless Health Needs Audit which will be analysed by the Director of Public Health and the findings used to produce recommendations which will help the HWBB and the CCGs in the city to inform priorities and shape services. Data from the Homeless Health Audit will be incorporated into the JSNA together with further data from stakeholders on the health needs of the street homeless which is being collated.

[7] First line of Birmingham City Council Homelessness Strategy 2012+

The aim is to give the JSNA a stronger emphasis on homelessness in order to better shape and direct service provision.

2.3.2 The Cabinet Member stressed his commitment to improving the health and wellbeing of all people affected by homelessness including statutory homeless and including rough sleepers and people living in unsuitable or insecure accommodation such as squats and hostels with a view to reducing health inequalities for all homeless people. Investment in homeless activity has been prioritised for 2015/16 and improved results had already been achieved at the time the evidence was given, in delivering additional temporary accommodation and opening a new homeless temporary accommodation centre in order to reduce the number of households in the city in B&B accommodation. The snapshot evidence at the time (January 2015) was that only 25 households were in B&B accommodation which was an 85% reduction from earlier in the year when there were over 150 households in B&B accommodation in the city. 19 of the 25 households were families and none were single 16 or 17 year olds.

2.3.3 There are various initiatives which are being introduced to tackle homelessness in the city. These include the development of a regional Housing First model for which the City Council is the lead partner. The idea of the Housing First Model is based on the premise that housing is a basic human right and entrenched rough sleepers and people with complex needs will be offered a tenancy directly from the streets with a support package and the initiative is contributing to Public Health England's population healthcare development project for single homeless people. The idea is that if people are given a tenancy then they will be more inclined to work with support agencies to go on and accept any support needed to maintain the tenancy. The package will provide a holistic support package of care for individuals who are entrenched rough sleepers and suffering from complex needs around mental health, community safety, ongoing drug or alcohol treatment and support to deal with behavioural issues. Reference was also made to reviewing the homelessness community mental health service (paragraph 8.4) and primary care services to support the needs of single homeless people, to the Homeless Hospital Discharge pilot (paragraph 9.3) to support single people back into the community when they are discharged from hospital and to the remodelled support provided within the new Public Health Lifestyle Service in which homeless groups are prioritised.

2.3.4 Birmingham's Supporting People programme commissions a wide range of supported housing services for vulnerable customers. These services include hostels for single homeless people, step down schemes and specialist schemes for single people who have experienced homelessness, accommodation schemes for offenders, domestic violence refuges and floating support services to support those who need extra help to continue to live independently or people who have difficulties due to drug or alcohol problems.

2.3.5 These services are provided by a range of voluntary sector organisations and access to the schemes is via the Birmingham Gateway which is a service provided by Birmingham City Council which assesses the needs of people requesting access to housing related support services and

based on a needs and risk assessment the service will seek to match service users to available support services. A bedspace may be allocated in an accommodation based scheme or a floating support worker may be allocated to provide housing related support at the person's current or future address.

2.3.6 The type of housing related support to help to develop and maintain a person's ability to live independently can include helping someone to get their correct benefits, to learn to budget properly for rent and bills, to access a GP or dentist, to get on a training or education course, to maintain a tenancy or to get a permanent home.

2.3.7 It was acknowledged that there are real issues about the depletion of the council housing stock and about how best to try to expand the supply of affordable housing. The Municipal Housing Trust is now the biggest house builder in the city in an attempt to increase supply and there is ongoing proactive work with the private rented sector through the Birmingham Social Lettings Agency 'Let to Birmingham' to increase the supply of housing and to provide more options for people.

2.3.8 The suitability of the housing stock the Council has available also presents an additional challenge for the city. The Council has in excess of 200 tower blocks in the city which makes up a substantial proportion of the overall housing stock. This obviously has an impact in terms of restricting the types of properties available. Homeless households have an opportunity to bid for properties on Birmingham Home Choice and tower blocks go for significantly fewer points than houses. This means that although a house is often the type of property of choice for most people, the large proportion of tower blocks in the housing stock means that often the Council is restricted into placing people into flats. Currently on the housing allocations system you will be allocated 140 points if you are accepted as being statutory homeless but a two bedroomed house at the moment would need, on average, in excess of 250 points to secure, so unless a person is classified as statutory homeless with additional points awarded they are unlikely to secure a house.

2.4 Commission for Inclusion

2.4.1 After the health needs of homeless people have been identified in the JSNA, there is a choice about how best to respond. There is no single solution and the most appropriate action will depend on a number of factors but it is clear that multi-agency working will be needed to tackle these problems. Health services are under a duty not only to reduce health inequalities in health outcomes, but also in access to health services. Commissioners need to aim for inclusive commissioning that overcomes these barriers and creates responsive and accessible health services. Commissioners of health and homelessness services need to ensure that services meet the health needs of homeless people and that they are easily accessible and welcoming by taking an integrated approach to addressing health and housing need. Arrangements to achieve this can range from pooling or aligning budgets to informal agreements between services.

2.4.2 Integrating health and housing may not always need special commissioning. Much can be achieved by using housing investment to target health inequalities or using health investment to support housing outcomes, for example, health professionals working out of homelessness services. The aim should be to look for opportunities to work together jointly to support services that tackle homeless health and to limit barriers to accessing care and be responsive to local need.

2.5 Joined up Commissioning

2.5.1 Whilst integrating health and social care and multi-agency working may not always necessitate special commissioning arrangements, sometimes it may mean commissioning services so they are joined up, eg jointly commissioning services for mental health, substance misuse and alcohol. The recent substance misuse commissioning exercise in Birmingham whereby drug and alcohol services were jointly re-commissioned is an example of this approach to commissioning.

2.5.2 In Birmingham it is calculated that there are approximately 10,000 opiate or crack users, 48,000 cannabis users, 15,000 powder cocaine users, 10,000 ecstasy users, 6,000 amyl nitrate users, 6,000 amphetamine users and 4,000 ketamine users. In relation to alcohol there are 117,000 hazardous drinkers (someone drinking above safe limits of 21 units for men and 14 for women), 39,000 harmful drinkers (someone drinking 50 units for men and 35 units for women) and 22,000 dependent drinkers (someone who needs medical intervention to stop drinking). 25% of men and 17% of women in the city are drinking above safe limits. It's fair to say that Birmingham has no greater issue than any other core city but, nevertheless, these are significant numbers.

2.5.3 Prior to March 2015 there were 28 separate organisations providing treatment in the city. The new approach aims at recovery outcomes ie. freedom from dependence on drugs or alcohol, sustained employment, sustained suitable accommodation, mental and physical wellbeing, improved relationships with family members, partners and friends, supporting effective and caring parenting, reduction in crime and re-offending and prevention of blood borne viruses.

2.5.4 Drug and alcohol services have been re-commissioned with a single lead provider who is also a provider of provision with a set of sub-contracted organisations. It also includes additional commissioning of small third sector organisations to ensure engagement of the diverse communities of Birmingham. All elements of the recovery system are part of the single contract with the new provider - CRI - which commenced on 1st March 2015 with a focus on smoothing the transition and an outreach approach and partnership working. At the time of the evidence gathering for the Inquiry various concerns were raised by organisations working in these areas about the transition arrangements but it was too early in the process to assess the success or otherwise of the new approach which will need to be revisited during 2015 when the new arrangements have been in place for a longer period.

2.5.5 The new approach to this commissioning is fundamentally an outreach model so that rather than service users having to go to the main centres the aim is to take the services out into communities and there is ongoing close working with GPs and pharmacies on what is known as 'shared care'.

This service will be retained and built on and partnership working and working in other locations will be a particular focus in delivering these services in the future. There are particular issues in relation to homelessness and work is ongoing with homeless hostels and with SIFA Fireside to support the delivery of a service at SIFA to make it easier for service users to engage with drug and alcohol services.

3 Statutory homelessness

3.1 Definition

3.1.1 Statutory homelessness is different from the wider definition of homelessness referred to in paragraph 1.1.2. It refers to local authority assessments of applicants who seek help with housing due to either imminent loss of accommodation or actual 'rooflessness'. Local authorities have a statutory duty to provide a homeless service and housing advice with 24 hour access.

3.1.2 A number of homeless people go to a variety of different agencies across the city to secure accommodation and assistance to get accommodation and don't necessarily approach the council. So the statutory service does not see all homeless households. These households who may be in a similar housing situation to those who apply to the local authority as homeless but who do not formally apply or register with a local authority or other homeless agency are often referred to as 'hidden homeless'.

3.1.3 When a person approaches a local authority, the local authority first has to make a decision about whether they have reason to believe, which is a low threshold, that somebody is threatened with homelessness, that they are eligible for assistance and that they do have a priority need. If that is the case, there is a duty to trigger a homeless application, to undertake investigations into that homeless application and then make a decision on that. This decision must be provided to the applicant in writing. Households 'accepted as homeless' means that they have been formally assessed as unintentionally homeless and in priority need and are therefore owed the main housing duty.

3.2 Tests for statutory homelessness

3.2.1 In order to be owed the full housing duty a household must pass five tests:

- **Eligibility**: whether someone is eligible in terms of their immigration status to be in this country and therefore to have access to social housing.
- **Homeless**: whether someone has accommodation to occupy in the UK or elsewhere, whether they can gain entry to it, whether it is reasonable for them to continue to live there eg. it wouldn't be reasonable to expect a victim of domestic violence to continue to remain in that situation if they approach the council for assistance or where the property is in a state of severe disrepair or where there is statutory overcrowding. The homelessness test also covers where someone is likely to become homeless within 28 days.
- **Priority Need**: automatic priority need applies if an applicant is pregnant or lives with someone who is pregnant, to households with dependent children, to all 16 and 17 year olds, to anyone aged 18-20 who was in local authority care when aged 16 or 17 years for three

months (referred to as a former relevant child) and to anyone homeless due to an emergency which would include a natural disaster such as a flood or fire. Consideration also needs to be given to whether someone is vulnerable in terms of the homelessness legislation as a result of age, mental illness, either a physical or learning disability or if someone has an institutionalised background such as having been in prison or been in the armed forces which makes them vulnerable. The test is whether the applicant is less able to fend for themselves when homeless in finding and keeping accommodation so that injury or detriment would result, than an 'ordinary homeless person'. Subsequent to the evidence gathering, there has been a very recent case in the Supreme Court which has said that councils assessing the needs of single homeless people should compare them with an 'ordinary person' rather than an 'ordinary homeless person'. This decision will change the vulnerability test as it is currently applied.

- **Intentionality**: whether the person has done something or failed to do something that as a direct consequence has caused them to lose their last settled accommodation. The most common intentional homeless cases would be cases where households have been evicted through rent arrears because they haven't paid the rent rather than because they can't pay or households who have lost their accommodation through anti-social behaviour.
- **Local Connection**: whether someone has a local connection to the local authority. The applicant must basically have lived in the area for 6 out of the last 12 months or 3 out of the last 5 years or have close family residing in the area or work in the city. Consideration must also be given as to whether the applicant has special reasons for needing to live in the city.

3.3 Single Homelessness: SIFA Fireside

3.3.1 The term 'single homeless' is generally understood to mean those people who are homeless but do not meet the priority need criteria to be housed by their local authority. They may nevertheless have significant support needs and may live in hostels, sleep rough, sofa surf or live in squats.

3.3.2 SIFA Fireside work with this very vulnerable group of people and gave evidence about some of the difficulties faced by this group in getting the assistance they need. Much of the evidence related to the kind of practical advice and support provided at SIFA, for example in providing meals, food parcels, warm clothing, sleeping bags and laundry facilities and the important support provided by faith groups, schools and churches to SIFA in this respect was acknowledged. Every day about 130 homeless people attend at SIFA Fireside's open access drop in, around 12% of whom will be sleeping rough with about a quarter to a third of those sleeping rough being from Central and Eastern Europe. Many of the remainder will be sofa surfing, or living in squats either because they have no recourse to public funds or because their benefits have been stopped or sanctioned.

3.3.3 Many of the people attending SIFA have become homeless because of relationship breakdown or domestic violence but many also have other underlying problems such as substance misuse or alcohol or mental health issues, which make it more difficult to get back into settled accommodation. Once people become homeless if they have any kind of health or addiction

problems these are likely to get worse quite rapidly and there are significant barriers to accessing healthcare which have already been referred to, including difficulties registering with a GP practice without a fixed address. SIFA do provide accommodation advice but the need for more resource around longer term resettlement advice, as opposed to just accommodation advice, to support people to have the life skills to manage and maintain a tenancy was highlighted.

3.3.4 One of the solutions put forward is to try to co-locate more statutory services where homeless people are already attending, at places such as SIFA or the Health Exchange, rather than expecting homeless people to travel to various different locations to access services. This is already happening to an extent and the example was given of the Homeless Mental Health Team who go into SIFA at least once a week to carry out a mental health triage clinic working alongside SIFA staff, which is a much more proactive way of picking up people who have either dropped out of mental health services or who have previously undiagnosed mental health problems or picking up and treating people in mental health crisis. **(R05)**

3.3.5 Mental health support was highlighted as a very important issue for this vulnerable group and in particular the need for flexibility in the way this support is provided was highlighted. The example given was the Improved Access to Psychological Therapies programme which is delivered through a very formal structured programme with a very formal assessment with a lot of required forms to be completed and improvement targets to be measured. This tends to present a lot of barriers for homeless people. SIFA had, at the time of giving evidence, been given funding which enabled them to recruit two part-time psychological wellbeing workers who are able to work in a much more flexible way than would otherwise have been possible.

3.4 Homeless prevention

3.4.1 Homeless prevention means providing people with the ways and means to address their housing and other needs to avoid homelessness. The majority of this work tends to be through providing housing aid and advice services which can help those at risk of becoming homeless to retain existing accommodation, for example through debt advice, or by working with landlords to assist people to access private tenancies to prevent homelessness occurring.

3.4.2 Unsurprisingly, the demand for services in Birmingham is significant. Over 16,000 households either had their homelessness prevented or made a statutory homeless application to the local authority or one of our funded partners in 2013/14. There was a 40% increase in demand for services since 2011 including a 19% increase from 2012/13-2013/14. Birmingham took 5,500 homeless applications in 2013/14 and out of those homeless households a duty was accepted to 3,100 households. This means that about 60% of those people who make a homeless application actually end up being accepted as homeless.

3.4.3 Out of the 2,400 households to whom it was decided that a homeless duty was not owed, 659 received a non-priority decision. For a non-priority household, the local authority has a duty to provide advice and assistance. This duty is discharged through funding Midland Heart to work at

the Bradford Street Homeless Centre where they see single people over the age of 25, in the 4 Housing Advice Centres and also the Rough Sleeping Outreach Team. In total Midland Heart prevented homelessness for in excess of 3,000 single people last year.

3.4.4 In terms of younger people under the age of 21, St Basil's Youth Hub recorded 2,293 homeless preventions in 2013/14 where they prevented young people becoming homeless or secured them accommodation. This would have been either supported accommodation or accommodation through the local authority or through registered providers within the private rented sector. From April 2015 the Youth Hub deals with young people aged 16-25 whereas previously they only dealt with young people up to the age of 21. SIFA Fireside also prevented homelessness for 601 single people last year.

3.4.5 In terms of supporting vulnerable people and preventing homelessness, the Supporting People Programme (see paragraph 2.3.4) also plays an important role in supporting people in accommodation who would otherwise have to be placed in bed and breakfast or other forms of temporary accommodation.

3.5 Homeless households in temporary accomodation

3.5.1 When a household presents to a local authority as homeless a decision needs to be made about whether the local authority are obliged to help that person to find a home. If there is a legal duty to assist the household local authorities cannot always find them a place to live immediately and may need to place them in temporary accommodation while inquiries are carried out, a decision is made on the homeless application or until settled accommodation can be found.

