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

BIRMINGHAM CITY COUNCIL

HEALTH AND WELLBEING BOARD

TUESDAY, 04 JULY 2017 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 Chair to advise/meeting to note that this meeting will be webcast for live or subsequent broadcast via the Council's Internet site (www.birminghamnewsroom.com) and that members of the press/public may record and take photographs.

3 - 4

2 **APPOINTMENT OF HEALTH AND WELLBEING BOARD - FUNCTIONS, TERMS OF REFERENCE AND MEMBERSHIP**

To note the re-appointment of the Health and Wellbeing Board with the functions, terms of reference and membership as set out in the schedule.

3 **DECLARATIONS OF INTERESTS**

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

4 **APOLOGIES**

5 **DATES OF MEETINGS**

To note dates for formal meetings of the Board commencing at 1500 hours:-
Tuesday 3 October 2017
Tuesday 16 January 2018
Tuesday 27 March 2018
(Two informal meetings will also be scheduled)

5 - 12

6 **MINUTES AND MATTERS ARISING**

To confirm the Minutes of the last meeting.

7 **CHAIR'S UPDATE**

To receive an oral update. (1505-1510)

13 - 26

8 **HEALTH AND WELLBEING BOARD STRATEGY**

To consider a report on the development and taking forward of the Health and Wellbeing Strategy. (1510-1530)

27 - 30

9 **USING THE IMPACT OF ADVERSE CHILDHOOD EXPERIENCES TO IMPROVE THE HEALTH AND WELLBEING OF BIRMINGHAM PEOPLE**

To note a report on the progress made by the Task and Finish Group. (1530-1545)

31 - 40

10 **IMPROVING THE INDEPENDENCE OF ADULTS**

To consider a report recommending that the Board adopts the targets in the Integrated Personal Commissioning (IPC) adopter programme in respect of improving the independence of adults. (1545-1600)

41 - 54

11 **(A) PROPOSALS FOR THE USE OF THE IMPROVED BETTER CARE FUND; (B) DEMENTIA FUNDING IN THE BETTER CARE FUND**

To consider reports seeking approval to the proposed use of the 2017/18 Improved Better Care (iBCF) allocation and the transfer of funds from Birmingham City Council for dementia commissioned services. (1600-1620)

55 - 74

12 **BIRMINGHAM AND SOLIHULL CCGS: TRANSITION UPDATE**

To consider a report and presentation on future CCG organisational commissioning arrangements and the proposed way forward. (1620-1635)

13 **OTHER URGENT BUSINESS**

NB: Only items of business by reason of special circumstances (which are to be specified) that in the opinion of the Chair are matters of urgency.

APPOINTMENT OF HEALTH AND WELLBEING BOARD

FUNCTIONS, TERMS OF REFERENCE AND MEMBERSHIP 2017/18 (as scheduled to be considered by Cabinet on 27 June 2017)

Functions

To discharge the functions of a Health and Wellbeing Board as set out in the Health and Social Care Act 2012, including the appointment of Board Members as set out in the schedule of required Board Members in the Act.

The Health and Wellbeing Board will:

a) promote the reduction in Health Inequalities across the City through the commissioning decisions of member organisations

b) report on progress with reducing health inequalities to the Cabinet and the various Clinical Commissioning Group Boards

c) be the responsible body for delivering the Joint Strategic Needs Assessment for Birmingham (including the Pharmaceutical Needs Assessment)

d) deliver and implement the Joint Health and Wellbeing Strategy for Birmingham

e) participate in the annual assessment process to support Clinical Commissioning Group authorisation

f) identify opportunities for effective joint commissioning arrangements and pooled budget arrangements

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

Terms of Reference

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

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

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

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

Members of the Board will be able to send substitutes with prior agreement of the Chair. Each member is to provide the name of an alternate/substitute member.

Vice Chair for 2017/2018 to be a Clinical Commissioning Group (CCG) representative (to be advised by the CCGs) - to reinforce the Board as a joint body rather than a solely LA committee

Membership 2017/18

City Council Appointments to the Health and Wellbeing Board

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

External Appointments to the Health and Wellbeing Board

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

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD 31 JANUARY 2017

MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON TUESDAY 31 JANUARY 2017 AT 1500 HOURS IN COMMITTEE ROOMS 3 AND 4, COUNCIL HOUSE, BIRMINGHAM

PRESENT: - Councillor Paulette Hamilton in the Chair; Andy Cave, Dr Aqil Chaudary, Councillor Lyn Collin, Dr Andrew Coward, Jonathan Driffill, Peter Hay, Chief Superintendent Chris Johnson, Councillor Brigid Jones and Dr Adrian Phillips.

