BIRMINGHAM CITY COUNCIL

HEALTH AND WELLBEING BOARD

TUESDAY, 19 JUNE 2018 AT 15:00 HOURS
IN COMMITTEE ROOMS 3 & 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1 **NOTICE OF RECORDING/WEBCAST**

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

2 **DECLARATIONS OF INTERESTS**

Members are reminded that they must declare all relevant pecuniary and non pecuniary interests arising from any business to be discussed at this meeting. If a disclosable pecuniary interest is declared a Member must not speak or take part in that agenda item. Any declarations will be recorded in the minutes of the meeting.

3 **APOLOGIES**

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4 **MINUTES AND MATTERS ARISING**

To confirm the minutes of the last meeting.

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

Chair of the Health and Wellbeing Board.

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6 **SUSTAINABILITY AND TRANSFORMATION PLAN VERBAL UPDATE (1515 - 1530)**

Dame Julie Moore, CEO, University Hospitals Birmingham NHS Foundation Trust will present the item.

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7 **HEALTH AND WELLBEING STRATEGY UPDATE - ACCOMMODATION AND EMPLOYMENT (ADULTS WITH A LEARNING DISABILITY) (1530 - 1545)**

The report sets out the need for a strategic approach to employment as a whole, with a focus within it for Adults with a learning Disability.

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8 **NHS BIRMINGHAM AND SOLIHULL CLINICAL COMMISSIONING GROUP UPDATE (1545 - 1630)**

Paul Jennings, CEO, NHS Birmingham and Solihull CCG will present the item.

67 - 140

9 **BIRMINGHAM BETTER CARE FUND (BCF) PLANNED SPEND FOR 2018/19 INCLUDING THE IMPROVED BETTER CARE FUND (IBCF) (1630 - 1640)**

Margaret Ashton-Gray, Head of City Finance, Children and Young People Directorate, BCC will present the item.

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10 **HEALTH AND WELLBEING STRATEGY LEAD - ROLE SPECIFICATION (1640-1650)**

This item will involve a verbal discussion to consider the role of the Health and Wellbeing Board and Operational Lead for each of the priorities in the Health and Wellbeing Strategy.

11 **WHAT DOES INTEGRATION MEAN TO YOU/US? WHAT ARE OUR AMBITIONS? (1650 - 1700)**

Professor Graeme Betts, Corporate Director, Adult Social Care and Health Directorate, BCC will lead a verbal discussion on the item.

12 **OTHER URGENT BUSINESS**

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

13 **DATE OF NEXT BIRMINGHAM HEALTH AND WELLBEING BOARD MEETING**

To note that the next Birmingham Health and Wellbeing Board meeting will be held on Tuesday 31 July 2018, at 1500 hours in Committee Rooms 3&4, Council House, Victoria Square, Birmingham B1 1BB

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD TUESDAY, 24 APRIL 2018

MINUTES OF A MEETING OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON TUESDAY 24 APRIL 2018 AT 1500 HOURS IN COMMITTEE ROOMS 3 & 4, COUNCIL HOUSE, BIRMINGHAM

PRESENT: - Councillor Paulette Hamilton in the Chair;
Professor Graeme Betts, Andy Cave, Operations Commander Steve Harris, Dr Peter Ingham, Paul Jennings, Commander Danny Long and Dr Adrian Phillips.

ALSO PRESENT: -

Mike Davis, Neighbourhood & Community Services, Place Directorate
Tony Davis, Commercial Director for WMAHSN
Dr Wayne Harrison, Assistant Director of Public Health, BCC
Carol Herity, Head of Partnership, NHS Birmingham and Solihull CCG
Richard Kirby, CEO, Birmingham Community Health Care Trust
Susan Lowe, Service Manager, Public Health Intelligence BCC
Claire Parker, Chief Officer for Quality, Sandwell and West Birmingham CCG as substitute for Professor Nick Harding
Errol Wilson, Committee Services, BCC

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At the start of the meeting the Chair invited the Board members who were present to introduce themselves.

NOTICE OF RECORDING

245 It was noted that the meeting was being webcast for live or subsequent broadcast via the Council's Internet site (www.civico.net/birmingham) and that members of the press/ public may record and take photographs except where there were confidential or exempt items.

DECLARATIONS OF INTERESTS

246 Members were reminded that they must declare all relevant pecuniary and non-pecuniary interests arising from any business to be discussed at this meeting. If a disclosable pecuniary interest was declared a member must not speak or take part in that agenda item. Any declarations would be recorded in the minutes of the meeting.

APOLOGIES

247 Apologies for non-attendance were submitted on behalf of Councillors Lyn Collin and Carl Rice, Professor Nick Harding (Claire Parker, Sandwell and West Birmingham CCG attended as substitute), Colin Diamond, Jonathan Driffill and Stephen Raybould. An apology was also submitted on behalf of Antonina Robinson, MBE for her inability to attend the meeting.

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

MINUTES

248 **RESOLVED: -**

That the Minutes of the meeting held on 27 March 2018 having been previously circulated were confirmed and signed by the Chair.

CHAIR'S UPDATE

249 The Chair gave a brief update on the things she had been involved with since the last Board meeting.

(See document No. 1)

The Chair highlighted that this was Dr Adrian Phillips last meeting. She placed on record her personal thanks and a thank you on behalf of the Board to Dr Phillips for all the hard work he had done, not just for the HWB, but for the city as a whole. The Chair further congratulated Dr Phillips for running the London Marathon in just over 4 hours. She added that she along with the Board will miss Dr Phillips and wished him well and all the best in his future endeavours.

HEALTH AND WELLBEING STRATEGY UPDATE

The following report was submitted:-

(See document No.2)

Dr Adrian Phillips, Director of Public Health, BCC introduced the item and advised that Dr Harrison and Carol Herity will present the key issues such as the role of the Board Lead and conflict of interest. He invited Dr Harrison and Carol Herity to present the item.

In putting some context to this, Carol Herity, Head of Partnership, NHS Birmingham and Solihull CCG advised that she was co-chair with Dr Harrison of the operations that sat below the HWB. She added that over the past year they had worked with organisations that were represented at this meeting to pull together this new

Strategy for the Board, basing it on work that they as a system were aiming to deliver so that the Board could have a collective holding to account of the programmes and the projects that had been identified. The people that sat on the Operations Board were people who were named key deliverers and managers of the programmes that were within the Strategy.

There were gaps in the Strategy around the Board Leads and Dr Phillips had alluded to the fact that there were people who had been asked, but felt that they would be unsure as to whether they would be able to identify themselves as that lead. She asked that the Board consider the Leads that they and their organisations would be able to undertake to ensure that they had the drive that they needed to deliver these programmes.

Dr Harrison stated that another issue was how they take this forward and get more details behind it. As the Board was moving to monthly meetings he suggested that they have a rolling programme where people who were leading this piece of work could come on an annual basis to give more detail behind the work they were doing, to allow the Board a better oversight of it, backed up by quarterly reports across the whole scope. This was the plan to take it forward and they were looking for the Board's support in that.

Dr Phillips stated that some of the Board Leads had indicated that they would like to attend as Board members and that they would pick up at least one of the issues. He added that following the local elections on the 3rd May, 2018, there may be other members who would come to this Board who may wish to pick up items.

The Chair commented that she was keen for these areas to be populated. They had some time where they knew what their key objectives were. She stated *liberally* that people that came to the Board would be requested to take the lead on certain areas. The Chair stated that she would like to see the names populated by June 2018 as it would be difficult to go forward and drive change if the names were not populated.

The Chair thanked Drs Phillips and Harrison and Carol Herity for reporting to the meeting. It was

250 **RESOLVED:-**

(i) That the Board noted the developments related to the Strategy;

(ii) Agreed to provide specific leadership to individual objectives; and

(iii) Agreed a programme of receiving more detailed updates from each of the priority leads as a rolling programme over 12 months.

DISTRICT AND NEIGHBOURHOOD CHALLENGES EXERCISES – MENTAL HEALTH

The following report was submitted:-

(See document No.2)

Mike Davis, Neighbourhood and Community Services, Place Directorate presented the item and drew the Board's attention to the information contained in the document. Mr Davis further drew the Board's attention to Recommendation 7 on page 54 of the report and added that the District Committee Members for Hodge Hill and Erdington Districts were interested in some mental health awareness training. He had met with Superintendent Sean Russell on a number of occasions who had commissioned on behalf of the WMCA the THRIVE report around mental health to see if there was any opportunity they could collaborate for the recommendations for WMCA report on mental health.

There were still some partnership activities taking place even with the discontinuation of District Committees. There was still a north, south, east and west Jobs and Skills Boards several of which had identified mental health as one of their priorities in terms of barriers to employment. Equally, there was also the local Community Safety Partnerships that were interested in mental health from the perspective of crime and disorder and the part that people with mental health issues may play in terms of this.

Members of the HWB then made the following comments:

- The report was helpful as it was getting a Place Based focus. A comment was that the anti-psychotic medication referred to in the report did not give a good indication of the prescribing; there was a need to look at anti-depressants which would be a better marker when looking at those levels of mental health that they were interested in. Anti-psychotic tends to give those specialist mental health offerings.

  Mr Davis advised that this was the information that the Public Health team was able to provide. Whether they had the other prescribed type of medication would help to move forward.

- That given the changes that were taking place it might be helpful if the reports were referred on to the constituency teams that was set up in Health and Social Care as they will be developing over time to become locality based teams that would be involved in primary care, mental health etc.

- The Chair commented that she was excited with the work that was going on with the former District Committees and did not wanted this work to be lost. She enquired how they were linking in with other partners such as the Third Sector.

  Mr Davis advised that they had not done as much as they would like in terms of working with Third Sector partners as this was a piece of work that was being done with limited resources. Within Erdington District there had been a local Erdington Health Partnership that was meeting regularly over the period the report was being produced which had a number of Third Sector representatives attending. They had also attended the Open Day at Highcroft, Reservoir Road, Erdington, where there was a whole range of practitioners and Third Sector organisations present.

The Chair advised that she had led the Perry Barr Health and Wellbeing Group which was successful. The officers leading that were Neill De Costa and Kyle Stott and they had the Third Sector, Health Service and the CCGs attending at the local

level. It was hoped that they would pull these together as she had sent it to the Corporate Director of Place and Adult Social Care and had requested that through that arena to go to Jonathan Tew, Assistant Chief Executive, BCC who leads on communities. She had further requested that it there was any good work that was happening that these be passed on to Jonathan Tew.

The Chair thanked Mike Davis for attending and presenting the information.

251 **RESOLVED:-**

(i) That the Birmingham Health and Wellbeing Board noted the content of the report and supports the recommendations of the respective Neighbourhood Challenge (mental health) reports produced in conjunction with Erdington and Hodge Hill District Committees; and

(ii) That the reports be referred to the Constituency Teams in Health and Social Care as they will be developing over time to become locality based teams.

RESPONDING TO THE PLACE BASED AGENDA

252 Dr Adrian Phillips, Director of Public Health, BCC introduced the item and advised that this would be a discussion by the Board which follows on from Mark Lobban's paper that was submitted at the previous HWB meeting.

Discussion

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

- The questions were what the opportunity to share intelligence and data across a whole range of institutions around criminal justice and local authority social care were; what were the barriers and challenges.

- As an organisation they would be interested in looking at where they identified opportunities and barriers and working with the wellbeing boards to address those, by either designing or moulding innovative approaches or going out and see where it works successfully in other communities and try to look at implementation or adoption into other communities and setting challenges.

- Six localities across Birmingham and Solihull were created which was the point of the compass and they fit in with Central and Solihull and with the Parliamentary Constituency boundaries.

- Each locality had an elected lead from the membership of GP Lead and those GP Lead sat on the Governing Body. The GP Leads were creating a substructure underneath them comprising of various networks, groups of GPs which reflects the local challenges within those areas. They had created a Place Based structure.

- It would be good to share the findings of Hodge Hill and Erdington from the previous item with the GP Locality Leads who could take this forward. There

was an avenue to start sharing what they were doing with Locality Leads which would be useful from a health perspective.

- There were three things that would be reinforcement as there was consistency between all as to how they should organise below the city. They were working on the same model and thinking what they do at city level. They act at locality level and all localities would do the same as the CCG, Mental Health Trust and Adult Social Care.

- What was needed to be done at a neighbourhood level or within the localities there was work to be done to be consistent at that level as they were about locality level.

- They needed to thing about data and patients as the power of this was in being able to get groups of clinicians at a local level looking at the groups of service users who needed them and working out what they do differently for that group who were the most vulnerable people in the localities. Data helps to find the right groups of people and was an agenda they should all start to work on together.

- Apart from constructing locality structures they needed to work out how they join up their teams within the localities - they were at a forming stage still. They needed to find parts of the city where the boundaries work where there was strong co-terminousity and try this out in practice.

- The Place Based approach from a local government perspective resonates with everything they stood for and seek to do. Local government was about place and the people. They could use this as a building block for care and health, but it requires shifting resources and they were keen to work with the STP to see the shift that was necessary.

- The HWB had a broader role, not just to think about care and health, but about broader engagement with a wider range of organisations that was responsible for economic development. The offer from the academic sides were important as they would be better place to understand people's needs.

- In terms of data, this would be anonymised data – they all collect data on movements of people, place and activities. There were successful models around the country and the world where if they utilised the resources of open data and the work with the data development … using an open and creative purpose working with the citizens or groups to design services that will help them to understand the locality and how services work or the type of interaction they need.

- They provide and incubator and accept the capacity around the region and tapping into those types of communities, they could start to develop some of those Place Based tools.

- It was important to look at localities and understanding people's experience. There was an opportunity to share people's stories as it was not just about listening about the services they were delivering.

- There was a need to look at health mapping and social isolation and how they could overlay that with health and social care.

- There was a need to link Mr M Davis paper with this in relation to recommendations 4 and 6. There was a need to consider different meetings in different places by the HWB to show connectivity. There were lots of infrastructure to get mobilised and get things going. The HWB was an opportunity to make this happen.

- There was a requirement and an interest in ensuring that every contact counts with citizens around their wellbeing regardless of which agency it was. There was a challenge for them to look at in relation to how they facilitate communication between organisations structure in terms of sharing that contact.

- Data and technology allows them to scan the latter at a larger level and to ensure those contacts are multiplied across a larger group of citizens through the development of Place Based tools.

The Chair commented that the points that were made would be taken on board.

JOINT STRATEGIC NEEDS ASSESSMENT PLACE BASED INTELLIGENCE

Dr Wayne Harrison, Assistant Director of Public Health, BCC and Susan Lowe, Service Manager, Public Health Intelligence, BCC presented the item and drew the attention of the Board to the information in the report. A brief discussion and comments from the Board it was

253 **RESOLVED:-**

(i) That the Birmingham Health and Wellbeing Board noted the place based intelligence available to inform development of a place based approach to delivering services; and

(ii) That Board Members feedback any additional locality based intelligence resources and needs as part of the further development of the JSNA.

The meeting ended at 1635 hours.

CHAIRMAN

Live healthy
Live happy
Birmingham and Solihull

Draft STP (Sustainability and Transformation) strategy


GPS Healthcare
General Practice Solihull

myhealthcare

Our Health Partnership
OHP A healthy future for patients and practices

mmp
TAKING CARE
MIDLANDS MEDICAL PARTNERSHIP

Birmingham
City Council

Solihull
METROPOLITAN
BOROUGH COUNCIL

NHS
Birmingham and Solihull
Clinical Commissioning Group

NHS
Birmingham Community
Healthcare
NHS Foundation Trust

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

NHS
University Hospitals
Birmingham
NHS Foundation Trust

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

NHS
The Royal
Orthopaedic Hospital
NHS Foundation Trust

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Our Vision

Live healthy
Live happy
Birmingham and Solihull

"Helping everyone in Birmingham and Solihull to live the healthiest and happiest lives possible"

Our partnership represents a dynamic and diverse place at the centre of the nation. Birmingham, a vibrant city, the most youthful core city in Europe; the UK's second biggest metro economy. Partnered with Solihull borough, a leading driver of economic growth in the region; ranked one of the best places to live in the country, with a green, high quality environment. Together, greater than the sum of our parts. A place that attracts talent from around the world, as well as developing our own. A place of creativity, connectivity and culture. A place of knowledge, knowhow and education, with six universities in one city. A legacy and a future in sporting excellence. A place with fast new transport links and technological possibilities. A place that led the way in the industrial age and that will do so again in the digital era. Innovative, inventive and international. A place for economic growth and social mobility.

A place of limitless ambition.

Our challenges and opportunities

Health and social care are often and rightly regarded as amongst the jewels in the crown of our public services. We want to ensure that this remains the case for future generations. We recognise the essential need for our local public sector organisations across Birmingham and Solihull to work in closer partnership than ever before in order to focus collectively on the challenges and opportunities ahead.

In recent years, health and social care have come under growing pressure in Birmingham and Solihull, as in the rest of the country. The funding for these services has not risen in step with demand.

As part of the national attempt to address the structural deficit, funding growth has slowed sharply for the NHS, and for social care it has actually reduced. However, the major underlying reasons that demand has outpaced affordability in our current model of care are driven by longer term, societal changes:

- **Our ageing society:** people are living longer, which is a great success, but it means we need a system that helps many more people to live well and independently in later life, and to meet their varied care needs.
- **A shifting burden of disease:** the last century has seen a major shift from death and illness being caused mainly by infectious diseases to non-infectious diseases, such as cancer, heart disease, diabetes, dementia and mental illness. This reduces somewhat the fear of sudden, catastrophic illness, but increases many-fold the chances of people living more years with ongoing, complex and expensive care needs.
- **Technological advances:** science and digital technologies are transforming every facet of modern life. We can introduce new treatments and innovations to improve clinical care and quality of life, but, whilst some may be cost saving, the net effect is to add to the cost of care, especially in the most specialised services.

These far reaching, societal changes are not unique to our region or our country; they are the challenges of all developed health and care systems around the world.

We need to find the most safe, effective and compassionate ways to manage the health and care needs of our population within the available resources; **to make high quality health and care sustainable now, and for future generations**. This will require action at national and local levels. We believe it is both essential and possible to do this whilst making things better for patients and citizens because higher quality care is more cost effective than poor quality, inefficient care.

We seek a greater emphasis on the **promotion of health and wellbeing** to keep people active and productive for longer, with a particular focus on supporting the most disadvantaged in our communities; we want to continuously **improve the quality of care** that people experience; and we want to **maximise efficiency** in how we use public resources.

That is why, locally and nationally, health and social care geographies have been formed together as "sustainability and transformation partnerships" (STPs).[i] These are not new organisations, but important partnerships of the existing health and social care organisations. They have been established to focus collectively, rather than separately, on the needs of the local people they serve.

Our Partnership

The map shows the geography of our local health and care system. It includes all of the Solihull Metropolitan Borough Council and much of Birmingham City Council. West Birmingham is included in a neighbouring STP, with which

we work closely. In addition to the two local authorities, our partnership includes:

- 177 general practices, many of which are within one of four large GP groups: Midlands Medical Partnership, MyHealthcare, Our Health Partnership, General Practice Solihull Healthcare
- Birmingham Community Healthcare NHS Foundation Trust
- Birmingham and Solihull Mental Health NHS Foundation Trust
- NHS Birmingham and Solihull Clinical Commissioning Group
- Birmingham Women's and Children's NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust
- The Royal Orthopaedic Hospital NHS Foundation Trust

West Midlands Ambulance NHS Foundation Trust is an associate member. We also have close relationships with neighbouring areas, such as the Black Country, Staffordshire, and Coventry & Warwickshire, in some cases providing services for each other's citizens. w

We serve a large and diverse population. The Birmingham area has a population of c.1 million, making it the largest local council in the country, and Solihull has c.210,000 residents. Over a hundred different languages are spoken in Birmingham and in some wards of the city up to 80% or residents are from Black, Asian and Minority Ethnic groups. We are, at once, young and ageing. Birmingham is a growing city that has the youngest average age of the core cities of Europe, with almost half of the population under 30 years of age. Some 90% of the adult population owns a smart phone, which is the highest coverage in Europe. Solihull has an older population, on average, with 21% aged over 65.

In common with other developed countries, the overall structure of society is changing as people live longer lives. Ageing societies are one of the great challenges for health and care systems across the developed world, and we are no exception. In three decades, the number of people over 65 years of age is expected to increase by a third. The number over 85 years of age will double, as will the number living with cancer and dementia, diseases that are often associated with ageing. This will increase costs significantly because, on average, the health costs for someone over 65 are four times higher than for a working age adult, and they are eight times higher for a person over 85.

Both Birmingham and Solihull have stark inequalities in terms of the health and wealth of their citizens. In Birmingham, 440,000 people, or 46% of the population, live in the 10% of most deprived areas in England, which accounts for some very poor health outcomes. The city has a level of homelessness that is more than three times the national average, long-term unemployment two and a half times higher, and one in three children live in poverty. One in four people live with a mental health condition that started in childhood.

Solihull has sharp contrasts in wealth and deprivation across different areas, although on average is more affluent than England as a whole. In the most northerly part of the borough, around one in three children live in a household without work or reliant on benefits. Whilst improving, there is a relatively high rate of homelessness.

People born in the most affluent parts of Birmingham and Solihull will live, on average, nine years longer than those born in the most deprived wards. This unacceptable gap drives our relentless determination to put at the forefront of our strategy the reduction of inequalities in health and outcomes.

Our progress so far

Our first task, after the STP was established in 2016, was to stabilise under-performance in the health and care economy. We had some strategically significant organisations providing variable quality of care and whose expenditure was far exceeding income. Unless we could stabilise these organisations, we would not have firm foundations for our ambitious transformation plans.

Notably, this has involved the successful mergers of Birmingham Women's and Children's hospitals, the three clinical commissioning groups (CCGs) coming together in a new, single commissioning organisation, and the merger by acquisition of Heart of England NHS Foundation Trust by University Hospitals Birmingham NHS Foundation Trust.

We are one of the most advanced places in the country for developing general practice at scale. Within the STP we have four substantial and formally constituted GP organisations offering opportunities locally that have not been available before. We are working hard to provide high quality primary care, with the ambition for all GP providers to have achieved a Care Quality Commission rating

of 'good' or above in 2018. We are also involved in the national programme to recruit additional GPs from overseas to help fill gaps in the workforce.

Birmingham Community Healthcare has begun to develop community services to care for people at home, including local integrated multidisciplinary teams, a rapid response nursing service and, most recently, 'virtual beds' to provide extra support in the most pressurised winter period.

We have made significant progress in mental health. Reach Out offers a new model for secure care. The MERIT programme aligns partners providing urgent care. We have also transformed access to community services for perinatal mental health. We have the only mental health global digital exemplar in the UK.

The health and local authority partnership, Solihull Together, is helping people to retain their independence through 'SupportUHome', which provides more timely support for people leaving hospital. The partnership has achieved significant reductions in delayed transfers of care. In its efforts to sustain and improve services, Birmingham City Council has set out a new vision for adult social care and health and the formation of a dedicated Children's Trust to lead services for some of our most vulnerable children.

In the first national ratings of STPs, Birmingham and Solihull was rated as 'Advanced', the second highest on a four point scale. This progress has laid the foundations for the more transformational next phase of our strategy.

Our vision and aspirations

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

We want to be the best place in the country for health and social care. We recognise that many of the factors that affect people's health and happiness are not within the direct responsibility of the NHS or social care, such as family life, employment, environment, transport and accommodation. But we define our ambition in terms that we believe matter to our citizens, rather than in terms of institutional responsibilities. We want to do everything that is within our considerable, collective power to contribute to our people's health and happiness.[ii] In particular, we want to help address the stark gap between the outcomes of the most and the least advantaged.

We see our vision for Birmingham and Solihull in the context of a wider regional mission. We will work closely with our partners in the West Midlands Combined Authority (WMCA) whose stated aim is to 'build a healthier, happier, better connected and more prosperous West Midlands'.[iii]

We are entering a new phase in which our city and region will once again be at the forefront of technological innovation and economic growth. Health, research and the life sciences sector can be major contributors to regional economic growth and inward investment. We must make sure that our citizens connect with these opportunities, and that the benefits for individual health and wealth are shared more evenly in the future.

As a health and social care system, there are five aspirations that we stand for:

1. Independence and resilience – we want to play an enabling role that helps individuals and families to live long, fulfilling and independent lives, taking personal responsibility for their health and well being, and with the physical and emotional resilience to cope with the stresses and strains of life and to recover from setbacks. Public services need to complement individual and community efforts, rather than substitute for them.

2. Equity, equality and inclusion – overall gains in health and prosperity have not been shared evenly, so we want to reduce the unacceptable gap between the health and well being of the most and the least advantaged. We want parity of esteem between mental and physical health. And we want to promote inclusive communities, reducing social isolation.

3.Integration and simplification – many of the problems of health and social care exist at the misaligned joins between separate organisations, services or professionals. We want to integrate our services around the paths that people want or need to take, making best use of technology and personal health budgets to do so, rather than expecting them to navigate a complex and disjointed offer for their health and care. They should not have to tell their story many times over because the system should be joined up and enabled by technology.

4. Promoting prosperity – better health and life outcomes are closely correlated to prosperity for individuals and communities. We want to make our contribution to economic growth and stable employment by supporting people and communities to be active and productive.

5. Social value – when we use our scale and act collectively, we have the potential to deliver social and economic benefits that are far broader than health and social care alone. We recognise that our vision and aspirations are complex and multifactorial, and we cannot achieve them alone. But we can and will be role models who provide leadership in some important areas, such as how we affect and interact with our environment, how we care for our many staff, how we tackle inequalities and the impact we have on people's diet and activity. We will hold ourselves to high standards in terms of the social value we create collectively.

How will we operate differently to achieve our bold aspirations?

Our approach: born well, grow well, live well, age well and die well

We know that people's social and economic circumstances substantially affect their health status and life chances, and that their course is often set very early in life, whether positively or negatively.[iv]

We want babies to have the best start in life; to have a healthy and happy transition through childhood and adolescence; to live well through adulthood; to age well; and, when the time comes, to reach the end of their life in a manner that meets their wishes and preferences.

For those people whose lives do not follow a smooth course because they are stuck in a cycle of disadvantage, we want to support them to break out of that cycle and to enjoy health and happiness.

We want to rediscover the benefits for society, education, health and happiness of different generations mixing together, which has become less common in an age when families may be dispersed for reasons of employment, migration or mobility, and in which loneliness has become endemic.

All of this requires a much more joined up approach to health and care, as well as wider public services.

The transformational change we propose is to work on the basis of 'place' rather than 'institution'. In essence, this means understanding in detail the needs of the people in each of the parts of Birmingham and Solihull and marshalling our collective assets in those localities to best meet those needs in a much more coordinated way. Those assets might be financial investment, professional time, the way we use public buildings, digital infrastructure, or knowledge and information. We can achieve more for our citizens, patients and staff, and their experiences of public services should feel more seamless, if we work together in much closer partnership to deliver place-based care.

This might sound obvious but it is not the way that public services have typically worked, so it represents a fundamental change in our 'operating model' as a health and social care system. It means we will focus primarily on what matters to people in the places where they live and work, rather than what may appear convenient for the public institutions with which they interact when they are unwell or in need of care.

It means our organisations, which are already under significant pressure to meet demands for care within the finances available, will have to be prepared to move resources to where patients and citizens most need them. In fact, precisely because we are under such pressure, now is the time to take bold and outward-looking decisions to transform our system of health and care to better meet demand, rather than to retreat into organisational or professional silos.

One of the examples of where we will take this approach is in **East Birmingham and North Solihull** which is the focus of major regeneration programmes involving both councils and under the auspices of the West Midlands Combined Authority. These will tackle some of the most entrenched socio-economic problems in our region, building on the successful regeneration work already completed in North Solihull. The focus will be on improving health, connectivity, education and skills for the people in that large urban area, in which some 300,000 people live. The new metro linking HS2 with the city centre, via the Eastern suburbs, will be a major catalyst for change, and we will play our full partnership role in addressing the health challenges as part of this place-based approach.

For Birmingham and Solihull as a whole, **we are completely committed to operating in partnership**

with a sense of common purpose. We see this as part of the essential path towards sustainability of high quality health and care services now and for future generations. The leadership roles and professional behaviours we encourage in the future will be about working collaboratively as a system and a local community, not guarding organisational boundaries.

We will embrace innovation, particularly in the realm of digital technologies and capabilities. Almost all aspects of our daily lives are changing dramatically in the digital era, but health and social care have lagged behind some other sectors in harnessing the possibilities of new technologies. For everything we do, we will look at how **technology can support integration** of services, professional communication and how it can support individuals to be informed about and manage their own health and wellbeing.

We will move from operational to strategic commissioning for outcomes. Local government and NHS commissioners will set out the health and social care outcomes that we want for the population, and providers will work together to deliver the **highest standards of care**. We will optimise personal budgets and empower people to be in charge of their own care.

We will work with our local academic institutions, such as Birmingham Health Partners and the West Midlands Academic Health Sciences Network, and take decisions on the basis of the **best available evidence**. This will ensure that our actions are addressing the issues of greatest need in health and care, reducing inequalities in outcomes and variations in care, and delivering the best return on investment in both the short and long term. We will also examine rigorously the evidence base so that we support interventions that are most likely to be effective in addressing those issues. We will publish our evidence base and evaluate periodically our actions for their effectiveness. Where new evidence or evaluation shows we should change tack to deliver better outcomes or cost-effectiveness, we will do that rapidly and pragmatically.

The best form of evidence about where to focus our efforts will come from the citizens of Birmingham and Solihull themselves. We will carry out a programme of **open and inclusive public engagement** so that we hear from the people directly about what matters to them and how we can best meet their needs. Details of how to have your say are included at the end of this document.

Health and Well Being Boards will continue to have democratic, strategic oversight of our health and care system developments and the impact on the people we serve.

Our resources

The overall intentions of this multi-year strategy are to improve the health and well being of our population, reduce inequalities, maintain and improve the quality of care we provide, and to live within our means financially.

The NHS is a national service funded through general taxation. Social care is funded through a combination of general taxation, local taxation and individual payments according to means. A more sustainable model for social care funding, in the context of our ageing society, will be the subject of an HM Government Green Paper later this year. [v]

For both services, therefore, the level of funding available is substantially affected by central Government decisions. Numerous Parliamentary and independent expert groups have now recognised that both the NHS and social care will need funding increases well above the levels of recent years, as soon as the economy can bear it.[vi vii viii ix] That will be an essential element of securing the long term sustainability of high quality health and social care for future generations. It is particularly significant for Birmingham's and Solihull's health services, which are in the lowest ten per cent of areas in England for the fairness of their funding according to the national, objective assessment of the population's needs.[x]

Nevertheless, we also have an important role to maximise our potential and productivity in Birmingham and Solihull. Local authorities are expected to fund many services through the retention of business rates, so economic growth is integral to our strategy.