3.5.2 The bulk of households placed in temporary accommodation are in either publicly or privately owned self-contained housing with a smaller proportion accommodated in B&B accommodation. One of the aspects of prioritising homelessness within the Birmingham Health and Wellbeing Strategy has been to bring a renewed focus on improving the way the city deals with temporary accommodation with a view to delivering more suitable temporary accommodation and specifically to reduce the number of individuals, and particularly families, in B&B accommodation.

3.5.3 As a result, there has been a reduction in the number of households in B&B accommodation in Birmingham from 180 on 31st March 2014 to 25 households in B&B accommodation in December 2014 when the evidence was taken (See paragraph 2.3.2).

4 Young people and homelessness

4.1 Causes of youth homelessness

4.1.1 The main causes of youth homelessness are parents, relatives and friends no longer willing or able to accommodate young people (69%). The underlying causes contributing to this are overcrowding and previous offending history (28% each), followed by mental health issues (21%). The small numbers of young people who resort to rough sleeping (45 in the last 12 months) tend to be those who do not have access to support networks such as friends and family and find themselves having to stay outside on the streets when they are made homeless. Substance misuse is cited as one amongst several reasons leading to increased tension within a family home, escalating in young people being asked to leave their home; others include issues such as various mental or physical illnesses and young people that have an offending history, (which young people tend to withhold and is therefore under represented).[8]

4.2 Centrally located Young Person's Hub: St Basil's

4.2.1 The Council has particular responsibilities for most 16-17 year olds and 18-21 year old care leavers, or up to 24 if in full-time education who have spent time in care when they were 16 or 17. In recognition of these responsibilities towards vulnerable young people the Council commissioned a Young Person's Hub service which is delivered by St Basil's Housing Association.

4.2.2 St Basil's works with young people aged 16-25 who are homeless or at risk of homelessness across Birmingham, Sandwell, Solihull, Worcestershire, Coventry and surrounding areas. They provide a range of advice and prevention services for young people at risk of homelessness as well as accommodation, engagement and support services to help those who have become homeless to regain the stability they need to rebuild their lives. Where possible they aim to prevent young people from becoming homeless in the first place. They provide services tailored to support young residents to build confidence and access further education, training and employment to help them break the cycle of exclusion and homelessness.

4.2.3 They offer a range of different options, depending on the needs of the young person. These include emergency accommodation options where young people can stay temporarily while a full assessment is carried out. Young people then move on to accommodation they can stay in for up to two years which ranges from fully supported accommodation with staff on site 24/7 to a range of increasingly independent options, depending on the age, vulnerability and needs of the young person. Every young person living with St Basil's is assigned a support worker who holds regular

[8] St Basil's Youth Hub Service Report April 2012 to March 2013

one to one meetings with that young person and helps them to move on from the housing crisis which caused them to become homeless and to rebuild their confidence and support networks.

4.2.4 St Basil's has been a Psychologically Informed Environment (PIE) since 2011. This means that all staff are trained in psychological skills so they can support young people to develop the practical skills and the emotional and psychological resilience needed to overcome the multiple challenges of being young and homeless and to achieve their potential. Currently the Birmingham and Solihull Mental Health NHS Foundation Trust are partners in St Basil's psychologically informed services. The view expressed by St Basil's was that a similarly targeted approach to providing in-reach access to primary health care is essential in addressing youth homeless health issues in a holistic way. St Basil's would welcome an opportunity to work with primary care services to extend this multi-agency approach to preparing young people for independence and to effectively access mainstream services by providing in-reach access to primary health care.

4.2.5 Building skills and finding employment is the most successful route out of homelessness and into independent living. The learning, skills and work service aims to help young people access education, training and employment opportunities and can also help with removing some of the financial barriers to accessing education, training or employment such as travel costs and sourcing clothes for interviews. This includes working intensively with a number of young people who are NEET (Not in Education, Employment or Training) and face multiple barriers to identifying appropriate opportunities which are suited to their skill-set.

4.2.6 The success of the work that they do is demonstrated by some of the headline figures highlighted in the 2013/14 Annual Review:

- 4116 young people provided with advice and homeless prevention services via the Youth Hub in Birmingham and the single access points in Solihull, North Worcestershire and Coventry.
- 1017 vulnerable young people and in some cases their children too, housed in St Basil's supported accommodation.
- 76% of the young people re-engaged with employment, education and training.
- 93% of young people established or maintained independent living.

4.3 NHS Young People's GP Charter

4.3.1 Young People at St Basil's have developed a Young People's GP Charter which has been presented to Birmingham South Central CCG to encourage its member GP practices to provide services in line with the principles in the Charter.

4.3.2 The Charter has seven statements:

- Access – I want to be able to see a GP at a time to suit both of us without needing to take time away from college or training during the day and I want to be able to get to the service by public transport.
- Believe Me – When I go to the GP it is often the last resort. Explain to me how the system works if you are referring me to other services. Don't judge me or make me feel as though I have brought it on myself.
- Publicity – Make sure that information is written in easy to understand language for everyone, explain clearly how we can get the help we need and what will happen when we access services and make sure that confidentiality is explained, including that we can see a GP without a parent or carer.
- Involve young people in monitoring services – I want to be included in patient satisfaction surveys. Have a suggestion box in the surgery so we can have our say and use the Department of Health's quality criteria for young people friendly services.
- Staff – Staff need to make me feel relaxed and supported. They need to see me as a person, not just a set of problems. Staff need to be trained on how to engage with young people.
- Environment – GP surgeries and other NHS buildings should be welcoming. We suggest a water machine, comfy chairs, enough room for buggies and up-to-date information on notice boards.
- Health issues for young people – If I ask for help to improve the quality of my life, refer me to services that can support me with smoking cessation, healthy lifestyles, mental health and emotional support, sexual health and other specialist services. We want to know what to expect before being referred to services.

4.4 Care leavers

4.4.1 For all care leavers in Birmingham, there are a number of options in relation to support to find accommodation, dependent on individual circumstances and the needs of individual care leavers. Housing and children's services work together on an established Housing Pathway, within which accommodation is an integral component, through which young care leavers can secure local authority accommodation. There are various alternative options to local authority accomodation, for example, a care leaver may stay with their former foster carer under the 'staying put' arrangement or BCC may seek to secure a suitable adult transition placement for a young person who has complex needs.

4.4.2 Care leavers are given priority in the allocations scheme. Once the team are made aware that a young person is leaving care, if their social worker is of the opinion that they need to be living independently the local authority will seek to facilitate their move into local authority or supported

or private rented accommodation. The local authority work closely with the St Basil's Youth Hub where St Basil's workers and social workers are co-located at the Youth Hub to facilitate dealing with the needs of care leavers in a timely way.

4.4.3 The suitability of accommodation is checked by the allocated social worker or personal adviser when undertaking statutory visits to the young person. The quality of the accommodation should also be quality assured by the independent reviewing officer for care leavers aged 16 to 18. There is a housing checklist used by social workers when placing a young person in supported accommodation. In terms of ongoing support, all care leavers are supported until the age of 21 or 24 if in full time education and supporting young people to maintain their accommodation is a key component of this. A number of emergency beds are available to be used where necessary to ensure that unsuitable B&B or other emergency type accommodation is not relied on.

4.4.4 In 2013/14 the authority took 193 homeless applications from care leavers. These are not necessarily all young people leaving care at the age of 18. They could be older and have had accommodation where the arrangements have broken down or they could be aged over 21 because the local authority has a duty up to the age of 24 for some young people such as those in further education. Although this is a significant figure, it represents a reduction on the previous year and the figures are showing a steady downward trend over the past few years; 2010/11 343, 2011/12 286, 2012/13 264 and 2013/14 193. The latest figures for 2014/15 up to when the evidence was taken were 105 up to November 2014.

4.4.5 In the case of particularly vulnerable young people aged 16-21 or for care leavers St Basil's operate Supported Lodgings schemes where young people lodge with a family in the local community (a Host). This arrangement is sometimes better suited to young people who have no support networks or those that are particularly isolated or vulnerable due to their age or other factors.

4.5 Healthwatch Birmingham

4.5.1 A representative from Healthwatch Birmingham spoke to the Inquiry Members about some of the work they have been involved in with homeless young people and highlighted some of the issues raised by young people relating to healthcare services and a healthy lifestyle. These included:

- The importance of supporting families whilst the children are young as a way of preventing homelessness later on.
- The need for young people to have access to mental health services that are more accessible.
- Signposting for pre-natal and maternity services.
- Linking young people into drug and alcohol support services.

- The general need, as also referred to by other witnesses including SIFA Fireside, to take the services out into the community and to where the young people are to venues such as family centres, and churches, mosques and other places of worship.

4.5.2 St Basil's GP Charter which has been developed by young people as a way of setting out to GPs what young people feel they need to help them feel confident and comfortable in accessing GP services (See paragraph 4.3) which looks at all the health issues that young people want to highlight with the NHS was referred to.

5 Homelessness and Rough Sleeping

5.1 The scale of the problem nationally

5.1.1 It is hard to imagine a more extreme form of poverty than sleeping on the streets:

> "It's horrible, it's bloody horrible sleeping rough. I don't care how hard people think they are, if you go and sleep rough, I tell you what, it'll make you scared."
>
> "When I was sleeping rough I was vulnerable, scared, was spat upon and told I'm a dirty tramp."
>
> "Sleeping rough was horrible. Waking up with frost over me in the morning." [9]

5.1.2 In their strategy, 'Vision to end rough sleeping: No Second Night Out Nationwide" (2011) the Government called on every local authority area to adopt the strategy and work to end rough sleeping in their area.

5.1.3 Given the shifting populations involved and 'snapshot' nature of street counts, any data in relation to rough sleeping tends to be approximate and tends to underestimate the numbers of those affected over a longer time period, but it can give an indication of a trend. However there is evidence nationally of rising numbers of people sleeping in our streets in recent years:

- Snapshots of the number of people sleeping rough on a single night shows a 31% increase from 1,768 in 2010 to 2,309 in 2012
- Over the course of 2012/13, 6,437 people slept rough at some point in London, an increase of 12 % on the previous year's total of 5,678.
- On average, every day in 2012/13, 12 people started sleeping on streets of London for the first time, an increase from 10 per day in 2011/12.[10]

5.1.4 Key points to emerge in relation to England from the fourth annual Homeless Monitor study which provides an independent analysis of the homelessness impacts of recent economic and policy developments showed that:

> officially estimated rough sleeper numbers have continued to grow, with the 2013 national total up 37% on its 2010 level. In the last two years however, the annual rate of increase has been more modest at around 5%, though continued

[9] St Mungo's No More: Homelessness through the eyes of recent rough sleepers 2013
[10] St Mungo's No More: Homelessness through the eyes of recent rough sleepers 2013

growth in the more 'entrenched' rough sleeping cohorts in London is a matter of particular concern. New restrictions on the Housing Benefit entitlements of European Economic Area migrants from April 2014 may further contribute to rough sleeping amongst Central and Eastern European nationals.[11]

5.1.5 The only national count of homeless people available is an annual snapshot gathered on one night of the year across the country, where the number of people sleeping rough is counted for the purpose of comparison year on year. The Autumn 2013 count was 2,414 people across England which is 5% up from 2012 and 37% from 2010. [12]

5.2 Factors leading to rough sleeping in Birmingham

5.2.1 Midland Heart presented evidence about some of the reasons for rough sleepers not accessing services by looking at the outcomes of three projects delivered by Midland Heart; Rough Sleepers Outreach Team, Rough Sleeper Personalisation Service and Homeless Hospital Discharge Pilot. Analysis of customers supported by Midland Heart Rough Sleepers Personalisation Service found that:

- 70% of customers who were supported by the service presented complex needs, involving physical and mental health issues and substance misuse.
- 30% of those who were identified as high needs required rapid intervention to manage their health
- 26% of customers were experiencing mental health issues and felt that this was the main contributing factor preventing them from maintaining accommodation.

5.2.2 The Midland Heart evidence also looked at some of the factors leading to homelessness. The main recorded reason for individuals becoming homeless was relationship breakdown. Nearly 60% of the people who attended Midland Heart's Homeless Service Centre during the period between April 2014 – September 2014 and who needed accommodation stated that they were homeless due to breakdown of a relationship either with their parents or a partner. The most common reasons cited as contributing to the relationship breakdown were offending, income, substance misuse and poor physical and mental health. These findings were supported by evidence presented by West Midlands Police about the reasons why people were sleeping rough. The main reasons they were given were relationship breakdown/family conflict (42%) and lack of social support (38%).

5.2.3 Although in many cases individuals were using substances prior to becoming homeless, people were found to experience a significant increase in their substance use once they were no longer in stable accommodation. The Midland Heart evidence showed that some customers used substances

[11] The homelessness Monitor: England 2015 (Crisis)
[12] Department for Communities and Local Government (2014) Rough sleeping statistics England Autumn 2013 Official Statistics

as a coping mechanism to help them to deal with the traumatic experience of becoming homeless and this pattern is supported by evidence from West Midlands Police who found that from the feedback collected through Operation 'Engage', substance misuse was not cited at all as a cause of sleeping rough. Many of the rough sleepers disclosed that their alcohol intake increased in the winter months as it helps them to feel warm. However this warmth is superficial and can lead to people putting themselves at an increased risk of hypothermia. Midland Heart's Homeless Welfare Services were accessed by 89 clients who were sleeping rough during a nine month period. Alcohol dependency was an issue for 42% of clients whilst 39% had drug related issues.[13]

5.2.4 There is other local data which highlights significant causes of homelessness and rough sleeping. 72% of clients at SIFA Fireside were deemed to have complex needs with three or more issues contributing to their circumstances, which included having learning or physical disabilities, mental health issues or a criminal record. Those accessing Midland Heart Welfare Services were also dealing with physical (19%) or learning disabilities (13%). Some were also previous offenders or were at risk of offending (35%).

5.2.5 In summary, there are a variety of complex reasons why people may start sleeping rough including relationship breakdown/family conflict, lack of social support, learning or physical disabilities, domestic violence, mental health issues or having a criminal record.

5.3 Numbers of Rough Sleepers in Birmingham

5.3.1 The West Midlands Police provided evidence focused on the work undertaken in Birmingham West and Central (BWC) Local Policing Unit (LPU) which is the command unit responsible for policing Birmingham city centre. The evidence was drawn from work carried out under the operational name 'Engage' which was initially an 8 week programme in 2013 which was extended to 6 months in 2014 and from activity reported from the Moseley area of the city focusing on the partnership between SIFA Fireside and the local police team in that area which is contributing to tackling homelessness in that part of the city. The police activity in the city centre focuses on the 'street population' which refers to people who have a 'street lifestyle' such as street drinking or begging. Many people who have a street lifestyle are also rough sleepers but a minority are not.

5.3.2 It is difficult to provide absolute figures for the number of people sleeping rough. One reason is that many rough sleepers hide themselves away in places where they are difficult to find in order to protect themselves. This is especially true for women. 44% of current rough sleepers surveyed by Crisis reported that they had not had any contact with a rough sleepers' team in the past month.[14]

5.3.3 The official estimated number of rough sleepers in Birmingham local authority has increased with 14 in the autumn 2013 count compared to 8 and 7 in the 2012 and 2011 counts respectively.

[13] Midland Heart Homeless Services Centre: Accomodation Access Team Welfare Service reports Q2,Q3&Q4 (2012/13)
[14] The Homelessness Monitor: England 2013 (Crisis)

Birmingham was officially recognised as an 'Ending Rough Sleeping Champion' in 2010/11 and still compares favourably to other city counts such as Manchester (24 in 2013) and Coventry (26 in 2013). However the police evidence rightly points out that it should be noted that this figure is a snapshot taken on one night and falls well short of the numbers evidenced by local agency reporting:

- SIFA Fireside gave housing advice to 249 rough sleepers and others of no fixed abode and found accommodation for 309 homeless or vulnerably housed clients in 12 months.[15] In one month, 25 sleeping bags were given out to rough sleepers by SIFA and the drop-in centre saw an average of 139 clients each day.[16]
- Street Link is a service that enables the public to alert local authorities about rough sleepers in their area. Their data records 187 referrals made for Nechells and Ladywood wards combined in 16 months. Five of the people referred were involved in 'street activity' such as begging or drinking.[17]
- Midland Heart Housing Association's Homelessness Prevention Services data shows that in nine months over 220 of the new clients who were referred to them were currently sleeping rough (10% of their total new referrals).[18] Additionally 89 homeless people accessed their Welfare Service in nine months.[19]
- St Basil's Youth Hub reports that 45 of the young people (aged 16-21) referred to them in 12 months were already sleeping rough (1% of all referrals)[20].