ALSO PRESENT:-

Judith Davis, Programme Director, Birmingham Better Care
Dr Sue Ibbotson, Director of Public Health England in the West Midlands
Superintendent Sean Russell, Implementation Director, West Midlands Mental Health Commission
Paul Holden, Committee Services, BCC

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NOTICE OF RECORDING

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

WELCOME AND APOLOGIES

181 Members introduced themselves and apologies were submitted on behalf of Cath Gilliver and Dr Gavin Ralston.

DECLARATIONS OF INTERESTS

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

MINUTES

183 The Minutes of the Board meeting held on 29 November 2016 were confirmed and signed by the Chair.

CHAIR'S UPDATE

184 The Chair advised the meeting that she had just come from an event hosted by the West Midlands Combined Authority Mental Health Commission to launch the Thrive Action Plan and knew that if the West Midlands worked together a real difference would be made. She also highlighted that Superintendent Sean Russell would be reporting on the work of the West Midlands Mental Health Commission during the meeting (Minute No. 185 refers).

In relation to the Council's budget proposals, the Chair reported that during December and early January, the Leader, Deputy Leader and Cabinet had been carrying out extensive consultation with citizens and partners. She pointed out that it had been a very challenging few weeks and not a position they wished to be in as no one wanted to consult on cutting services. Members were informed that they had listened to lots of strong and hard messages and had been assessing how these should be reflected in the final budget to be put to City Council on 28 February, 2017 for ratification.

(The following report was brought forward on the agenda)

WEST MIDLANDS MENTAL HEALTH COMMISSION BRIEFING PAPER

The following report was submitted:-

(See document No. 1)

Superintendent Sean Russell, Implementation Director, West Midlands Mental Health Commission introduced the information contained in the report and also referred to the Thrive Action Plan which had been published earlier in the day and circulated to members of the Health and Wellbeing Board.

The following were amongst the issues raised and responses to questions:-

1) Tracy Taylor considered that work taking place reflected what the majority of the Sustainability and Transformation Plans were trying to achieve and requested that the Wellbeing Board being set-up be used to share good practice so that some speed and pace could be injected into the work across the West Midlands. She highlighted that some areas would be doing some aspects really well and quickly and this learning needed to be shared to avoid duplication.

2) Dr Andrew Coward referred to one of his patients who wanted to work but had developed a debt problem and become lonely, withdrawn and, a few years ago, suicidal. He also highlighted that the individual had received letters from the Department of Work and Pensions that even he could not understand. However, Dr Andrew Coward indicated that after putting his patient in contact with the Mental Health Trust the person's wellbeing was

gradually improving. Dr Andrew Coward underlined that through the work of the Mental Health Commission he wished to see people like this thrive and offered the Implementation Director his full support.

3) The Implementation Director reported that the Independent Placement Support Budget would seek to put 5,000 people back into mainstream work and keep them in employment. In referring to work that was taking place on producing a £10m plan for the region he highlighted that across the West Midlands there were about 70,000 people inactive due to mental ill heath which cost the taxpayer £12.1bn each year.

4) Dr Adrian Phillips referred to conversations that had taken place with people in crisis due to a mental health condition and reported that a large number of them had said that they did not want more treatments or therapists: they wanted a purpose. He stressed the important contribution that work played in this respect.

5) In acknowledging that it was outside the scope of the West Midlands Mental Health Commission, Dr Adrian Phillips nevertheless highlighted that poor mental health was starting to be seen at a younger age and its prevalence increasing due to pressures placed on children and young people at school. In referring to work taking place with the Birmingham Education Partnership in schools as reported upon at the last meeting he therefore underlined the need for this issue to also be addressed by the Board.

6) The Chair emphasised the need for a person-centred approach so that people were not lost track of when moving around the country or from one system to another. The Implementation Director indicated that it was hoped that there would be a strand of work which addressed this and emphasised that they were determined to make a difference.