Benchmarking data shows that we have some opportunities to deliver high quality care, more efficiently, if we achieve the best practice amongst out peers.[xi] We can also take a more proactive approach in certain areas to moderate the demand for our services, such as preventing people from becoming acutely unwell. These opportunities include:

- **Health promotion** – a system that supports people to maintain their health and well being can reduce substantially the costs of treating preventable diseases, such as type II diabetes, lung cancer and many other conditions linked to unhealthy lifestyles. Benchmarking shows that if we achieved best practice in the NHS we

could save around 70 lives per year that are lost to cancer or respiratory illnesses. We could also save around 8% of the £46m we spend per year on treating respiratory conditions. There will also be multiple wider benefits for economic productivity in supporting people to stay health and active.

- **Independence and work** – as the structure of society is changing, so is the dependency ratio, which is the number of people in work relative to those who require support from public services. We want to support people to maintain their health, independence and productivity for as long as possible. We will be active in supporting local skills and employment opportunities to tackle the anomaly that we have pockets of high unemployment in Birmingham and Solihull, whilst also having vacancies at most skill levels in our health and care organisations.

- **Right care, right place** – the current model of care too often defaults to hospitalisation. In many cases, more preventative care in the community, or swifter discharge from hospital supported by a package of community support or social care, would be better for patients and more economical. This is particularly relevant for the care of older people and for those at the end of their life. Analysis has shown that we could save around £40m per year locally by caring for older people in the most appropriate settings, with enablement support, and by reducing clinically unnecessary stays in hospital. There are also opportunities for stable patients to have more of their follow up care in primary or community settings, rather than in hospital outpatients.

- **Reducing variation** – we want citizens to receive the best quality care wherever they live, but there is too much variation in care and outcomes. There is ample evidence that higher quality care, with fewer errors, is both better for patients and more cost effective. Benchmarking data shows that if we achieved best practice in the NHS we could save each year £20-27m on non-elective admissions, £14-16m on elective admissions and £15m through more consistent primary care prescribing.[xii]

- **Harnessing technology** – whilst the net effect of technological advances in healthcare has been to increase costs, especially for new medicines and in specialised services, technology can also reduce costs in other ways, for example by delivering services virtually, removing inefficiencies and automating repetitive tasks. We will seek out the potential productivity gains from new technologies, so that they support, rather than threaten, the sustainability of high quality care.

- **Economies of scale** – we can deliver substantial efficiencies by working together to merge some corporate and back office functions, and by using our considerable purchasing power to make procurement savings and to deliver social value. [xiii] This will be one of the major advantages of using our scale to work in partnership, and it will release significant savings to reinvest in direct care.

In other parts of the country, some STPs have become associated with potential closures of A&E departments or large scale reductions in hospital beds. We are clear that is not what we are proposing for the NHS in Birmingham and Solihull. As demand for our services grows, we will work continuously to provide high quality, responsive care to local people within available resources. For the most specialised services, it will often be the case that they are best delivered at scale in order to concentrate specialist clinical skills and equipment. Less specialised clinical or care services, however, can be delivered more locally to people and communities.

Our most important resource is of course our many thousands of staff. Their skills, expertise and commitment to public service are the lifeblood of high quality health and care services. We want Birmingham and Solihull to be a great place to live and work.

But the funding squeeze in health and social care of recent years has taken its toll on staff. Their workload has increased due to rising demand for services. This is damaging to the well being of our staff, with too many suffering from burnout and considering leaving their professional vocation. The lack of a long term national plan for the workforce has been described as the greatest threat to the NHS,xiv and the same could be said equally for social care.

There are shortages in all parts of the sector: from GPs and other primary care practitioners who deliver the great majority of patient contacts; to nurses, midwives and allied health professionals who are integral to all parts of the sector; to psychiatrists, psychologists and therapists providing comprehensive mental health services; to hospital specialists delivering advanced and specialised care; and to carers and social workers who support people's independence and quality of life at home or in residential settings. We understand these very real pressures, which is why many of our priority actions will be about supporting

current staff and encouraging the future supply of our workforce.

The other crucial contribution we will seek is the energy, knowledge and resourcefulness of our citizens, patients and carers. We know that individuals have the greatest motivation to look after their own health and many become experts by experience, especially when they have long term conditions. We will increase significantly the availability of personal health budgets, across all age groups, to help people to manage complex, chronic and terminal conditions more effectively and efficiently.

Our priorities for action

We have identified below a number of high priority areas for action. We now want to hear the views of our citizens and those who use our services about whether these feel like the right ones based on their knowledge and experience.

These are by no means the only things we will be doing across health and social care in the months and years ahead. We will of course continue to pursue numerous other goals and initiatives within our own organisations and services to meet national and local priorities as part of business as usual.

However, the proposals listed in this strategy are those things where there is the greatest gap between how things are now and where we aspire to be in terms of people's outcomes and our services. They are also the things where we believe we can deliver the greatest benefit by working together in partnership as a health and social care system, rather than those things that should happen within a single organisation.

1. CHILDHOOD AND ADOLESCENCE

A healthy start in life – Birmingham and Solihull is home to one of the youngest urban populations in Europe. There are 330,000 children and young people here, nearly 20% of the total population. One in ten mothers suffer mental health problems in the first years after giving birth. One third of children are deemed to be living in poverty and one in ten have a mental health problem. The impact of a difficult start in life can be very harmful to children's chances in life. In Birmingham, on average, children's overall health and well being, development at the end of reception, levels of obesity and rates of emergency hospitalisation, are all worse than the national average. By contrast, the average in Solihull is better than the national picture for childhood health and wellbeing, poverty and obesity. However, that average masks stark inequalities within Solihull. There are some unacceptably poor health outcomes, particularly in the north of the borough, and the rate of children in care is higher than the national average. We want all of our children to have the best start in life, from birth through to adolescence. To deliver this priority, we will:

- Implement a single local maternity system for Birmingham and Solihull that will increase choice, enhance maternity care and support, and improve the experience for mothers. This will help to reduce neonatal mortality rates and adverse childhood experiences, and will give babies the best start in life.

- Roll out community perinatal mental health support for mothers through multi-disciplinary teams.

- Integrate health visiting services, children's centres and other support services, creating local early years hubs where families can access the help they need from pregnancy until their child starts school.

- Develop an integrated, strategic commissioning plan for children's and young people's services across Birmingham and Solihull, involving schools, public health, NHS services and social care. Priorities for action will be delivered through place-based plans and will include Special Educational Needs and disability services.

- Pilot a transformed model of healthcare for children through community-based, multi-disciplinary teams (virtual and physical) across primary and social care. These will have a clear focus on the prevention of key risk factors and will provide support for self-management from an early age, including diet, exercise, mental well being and school readiness.

- Promote opportunities in our schools, youth centres, workplaces, and other services for which we are responsible, for increasing daily exercise, such as 2,000 step routes and the 'run a mile' schools programme, and post- and pre-natal exercise programmes. In this we will harness the unique opportunity of Birmingham hosting the 2022 Commonwealth Games to build a legacy of physical activity and sporting participation, especially for our children and young people.

- Increase access to children's and young people's mental health services by 35%, in line with the national ambition; and reduce the number who have to go out of the area to be admitted to hospital for psychiatric care, saving in the region of £2.7m per year and providing a better experience for our young patients and their parents or carers.

- Address variation in access and clinical provision across our urgent and emergency care pathways for children by implementing a single integrated clinical advice and guidance service, and rolling out a standardised pathway of care for the most common conditions.

2. ADULTHOOD AND WORK

Promoting health and well being, and managing chronic disease – we know that modern lifestyles are contributing to an increase in chronic and non-communicable diseases, such as type II diabetes, cardiovascular disease, cancer and dementia. Many of the risk factors are similar or linked for these diseases, including social isolation, smoking, excess alcohol consumption, high calorie diets and low exercise leading to overweight and obesity. These unhealthy behaviours are quite often established early in life. There are close correlations between these risk factors and socio-economic status – with the least advantaged being at most risk – and between people's physical and mental health. People with a severe mental illness have a life expectancy 20 years below the average. We want to ensure that everyone has a fair chance to enjoy good health and well being. We will take a proactive approach to identifying and preventing illness, and to supporting people to manage their chronic conditions. To deliver this priority, we will:

- Put GP social prescribing at the heart of our support for citizens to access health and well being initiatives, such as exercise, diet and opportunities to reduce isolation, and ensure our staff have the skills to support behavioural change.
- Utilise the skills of GPs and their teams to manage patients holistically, developing a consistent offer from general practice for enhanced services for patients across multiple chronic diseases.
- Work with our partners, including the West Midlands Academic Healthy Science Network (AHSN), to analyse large datasets (with appropriate and statutory safeguards for how identifiable data is used) to identify those people at greatest risk of major diseases, including type II diabetes, cardiovascular disease and cancer. We will then target screening programmes accordingly.
- Offer targeted services, such as health checks and other preventative services, to promote well being and early identification of symptoms for high risk groups, such as people with diabetes, mental illness or learning disabilities.
- Implement the 2015 NICE cancer referral guidelines [xv] and redesign access and referral pathways, increasing the use of digital access points, to reduce unnecessary steps or delays in the pathway.
- Set a 'zero suicide' ambition, supported by evidence-based, preventative actions and high quality crisis support. Reduce stigma around mental health and improve access through early intervention services.

Staff health and well being – as the health and social care organisations of Birmingham and Solihull, we are major regional employers, with some 45,000 staff between us [note: check figure. All NHS and primary care staff comes to c.40,000 but need to add relevant sections of local government and social care]. There is certainly room for improvement in terms of our staff health and well being. The most common reasons for sickness absence are stress, musculoskeletal conditions and cold and flu (the latter predominantly in the winter). We lose an average of 6.6 days each year in sickness absence per member of staff, 40% of which is related to mental health. The health and well being of our staff is extremely important for its own sake, and to support those for whom they care. Most of our staff have families and dependents, so our ability through them to influence lives for the better extends to many thousands more people. A healthy and happy workforce is also more productive. We want to play our part in Birmingham and Solihull being an attractive place to work and live. To deliver this priority, we will:

- Work together to scale up an overall staff health and well being offer to support each other's staff as if they were our own, making full use of the resources we have available, such as clinical services, gyms, leisure facilities, online resources and support forums. This will apply to all staff directly employed in the NHS, general practice and council run social care.
- Extend progressively the scope of staff clinics by pooling the specialist expertise across our organisations and encourage staff to have check-ups.
- Identify innovative practices for promoting staff health and well being within our organisations and spread them more widely across our partnership.
- Adopt a common engagement standard to promote best practice in how we engage with staff and respond to their wishes and feedback.
- Make mental health first aid widely available within workforce training and ensure our managers have the skills to support staff with mental health problems.

- Ensure that canteens and food available to staff encourage healthy choices and cut down on high fat, sugar and salt content, and that we make available a range of structured exercise options for staff.

- Aim for best practice levels of uptake of the seasonal flu vaccine for all staff, and undertake local research into the most effective methods of encouraging uptake.

- Support our staff to volunteer and mentor within approved schemes that have social value in our local community.

Promoting skills and prosperity – nationally and locally there is a significant shortfall in the number of health and social care professionals required to meet the demand for our services. This can impact on the well being of existing staff, the quality of care we are able to provide and can raise costs when we have to hire locums or from agencies rather than directly employed staff. Our organisations provide secure jobs for all skill levels in the formal economy and with long term career prospects. The majority of our staff live in Birmingham or Solihull, as well as working here, and they contribute positively to the local economy. We will invest in recruitment and retention locally, from entry level posts supported by the Apprenticeship Levy, through to the highest skilled posts, so that we, as major local employers, can support a virtuous cycle of employment and economic growth. We will target this effort to areas that have greatest scope for economic regeneration, such as East Birmingham and North Solihull. To deliver on this priority, we will:

- Develop a staff training passport so that staff who undertake core induction and training can have that experience recognised and not repeated when they move between our organisations.

- Take a collaborative approach to recruitment and appointments: using our collective scale and reputation to attract the best candidates to Birmingham and Solihull, for instance through careers fairs; making more joint appointments to promote system working; and deploying staff more flexibly across our organisations, for example to address critical shortages or skills gaps.

- Maximise the possibilities for new professional roles, such as nursing associates, to meet the service needs of the future.

- Improve significantly the retention rates of GPs each year by developing a workforce plan for general practice, including training hubs and opportunities for flexible working.

- Support our staff to gain experience in different parts of the sector through work shadowing and placements, including in primary care centres.

- Develop a joint staff bank and agency protocol, building on work that is already taking place.

- Develop and enact an STP social value policy, building on the good work of Birmingham City Council; increase social value weightings in our contracts for procurement, in line with best practice, and include common indicators on apprenticeships and recruitment from vulnerable groups.

- Provide mentoring, coaching and work experience, and offer apprenticeships and entry level employment opportunities, to people with mental health conditions, young people in the care system and other vulnerable people within our communities, so that they are supported to find work. This will building on initiatives such as the University Hospitals Birmingham Learning Hub and Birmingham and Solihull Mental Health Trust's Integrated Placement Support for new routes to employment.

- Commission a workforce economic analysis of traditionally lower paid roles (e.g. care workers) to assess the potential of systematic pay progression to deliver off-setting savings through better retention and development of people and skills, reduced agency spending and improved quality of care.

Breaking the cycle of deprivation – whilst there is quite widespread economic and social disadvantage in Birmingham and areas of Solihull, there is a relatively small number of people who are stuck in a cycle of chronic and severe disadvantage. Often the cycle starts before birth because their parents were in the same cycle, and they may have had one or more of the recognised Adverse Childhood Experiences (ACEs). They may have dysfunctional families, poor educational outcomes, low employment prospects, and suffer poverty, unhappiness and poor mental and physical health as a result. Some may have been traumatised through exploitation or people trafficking. There are about 2,500 people with at

least three markers of extreme disadvantage, including homelessness, severe mental illness, substance misuse, or having been offenders. Approximately 750 looked after children leave care every year, 60% of whom have emotional and mental health problems. Nine out of ten people in prison have a mental health or drug problem. About 1,500 supported adults with a learning disability live in unsettled accommodation and their life expectancy is lower than the average by 19.2 years for men and 14.9 years for women. We will take a targeted approach to support people in severe disadvantage to break out of the pernicious cycle. To deliver on this priority, we will:

- Commit our full support as partners to delivering the aims of the Changing Futures and Fulfilling Lives initiative for people with the most entrenched and severe problems, which is led by the voluntary and third sector in Birmingham.
- Work in partnership with the voluntary and community sector in Solihull on a joint investment strategy to make the best use of our resources and target them to specific challenges in Solihull.
- Support local social enterprises that share our aim of helping people build skills, independence and resilience, and finding work, to break out of the cycle of disadvantage.
- Expand our efforts to help people in severe need get back on their feet through our hospital-based food and clothing banks.
- Roll out the Red Thread programme across our hospital A&E departments to help prevent gang-related and other serious youth violence and to support young victims of violent crime.[xvi]
- Commit to the delivery of the Transforming Care Programme by 2020 to support people with learning disabilities as close to home as possible, in the least restrictive environment.
- Increase significantly the proportion of people with learning disabilities who receive their annual health check from the current low level of 28%.
- Implement the WMCA Mental Health Commission concordat and deliver the Thrive West Midlands action plan across our organisations to improve mental health and wellbeing.
- Support the MERIT programme to reduce the number of people who are placed out of their area for acute psychiatric care, and to improve their recovery and outcomes.

3. AGEING AND LATER LIFE

Ageing well and improving health and care services for older people – better healthcare and living standards mean more people are living longer. The number living beyond 85 will double over the next generation, and there will be a three-fold increase in those reaching 100. People over 85 account for 11% of our NHS budget, despite only representing 1.8% of the population locally. When the NHS was founded 70 years ago, people lived an average of only five years beyond the state retirement age. Even with a higher pensionable age, that average is now 15 years. Longer lives are a major success overall, but they present challenges too. Many people reach older age in relatively good health, but with an ageing population there will be more people living with dementia, musculoskeletal problems and frailty. We need to enable older people to stay healthy, active, independent and with meaningful engagement for as long as possible. When people do need assistance and support, they should be able to access it easily and promptly, from skilled and caring teams and professionals, and receive help as close to their own home and support networks as possible. To deliver on this priority, we will:

- Develop and implement an Ageing Well strategy. This will support people to manage their own health, well being and social participation. It will signpost community opportunities and activities to citizens and carers and to GPs as social prescribers. It will establish the concept of 'supportive communities', involving businesses, educational institutions and the voluntary and community sector. It will support people to remain healthy, engaged in society and reduce loneliness and isolation. It will take a life course perspective to educate children about how living well in earlier life can help with good ageing, and to support inter-generational opportunities.

- Promote awareness so that our community becomes more dementia friendly.

- Coordinate health and social care into a locality framework, aligning mental health, and primary, secondary and community care with the local authorities, independent social care providers and third sector.

- Establish multidisciplinary teams to remove barriers in the care system that cause delays when people need care urgently. When a person is unwell they will receive a comprehensive assessment by an expert team of professionals to make an accurate diagnosis, and a plan will be made for treatment and care, including their physical, mental and social needs. This will be accessible at the front door of hospitals seven days a week to avoid unnecessary hospitalisation and promote the 'home first' ethos, building on developments such as SupportUHome.

- Establish specialist care centres for older people in Birmingham to bridge the gap between hospital and home. These community-based centres will provide enablement beds, therapies, mental health support and specialist clinics, as well as wider services from voluntary and community groups.

- Revise local authority contracts for home care services over a phased period to incorporate the need for care staff to deliver an enabling approach, supporting people to maximise their abilities and remain as mobile as possible.

- Take a joint approach to commissioning and supporting high quality residential and nursing home provision and associated services, so that people in residential care have the same access to multidisciplinary teams as those who remain in their own homes.

- Test and take up current and emerging assistive technologies, especially in settings where they have the most potential to enhance care, such as care homes and extra care housing.

- Recognise the vital role that 135,000 unpaid carers play across Birmingham and Solihull, by establishing a Carers' Commitment to help them access the support that they need.

Creating a better experience at the end of life – When most people reach the end of their life, they would prefer to die in their own home with their family and loved ones around them, rather than in unfamiliar or overly medicalised surroundings. Yet hospital remains the most common place of death, and people spend an average of six weeks there in the last year of their life. The amount of time people at the end of life spend in hospital in their last year of life is greater in Birmingham and Solihull than the national average. Emergency attendance and admission to hospital often peaks in the month before death. This is rarely what people want and is a costly use of resources. We will support choices for those at the end of their life to achieve what for them is

a good death and to make sure this period reflects their wishes. We will create a centrally co-ordinated system for all end of life services that will ensure better and more timely identification of needs, as well as a greater focus on patient centred care, designed according to people's priorities and choices. This system will reduce unwanted hospital admissions that add little clinical benefit, offer equitable access to services with fewer gaps in provision and ensure more robust information sharing. To deliver on this priority, we will:

- Focus at all times on the person and their wishes, promoting advance care planning, including advance directives, lasting powers of attorney, 'living wills' and Respect Forms.

- Use technology and other mechanisms to ensure those wishes are known and adhered to wherever an individual enters the health and care system. Agree effective systems to transfer data (including health records where appropriate), share intelligence and remove duplication.

- Support those caring for people at the end of their lives, whether they are professionals or family members, so that they can do so confidently, with the ability to access practical and emotional support when needed.

- Embody the Compassionate Community[xvii] ethos of working in broad and varied partnerships with our diverse communities, rather than simply delivering services to those communities.

- Support open and honest conversations about death across the diverse communities we serve through engagement, education and communication, leading to a significant increase in the number of people actively articulating their wishes for end of life care.[xviii]

4. ENABLING PRIORITIES

Improving air quality for a healthier environment – air pollution has a harmful impact on health throughout life,[xix xx] from before birth to later life. It is the fourth greatest risk to public health, after cancer, obesity and cardiovascular disease, and is a significant cause of premature mortality. Children, pregnant women, older people and those with chronic health conditions are among the most vulnerable. Each year air pollution costs the city economy c.£1bn and a 4% loss in productivity. Tackling it is a priority for Birmingham[xxi] and Solihull[xxii] councils and for the WMCA. As with so many other things, air pollution disproportionately affects those who live in more deprived and congested parts of the city. As health and social care organisations, we cannot transform air quality on our own, but we can make an important contribution. Five per cent of all the traffic on the road in England is related to the NHS.[xxiii] We can provide leadership on this vital issue, create social value through our scale, and avoid or mitigate pollution hot spots around our estates. We will also advocate for clean air and green transport policies with other partners. To deliver this priority, we will:

- Assess ourselves using the Sustainable Development Unit's Health Outcomes of Travel Tool[xxiv] to measure our environmental impact and to support prioritisation.
- Champion the development of Green Travel Districts to improve air quality, transport safety and physical exercise.
- Operate 'green fleets' across our organisations, ensuring that any new vehicles that we purchase or lease are electric or hybrid, where those options are available and practical, and that we phase out diesel engines in our fleets.[xxv]
- Initiate a 'no idling' policy for vehicles outside all of our premises to reduce emissions in the vicinity of our patients, visitors and staff.
- Set progressively lower emissions standards for any external suppliers from whom we procure services, such as non-emergency patient transport, and buy products locally where possible to shorten supply chains and promote the local economy and social value.
- Remove unnecessary physical journeys by using digital technologies, such as virtual consultations for some primary care or outpatient appointments. Support flexible or home working and cycling to work, where practical, to prevent unnecessary journeys and emissions and to improve staff productivity and well being.

Broadening access to urgent care – in recent years, the demand for hospital based urgent and emergency care has increased substantially.[xxvi] A significant factor has been the increase in people living longer with more complex needs, many of whom are so ill by the time they reach hospital that they need to be admitted for treatment. However, more proactive management of their care needs in primary, community or social care settings may be able to prevent the need for hospitalisation in many cases. That will be a major area of focus for our work with children, people experiencing severe disadvantage, older people and people at the end of life, as described above. There are also many people who attend a hospital Emergency Department for conditions that could have been treated more appropriately in another setting. Estimates suggest that between 1.5 million and 3 million people nationally who attend A&E each year could have had their needs met in other parts of the urgent care system; in Birmingham and Solihull that would equate to between 75,000 and 150,000 attendances [note: can we use actual BSOL data?]. Patients often see urgent care services outside hospital as fragmented and confusing, so, understandably, they default to A&E. By working as a system across our hospitals, primary care, community and care services, we will set out a much clearer, stratified system for urgent care with a greater focus on keeping people out of hospital when their clinical needs to do not require them to be there. To deliver on this priority, we will:

- Increase access to general practice, including more evening and weekend appointments.
- Work with local people and communities to ensure that everyone understands the importance of registering with a local general practice, particularly for those people who are not currently registered.
- Use technology in ways that are clear and simple so that people can obtain advice and support through apps and online consultations at times that are convenient for them.
- Develop a wider network of primary urgent care, including urgent treatment centres with access to diagnostics out of normal business hours.

- Analyse large datasets, combined with local knowledge, to understand demand and plan capacity for urgent care, both at a strategic level for the whole of Birmingham and Solihull and at a detailed level in localised places.

Digital innovation and integration – the pace of change in digital technologies has been phenomenal in recent years. Just a generation ago, smartphones seemed like a work of science fiction; now 90% of the adults in Birmingham own one and people manage much of their daily lives through them. We live in a world of genomic sequencing, big data analytics, artificial intelligence and autonomous vehicles. We have some centres of excellence in Birmingham and Solihull, with two NHS Global Digital Exemplars in our partnership. However, in general, health and social care has not yet been at the forefront of the digital revolution. Systems have developed in a fragmented way, which makes it hard for professionals to communicate smoothly with each other, and means patients have to tell their story many times to different organisations. This is both frustrating and inefficient. Many of the opportunities that lie ahead for better services, more convenience for citizens and patients and greater efficiency will depend on our ability to lead the way in the digital era, just as we did in the industrial era. We will harness digital technologies in ways that improve the experience for patients and the workflow of clinicians, and all of our developments will be driven by clinical engagement and patient participation. Our digital platforms and use of data (with appropriate safeguards) will exemplify our aspiration for integration and simplification, and our major commitment to working in partnership. To deliver on this priority, we will:

- Create a single electronic entry point (a 'digital front door') to make it easier for citizens and patients to access the right care, in the right place and at the right time.

- Empower people to be active partners in managing their care through secure online access to health advice, their records, test results and prescription and appointment details.

- Roll out the same leading edge and locally developed clinical information system to all of our hospitals, so that there will be a single, electronic patient record for all hospital based care. We will also work towards interoperability with patient records in primary and community care and in mental health.

- Support the development of real time communication platforms between primary and secondary care clinicians, and other professionals, so that patients can be managed in the most appropriate setting by virtual multi-disciplinary teams.

- Move towards secure electronic document transfer for communications between GPs and hospitals.

- Explore the potential application of artificial intelligence to provide reliable and efficient diagnostics, such as reading scans, and for the analysis of large data sets to inform business intelligence on local services and utilisation.

- Pilot a ground-breaking approach to using digital signs around the city for health campaigns and information.

Making the best use of the public estate – there are hundreds of separate health and social care sites across Birmingham and Solihull, ranging from large hospitals to localised clinics and care homes. Our NHS sites alone cover nearly 725,000m^2 of land. These sites have been built, acquired or leased over many decades, sometimes in a rather patchwork manner. Fifty six per cent of the NHS buildings are at least 25 years old and several are over 50 years old. Many are ill suited to the requirements of modern care and are in need of substantial maintenance. The way we plan, manage and use our public estates will be pivotal to our transformation from working as separate institutions to working as a single place in the best interests of our citizens and patients. The spread of our buildings give us huge reach across our geography and into our many communities. We need to use these public assets efficiently and in the collective interest. We will be much more innovative in how we use our estates, as well as other assets such as technology and our workforce, to make co-location of services the norm, so that citizens and patients do not have to trek from A to B, when they could have multiple needs met in a 'one stop shop'. To deliver on this priority, we will:

- Develop a single estates strategy for health and social care in Birmingham and Solihull.

- Use that strategy to prioritise the finite major capital investment that will be available in the coming years, both for new builds and the maintenance and redevelopment of existing sites.

- Compile a single, comprehensive dataset on our health

and care estates, so that we take decisions based on the best available evidence.

- Make best use of void or unoccupied space on our estate, where it is financially practical to do so, whilst recognising that we have relatively little unused space compared to other parts of the country.

- Increase the proportion of our major NHS sites that are used for clinical purposes, as opposed to non-clinical, making best use of shared back office arrangements and technological solutions.

- Develop the care centres in the community for older people to provide enablement support and a broad range of other services, as described above.

- Promote innovative and flexible practices in delivering services out of our current buildings and co-locating services around the needs and convenience of our citizens and patients, following the ethos of 'one public estate' and multi-disciplinary working.

- Ensure energy efficiency is a key design criterion in new build and major renovations.

Have your say

This updated strategy sets out our main proposals for how we will work together in a health and social care partnership across Birmingham and Solihull to meet the challenges and seize the opportunities ahead. Versions of this document are available on our website in other languages, or as an audio version on request.

It is most important now that we hear from everyone with an interest, including citizens, patients, carers, staff and community and stakeholder groups. There are a number of ways that you can comment on these proposals: face to face, in writing and online at the Live healthy Live happy Partnership website:
www.livehealthylivehappy.org.uk.
The website gives you the options to comment on the proposals by answering a series of questions in our structured survey, by typing free text comments or by uploading a document with your response.

We will hold a series of public engagement events across Birmingham and Solihull in the summer of 2018. The dates and venues are included on our website.

We will also approach directly representatives of some of the groups in our community who have been harder to reach by traditional consultation methods, so that we ensure everyone's voice is heard and so that we act on our commitment to tackle inequalities in health outcomes.

Once we have heard from as many people as possible in the summer and collated their views, we will publish revisions to this strategy based on that feedback in the autumn of 2018.

This strategy is about the health and happiness of everyone in Birmingham and Solihull. Please help us by having your say.

Live healthy Live happy Partnership

Birmingham and Solihull

End notes

[i]https://www.england.nhs.uk/systemchange/
[ii]There is a growing body of academic literature that promotes the measurement of subjective well being, or 'happiness' in more recognisable terminology (for example http://www.pursuit-of-happiness.org/science-of-happiness/measuring-happiness/ and http://www.happycity.org.uk/measurement-policy/about-measurement-policy/)
[iii]https://www.wmca.org.uk/
[iv]Fair Society Health Lives. Sir Michael Marmot. February 2010.
[v]https://www.gov.uk/government/news/government-to-set-out-proposals-to-reform-care-and-support
[vi]The Office for Budget Responsibility (OBR) estimates that spending on the NHS and long term care will need to increase from a combined 8.3% of GDP now to 10.7% of GDP in 20 years' time and 14.6% in 50 years' time. Office for Budget Responsibility. Fiscal Sustainability Report. January 2017.
[vii]Nuffield Trust, the Health Foundation and the King's Fund. The Autumn Budget: Joint Statement on Health and Social Care. November 2017.
[viii]House of Lords, Report of Session 2016-17. The Long-term Sustainability of the NHS and Adult Social Care.
[ix]House of Commons, Communities and Local Government Committee. Adult Social Care: Ninth Report of Session 2016-17. March 2017.
[x]Source: 2017/18 CCG Allocations, NHS England. April 2017.
[xii]https://www.england.nhs.uk/rightcare/
[xiii]NHS RightCare
[xiii]Best practice suggests that large procurements can deliver additional social value of at least 20% of contract value. https://socialvalueportal.com/
[xiv]House of Lords, Report of Session 2016-17. The Long-term Sustainability of the NHS and Adult Social Care.
[xv]https://www.nice.org.uk/guidance/ng12
[xvi]http://www.redthread.org.uk/
[xvii]http://www.dyingmatters.org/sites/default/files/user/documents/Resources/Community%20Pack/1-Introduction-1.pdf
[xviii]https://www.ageuk.org.uk/globalassets/age-uk/documents/booklets/talking_about_death_booklet_final_version.pdf
[xix]Prof. Dame Sally Davies. Annual Report of the Chief Medical Officer 2017, Health Impacts of All
Pollution - what do we know? February 2018.
[xx]NICE Air pollution: outdoor air quality and health. NICE guidance. 30 June 2017
[xxi]http://www.makingbirminghamgreener.com/
[xxii]http://webtest.solihull.gov.uk/Portals/0/Planning/Green_Prospectus_2017-18.pdf
[xxiii]https://www.sduhealth.org.uk/areas-of-focus/carbon-hotspots/travel.aspx
[xxiv]https://www.sduhealth.org.uk/delivery/measure/health-outcomes-travel-tool.aspx
[xxv]For ambulances and emergency vehicles, speed of response and turnaround will remain paramount, although this will become less of a barrier as battery technology advances.
[xxvi]https://www.kingsfund.org.uk/publications/hospital-activity-funding-changes

	Agenda Item: 7
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19th June 2018**
TITLE:	**ACCOMMODATION AND EMPLOYMENT (ADULTS WITH A LEARNING DISABILITY)**
Organisation	**Birmingham City Council**
Presenting Officers	**Melanie Brooks Assistant Director Adult Social Care** **Kalvinder Kohli Head of Service Adult Social Care Commissioning**

Report Type:	**For Decision**

1. Purpose:

The purpose of this report is to set out a new and systematic approach to addressing the accommodation and employment support needs for people with learning disabilities. There are two key proposals:

1) Establishing a coherent independent accommodation pathway that builds upon the work that is underway within the housing and homelessness sector both nationally and locally (Appendix 1 and 2)

2) Developing an equally coherent approach to supporting people with learning disabilities into paid work opportunities (Appendix 3)

Health and Wellbeing Priorities

Ref**: Improving stable and independent accommodation for those with a learning disability.**

Ref**: Improving the wellbeing of the most disadvantaged with specific reference to employment/meaningful activity and stable accommodation for people with mental health needs.**

2. Implications:

BHWB Strategy Priorities	Detect and Prevent Adverse Childhood Experiences	
	All children in permanent housing	
	Increase the control of individuals over their care through Integrated Personal Commissioning (Personal Health Budgets and Direct Payments)	
	Increasing employment/ meaningful activity and stable accommodation for those with mental health problems	Contributing
	Improving stable and independent accommodation for those learning disability	Yes
	Improve the wellbeing of those with multiple complex needs	
	Improve air quality	
	Increased mental wellbeing in the workplace	
Joint Strategic Needs Assessment		
Joint Commissioning and Service Integration		Contributing
Maximising transfer of Public Health functions		
Financial		
Patient and Public Involvement		
Early Intervention		Yes
Prevention		Yes

3. Recommendations
Health and Wellbeing Board are requested to:

1) Approve the development of an accommodation and support pathway for people with learning disabilities.