5.4 Outreach: West Midlands Rough Sleeper Project, Midland Heart

5.4.1 Midland Heart operate a West Midlands Rough Sleepers Outreach Team which is often the first point of contact for people sleeping rough. The project works across the local authorities in the West Midlands to identify people who have consistently refused previous offers of services which is helpful in engaging with a transient population. It runs out of Midland Heart's Homeless Centre in Birmingham and offers a range of advice and health support to rough sleepers and other homeless people in the city. The project aims to support an identified group of around 25 long-term rough sleepers in the area and give them an alternative to the usual offer of a direct access hostel, which many had previously refused.

[15] SIFA Fireside Impact Report 2011-2012
[16] Data for Feb 2014 contained in e-mail dated 17/03/14 from Enterprise Manager SIFA Fireside
[17] http://www.streetlink.org.uk/ between Dec 2012 & Mar 2014
[18] Midland Heart Homelessness Prevention Services Performance Monitoring reports for Q1, Q2 & Q3 2012/13 & 2013/14
[19] Midland Heart Homelessness Prevention Services Performance Monitoring reports for Q1,Q2&Q4 (2012/13)
[20] St Basil's Youth Hub Service Report April 2012 to March

5.4.2 At the time of giving evidence, there were 27 clients using the project, of whom all but two were men. Most (24) were White British and the average age was 46 years. Over half of clients had alcohol issues (18) or mental health issues (17), 11 had drug issues and 17 clients had two or more of these issues. Many clients had also been in prison or had contact with the police, 17 were still sleeping rough, 4 were in hostels or supported accommodation and 2 clients were housed.

5.4.3 Referrals to the project come from local authorities, from other services like drug or alcohol treatment or from Street Link, a helpline for members of the public to alert services to rough sleepers in their area. Clients are allocated to a project worker who works with them to move them off the street. This involves building a trusting relationship and getting to know clients, before starting to talk to them about what would help them to move into accommodation. Project workers have considerable freedom to support clients as needed and offer a high degree of support to help individual rough sleepers address their issues and move into secure accommodation. The project also allocates a personal budget for each client to help them move away from sleeping rough.

5.4.4 Staff, who have the skills and knowledge of services to meaningfully advise and support people, carry out an initial assessment with individuals to establish their risk and needs. This would cover needs connected to substance use, housing, mental health, sexual health and domestic violence. Staff are then able to take customers through the treatment options available and support them to access GP services, counselling etc. If external agency support is required, staff can arrange joint outreach with partner agencies as appropriate. Several of the project staff are peer support workers who have experienced homelessness themselves and who were recruited as a way of helping clients to engage more effectively.

5.4.5 The project had only been running for a few months with most clients at the time the evidence was given but staff did describe positive outcomes for some clients including accessing appropriate healthcare, moving into residential care, securing a council tenancy and re-building relationships with family members.

5.5 Other unmet needs of rough sleepers

5.5.1 The evidence suggests that people who sleep rough are in an especially disadvantaged position. People sleeping rough are more likely than the general population to suffer from mental and physical ill health. The rate of tuberculosis among rough sleepers and hostel residents is 200 times that of the known rate among the general population and people who sleep rough are 35 times more likely to commit suicide than the general population. They are likely to present a high level of health needs and at the same time are not accessing health services for a number of reasons which exacerbates their vulnerability and level of exclusion.

5.5.2 Health needs are not the only unmet needs which were highlighted when Inquiry members spoke to a group of rough sleepers. Members were told that frequently rough sleepers are not claiming benefits to which they would be entitled because of some of the difficulties they face in claiming or

in maintaining benefit claims. Claims now need to be made online and this presents a barrier for people in circumstances with no access to a computer where they can process a claim. There are computer terminals available in the library but these are not always available and although there are computers in Jobcentres, access to these computers need to be booked in advance. Members were told that people may have to wait a week to get access and then it takes 7-14 days to process the claim. This obviously causes huge difficulties for homeless people who may be living a chaotic lifestyle where their main concern is where there next meal is coming from and where they are going to sleep tonight so that making and keeping an appointment to access a computer to make a benefit claim may come fairly low on their list of priorities. This links to a slightly different but related issue for homeless people being released from prison which is set out in the evidence in paragraph 6.3.3 and R08 about the need to work better with prisons to improve the connection between prison healthcare and other services and the services in the community when prisoners are released from prison. This was also highlighted by the group of rough sleepers who gave evidence to the Inquiry who spoke about the difficulties of linking back into community services and in particular about the difficulties in making benefit claims when a homeless person has been released from prison. It was suggested that it would be relatively easy to address this before a prisoner is released from prison if someone with a laptop could go into the prison before release and set up the claim online before the homeless person is released from prison. **(R06)**

5.5.3 This is part of a wider issue which needs to be addressed which was also raised during the discussion with members which is the lack of access to somewhere in the city centre that homeless people can go for advice and support. The homeless offices are some way from the city centre and they do not all open five days a week. Significant numbers of homeless people turn up at the reception desk in the Council House and then have to be sent to whichever office is open on that day and they have to make an appointment if one is available. Often they do not have the bus fare to get there and if they do manage to get there and are turned away, they do not have the bus fare to get back to the place where they live. There needs to be a location in the city centre where homeless people can go for advice and support with accommodation, benefits and referrals to healthcare services. Many of the services are already there for homeless people but they need to be working together and engaging with service users and building relationships with service users and a central point of contact in the city centre would be a helpful start to this process. There needs to be a location in the city centre, such as for example the Homeless Health Exchange which is based in the William Booth Centre, but it could be somewhere else in the city centre, where homeless people can go to get advice and support on accommodation, claiming benefits and health services. **(R01)**

5.5.4 As part of the discussion, there was also a feeling expressed that currently there is no direct channel of communication for people sleeping rough in the city to raise problems or issues encountered by them. The city council need to explore the best way to provide a means of communication, for example this could potentially involve advice surgeries in the city centre or

other suitable means, to enable people sleeping rough who have issues that they wish to raise to be heard. **(R08)**

6 Joint working

6.1 West Midlands Police

6.1.1 Much of the evidence provided by West Midlands Police to the Inquiry focused on the work of the command unit responsible for policing Birmingham city centre based on feedback from Operation 'Engage'. The work carried out under the operational name 'Engage' was initially an 8 week programme in 2013 which was extended to six months in 2014 and is based on police activity driven through the local community concerns in relation to begging and homelessness. Much of this evidence has contributed to and been incorporated into section 5 on homelessness and rough sleeping.

6.1.2 Concern about begging is a main source of complaints to the police from the business community and has been identified as the top anti-social behaviour issue for the city centre. However the police data tends not to support the hypothesis that people beg because they are homeless or have no settled accommodation. The data shows that whilst force wide begging offences are concentrated in the city centre police unit and that this proportion has increased significantly between 2012 and 2013, the majority of people who were arrested for begging were not in fact homeless: over the three years 2011 to 2013 between 70 and 90 per cent of beggars did have a home address.[21] In contrast, Arrest Referral Workers' surveys conducted for Operation Engage suggested that 41% of beggars in the city centre were also sleeping rough. However, anecdotal evidence from the Council's Safer Communities Team supports the arrest data findings and suggests that most of the high risk aggressive beggars do have access to accommodation and that some have settled accommodation.

6.1.3 The police evidence said that substance misuse and addiction, primarily to drugs, is the main driver for people begging in the city centre. However, whilst it is true that many rough sleepers are addicted to drugs and alcohol, they do not consider this to be a significant factor in causing their homelessness. Rough sleepers and homeless people cite a variety of complex issues as causing their circumstances, primarily family breakdown and lack of social support, which suggests that substance misuse is a consequence rather than a cause of becoming homeless.

6.1.4 The work has highlighted the complex nature of the issues which cause homelessness and rough sleeping but there have also been a number of positive outcomes from the referrals made under Operation 'Engage' which illustrate the complex issues faced by homeless people and the difference that can be made to their lives by effective joint working.

[21] West Midlands Police Drug Intervention Programme tests analysis

Good Practice Case Study

Male G is a long term rough sleeper in the city centre. He funded his heroin addiction through begging around the city centre. G was one of the most prolific beggars in the city centre. Among other issues, G needed assistance with the following; accommodation, registering with a GP surgery in order to obtain methadone prescriptions and obtaining his benefits. Sorting out these basic requirements is especially complex given the 'chaotic' lifestyles of some of those referred. Initially, G was extremely sceptical of the help offered, however with some persuasion by officers, he was taken in person to his first Swanswell's appointment.

Since his original referral in June this year, G has engaged well and attended regular appointments with both Swanswell and then also Midland Heart (who have assisted him with accommodation). As a result of Operation Engage, G has been registered with a local GP surgery away from the city centre and is now on a daily 80ml methadone prescription. Together with these regular prescriptions, G has also received assistance in relation to his ESA benefits, and subsequently G no longer has any need to continue to beg and is currently in the process of being transferred to shared care as he has stabilised well on his methadone prescription.

6.2 West Midlands Fire Service

6.2.1 The Inquiry heard evidence about the work that happens within the Fire Service on community risk reduction. The Fire Service has a number of specially trained Vulnerable People Officers who work to build relationships with the most vulnerable people, many of whom may be living in squats in the city centre and in places such as Paradise Forum and at high risk, and can open doors for a range of other partner agencies such as Midlands Heart, SIFA Fireside and others, by signposting them to services that are available through other agencies and targeting resources where they are most needed to keep people safe. The West Midlands Fire Service visit squats primarily to provide fire safety information in the first instance and they provide wind-up torches to discourage the use of candles which is an obvious fire risk and they also fit smoke alarms. At the same time they are also talking to and getting to know the homeless people they are helping and will leave leaflets signposting them to other services. They no longer close squats down unless the building is deemed to be dangerous as the prevailing view is that the interaction and engagement and chance to build trust with the individuals concerned would be lost if the squat was closed and they were forced to move to another derelict building.

6.2.2 The opportunity to build on the knowledge gleaned and relationships built by the work of the Fire Service in facilitating and enabling other agencies to take a more joined up approach to identifying

the location of where people are living in squats and working together to find a more permanent outcome and to make sure that their health and other needs are met is an important opportunity that needs to be used to maximum advantage. Clearly much excellent work is already being done in this area. Members were told that there is already at least one multi-agency working group in existence which works in the city centre that includes a range of agencies including Drugline, the West Midlands Police, the Salvation Army, SIFA Fireside, Midlands Heart and others. There is an opportunity to build on the work of this group and to find out whether there may be other groups already doing similar work and to develop this further to ensure that all opportunities for joint working are maximised wherever possible to strengthen multi agency working further and to ensure better outcomes for homeless people. A review needs to be carried out of what groups are already operating in this area and whether they are working together effectively, for example there may be more opportunities to include public health in this work to strengthen partnership working to ensure that more health needs are met. **(R03)**

6.2.3 Members also asked questions about the situation where it becomes known that redevelopment or regeneration of an area where there may be people sleeping rough is being planned. There was general support for the idea that it would be useful to review the existing city centre protocol to ensure that the agencies involved in the StreetLink multi-agency working group in the city centre are aware in advance of major regeneration work starting. This would provide an opportunity to work with rough sleepers in an area in advance of any redevelopment starting. **(R03)**

6.3 HM Prison Birmingham

No fixed abode (NFA) is the formal term used to identify homeless prisoners. In 2012 the Ministry of Justice found that 15 per cent of people in prison were homeless prior to custody, which represents nearly 13,000 people. This is possibly an underestimate as in 2002, a report by the Social Exclusion Unit found that 32 per cent of all prisoners were 'not living in permanent accommodation prior to imprisonment' (p21). A third of people leaving prison say they have nowhere to go (Centre for Social Justice, 2010). Including those on remand, this could represent up to 50,000 people annually (Ministry of Justice, 2013a, 2013b). The large portion of people in prison with no permanent accommodation prior to and post imprisonment, begs the question: where do homeless people in the criminal justice system go when they are not detained in custody?[22]

[22] The Howard League for Penal reform 'No Fixed Abode'

6.3.1 When homeless people enter Birmingham prison they have access to a range of healthcare facilities including mental health services, substance misuse services and primary care services including GPs, general nurses, dental care, chiropody, optician, physiotherapy, smoking cessation and sexual health clinics. All prisoners receive an initial health screening which covers both physical and mental health issues. If any further intervention is required then the appropriate referrals are made within the service to ensure that people gain access to the services they require. Homeless people are considered to be high risk for TB and are routinely screened on reception into the prison.

6.3.2 The written evidence submitted to the Inquiry by the Head of Healthcare at HMP Birmingham reinforced some of the issues already raised by other witnesses in relation to homeless people who may have lost contact with services entering prison with untreated mental health issues. This often links, not just with physical and mental health issues, but often with offending behaviour and with the high prevalence of substance misuse amongst homeless people which is often related to coping strategies for underlying mental health issues or underlying distressing life events such as sexual abuse, domestic violence and relationship breakdown which can leave them very isolated.

6.3.3 Some of the Inquiry members were taken to some sites near the city centre which are often frequented by rough sleepers and also met with and listened to a small group of rough sleepers who agreed to meet with the Inquiry members in the Council House. The evidence provided by the prison further reinforced an issue which was raised by the group of rough sleepers who spoke to members of the Inquiry about the need for more joined up working and improved pathways between the prison service and the general community in order to be able to provide better support for homeless people on release from prison. When people are homeless one of the difficulties on release from prison is linking people back to appropriate healthcare services and appropriate accommodation that will be able to meet their needs and provide appropriate support especially for people with drugs and/or alcohol problems when released from prison. A 'Forum' or some other means of linking homeless prisoners back into services and support in the community, needs to be developed between HMP Birmingham and the local authority with a view to supporting prisoners into housing and other services in the community both before and after release and to link prisoners into appropriate healthcare services, in particular where prisoners are known to have drug or alcohol problems. **(R06)**

6.3.4 The provision of more appropriate accommodation on release from prison is a key area in terms of stabilising people who are homeless and in trying to reintegrate people back into a lifestyle that provides them with motivation to change and work towards their goals in life. Members were told that Birmingham has signed up to the West Midlands Resettlement Protocol whereby referrals come through the Pathways Team which should start to help to address this issue but clearly there is more work to be done regarding the provision of accommodation for prisoners being released. **(R06)**

6.3.5 One of the particular issues highlighted in the evidence from the prison was the vulnerability of homeless women to being exploited on release from prison by drug dealers who may end up forced into prostitution and a never ending cycle of ongoing debt. Women who are released from prison who may become homeless are a vulnerable group highlighted by both the evidence from HM Prison Birmingham and by the Director of Public Health. There is some excellent work that is already happening to help women on release from prison and the work being done by Anawim Women's Centre was cited in terms of good practice. **(R06)**

Good Practice The work done by The Anawim Women's Centre in Balsall Health with women released from prison who may become homeless was highlighted. The centre undertakes prison in-reach to the three main prisons which accommodate women from the Birmingham area. These are HMP Foston Hall, HMP Drake Hall and HMP Eastwood Park. They visit each prison every three weeks and during the visits they support women leading up to their release, helping them to prepare for life in the community and to ensure that on release they have a network of support ready for them in the community and are re-connected with family members. They also deliver a community sentence programme as an alternative to going to prison. Anawim places emphasis not only on ensuring that all clients are supported towards finding accommodation that meets their needs, but also on supporting clients so that they are able to sustain their accommodation in the longer term. One source of support is referral to outside agencies who attend the centre. A member of staff from the Sparkbrook Neighbourhood Office and SIFA Resettlement attend each week offering appointments and follow-up work. As part of this work Anawim have a partnership agreement with Midland Heart called the Re-Unite programme whereby Midland Heart have undertaken to offer up to 40 suitable properties a year on a priority letting scheme to women on release from prison so that they can be re-united with their children with support from Anawim.