7) Reference was made by the Chair to how many different agencies were present at the launch of the Thrive Action Plan earlier in the day and to the need for them to follow through and deliver.

8) The Chair referred to a Walking Out of Darkness event scheduled to take place on 6 May 2016 and asked that members of the Board be invited to attend. The Implementation Director explained that this would be a 10-mile walk from Eastside to Cannon Hill Park and was in support of the prevention of suicide agenda and raising awareness of the importance of good mental health. He indicated that they were aiming for a turnout of around 3,000 people and hoped that members of the Board would be able to join them.

The Chair thanked the Implementation Director for reporting to the meeting.

185 **RESOLVED:-**

That the West Midlands Mental Health Commission's work be reviewed and that priorities be established from the Thrive Action Plan that it would be appropriate for this Board to support.

(The following report was brought forward on the agenda)

HEALTH AND WELLBEING STRATEGY

The following report was submitted:-

(See document No. 2)

Dr Adrian Phillips, Director of Public Health introduced the information contained in the report.

The following were amongst the issues raised and responses to questions:-

1) In referring to the Birmingham and Solihull Sustainability and Transformation Plan (STP) (Minute No.188 refers), Tracy Taylor considered that it was important that the Birmingham and Solihull Health and Wellbeing Boards had very high profiles and played an active part in the new Improving Health and Wellbeing programme element of the STP process. She also highlighted the need to use the priorities in the Health and Wellbeing Strategy report to get things moving across the footprint.

2) Tracy Taylor considered that the personalisation agenda was really important moving forward as it would lead to organisations listening more to what care and support communities and individuals wanted and help to integrate services. In addition, the member pointed out that good mental and physical health often came together. She highlighted that there was therefore a need to consider how this was addressed when integrating services and recognise that patients/individuals and their families were a unit and came as a package.

3) Further to the ambition for all children to be in permanent housing, Jonathan Driffill suggested that the delivery mechanism for the objective be Housing Birmingham which was a multi-agency body. He highlighted that the opportunity to address some of the issues would only be achieved if organisations worked collectively. The member therefore undertook to seek a cross reference to this objective in their Housing Delivery Plan and then arrange for the document to be circulated to the members of the Health and Wellbeing Board. The Chair welcomed this approach and the Director of Public Health informed the member that he would be happy to attend a meeting of Housing Birmingham if required.

4) In response to comments made by Dr Andrew Coward, the Director of Public Health suggested that it might be best for him to consider the Adverse Childhood Experiences (ACEs) Task and Finish Group's report and recommendations as a member of the Board when that information became available, rather than serve on the Group itself.

5) The Chair reinforced the comments made regarding the importance of the personalisation agenda and considered that until there was any real progress in this area, organisations would continue to struggle to provide services in a joined-up way.

6) Councillor Brigid Jones highlighted that personalisation was something that she also wished to replicate in children's services and commented that not enough was being done, particularly in respect of young people with learning or physical disabilities. The member referred to an Inclusion

Commission that was looking at issues concerning children with special educational needs and disabilities and hoped that from that work there would be a greater push towards personalisation.

At this juncture Dr Sue Ibbotson, Director of Public Health England in the West Midlands presented the following PowerPoint slides:-

(See document No. 3)

The Chair thanked the Director of Public Health England in the West Midlands for the presentation and highlighted that the Board would welcome her support over the coming years.

186 **RESOLVED:-**

(a) That the limited number of priorities for the refreshed strategy be agreed;

(b) that further development of measures be delegated to the Operations Group;

(c) that a Task and Finish Group be commissioned to identify suitable outcomes related to Adverse Childhood Experiences (ACEs);

(d) that the Mental Health System Strategy Board be invited to comment on the proposed outcomes or suggest alternatives;

(e) that the Health and Wellbeing Board liaise with other Boards, as appropriate.

AIR POLLUTION AND HEALTH IN BIRMINGHAM

The following report was submitted:-

(See document No. 4)

Dr Adrian Phillips, Director of Public Health presented the PowerPoint slides accompanying the report.