2) Approve a new employment indicator within the Health and Wellbeing strategy for people with learning disabilities.

3) Note the variety of funding streams and partners engaged in providing support employment support across the City.

4) Authorise the taking of urgent steps to ensure that these funding streams are properly coordinated and positive outcomes are maximised, alongside the development of a city-wide vulnerable persons' employment strategy.

4. Background

This papers attached (Appendix 1, 2 and 3) cover two related issues for people with learning disabilities in the City:

1) The need to develop an accommodation and support pathway for people with learning disabilities in the City which compliments and enhances the parallel work currently underway as part of the Housing Strategy and Homelessness Prevention Strategy Action Plans.

2) The need to ensure that a suitable and sustainable employment offer is available and accessible for people with learning disabilities. This approach also supports the new day opportunities strategy that is being developed.

5. Future development

Affordable and sustainable community based housing solutions that support adults and young people in transition with a learning disability need to be developed.

These need to be delivered in a systematic way, through a partnership of the local authority, housing developers, social and private landlords.

The recent additional investment in employment should be used to develop a clear plan to increase the number of adults with a Learning Disability in employment, in part by challenging existing culture and practices.

There is a connection between affordability of housing costs and access to employment.

6. Compliance Issues

6.1 Strategy Implications

These proposals mirror and parallel the delivery of both the Housing Strategy and Homelessness Prevention Strategy.

At present, the city has no coherent strategy to support vulnerable people considered to be the furthest away from the labour market into employment. This needs to be developed as part of the as part of the overall strategy for improving the employment indicators for vulnerable people.

The development of a new day opportunities strategy for the city will also highlight the need to improve access into paid work opportunities for vulnerable people.

6.2 Governance & Delivery

The delivery of the recommendations sits with the Health and Wellbeing Board. However, it must be noted that the nature and accountability of the delivery of the recommendations stems across the local authority directorates of Place, Economy. Adult Social Care, Children's Trust and wider partners organisations referenced within the reports.

Relevant scheduled Cabinet Report:

Adult Social Care and Health Strategy for Day Opportunities June 2018

ESF/ERDF Acceptance Report for the match funded PURE Project to support vulnerable adults into employment July 2018

6.3 Management Responsibility

Management responsibility will be jointly owned within the local authority in the following ways:

1) The Corporate Strategic Director for Adult Social Care and Health will facilitate a dialogue across the Council's Directorate, Children's Trust and with health and other external partners to identify key commitments.

2) The Assistant Director - Adult Social Care and Service Director for Adult Social Care Commissioning will ensure co-ordination between frontline social work practice and commissioning approaches.
3) The Assistant Director - Economy Directorate will support the development of a vulnerable person' employment strategy and broker the relationship with housing developers in the City.

6. Risk Analysis

There is a general risk that fewer vulnerable people will have the opportunity to live and work independently if these recommendations are not implemented.

Identified Risk	Likelihood	Impact	Actions to Manage Risk
#	#	#	#

Appendices

1. Accommodation and Support Pathway
2. Internal Management Team Briefing
3. Employment and Employment Support Opportunities for People with Learning Disabilities.

Signatures	
Chair of Health & Wellbeing Board (Councillor Paulette Hamilton)	
Date:	**19th June 2018**

Learning Disability and Supported Accommodation

Existing Supported Housing Provision:

Birmingham has a number of supported housing services for people with learning disabilities which cater for a range of needs and abilities. Provision comprises of supported living services, registered care homes and community based accommodation support models with visiting or some onsite support.

The models of provision are outlined below;

• **Independent/Supported Living**: Small units of accommodation, either purpose built with independent flats or using larger homes converted into bedsits or shared housing that allow a small group of adults with learning disabilities to live as independently as possible in a home setting. Support and care is provided with by a staff team based on site. Staffing, care and support levels will vary according to assessed client's needs, but will usually include waking night or sleep-in staff.

• **Visiting Support**: Support delivered to people in their own home within the community. Usually this will be rented accommodation (often social housing) and may be accommodation they occupy alone, accommodation within a block designated as supported accommodation or a house/flat shared with other people with similar needs. The level of support provided and frequency of visits will depend on the assessed needs of the client, but generally those receiving this kind of service will have greater levels of independence, will not require a constant staff presence and will be able to undertake a number of day to day tasks unsupervised (e.g. prepare meals, attend social activities, visit local shops).

• **Registered care homes**: Staffed facilities providing accommodation, meals and where needed, personal care (help with washing, dressing and giving medication). Staff at services will also arrange social activities within and outside the service and be able to accompany individual clients on outings and to appointments. These services are staffed 24hrs a day, every day and must be registered with the Care Quality Commission.

The tables below list the various independent/supported living services

The current housing related support provision has been commissioned following the development of a Housing Related Support strategy and an accompanying needs assessment. This includes a combination of supported accommodation with either on-site or visiting support, together with floating support for people living within independent tenancies across a range of tenures.

Housing related support provider	Number of supported accommodation units	Number of floating support service users supported per contract year
Accord Housing	8	152
Friendship & Care Housing	26	992

Birmingham Rathbone	100	240
Sanctuary Housing	35	0
Trident	30	0
Midland Mencap	0	1500

All commissioned services are on a payment by outcomes contracting methodology which has been co-designed with citizens and service providers.

Current Activity, Risks and Issues

Birmingham has approximately 4500 younger adults placed in accommodation with support. A large percentage of this cohort is placed within residential care.

The proportion of adults with a learning disability who live in their own home or with their family (2016-17) was 1,336 or 61.7%. The England average is 76.2%, so Birmingham's performance is clearly much worse than the average.

Adults placed outside of Birmingham

Birmingham has a large proportion of adults with a learning disability who are placed outside of the city's boundaries. As of May 2018, 235 Birmingham citizens are placed outside the city of which 23 are aged over 65. Historically, lack of provision in Birmingham, including provision for children, has led to people being placed away from home.

The Specialist Impact Team is funded for one year through the BCF to work with this cohort. The aim is to undertaken an asset-based review to understand the person's potential to move to more independent accommodation and where possible, return to Birmingham. To date, the team has identified eight citizens who should move to supported accommodation.

Assistive technology

Birmingham has not yet developed a coherent approach to utilising assistive technology for adults with a learning disability that enables them to live with greater independence. This is an issue that will be addressed in the Assistive Technology strategy, but is a barrier to impendence currently.

Shared Lives

The best performing Shared Lives schemes nationally support 10% of their adult learning disability population in Shared Lives schemes. Birmingham current supports 65 adults, which is less than 0.5%.

Shared Lives has undergone an improvement process and now has a recruitment strategy to build to 450 placements by 2020. This would deliver 10% of younger adults in placement are supported by Shared Lives schemes.

Transitions into Adulthood

Young people with learning disabilities transitioning from children's social care into adult social care access a range of accommodation settings including residential care. Similarly there is the opportunity to utilise a range of housing tenures with the appropriate levels of care and support best suited to the needs of the young person.

Ambition

The ambition is to support all younger adults in Shared Lives or Supported Accommodation or Independent Living unless there are physical care needs that require residential care.

The aim is to increase the numbers living in supported or independent accommodation and to ensure that wherever possible these are located within Birmingham.

There are a number of initiatives that bring together partners to deliver accommodation to this group – Transforming Care and the development of a positive homelessness prevention pathway. Yet there is not a single vision that enables stakeholders to do this effectively or to share a common understating of the risks that different options propose.

Adult Social Care proposes to develop a more coherent approach with partners, but requires the support of the system to do so.

What needs to happen to get there?

- The development of a positive accommodation and support pathway for people with learning disabilities and or mental health support needs.
- A gap analysis along the pathway to identify what needs to change or be realigned, remodelled to move towards the pathway.
- A dialogue with accommodation and support providers as part of the co design or delivery.
- A dialogue with the Economy Directorate with regards to future affordable housing developments in order to ensure that the requirements of people with learning disabilities are factored in. This will enable a more effective link to access to paid work enabled through affordable housing costs.
- Development of an overarching accommodation and support delivery plan

What does this look like - numbers, impact and outcomes?

- Greater numbers of people with learning disabilities living close to their communities and connections (less people placed outside of the City) and in more independent forms of accommodation across a range of tenure.

- Possible outcomes: Improved health and wellbeing, maintaining independence, greater focus upon access to employment as part of the accommodation offer.

- There are good transitions outcomes for young people related to their accommodation and options to live as independent as possible within communities.

What should HWBB do?

- Support greater connection with the housing sector across a range of tenure, including oversight of any house building programmes in order to ensure that the needs of people with learning disabilities are factored in.

What can HWBB track and influence?

- Retain oversight of future Prevention First commissioning for vulnerable persons housing support.

- Retain oversight and read across to the Housing Strategy Implementation and Homelessness Prevention Strategy action plan and positive pathway.

Accommodation and support proposal being taken through Council management teams

Purpose

This paper recommends that BCC develop an Accommodation and Support strategy sets out the reasons why the strategy is required.

Issues

Accommodation and support is a key priority for the following reasons:

- The Labour Group 2018 Manifesto promises to tackle homelessness. Good housing solutions and preventing people from becoming homeless in the first place will be key to delivering this aspiration.
- Citizens have identified Housing and Housing Support as a key outcome. This is detailed as the Prevention First Outcome within the Cabinet Report entitled Putting Prevention First, Delivering the Vision for Adult Social Care, which was approved by Cabinet in November 2017.
- Citizens continually tell us that the provision of accommodation and support to live independently is an issue across the city. This is also evident from the number of Members Enquiries we receive.
- The new social work model with it focus upon community based solutions (via Three Conversations) and locality working provides a good basis to explore greater independence for citizens in their housing options.
- Birmingham along with the other West Midlands Combined Authority Areas is Housing First pilot site. Learning from this work will support the boarder work around vulnerable groups and their housing solutions.
- While housing related support is different from social care, or housing management and advice, it is able to essential to support Social Care delivery and provision.
- To deliver the vision for Adult Social Care, we need to ensure we have an appropriate range of housing and support options for citizens located in the City.
- Within Adult Social Care and Housing, we commission and provide different aspects of accommodation and support, but without a clear approach or planning strategy as to what we expect watch element to deliver or how they relate. We have the building block to ensure that more people are supported as far as is possible close to where they live, connected with their community assets and family networks. There is an opportunity to establish a positive accommodation and support pathway specifically for people with learning disabilities and mental health support needs in line with best practice relating to homelessness prevention pathways.

Current Position

There is currently not a shared vision across partners as to how we will support the delivery of accessible and cost effective accommodation for vulnerable people. Currently social work practice is driving the choice of housing options, without a clear plan for how we will support decision-making for access to the spectrum of support from residential care to Supported accommodation to supported independent care.

Work is starting in relation to how we better transition young people from packages of children's social care into adult social care, which includes exploration of the full range of possible of accommodation and support options.

The market has developed Extra Care Housing and there is no clarity for Social Workers as to how best to utilise such resource for citizens. Evidence from the work of Specialist Impact Team and voids in the City suggests the lack of coordinated approach means that we are not utilising housing options appropriately.

Given the pressures on the social housing sector in the City, a step change is required for adult social care to move into considering broader, innovative tenure options including private rented sector, live and work schemes, home - share, modular housing and home ownership. Dependent upon the needs of the individuals these options could include some housing related floating support to help sustain the accommodation, retain a preventative community based approach and prevent or lower the of any crisis or higher cost interventions.

Recommendations

It is recommended that work takes place in partnership between Place, Adult Social Care Economy Directorate and Children's Trust to deliver the following:

1) An accommodation and support pathway for people with learning disabilities and mental health support needs. This could be through a co-design approach with existing supported accommodation and care providers across the different funding streams and citizens. This will enable the creation of an excellence pathway, determine the level and type of provision at each stage of the pathway and provide visibility for how citizens are able to access, exit and regain access according to their needs. The design of the pathway will be to enable independence at all stages. The pathway will then enable a focused discussion in relation to the gaps, what we need to do more of, less of in order to get VFM and good outcomes for citizens.

2) Learning from the work on positive pathways via the Homelessness Partnership Board and the Regional Homelessness Taskforce will need to be included in this work in order to ensure a read across with that work and also so that we maximise any opportunities.

3) Explore the different types of housing models and tenures that will be suitable for people with learning disabilities. Options should be truly affordable to the citizen and enable their participation in employment options. Housing costs should not act as a deterrent for getting people with learning disabilities into paid work.

Employment and Employment Support for People with Learning Disabilities

Purpose

This paper recommends that Birmingham City Council develop a vulnerable person's employment strategy for the City with a primary focus upon learning disabilities. The definitions and activities will include a range of preparatory activities including job related training, skills development, confidence and workplace orientation, volunteering, apprenticeships, taster sessions, as well as paid work.

Issues

Employment is a key priority for the following reasons:

- The Labour Manifesto promises to increase employment.
- Service users tell us that employment and being supported to gain and retain employment is important to them. Currently performance in the city for supporting adults with a learning disability is very low, less than 1% of that cohort is in paid work.
- Financial inclusion and income maximisation is a key prevention first outcome set out in the Putting Prevention First: Delivering the Vision for Adult Social Care Cabinet Report November 2017.
- The improved employment opportunities for people with learning disabilities must be integral to supporting any future model for day opportunities.
- Employment is a priority in the West Midlands Combined Authority, particularly in relation to mental health.
- Employment is integral to supporting adults to enjoy wellbeing, economic stability and recovery. To deliver the vision for Adult Social Care, we need to ensure we have an appropriate range of employment support options for citizens. This therefore needs to be embedded into practice via the new social work model.

Current Position

- There no shared vision or strategy across partners in the City as to how we will collaborate to support employment for vulnerable people furthest away from the labour market including those with learning disabilities.
- Work to review the current Day Opportunities provision in the city has shown a lack of pathways for employment, a lack of evidence based employment support, and a lack of service to support people to be ready for employment.
- There is no join up of commissioned employment support service for vulnerable people in the City. A number of historic services aimed at the most vulnerable citizens have ceased to exist. Similarly, there is space for an improved dialogue with DWP. Therefore whilst there is significant learning across the local authority and with external partners which has not been drawn together for maximum effect.

- There are a number of externally funded initiatives currently in place or due to be awarded shortly for access into employment, training and volunteering which are not being maximised in a coordinated way (European Funding ERDF/ESF). The funded model includes historic learning from across a range of agencies, support providers and citizens themselves in terms of what success looks like, the barrier that may be faced by people with learning disabilities and some evidence based practice on how these might be overcome.

- The short term nature of funding streams, lack of capacity or lack of expertise within employer organisations alongside a lack of impetus to drive the cultural change needed within organisations has contributed to low levels of employment across the country for people with learning disabilities.

Some further background

Performance for employment for adults with a learning disability in Birmingham is poor. The proportion of adults with a learning disability in paid employment (2016-17). The actual number is 21 and this is 1%. The England average is 5.7%.

Learning from historic employment projects for people with learning disabilities shows the following are crucial to successful engagement:

1) Onsite support within the employment environment to persons with learning disabilities

2) Onsite support to the employer

3) A systematic approach to generating paid employment opportunities. This could be across partner agencies (public and private sector) including commissioned providers and organisations doing business with the local authority and other key strategic partners.

There is a currently a lack of social work ethos in systematically addressing employment as part of the assessment and support planning process. This is being addressed via the three conversation work to develop social work practice.

There are nine Day Centres in the City. The centres are currently being reviewed by an external agency (NDTi) who has particular expertise in employment and day opportunities. This review will inform the Day Opportunities Strategy which Cabinet will consider in June 2018. It is expected that this will recommend how elements of day services will be reshaped to better support employment. The review is not complete, but has found that pathways to employment are broken and there are poor links between different employment schemes commissioned.

The Health and Wellbeing Board can provide support in a number of ways including:

1. Retaining oversight of the delivery and outcomes of all external funded projects and providing support through Health and Wellbeing Board member influences to ensure that the projects deliver to maximum effect. For example, the organisations

represented at Health and Wellbeing Board offering employment placements and providing a robust cross agency challenge and dialogue.

2. Provide influence to commissioned and non-commissioned organisations across the City to support this agenda.

3. Oversee the development of a sustainable vulnerable person's employment strategy for the City. There is also a read across to the work of the Combined Authority, West Midlands Wellbeing Board and West Midlands Mental Health Commission (Thrive Action Plan).

4. As per the recommendations below; consider the establishment of targets for an employment indictor for people with learning disabilities. This could be framed within the context of the employment strategy action plan.

Recommendations

- It is recommended that work takes place between Adult Social Care, Place and Economy Directorates, DWP and wider health partners to develop a vulnerable persons employment strategy which builds upon the learning so far both locally, nationally and across the European Funded Projects (where appropriate).

- It is also proposed that the delivery model set out in the pending ERDF for £6m is either adopted in its entirety or in part as the approach for improving the employment indicator for people with learning disabilities. The timescales for the ERDF funding as with any European Fund projects are tight and therefore by their nature provide an opportunity to focus on this important issue.

- It is recommended that Health and Wellbeing Board adopt a new indicator for the Health and Wellbeing Strategy for employment for people with learning disabilities. That a further dialogue takes place to propose targets and outcomes to help monitor progress.

	Agenda Item: 8
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19th June 2018**
TITLE:	**NHS BIRMINGHAM AND SOLIHULL CCG – UPDATE**
Organisation	**NHS Birmingham and Solihull CCG**
Presenting Officer	**Paul Jennings – Chief Executive**

Report Type:	**Update/Presentation**

1. Purpose:
To provide an update on the CCG's progress since the merger on 1st April 2018 and set the direction of travel for the organisation's future.

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

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

3.	**Recommendations**
	To receive and note the presentation.

4.	**Background**
	Board members have received presentations form the CCG over the past 12 months, regarding the transition and merger process.

5.	**Future development**
	N/A

6.	**Compliance Issues : -**
6.1	***Strategy Implications:***
	N/A

6.2	***Governance & Delivery***
	N/A
6.3	***Management Responsibility***
	N/A

7.	**Risk Analysis**		
N/A			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
#	#	#	#

Appendices	
1.	Presentation

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

Birmingham and Solihull
Clinical Commissioning Group

NHS Birmingham and Solihull CCG

Paul Jennings, Chief Executive

Where we are now

- Merging the three CCGs was the first step in the journey.
- A focus on making the right decisions for our population through:
  - Clinical engagement
  - Public involvement
  - Staff engagement
- Establishing our position in the STP.

Birmingham and Solihull CCG

Responsible for commissioning services for:

A budget of

£1.8 billion

(that's 2% of the overall NHS budget)

Two clear areas of focus:

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

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

Strategic commissioning

- Steering, not rowing.
- Population health management.
- Defining and articulating clinical pathways.
- Associating a budget for a population.
- Commissioning and contracting for outcomes.
- Defining and monitoring quality standards.
- Moving to a value-based contract.

Moving to integrated care

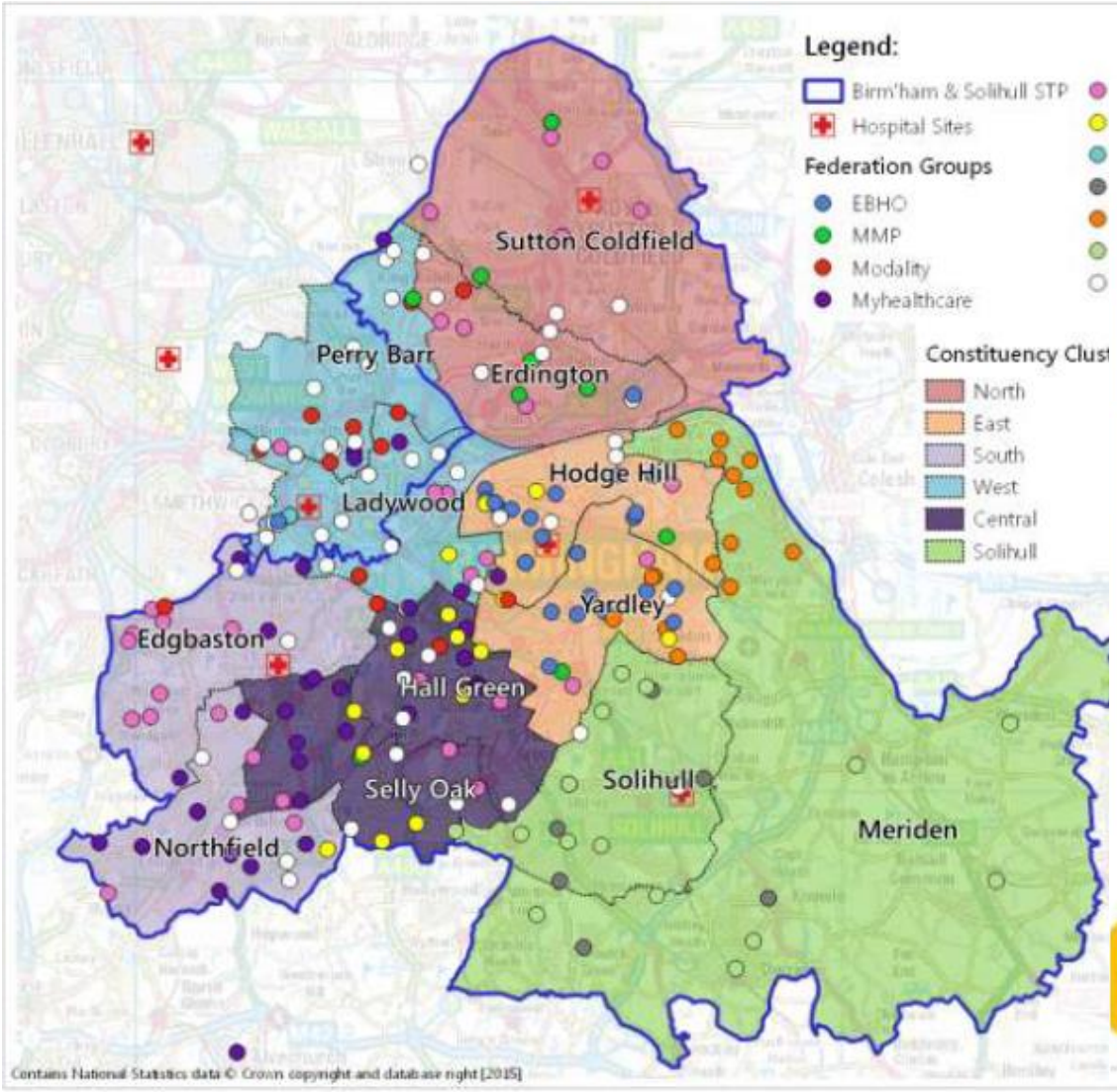
- Work as one care system to address population health management issues, with the LAs and third sector.
- Tackle the challenges faced by the health and care system in a collective way.
- Commission connected pathways of care.
- Remove organisational boundaries to create a care system that feels joined up.
- Shifts the focus from organisations, to populations, whole system and places.
- Supports the development of new care models.
- Ensure sustainability, now, and for the future.

How do we get there?

- Developing an organisational strategy.
- Removing organisational/geographical boundaries, with a united approach across all partners.
- Challenging and changing the status quo.
- Defining who we are as an organisation, through developing clear ambition and values.
- Developing a clear organisational development plan.
- Engage in the NHS England integrated care system support programme.

Overview of localities

- To enable ‘place-based’ commissioning we have organised the Birmingham and Solihull patch into six localities:
  - North
  - East
  - South
  - West
  - Central
  - Solihull



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

The Strategy Unit

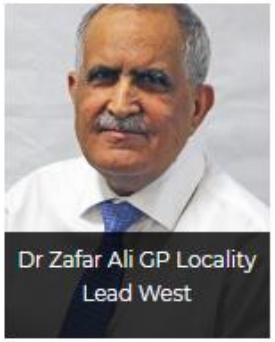
** of patients registered to the practices aligned to each constituency cluster*

Governing body


Dr Peter Ingham
Clinical Chair


Sir Tony Hawkhead
Independent Vice Chair


Paul Jennings Chief Executive


Dr Zafar Ali GP Locality Lead West


Dr Olav Van Loon GP Locality Lead North


Dr Rizwan Alidina GP Locality Lead East


Dr Sonia Ashraf GP Locality Lead Central


Dr John Davenport GP Locality Lead Solihull


Dr Clare Elliott GP Locality Lead South


Phil Johns Chief Finance Officer


Rhod Mitchell
Independent Member


Anita Bhalla
Independent Member


Stephen Beck
Independent Member


Qulsom Fazil
Independent Member


Karen Helliwell
Director of Integration


Rachel O'Connor
Director of Planning and Performance


Stan Silverman
Secondary Care Consultant


Carmel O'Brien Chief Nurse


Dr Richard Mendelsohn Chief Medical Officer


Paul Sherriff Director of Organisational Development and Partnerships

Thank you for listening.
Any questions?

	Agenda Item: 9
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19th June 2018**
TITLE:	**BIRMINGHAM BETTER CARE FUND (BCF) PLANNED SPEND FOR 2018/19 INCLUDING THE IMPROVED BETTER CARE FUND (IBCF)**
Organisation	**Birmingham Better Care Fund**
Presenting Officer	**Margaret Ashton-Gray**

Report Type:	**Decision**

1. Purpose:

1.1 The Better Care Fund (BCF) is a continuation of the Government's initiative to support NHS organisations and Councils in the creation of an integrated health and care system locally.

1.2 The iBCF – a local authority section 31 grant is in its second year and is required to be part of the BCF pooled fund

1.3 Integrated working promotes a system-wide approach to improving health and wellbeing, which contributes to the Council's outcome framework, and will also contribute to the creation of a sustainable health and care service in the local area.

1.4 The Better Care Fund has been improved in this current financial year following additional planned assistance from the Government to recognise the continued growth in demand for health and care services.

1.5 A BCF plan was approved in 2017/18 which determined the spending plans for 2 financial years – namely 2017/18 and 2018/19.An agreed plan is a requirement of the policy framework agreed by the Department of Health (DH) and the Department for Communities and Local Governments (DCLG), developed in partnership with the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS) and NHS England.

1.6 This is the fourth Better Care Fund plan for Birmingham. It builds on the plans and progress of the previous three years and has been agreed by the Birmingham BCF Commissioning Executive, Birmingham and Solihull Sustainability and Transformation Plan (STP) Board.

2.	**Implications:** # Please indicate Y or N as appropriate]	
BHWB Strategy Priorities	Child Health	
	Vulnerable People	Y
	Systems Resilience	Y
Joint Strategic Needs Assessment		Y
Joint Commissioning and Service Integration		Y
Maximising transfer of Public Health functions		
Financial		Y
Patient and Public Involvement		Y
Early Intervention		Y
Prevention		Y

3.	**Recommendation**
	Board members are asked to approve the spending planning template.

4.	**Background**
4.1	The BCF plan was approved in 2017/18 for 2 financial years therefore there is not a requirement to produce a further narrative plan in this financial year. This report seeks to inform and gain approval from the Health and Wellbeing Board for the planned spending of both the BCF and iBCF for the 2018/19 financial year.

5.	**Compliance Issues**
5.1	***Strategy Implications***
	Health and Wellbeing Boards have overall responsibility to ensuring the integration of health and care functions within their localities and it is a requirement of the BCF that local plans are agreed by Health and Wellbeing Boards.
5.2	***Governance & Delivery***
	Governance arrangements include the Better Care Fund Commissioning Executive Board, and link firmly with the STP plans for Birmingham – BsoL

	and the Black Country STP areas, , Adult Social Care, and NHS Commissioning Reform.
5.3	***Management Responsibility***
	Louise Collett Service Director Commissioning

6.	**Risk Analysis**
	A detailed Risk Assessment was included in the previously approved narrative plan

Appendices	
1.	Birmingham Integration and Better Care Narrative Plan 2017/19
2.	BCF spending plan for 2018/19
3.	iBCF spending plan for 2018/19
4.	iBCF Outturn Finance Report 2017/18
5.	BCF Outturn Finance Report 2018/18

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

Birmingham Integration and Better Care

Narrative Plan - 2017/19

Table of Contents

1. Approval and Sign Off

KLOE

- The 2017-19 Birmingham Better Care Plan has been approved by the Birmingham BCF Commissioning Executive following engagement with the BSol STP Board and SWB (Sandwell and West Birmingham) Strategic Commissioning and Redesign Committee prior to receiving final sign off by Birmingham Health and Wellbeing Board. — 1, 37

- To support assurance, the Plan has also provides evidence that the **Key Lines of Enquiry (KLOE)** have been met in a way that makes sense to assurers as well as partners and the public. The KLOE's are outlined in Appendix 1.