7 Healthcare needs amongst homeless

7.1 Homelessness and physical health

7.1.1 As previously stated in this report, being homeless can have a huge impact on a person's health and homeless people face inequalities in accessing health services. In addition people who are homeless or living in poor quality temporary accommodation can often suffer worse health than those living in settled accommodation due to their physical surroundings. Poor health, whether mental or physical or both, can also be a contributing factor to a person becoming homeless in the first place.

7.1.2 The 2014 Homeless Link Needs Audit found that 73% of homeless people reported a physical health problem. In total, 41% of those surveyed reported a long term problem, compared with 28% of the general population who report a long term physical health condition.[23]

7.1.3 Some of the most common conditions which occur in homeless patients presenting in primary care were described in the evidence from the Homeless Health Exchange (see paragraph 8.3). Homeless people experience significantly higher rates of physical health problems such as respiratory and circulatory problems especially chronic obstructive pulmonary disease, bronchitis, pneumonia and lung infections, skin problems and musculoskeletal problems than the general population. Physical health problems in homeless people are two to three times greater than the general population. The resulting healthcare needs are often far more complex than the average patient accessing primary care due to the need to address multiple chronic illnesses and diseases which may have gone untreated for a number of years.

7.1.4 These are in addition to infectious diseases such as tuberculosis (TB), sexually transmitted infections, blood borne viruses such as hepatitis C and HIV, vascular problems such as deep vein thrombosis and ulcers, cardiovascular disease, bad feet, minor illness, dental problems and all the normal chronic diseases.

7.1.5 The Director of Public Health referred to the fact that there is a particular niche issue around tuberculosis and homelessness. The rate of tuberculosis among rough sleepers and hostel residents is 200 times that of the known rate among the general population. The evidence shows that over 90% of TB patients complete their treatment but out of the remaining 5 or 6% who don't complete their treatment many of those are homeless. Treatment completion is important because if they don't complete their treatment they risk getting 'multiple drug resistance' (MDR) and once they are MDR positive, they will basically die with TB. There is no treatment and they risk passing on MDR resistant TB to other people. This is just one example on a very practical level of why tackling homelessness is important.

[23] Homeless Link (2014) The unhealthy state of homelessness: health audit results 2014

7.2 Homelessness and substance and alcohol misuse

7.2.1 Alcohol is often a contributing factor to becoming homeless. However problems can also develop after becoming homeless. It is not uncommon for alcohol and drug addiction to develop as a means of coping with the difficulties associated with homelessness.

7.2.2 The effects of drug and alcohol use have an extremely detrimental effect on the physical health of homeless people. It causes early alcoholic liver disease and is often also associated with Hepatitis C, both of which often result in severe liver disease and early death. Homeless people with alcohol dependency are 28 times more likely to have an emergency admission to hospital than the general public.[24]

7.2.3 However it also affects the brain and causes brain damage and results in early onset dementia. The Homeless Health Exchange encourages engagement with services, provides proactive, multidisciplinary care, provide regular physical health checks (blood tests etc), prescribe high doses of vitamins and thiamine, attend to other factors such as smoking, provide regular support from alcohol nurses and can organise admission for detox or rehab.

7.2.4 Drugs are also a common problem and injecting drugs carries associated risks including hepatitis C, HIV, abscesses, DVT, chronic leg ulcers and endocarditis. Death from overdose is more common when people have lost their tolerance by being in prison or after coming out of rehabilitation but it can be prevented by the use of naloxone which is the drug that reverses the effects of opiates.

7.2.5 Legal highs are an increasing problem. In spite of changes in the law to try to ban them the manufacturers are constantly one step ahead. They usually contain mephedrone or synthetic cannabinoids, amphetamines or cocaine and appear to be causing a risk of drug induced psychosis similar to that caused by super strong cannabis. The government has recently announced that it intends to bring in new legislation under the Psychoactive Substances Bill which will introduce a blanket ban on so-called legal highs and make it an offence to produce, supply, offer to supply, possess, import or export psychoactive substances.

7.3 Homelessness and mental wellbeing

7.3.1 Homelessness increases the risk of mental health problems - research from the Queens Nursing Institute was quoted in evidence which shows that for 33% of homeless cases, the first episode of mental ill health occurs whilst homeless - but having a mental health problem makes you much more likely to become homeless in the first place. In other words poor mental health is both a cause and a consequence of homelessness and the connection between the two is complicated There are also complex associations with issues such as childhood trauma, drug and alcohol misuse, domestic abuse, violence, neglect and relationship breakdown.

[24] Data from Central London CCG 2011

7.3.2 Mental ill health is far more prevalent amongst the homeless population than amongst the general population.

- Homeless Link's Health Needs Audit found that 80% of those surveyed had some sort of mental health problem, with 45% having a mental health diagnosis compared to 25% among the general population.[25]
- West Midlands Police evidence was that 76% of the individuals who were in custody for begging offences during the eight weeks of Operation Engage declared that they had a mental health issue. This is similar to levels amongst the prison population where 70% have two or more mental health issues.
- SIFA Fireside Drop-in Centre's 'snapshot study' found that 48% of their respondents said that they had a mental health issue.[26]

7.3.3 The prevalence of common mental health problems like depression is over twice as high amongst the homeless and the prevalence of psychosis is up to 15 times higher among the homeless population compared to the general population. This is even worse if you are a street homeless person, who are probably up to 100 times more likely to have or to have had a serious mental illness such as a psychotic disorder or schizophrenia than the general population. One third of people with schizophrenia experience homelessness in their lifetime. Overall research shows that as the stability of housing increases then rates of serious mental illness decreases.

7.3.4 In relation to Birmingham, the evidence presented to the members by Birmingham and Solihull Mental Health NHS Foundation Trust said that within their own homeless mental health service, they had noted a 39% increase in patient numbers over the last two years, with a 29% increase of service users with a serious and enduring mental health diagnosis. Overall the mental health team have seen an increase in psychotic disorders and those with dual diagnosis and a reduction in common mental health problems.

7.3.5 Personality disorder rates are also high. Members were told that two thirds of homeless people could be considered to have a personality disorder which can result in self destructive behaviour which can make it quite difficult and challenging to help a person who sometimes may not want to be helped. The evidence from the Homeless Health Exchange was that there are long waiting lists and that it is very difficult to get people into personality disorder services. In addition people who have personality disorders often engage well with services and often don't attend appointments or comply with treatment.

7.3.6 In relation to homelessness and mental wellbeing, Members visited the hostel at the William Booth Centre, which is run by the Salvation Army and receives funding from Supporting People, during which mental health was highlighted as a major issue. Since December 2014, all clients are referred to the centre through the BCC Gateway Service and are only allowed to live on the

[25] Homeless Link (2014) The unhealthy state of homelessness: health audit results 2014
[26] SIFA Fireside Complex Needs Snapshot Studies – survey conducted in the drop-in centre

premises for a maximum of three months. Members were told that in the last year, 94% of clients were found accommodation at the end of their three month stay and 87% have maintained their tenancy. Their evidence highlighted a particular issue they have encountered relating to their ability to access emergency or out of hours specialist mental health homeless services which can cause difficulties in obtaining a mental health assessment for homeless service users.

7.4 People with a dual diagnosis

7.4.1 Serious mental illness is often accompanied by alcohol and/or by substance misuse problems with the result that dual diagnosis is common amongst homeless people ie people who have a mental health problem and an addiction. Most studies suggest that around 10-20% of the homeless population would fulfil the criteria for dual diagnosis and they are nearly 5 times more likely to die than the equivalent age group in the general population.

7.4.2 There is a particular lack of support for people with a dual diagnosis of mental health and substance misuse. Many mental health services exclude those who are currently using drugs or alcohol. However, often people need to deal with their mental health problems in order to tackle their drug or alcohol use. If someone is drinking a large amount of alcohol it is difficult to know what is alcohol related and what is mental health related. If someone has mental ill health then they are very much less likely to be in a position to be able to stop drinking.

7.4.3 There is another group of patients with a different type of dual diagnosis, who have an alcohol addiction and who also suffer from dementia, for whom there is very limited access to services at the moment. This is because dementia services won't take people under a certain age and the younger people's dementia services won't take people that are drinking. An example of good practice in relation to commissioning services is the recently re-commissioned public health substance misuse services where the ring-fence on drug budget and alcohol budget has disappeared and drug and alcohol services have been re-commissioned. Should we be looking at commissioning specialist dual teams to deal with people with a dual diagnosis of mental health and substance misuse issues? **(R04)**

7.5 Difficulty accessing dental services

7.5.1 People who are homeless have difficulty accessing dental services, even though they often have poorer dental health than the general population and therefore have a high treatment need. When appointments are made they have poor attendance rates. This poor access was highlighted in the Birmingham Homeless Health Needs Audit where only 60% of respondents were registered with a dentist, with the over 25 age group less likely to have registered with a dentist.

7.5.2 This is also supported by the evidence provided by Birmingham Community Healthcare NHS Trust which provided evidence about some of the reasons for poor access to dental services by this group. Poor access to care can be a result of a lack of perceived need for dental care and

knowledge of how to access dental services, possible negative attitudes of some dental staff and high levels of client dental anxiety. Neglect of their general health and personal hygiene, in addition to heavy smoking and drinking, makes homeless people high risk for many diseases including cancer.

7.5.3 There is a need to provide dental services specifically aimed at this group that are easy to access in a non-threatening environment. Delivering a drop-in dental service allows contact with this hard to reach group.

7.6 Dental Drop-in Service for Homeless in Birmingham

7.6.1 A dedicated dental drop-in service for people who are homeless in Birmingham opened in September 2012. It provides a dedicated service where homeless people can just drop-in, in a convenient city centre location, integrated with other health and social services and providing a combination of fixed site and outreach services.

7.6.2 Birmingham Community Healthcare Trust Special Care Dentistry Team provide this NHS dental service at Attwood Green Health Centre. This provides an NHS dental service on Thursday afternoon between 1.15 and 4pm on a drop-in basis, on a first come first served basis. They provide check-ups, X-rays, fillings, scale and polish, extractions, dentures and emergency treatment for toothache or swelling. They are highly experienced in providing care for people with complex health problems, mental health problems, learning and other disabilities and social impairment/exclusion including alcohol and substance misuse and homelessness.

7.6.3 Outreach services are also required to provide preventative advice, screening for oral cancer and information on accessing dental services for more comprehensive care and so highlighting the importance of good oral health to a client group who are at high risk of oral disease.

8 Medical care for the homeless: Primary care

8.1 Access to Primary Care Services

8.1.1 GPs are the primary point of access to health services. One of the striking issues highlighted in the Homeless Health Needs Audit is the fact that only 75% of those responding were registered with a GP. People who are homeless frequently struggle to access health services and are 40 times more likely not to be registered with a GP and are 4 times more likely to use an A&E department than the general population. The evidence given by Birmingham and Solihull Mental Health NHS Foundation Trust was that less than a third of the mental health service patients they deal with are accessing other homeless healthcare services and there is an increasing trend in patients that are not registered with any GP at the time of assessment.

8.1.2 There are many barriers which prevent homeless people from being able to access primary care services. Priorities are understandably different for people who are trying to survive without a permanent home or on the streets. They may often be living a chaotic lifestyle, may not have the perseverance to navigate the system, they may not be good at filling in forms, they may not deal well with complexity or may not have any identification and GP surgeries don't necessarily make it easy for people to register without a fixed address. Some do, but there is huge variation. If GP surgeries ask a homeless person for a utility bill or proof of their name which they cannot provide the result is often that they cannot register. Members were told that the Homeless Health Exchange Primary Care Service register people care of the surgery and sometimes use organisations such as SIFA Fireside, one of the day centres or the Homeless Service Centre in order to get homeless people registered with a GP. More work is needed to ensure that every homeless person can register with a GP. **(R02)**

8.1.3 However making it easier for homeless people to be able to register with a GP is only the start of what needs to be done. Even if homeless people do manage to become registered with a GP, they don't necessarily keep appointments which leads to problems with health services and statutory services in general. If they do not turn up for appointments they will often be discharged as not engaging. This is part of a wider issue in relation to engagement of homeless people with services whereby they may frequently be banned from using or discharged from services for not complying with rules or for behaviour which is deemed to be unacceptable. Services generally need to be as flexible and tolerant as possible when dealing with homeless people and awareness training for front line staff dealing with homeless people can help staff to better understand how to deal with some of the behaviours which may be encountered by services engaging with homeless people.

8.1.4 The relationship that a person builds with their GP is important and once someone has registered with a GP they should be able to remain on that list and stay with that GP with whom they have built a relationship even if they move out of that area, especially if they are vulnerable because they become homeless. This would enable that GP to ensure that other services are contacted and alerted and brought in to support the homeless person, even if they have moved away from the area and the GP may not be able to visit personally. It would provide valuable continuity to provide greater protection for this vulnerable group. **(R02)**

8.1.5 A much better solution to providing services for homeless people would seem to be to take services to where the people are, along the lines of what happens at SIFA Fireside, rather than placing services where different providers are at various locations across the city. SIFA see around 130 people every day at their open access drop in where various services can work alongside SIFA staff. For example, the Homeless Mental Health Team work alongside SIFA staff at the SIFA premises once a week to do a formal mental health triage clinic. This tends to be a more successful way of picking up people who have dropped out of services or in the case of mental health services, provides an opportunity to spot people with undiagnosed mental health issues or to spot people in mental health crisis. **(R05)**

8.1.6 Developing and improving access to primary care services for homeless people in this way and facilitating registration of homeless people with GP services are both important steps towards making access to primary care services easier and more accessible for homeless people. Improving access to primary care services is also the first step in ensuring that health problems get treated at an earlier stage to avoid homeless people presenting at primary health services at a late stage with multiple and entrenched problems. This will also help in avoiding the delay which causes problems to become more serious until they become critical and are therefore likely to require more intensive and more expensive treatment leading to a disproportionate reliance on emergency and acute services and avoidable emergency admissions to hospital.

Good Practice Case Study – Inclusion Healthcare Social Enterprise CIC, Leicester

Inclusion Healthcare is a specialist GP practice for homeless people in Leicester. It is run as a social enterprise based at a city centre venue, close to public transport. It has around 1000 patients registered with a turnover of 50-70% per year. Translation services are available for those patients who do not have English as a first language.

The clinical team is led by a GP and consists of a consultant nurse, three female and one male part time GPs, two practice nurses, a primary care plus (PCP) nurse, specialist alcohol worker and a healthcare worker. Patients with poor mental health have access to a dual trained GP and psychiatrist and the practice has an Improving Access to Psychological Therapies (IAPT) therapist who works with clients who have a range of complex problems related to anxiety and depression.

The practice operates flexibly and offers longer appointments for patients with complex needs. When a patient does not attend the practice contacts other agencies to ensure that the patient is safe.

All patients with a long term condition have a named GP and the practice carries out annual reviews for long term conditions such as diabetes or heart failure. GPs also offer smoking cessation advice, NHS Health Checks to all patients aged 40-75 years old and chlamydia screening to patients aged 18-25.

Due to the complex nature of the physical and psychological problems of homeless patients referral rates to hospital and 'do not attend' (DNA) rates were high. To reduce the DNA rate the practice put in place a system where a healthcare assistant attends with the patient, to act as an advocate if necessary and the healthcare assistant reminds the patient about the appointment; accompanies them and, if requested, will be with them in the consultation room.

The practice is commissioned to provide an enhanced level of service provision above what is normally required under the core GP contract and has a process in place to follow up patients discharged from hospital. The PCP nurse works as the interface between primary and secondary care and other agencies such as social care. She provides a link for patients and ensures a safe admission and discharge for the patient which helps to reduce inappropriate attendance at the hospital's emergency and urgent care departments.