The following were amongst the issues raised and responses to questions:-

1) Dr Andrew Coward advised members that he considered that Birmingham's 'motor city' was not only the prime cause of air pollution that was resulting in early deaths (e.g. 891 deaths in 2010/11) but also associated with the obesity epidemic, inactivity and social isolation / loneliness. He reported that that what had been learnt from such cities as Copenhagen and Amsterdam was that £10-£20 per head had to be invested every year to reduce the number of vehicles and create a city that was friendly for walkers, runners and cyclists. In highlighting that there was a projected cost of £2.6bn by 2050 for child obesity alone he

therefore asked whether an economic case could be made for the per capita investment each year.

2) In referring to some of the negative experiences associated with travelling on buses, Councillor Brigid Jones considered that unless pricing was addressed and improvements made around such issues as quality, safety and journey times, people would not use public transport in preference to their cars. She therefore enquired what plans there were to liaise with the public transport sector to address these issues.

3) The Chair felt that national policy on air pollution was to some extent confusing and that clarity had been lost as legislative requirements had passed from the European Union (EU) to the UK Government and then been conveyed to Local Authorities. Nonetheless, at a local level, she considered that a key question for Birmingham as part of a large conurbation was whether it wished to move in the direction of having much fewer cars in the City.

4) The Director of Public Health underlined that Birmingham had to do something to reduce the level of outdoor air pollution and drew attention to paragraph 4.1.4 in the report where it was highlighted that the City exceeded the EU legal limits in this regard. Further to (2) above, he also informed members that there was representation from transport groups within the West Midlands on the Air Quality Board.

5) Chief Superintendent Chris Johnson had concerns that there appeared to be more emphasis on enforcing rather than encouraging i.e. making it hard for an individual to do something that they wanted to do rather than make it easy for the person to do something that government / public organisations wished them to do.

6) Further to 5) above, the Director of Public Health indicated that the London congestion charge had only had a temporary beneficial effect.

7) In responding to a question from Councillor Lyn Collin, the Director of Public Health reported that he believed that poor air quality was not just an issue in some areas of the City but a problem throughout the whole of Birmingham. However, he acknowledged that there was a need for more information in this regard. He highlighted that current day air pollution was different to the ‘smogs' of the past and referred to research in North America where well away from roads and residential suburbs there had been high readings for $PM_{2.5}$ and nitrogen oxides.

8) The Director of Public Health considered that there would need to be a mixture of enforcement measures, encouragement and innovative ideas in order to achieve the ambition of cleaner air in Birmingham.

The Chair thanked the Director of Public Health for reporting to the meeting.

187 **RESOLVED:-**

(a) That adverse outdoor air quality be considered as a theme in the Health and Wellbeing Strategy;

(b) that this Board supports the improvement of air quality by reducing air pollution as being a collective priority;

(c) that updates be received at future meetings.

BIRMINGHAM AND SOLIHULL SUSTAINABILITY TRANSFORMATION PLAN

The following report was submitted:-

(See document No.5)

Judith Davis, Programme Director, Birmingham Better Care introduced the information contained in the report.

The following were amongst the issues raised and responses to questions:-

1) Andy Cave enquired what the intentions were with regard to the engagement plan and how people would be able to access the document and influence the work taking place. In also referring to the Black Country Sustainability and Transformation Plan (STP) and West Birmingham he also asked how it was proposed to address the issue of the confusion that the public experienced due to there being various health related engagement / consultation exercises.

2) Dr Adrian Phillips reported that he would soon be meeting with his counterpart from the Solihull Health and Wellbeing Board, the Programme Director and other colleagues to look at what themes / issues should be included in the new Improving Health and Wellbeing programme that formed part of the Birmingham and Solihull STP process.

3) Councillor Lyn Collin asked why the new models of care approach had not been covered in the Birmingham and Solihull STP.

4) The Programme Director acknowledged that the current arrangements caused confusion to people who lived in West Birmingham and highlighted that NHS England's position this time last year was that Sandwell and West Birmingham CCG could only be part of one STP. However, in referring to developments on this issue, she felt that it might now be possible to find a way for the CCG to formally work within two STP areas. In relation to new models of care, she highlighted that STPs were a completely new way of working for health organisations that had a responsibility through their governance and accountability arrangements to see themselves as separate bodies rather than how they contributed to a place / locality. However, she considered that there was a growing recognition within the organisations that a different balance had to be found in this regard.