1.1. Summary of plan

- This is the third Better Care Fund (BCF) Plan for Birmingham and builds upon previous ones. We have reframed our approach to delivering the vision, learning from and applying, local and national evidence. There are two key differences between this and our previous plans. Firstly, we are further developing the focus on preventing and delaying the need for care – *keeping people well where they live*. Secondly, our approach will embed the BCF across current city wide Health & Social Care transformation programmes, all of which are led by key Birmingham 'system' leaders. — 15, 18

- This is in contrast to creating a separate plan, with separate, standalone governance with limited ownership. The plan shows our four key priorities are:

    1. **Integrated urgent and emergency care**
    2. **Stabilisation and transformation of social care Birmingham**
    3. **Integrated care & support for people who want to remain independent**
    4. **Commissioning reform**

- The Plan has a particular focus on;
'***keeping people well at home for longer and when they are in need of health and social care provision ensuring our services are integrated enough to provide seamless provision***'

- To support assurance, we have referenced and provided direct links to planning documents that are currently in the public domain - either 'signed off' through NHS or Birmingham City Council processes. We will continue to 'sense check' with all our partners throughout the life of this plan. — 1

1.2 Budget/Pooled funds

- Delivery of the BCF Plan is supported by a pooled budget of £132.7m for 2017/18 and £147.6m for 2018/19. Included in this allocation is the iBCF grant allocation of £33.792m for 2017/18 and £47.327m for 2018/19. Pooled funding amounts are outlined in Table 1. — 27

KLOE

Table 1 Planned Funding Analysis for 2017/18 & 2018/19

	2016/17 (£)	2017/18 (£)	2018/19 (£)	KLOE
				1
Local Authority Contribution	**14,103,000**	**11,392,294**	**12,019,620**	
iBCF Contribution	**0**	**33,792,214**	**47,327,714**	
Minimum CCG Contributions	**75,939,917**	**77,299,241**	**78,767,927**	
Additional CCG Contributions	**11,559,327**	**10,178,754**	**9,479,955**	
Total BCF Pool	**101,602,244**	**132,662,503**	**147,595,216**	

Planned Funding Analysis for 2017/18 & 2018/19

	2016/17 (£)	2017/18 (£)	2018/19 (£)	KLOE
				15
Local Authority Contribution	**14,103,000**	**11,392,294**	**12,019,620**	18
iBCF Contribution	**0**	**33,792,214**	**47,327,714**	
Minimum CCG Contributions				
Birmingham Cross City CCG	*47,735,704*	*48,590,174*	*49,513,387*	
Birmingham South & Central CCG	*16,411,906*	*16,705,679*	*17,023,087*	
Birmingham South & Central CCG Practice Transfer Adjustment	*0*	*468,694*	*468,694*	
Sandwell & West Birmingham CCG	*11,792,306*	*12,003,388*	*12,231,453*	
Sandwell & West Birmingham CCG Practice Transfer Adjustment	*0*	*(468,694)*	*(468,694)*	
Minimum CCG Contributios	**75,939,917**	**77,299,241**	**78,767,927**	
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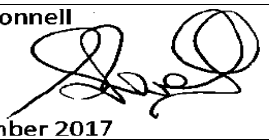
Total BCF Pool	**101,602,244**	**132,662,503**	**147,595,216**	

1.3. Approval and Signatures

Birmingham City Council Interim Corporate Director for Adult Social Care and Health	Name: Graeme Betts Signature  Date 11th September 2017
Birmingham City Council Section 151 Officer	Name: Mike O'Donnell Signature  Date 11th September 2017
Signed on behalf of Birmingham CCGs Interim Chief Executive	Name: Paul Jennings Signature  Date: 11th September 2017

Signed on behalf of Health & Wellbeing Board Cabinet Member for Health and Social Care	Name: Cllr Paulette Hamilton Signature  Date 11th September 2017
Signed on behalf of Sandwell & West Birmingham CCG Accountable Officer	Name: Andy Williams Signature  Date: 11th September 2017
Better Care Fund Lead Officer & Service Director for Commissioning	Name Louise Collett Signature  Date: 11th September 2017

KLOE

4

KLOE

2. Our vision

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- The BCF will support the Birmingham Vision for Integration. By 2020:

Birmingham will have an integrated health and social care system that will ensure:

- The most vulnerable people are supported to improve their health and wellbeing
- People are enabled to stay independent as long as possible
- We support people to effectively manage their conditions themselves but easily get help when they need it
- We support people to remain active members of their communities for as long as possible
- We support communities to be healthy and well for as long as possible
- Crises are managed better, only utilising hospitals and long term residential care when needed
- We improve the resilience of our health and care system

- The vision was built on the Birmingham Health and Wellbeing Strategy[1] and the national Think Local, Act Personal - Making it Real framework[2] developed locally through engagement with Birmingham City Councillors, Health partners, members of the public, experts by experience, providers, commissioners and other practitioners.

- The Vision has been revised for 2017-19 to reflect interdependencies across the current system, including, the Birmingham City Council Vision and Plan[3], Birmingham and Solihull Sustainability and Transformation Plan[4] and the Birmingham improved Better Care Fund (iBCF) plan[5].

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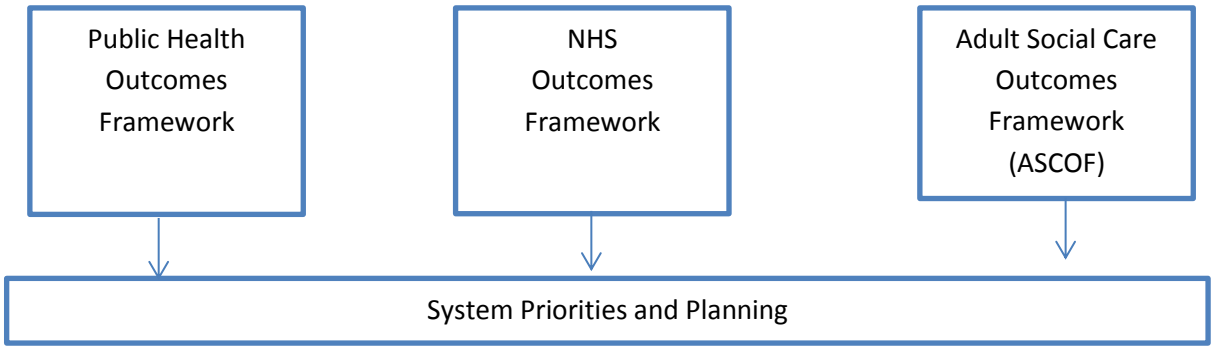
- It remains underpinned by the Birmingham JSNA function which provides a useful oversight and comparison of how the Birmingham health and social care 'system' is performing now, utilising nationally set indicators. The indicators are brought together in the form of three key national frameworks which are:



[1] Birmingham Health & Wellbeing Strategy http://hwb.birmingham.gov.uk/health-and-wellbeing-strategy/
[2] New guide for person-centred support https://www.thinklocalactpersonal.org.uk/News/New-guide-for-person-centred-support-for-people-with-experience-of-supported-housing/
[3] https://www.birmingham.gov.uk/downloads/file/1543/strat1_sustainable_community_strategy_birmingham_2026_2008pdf
[4] Birmingham and Solihull Sustainability and Transformation Plan https://www.birmingham.gov.uk/downloads/download/1008/birmingham_and_solihull_sustainability_and_transformation_plan
[5] Birmingham Improved Better Care Fund Proposals <<link>>

3. Background factors and context to the plan

	KLOE
• There were a number of key challenges in Birmingham during 2016/2017 that have helped to form a view for future planning. Acknowledging these challenges helps support the rationale for our future approach, which is outlined in this plan.	17
• From a policy perspective, 2016/17 saw the introduction of the Sustainability and Transformation Planning (STP) processes by NHS England. Despite commitments to integrate the BCF into this process locally, it has proved challenging to do so in reality in 16/17 for the reasons outlined below.	14
• Firstly, there have been significant changes in organisational form and system leadership in Birmingham:	17
a. Practically this means that only one member of the original BCF Commissioning Executive remains in post. This has provided both an opportunity to develop new relationships and go 'back to basics' whilst ensuring current momentum is not lost.	
b. The Chief Executive of the University Hospitals Birmingham Foundation Trust and interim Chief Executive of the Heart of England FT, Dame Julie Moore, has been confirmed as the BSol System Leader and has made the improvement of services and experience for older people across the system a clear priority.	
c. Under interim senior officer leadership at Birmingham City Council proposals are advanced for the stabilisation and modernisation of adult social care as part of the journey to integration. This will link directly with the STP - and the BCF will support this work from both social work and commissioner perspectives.	
d. There are also significant changes taking place within CCGs as part of the proposed creation of a new health commissioning organisation to cover the Birmingham and Solihull CCG's/ current Birmingham Solihull STP footprint. A single interim Accountable Officer came into post in August 2017.	
e. In addition, the introduction of A&E Delivery Boards to oversee emergency and urgent care system resilience in recent months also brings an interest in some elements of the BCF programme and we are currently rationalising plans to avoid the issues of duplication and multiple priorities which the BCF plan delivery has previously faced. This is reflected in the proposed governance framework.	17
f. System leaders firmly believe that working together in a different way – around an approach to accountable care, will help improve the health and wellbeing of and services offered to our populations. In order to do this new relationships and levels of trust continue to develop and this remains work in progress. With the STP is starting to gather momentum and offering an opportunity in a way that has not happened before.	17

KLOE
- The implementation of iBCF will be critical to the current issues of winter planning and medium to longer term transformation of place/primary care to meet need (iBCF area 1), urgent and emergency care systems (iBCF area 2) and sustaining the social care provider market (iBCF area 3).	17 27
- There will be a focus in 17/19 on building on the learning from the previous BCF pilots and developing sustainable funding models. This is being done in collaboration with the Local authority and the third sector as part of a review of currently commissioned third sector services (including 'out of hospital' pathways), and exploring new sources of funding, including charitable funding, or the use of social impact bonds, which are being explored in neighbouring economies as part of the development of a clear asset based 'offer' that supports diversion from and avoidance of social care.	2
- It is planned that the implementation of the Clinical Utilization Review tool and the work with Newton, as part of the Crisis and Recovery Strategy, will create the infrastructure for the system wide change needed to support the development of the 'High Impact change' approach in Birmingham. This is fundamental to the BCF plan and to iBCF as well as to STP and A&E Delivery Board planning, in terms of supporting system change. They will support better patient flows (including in hospital social care), acute 'front door' services, timely discharge and 'out of hospital' support, and will contribute to the implementation of 7 day working as well as taking account of more 'at risk' cohorts such as those with dementia or frailty.	
- The work around informal carers and the ongoing implementation of the local Dementia Strategy will also add to the infrastructure for the development of 'preventative' capacity in communities & the building of community resilience.	24
- This plan continues to deliver the initial aspirations of the 15/16 BCF, namely: o Keeping people well where they live o Looking after people better when crises occur o Making the right decisions when people can no longer cope	

4. Health and Social care integration

- The changes to key leaders within the system and their coming together has enabled us to define what health and social care integration means for Birmingham.	
- Nationally, Health and Social Care integration has been attempted by successive Governments since the mid 1990's, organisational and cultural differences as well as financial challenges have limited progress on this front, so much so that the Better Care programme remains the only national policy with a primary mandate for integration. At a local level, integration in Birmingham has been influenced by a number of factors that are not uncommon in other areas of the country. Acknowledgment of these challenges has helped Birmingham form a fresh view on our approach to integration: o *Organisational sovereignty and financial balance:* Birmingham has a single Council responsible for a population of 1.3 million people. Its social care provision operates	17

KLOE

within a clearly defined geographical boundary. This is complimented by three acute NHS Providers, one Community Healthcare Trust, one Mental Health Trust, and three NHS commissioning organisations. Each organisation has its own culture, governance and financial accountability arrangements. Birmingham's system faces a huge future funding gap, that gap is not collectively owned, but is owned at individual organisational level.

- *Different financial incentives:* NHS healthcare providers in Birmingham are currently paid for each patient seen or treated which, it has been highlighted nationally encourages increased hospital activity, whilst integration attempts to reduce hospital activity. As well as this the misalignment of financial incentives is a barrier to integration.

- *Different funding models:* NHS treatment is free at the point of use, whilst local authority social care is means-tested. This is a well acknowledged conflict over funding and funding eligibility for patients between the two services.

- *Information sharing:* Ideally, a patient's care record would move with them through the Health and Social Care system, but frequently, there are differences between organisations regarding the interpretation of information sharing frameworks. Whilst there are some good examples in Birmingham, interpretation has affectively complicated consistency.

- *Competing policy priorities:* Recent national reforms have focussed on promoting citizen choice and control. This, in turn, has promoted competition within the NHS, making coordination of care across multiple providers more difficult. Also, concerns have been raised nationally regarding how the Better Care Programme and the Sustainability and Transformation Plans (STPs) interrelate.

- *Geographical Boundaries:* Around 20% of Birmingham residents live within the Sandwell and West Birmingham CCG (SWBCCG) footprint and this CCG currently sits within the Black Country STP meaning this BCF sits within 2 STPs. This is currently managed through SWBCCG having associate membership of the Birmingham and Solihull STP.

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- Given the challenges outlined, the 2017/19 Better Care Fund Plan for Birmingham has been reframed. System leaders across Birmingham have agreed that at present Birmingham will ***not aim to change organisational form as the key delivery vehicle for integrated services*****.** Our reframed approach will focus on promoting the principles of integration and integrated planning to ensure that the services provided:

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  - Are integrated from the point of view of citizens and service users
  - Improve the quality of life of Birmingham citizens
  - Promote the independence of adults
  - Focus on maintaining the participation of the citizen in the community in which they live
  - Protects and improves the safety of vulnerable people

KLOE

- Improves the quality of services
- Best anticipates needs and prevents them arising
- Makes the best use of the available resources, including people and other resources

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- The BCF programme and plan will be repositioned to facilitate integrated working, complimenting existing key local programmes and priorities.

5. Understanding Birmingham

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- A gap analysis, undertaken during 2016/17 as part of the STP process, has further enhanced the understanding of the challenges outlined in our previous BCF plans. The work was supported by the Birmingham JSNA and focussed on three key areas of; Health and Wellbeing, Care Quality and Financial Sustainability:

5.1. Health and Wellbeing

- Birmingham is a very diverse city, with 22% (238,313) of residents born outside the UK and 103,682 of these arrived in the UK since 2001. This diversity is reflected throughout our communities, for example, almost 40% of Bordesley Green, (38.3%), Sparkbrook (38.1%) and Washwood Heath (36%) ward residents report a main language other than English, compared with the Birmingham average of 15%. Overall, over 130 different languages are spoken in Birmingham schools. We have significant levels of educational and economic migration with 65,000 university students in the city. This diversity can present particular challenges in matching provision to need.

- In addition, the city is ranked the 9th deprived Local Authority in the UK. Over three quarters of the city is in the most deprived 40% of areas nationally, 430,000 people live in the most deprived 10% of areas nationally. The level of child poverty in Birmingham is worse than the national average; with 29.9% of children under 16 years in the city living in poverty. This is equivalent to 144,000 children living in the bottom decile. Almost one in five households in Birmingham suffers fuel poverty compared to an England average of around 10%.

- Birmingham men have a life expectancy of 77.6 years compared to 82.2 years for women. This compares to national figures of 79.4 and 83.1 years respectively.

- Life expectancy also varies greatly for males and females depending where in Birmingham people live. For example, men in Shard End (an area of high deprivation) live ten years less than men living in the mostly affluent area of Sutton Four Oaks (72.8 vs 83.4 years) demonstrating the stark inequalities that exist across the city.

- In addition, healthy life expectancy is lower than the national average at 58.8 years for men and 60.5 years for women compared to 63.3 and 63.9 years. The main causes of excess years of life lost in Birmingham, when compared to England have been identified as: Infant Mortality, Coronary heart disease; Lung cancer; Alcoholic liver disease; Stroke; COPD and Pneumonia.

KLOE

- Looking to the future, Birmingham's population is also projected to increase by 146,000 (13%) over the next 20 years. By 2035, the proportion of people aged 65-84 will increase by 35% and people aged 85+ by 75%.

19

- The diversity, poor health, stark inequalities and projected population growth in Birmingham are all key influences on demand for health and social care services. This means that the key critical challenges are to improve population health and the way in which support is configured. Unless this is achieved, pressure and demand for services will continue to increase.

19

- Improving the 'average' of population health of Birmingham will obviously be beneficial, but the key focus needs to be 'reducing the gap'. Birmingham has nearly half its population (c440, 000) living in the lowest decile of deprivation within the country. Within this population there are significant and shocking issues relating to health outcomes. Our 'life at the bottom' presentation below outlines this:

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- In summary, the key challenges facing Birmingham in terms of health and wellbeing are finding ways to support and embrace the diversity of our population alongside the issues of deprivation and inequalities and changes in demography.

KLOE

5.2 Quality Gaps

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- The additional quality challenges faced within our system are emphasised when key interfaces within the system are considered:

PRIMARY CARE – ACUTE CARE – POST ACUTE CARE INTERFACES

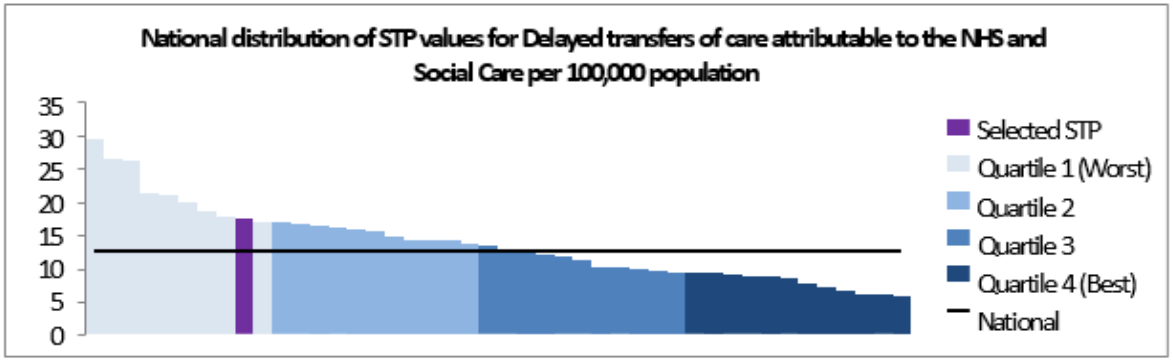
This relates to key 'touchpoints' or hand-off's between the sectors e.g. primary care to the acute sector or from the acute sector to community or social care. Analysis on total spend shows that 8% of the over 65s account for 62% of total spend - which reflects the significance of these touch points.

A & E ADMISSIONS

- There is a growth in emergency admissions for ambulatory care sensitive conditions (currently 940.8 per 100,000 population).

DELAYED TRANSFERS OF CARE (DTOC)

- Delayed transfers of care attributable to the NHS and Social Care across the LDP is 17.39 per 100,000 population (worst performing quartile nationally)



A AND E ATTENDANCES

- In 2015/16 Local analysis identified Birmingham Cross City and Birmingham South and Central CCG as above for average emergency admissions – further analysis indicated many of these admissions were unnecessary.

CHC AND DOMICILIARY SERVICES

- There are significant challenges with available capacity as well as variability in quality of care in nursing homes and domiciliary care
- There is also a need to improve quality assurance in relation to personal budgets

PRIMARY CARE

- The Birmingham and Solihull CCG's combined have the second lowest ratio of GPs and Practice Nurses per 100,000 population (0.53). The respective figures are Birmingham CrossCity CCG 0.48, Birmingham South and Central CCG 0.65 and Solihull CCG 0.56

- The quality and outcomes of Birmingham's Adult Social Care system (which reflects how health, social care and wider support is joined up) is poor. Using ASCOF as the key indicator, Birmingham is ranked in the bottom 3% in the country and has been for over 5 years.

KLOE

- We acknowledge that the improvements made against national metrics in year 1 of the BCF, except avoidable emergency admissions, have not been sustained against an increase in demand and this is why we are changing our approach.

- We are also working to further understand what is driving our local position around delayed transfers of care in both health and social care settings. Whilst these can affect inpatients of any age, there is evidence that the majority of patients experiencing delayed discharges are elderly. Utilising the business intelligence functions of both the NHS and Local Authority, analysis has shown that 70% of the patients experiencing delayed discharges were aged 70 years or more, and 51% were aged 80 or more. Whilst we have made some progress with this age group the cohorts are still seen as a significant factor in DToC's. Further analysis is outlined in section 14.

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5.3 Financial Gap

- The overall financial gap identified for the system by 2020 within the BSol STP, which included adult social care, was c £730 million. Much of this is driven by rising demand linked to the challenges of health and wellbeing of Birmingham citizens and the variation in quality of services. The financial gap is the equivalent of opening a new hospital with over 400 beds. Birmingham City Council had overall cost pressures of c.£60m in 2016/17, resulting from externally driven cost pressures; significant challenges in delivering annual agreed savings; and additional growth in care packages and prices. Extrapolating the savings gap to 2020/21, Birmingham City Council faces an overall gap of £123m within the BSol STP footprint for Adults, Children's, and Public Health services.

- When we consider how we spend our resource, indicative patient segmentation[6] shows that Birmingham spends most money on the healthy adult (16 – 69) patient group. That said, there are groups where both the volumes and the average spend per capita are high, these are; adults with 1 Long term condition (LTC), adults with 2 or more LTC and people >70 years of age with 2 or more LTC. These groups are most likely to benefit from integrated care.

- There is evidence that in Birmingham there is ongoing growth in emergency admissions for conditions which would not usually need a hospital stay. For example, for conditions such as dementia where issues arise, the default often is an acute admission - when evidence suggests there could be more suitable alternatives[7].

- Although there are increasing pressures on social care 'disability free life expectancy' at age 65 has been falling from its peak in 2010-12. It increased significantly between 2005-07 and 2009-11, however, since then men have lost 66% of the gains made earlier in the decade and women have lost 60%. In addition, there are huge socio-economic differences in disability free life expectancy at age 65 – a fivefold difference between people in the poorest and most affluent areas – e.g. a woman aged 65 has an expected 3.3 years of healthy living in the most deprived areas of the city compared to 16.7 years in the most affluent.

[6] Birmingham JSNA
[7] https://www.kingsfund.org.uk/sites/default/files/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010.pdf

KLOE

- Social Isolation is likely to become a significant issue, with more people are living alone - by 2032 11.3 million people in the UK are expected to be living on their own, more than 40 per cent of all households, (with the number of people over 85 is expected to grow from 573, 000 to 1.4 million[8]).

- In summary, the most pressing challenges for Birmingham relate to poor quality outcomes, variable service quality and financial pressure. From a system and population view this has amplified by;

  I. A fragmented urgent health and care system which drives people to default to A&E departments,
  II. A poor offer for frail individuals, particularly in an urgent situation which drives hospital care and, for too many, subsequent long term care
  III. The need to improving the capacity and quality of primary care
  IV. The need to modernise and transform adult social care and Continuing Health Care approach

- The STP has helped act as an additional support for delivering greater service integration and integrated commissioning at a faster pace across the health and social care system. Commissioning reform is taking place in response to challenges faced by local health and care systems reflecting the changes locally with the decision of the CCGs to establish a single commissioning voice in Birmingham and Solihull.

16

- In the past year progress made against key contributory indicators such as the reducing rates of emergency admissions and reducing Delayed Transfers of Care (DTOC) have not matched expectations; too many citizens still lose their independence and live in residential/nursing settings and the quality of care provided in those settings varies; the quality & availability of care and support in the community again varies too much; and those families, friends and communities that care for those who need support often need better support themselves.

- Our most significant medium to long term challenge collectively is to better promote health and wellbeing and better support for individuals within the communities that they live, in the context of current health inequalities and deprivation.

- Our most significant immediate challenge is to reform our urgent care system and stabilise and transform adult social care & primary care.

[8] https://www.kingsfund.org.uk/projects/time-think-differently/trends-demography

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6 Our approach

- The second BCF plan identified a range of challenges in delivering the agreed programmes to achieve the integration of health and social care in Birmingham. Since then, in addition to the STP, significant changes have taken place within the Birmingham organisations which have provided an opportunity for a new approach. Whilst building on the approved Better Care Fund plan for 2016/17 this plan builds upon the benefits of the changes in organisational form and changes in key system leadership. These changes have enabled us to refocus and set a different, positive tone for collective change; creating a firmer platform for the progressive integration of health and social care services.

- The key challenges facing us have already been outlined in Section 4, which have helped inform our priorities:

    - *Our most significant medium to long term challenge collectively is to better promote health and wellbeing and better support for individuals within the communities that they live, in the context of current health inequalities and deprivation.* This will be delivered through our integrated care and support for people who want to remain independent STP programme. The development of sustainable high quality general practice health services are a key interdependency in this programme.

    - *Our most significant immediate challenges is to reform our urgent care system and stabilise and transform adult social care*. These will be delivered through delivering integrated care and support for people who need urgent and emergency care programme and a BCC Social Care programme identifying interdependencies were they occur.

6.1. The Contribution of the BCF

- The BCF will contribute to these changes through these programmes:

- Through a joint commissioning approach within the *'Integrated care and support for people who want to remain independent'* STP programme, developing a single approach to community assets and the voluntary and independent sectors, including housing. In addition, to develop clear pathways for people with dementia, at end of life and for informal carers across the area. This will help support people to remain at home and reduce pressures in secondary care as well as enhancing the quality of life and care for citizens. It will also contribute to improving the quality of care in care homes through evaluation of existing pilots.

2

- The development of integrated community services together general practice, community nursing and social care (this list is not definitive) through the Integrated care and support for people who want to remain independent STP programme.

- The reconfiguration of services to an integrated out of hospital recovery, rehabilitation and re-ablement (RRR) care system and offer for frail individuals; and the joint commissioning actions required to support this, through the Integrated care and support for people who need urgent and emergency care STP programme. This programme will include the joint assessment of long term needs – continuing healthcare and social care.

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- The Improved Better Care Plan (iBCF), for which additional Local Authority funding which was announced in the Spring Budget 2017). This was provided for the purposes of:
    - Meeting adult social care needs;
    - Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and
    - Ensuring that the local social care provider market is supported.
- The iBCF programme will contribute to all programmes.

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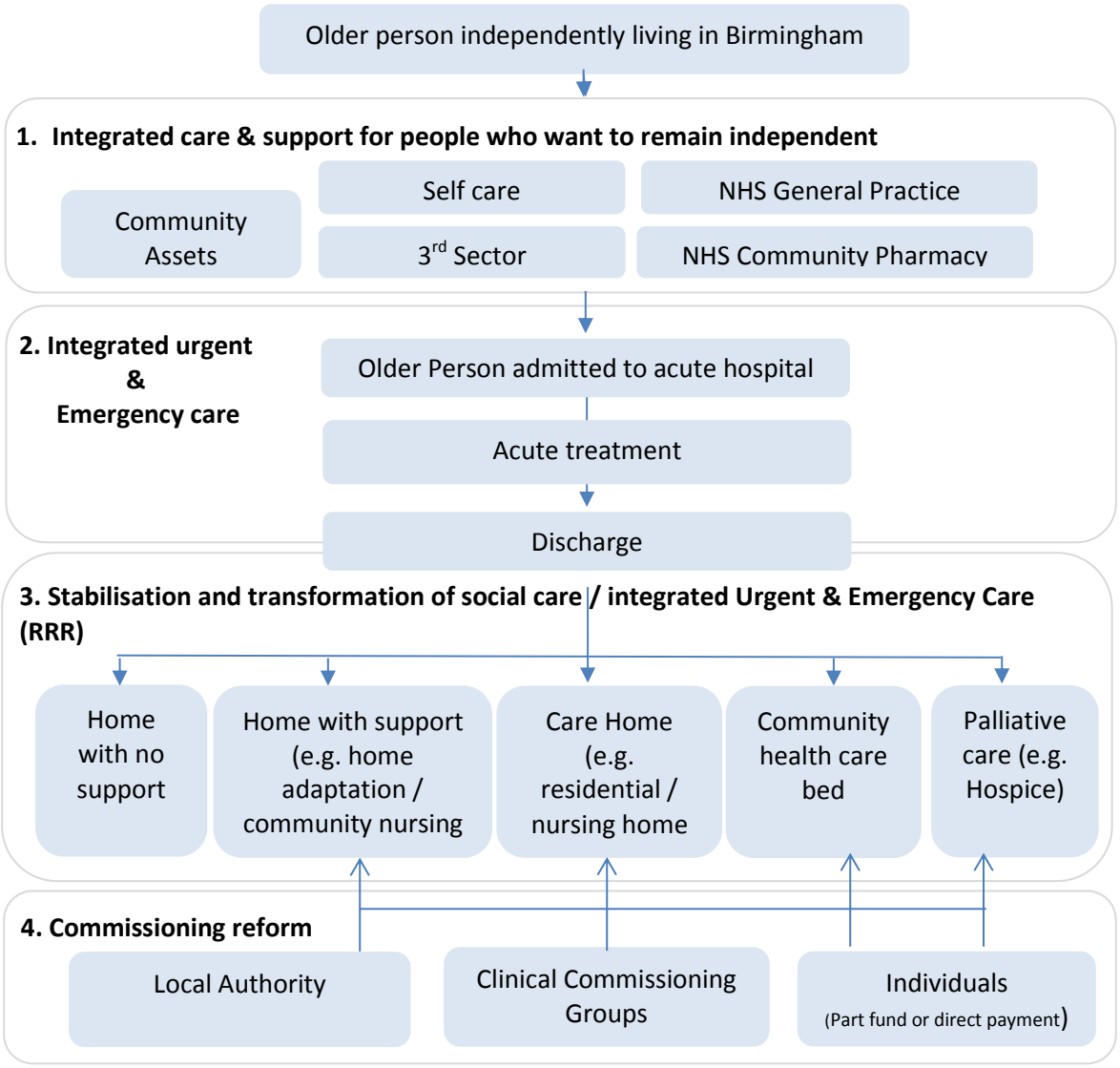
- Our approach will focus on the Birmingham citizen, keeping them as independent for as long as possible. If citizens require support to retain or regain independence, they will be able to find this support in their own community. If further support is required from our health and social care system it will be provided promptly, and it will be of good quality. This is why we have chosen our 4 key priorities. Our 4 priorities will impact on both the Birmingham citizen and the health and social care system:



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- Our Plan will also ensure continuous progress is made across Birmingham through:
    - The development of seven day services across health and social care;
    - Improved data sharing between health and social care; and
    - A joint approach to assessments and care planning.