The two GPs who work at the practice also go into the local prison three times a week during the day and also provide out of hours care for substance misuse patients. They also carry out two sessions of substance misuse in the community drug treatment team. Some patients go between prison and the practice's care so the practice provides an integrated system which includes developing yearly care plans.

8.2 Primary Care Services for the homeless in Birmingham

8.2.1 There are excellent examples of specialist primary care provision in the city which illustrate some common themes in providing appropriate primary care to homeless people. A flexible approach needs to be taken to working and engaging with people who are homeless because of the multiple and complex health needs which need to be dealt with. This would include making patients feel welcome, taking a non-judgmental approach, offering a variety of appointments with a mix of drop-in and scheduled appointments. Longer than average appointments are needed to allow time to investigate and respond to a range of complex and multiple health needs. Providing services in a range of settings where homeless people are, such as homeless centres and offering a range of assertive outreach support which actively tries to engage rough sleepers. Also because patients often find that they can't comply with the multiple appointments needed to treat each of the problems at once, a better approach is often to triage conditions and address health needs through a structured health programme over time.

8.3 The Homeless Health Exchange Primary Care Service

8.3.1 The Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) are commissioned by the Joint Commissioning Team to provide a primary care and a mental health service to the homeless people of Birmingham. The Homeless Health Exchange Primary Care Service is a GP surgery for the homeless based at William Booth Centre in the city centre which provides a specialist GP service for homeless adults over the age of 18. Patients are fully registered and the surgery is open Monday to Friday between 9 and 5. They are staffed by three part time GPs, two practice/community nurses, three alcohol nurses, one CPN, two counsellors/psychotherapists and two administrators/receptionists.

8.3.2 The Community Mental Health Team does have 24 hour 7 days a week provision of mental health services for homeless people available through their universal crisis provision. The evidence from BSMHFT was that unfortunately they are not currently commissioned to provide an emergency or out of hours specialist homeless primary care service for the city. This means that the default position for homeless service users would be to attend a walk in centre or A&E. **(RO7)**

8.3.3 The practice is specifically for homeless people and differs from a standard GP practice in a number of ways. The criteria for access to the service would be someone who is of no fixed abode, sofa surfing, living in temporary accommodation or a hostel. The service has open access which means that service users can self-refer and drop in appointments are available.

8.3.4 A normal GP practice would have a relatively stable population of approximately 1800 patients per GP with an equal male and female patient mix but with females and children attending more often than males. By contrast, the Exchange has about 850 patients but with a high turnover of about 50% per year and the male to female ratio is about 90% male to 10% female with no children registered and very few patients over the age of 60 years of age.

8.3.5 The services offered include GP appointments and consultation, generic primary care nursing provided by practice nurses, specialist prescribing for minor illnesses and chronic disease, community nursing delivered on an outreach basis. A number of specialist services are also offered including blood borne virus and sexual health screening, women's health services, chronic disease management, wound management, smoking cessation and supply and training in the use of Naloxone for high risk drug users. There are specialist alcohol nurses who provide harm reduction advice, management and interventions for dependant drinkers and those with chronic physical health disease related to their alcohol misuse, and they also undertake preparation work with service users to support an inpatient detoxification programme in consultation with substance misuse providers. They also do outreach work, for example, at SIFA Fireside.

8.3.6 There is also provision of a primary care community psychiatric nurse and two counsellors who provide psychological therapies. Service users also have access to podiatry by way of a weekly screening clinic and limited dental care by means of specialist support once a month with onward referral to community dental services as required.

8.3.7 The evidence presented to the committee on behalf of the Exchange was that many of the homeless people they see are likely to have been in care as a child or had a disturbed childhood. A high proportion have some form of mental illness or addiction or have been in the armed forces. A very high proportion have spent some time in prison, often multiple times and an increasing proportion have migrated to this country from Eastern Central Europe or arrived as asylum seekers. This often results in patients presenting in crisis with multiple, severe problems, high levels of morbidity and a lack of engagement with medical care. Many of the patients seen and treated at the Exchange would otherwise be in secondary care.

8.4 The Homelessness Community Mental Health Service

8.4.1 This service is based at the Matthew Centre in Nechells and provides a city wide service between 9 and 5 Monday to Friday. Out of hours access to services is via the trusts' wider home treatment services. The criteria for access mirrors the criteria for access to the primary care service except that this service is for adults over the age of 18.

8.4.2 The service offers community psychiatric support, medication and psychiatric nursing care to service users requiring clinical management by a consultant psychiatrist. The service provides physical health monitoring for service users in receipt of psychiatric medication, assessment and management of complex psychological and social needs, psycho-social interventions and relapse prevention and care planning.

8.4.3 Referral to the service is via the trusts single point of access telephone triage service and from other trust services including those working within A&E departments. The service also liaises and takes referrals directly from other statutory services such as prisons, probation, addiction and forensic services.

8.5 The Homeless Service Centre

8.5.1 Midland Heart deliver a walk in service for individuals who are homeless or at risk of homelessness. A number of initiatives within the Homeless Service Centre address health needs:

8.5.2 Prescribing clinic for homeless customers – Whilst assessing customers housing needs it became apparent that some people could not access accommodation due to their substance use. To address this a prescribing clinic was arranged and GP and substance misuse agency staff are available on site to assess, provide advice as well as carry out drug screening and to prescribe medication.

8.5.3 Regular surgeries for customers not in accommodation who need specialist services such as chiropody and a hot shower and laundry facilities are also provided.

8.5.4 By accessing these health services within a less traditional setting people can get information about support available to them in an informal way and agencies can build trusting relationships with customers.

9 Medical Care for the homeless: Secondary care

9.1 Inappropriate admission to hospital

9.1.1 Homeless people are much more likely than the general population to attend A&E and are often less likely to stay around in the hospital once they have had their medical checks to make sure any appropriate care plan follow up support is provided. Members heard of an example of one homeless person who attended 4 different A&E departments in 4 different cities within 24 hours.

9.1.2 The evidence from Midland Heart estimated that homeless people attend A&E six times more often than people in stable accommodation; are admitted to hospital four times more often and stay in hospital three times longer. This can obviously lead to a disproportionate use of emergency and acute health services and paints a troubling picture of society's most vulnerable individuals stuck in a damaging cycle of homelessness, poor health and hospital admission.

9.1.3 A number of issues for homeless people accessing hospital treatment were identified during the Homeless Hospital Discharge Pilot:

- It was found that in the majority of cases, homeless individuals were discharged from hospital without a discharge summary, care plan or risk assessment. This created delays in assessing housing and support needs.
- Previously, front line medical staff had to spend time trying to arrange accommodation for homeless patients to enable discharge which impacted on time that would have been spent providing medical care.
- A review of hospital data showed that 'no fixed abode' (NFA) coding was used inconsistently resulting in variations in data and there was no way to capture the extent of homelessness according to the definition by Shelter, 2013.

9.2 Reasons for hospital admission

9.2.1 Data from the Homeless Hospital Discharge Pilot which worked with 70 customers, illustrated a number of findings from the pilot.

- Heavy alcohol use was thought to be a contributing factor to some of the primary reasons leading to admission.
- 80% of patients within the pilot had a recorded mental health issue.

- Financial problems including issues such as debts and no income were recorded in 62% of the patients in the pilot. Those on low income were not recorded as having financial problems unless they stated difficulties with budgeting or managing debts.

9.2.2 Unsafe hospital discharge of homeless people is a regular occurrence. A report on hospital discharge across the country found that more than 70% of homeless people are discharged from hospital back to the streets.[27] The types of issues which happen around unsafe or inappropriate discharge of homeless people from hospital would include early discharge before the patients' needs have been met, discharge without addressing housing needs ie discharge with inappropriate or no housing, discharge with no support or discharge having been given some doses of methadone in hospital but then facing a long wait to enter into a detoxification programme because there are no places available, failure to communicate effectively with relevant agencies around discharge and discharge without clothing or transport.

9.2.3 Members were told in the evidence from SIFA Fireside of very occasional instances where a homeless person has been discharged from hospital to the drop-in at SIFA in pyjamas and with nowhere to go. The SIFA evidence also flagged up a lack of active discharge planning from the start. Quite often it seems, it is not flagged up on admission that somebody is homeless and the issue is not recognised until the person is ready to be discharged.

9.3 Homeless Hospital Discharge Pathways

9.3.1 Funding was secured from the Department of Health to deliver two hospital discharge projects based at University Hospitals NHS Foundation Trust with Midland Heart and at Sandwell and West Birmingham NHS Hospitals Trust and the Heart of England Foundation Trust with Trident Reach. The service provided a 'Navigator' located in each of the hospitals who worked with the hospital discharge teams to identify and assess homeless patients and to look at how individuals who were likely to be discharged as 'no fixed abode' could be supported back into the community with accommodation and into ongoing care support. This work was further supported by having a brokerage service in the community with access to flexible funding to purchase ad-hoc services such as housing support and/or accommodation where appropriate to ensure that services which were being delivered from a clinical setting in the hospital continued out in the community. The clinical element was provided by way of a part-time GP and two nurses.

9.3.2 The project aims to prevent the 'revolving door' scenario of homeless people being treated, discharged and then returning to hospital with worsening health problems because they have nowhere to go and no proper support. This supports more effective discharge to get people home and prevents unplanned admissions by keeping people in hostels or supported housing. The team work together to assess patients, establish their needs and deliver a package of housing, healthcare and support which continues into the community after the person has left hospital. This

[27] Homeless Link and St Mungo's 2012

includes nurses carrying out regular support home visits in the community after discharge, as well as making sure people are registered with a GP and dentist and accessing the health and other services they need. This involves working with specialist hospital consultants, housing providers and other agencies such as social services, alcohol advice services and specialist mental health services.

9.3.3 The pilot ended in July 2014 but was extended for a further twelve months from November 2014 at the Sandwell and West Birmingham Hospitals Trust and at the Heart of England Hospitals Trust with Trident Reach. In its first three months the extended scheme, now known as the Homeless Patient Pathway at Birmingham City Hospital helped 131 people, aged from 18 to 74 find housing and become re-integrated back into the local community, reducing the average length of stay in hospital by 3.2 days per person. 80% of people helped have not been re-admitted to hospital, 10% have since gained employment and 10% are doing voluntary work. Various funding options are being explored with a view to embedding the pilot as a mainstream service in the future.

10 Conclusion

10.1 Health and homelessness

10.1.1 There is an intrinsic link between health and homelessness. Homeless people face poorer health than the general population with many suffering long term physical and mental health problems which can be difficult to manage for people who are living in hostels or on the street. They struggle to access the healthcare that most people take for granted. This failure to improve health at an early stage places a significant financial burden on the health system in terms of avoidable emergency admissions to hospital and reliance on long term care.

10.1.2 Some services are very effective in addressing the health needs of homeless people and there are some excellent examples of innovative and flexible approaches to addressing the health needs of the homeless, with inclusive commissioning and effective joint working. There is no easy answer but it is clear that local authorities and homelessness services need to listen to what homeless people have to say in order to work together better to provide more flexible and person centred services which are designed to meet the health needs of homeless people.

Appendix: Contributors

The Committee would like to thank all those who have taken the time to contribute to this inquiry.

Contributor	Organisation
Bernadette Byrne	Head of Addictions & Homeless Services, Birmingham & Solihull Mental Health Foundation Trust
Cath Gilliver	Chief Executive, SIFA Fireside
Cllr John Cotton	Cabinet Member for Neighbourhood Management and Homes (formerly Cabinet Member for Health and Wellbeing)
Dean Hatton	Chief Inspector, West Midlands Police
Derek Tobin	Head of Healthcare, HMP Birmingham
Dr Adrian Phillips	Director of Public Health
Dr Kenneth Wilson	Consultant in Special Care Dentistry, Birmingham Community Healthcare NHS Trust
Dr Sarah Marwick	GP for the Homeless
Gail Read	Community Risk Reduction Officer, West Midlands Fire Service
Garry Murphy	Service Manager, Salvation Army William Booth Centre
Ian Sturmey	Firefighter, West Midlands Fire Service
Jacqueline Latty	Young People and Families Engagement Officer, Healthwatch Birmingham
Jean Templeton	Chief Executive, St Basil's
Jim Crawshaw	Integrated Service Head Homeless & Pre-Tenancy Services, BCC
Jo Davis	Acting Service Manager for Homeless and Addictions, Birmingham & Solihull Mental Health Foundation Trust
John Denley	Consultant in Public Health
John Hardy	Policy & Development Officer, Housing Strategy Policy & Commissioning, BCC
Max Vaughan	Commissioning Manager – Substance Misuse, BCC
Paulina Korgol	Operations Manager, Midland Heart
Sam Henry	Youth Engagement Coordinator, St Basils
Vanessa Devlin	Associate Director of Operations, Birmingham & Solihull Mental Health Foundation Trust

Member Visits
Organisation
Health Exchange
Salvation Army William Booth Centre
St Basil's Youth Hub

Report of:	**Cabinet Member for Health and Social Care**
To:	**Health, Wellbeing and the Environment Overview and Scrutiny Committee**
Date:	**21st February 2017**

Progress Report on Implementation: Homeless Health

Review Information

Date approved at City Council:	7 July 2015
Member who led the original review:	Councillor Susan Barnett
Lead Officer for the review:	Rose Kiely
Date progress last tracked:	20th October 2015

1. In approving this Review the City Council asked me, as the appropriate Cabinet Member for Health and Social Care, to report on progress towards these recommendations to this Overview and Scrutiny Committee.
2. Details of progress with the remaining recommendations are shown in Appendix 2.
3. Members are therefore asked to consider progress against the recommendations and give their view as to how progress is categorized for each.

Appendices

1	**Scrutiny Office guidance on the tracking process**
2	**Recommendations you are tracking today**
3	**Recommendations tracked previously and concluded**

For more information about this report, please contact

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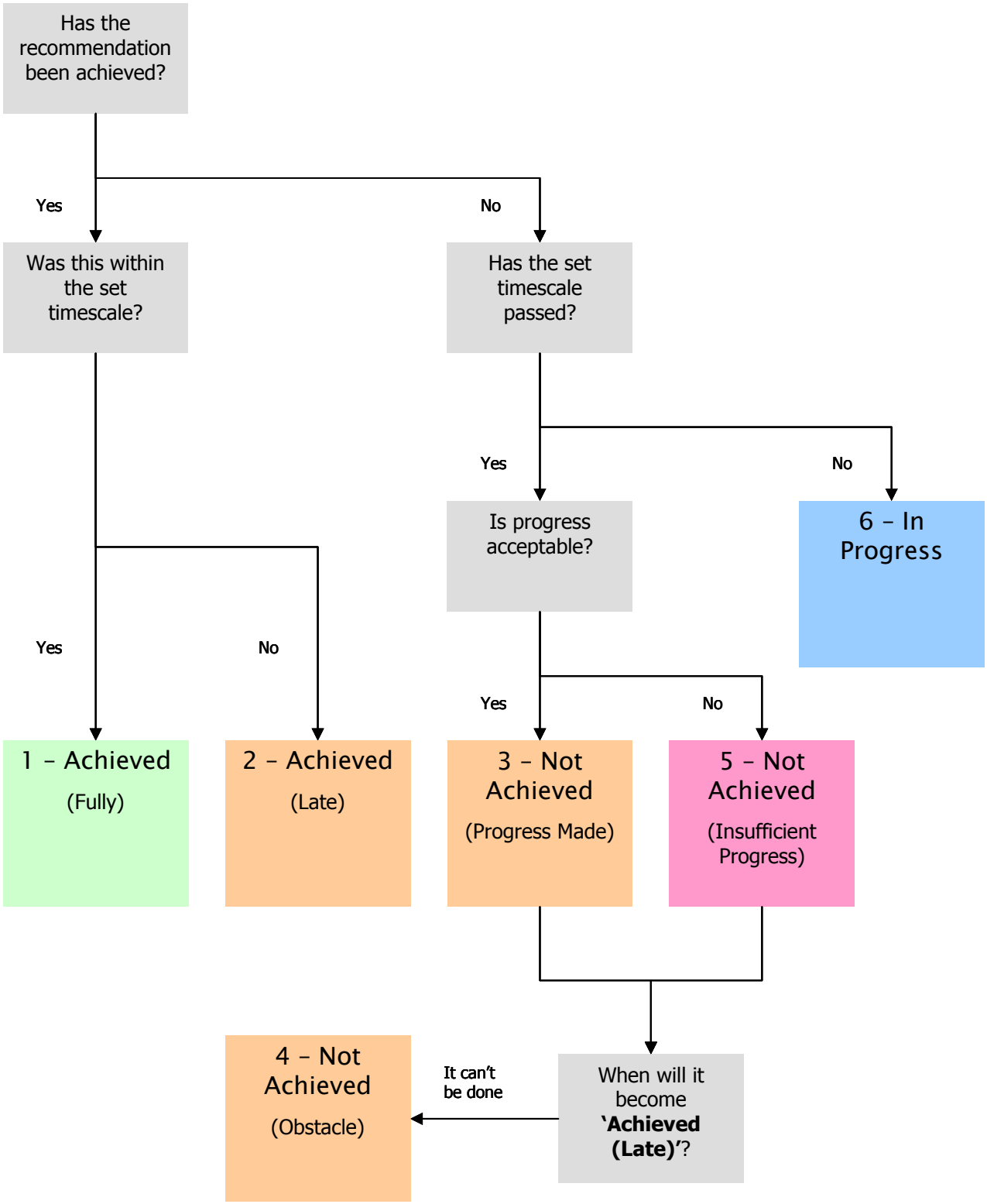
Appendix ❶: The Tracking Process

In making its assessment, the Committee may wish to consider:

- What progress/ key actions have been made against each recommendation?
- Are these actions pertinent to the measures required in the recommendation?
- Have the actions been undertaken within the time scale allocated?
- Are there any matters in the recommendation where progress is outstanding?
- Is the Committee satisfied that sufficient progress has been made and that the recommendation has been achieved?