5) The Chair welcomed that the pace of STP activity had slowed in a way that would allow the public to be involved and also that it appeared that the process was now being looked at over a longer timescale. Furthermore, she asked that when the dates of the engagement events became publically available the members of the Board be provided with details.

6) The Programme Director reported that she considered that conversations would begin to change from talking about STPs to discussing collective Local Delivery Plans. She also indicated that she would contact communication leads over the need for them to talk to Healthwatch Birmingham.

The Chair thanked the Programme Director for reporting to the meeting.

188 **RESOLVED:-**

That the review of the Birmingham and Solihull STP feedback, amended programme framework and the proposals for engagement be noted.

OTHER URGENT BUSINESS

Retirement of Peter Hay, Strategic Director for People

189 Members were advised that Peter Hay, Strategic Director of People would be retiring in July, 2017 and be standing down from his current role at the end of March. The Chair informed the meeting that she would very much miss the support that she'd received from Peter Hay over many years and wished him all the best in his retirement.

The meeting ended at 1657 hours.

…….……
CHAIRPERSON

	Agenda Item: 8
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**4th July 2017**
TITLE:	**HEALTH & WELLBEING STRATEGY**
Organisation	**Birmingham City Council**
Presenting Officer	**Adrian Phillips, Director of Public Health**

Report Type:	**Decision**

1. Purpose:
To recommend indicators and ambitions for the Health & Wellbeing strategy

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

3. Recommendation	
	The Board is recommended to; -
3.1	Note the developments related to the Strategy Board Members' report on how the strategy relates to their organisational objectives.
3.2	Agrees to support the development of the Operations Group
3.3	Agree to provide specific leadership to individual objectives

4. Background

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

4.2 The strategy was not complete as it was agreed that further work was required to describe the ambition relating to Adverse Childhood Experiences (ACEs). It was agreed that an ACEs Task and Finish group would be set up to report back to the Board. An interim report describes that process.

4.3 It was also agreed that the Operations Group of the Health and Wellbeing develop potential indicators and targets for the ambitions outlined in the HWBS.

4.4 Further work agreed by the Board has taken place:

- All children in permanent housing – discussion with Birmingham Housing Board
- Increasing employment/meaningful activity and stable accommodation for those with mental health problems – discussion with Mental Health Strategy Board
- Improve air quality – discussion with Air Quality Steering Group

4.5 Informal discussions have taken place with Solihull Health and Wellbeing Board regarding a joint approach to workplace wellbeing.

4.6 Further discussion is required to link improving stable and independent accommodation for those with Learning Disability into both the Integrated Commissioning Board as well as the Housing Board. A paper on Multiple Complex Needs is planned for the next meeting of the Board.

4.7 The following table details the strategy as well as the rationale. In addition links to the newly formed vision and priorities of Birmingham City Council are included.

4.8 It is recommended that partner organisations report how the strategy relates to their organisational aims.

5 Targets

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

6 Operations Group

6.1 Much of the activity related to the implementation of the strategy, including

developing targets, has been delegated to the Operations Group. For a variety of reasons including staff changes, redundancy, changing roles, etc., it has been difficult for this group to complete this work.

6.2 The model has worked for the Board before and it is not proposed to develop a different structure. Instead it is proposed that the current co-chairs of the Operations Group are asked to review the membership of the Group to ensure it reflects the priority areas in the strategy. Then they will identify appropriate links officers to the Board. If agreed then the Board members will be responsible for ensuring appropriate support.

6.3 It is proposed that this is done virtually over the summer period.

7 Board Member Involvement

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

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

6.	**Risk Analysis**
	A risk assessment cannot be completed until the draft strategy has been agreed

Appendices	
1.	Health & Wellbeing Board Strategy Potential Indicators and Targets

Signatures

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

The following people have been involved in the preparation of this board paper:

Priority	Ambition	Rationale
Improving the Wellbeing of Children	Detect and Prevent Adverse Childhood Experiences (ACEs)	**Evidence – is mounting regarding the importance of ACEs in future life such as domestic violence, parental dysfunction etc. This relates to mental ill health (including suicide), physical ill health etc. The precise objective and actions for the Board are not clear and a task and finish group has been assembled to clarify the questions for the Board to consider.** **BCC Vision and Forward Plan:** ***Birmingham – a great place to grow up in*** • An environment where our children have the best start in life. • Our children and young people are able to realise their full potential through great education and training. • Our children and young people are confident about their own sense of identity. • Families are more resilient and better able to provide stability, support, love and nurture for their children. • Our children and young people have access to all the city has to offer. ***Cross-cutting*** • Reduction in the percentage of workless households overall and implement the recommendations from the Child Poverty Commission • Reduction in health inequality