- This plan also acknowledges that a key requirement for the development of integrated care is a strong primary care system.

- One of the key indicators of health & social care system integration is demonstrated by how, when treatment and support is provided to citizens, they are supported through the 'system'. This is why this Plan has a particular focus on managing transfers of care, and the related performance indicator Delayed Transfer of Care.

7 What will success look like?

- In previous plans we have outlined the benefits for Birmingham people linked to the **'I statements'** that have been developed. We believe our approach will deliver the following successes:

Integrated care & support for people who want to remain independent	• People will tell their story only once and having a single person to contact for support • Increased independence, health and wellbeing, and reduced loneliness and isolation • Improved accessibility to co-ordinated health and social care help, support and advice in people's local communities. • Practical support and 'quick fixes' in the local community for those in need. • People have more options for support as their needs start to change • People will be able to retain some levels of independence for longer • Support for Carers
Integrated urgent & Emergency care	• Hospital admissions are prevented where possible • Mental health needs are addressed as well as and alongside physical health needs. • People get back on their feet as soon as possible. • People with needs of specialist support will receive it
Stabilisation and transformation of social care / integrated Urgent & Emergency Care (RRR)	• People leave hospital earlier and are supported quickly at home and in their community • More people get back home after hospital rather than entering long-term care. • Money is spent more effectively, within communities, to support people's needs. • Better support for people with dementia to live well at home. • People are better informed and less anxious about the process and choices

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8. Local Area Performance Metrics

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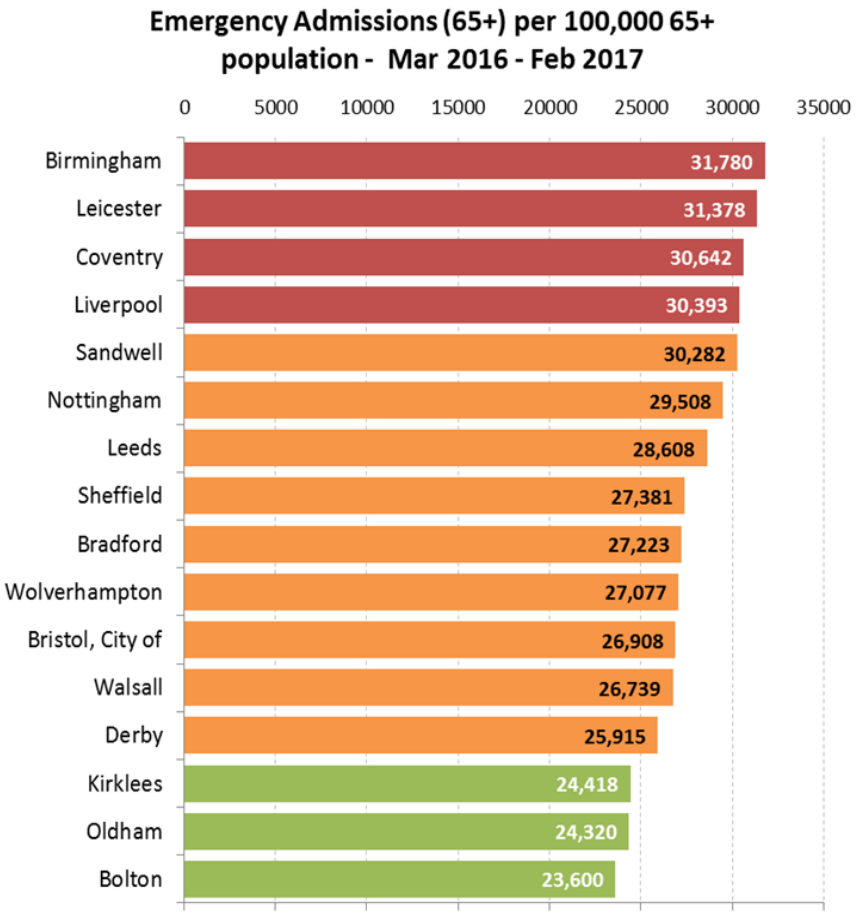
- The BCF policy framework establishes that the national metrics for measuring the progress of integration through the BCF will continue as they were set out for 2016-17. With the exception of measuring Patient satisfaction.

- The Department of Health and Department for Communities and Local Government have worked with stakeholders to develop a performance dashboard. The dashboard provides a set of measures indicating how health and social care partners in every Local Authority area in England are performing at the interface between health and social care.

- The summary below outlines comparison and progress made towards improving the key national metrics to date.

8.1. Emergency Admissions



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Why is this important? Good management of long term conditions requires effective collaboration across the health and care system to support people in managing conditions; and promote swift recovery and reablement after acute illness. There should be shared responsibility across the system so that all parts of the health and care system improve the quality of care and reduce the frequency and necessity for emergency admissions.

Overall Rank **143rd** out of 152 LA
46,304 Admissions
31,780 per 100,000

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- **Birmingham Performance:** Birmingham has very high emergency admissions - there are almost 25% more emergency admissions for people in this age group (65+ population) in Birmingham than the West Midlands and all England averages.

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- The introduction of the A&E Delivery Board and the national NHSE priority Urgent and Emergency Care programme has allowed a new focus on admissions and work to ensure that developments are

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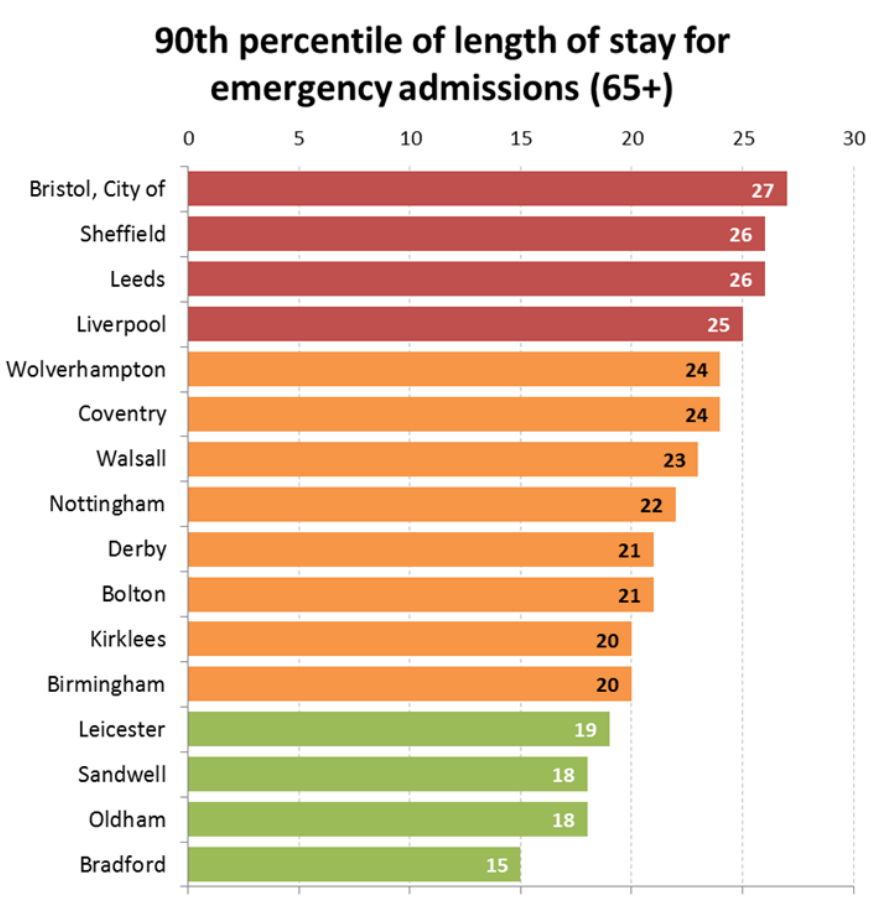
integrated across the system. The *'Hospital to Home'* element of this programme is one of the foundations of the 17/19 BCF and there will be links into the work being undertaken with Newton.

- No further 'Non Elective admissions' targets have been set for BCF, over and above those proposed in CCG operational plans.

8.2. Length of stay



Why is this important? - Longer lengths of stay can act as a powerful proxy indicator of poor patient flow.

Patient flow indicators have been trialled with systems taking part in the Emergency Care Improvement Programme (ECIP), and have supported reductions in length of stay and improvements in patient flow.

Overall Rank **55th**
20 days

- **Birmingham Performance:** Birmingham has a slightly shorter average length of stay compared to average and our statistical neighbours, with 10% of patients having a length of stay longer than 20 days (regionally and nationally the length of stay at the 90th percentile is 21 days).

- The data for March 2017 shows the end of year position to be a maximum length of stay of 33 days compared to the target of 29.This was mainly due to delays at one site whilst at other sites delays ranged from 18 days to 27 days.

- Work in 17/18 that will support improved performance includes the Newton System Diagnostic (Newton) work, the development of specialist care home capacity and the improvement of social care discharge pathways from NHS Acutes as well as the development of primary care enhanced, multi-disciplinary and Hub arrangements, providing alternatives to bed stays and to facilitate early discharge.

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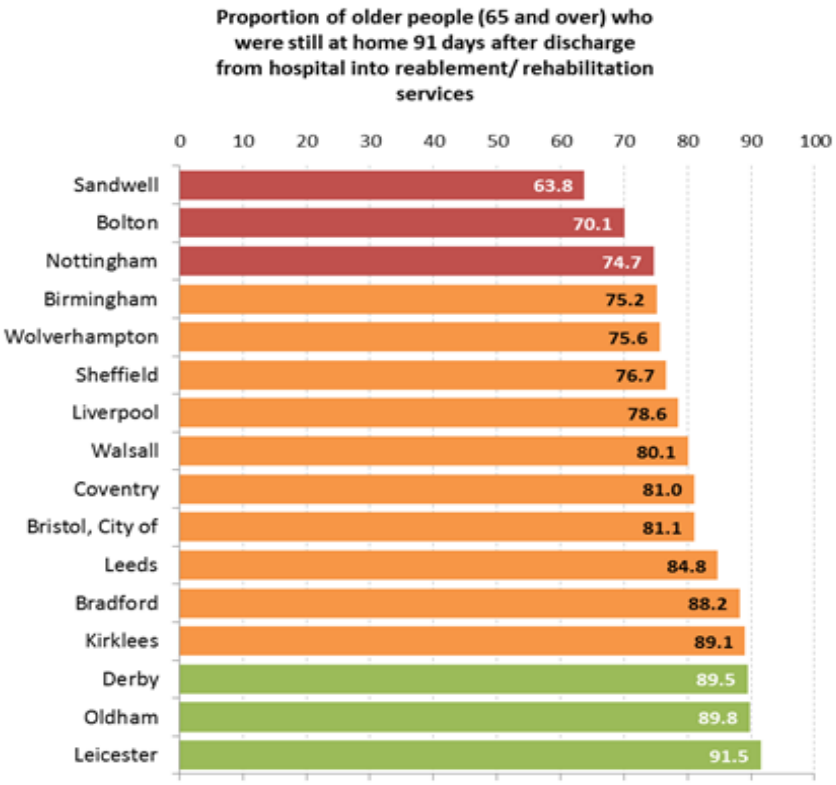
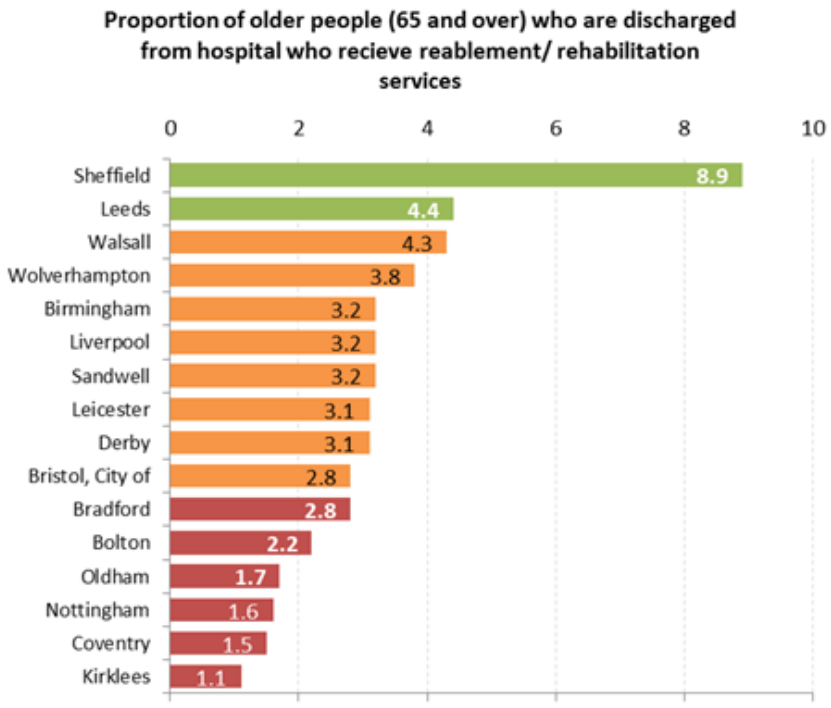
8.3. Reablement



Why is this important? - There is strong evidence that reablement services lead to improved outcomes and value for money across the health and social care sectors. Reablement seeks to support people and maximise their level of independence, in order to minimise their need for ongoing support and dependence on public services.

This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services



Birmingham Performance: Whilst the proportion of older adults discharged from hospital into reablement and rehabilitation services is better than the regional average (2.8%) and in line with the national average (3.2%), reablement effectiveness as measured by the proportion of people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services has worsened, with 24.8% of patients being readmitted within 3 months of discharge (compared to just 21.5% in the West Midlands and 16.6% nationally).

- Amongst the work in 2017/18 that will support performance to this metric will include development of recovery pathways, primary care enhanced delivery/ multi-disciplinary teams and HUBs, integrated services for frailty and respiratory, enhanced social care capacity and pathways, EAB capacity, and the development of community capacity driven by iBCF review of third sector services

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and the implementation of the Dementia and Carers Strategies. The expansion to include STP allows us to do this in a more coherent way than was previously possible.

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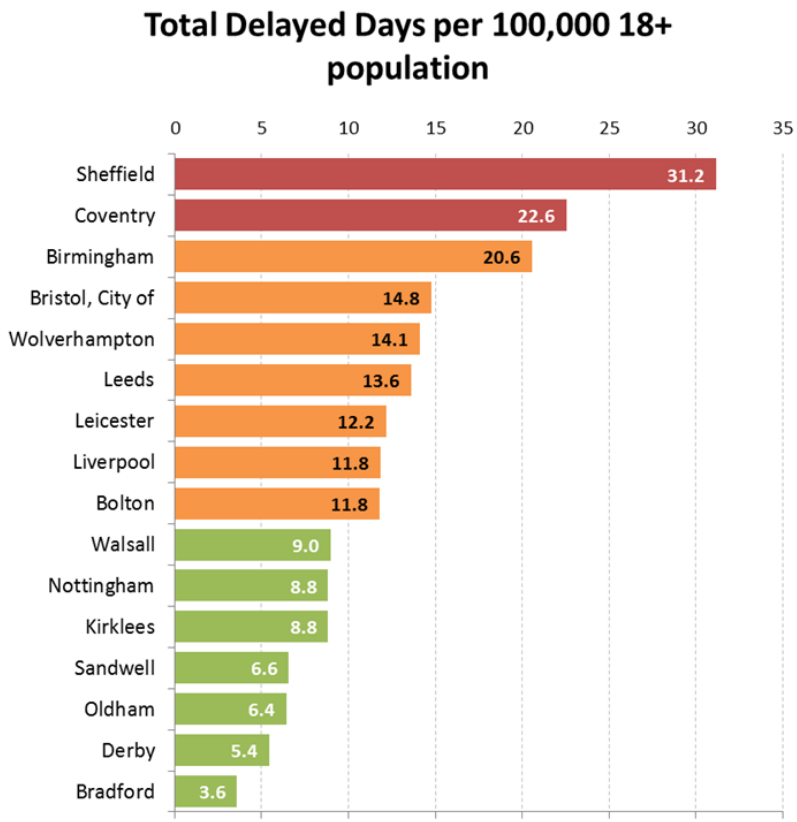
8.4. Admissions to residential and care homes

- BCF has contributed positively to managing the rate of residential and nursing care home admissions for older people and has achieved well against a challenging target - with a continuing downward trend. However, it should be noted that this decreasing number is offset by an increasing number of community and home care clients. There is further work planned, building on the 2 BCF pilots, to improve the quality of care home services and develop specialist capacity to accommodate more complex needs.

8.5. Delayed Transfer of Care



Why is this important? - This indicates the ability of the system to ensure appropriate transfer from hospital to social care services for the entire adult population.

It is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services.

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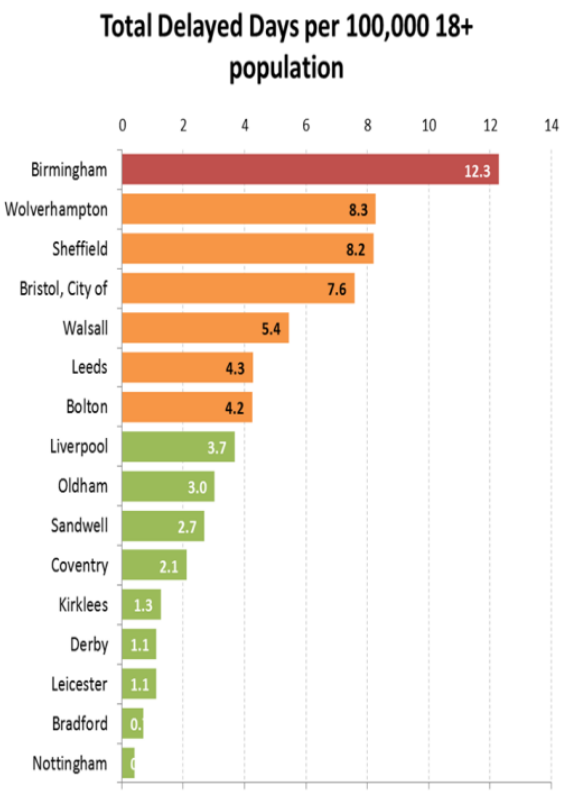
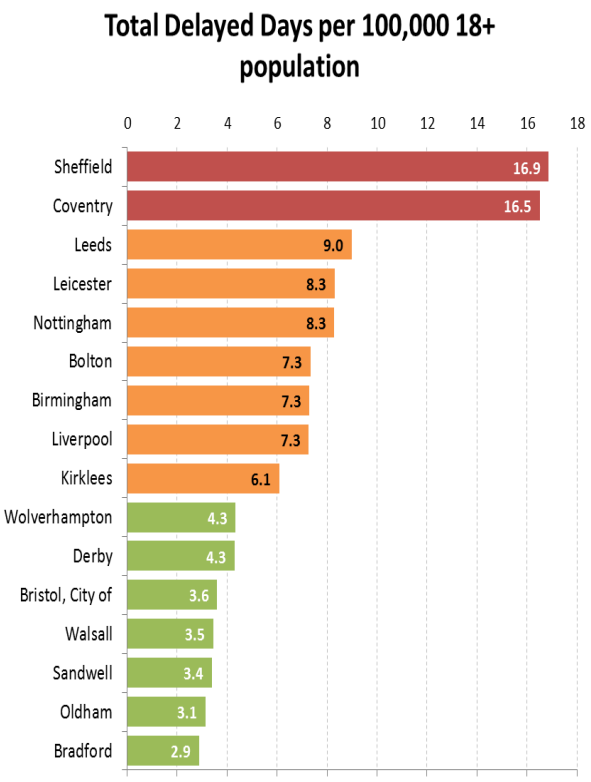
- **Birmingham Performance:** In 2016/17, Birmingham residents experienced a total of 58,379 delayed days. The majority of these delays occurred in five Trusts: UHBFT, BSMHT, HEFT, BCHFT, and SWBFT. The charts below show performance split between Social Care and NHS Delays. Birmingham is a considerably poorer performer, regarding social Care delays, when compared to its statistical neighbour.

Social Care Delayed Transfer of Care



NHS Delayed Transfer of Care



- Overall, DTOC end of year outturn (March 2017) was 4% against a year end target of 3%. The BCF has played a key role in working with partners to achieve reductions however, this has occurred against a backdrop of rising demand and worsening performance across the health economy.

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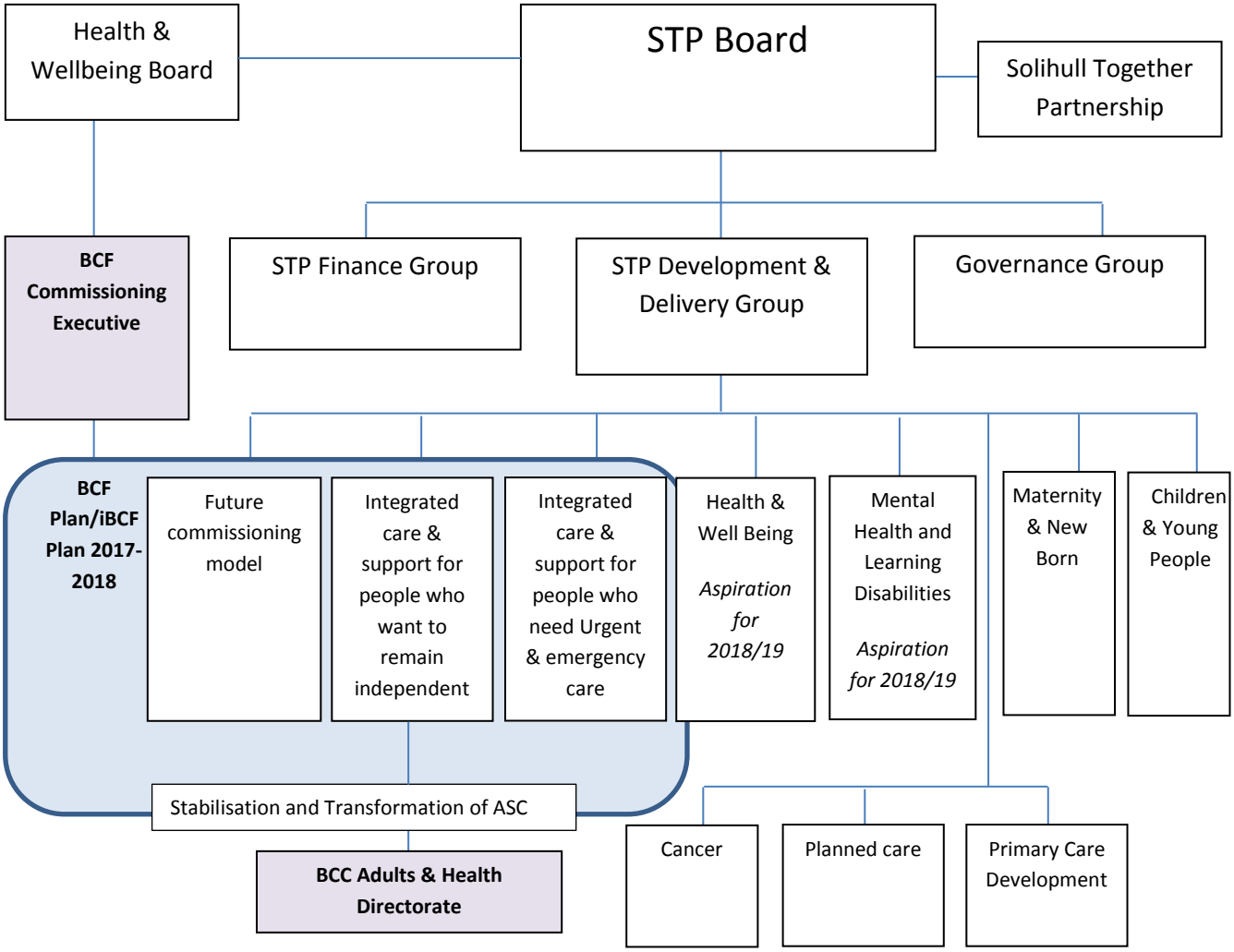
9. Governance

- As outlined previously, Birmingham needed to recognise the influences in the system and learn lessons from BCF implementation issues encountered both locally and nationally. For 2017/19 Birmingham has reframed its approach to the BCF ensuring that it is not separate to the delivery of other policy initiatives or plans. Instead, the BCF is firmly embedded and complimentary to wider system priorities. 18

- For this reason, the BCF will complement the refreshed approach to the BSol STP and its governance (September 2017). This is a significant move from the previous BCF programme and governance arrangements, which was set separately to the other system programmes. This is described below. 17



- The governance arrangements link firmly with the BSol STP plan, Adult Social Care Transformation and NHS Commissioning reform. The BCF Executive has reviewed its terms of reference given the changes in organisational configuration and closer alignment with the STP. 18

10. Better Care Fund plan 17/19

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- New interim officer leadership at Chief Executive and DAS levels at BCC, has provided the starting point of a new and positive approach to considering a system wide approach to improvement.

- The BCF (incorporating the iBCF) is now viewed as integral to the stabilisation and transformation of adult social care and the bridge between the City Council and the STP within Birmingham and Solihull. Work is in place to ensure delivery of integrated BCF and STP planning.

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- The BCF now forms one of a number of foundation blocks for the STP. Our experience over the last two years is that this alignment of plans and effort is critical to success and the Birmingham Health and Wellbeing Board welcomes the direction of travel as a positive thing. Oversight of a number of issues is intended to make this possible:
    - That social care and health are considered together equally, including the pressures faced by both
    - That west Birmingham is part of Birmingham
    - That appropriate and effective engagement takes place with the public

- As we move forwards with engagement around the STPs we will further develop the detail of changes with our public and people who use our services, building upon the work of the BCF and other programmes to date.

- The 'System' is considering how to apply the principles of integrated commissioning from a service user perspective which will also help form a view in considering an accountable care approach for service provision in Birmingham. The STP is focussing on what integrated commissioning and integrated provision could look like. The Birmingham and Solihull STP is in the process of agreeing a Memorandum of Understanding between partners which will form a formal foundation for this. The BCF will complement this work.

- As already outlined the BCF programmes 17/19 four key programme areas.

BCF Programme areas

Programme Area 1: Integrated Urgent and Emergency Care
(Governance through the STP Programme)

Programme Area 2: Stabilisation & Transformation of Adult Social Care
(Governance through BCC Adults and Health Directorate)

Programme Area 3: Integrated care and support for people who want to remain independent
(Governance through the STP programme)

Programme Area 4: Birmingham Commissioning reform
(Governance through STP Programme)

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Key system leaders across the Birmingham area are leading each of the programme areas. The tables below outline the programme areas, prioritised work areas. The governance links back to the structure outlined in Section 8.

Programme Area 1: **Integrated Urgent and Emergency Care**	**System Lead: Dame J Moore, CEO UHB**	20
Better Care Programme	**Work stream & Governance**	
System diagnostic (Newton Europe) to assess required systems capacity and develop a recognised and described model for post hospital recovery, rehabilitation and re-ablement.	BCF/ STP Urgent & Emergency care	
Rapid Response (front and back door)	BCF Urgent & Emergency care	
'Roll out ' of Clinical Utilisation Tool- The roll out of the Clinical Utilisation Review tool (CUR) began across two of the acute trusts and community trust in January 2016 and is continuing.	BCF Urgent & Emergency care	
Review of hospital social worker capacity and development of a structure which places social workers and OTs at the acute 'front door'	iBCF Priority 2 To provide support to the NHS	27
Review effectiveness, impact & scalability of Hospital to Home Commissioned Services	iBCF Priority 2 To provide support to the NHS	27
Develop a model of 'trusted assessors' with providers	iBCF Priority 2 To provide support to the NHS	27
Implementation of 7 day services – continuous progress and implementation of a permanent 7- day social work, brokerage & emergency duty team	iBCF Priority 2 To provide support to the NHS	27
Fund existing EAB beds funding gap	iBCF Priority 2 To provide support to the NHS	27
Other related programmes		
• Single Point of Access	STP/ Urgent and Emergency care	
• MDT Geriatric front door/ clinical hub	STP/ Urgent and Emergency care	
• Recovery, rehabilitation and reablement model	STP/Community Care First	
• Social care & CHC long term assessment	STP/ Planned care	
• Support to Care Homes	STP/ Planned care	
• Community IV/Pain Control services	STP/ Primary Care Development	
• Urgent End of Life Care	STP/Community Care First	

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• Integrated services for Frailty and Respiratory	STP/ Primary Care Development	
Likely impact on National Metrics • Non-elective admissions • Delayed Transfers of Care		15,7
Evidence of plans being in place FINAL BCF Newton proposal 0617.ppt Hospital to Home Plan 0817 v2.docx Copy of Item 5a - iBCF High Level Proje		

Programme Area 2: **Stabilisation & Transformation of Social Care**	**System Lead: Graeme Betts, Corporate Director, BCC**	20
Better Care Programme	**Work stream & Governance**	
Implementation of joint Carers Strategy	BCF 10 Carers Strategy	
Support communities & community based organisations to develop offers that support diversion and avoidance from SC services	iBCF Priority 1 To meet Adult Social Care need BCF 10 Carers Strategy BCF 09 Dementia Strategy	24 27
"Channel shift" carers assessments to Carers Hub, with associated support embedded in communities	iBCF Priority 1 To meet Adult Social Care need BCF 10 Carers Strategy	24
Citizen centred approach to social work which develops the community model	iBCF 1 Priority To meet Adult Social Care need	27
Reconfiguration of enablement services to optimise potential and align with health service	iBCF 1 Priority To meet Adult Social Care need STP/ Urgent & Emergency care	27
Bring forward the implementation of the new adult social care market framework	iBCF 3 To sustain the social care provider market	27
Care Homes - Incentivisation of gold standard providers	iBCF 3 To sustain the social care provider market STP Planned Services	27
Accelerate the uptake of Integrated Personal Commissioning	iBCF 3 To sustain the social care provider market	27
Commission an 'experts by experience' peer review function	iBCF 3 To sustain the social care provider market	27
Keeping people independent at home through Disabled Facilities Grant	BCF	
Likely impact on National Metrics		

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• Delayed Transfers of Care	
Evidence of plans being in place • See section 14	15,7

Programme Area 3: **Integrated care and support for people who want to remain independent**	**System Lead: Graeme Betts, Corporate Director, BCC**	20
Better Care Programme	**Work stream & Governance**	
Support communities & community based organisations to develop offers that support diversion and avoidance from SC services	iBCF Priority 1 To meet Adult social care need BCF 09 Dementia Strategy BCF 10 Carers Strategy	27
Review pilots of : Well Being Co-ordinators & Street Associations	BCF 03 Place based integration and the accountable community professional	
Carers – implementation of integrated Carers Strategy and Channel shift carers assessments to VCS	BCF Priority 1 to meet Adult Social Care need BCF 10 Carers Strategy	24
Social care – develop asset based integrated assessment	iBCF Priority 2 To provide support to the NHS	
Dementia – implementation of refreshed Dementia Strategy	BCF 09 Dementia Strategy	
Citizen centred approach to social work which develops the community model	iBCF Priority 1 To meet Adult social care need	
Reconfiguration of enablement services to optimise potential and align with health services	iBCF Priority 1 To meet Adult social care need STP/ BCF Urgent & Emergency care	
Purchase additional capacity in the care market, including for dementia	iBCF Priority 3 To sustain the social care provider market BCF 09 Dementia Strategy	
Other related programmes		
• Care homes- quality improvement framework	STP/ Community Care First	
• Falls prevention- develop and implement local strategy	STP/ Community Care First	
• Development of Primary care hubs/ multi-disciplinary teams	STP/ Community Care First/ Primary Care Development	
• End of Life Care Implementation of End of Life Strategy	STP/ Community Care First	
Likely impact on National Metrics		

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• Carer Satisfaction (SALT) • Dementia Diagnosis rate • Non Elective Admissions • Delayed transfer of care	15,7
Evidence of plans being in place • https://dementiaroadmap.info/birmingham/wp-content/uploads/sites/13/Birmingham-and-Solihull-Dementia_Strategy-2014-17.pdf	
Programme Area 4: **NHS Commissioning Reform** **System Lead: Paul Jennings, CEO Birmingham & Solihull CCGs**	20
• Support development of shared strategic direction	
Related Programme	
• Change the way NHS commissioning is arranged in Birmingham and Solihull • Set a clear direction for planning and partnership working • Develop a single commissioning vision and voice that is 'strong, consistent and credible' • Oversee transformation of health commissioning through shifting resources into prevention, early intervention, communities and primary care. To ensure: Effective system management underpinned by comprehensive information system • More effective and efficient commissioning processes – fewer gaps and less duplication • Greater focus on outcomes based commissioning • Better value through improved efficiency and reduced costs of commissioning function • Simpler and more effective governance of commissioning and decision making • Stronger service transformation approaches, decommissioning and re-commissioning • Aligned budgets (as a minimum) and agreed risk share arrangements	22
Likely impact on National Metrics • Non-elective admissions • Delayed Transfers of Care	
Evidence of plans being in place Supporting document 4 http://bhamcrosscityccg.nhs.uk/about-us/publication/get-involved/consultations/3440-final-report-on-2017-consultation-on-the-future-of-birmingham-and-solihull-ccgs/file	

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11. Key Programme initiatives

- The following section outlines additional narrative relating to key initiatives referenced in this BCF plan. The section also provides additional narrative relating to ongoing BCF supported initiatives that will contribute to the delivery of better outcomes.