Category	Criteria
1: Achieved (Fully)	The evidence provided shows that the recommendation has been fully implemented within the timescale specified.
2: Achieved (Late)	The evidence provided shows that the recommendation has been fully implemented but not within the timescale specified.
3: Not Achieved (Progress Made)	The evidence provided shows that the recommendation has not been fully achieved, but there has been significant progress made towards full achievement. **An anticipated date by which the recommendation is expected to become achieved must be advised.**
4: Not Achieved (Obstacle)	The evidence provided shows that the recommendation has not been fully achieved, but all possible action has been taken. Outstanding actions are prevented by obstacles beyond the control of the Council (such as passage of enabling legislation).
5: Not Achieved (Insufficient Progress)	The evidence provided shows that the recommendation has not been fully achieved and there has been insufficient progress made towards full achievement. **An anticipated date by which the recommendation is expected to become achieved must be advised.**
6: In Progress	It is not appropriate to monitor achievement of the recommendation at this time because the timescale specified has not yet expired.

The Tracking Process



Appendix ❷: Progress with Recommendations

No.	Recommendation	Responsibility	Original Date For Completion	Cabinet Member's Assessment
R01	That potential locations in the city centre be explored to find the most suitable venue which can be made available to be used as a central point where homeless people can go to access information, advice and support on accommodation, benefits (including accessing a computer to start the process of registering to make a claim) and be referred to available health services without needing to make an appointment or travel to one of the customer service centres.	Cabinet Member for Neighbourhood Management and Homes Cabinet Member for Health and Social Care as Chair of the Health and Wellbeing Board	30 September 2015 for final version of Welfare Specification and new service to start 1 April 2016. 31 July 2015 for remodelled Housing Advice Centre Options	1
Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')				
The Homeless Welfare Service commenced on 1st May and is a joint contract delivered by Shelter and SIFA from SIFA's Digbeth premises. The contract runs until 30 April 2018. The Housing Options Service moved to one Housing Options Centre on 7 July 2016				
R02	That the three Birmingham Clinical Commissioning Groups should explore: 1. How they can make it easier for homeless people to register with a GP even if they are only temporarily residing in an area and have a permanent address elsewhere or have no permanent address. 2. How homeless people can be facilitated to maintain registration on a GP list once they have registered even if, due to the transient nature of their lifestyle, they subsequently move out of that area.	Birmingham Cross City, Birmingham South Central and Sandwell and West Birmingham Clinical Commissioning Groups	31 March 2016 Health and Wellbeing Board Agenda 13 October 2015	1
Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')				
In addition to the Health Exchange contract patients can register at any practice of their choice in the city and have access to the city's WIC and A&E services. See attached information from SWB CCG.				

R03	That the multi-agency working that is already starting to happen to tackle the housing and health problems of people sleeping rough in the city centre by connecting rough sleepers to local support and services is strengthened. Groups already in existence need to be reviewed to establish whether they are working together effectively with a view to building on the existing protocol and the work already being done by the StreetLink multi-agency working group, to ensure that relevant agencies are alerted before major regeneration work starts, to provide an opportunity to support homeless people squatting or sleeping rough in the area.	Cabinet Member for Neighbourhood Management and Homes Cabinet Member for Health and Social Care	31 October 2015	2

Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

Multi-agency working in response to tackling rough sleeping has grown. Partnership working now exists across BCC, Police, BIDs, commissioned services, Fire Service, BSMHFT, CCGs, Changing Futures, Big Issue, CGL, voluntary agencies, Crisis, Shelter, CSP.

A new partnership network has been established with voluntary agencies and charities including Reach Out Network, Socks and Chocs, As- Suffa, Sifa, Midland Heart, Up for Giving, Red Bag Company, Help the Homeless Society, Homeless Heroes Outreach, We Are Happy, Helping Homeless in Birmingham, Health Exchange .

Further work is being undertaken to maximize the use of all of the services that are in place and to ensure that there is a clear constellation map of all the services available and how they work together and can be accessed.

R04	That services should be commissioned in a joined up way wherever possible, specifically when commissioning services for people with a dual diagnosis of either: 1. mental health and substance misuse or 2. people with alcohol problems who also suffer from dementia, where there is currently a gap in service provision.	Cabinet Member for Health and Social Care	31 January 2016	2

Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

Providers of addiction and mental health services in the City have developed and signed up to a new joint policy which sets out how organisations will work together to treat and support people with co-existing mental health and substance misuse issues. The policy was developed during 2016 and agreed by providers in January 2017. Implementation is to be completed by 31st March 2017.

The aims and objectives of the work are to:

- Promote and encourage joint working and assessment between organisations involved
- Reduce the risk of referrals being delayed or diverted
- Utilise the expertise of each organisation to ensure the appropriate treatment package
- Map out and match community resources

The changes will

- Reduce waiting times
- Reduce the risk of over-prescribing

- Reduce the number of Serious Incidents
- Improve the experience of accessing treatment and support for this client group
-

A project plan sets out the work required to implement the policy and is being monitored by the Mental Health Collaborative Group which forms a part of the City-wide governance structure for mental health. The Group includes representation from all key commissioning organisations.

R05	That wherever possible services for homeless people should be designed to reach out to homeless groups who need them by moving away from a silo culture and exploring options for placing statutory services where homeless people already attend, such as the Homeless Health Exchange or SIFA Fireside, along the lines of the Inclusion Healthcare Social Enterprise Model	Cabinet Member for Health and Social Care Cabinet Member for Neighbourhood Management and Homes	31 October 2015	1

Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

The concept of the Welfare Service was to make available the range of service needed to support an individual in one key location. As well as access to food, bathing and clothing facilities the Welfare Service has established a range of health clinics such as

- Mental Health (access to Community Mental Health Outreach team)
- Substance Misuse (both drug and alcohol provided by CGL)
- Sexual Health clinics (provided by Umbrella/UHB)
- Chiropody
- Optician
- Dentist
- Regular access to nurse
- Support and encouragement to register with GP services
- Smoking cessation service (provided by nurse)
- Cooking and healthy eating courses

There has only been a 26% take up of these services from those known to be rough sleeping and work is being done to analyse the reasons for this. In addition an element of the successful rough sleepers bid was to introduce a multi-disciplinary team that would provide a peripatetic universal service offer of access to accommodation, health and well being check, mental health assessment and substance misuse screening. The use of mobile units to undertake these assessments as close to where an individual is located whilst at the same time offering the required level of privacy is also being explored.

R06	That a forum or other appropriate mechanism be established between HM Prison Birmingham and Birmingham City Council to facilitate more joined up working with prisons and the probation services to provide improved pathways between prison and the general community with a view to: 1. Linking prison healthcare provision better to wider community healthcare services on release from prison in particular for prisoners with serious mental health, drug and/or alcohol problems; 2. Supporting prisoners into appropriate accommodation before and after discharge from prison; 3. Prioritising appropriate accommodation for homeless women in contact with the criminal justice system.	Cabinet Member for Health and Social Care Cabinet Member for Neighbourhood Management and Homes	31 March 2016	3

	4. Supporting prisoners to link into the benefit system before and after release from prison. 5. Providing/sharing information about services available in the community to facilitate improved pathways between prison and the general community.			

Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

The rough sleeper bid seeks to establish a Prison Community navigator to work alongside and co-ordinate the services that are already available in prison settings such as mental health and health provision, benefits advice and housing options.

The navigator will then ensure that the ongoing delivery of these services is continued in the community upon release.

As part of the supported housing review, detailed further discussions will be taking place with the Prison Service, National Probation Service and the Community Rehabilitation Company to understand the pathways for ex-offenders and the required levels of support that are beyond the requirements for effective offender management.

Birmingham City Council attends the Multi-Agency Integrated Offender Management Board to ensure that the housing issues are considered as part of the agenda as well as the Birmingham Offender Accommodation Forum with National Probation Service, Community Rehabilitation Company and Providers.

R07	That the Joint Commissioning Team should examine the feasibility of commissioning an emergency and/or out of hours specialist homeless primary care service for the city.	Cabinet Member for Health and Social Care Birmingham and Solihull Mental Health NHS Foundation Trust Cabinet Member for Neighbourhood Management and Homes	31 December 2015	2

Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

The Homeless Primary Care Service Model provided by Birmingham & Solihull Mental Health Foundation Trust – in hours provision

The Homeless Primary Care Service adopts an assertive engagement approach in its work with individuals which is commissioned on behalf of Sandwell & West Birmingham, Birmingham Cross City and South and Central CCGs. The 'assertive outreach' model of working originates from within the mental health field. It is an approach that is employed when the relationship between services and an individual is complex and chaotic. The flexibility of this approach enables the service to be provided to those who may not otherwise access it. The overall aim in working within this approach is to develop trusting relationships with individuals in a needs-focused way, employing flexibility and creativity, so enabling the delivery of a care package that is specific to client need. The service aims to stay in contact with individuals, making repeated assertive attempts to make contact with people if they miss appointments. The service also provides an outreach element to hostels.

Key Services Outcomes

- Increase in the number of homeless or vulnerably housed people appropriately accessing primary care services and holding permanent registration with a General Practitioner.
- Reduction in the number of inappropriate attendances at Accident & Emergency Department by homeless

and vulnerably housed people.

- Increase in the number of homeless or vulnerably housed people accessing specialised support for drug & substance misuse.
- Improved access to primary and secondary mental health care services (including access to psychological therapy) for homeless and vulnerably housed people.
- Prevention of homelessness through appropriate, targeted health support.

Location(s) of Service Delivery

The service is currently located at the William Booth Centre, which is located centrally to the main core of hostel beds in the City.

The Homeless Primary Care Service
William Booth Centre
William Booth Lane (Off Constitution Hill)
Birmingham
B4 6HJ

Days/Hours of Operation

The Homeless Primary Care Service is available between the hours of 9.00am-5.00pm, Monday - Friday (excluding Bank Holidays)

In addition to the service provided at the Health Exchange patients can register at any practice of their choice in the city and have access to the city's Walk In facilities and A&E services.

Also see attached information from SWB CCG.

R09	That an assessment of progress against the recommendations made in this report be presented to the Health and Social Care O&S Committee.	Cabinet Member for Neighbourhood Management and Homes	31 October 2015	

Evidence of Progress (and Anticipated Completion Date if 'Not Achieved')

Appendix ❸: Concluded Recommendations

These recommendations have been tracked previously and concluded.
They are presented here for information only.

No.	Recommendation	Responsibility	Date Concluded by Overview and Scrutiny Committee	Tracking Assessment
R08	That the best way to provide a direct line of communication between the City Council and people sleeping rough in the city centre who have a problem or a complaint, for example through advice surgeries in the city centre, be explored.	Cabinet Member for Neighbourhood Management and Homes	October 2015	1

All you need to know about…

Patient registrations
GMS / PMS / APMS contracts

- Access to primary care services is free to everyone in the UK – whether they are permanent residents or visitors from overseas
- Patients **do not** need to provide proof of ID to register with a practice. It's helpful if they can provide a medical card or confirm their NHS number but if they can't submission of a GMS1 Form is acceptable
- Practices can only refuse a registration if the patient:
    - Is already registered under a Zero Tolerance Scheme
    - Lives outside the practice boundary and it's not clinically appropriate or practical for them to be registered at the practice
    - Has previously been removed from the practice list due to relationship breakdowns with the practice
    - Other exceptional circumstances may apply – if unsure contact Time2Talk

We often get queries from member practices around the Do's and Don'ts.

Most of this will be familiar to you.

To help support you, we're pulling together a series of factsheets that will give you everything you need to know.

Don't forget our Time2Talk team is happy to help with any queries you have, call them on 0121 612 4110.

- No patient should be refused on the grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition

- If a practice does refuse a patient then the patient must be informed in writing, confirming the reason for refusal, within 14 days and the practice should keep a log of all refused registrations

See appendix one for more information

APPENDIX 1

Patient registration
Supporting information

New patient registration

Patients who wish to register with a GP practice can do so by either:

a) Providing their medical card that will have details of their name, address, and NHS number; or if the patient does not have a medical card
b) Submitting the GMS1 form (forms may vary slightly and some practices use their own version).

The GMS regulations state *"an application for inclusion in the contractor's list of patients shall be made by delivering to the practice premises a medical card or an application signed (in either case) by the applicant or a person authorised by the applicant to sign on his behalf"*. **GMS Regulations 2004 No. 291 Schedule 6 Part 2 Regulation 15**

NB: Although it is useful if patients are able to produce a NHS medical card or provide their NHS number to register with a GP or get NHS treatment, it should not prevent them from registering.

Temporary resident registration

A patient may be regarded as a temporary resident if they are away from their normal place of residency and intend to stay in the area for more than 24 hours, but not more than three months. A practice may accept the patient onto its list as a 'temporary resident' where:

a) The patient is away from their normal place of residence and is not being provided with essential services (or the equivalent) under any other arrangement in the locality where they are temporarily residing; or
b) The patient is moving from place to place and is not currently resident in any place.
GMS Regulations 2004 No. 291 Schedule 6 Part 2 Regulation 16

GP choice scheme – out of area registration

From 5 January 2015, all GP Practices in England are free to register new patients who live outside their practice boundary area without the obligation to provide home visits.

However, before registering a patient under this scheme a practice should:

a) Consider each application on a case by case basis to ascertain whether it is clinically appropriate and practical for the patient to be registered in this way
b) Ensure that the patient is aware of their registration status and the impact this may have should there be a requirement to refer them to other specialist services / community services closer to their home
c) Ensure that the patient is aware of what they should do if they require urgent primary medical care when they are at home and it is not reasonable to expect them to attend the practice.

Overseas visitors

Overseas visitors have no formal obligation to prove their identity or immigration status to register with a practice. However, asylum seekers may be able to show an Immigration Service issued 'Application Registration Card' (ARC) or official documents that confirm their status.