Priority	Ambition	Rationale
	All children in permanent housing	**Rationale: Birmingham has a very high level of families who are homeless and/or in temporary accommodation as measured by the Public Health Outcomes Framework. It affects social bonding, school performance as well as linked to disadvantage in future generations.** **BCC Vision and Forward Plan:** ***Birmingham – a great place to grow up in*** • An environment where our children have the best start in life. • Families are more resilient and better able to provide stability, support, love and nurture for their children. ***Birmingham – a great place to live in*** • Working with our partners to reduce homelessness. ***Cross-cutting*** • Reduction in the percentage of workless households overall and implement the recommendations from the Child Poverty Commission • Reduction in health inequality

Priority	Ambition	Rationale
Improve the Independence of Adults	Increase the control of individuals over their care through Integrated Personal Commissioning (Personal Health Budgets and Direct Payments)	**Rationale: Birmingham has a low uptake of personal budgets as measured by ASCOF (for the Council) as well as NHS digital (for CCGs). Increasing choice and control improves outcomes. The focus is on MH and LD. Our systems are too complex and disjointed. Personalisation allows the "person" to make decisions which improve their wellbeing, thus an "asset" model, not a "problem" based model** **BCC Vision and Forward Plan:** ***Birmingham – a great place to grow old in*** • Promoting independence of all our citizens. • Joining up health and social care services so that citizens have the best possible experience of care tailored to their needs. • Preventing, reducing and delaying dependency and maximising the resilience and independence of citizens, their families and the community. ***Cross-cutting*** • Reduction in health inequality

Priority	Ambition	Rationale
Improving the Wellbeing of the Most Disadvantaged	Increasing employment/ meaningful activity and stable accommodation for those with mental health problems	**Rationale: The majority of people in the City on Employment Support Allowance (ESA) have mental health problems (over 30,000). Few have long term employment yet all the evidence shows that this improves outcomes. Only 6% of people with long term, enduring mental health problems are in employment. Housing is key to generate stability. The WMCA mental health commission advocates the "Housing First" model for people with mental health problems.** **BCC Vision and Forward Plan:** ***Birmingham – a great place to live in*** • Making the best use of our existing stock. • Delivering through a range of partnerships to support a strong supply of new high quality homes in a mix of tenures. • Supporting the people of Birmingham to access good quality housing provision. • Working with our partners to reduce homelessness. ***Birmingham – a great place to succeed in*** • Creating the conditions for inclusive and sustainable growth that delivers and sustains jobs and homes across Birmingham. • Birmingham residents will be trained and up-skilled appropriately to enable them to take advantage of sustainable employment. ***Birmingham – a great place to grow old in*** • Promoting independence of all our citizens. • Joining up health and social care services so that citizens have the best possible experience of care tailored to their needs. • Preventing, reducing and delaying dependency and maximising the resilience and independence of citizens, their families and the community. ***Cross-cutting*** • Reduction in the percentage of workless households overall and implement the recommendations from the Child Poverty Commission • Reduction in health inequality

Priority	Ambition	Rationale
	Improving stable and independent accommodation for those learning disability (LD)	**Rationale: Outcomes for people with LD are too low in the city. We have too many in residential settings as measured by ASCOF and CCGOF. We need to increase the number living in accommodation of their choice (Shared Lives) to improve their outcomes** **BCC Vision and Forward Plan:** ***Birmingham – a great place to live in*** • Making the best use of our existing stock. • Delivering through a range of partnerships to support a strong supply of new high quality homes in a mix of tenures. • Supporting the people of Birmingham to access good quality housing provision. ***Birmingham – a great place to grow old in*** • Promoting independence of all our citizens. • Joining up health and social care services so that citizens have the best possible experience of care tailored to their needs. • Preventing, reducing and delaying dependency and maximising the resilience and independence of citizens, their families and the community. ***Cross-cutting*** • Reduction in health inequality