11.1. System Diagnostic (Newton) Crisis and Recovery Strategy

- This builds on previous 2016/17 BCF 05 'step up and step down care' workstream which was merged with the Urgent care planning group to develop 'Crisis and recovery teams'.

- The impetus for this work was evidence that the system requires a better and more coherent front-line response for people who do not need to be treated in Emergency Departments (ED) in hospital or who present, in a crisis, with problems that do not require acute hospital care.

- There has been a measurable increase in the numbers of attendances at EDs and admissions of people who have conditions that could be treated more effectively in settings other than an acute hospital bed. Specifically, there are people who can be managed in the community effectively, without requiring the collective weight of diagnostic, specialist support and treatment capability that comes from a traditional hospital setting.

- The proposal developed outlines for three pilots of a new co-ordinated approach within ED involving other hospital and community health staff and adult social care working in parallel with ED clinicians to make the most appropriate decisions for individuals prior to entering the hospital system. The 'crisis team' is the current title for this approach and there will be a pilot in each hospital, namely, Heartlands, Good Hope and Queen Elizabeth Hospitals.

- Currently, each hospital has a different approach to admission avoidance and access to different services with only a limited level of consistency across the system in Birmingham. In addition, there are a number of services and their associated staff who we believe could have a more positive impact across the system if they were deployed in different ways within a 'crisis team' model.

- Once a patient can be safely discharged into the community the aim is to transfer the care from the crisis team to the recovery team where required. The development of this work will be led in conjunction with our partners Newton to create a Recovery Team that fully integrates both health and social care services and teams and has the systems, management, governance, capacity and resource to keep patients away from acute care and maintain care in settings close to, or at home.

- The 8 High Impact Changes are also be at the focus of this work and it will provide the following products to support the BCF programme, and future decision making:
    - A recognised and described model for post hospital recovery, rehabilitation and re-ablement.
    - Recognised and agreed models for integrated discharge teams and in hospital processes.

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- An assessment of the required capacity in each part of the model over 7 days informed by an assessment of opportunities for admission avoidance at the front door through improved front door decision making and in services which interface with the pathways.
- Agreement on how to fund the required capacity.
- Clarity of underpinning systems and processes to optimise flow, with accountability agreements.
- Single trusted assessments at the appropriate points within pathways.
- An agreed delivery plan that starts with the greatest identified opportunities taking into consideration the requirements on the system as a whole and individual organisations within it.

13, 14, 17, 18,

11.2. Clinical Utilization Tool Implementation

- The roll out of the Clinical Utilisation Review tool (CUR) began across two of the Birmingham acute trusts and the community trust in January 2016. Leading up to this there was a preparation phase to action a procurement requirement to secure the most appropriate provider, put in place staff training and ensure technical readiness at an organisational level.

- The tool has now been implemented on relevant wards and each ward round considers whether the patient is appropriately placed in the bed they are occupying. The Trusts involved have produced some interesting data regarding the ratio of 'appropriate patients' and recent data has indicated that internal delays are a higher percentage of all delays than external delays.

- The commonest reasons for internal delays are shown to be:
  - Requiring on going physiotherapy,
  - Awaiting pathology
  - Continued stay determined by Consultant decision.

- The commonest top reason for external delays are shown to be:
  - Awaiting a social care assessment;
  - Waiting for an EAB bed
  - Waiting a social care package

- In 2017-18 work will focus on identifying internal blockages and set an improvement plan to rectify these. Birmingham will also be implementing the first CUR nationally in the mental health Trust. Work is underway currently to ensure that the algorithms used are fit for purpose and local implementation can be applied.

11.3. Carers

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- Work began in 2016 through the BCF to develop and implement a Birmingham Carers Strategy and has progressed well during the year. A strategic steering group is in place reporting to the BCF Executive.

- A key priority was to review and revise the local strategy in the context of national guidance. However, the continued delay in the issue of national guidance has meant that this will now be

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finalised later in 2017. The strategy, and the development of a commissioning infrastructure, has been supported by needs assessment, including a focus on the needs of BAME carers and the development of BAME specific support.	
• BCF funding enabled the establishment of Grant Awards. Providing community level, support to third sector and community groups. In total, 16 proposals were approved (out of 27 submitted) and commenced implementation from January 2017 onwards. The success of this work will be evaluated.	
• In addition, work in partnership with the Third Sector consortium provider, Birmingham Carers Hub 'Forward Carers', has helped to develop additional capacity in some existing services such as the 'sitting service' that forms part Carer's Emergency Response Service (CERs).	2
• We were also able to support 'Forward Carers' to work with (and in) GP Surgeries and Acute Trusts to promote carer self- recognition, and awareness, offering a health and wellbeing check with advice and signposting and access to a 'Carers MOT' as well as 'Social prescribing'.	
• In addition, we were able to develop a pilot with the same provider aimed at developing capacity in the organisation to undertake 'Carers Assessments'. This was very successful with over 170 completed as part of a pilot in 2016/17. In addition other projects looking variously at Safeguarding and carers and support for working carers were commenced in-year.	
• Work with Community Pharmacies included the production of information for carers and the offer of Carers MOT's and 'Carers Corners'.	
• In terms of training for carers the BCF has supported work with Birmingham City University to offer 'Carers Knowledge Information and Skills Sharing' (C-KISS). This aims to facilitate the delivery of skills information sessions to informal carers focusing on basic care strategies. These include manual handling, nutrition, skin care and stress management. As well as this we were able to offer training to carers of people with dementia around the early identification and management of UTI's and other common infections through Dementia Information and Support for Carers (DISC). This was intended to reduce the number of unplanned admissions that so often arise from common infections or conditions such as constipation that could be managed at home if identified early enough.	
• We were also able to fund a number of other projects including a 'Street Associations' project in the north of the city which has been very successful in identifying carers as it works to empower local communities to develop a more supportive local environment.	
• In 2017/18/19, as part of a joint plan between Birmingham CCGs, BCC and the third sector, funded through the iBCF, the 'Carers Hub' will be supported to complete all Carers Assessments. The Carers Hub will also be able to support the development of local networks for Carers.	2
• We will also be looking to increase the numbers of carers who are able to access direct payment and personal budgets (where applicable). We will also build on work to date to increase the links with	

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primary care, acute and community services and domiciliary care, mental health and respite services, care homes to ensure there is earlier identification of potential carer breakdown and increased support and access to pathways.

11.4. Dementia Strategy

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- The Birmingham and Solihull Dementia Strategy *'Give me something to believe in'* was adopted by Birmingham City Council and the local CCG's and other partners in 2014. Its overarching purpose was to understand the experiences of people with dementia, to identify what was already in place across Birmingham, and what we still needed to do to improve the outcomes for people with dementia and their carers. Following that Dementia moved into the Better Care Fund in 2015 and has worked closely with other workstreams to realise the potential of integrated working for people with dementia and their carers.

- In 2016/17 the Dementia Adviser and Dementia Support Worker services across the city were increased through CCG and BCF investment with a focus on developing links to primary care, supporting the work around increasing early diagnosis and ensuring patients are able to access support both during and after a diagnosis, and reducing unnecessary acute admissions.

- In addition, through the BCF, the carer support service across Birmingham has been increased as well as increasing numbers of dementia and activity cafes. Also training for carers in the early identification and management of UTIs and other infections (in order to prevent hospital admissions where possible) has been funded through the Carers workstream.

- Through the BCF, a 'pooled budget' for dementia has been developed for inclusion in the overall Better Care 'Section 75' agreement for 2017/18 that will help to align and protect budgets for services and ensure a more integrated approach to pathway development for people with dementia and their families and carers.

- Work has also been ongoing with Birmingham and Solihull Mental Health Foundation Trust to streamline diagnostic and post-diagnostic pathways for people with dementia, including piloting the prescribing of anti-dementia drugs in primary care and primary care models for assessment and diagnosis, whilst at the same time ensuring that secondary care assessment pathways provide a diagnosis in a timely manner.

- The CCG has continued to work towards the dementia diagnosis rate target - that 67% of people with dementia have access to a diagnosis and post-diagnostic support. Progress has continued throughout the year and February 2017 data shows CCG diagnosis rate varying from 63.4 to 97.8% at 63.4% against national achievement of 67.3%. This represents an increase of 18.5% since the work has been coordinated support through the BCF.

- The BCF team has worked closely with the BCC Health Overview and Scrutiny Committee inquiry "*Living life to the full with dementia*" to implement the recommendations of a previous review including the development of a Dementia Ambassador role among elected members. We have also

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produced local guides to services and access to information about services online through the Dementia Roadmap.

11.5. Supporting Communities

- Through the BCF two pilot projects have been introduced to support prevention activities within local communities across Birmingham, these are;
  - **Well Being Co-ordinators:** focussing on six pilot sites across Birmingham, delivered by four third sector organisations. The project aims to help vulnerable people, including frail elderly and/or those with long-term health conditions to access a wide variety of services and activities provided by voluntary organisations and community groups in Birmingham. The model is based on several social prescribing services across the country, which helps patients to access community services that promote good health and wellbeing, for example finance advice, physical activity sessions and social groups. There is a focus for the project on improving service users' health and wellbeing, and reducing unplanned admissions, A&E attendances and GP appointments.
  - **Street Associations:** Entering the second year of a two year project, the aim of Street Associations is to create resilient communities that support people to enjoy happy, healthy lives for longer. Street Associations are resident-led frameworks aimed at bringing people together, overcoming barriers and rekindling community spirit in streets where supportive community is most lacking. This is combined with a Connected Communities research-to-action project and we have included a clear focus on identifying carers and linking them to support.

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11.6. Multi Disciplinary Teams (MDTs)

- Multi-Disciplinary Teams (MDT) are a recognised discipline that improve the efficiency and effectiveness of patient care and are promoted in all national policy guidance. These are now being developed as part of the CCF programme as part of STP. The BCF will continue to support this programme and provide all the relevant products and experience that has been gathered to date, BCF will also support as part of A & E delivery Board remit.

11.7. Care Homes

- Two Care Home projects were previously included in BCF. These were a Digital Nursing Project and a Residential Care Home Support Service model and BCF will work with the STP to support further work as part of STP Enhanced Primary Care Models and Urgent care workstreams.

11.8. Virtual beds

- The "Community Virtual Beds" (CVB) admission avoidance service was developed by BCF as a pilot in 2016/17. The service focused on avoiding 'unnecessary' or 'inappropriate' admissions to acute settings and was based on evidence that a significant proportion of admissions could be avoided if appropriate alternative forms of care were available or if care had been managed better in the period leading up to the admission. It also focused on the need for high-quality expert decision-making as early in the process as possible (particularly for elderly patients), and that decision-makers have easy and rapid access to alternative services and diagnostics. An external evaluation of

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the pilot provided evidence of successful outcomes for the project that are being fed through the STP and A & E Delivery Board.

11.9. Disabled Facilities Grant (DFG)

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- Mandatory Disabled Facilities Grants (DFGs) are available from local authorities in England and Wales and the Housing Executive in Northern Ireland. They are issued subject to a means test and are available for essential adaptations. In order to qualify for adaptations in the home:
  - The person for whom the adaptations are being considered must be someone who is substantially and permanently disabled by illness, injury or from birth.
  - The person must also be 'ordinarily resident' in the area i.e. Birmingham
  - The adaptations must be 'required for meeting the needs' of that person, as defined in the Housing Grants Construction & Regeneration Act 1996. That is, essential or of major importance to the person because of the nature of their disabilities.

- To access DFG service users are advised to make a referral to the Occupational Therapy Service through Adult Social Care & Health Directorate access teams: Adults and Communities Access Point (adults) and Multi Agency Safeguarding Hub (children). The recommendation for provision of major adaptations for housing is made following the completion of an occupational therapy assessment. The assessment for this provision is a statutory requirement and conducted by the Occupational Therapy Service. Birmingham Occupational Therapy Service receives approximately 12,000 referrals per year requesting an assessment for major adaptation through DFG funding.

- DFG budget (Capital) is released as a Section 31 grant allocation from central government. The DFG is only used for owner occupier or privately rented properties.

- The Disabled Facilities Grant (DFG) was transferred to the Better Care Programme in 2016 and DFG Service was transferred from the Place Directorate to Adult Social Care and Health in April 2016.

- A service review was recommended by audit and commissioned by Senior leadership in BCC. The review is in the final stages of completion, and one of the identified priorities is to consider and review how efficiently this service works. It has been also highlighted that delays in provision of adaptation such as access to community and essential facilities (internally) have a negative impact on citizen's health and well-being and also increases the risk of hospital admissions and care.

11.10. iBCF priorities

- 1. To meet adult social care need
- 2. To provide support to the NHS
- 3. To sustain social care provider market

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- A traditional response to meeting adult social care need is to create more capacity or provision. We have shown in previous sections, through the JSNA, business intelligence and evidence that this is not a viable approach for the future. Therefore, our Birmingham approach will be to focus on prevention and building capacity within communities, in partnership with the third sector, to support an asset based approach to care. This will be matched by how both the social work offer is

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configured and our approach to commissioned social care. This is articulated in the section 11 of this narrative plan.	
• A key part of the iBCF plan is to work closely with the A&E Delivery Board and STP workstreams. This will provide support to the NHS especially in the application of the 8 High Impact Changes – included in section 14 of this plan. The work being undertaken in partnership with Newton (section 11.1) will provide the basis for redesign at a health and social care system level. It will be supported by a review of the effectiveness of out of hospital support (linked to the review of third sector support described above); development of a model of trusted assessors; development and implementation of a 7 day social work model; and a clear structure for adult social care support at the front door of acute hospitals and supporting diversion.	
• For the third element of the iBCF sustaining the social care provider market, we will ensure the implementation of the new adult social care framework together with an increase in provider capacity (particularly for nursing/ dementia). We will also ensure better quality of provision by incorporating customer experience/ experts by experience to inform this view. We will also be further encouraging uptake of Integrated Personal Commissioning.	27
• This work forms part of a broader strategic approach which is outlined in section 12 below.	

12. Stabilisation and Transformation of Adult Social Care– Strategic approach

• The goals that Birmingham City Council and its partners are seeking to achieve for adults and older people are that they should be resilient, living independently whenever possible and exercising choice and control so that they can live good quality lives and enjoy good health and wellbeing. These goals are reflected in our reframed approach to the Birmingham Better Care Programme.	
• Most adults and older people can achieve these goals independently or with help and support from their families, friends and social groups. However, for the most vulnerable people in Birmingham, this is only possible with support from Adult Social Care services and from other public sector agencies.	
• We have highlighted in previous sections of this plan how our current approach to providing Adult Social Care services and NHS services are not having the desired impact on improving outcomes, particularly for our most vulnerable. We have also highlighted that the way we currently deliver services will not be able to meet demand. This is why BCC, and the wider health and social care system needs to change	
• Birmingham system leaders recognise that these goals cannot be achieved simply through the provision of care services, it has to utilise its broader responsibilities across a range of areas to support achievement as well as working in partnership with communities. For example, the Council has a key role in ensuring there is appropriate housing which offers choice to people with a wide diversity of needs. This is why Birmingham Homelessness Prevention Strategy is also aligned to the Better Care Plan and forms part of our approach to improving health, wellbeing and independence.	2

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- BCC & its partners have recognised that they need to change the type of services they provide and that in order to deliver the desired goals for adults and older people, it is necessary to put in place a strategy that addresses potential barriers and obstacles and puts in place a framework to make the outcomes achievable.

- The narrative behind this strategy is that on the whole, people want to lead happy, fulfilled lives in touch with their families, friends and communities. They cherish their independence and prefer to live at home or in the community with support if necessary.

- The vast majority of people do not want to be dependent on others but will accept one-off support or ongoing support if it helps them to maintain their independence. For most people, this is achievable and it is only those people with disabilities or who lose their abilities with age that require long term interventions from adult social care services. And of course, for some people, because of disability, placements in residential and nursing settings are the best way in which these people can lead good quality lives.

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- Therefore, the iBCF plan which will enable these outcomes to be delivered contains these key elements outlined below.

12.1. Information, advice and guidance

- People need easy access to high quality information, advice and guidance and whenever possible and appropriate, they need to be able to self-serve or their carers and families need to be able to do so on their behalf. This approach allows people to maintain control and to exercise choice at whatever point they are at in their lives. Further, it helps the Health and Social Care system to use its resources more effectively.

- Building on this, it is essential that when people contact adult social care, they are given a positive response and support to help resolve the issues they face but by emphasising what people can do for themselves, what support is available from other organisations and what support is available in the community. The aim is to divert people to appropriate support other than formal care which fosters dependency.

- In order to deliver this element of the strategy, adult social care will continue to promote its services and how people can contact them. The first point of contact which can be through the internet or through a telephone contact centre will be continuously improved. The number of calls that are abandoned because of long waits will be reduced and more experienced workers will be based in the centres. The range of services that people can access directly will be increased (by building capacity in communities and supporting the third sector) and it will be made easier for carers to have their needs assessed.

12.2. Personalised support

- People require and respond better to personalised services. The approach that works most effectively always puts users and carers at the centre and builds support round them rather than fitting people into services. Essentially, there needs to be a strength-based approach to assessing

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people's needs – building on the assets people, their families, friends and communities can offer to support them. Further, Direct Payments are the preferred option for delivering support because they maximise the opportunity for people to exercise choice and control.

- In order to deliver this element of the strategy, there will be a reorganisation of the social work and care management services. This will be an ongoing journey as it is not desirable to throw all the pieces of the jigsaw up in the air at once. It is essential that the approach moves from assessing people for services to assessing them for the outcomes they desire and the assets they have to achieve them.

- There will be improvements to the systems that support this area of service. Further, the service will be delivered on a locality basis to strengthen workers' affinity to a local place, to strengthen joint working with workers from other services and to increase knowledge about the assets available in a local area.

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12.3. Community assets

- People need to be able to access a wide range of community assets which are local, flexible and responsive. Through being able to access these resources people can continue to enjoy good quality lives while maximising their independence.

- While the use of community assets is part of a broader approach to prevention, these assets are important for people to enjoy good quality of life whatever period of life they are in. Some may use them once in a while but still see them as a key part of being part of a wider community and others will make good use of them.

- Community assets are the wide network of services which range from very small, very local services provided by volunteers through to faith groups and community groups, national charities and private companies and businesses. They are all part of the wide network of community assets which provide choice and enable people to engage with others in activities they enjoy and which add meaning to their lives.

- In order to deliver this element of the strategy, we will be investing in local services. Resources need to be made available for local groups to provide the wide range of support that enables people to remain in the community. This will include support for volunteers to run activities and for micro-enterprises to run services such as personal assistants and day opportunities. There will need to be workers to undertake this work and they too will be based in the community. Essentially, they will be link workers or network workers and their role will be to make the links between formal services and the community assets.

- This approach needs to be supported by a broad corporate, and system wide, approach which ensures there is an emphasis on locality working. Similarly, GP practices need to be engaged as do community based health services and mental health services. Learning from the Vanguard pilots can be brought into this approach to locality working, ensuring that there is a partnership of integrated provision across formal care and health services and a diverse range of community assets.

12.4. Prevention and early intervention

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- People need to be able to access prevention and early intervention services quickly and at any time in their lives. Services such as assistive technology can be beneficial at different times as can reablement and rehabilitation services. These services can help people to maximise their independence throughout their lives and as people's needs change, their needs for these services change as well.

- It is important to have a comprehensive strategy for prevention to ensure that organisations in the public sector and in the third sector are 'joined up' in their approaches and maximise the available resources. Much can be done through 'Making Every Contact Count' principle and there are a wide range of partners who are keen to work in this area such as the Fire Service. 2

- One of the weaknesses of the public sector has been that it can be poor at anticipating demand. Too often, organisations wait until there is a crisis for services to click into gear but by then the only options may be high cost, acute services. That is why we will have a strategic approach to prevention which anticipates potential needs and intervenes early before they become a crisis. For example, people often fall several times before they break a hip. Investing early in low cost solutions and preventive actions can help avoid falls. 27

- In response to this a comprehensive approach to prevention will be developed and implemented. A key element of it will be the link to community assets and the link workers. These will play a key role in ensuring that people with lower level needs aren't left until they develop acute needs. A multi-organisation group needs to be established or an existing one such as the Health and Wellbeing Board needs to take the lead on prevention to ensure the strategic approach is implemented.

- Other preventive services need to be developed and invested in. This will include assistive technology, aids and equipment, support for carers & people with dementia and easy access to reablement programmes.

12.5. Partnership working

- People's needs are often complex and require support and interventions from a range of organisations. Therefore, services need to be integrated and built on partnership working utilising multi-disciplinary teams and where feasible single points of access. This approach needs to be developed at all levels – quite simply, care and health services are a whole system and if one part of the system is not working then the system as a whole isn't and the people that suffer are the residents of Birmingham.

- For commissioners, working in partnership can deliver better quality services that are more integrated and better value. At locality level, trust needs to be developed between professionals such as district nurses and social workers so that packages of care and support can be flexed without reassessment from social care staff and there need to be more joint visits and assessments.

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- In order to deliver this element of the strategy, the City Council & its partners recognises the need to work as a whole system and need to support each other to achieve their separate and joint goals, and the BCF provides a vehicle for this.

12.6. Making safeguarding personal

- While recognising that for some people there is a need to protect them, it is essential that we ensure we "make safeguarding personal". It is essential that we understand what outcomes people want from safeguarding enquiries and actions. In this area, there is a balance to be achieved. It is essential that there is an effective Safeguarding Adults Board, that strategies are in place, that there is an effective team, that enquiries are robust, that there is excellent partnership working and there is high quality intelligence about safeguarding issues and performance. Further, it is essential that safeguarding is seen as everybody's business and that staff across the care and health sector are aware of the issues and know how to deal effectively with safeguarding concerns. Also, it is essential that this issue is kept in the public eye.

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- In order to deliver this element of the strategy, the strategy for safeguarding needs to be implemented and the service and its performance regularly reviewed. This area needs to be resourced at a level proportionate to the risks that exist in the system.

12.7. Co-production

- All services should be co-produced with users and carers as they are directly impacted by services and have first-hand experience of what works well and what doesn't. While this is important for all services, it is essential that commissioning demonstrates excellence in this area. Far too often, people feel they are being paid lip service when consulted on service developments. Approaches based on ongoing engagement need to be at the heart of commissioning and service delivery.

- In order to deliver this element of the strategy, an approach to co-production needs to be implemented across all services. For most services, this will serve as a reminder of best practice but for others it may provide the opportunity to refresh or develop their approach.

- In addition, a review of the use of resources will provide a framework for moving resources from areas where best value is not being delivered to areas where it can. So, for example, areas of service will receive investment such as the development of community assets and Shared Lives while other poorly performing services will have their resources reduced. This is not a one-off exercise and there will be on-going monitoring and review of spend to ensure resources are maximised.

- This paper will be discussed with managers and staff, partners and Members. It will be finalised over the next few months and it will provide a framework for the actions required to modernise services in Birmingham, ensure a corporate and partnership approach to delivering high quality outcomes and provide the framework within which resource decisions can be made.

13. Stabilisation and Transformation of Adult Social Care– Turning Strategy into action

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Delivery of the strategy is beginning to take shape with three core areas of work being undertaken

1. Social work offer (Assessment and support planning services)
2. Commissioned social care
3. Prevention First: An integrated Approach

13.1. Birmingham City Council Social Care offer (Assessment and Support Planning services)

- As recognised 'business as usual' cannot continue given the increase in demand for services and growing financial pressures. Therefore, in line with the strategy, a service delivery model is being introduced which adopts an asset based approach to social care assessments, alongside a community development model.

- Key areas that we need to improve on our journey to an asset based approach and community development model are the development of closer links to communities and the ability to identify family and other support networks for the citizens we assess, that share in the support of the citizen. 27

- As part of this model we need to empower decision making as much as possible at the point of contact with citizens to minimise the delays and any unnecessary bureaucracy in decisions being taken.

- The asset based approach and community development forms part of wider changes, that are key to addressing the shift from institutional care to promoting wellbeing. They will also form the basis of how demand for service is managed in future.

- For the service delivery model to be successful a major change in how BCC's current social care workforce is configured needs to be implemented. The BCC Social care workforce will be a vital 'connector' to other public services and community resources, especially the NHS and also local housing. Teams will work in partnership with community groups, voluntary and private providers and organisations that represent people who use services. To achieve this BCC are moving to formalise a constituency based model where social work teams serve a defined local constituency, also moving to work more closely with health colleagues particularly within primary care settings. The changes that are being proposed are:

    - Merging the workforce and delivery roles
    - Aligning teams to constituencies

- Ensuring that teams are aligned to constituencies is the first step in building local knowledge and working with partners and other local groups. Moving to a constituency model will also allow us to provide further opportunities to engage in community development.

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- The merging the workforce and delivery roles will allow us to be more efficient by removing the current overlap between the existing roles and also simplifying the assessment process in keeping with an asset based approach.

- This will streamline the process of recording by frontline staff while reducing the time and effort of management in terms of oversight. This approach has been developed in conjunction with Research. In Practice for Adults and Social Care Institute for Excellence underpinned by national research.[9]

- The model has been consulted on and is being implemented from November 2017.

13.2. Commissioned social care

- In conjunction with a change in the social care workforce model BCC is also introducing a significant changes in how we commission social care from third sector and private providers, utilising and aligning with the BCF, our commissioning approach will aim to; 27
    - Improve outcomes for those with health, care and support needs
    - Improve the quality of commissioned health and care services
    - Improve the resilience and sustainability of our health and care system
- These align closely to the eight key outcomes of an emerging BCF Vision and Strategy for Adult Social Care and Health:

    - **Information, advice and guidance** – by providing easy to use information about the quality of services and support informed choice.
    - **Personalised support** – by having specifications and a quality framework that focus on delivery of personalised care and support.
    - **Community Assets** – commissioning of services at a local level and working with care providers to develop their services to add social value.
    - **Prevention and early intervention** – a quality rating system that rewards those services that are working hard to support the independence of service users and those that are adding social value to the wider community to offer prevention and early intervention service.
    - **Partnership working** – working closely with NHS colleagues on the joint quality rating of providers and sharing market intelligence with regional commissioners, regulators and partners.
    - **Making safeguarding personal** – working to support the development of high quality services that reduce the risks of neglect to service users and sharing of intelligence with partners to safeguard vulnerable citizens.
    - **Co-production** – use of customer feedback in the ongoing monitoring and quality rating of providers.
    - **Use of resource** – transparent approach to pricing, including open book accounting to ensure value for money.

[9] https://www.scie.org.uk/prevention/research-practice/

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- To implement these aims and the vision, the following key proposals were consulted upon with service users, potential service users, members of the public, providers, staff, Elected Members, partners and stakeholders:
  - Implementing a geographic model for the commissioning of home support, closer to communities.
  - No longer doing business with poor or 'Inadequate' care providers and ensuring citizens who requires care and support can be assured that the support will be of good quality
  - Having clear quality standards, and allocating work based on quality
  - Having an annual inspection for each service to identify the quality of that service
  - Having a twice-yearly self-assessment of quality by providers
  - Moving to a fixed-fee approach linked to quality
  - Ensuring an annual review of prices
  - Increasing the scope of the new framework to include Supported Living and residential services for under 65's with and without nursing
- The approach has been consulted on with implementation from April 2018.

13.3. Prevention First: An integrated Approach

- Work with third sector providers, citizens representatives and partner agencies is currently underway to co design a new approach to commissioning/ prevention services that supports the delivery of the vision for Adult Social Care and Health: 27

  'Citizens lead healthy, happy, resilient and independent lives within their own homes and communities'.

- The preventative focus therefore needs to be firmly placed in the first instance within the universal offer whereby citizens are able to support themselves deploying community based responses wherever possible.