A practice may register an overseas visitor as a temporary or permanent resident, but this does not necessarily entitle them to receive free NHS hospital treatment. It's the relevant hospital's duty, not the GP's, to establish entitlement for free NHS hospital treatment and so this should not be a barrier to registering overseas visitors.

Homeless patients / No Fixed Abode

If a patient is not able to provide a home address because they are homeless or have no fixed abode this should not prevent the patient from registering with the practice. It's acceptable to use the practice address as the patient's address in these circumstances.

NB: The practice may need to establish ways of keeping in touch, suitable to the patient's needs.

Requesting ID / proof of address

When registering patients GP practices may ask to see proof of the patient's identity, for example photo identification such as a passport or driving licence and proof of address such as a recent utility or council tax bill, but there is no legal obligation to do this.

If a patient is unable to produce any proof of identity they should not be refused registration.

When can a practice refuse a patient?

Practices can only refuse a patient registration if it has reasonable grounds for doing so, which do not relate to the applicant's race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition.

GMS Regulations 2004 No. 291 Schedule 6 Part 2 Regulation 17

There are limited reasons, where a practice is able to refuse a registration, including:

a) The patient resides outside of the practice boundary and it is not clinically appropriate or practical for them to be registered, without provision of home visits (GP Choice – Out of Area Registration)
b) If the patient is registered with the zero tolerance scheme
c) If the patient has previously been removed from the practice register at the doctor's discretion due to an irrevocable breakdown in the relationship between the patient and the practice.

Refusal process

Where a practice does have reasonable grounds to refuse a patient's request for registration it must notify the patient within 14 days of its decision in writing and provide the reason for the refusal. The practice must also keep a record of all refusals and make available for the commissioner on request.

Appendix 3

Progress Report on the Homeless Prevention - Welfare Service

Background

The contract for the Homeless Prevention – Welfare service was awarded to Shelter who deliver the service in partnership with SIFA Fireside. SIFA Fireside are sub-contracted by Shelter to deliver the Health and Welfare element of the service while Shelter focus on housing advice. The service is delivered from SIFA Fireside's premises in Digbeth and began on 1st May 2016. It is expected to run up until 30th April 2018.

Overview of Service

The purpose of the service is to provide an access point for single homeless and street sleepers to move towards independence, through the provision of housing advice, health services and support.

Homeless Prevention

The service is expected to deliver housing advice from a location that is independent of Birmingham City Council. The support offered includes;

- Advice and assistance in accessing temporary accommodation
- Help in completing necessary forms such as housing applications, benefit forms etc.
- Help accessing privately rented accommodation including the rent deposit scheme
- Assistance in bidding for properties using Birmingham Home Choice.
- Advice regarding accessing properties with Registered Social Landlords
- Advice regarding accessing local authority accommodation including supply and demand information.
- Advice regarding accessing supported accommodation and/or floating support.
- Assistance obtaining immigration advice in relation to entitlement, right to work and accommodation.

Health & Welfare

Welfare facilities are provided, such as bathing and clothing along with easy access to a range of health services who hold regular clinics on site. These include;

- Mental Health (access to Community Mental Health Outreach team)
- Substance Misuse (both drug and alcohol provided by CGL)
- Sexual Health clinics (provided by Umbrella/UHB)
- Chiropody
- Optician
- Dentist
- Regular access to nurse

- Support and encouragement to register with GP services
- Smoking cessation service (provided by nurse)
- Cooking and healthy eating courses

The service is currently working with Public Health England to strengthen the offer around effective testing and screening for TB and to enable better access to treatment services. This will include training staff to spot the signs of TB and be able to better identify those most at risk.

Outcomes to date

Performance is reported on a quarterly basis and to date Commissioners have received performance reports for the first 3 quarters of this financial year (16/17). As the contract started on 1st May 2016 the first quarter only comprises two months data instead of three.

Below is a summary of performance to date linked to expected outcomes. The data represented is a cumulative total taken from Q1 to Q3 (16/17) and reflects Year to Date totals.

1. **General Findings**

To date it has been reported that 1812 people have accessed the service for either housing and/or welfare support. Of this number 96% were classed as single homeless, 86% of whom were male. ***To date only 26% have reported to be sleeping rough. Recording of data in this area is lower expected. Therefore, Commissioners have asked the service to review the pathway and recording of information with the Rough Sleepers Team and to re-submit this figure in Q4 (16/17).***

2. **Assistance to remain at Home**

1479 (81%) have accessed support to assist them to remain in their own home. Interventions delivered include activities such as;

- Referral to mortgage arrears/rescue services
- Negotiation or legal advocacy to ensure that some can remain in the private or social rented sector
- Crisis Intervention

However, the bulk of reporting (82%) falls under the non-specific title of 'other' support and Commissioners will review this reporting to attain a clearer picture of what activity is being delivered and captured.

3. **Assistance to obtain alternative Accommodation**

1118 (62%) have accessed support to assist them to obtain alternative accommodation. Interventions delivered in this area have included referrals to;

- Any form of hostel or House in multi occupation (HMO) with or without support (81%)
- Supported accommodation (including supported lodging schemes)(8%)
- Other (non-specified services) (10%)

- Private rented sector accommodation with/without landlord incentive scheme (1%)

4. Improvement in physical and mental health

A range of health and lifestyle services are available on site. To date the following activity has been reported;

- Service Users not already registered with a GP practice are actively encouraged to and to date the service has supported 503 people to register with a GP.
- 139 people have accessed help with substance misuse issues
- 290 have received advice on mental health issues and 32 (11%) have gone on to engage further with mental health services
- 377 have accessed sexual health services with 126 (33%) going on to follow appointments
- 42 people have been screened for TB, hepatitis and other blood borne viruses 6 (14%) of whom have gone on to engage in treatment. Commissioners expect these figures to increase following input from Public Health England.
- Cooking courses are delivered by volunteers and are reported to be well attended. However, we are waiting on exact numbers as there have been technical issues with capturing this information.
- Smoking cessation services have been delayed following decommissioning of the original service however this will be delivered by the nurse who regularly attends SIFA and will be reported on from Q4 16/17.
- 608 people have gone on to receive support around debt or hardship following access to the health and welfare services
- 24 people received support around domestic violence
- 506 people were helped into employment opportunities.

Overall activity levels have seen a steady increase since Q1 16/17. Work is in had at present to advertise and promote more effectively the health and welfare services and the housing advice provision to service users. It is expected that activity levels will increase further.

Birmingham City Council

Information Briefing

Report from:	STP System Leader & Chief Executive	Date:	21st February 2017
Report to:	Birmingham Health and the Environment Overview and Scrutiny Committee		

Progress Update – Birmingham and Solihull Sustainability and Transformation Plan (BSol STP)

1. Summary

This is a progress update on the development of the Birmingham and Solihull Sustainability and Transformation Plan (BSol STP).
The Committee received it's last formal progress update on 25th October 2016, and reported to Full Council on 6th December 2016.
This report sets out a further update on progress to date.

2. Progress on BSOL STP – October 2016 – February 2017

The final draft of the BSOL STP plan was submitted to NHS England (NHSE) on 21st October 2016, and subsequently published on the Council's website, with the full agreement of all partners. This enabled the content of the plan to be formally considered by HEOSC on 25th October.

Formal feedback from NHSE has been received. A number of observations were made about how the plan could be improved and also outlined where NHSE judged the plan to be best in class or good – in this instance in the areas of maternity and newborn (the BUMP programme), mental health and the more detailed overarching communications strategy that accompanied the STP submission.

This feedback alongside other feedback from initial stakeholder events and key stakeholders, including discussions at both Birmingham and Solihull Health Overview and Scrutiny Committees, recommendations by previous funded support and reviews of other plans has been brought together to inform a series of recommendations to the STP Board which require action.

The Board has subsequently committed to:

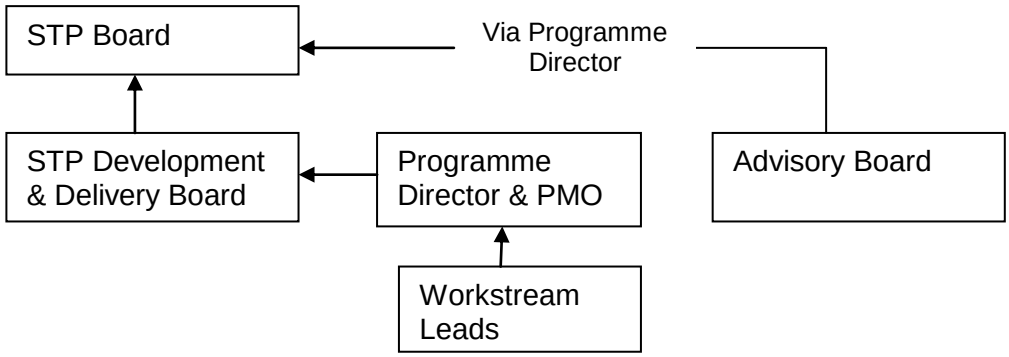
- A strengthening of governance and collective decision making (already underway)
- A rewrite of the plan is undertaken to better support public, staff and patients to understand the issues and inform it. This should include a better articulation of our vision and strategy.
- The programme is presented and managed differently to make it more understandable and easier to manage.

- The discussion about new models of care takes place as a matter of urgency particularly in Birmingham, building upon discussions already undertaken in Solihull.
- There is a stronger link between the priorities identified in the gap analysis of health and wellbeing, care and quality and financial opportunities and the phasing of work within the programmes
- The engagement plan is implemented as soon as possible following the rewrite of the plan

Changes to Governance Arrangements

The governance structure and reporting lines for the STP process are in the process of being re-designed and strengthened for the next stage of the programme. This will provide a more structured approach that will link more easily to standard programme management governance arrangements, ensuring greater accountability and clearer decision making.

A memorandum of understanding (MOU) is being worked on for the STP Board, however NHSE are expected to publish a revised Forward View in March, which may propose some different models for delivery. Given this uncertainty which would almost certainly impact on decisions around governance models, the decision has been taken by Cllr Sleigh and Jacqui Smith to pause the current work on the MOU until there is greater clarity from NHSE. Until such clarity is provided, work will progress via the governance model set out below.



STP Board
Membership of the STP Board will comprise of the System Leader, Chairs and Chief Executives / Accountable Officers for each organisation, and the Leaders and Chief Executives of both local authorities. The Chairs of both Health and Wellbeing Boards / Cabinet Members are ex-officio members of the Board. The STP Board is chaired by Councillor Sir Bob Sleigh, with Jacqui Smith as Vice Chair, and will be responsible setting the overall direction of the STP and agreeing the strategy, priorities and associated objectives for delivery.

Development and Delivery Board
The development and delivery board will direct the implementation of the STP and to develop further proposals for approval by the STP Board in areas where ongoing planning is necessary and which necessitate cross system working. The membership is comprised of the System Leader, Chief Executives of NHS providers, Chief Executives of both local authorities, CCG Accountable Officers, the Programme Director and work stream leads. Chairing arrangements are to be confirmed.

Advisory Board
The Advisory Board will facilitate engagement between the STP and other representative parties, and will receive reports on plans and progress. The membership of the board is still to be determined, but could include representation from the voluntary and charitable sectors, other public sector agencies, housing providers, nursing and residential care providers and Healthwatch.

Review of the Plan
The STP Plan has been revised in light of feedback from NHSE, and taking into account comments received via the STP Mailbox, and feedback from the initial informal engagement events. This new format was agreed by the STP Board at their meeting on 6th February, and the new proposed structure of the plan is set out in Appendix 1.

The content and narrative for the plan has been further revised so that it is more understandable for the public and to further develop the vision and priorities. Further work is underway to produce a formal public-facing summary, which will be available by March.

The changes to the plan are more to do with the organisation and structure of the programmes rather than the content of the work streams. The key changes are:

- There is now one approach to Maternity and Children & Young People's services, bringing together the transformation approach to specialist in-hospital paediatric services and services in the community.
- Health and Wellbeing has been re-framed as a specific, cross cutting work stream in its own right, creating a more prominent role for Health and Wellbeing Boards and developing links up to work at Combined Authority level.
- The scope of Community Care First (CCF) has been tightened, bringing clarity to the approach to transforming General Practice, wider community services, Adult social care and primary care. Work is ongoing in further refining the programme scope, and the upcoming discussions around New Models of Care will have an impact on the further development of the CCF programme.

Discussion on New Models of Care
The debate about new models of care refers to how the health and care system should organise itself and its resources in order to provide integrated care to citizens. The commitment to integrate health and care systems is not new, and integration by 2020 remains a key target for the Better Care Fund (BCF) – but there is currently no national or local agreed definition of 'integration'. In addition to the BCF, the NHS has 2 other work programmes that look at integration of care – Integration Pioneers and the NHS Vanguard Programme.

The NHS has subsequently published potential contracting frameworks for two specific models:

- Multispeciality Community Providers (MCPs) where GP practices would come together to offer community and outpatient services with a view to potentially becoming responsible for the health budget for the population.
- Primary and Acute Care Systems (PACS) – a single entity or organisation would take responsibility for delivering primary, community, mental health and hospital services, with the ultimate aim of improving co-ordination and moving care out of hospital

Current thinking from NHS England suggests that the development of Accountable Care Organisations (ACOs) will become a priority within the next iteration of the NHS Forward View. Early indications from NHSE and NHS Improvement (NHSI) and the language used is that an accountable care system will have a number of accountable care organisations within it.
This is important as the nature of organisations within Birmingham - which have considerable and significant income from specialised services - mean that awards have already been made in this space. BSMHFT already commission mild to moderate secure services for the West Midlands, and Forward Thinking Birmingham service for 0-25 years with mental health. The BUMP proposal is to establish a lead provider for maternity and new born services. Whilst these are population based i.e. people with defined mental health needs, or people who are pregnant there are not whole population models, but are considered accountable care models by many.

However, at present the formal line from NHSE is that any decision on care models is to be determined locally.

A facilitated workshop is being held on 7th March for all BSOL STP Board members to begin to consider what might work for the STP footprint. The Accountable Officer for Sandwell and West Birmingham CCG, who is also the Black Country STP System Lead will also be invited.

From a local authority perspective it is difficult to determine whether there is a preferred model. We have sought some advice from the LGA in terms of the key questions local authorities should consider when participating in this debate. These are:

- Will this deliver the best outcomes for our population in terms of their whole life experience (including wider determinants of health)?
- Does it enable us to operate as a whole system – ie not just social care and the NHS but the wider work that needs to be undertaken with local authorities, housing providers and the voluntary and community sector?
- To what extent will this remove existing barriers to good, joined up health and care?
- Does this approach create new barriers?
- Is it affordable, sustainable, and offering good value for money?
- Does it deliver strong and transparent governance and accountability, including the ability of elected members to oversee and influence where appropriate?
- Does it enable statutory responsibilities for all organisations to be discharged?

Officers have started to look at how the council should engage with the debate, discussing issues for Birmingham with key partners and external advisors. Scrutiny will be kept updated as the conversation and discussions progress.