- There are four commonly identified barriers to this vision: the need to reduce isolation, maximise income, improved health and wellbeing and good quality housing and housing support. 2
  - The Prevention First model therefore has two integrated component parts:
  - Community assets and local networks are the natural first point of contact when citizens or carers need support
  - Where appropriate effective integrated pathways are available into targeted or more structured prevention activity

- Third sector expertise, resource, knowledge of localities and their place based assets are crucial to the delivery of this model. The co design work to date with third sector providers and BVSC[10] (as a gateway to Birmingham's Third sector) includes work to identify best practice locally and nationally, co/ design of local network models for commissioning; establish an evidence base to support investment decisions and associated methodology to evaluate the impact of the proposed commissioned activity. Running alongside this are the considerations to capacity build 2 21

[10] Birmingham Voluntary Services Council https://www.bvsc.org/

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third sector organisations to diversify their business models to reduce risk and dependency on one funding stream alone.

- A report is being prepared for the BCF Executive and BCC Cabinet for November which will set out the need to invest in prevention services and the proposed new commissioning activity. This includes the associated commissioning of housing support services using the pathway approach set out in Appendix 2.(Homelessness Prevention Positive Pathway)

14.Focus on Delayed Transfers of Care (DTOC)

14.1. Background

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- Reducing delayed discharges in the city is a central focus of this Better Care Fund plan. For too long the DTOC rate in the city has been far too high. While there have been improvements in recent years (in particular in 2015) recent benchmarking clearly positions Birmingham as one of the worst performing areas nationally.

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- Making improvements around delays has always been difficult when taking place against a backdrop of rising demand and worsening performance across the health economy. However performance has also been hampered by distinct factors associated with Birmingham. For example there has been a lack of a consistent approach to monitoring and measuring DTOCs across the different parts of the Birmingham system, punctuated by lack of shared vision for what we are trying to achieve. Often there are significant concerns about data accuracy both in respect of the designation of patients as delayed, and the attribution of responsibility for delays.

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- This plan will address these issues. The key outcomes of our plans around DToC are to:
  - Improve and strengthen relationships between the hospital trusts and the Local Authority ensuring there is one consistent well-understood approach to addressing delays in the acute sector
  - Take a preventative approach by working together across the health and social care system to deliver a range of services that prevent delays occurring
  - Improve services for patients by avoiding situations where, particularly older people, are put at risk by remaining in the acute sector when they no longer need acute care.

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14.2. Current Position

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- Benchmarking information provided in Section 8 of this report shows that Birmingham is one of the worst performing systems nationally, in particular around delays associated with Social Care. The recently agreed Better Care Fund DTOC targets agreed with LGA/NHS England are extremely challenging.

- As the chart below indicates – our current trajectories alone put us some way off meeting those targets so a step change in approach is needed. In addition the inclusion of sub-targets for NHS and Adult social care delays is intended to encourage a shared contribution to a planned bed day reduction. Targets place a disproportionate burden on the council and fail to recognise the improvement required to allow individual NHS Trusts to meet their targets.

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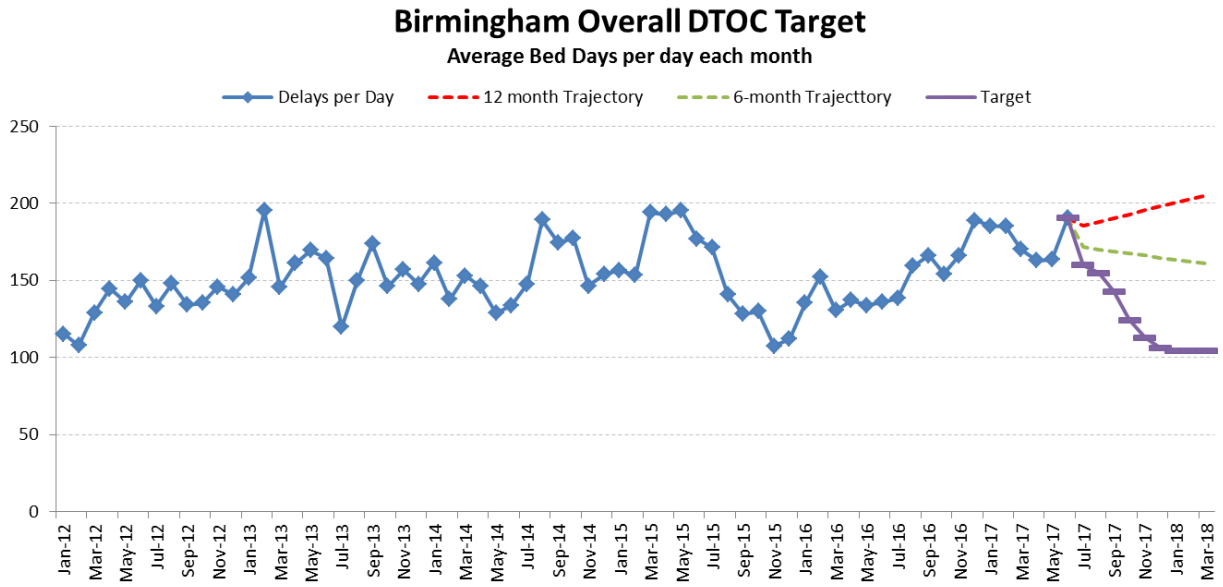
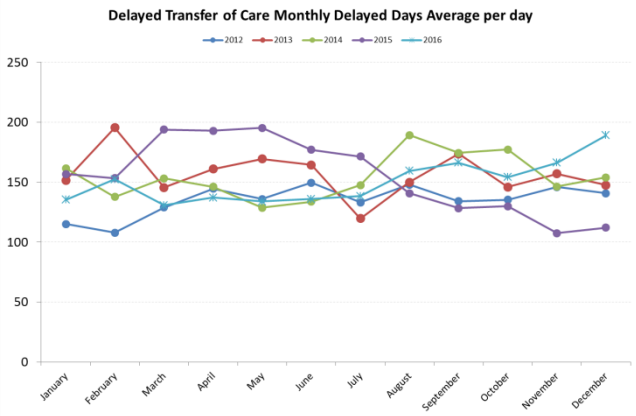
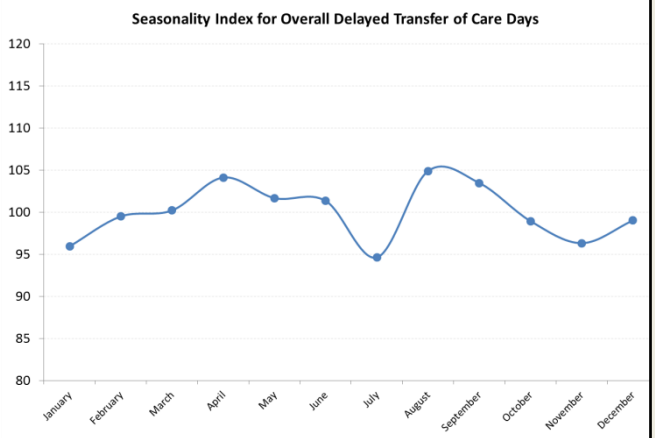
	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
NHS attributed delayed days	1956	1840	1673	1508	1393	1440	1440	1300	1440
Social Care attributed delayed days	2675	2644	2317	2078	1737	1587	1526	1378	1526
Jointly attributed delayed days	329	316	290	269	253	262	262	236	262
Total Delayed Days	**4960**	**4800**	**4280**	**3855**	**3383**	**3289**	**3228**	**2914**	**3228**



- One of the key issues around DToC traditionally has been around seasonality – for example greater demand due to winter pressures. However an analysis of seasonal delays indicates little correlation with health related seasonal differences, indicating that when needed, the system can cope to an extent with increased demand. This needs greater analysis.





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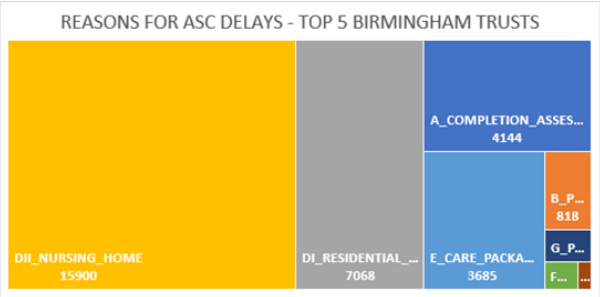

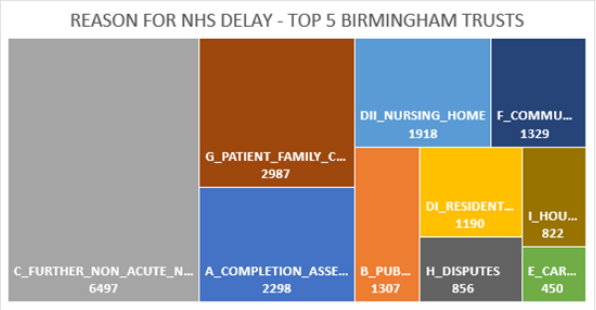

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Monthly Delayed Transfers of Care 'SitRep' returns provide further information about the reasons Birmingham residents have been delayed in hospital and provide some insight into the improvement effort and capacity requirements in the Birmingham system. NHS delays are most frequently recorded for patients awaiting further non-acute NHS treatment (33.1%), followed by Patient & Family Choice (15.2%), Completion of Assessment (11.7%) and Nursing Home placements (9.8%). Delays attributed to Adult Social Care are primarily due to Nursing Home placements (49.3%), Residential Home placements (21.9%), Completion of Assessment (12.9%) and Home Care Package (11.4%)[11].

14.3. National Condition 4: Managing Transfers of Care–Utilising the 8 High Impact Changes

- The High Impact Change Model aims to focus support on helping local system partners minimise unnecessary hospital stays and to encourage them to consider new interventions for future winters.

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- It offers a practical approach to supporting local health and care systems to manage patient flow and discharge and can be used to self-assess how local care and health systems are working now, and to reflect on, and plan for, action they can take to reduce delays throughout the year.

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- The 'High Impact Model' establishes the principles and best practice which underpin the single plan that will be the DTOC, Hospital to Home and elements of the BCF plan for the Birmingham system. This will fulfil the requirements within the iBCF, BCF, and the STP national Urgent and Emergency Care Plan. Steps have already been taken to develop the work programme which has been previously described. In summary:

12

  - Change 1– Early Discharge Planning: This model is under review currently considering the impact of social care involvement to assist with early discharge assessment particularly at the Heart of England Foundation Trust.
  - Change 2– Systems to monitor Flow: All acute Trusts currently monitor patient flow but it is not joined up with the 'out of hospital' system and does not have the same processes.
  - Change 3- Multi disciplinary and Multi agency Discharge: MDTs via discharge hubs are in place in all hospital sites but not community hospitals. Their refinement if necessary will be a focus of the Newton work outlined below
  - Change 4- Discharge 2 Assess: Our current model, which is not operating effectively for the system will be reviewed as a part of the wider system work discussed below. The principle of 'Home First' is not established.
  - Change 5- There is a 7 Day collaborative plan to be implemented which supports clinical Standard 9 describing the actions required from providers to respond to a whole system

[11] NHS – Adult Social Care Interface Dashboard - Further Analysis, Paul Johnson Impact Change Solutions

	KLOE
approach to deliver a continuum of a 7 day pathway for appropriate services to improve patient flow. ○ Change 6- Trusted assessment: Currently modelling the trusted assessor approach based on work already completed at one acute trust and pilot at another. Consideration to be given as to how this can be rolled out across all providers ○ Change 7- Focus on Choice. There is universally agreed policy in place, further work required on full implementation. ○ Change 8- Enhancing health in Care homes: Pilots in 16/17 for digital nursing and support to residential care homes are currently being evaluated.	
• The 8 High Impact Changes are also at the centre of work, previously described, with our partners Newton. The aim is to provide an evaluation of current practice and identify and prioritise opportunities to achieve a collaborative system wide plan for improvement. This work is due to start in July 2017 with a preliminary report of opportunities in November 2017. In the longer term we hope to deliver on the aims described below, however timescales will be dependent upon the Newton initial findings. The aims are:	13 11
○ A recognised and described model for post hospital recovery, rehabilitation and re-ablement. ○ Recognised and agreed models for integrated discharge teams and in- hospital processes. ○ An assessment of the required capacity in each part of the model over 7 days informed by an assessment of opportunities for admission avoidance at the front door through improved front door decision making and in services which interface with the pathways. ○ Agreement on how to fund the required capacity. ○ Clarity of underpinning systems and processes to optimise flow, with accountability agreements. ○ Single trusted assessments at the appropriate points within pathways. ○ An agreed delivery plan that starts with the greatest identified opportunities taking into consideration the requirements on the system as a whole and individual organisations within it.	12
14.4. Short term Activity - To support meeting the November 17 DTOC trajectory	
• As outlined the trajectory target report for November 2017 (which will report September DTOC position, requires some immediate, short term work. This includes;	
○ **Implementation of consistent process for counting and validating DToCs:** This involves working closely across organisations to embed national guidance around counting and validating individuals.	12
○ **Implementation of weekly DToC review:** Ensuring senior leadership and ownership across all organisations	11
○ **Implementation of Escalation Process** – Introducing a consistent system of appropriate escalation. Communication to be sent to relevant managers at all hospitals setting out how issues should be properly escalated	11
○ **Shared understanding of organisation at work –** e.g. Educating health colleagues on the elements of good social work practice and providing an overview of social work practice for the benefit of clinical staff especially at discharge hubs	

- **Implementation of Patient/Family Choice Policy -** Incentivisation of providers to assess before offering choice
- **Better Utilisation of Bed Based Enablement capacity –** To better use the 70 bed enhanced assessment bed resource which currently is considered to be used inappropriately at times

14.5. Longer term Activity

- The Home to Hospital Plan constitutes a single plan Birmingham and Solihull footprint which covers the areas of:
  - DTOC planning,
  - Urgent and Emergency Care Hospital to Home Planning and
  - Parts of the Birmingham and Solihull Better Care Fund Plans.

- A key part of this plan has been the agreement for all partners within the Birmingham system to a joint piece of work with consultants called Newton to undertake a definitive review of the out of hospital system particularly linked to hospital discharge but also considering admission avoidance opportunities at the front door. This will inform the medium to long term planning actions required and is expected to report to the A&E Delivery Board in early November.

- In summary the Hospital to Home Plan has the following key milestones and deliverables:

National Milestones	Local Deliverables	KLOE
Early Discharge Planning: In emergency/ unscheduled care, robust systems need to be in place to develop plans for management and discharge and to allow an expected date of discharge to be set within 48 hours	**HEFT:** LOS reduction programme - supported by relevant task and finish groups	12
	UHB: Unscheduled Care Board	12
Systems to monitor patient flows: Robust patient flow models for health and social care, including electronic flow system, enable teams to identify and manage problems and to plan services around the individual	Newton Review	
	Developing an integrated service which appropriately supports ED and short stay units – capacity and flow modelling, systems and processes	12
	Data sharing agreement, integrated IT systems and processes tested at UHB as part of trusted assessor project	
Multidisciplinary/ multi agency Discharge Teams including the voluntary and independent sectors: Co-ordinated discharge planning based upon joint assessment processes and protocols, and on shared agreed responsibilities, promotes effective	Newton Review	
	Developing an integrated service (including CHC) which appropriately supports ED and short stay units - this will be a consistent service over 7 days and will include BCHC rapid response and mental health requirements to support those in crisis	12

		KLOE
discharge and good outcomes for patients	Developing an integrated service (including CHC)which appropriately supports base wards, BCHC and EAB - this is likely to be a core five day service with a defined specification for cover over weekends and response at bank holidays and other key holiday periods.	
	Joint BCC/CCG Commissioning strategy for home care and residential/nursing care home providers	13
	Continuation of (until March 2017) and review of voluntary sector Hospital to Home service to develop long term strategy for recovery	
Home First / Discharge to Assess: Providing short term care and enablement in people's homes or using 'step down' beds to bridge the gap between hospital and home means that people no longer need to wait unnecessarily for assessments in hospital. In turn this reduces delayed discharges and improves patient flow.	Newton Review	
	Existing **EAB funding gap closed** in Birmingham - to be covered by iBCF	12 27
	Reconfiguration of enablement services in Birmingham	
	Additional long term nursing dementia capacity in Birmingham	12
	Joint BCC/CCG Commissioning strategy for home care and residential/nursing care home providers	
	Continuation of and review of voluntary sector **Hospital to Home** service to develop long term strategy	13 11
Seven Day Services: Successful joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs	**Newton Review** (see above)	
	Developing an **integrated service** (including CHC) which appropriately supports **ED and short stay units** - this will be a consistent service over 7 days and will include BCHC rapid response and mental health requirements to support those in crisis	13
	Developing an **integrated service** (including CHC) which appropriately supports **base wards, BCHC and EAB -** this is likely to be a core five day service with a defined specification for cover other periods**.**	12
	Continuation of (until March 2017) and review of voluntary sector **Hospital to Home** service to develop long term strategy for recovery	12
Trusted Assessors: Using trusted assessors to carry out an holistic assessment of needs avoids duplication and speeds up response times so that	**Newton Review** (see above)	
	Continuation of **SIDs model** at HEFT over winter.	12
	Extension of **OT /ASC pilot** at UHB both numbers of wards	12

		KLOE
people can be discharged in a safe and timely way	covered and levels of packages commissioned on basis of 'trust'. Integrated IT developments.	
	Incorporate trusted assessor developments into **'short stay'** and **'base ward'** projects	12
Focus on Choice: Early engagement with patients, families and carers is vital. A robust protocol underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their options and reaching decisions about their future care	**Joint post implementation review of policy to improve from experience informed by Newton review**	
	Improvement plan for delivery at organisational level	
Enhancing Health in Care Homes: Offering people joined up and co-ordinated health and care services can help reduce admissions to hospital as well as improve hospital discharge	**Newton Review**	
	Joint BCC/CCG Commissioning strategy for home care and residential/nursing care home providers	11
	Hospital to Home Plan 0817 v2.docx	12 13 20 37

15.Review of National Conditions

- The four BCF National conditions (reduced from 8 in 2016/ 17) are:

National Condition One	A jointly agreed plan
National Condition Two	NHS contribution to social care is maintained in line with inflation
National Condition Three:	Agreement to invest in NHS-commissioned out-of- hospital services
National Condition Four	Implementation of the High Impact Change Model for Managing Transfers of Care

- The following section outlines how these conditions have been met

15.1. National Condition One: A jointly agreed plan

- The Plan has been approved by the Birmingham BCF Commissioning Executive following engagement with the BSol STP Board and SWB Strategic Commissioning and Redesign Committee prior to receiving final sign off by and Birmingham Health and Wellbeing Board. 1

	KLOE
• The Birmingham STP Board is chaired by the Leader of Solihull Metropolitan Borough Council and has CEO and Chair members from all provider and commissioner organisations with Birmingham. Its membership also includes the Chairs of the Health and Wellbeing Boards of Birmingham and Solihull. The BSol STP Board will be underpinned by a Memorandum of Understanding, prior to more formal arrangements being established. Plans are underway to ensure that this includes appropriate representation from voluntary and community services.	1
• The iBCF plan was approved by the Birmingham Health and Well Being Board on 4th July 2017 following a consultation with stakeholders.	27
• The BCF Plan was approved by the Birmingham Health and Well Being Board on 4th October 2017.	1

15.2. National Condition 2: Social Care maintenance

- The overall strategic approach to adult social care being taken by Birmingham City Council, in common with other local authorities is outlined below:
    - Reshaping care in terms of driving a fundamental personalisation and market reshaping agenda.
    - Strengthening, in terms of quality, price and volume, independent sector residential care and other market capacity.
    - Income maximization for service users and carers.
    - A range of prevention activity including assisted technology (helped by both capital and recurring expenditure investment), falls prevention, and low level dementia support.
    - Home care enablement.
    - Informed choice/signposting through fundamental systems support such as the My Care in Birmingham website and its associated arrangements.
    - Support for carers.
    - Transformation of social work services to make them more productive and effective, including a significant diversion of demand from the "back door."
    - Other efficiencies and rationalisation around, for example, common management and administrative savings.

- In this context the approach to the Birmingham BCF to 'maintaining' social care services has been as follows: 7
    - Supporting the transformation of Social Care through the iBCF (see section 11.10) considering a change in social care model, focus on prevention and a new approach to commissioning social care
    - Continuing to fund areas identified for 256 resources: re-ablement, carers, Implementation of Care Act
    - Providing financial support for additional capacity to manage DTOC (see section 12) – beds, social work staff
    - Supporting alternatives to admission which include social care – virtual beds
    - Directly supporting social care bottom lines to retain current capacity as far as possible - Enablement, Social work staff

KLOE

- Supporting prevention services and instigating pilots – route to wellbeing, wellbeing co-ordination

- Whilst BCF was able to afford a certain level of support to social care in 2016/17 (as described above), it was not able to avert some of the planned reductions of service. This is one reason why Social care maintenance and transformation is a key priority for the iBCF and a clear focus in priority areas 1 and 3 of the iBCF plan (see section 11). The significant management changes within Birmingham City Council have provided the opportunity to 'go back to basics' and ensure that we can learn from other areas that are doing things differently and more effectively with the same strategic aim. It also allows us to learn from each other- where expertise exists among partners e.g. implementing systems and processes to manage demand and capacity.

- In line with this, we have demonstrated that in 17-19 the Better Care Fund will focus upon the stabilisation and modernisation of adult social care and the development of joined- up services and approaches which are as efficient and effective as possible, both through statutory and non-statutory service developments. This will be done alongside the development and implementation of plans for out of hospital health and care services, and enhanced primary care services particularly supporting improvements and reducing pressures in urgent and emergency care through both the STP's and the iBCF plan.

- In the longer term, the BCF vision, as described in this report is to proactively intervene to support people at the earliest opportunity ensuring that they remain well, are engaged in the management of their own health and wellbeing, and wherever possible enabled to stay in their own homes. We have demonstrated that we will do this through taking the decisions and actions in managing markets and our own assessment functions which improve quality and place a focus on enablement and support rather than service.

- The expected contributions from CCG's for 2017/18 and 2018/19 are included in the planning template and meet the requirement of these National Conditions

15.3. National Condition 3: NHS commissioned out-of-hospital services

- Pool investment is summarised in the submitted template Expenditure Plan – our programme areas and governance demonstrate National Conditions have been met

8

- No contingency fund has been allocated against BCF

10

15.4. National Condition 4: Managing Transfers of Care

- Section 14 provided an in depth overview of how the Birmingham Health and Social Care System is tackling Delayed Transfers of Care. There is a clear understanding of the influences and the need for immediate short term actions to meet the challenging agreed trajectories.

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12
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16. Finance

	KLOE
• This plan is intended to support work to address the financial challenges facing the Birmingham Public Sector organisations namely Birmingham City Council have made savings of almost £600 million since 2010 and expect to make a further £170 million savings by 2021. Also, based on current demand and activity Birmingham NHS face a £582million 'do nothing' deficit by 2021.	
• Over the two year period of 2017-19, the Better Care Fund will focus on supporting the stabilisation and modernisation of adult social care and the development of joined- up services and approaches in health and social care, which are as efficient and effective as possible, both through statutory and non-statutory service developments.	
• This will be undertaken alongside the development and implementation of plans for out of hospital health and care services, particularly supporting improvements and reducing pressures in urgent and emergency care through both the STP's and the iBCF plan. In the longer term, the BCF vision is to proactively intervene to support people at the earliest opportunity ensuring that they remain well, are engaged in the management of their own health and wellbeing, and wherever possible enabled to stay within their own homes.	7
• It can be confirmed that the CCG contribution to Social Care exceeds the minimum requirements for 18/19. In 17/18 from the template, it appears an inflationary amount of 1.2% has been achieved rather than the prescribed 1.7%. This is relating to an adjustment that was required on the 16/17 plan and budget. The plan for 16/17 was overstated by £528k, when this adjustment is taken into account the 17/18 to contribution to Social Care from the CCG minimum contribution does meet the inflationary requirement of 1.7%. The detail is included in the finance template contributions from CCG's for 2017/18 and 2018/19 are included in the planning template.	4
• The contributions to Social Care from the CCG minimum finance plan meets but does not exceed the prescribed contribution. Therefore the issue of affordability does not affect the BCF plan overall.	5
• The contribution to Social Care from the CCG's is in line with the previous years on going plans and in developing projects therefore there are no issues of destabilisation to the local Health and care system. We continue to work jointly to improve the DToC position and implement the High Impact changes to benefit the health and social care of the citizens of Birmingham.	6 11
• The contribution to Social Care from the CCG's minimum is being used to support and maintain social care services, but also to; further develop joint working on out of hospital services; refocus on prevention and reducing inequalities; develop community services in a multi- disciplinary setting; protect and sustain the provider market and invest in alternative provisions of care.	7

17.Assessment of Risk and Risk Management

KLOE

- The Better Care Fund was established in Birmingham building on a local track record of integration around Learning Disabilities and Mental Health and has been able to model robust dialogue through the strategic partnership created by the Commissioning Executive as risk owner and accountable body.

- The commencement of the STP has taken this further and brokered commitment to shared planning and a trust based approach to financial risk and BCF programme level risks are included in CCG and Local Authority risk monitoring and reporting. This recognised the system wide savings challenges early on and built into its deliver modelling of savings based on both fixed and variable costs.

- A clear financial and programme management infrastructure has supported decision making through an established Commissioning Executive with membership at Accountable Officer level and governance has been revised this year in the light of changes external to BCF to support interaction with the revised strategic environment. Therefore the main delivery risks in taking BCF forward include: 18
    - **Level of cross organisational commitment to transformation:** The approach of this current plan is intended to ensure collaboration between organisations, to be built upon through STP, by being clearly based on existing plans in place across the health and social care system.
    - **Financial Risk:** There is a risk that the overall financial position is so severe and challenging that it impacts on 17/19 onwards in terms of available budgets, making plan delivery impossible 21
    - **Level of Workforce change required:** The level of change required is unprecedented across; clinical and professional practice, terms and conditions, organisations, culture, engagement with people and each other
    - **Challenges in implementing change across diverse STP's and H&WB Boards:** Due to the unique nature of Sandwell and West Birmingham CCG's footprint we may have more than one approach within Birmingham. This increases the complexity of delivery, performance management and outcomes across the Birmingham HWB area.

- Mitigating actions have been taken to address all the risks identified – these include:
    - Ensuring there is clear and shared financial planning in place supported by defined process for decision making with appropriate schemes of delegation. 21
    - Ensuring clear organisation commitment to work together through clear partnership arrangements and inclusion of strategic planning to ensure progress
    - Ensuring there is robust financial governance and scrutiny in place supported by agreed risk-sharing agreement that sets out interdependencies and how pooled budget arrangements will work across health and social care 22
    - Ensuring clear accountability as part of Terms of Reference
    - Ensuring robust programme management is in place and schemes are implemented on time and to budget supported by a clear performance framework with close monitoring of KPI's including activity, performance and associated spends.

The risks and Risk assessment is described below

Risk Log for Better Care Fund plan 2017/18/19						**KLOE**
There is a risk that:	**How likely is the risk to materialise?**	**Potential impact**	**Overall unmitigated risk factor**	**Mitigating Actions**	**Mitigated risk factor**	
BCC financial position remains challenging impacts on 17/19 onwards available budgets, making plan delivery impossible	4	5	20	Clear and shared financial planning Financial governance and scrutiny in place Clear accountability as part of Terms of reference	8	21 22 23
Better Care Fund Schemes will not succeed in reducing non-elective admissions, leading to higher costs for the CCGs	4	4	12	Ensure implementation of schemes on time and to budget through robust programme management. Better Care Board to review performance against plan and take corrective action. Risk share	7	29
Better Care Fund schemes will not succeed in reducing permanent admissions to residential care	2	2 Risk falls on LA	4	Performance in 2015/16 has achieved target trajectory	2	
Schemes fail to have impact on desired priority outcomes, acute activity and savings not achieved or whole system spend increases.	4	5 Risk falls on CCG commissioners	20	Commitment of organisations to work together through the new partnership board – indicative letter of intent Developing schemes that can evidence impact on target population. Programme management of schemes overseen by Programme lead supported by a team of project managers. Implementation of a clear performance framework with close monitoring of KPI's including activity, performance and associated spends. Remedial actions taken if off target. Exploring options around commissioning and provider delivery models to incentivise whole system performance.	12	
Governance arrangements are insufficient to make investment decisions, ratify the vision and ensure ongoing alignment of the programme with whole	2	4	8	Programme has clearly defined purpose Commissioning Executive established - Members AO and CFOs	4	18

						KLOE
system strategic direction.				Defined process for decision making with appropriate schemes of delegation. Clear method for disagreement resolution. Rules on data and performance management agreed.		21, 22, 23
Failure to separate the business of making partnership work from internal priorities of each organisation.	4	4	16	Agreed risk-sharing agreement that sets out interdependencies and how pooled budget arrangements will work across health and social care to be developed New strategic partnership between BCC and health partners will enable this	7	
Failure to understand and agree appropriate funding flows throughout the system particularly in relation to savings (perception of double counting), benefits and risk.	2	3	6	Track record of integration around LD and MH. Already recognise system wide savings challenge Modelling savings based on both fixed and variable costs. Dialogue commenced through strategic partnership.	3	
Unprecedented level of Workforce change required across; clinical and professional practice, terms and conditions, organisations, culture, engagement with people and each other	4	4	16	Workforce will form part of the Sustainability and Transformation Plans but experience of 15/16 suggests achieving change will be challenging. Strategic partnership gives opportunity for collaboration and change	7	
Community capacity not in place in sufficient scale to meet demand pattern changes	3	4	12	Modelling of requirement to ensure accuracy and building clarity on current capacity. Pump priming investment achieved in 2015/16 and continued into 16/17 Strategic partnership gives opportunity for support	6	
Due to the unique nature of Sandwell and West Birmingham CCG's footprint we may have more than one approach within Birmingham. This increases the complexity of delivery, performance management and outcomes across the Birmingham HWB area.	4	3	12	Commitment of organisations to work together through the programme board to develop detail on the economy level governance, risk, measures, equity of delivery and finance for 16/17 BCC have signed MOU of support for 'Right Care/ Right Here' programme.	6	
Patients and the public do not adequately engage with	3	4	12	Continue to engage with patients, public and local communities	6	

the BCF schemes resulting in dissatisfaction and associated reputational risk.				through existing forums and involvement of Health Watch in BCF programme, via BCF02.	

Appendix 1

Birmingham Better Care Plan - Key Lines Of Enquiry

Planning requirement area	BCF Planning Requirements (the confirmations for these requirements will be collected and analysed centrally)	KLOEs to support assurance of the planning requirements (these KLOEs underpin the assurance for the planning requirements but will not be collected/analysed centrally)	Is KLOE evidenced in Birmingham Plan? (Page)
National condition 1: jointly agreed plan (Policy Framework)	**1.Has the area produced a plan that all parties sign up to, that providers have been involved in, and is agreed by the health and well-being board?** **2.In all areas, is there a plan for DFG spending? And, in two tier areas, has the DFG funding been passed down by the county to the districts (in full, unless jointly agreed to do otherwise)?**	1. Are all parties (Local Authority and CCGs) and the HWB signed up to the plan? 2. Is there evidence that local providers, including housing authorities and the VCS, have been involved in the plan? 3. Does the Narrative Plan confirm that, in two-tier areas, the full amount of DFG Money has been passed to each of the Districts (as councils with housing responsibilities), or; where some DFG money has been retained by the Upper Tier authority, has agreement been reached with the relevant District Councils to this approach?	4 35
National condition 2: Social Care Maintenance (Policy Framework)	**3.Does the planned spend on Social Care from the BCF CCG minimum allocation confirm an increase in line with inflation* from their 16/17 baseline for 17/18 and 18/19** **1.79% for 2017/18 and a further 1.90% for 2018/19*	4. Is there an increase in planned spend on Social Care from the CCG minimum for 17/18 and 18/19 equal to or greater than the amount confirmed in the planning template? 5. If the planned contributions to social care spend from the BCF exceed the minimum, is there confidence in the affordability of that contribution? 6. In setting the contribution to social care from the CCG(s), have the partners ensured that any change does not destabilise the local health and care system as a whole? 7. Is there confirmation that the contribution is to be spent on social care services that have some health benefit and support the overall aims of the plan? NB this can include the maintenance of social care services as well as investing in new provision	53 53 53 51,53
National condition 3: NHS commissioned Out of Hospital Services (Policy	**4.Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	8. Does the area's plan demonstrate that the area has committed an amount equal to or above the minimum allocation for NHS commissioned out-of-hospital services and this is clearly set out within the summary and expenditure plan tabs of the BCF planning template? 9. If an additional target has been set for Non	52 52

Framework)		Elective Admissions; have the partners set out clear evidence based process for deciding whether to hold funds in contingency, linked to the cost of any additional Non Elective Admissions that the plan seeks to avoid? 10. If a contingency fund is established; Is there a clear process for releasing funds held in contingency into the BCF fund and how they can be spent?	52
National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care	**5.Is there a plan for implementing the high impact change model for managing transfers of care?**	11. Does the BCF plan demonstrate that there is a plan in place for implementing actions from the high impact change model for managing transfers of care? Does the narrative set out a rationale for the approach taken, including an explanation as to why a particular element is not being implemented and what is approach is being taken instead? 12. Is there evidence that a joint plan for delivering and funding these actions has been agreed? 13. If elements of the model have already been adopted, does the narrative plan set out what has been commissioned and, where appropriate, link to relevant information?	53 43-49
Local vision for health and social care	**6.A clear articulation of the local vision for integration of health and social care services?**	14. Does the narrative plan articulate the local vision for integrating health and social care services, including changes to patient and service user experience and outcomes, and a strategic approach to housing, social care and health, cross-referenced and aligned to other plans impacting on integration of health and social care such as STPs or devolution deals? 15. Is there an articulation of the contribution to the commitment to integrate health and social care services by 2020 in line with the intent set out in the 2015 spending review and the BCF policy Framework? 16. Is there a description of how progress will continue to be made against the former national conditions 3, 4 and 5 in the 2016/17 BCF policy framework?	18,24 10
Plan of action to contribute to delivering the vision for social and health integration	**7.Does the BCF plan provide an evidence-based plan of action that delivers against the local needs identified and the vision for integrating health and social care?**	17. Is there a robust action plan that addresses the challenges of delivering the vision, including: •Quantified understanding of the current issues that the BCF plan aims to resolve •Evidence based assessment of the proposed impact on the local vision for integrating health and social care services through the planned schemes and joint working arrangements	8-10,12,24

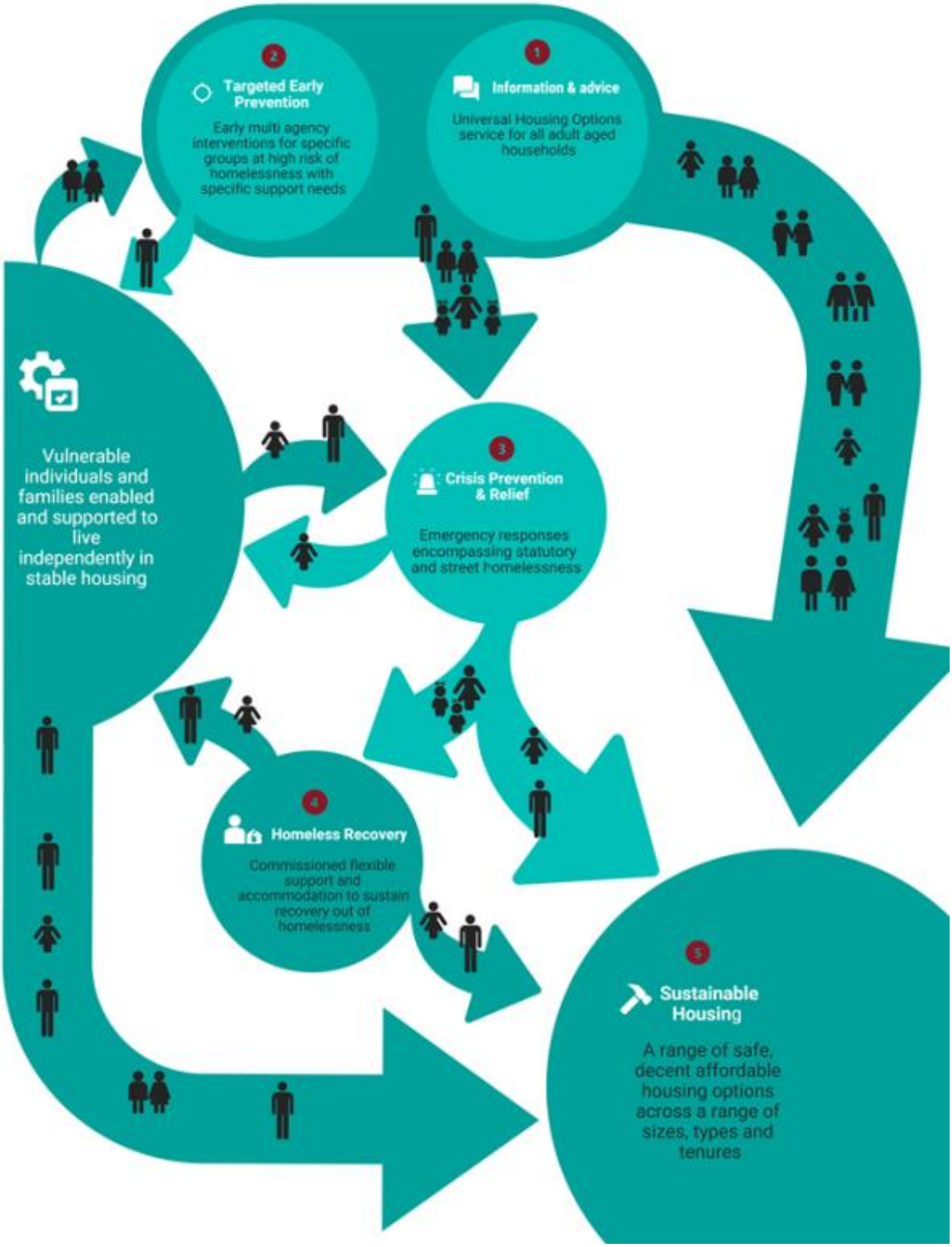
Approach to programme delivery and control	**8.Is there a clear, jointly agreed approach to manage the delivery of the programme, identify learning and insight and take timely corrective and preventive action when needed?**	18. A description of the specifics of the overarching governance and accountability structures and management oversight in place locally to support integrated care and the delivery of the BCF plan? 19. A description of how the plan will contribute to reducing health inequalities (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics under the Equality Act 2010? 20. Does the narrative plan have a clear approach for the management and control of the schemes? including as a minimum: •Benefit realisation (how will outcomes be measured and attributed?) •Capturing and sharing learning regionally and nationally •An approach to identifying and addressing underperforming schemes	24,54,55 12 29,28,27,26, 50
Management of risk (financial and delivery)	**9.Is there an agreed approach to programme level risk management, financial risk management and, including where relevant, risk sharing and contingency?**	21. Have plan delivery and financial risks, consistent with risks in partner organisations, been assessed in partnership with key stakeholders and captured in a risk log with a description of how these risks will be proportionally mitigated or managed operationally? 22. If risk share arrangements have been considered and included within the BCF plan, is there a confirmation that they do not put any element of the minimum contribution to social care or IBCF grant at risk? 23. Is there sufficient mitigation of any financial risks created by the plan if a risk share has not been included?	43,54 29,53,54 53
Funding contributions: **1.Care Act,** **2.Carers' breaks,** **3.Reablement** **4.DFG** **5.iBCF**	**10.Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose and this is appropriately agreed with the relevant stakeholders and in line with the National Conditions?**	24. For each of the funding contributions, does the BCF evidence: •That the minimum contributions set out in the requirements have been included? •How the funding will be used for the purposes as set out in the guidance? •That all relevant stakeholders support the allocation of funding? •The funding contributions are the mandated local contributions for: •Implementation of Care Act duties •Funding dedicated to carer-specific support •Funding for Reablement •Disabled Facilities Grant? 25. Does the planning template confirm how the minimum contribution to Adult Social Care and the funding for NHS Commissioned Out of Hospital Services will be spent? 26. Does the BCF plan set out what proportion of each funding stream is made available to social care and that the improved Better Care Fund has	22,27,31,35 See template 4,7,9,17,25, 26,27,49,51

		not been offset against the contribution from the CCG minimum? 27. Is there agreement on plans for use of IBCF money that meets some or all of the purposes set out in the grant determination?	
Metrics – Non Elective Admissions	**11.Has a metric been set for reducing Non Elective Admissions?**	28. Does the narrative plan include an explanation for how this metric has been reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19? 29. Has a further reduction in Non Elective Admissions, additional to those in the CCG operating plan, been considered?	See Planning template 55
Metrics – Non Elective Admissions (additional)	**12.If a metric has been set for a further reduction in Non Elective Admissions, beyond the CCG operating plan target, has a financial contingency been considered?**	30. Has the metric taken into account performance to date and current trajectory and are schemes in place to support the target?	19,20
Metrics Admissions to residential care homes	**13.Has a metric been set to reduce permanent admissions to residential care?**	31. Does the narrative plan include an explanation for how this metric will be reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19?	See Planning template
Metrics – Effectiveness of Reablement	**14.Has a metric been set for increasing the number of people still at home 91 days after discharge from hospital to rehabilitation or reablement?**	32. Does the narrative plan include an explanation for how this metric will be reached, including an analysis of previous performance and a realistic assessment of the impact of the reablement funding allocation for health and social care and other BCF schemes on performance in 2017-19?	See Planning template
Metrics Delayed Transfers of Care	**15.Have the metrics been set for Delayed Transfers of Care?**	33. Have all partners agreed a metric for planned reductions in delayed transfers of care across the HWB that is at least as ambitious as the overall HWB target for reductions of DToC by November 2017? 34. Is the metric in line with the expected reductions in DToC for social care and NHS attributed reductions for the HWB area set out in the DTOC template? 35. If the local area has agreed changes in attribution from those set out in the template is there a clear evidence base and rationale for those changes? 36. Does the narrative set out the contribution that the BCF schemes will make to the metric including an analysis of previous performance	44 44 44

		and a realistic assessment of the impact of BCF initiatives in 2017/19 towards meeting the ambition set out in the local A&E improvement plan? 37. Have NHS and social care providers been involved in developing this narrative?	50
Integrity and completeness of BCF planning documents	**16.Has all the information requested in the DTOC and planning templates been provided and are all the minimum sections required in the narrative plan elaborated?**	38. Have the DTOC template, Planning template and Narrative plans been locally validated for completeness and accuracy as per the planning requirements? (Better Care Support Team will carry out central data validation)	See planning template

Appendix 2

Homelessness Prevention Positive Pathway



2018-19 Better Care Pooled Budget PLAN

System Resilience Schemes	Proposed Budget
	£'000s
Enhanced Assessment Beds	
- Bromford Lane (25)	1,063
Conversion Interim to EAB	0
Residential Dementia	
- Bromford (5)	213
- Perrywell (4)	138
Balance of funding	23
Unfunded Beds	0
Spot Purchase Beds	0
Total Bed Based additional provision	**1,436**
BCF Funds	
Social Worker Capacity (Hospitals)	678
7 Day Working - Original	305
7 Day Working - New, City	78
Home Care Capacity-enablement	507
Total Social Care Based additional provision	**1,569**
BCF Committed Schemes	
Kenrick Centre	1,539
Care Act	3,139
Carers Strategy	1,900
Eligibility Criteria	21,185
Clinical Utilisation Review Tool procurement	740
Management of Programme	1,032
Total BCF Committed Schemes	**29,536**
Other Areas of Spend	
Community Services	47,204
Reablement - RAID	1,703
Planned Community/Intermediate Care investment	105
OPAT - HEFT	34
Dementia	2,633
AOT	291
Equipment Contracts	5,454
Contingency	0
Total Other Areas of Spend	**57,423**
Total	**89,964**
DFG and Capital (Ring Fenced)	10,571
Non Recurrent Funding Available	
Underspend b/f from 17/18	3,317
Total Expenditure Plans	**103,852**

Notes
Assuming there are no price increases due for 18/19
To be confirmed
Based on 18/19 proposed contract value
To be confirmed as introduced by SWB CCG for BCF Plan
Budget reduced by BCC
underspend from 17/18

IBCF 2 Monitor	Period 1			2018/19 Current Budget	Proposed 2018/19 Commtments	Period 1 Actuals	Forecast	Notes	Further Notes	Service Area	Code(s)
					£'000						
AREA 1: To meet adult social care need											
1.1 Support Communities	Staffing CCoE										
1.2 Carers	Carers Hub				263			Proposed Costs to be transferred to BCF		Commissioning	
1.3 Citizen Centred Approach					3,500			Mitigations			
1.4 Reconfigure Enablement					2,000			Mitigations			
1.5 Day Care review (Amanda Sharman)					356				1 TM + 14 GR4 (6 months)	ASP	
1.6 SIT Team (High Costs) + JM					576				1 TM + 10 GR4 + 1GR6 (JM)	ASP/Commissioning	
				8,000	6,695	0	0				
AREA 2: To provide support to the NHS (especially through application of the 8 High Impact Changes)											
2.1 System Change	Newton				2,000			Element of £10m costs		Commissioning	
2.2 Hospital social workers	8 UHB Social Workers				343				Acutes Agency - up to 8 ?	ASP	RV3BL
	Discharge Facilitators/Admin Trackers				318				5+5 GR3	ASP	
	HPDT				224				3 GR4 + 3 GR3	ASP	
	Rapid response				75				1 GR4 + 1 GR3	ASP	
2.3 Home From Hospital	Home from Hospital/Service Review				100				GTVOs - Home from Hospital report £100k 2017/18 & 18/19 (from December 2017).	Commissioning	
2.4 Fund EAB Gap	EAB Beds				0				RV514 ?	APoC	RV514
	EAB Team				1,900				RV3LL	ASP	RV3LL
2.5 Trusted Assessors					250			Revised provision	In Acutes / Provider settings.		
2.6 7 Day SW, EDT, Brokerage					429				10 GR4 (7 Day Working)	ASP	RV3H5
2.7 SW / OT Model	ADAPT/React Plus				679				Supporting Acutes	ASP	RV3BL
2.8 Commissioning Support	JL + Broker				53				Backfill for JL + 1 GR3 Broker	Commissioning	
2.9 Additional staff capacity to deliver the required changes					269				1. Mark Lobban (employed by UHB £750/day) to implement Newton recommendations 2. 1.5 FTE OT's (1.25 Therapists UHB £60k) 3. Local Area Co-ordinators (3xGR3 Feb-)	1. UHB 2.UHB/Acute 3.ASP	1. Invoice 2. Invoice ? 3.RV3BL
2.10 Additional Costs for quick discharge					1,921				1. Providers various APOC Res £860k+Nursing £1,061k.	APoC Commissioning	1. Various OA
2.11 Additional Bed Capacity to support NHS	15 interim + 60 Nursing Dementia + 20 further				2,848				EA Beds Austin Rose(15), MACC (30), Harborne Lane (20), Uplands (15), + Not used so far (Orchards (10), Hodge Hill (5)	APoC	RV510/RV601/RV514
				7,400	11,410	0	0				
Area 3: To sustain the social care provider market											
3.1 Peer Review					0						
3.2 CQC Registration payment					0						
3.3 End of Life Pilot					300				Anita Holbrook-Adrian Philips End of Life PHBs-pilot	PH	
3.4 Neighbourhood Networks / Pump Priming Diversion Services					2,700					Commissioning	
3.5 Adult Social Care (Ref. GB) - Framework					2,000						Invoice-No vendor ?
0				7,400	5,000	0	0				
Total				22,800	23,105	0	0				

Appendix 4 - iBCF outturn report for 2017/18

IBCF 2 Monitor	Period 12	Original Budget	Budget Movement	Current Budget	Period 12 Actuals	Outturn for 2017/18
		£'000	£'000	£'000	£'000	£'000
AREA 1: To meet adult social care need						
1.1 Support Communities	Staffing CCoE	2,600	(2,600)	0	0	0
1.2 Carers	Carers Hub	750		750	66	75
1.3 Citizen Centred Approach		3,500	(3,500)	0	0	0
1.4 Reconfigure Enablement		2,000	(2,000)	0	0	0
	Carry Forward for 2018/19 and 2019/20		11,300	11,300	0	9,300
1.X Mitigations			5,000	5,000	7,608	2,400
		8,850	8,200	17,050	7,674	11,775
AREA 2: To provide support to the NHS (especially through application of the 8 High Impact Changes)						
2.1 System Change	Newton	0		0	150	250
2.2 Hospital social workers	4 UHB	192		192	176	192
	TBC	1,058		1,058	1,089	291
2.3 Home From Hospital	Home from Hospital/Service Review	200		200	0	33
2.4 Fund EAB Gap	EAB Beds	420		420	385	420
	EAB Team	1,930		1,930	1,742	1,900
2.5 Trusted Assessors		1,000	(1,000)	0	0	0
2.6 7 Day SW, EDT, Brokerage	including HPDT/BCF unfunded	2,000	(1,000)	1,000	553	1,146
2.7 SW / OT Model	ADAPT	2,000	(1,500)	500	391	489
2.8 Under 65s in Hospital	Invest to save/shared lives	300	(300)	0	0	0
		9,100	(3,800)	5,300	4,486	4,721
Area 3: To sustain the social care provider market						
3.1 Framework		1,400		1,400	724	508
3.x Additional staff capacity to deliver the required changes		750	(436)	314	152	306
3.2 Peer Review		0		0	0	0
3.3 CQC Registration payment		400	(400)	0	0	0
3.4 Purchase additional Capacity	15 interim + 60 Nursing Dementia + 15 further	3,500	(2,500)	1,000	745	955
3.5 integrated Personal Commissioning		400	(400)	0	0	0
3.6 Pump Priming Diversion Services		2,600	(2,600)	0	0	0
3.7 Adult Social Care (GB)			2,000	2,000	0	2,088
0		9,050	(4,336)	4,714	1,620	3,857
Total		27,000	64	27,064	13,781	20,354
		11,300				9,300
		5,000				2,400
		10,764				8,654
		27,064				20,354
			C/FWD			6,710

2017-18 Better Care Pooled Budget Performance	Month	12

Planned Application of the Pool

System Resilience Schemes	Annual Budget	YTD Budget	YTD Actual	Variance	Variance	Nature of Arrangement	Expenditure: Gross / Net Reporting	Year End Balances: Who picks up over/underspend	Council Share of Over/Underspend	CCG Share of Over/Underspend	Split of CCG Share: BXC	BSC	SWB
	£'000s	£'000s	£'000s	£000s	£'000s				£'000s	£'000s	£'000s	£'000s	£'000s
Enhanced Assessment Beds													
- Bromford Lane (25)	1,043	1,043	1,043	0	0	Lead Commissioning - by Council	Gross Accounting	Share	0	0	0	0	0
Conversion Interim to EAB	0	0	0	0	0	Lead Commissioning - by Council	Gross Accounting	Share	0	0	0	0	0
Residential Dementia													
- Bromford (5)	209	209	209	0	0	Lead Commissioning - by Council	Gross Accounting	Share	0	0	0	0	0
- Perrywell (4)	136	136	136	0	0	Lead Commissioning - by Council	Gross Accounting	Share	0	0	0	0	0
Balance of funding	0	0	0	0	0	Lead Commissioning - by Council	Gross Accounting	Share	0	0	0	0	0
Unfunded Beds	75	75	75	0	0	Lead Commissioning - by Council	Gross Accounting	Share	0	0	0	0	0
Spot Purchase Beds	58	58	58	(0)	(0)	Lead Commissioning - by Council	Gross Accounting	Share	(0)	(0)	(0)	(0)	(0)
Total Bed Based additional provision	**1,520**	**1,520**	**1,520**	**(0)**	**(0)**				**(0)**	**(0)**	**(0)**	**(0)**	**(0)**
BCF Funds													
Social Worker Capacity (Hospitals)	3,991	3,991	665	3,326	3,326	Sole Control - by Council	n/a	Council	3,326				
7 Day Working - Original	300	300	300	0	0	Sole Control - by Council	n/a	Council	0				
7 Day Working - New, City	77	77	77	0	0	Sole Control - by Council	n/a	Council	0				
Home Care Capacity-enablement	498	498	498	0	0	Sole Control - by Council	n/a	Council	0				
UHB Social Workers (4)	0	0	0	0	0	Sole Control - by Council	n/a	Council	0				
Total Social Care Based additional provision	**4,865**	**4,865**	**1,539**	**3,326**	**3,326**				**3,326**	**0**	**0**	**0**	**0**
BCF Committed Schemes													
Kenrick Centre	1,511	1,511	1,511	0	0	Sole Control - by Council	n/a	Council	0				
Care Act	3,081	3,081	3,081	0	0	Lead Commissioning - by Council	Gross Accounting	Share	0	0	0	0	0
Carers Strategy	999	999	999	(0)	(0)	Joint Control	Net Accounting	Share	(0)	(0)	(0)	(0)	(0)
Eligibility Criteria	20,790	20,790	20,790	0	0	Sole Control - by Council	n/a	Council	0				
Clinical Utilisation Review Tool procurement	73	73	73	0	0	Joint Control	Net Accounting	Share	0	0	0	0	0
Management of Programme - BXC			*194*										
Management of Programme - BCC			*201*										
Management of Programme	395	395	395	(0)	(0)	Joint Control	Net Accounting	Share	(0)	(0)	(0)	(0)	(0)
Total BCF Committed Schemes	**26,849**	**26,849**	**26,849**	**(0)**	**(0)**				**(0)**	**(0)**	**(0)**	**(0)**	**(0)**
Other Areas of Spend													
Community Services	45,608	45,608	45,608	(0)	(0)	Sole control - by CCGs	n/a	CCGs		(0)	(0)	(0)	(0)
Reablement - RAID	1,701	1,701	1,701	0	0	Sole control - by CCGs	n/a	CCGs		0	0	0	0
OPAT - HEFT	34	34	34	0	0	Sole control - by CCGs	n/a	CCGs		0	0	0	0
OPAT - BCHCT	0	0	0	0	0	Sole control - by CCGs	n/a	CCGs		0	0	0	0
Dementia	2,633	2,633	2,633	(0)	(0)	Sole control - by CCGs	n/a	CCGs		(0)	(0)	(0)	(0)
AOT	187	187	187	0	0	Sole Control - by CCGs	n/a	CCGs		0	0	0	0
Well being Coordinators (May to Oct 17)	21	21	21	0	0	Joint Control	Net Accounting	Share	0	0	0	0	0
Equipment Contracts	4,683	4,683	4,683	0	0	Lead Commissioning - by Council	Gross Accounting	Share	0	0	0	0	0
Contingency	0	0	0	0	0	Joint Control	Net Accounting	Share	0	0	0	0	0
Total Other Areas of Spend	**54,866**	**54,866**	**54,866**	**(0)**	**(0)**				**0**	**(0)**	**(0)**	**(0)**	**(0)**
Total	**88,099**	**88,099**	**84,774**	**3,326**	**3,326**				**3,326**	**(0)**	**(0)**	**(0)**	**(0)**
DFG and Capital (Ring Fenced)	9,687	9,687	9,687	0	0	Sole Control - by Council	n/a	Council	0				
Non Recurring Pump Priming Schemes (see below)													
Equipment - Invest to save	92	92	92	0	0	Joint Control	Net Accounting	Share	0	0	0	0	0
Wellbeing Coordinators (May to Oct 17)	166	166	166	0	0	Joint Control	Net Accounting	Share	0	0	0	0	0
Total Expenditure Plans	**98,045**	**98,045**	**94,719**	**3,326**	**3,326**				**3,326**	**(0)**	**(0)**	**(0)**	**(0)**

Contribution into BCF Pool					
	BXC	BSC	SWB	BCC	TOTAL
BCF	£55,881,668	£19,061,165	£11,555,709	£11,392,294	£97,890,836
iBCF	£0	£0	£0	£33,792,214	£33,792,214
				TOTAL	£131,683,050

Share	(0)	(0)
Council	3,326	0
CCGs	0	(0)
	3,326	**(0)**

	£k
Birmingham City Council	3,326
Birmingham Cross City CCG	(0)
Birmingham South Central CCG	(0)
Sandwell & West Birmingham CCG	(0)
	3,326

	Agenda Item: 10
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**19th June 2018**
TITLE:	**HEALTH AND WELLBEING STRATEGY LEADS**
Organisation	**Birmingham City Council**
Presenting Officer	**Carol Herity/Wayne Harrison**

Report Type:	**Discussion**

1. Purpose:

For the Board to consider the role of Health & Wellbeing Board and Operational Lead for each of the priorities in the Health & Wellbeing Strategy.

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

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

3.	**Recommendations**
	That the Health and Wellbeing Board consider the role specification for the Board and Operational lead for specific areas of the Health & Wellbeing Strategy and feed any comments back before the July meeting.

4.	**Background**
4.1	The Board has previously agreed that a Board level lead should be identified for each of the priorities in the Health & Wellbeing Strategy to provide high level support the Operation Group lead in each area.
4.2	At the April meeting it was noted that Board leads had not been agreed for many of the priorities in the Health & Wellbeing Strategy.
4.3	The Operations Group were asked to outline a role specification for the “Board Lead” and “Operations Lead” to clarify the requirements of each of these roles

5.	Future development
	The roles specifications will be agreed at the July board with a view to agreeing leads at the September meeting.

6.	Compliance Issues
6.1	***Strategy Implications***
	No information available
6.2	***Governance & Delivery***
	No information available
6.3	***Management Responsibility***
	No information available

7.	Risk Analysis		
No information available			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
#	#	#	#

Appendices
1. Role Specification for Board Lead 2. Role Specification for Operational Lead

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

Appendix 1

Health and Wellbeing Board Strategy

Role Specification

Role Title: Health and Wellbeing Board Lead

Thematic Areas:

Priority	Ambition
Improve the wellbeing of children	• Detect and prevent Adverse Childhood Experiences (ACEs) • All children in permanent housing
Improve the independence of adults	• Increase the control of individuals over their care through Integrated Personal Commissioning (Personal Health Budgets and Direct Payments)
Improve the wellbeing of the most disadvantaged	• Increasing employment/ meaningful activity and stable accommodation for those with mental health problems • Improving stable and independent accommodation for those with learning disabilities • Improve the wellbeing of those with multiple complex needs
Make Birmingham a Healthy City	• Improve air quality • Increased mental wellbeing in the workplace

In order to develop the indicators and ambition around the priorities outlined in the strategy and assure the Health and Wellbeing Board of the delivery against the priorities, members of the Health and Wellbeing Board group will need to take ownership the specific areas in the strategy and drive this forward implement change for the communities we serve. The role will involve building partnerships with key players within system, and other boards and committees in delivery who have been delegated priorities.

This role will also entail:

- Identify structures that are working in that area
- Identify key links to establish to ensure clear communications flow

- Identify indicators and existing / alternatives targets for the specific area
- Review existing or proposed activities that are in place to deliver against the ambition
- Identify gaps for additional for alternative activity that may be required in order to drive the Health and Wellbeing Strategy for Birmingham
- To monitor and report progress on implementation of the work programme in accordance with agreed reporting schedules and processes to the Health and Wellbeing Board
- To support operations group to develop and implement action plans in relation to specific themes as these arise. These will be established at the discretion of the Chair of the Health and Wellbeing Board.

Objectives:

- Support the development and delivery of the Health and Wellbeing Strategy
- Advocate for the identified workstream
- Make key links with key players to provide an update on priority area
- Progress and report against the Health and Wellbeing Strategy
- Foster and develop partnership arrangements to deliver core functions to support the strategic priorities

Appendix 2

Health and Wellbeing Board Strategy

Role Specification

Role Title: Health and Wellbeing Operations Lead

Thematic Areas:

Priority	Ambition
Improve the wellbeing of children	• Detect and prevent Adverse Childhood Experiences (ACEs) • All children in permanent housing
Improve the independence of adults	• Increase the control of individuals over their care through Integrated Personal Commissioning (Personal Health Budgets and Direct Payments)
Improve the wellbeing of the most disadvantaged	• Increasing employment/ meaningful activity and stable accommodation for those with mental health problems • Improving stable and independent accommodation for those with learning disabilities • Improve the wellbeing of those with multiple complex needs
Make Birmingham a Healthy City	• Improve air quality • Increased mental wellbeing in the workplace

In order to develop the indicators and ambition around the priorities outlined in the strategy and assure the Health and Wellbeing Board of the delivery against the priorities, members of the operations group will need to take ownership the specific areas in the strategy. The role will involve coordinating with other boards and committees in delivery who have been delegated priorities.

This role will also entail:

- Identify structures that are working in that area
- Identify key links to establish to ensure clear communications flow
- Identify indicators and existing / alternatives targets for the specific area

- Review existing or proposed activities that are in place to deliver against the ambition
- Identify gaps for additional for alternative activity that may be required in order to drive the Health and Wellbeing Strategy for Birmingham

Objectives:

- Support the development and delivery of the Health and Wellbeing Strategy
- Support the Board lead by ensuring regular updates on priority area are provided
- Progress and report against the Health and Wellbeing Strategy

  Foster and develop partnership arrangements to deliver core functions to support the strategic priorities