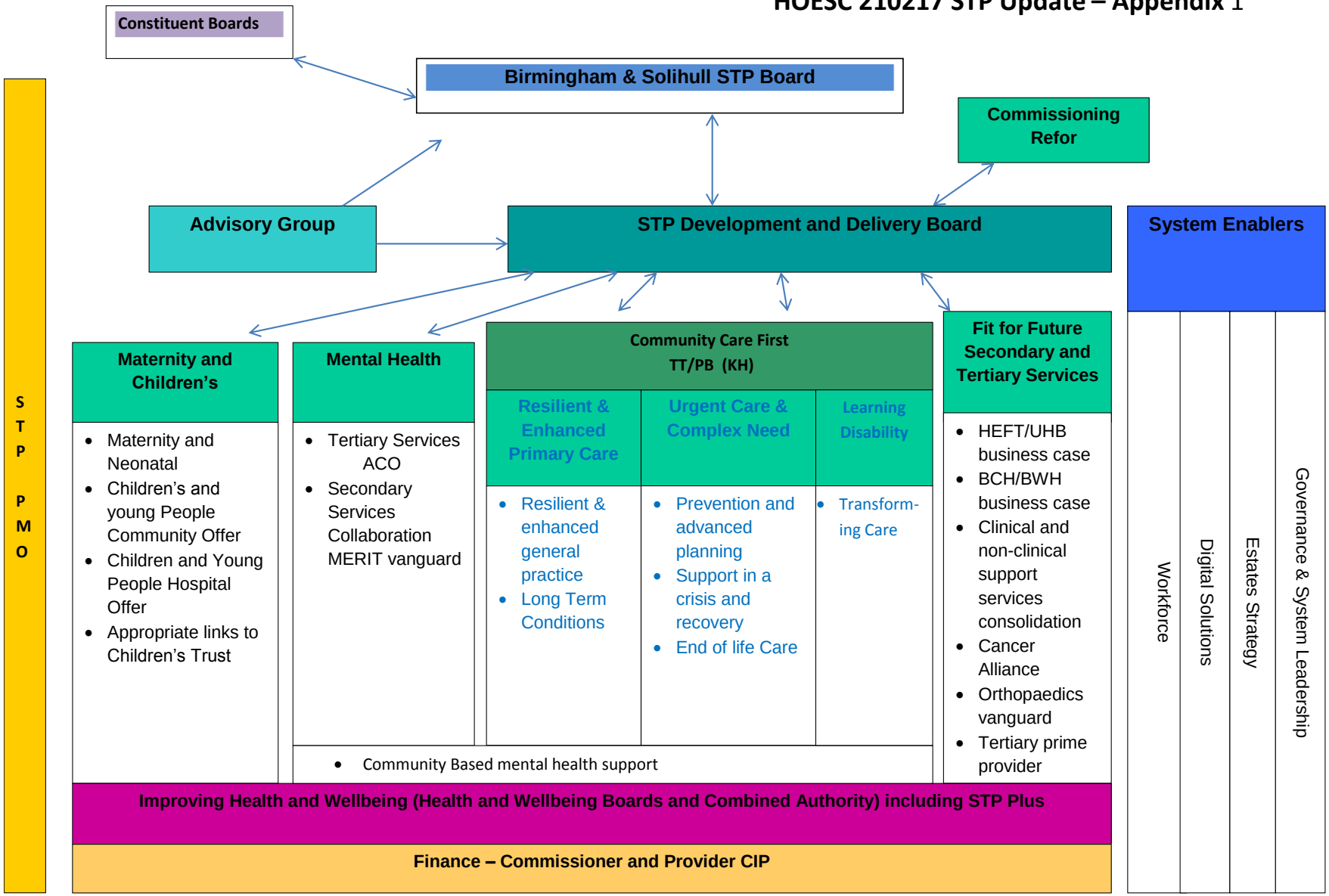
Communications and Engagement

- Following the re-write of the plan a draft 'public facing summary' is being prepared and is currently with with programme managers for comment, with a view to being discussed at the next STP Board meeting in March and issued into the public domain, alongside a short infographic, by mid March.
- A further 3 stakeholder engagement events are being planned for the end of February – mid March that will set out the narrative so far, and demonstrate changes made to the proposals as a result of feedback.

Stakeholders are being identified and will include representatives from the voluntary and charitable sectors, patient groups, elected members, clinical representation, faith groups etc.

- There are plans to offer sessions to members of both councils from the end of March, as well as tailored sessions with individual partner organisations for governors, members etc.
- Links will be made with Healthwatch following the refresh of the plan to discuss the tools that they have available to promote community engagement and involvement in the STP as it moves forward.

Contact Officer: Telephone: E-Mail:	Cat Orchard, Senior Policy Officer to the Chief Executive cat.orchard@birmingham.gov.uk


Constituent Boards
Birmingham & Solihull STP Board
Commissioning Refor
Advisory Group
STP Development and Delivery Board
System Enablers
STP PMO
Maternity and Children's
Mental Health
Community Care First
TT/PB (KH)
Resilient & Enhanced Primary Care
Urgent Care & Complex Need
Learning Disability
Fit for Future Secondary and Tertiary Services
Maternity and Neonatal
Children's and young People Community Offer
Children and Young People Hospital Offer
Appropriate links to Children's Trust
Tertiary Services ACO
Secondary Services Collaboration MERIT vanguard
Resilient & enhanced general practice
Long Term Conditions
Prevention and advanced planning
Support in a crisis and recovery
End of life Care
Transform-ing Care
HEFT/UHB business case
BCH/BWH business case
Clinical and non-clinical support services consolidation
Cancer Alliance
Orthopaedics vanguard
Tertiary prime provider
Community Based mental health support
Workforce
Digital Solutions
Estates Strategy
Governance & System Leadership
Improving Health and Wellbeing (Health and Wellbeing Boards and Combined Authority) including STP Plus
Finance – Commissioner and Provider CIP

Health, Wellbeing and the Environment Overview & Scrutiny Committee 2016/17 Work Programme

Committee Members: Chair: Cllr John Cotton

Cllr Uzma Ahmed
Cllr Deirdre Alden
Cllr Sue Anderson
Cllr Mick Brown
Cllr Carole Griffiths
Cllr Andrew Hardie
Cllr Kath Hartley
Cllr Mohammed Idrees
Cllr Simon Jevon
Cllr Karen McCarthy
Cllr Robert Pocock

Committee Support:

Scrutiny Team: Rose Kiely (303 1730) / Gail Sadler (303 1901)
Committee Manager: Paul Holden (464 4243)

Schedule of Work

Meeting Date	Committee Agenda Items	Officers
21 June 2016	Formal Session – Appointments to Deputy Chair and Joint HOSCs Informal Session – Briefings and Background Documents	Dr Louise Lumley, Clinical Lead for Urgent Care. Karen Richards, Head of Urgent Care, Gemma Caldecott, Senior External Comms & Eng. Manager Alan Lotinga, Service Director, Health & Wellbeing / Judith Davis, Programme Director, Better Care Fund/John Wilderspin, Strategic Programme Director Sustainability & Transformation Plan Adrian Phillips, Director of Public Health Alan Bowley, Reduce, Reuse, Recycle Programme Manager

19 July 2016 @ 10.00AM	Use of Enhanced Assessment Beds including capacity in Care Centres	Diana Morgan, AD Specialist Care Services
	Tracking of the 'Mental Health: Working in Partnership with Criminal Justice Agencies' Inquiry	Joanne Carney, Associate Director, Joint Mental Health Commissioning Team, CrossCity CCG, Robert Devlin, Senior Strategic Commissioning Manager, Peter Wilson, Stephen Jenkins, BSMHFT
19 July 2016 @ 1.00PM	From Waste to Resource Workshop	Alan Bowley, Reduce, Reuse, Recycle Programme Manager
9 August 2016	Urgent Care in Birmingham (including the re-procurement of NHS 111 Service)	Karen Richards, Associate Director of Urgent Care / Carol Herity, Associate Director of Partnerships, CrossCity CCG
27 September 2016 @ 10.00AM	Cabinet Member for Health and Social Care Birmingham & Solihull Sustainability & Transformation Plan - progress update	Cllr Paulette Hamilton/ Peter Hay, Strategic Director, People Directorate
	Cabinet Member for Clean Streets, Recycling & Environment - DEFERRED	Cllr Lisa Trickett / Jon Lawton
	Healthwatch – Update	Andy Cave, CEO, Healthwatch Birmingham
27 September 2016 @ 2.00PM	Tracking of the 'Tackling Childhood Obesity in Birmingham' Inquiry	Charlene Mulhern, Senior Officer – Collaboration, Birmingham Public Health
	Tracking of the 'Living Life to the Full with Dementia' Inquiry	Mary Latter, Joint Commissioning Manager Dementia

25 October 2016	Sustainability and Transformation Plan • Mark Rogers (System Lead) • Dame Julie Moore • Sarah-Jane Marsh • John Short • Les Williams Mental Health Day Services	 Carol Herity, Associate Director of Partnerships, CrossCity CCG
22 November 2016	Update on Umbrella – the Sexual Health Services in Birmingham and Solihull Contract Birmingham Substance Misuse Recovery System– Review of first 12 months Update on Care Centres and Enhanced Assessment Beds Terms of Reference – Impact of poor air quality on health in Birmingham Inquiry	John Denley, AD People Directorate, Nic Adamson, Director CRI Max Vaughan, Head of Service, Universal and Prevention Alan Lotinga, Service Director for Adult Care, Louise Collett, Service Director, Commissioning, Alison Malik, Head of Service, Complex & Statutory Services, Commissioning Centre of Excellence, Maria B Gavin, Assistant Director, Commissioning Centre of Excellence
13 December 2016	Budget Forward Thinking Birmingham – Mental Health Care for 0-25s (Update 6 months into new contract)	TBC Elaine Kirwan, Associate Director of Nursing, Forward Thinking Birmingham
17 January 2017 1000-1300 1400-1600	Impact of poor air quality on health in Birmingham Inquiry	

21 February 2017 **2.00pm**	Update on the Birmingham and Solihull Sustainability and Transformation Plan West Midlands ADASS Peer Challenge of Birmingham Adult Social Care Services & Action Plan Tracking of the 'Homeless Health' Inquiry	Councillor Paulette Hamilton, Cabinet Member for Health and Social Care; Mark Rogers, System Lead. Mike Walsh, Head of Service – Intelligence, Strategy & Prioritisation, Commissioning Centre for Excellence John Hardy, Policy & Development Officer
14 March 2017 (Informal meeting)	Consultation of the Future of Acute Hospital Services in Worcestershire	Lucy Noon, Director of Corporate and Organisational Development (across the 3 Worcestershire CCGs); Claire Austin, Communications & Engagement Lead, Future of Acute Hospital Services in Worcestershire Programme
28 March 2017	15/16 Local Performance Account Report	Mike Walsh, Head of Service – Intelligence, Strategy & Prioritisation, Commissioning Centre for Excellence
25 April 2017	Cabinet Member for Health and Social Care Report from the Waste Strategy Task and Finish Group	Cllr Paulette Hamilton / Suman McCartney

Items to be scheduled in Work Programme

- Outcome of the Mental Health Recovery, Learning and Work Services Consultation (Baljit Bahi/Rob Devlin)
- Tracking of the 'Tackling Childhood Obesity in Birmingham' Inquiry (October 2017)
- Tracking of the 'Living Life to the Full with Dementia' Inquiry (October 2017)
- Proposed Changes to NHS Specialist Services for People with Congenital Heart Disease
- Informal Briefing – Healthwatch Birmingham Quality Standard Tool
- Outcome of the Older Adults Day Services Consultation and Norman Power and Perry Tree Care Centre Consultation
- Forward Thinking Birmingham Update Report – June 2017
- Maximising Independence in Adults Programme
- Framework Agreement with Domiciliary Care Providers
- Birmingham Adult Safeguarding Annual Report 2015/16 (Tapshum Pattni/Cherry Dale) (June 2017)

Joint Birmingham & Sandwell Health Scrutiny Committee Work		
Members	Cllrs John Cotton, Carole Griffiths, Kath Hartley, Deirdre Alden, Sue Anderson	
Meeting Date	**Key Topics**	**Contacts**
5 July 2016 at 2.00pm in Birmingham	• Right Care Right Here – Its Evolution (transition to the Black Country Sustainability & Transformation Plan) • Update on Sandwell and West Birmingham End of Life Care Service	Jayne Salter-Scott, Head of Engagement, SWBCCG Jon Dickens, Chief Operating Officer – Operations, SWBCCG, Sally Sandal, Senior Commissioning Officer
23 November 2016 at 3.30pm in Sandwell	• Findings of Improving Day Hospice Service Consultation – Sandwell and West Birmingham CCG	
18 January 2017 At 3.00pm in Birmingham	• Better Health & Care (Black Country STP) • Commissioning New Models of Care • Prescribing for Clinical Need Policy	Andy Williams, SWBCCG Angela Poulton, Programme Director, SWBCCG Dr Gwyn Harris, Clinical Lead for Medicines Quality; Liz Walker, Head of Medicines Quality, SWBCCG
TBA	• Commissioning New Models of Care o Evaluation of the outcomes analysis on modality work o Outcome of the Engagement Process	Angela Poulton, Programme Director, SWBCCG Jayne Salter-Scott, Head of Engagement, SWBCCG

Joint Birmingham & Solihull Health Scrutiny Committee Work		
Members	Cllrs John Cotton, Rob Pocock, Mohammed Idrees, Mick Brown, Uzma Ahmed, Andrew Hardie, Simon Jevon.	
Meeting Date	**Key Topics**	**Contacts**
27 July 2016 at 5.00pm in Birmingham	• NHS Procedures of Lower Clinical Value – Solihull and Birmingham	Gemma Caldecott, Senior External Communications & Engagement Manager, CROSSCITY CCG Neil Walker, Chief Contract & Performance Officer, Solihull CCG, Rhona Woosey, Network & Commissioning Manager, B'ham South Central CCG, Clinical Lead TBC
3 October 2016 at 6.00pm in Solihull	• HoEFT ○ Update on the performance/finance position ○ Report on progress made on implementing plans ○ Planned changes as a result of need to make savings to address deficit issues.	Dame Julie Moore, Interim Chief Executive / Jacqui Smith, Interim Chair / Rachel Cashman, Project Director, Integration Programmes / Kevin Bolger, Interim Deputy Chief Executive, Improvement
8th March 2017 at 5.00pm in Birmingham	• Birmingham & Solihull Sustainability & Transformation Plan • The merger of the CCGs across the footprint and budget implications	
TBA	• Birmingham & Solihull Mental Health Trust performance and planned service changes • NHS Procedures of Lower Clinical Value – The next round	

West Midlands Regional Health Scrutiny Chairs Network		
Meeting Date	**Key Topics**	**Contacts**
15 June 2016 10.00am	The Work of the West Midlands Mental Health Commission Mental Health Service Provision – from a provider perspective	Steve Appleton Managing Director – Contact Consulting West Midlands Mental Health Commission Secretariat and Project Manager Sue Harris, Director of Strategy and Business Development Stephen Colman, Director of Operations
5 October 2016	Sustainability and Transformation Plans (STPs) Scrutiny and STPs Single Commissioning - The 3 Birmingham CCGs	Brenda Cook, CfPS

CHAIR & COMMITTEE VISITS		
Date	**Organisation**	**Contact**
TBA	West Midlands Ambulance Service – Visit to Hollymoor Ambulance Hub	Diane Scott, Deputy CEO
7 December 2016 @ 2.00pm	West Midlands Ambulance Service – Visit to an Ambulance HQ.	Diane Scott, Deputy CEO
2 November 2016 @ 10.30am	Birmingham Substance Misuse Recovery System:- Visit to CRI premises, Scala House, Birmingham.	John Denley, AD Commissioning Centre of Excellence / Nic Adamson, Director CRI

INQUIRY:	
Key Question:	Is there an evidential link between poor air quality and poor health, what are the main controllable sources of this in Birmingham, and what can be done to improve air quality with a view to improving health outcomes in Birmingham?
Lead Member:	Councillors John Cotton and Zafar Iqbal
Lead Officer:	Rose Kiely
Inquiry Members:	Cllrs Uzma Ahmed, Mick Brown, Carole Griffiths, Kath Hartley, Mohammed Idrees, Karen McCarthy, Robert Pocock, Deirdre Alden, Andrew Hardie, Simon Jevon, Sue Anderson, Phil Davis, Diane Donaldson, Ziaul Islam, Josh Jones, John O'Shea, Eva Phillips, Sharon Thompson, David Barrie, Timothy Huxtable, Ken Wood, Zaker Choudhry.
Evidence Gathering:	17th January 2017
Drafting of Report:	January/February 2017
Report to Council:	4th April 2017
Councillor Call for Action requests	

Cabinet Forward Plan - Items in the Cabinet Forward Plan that may be of interest to the Committee			
Item no.	**Item Name**	**Portfolio**	**Proposed date**
002820/2016	Personal Budget Allocation System	Health and Social Care	18 Apr 17