Priority	Ambition	Rationale
	Improve the wellbeing of those with multiple complex needs **To Be Agreed**	***Rationale: There are between 1500 and 2250 people in the City with "multiple complex needs" as described in the "Hard Edges" research. This includes people who have been homeless, ex-offenders and those with substance misuse issues. This small number has a wide ranging impact upon society but are also the parents of tomorrows most disadvantaged. Local evidence shows that employment is the route to improving well being. Most have also encountered many ACEs. The number is relatively small yet they disproportionally account for continuing the cycle of disadvantage in future generations. Many local partners want to affect this group to reduce current disadvantage now and for the future.*** ***Birmingham – a great place to live in*** • Working with our partners to reduce homelessness. ***Birmingham – a great place to grow old in*** • Promoting independence of all our citizens. ***Cross-cutting*** • Reduction in the percentage of workless households overall and implement the recommendations from the Child Poverty Commission • Reduction in health inequality

Priority	Ambition	Rationale
Making Birmingham a Healthy City	Improve air quality (and be legally compliant)	**Rationale: Poor air quality accounts for up to 900 early deaths in Birmingham. It causes death from Stroke and cardio-vascular diseases. It is mainly caused by diesel fumes. It also is implicated in dementia, poor mental wellbeing, poor infant health and other conditions. It disproportionally affects communities that are already economically disadvantaged. Our ambition should be to improve air quality by 2030 so that the annual death rate due to air pollution will be halved.** **BCC Vision and Forward Plan:** ***Birmingham – a great place to grow up in*** • An environment where our children have the best start in life. ***Birmingham – a great place to succeed in*** • The development of a modern sustainable transport system that promotes and prioritises sustainable journeys. ***Birmingham – a great place to grow old in*** • Creating a healthier environment for Birmingham. • Increased use of public spaces for physical activity; more people walking and cycling; greater choice of healthy places to eat in Birmingham. ***Cross-cutting*** • Increase in the percentage of total trips by public transport • Reduction in health inequality • Improved air quality

Priority	Ambition	Rationale
	Increased mental wellbeing in the workplace **To Be Agreed**	**Rationale: Poor workplace wellbeing is a significant issue, the main cause of lost days from work and thus productivity. It is linked to the WMCA Mental Health "thrive" report.** **BCC Vision and Forward Plan:** ***Birmingham – a great place to succeed in*** • Creating the conditions for inclusive and sustainable growth that delivers and sustains jobs and homes across Birmingham. ***Birmingham – a great place to grow old in*** • Leading a real change in individual and community mental wellbeing. • Preventing, reducing and delaying dependency and maximising the resilience and independence of citizens, their families and the community.

Appendix 1. Potential Indicators and Targets

Ambition	Indicator (Source)	Target	Key links/external bodies	Target agreed?	Board Lead
Detect and Prevent Adverse Childhood Experiences					
All children in permanent housing		All children in permanent housing	Housing Board		
Increase the control of individuals over their care through Integrated Personal Commissioning (Personal Health Budgets and Direct Payments)		To be agreed with NHSE	Integrated Personalised Commissioning Board		
Increasing employment/ meaningful activity and stable accommodation for those with mental health problems		STP target 8.9% patients with MH conditions (on CPA) in paid employment by 2020/21	Mental Health System Strategy Board		
Improving stable and independent accommodation for those learning disability			? Integrated Commissioning Board (tbc)		

Ambition	Indicator (Source)	Target	Key links/external bodies	Target agreed?	Board Lead
Improve the wellbeing of those with multiple complex needs **To Be Agreed**					
Improve air quality (and be legally compliant)	Fraction of mortality attributable to particulate air pollution (PHOF) Killed and seriously injured casualties on England's roads (PHOF) Children killed and seriously injured on England's roads (CHIMAT)	Halved by 2030 No increase No increase	BCC Air Quality Steering Group	No No No	
Increased mental wellbeing in the workplace **To Be Agreed**			West Midlands Combined Authority Mental Health Commission		

	Agenda Item:9
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**4th July 2017**
TITLE:	**USING THE IMPACT OF ADVERSE CHILDHOOD EXPERIENCES TO IMPROVE THE HEALTH & WELLBEING OF BIRMINGHAM PEOPLE**
Organisation	**Multi-Agency Task & Finish Group**
Presenting Officer	**Dr Dennis Wilkes, Assistant Director of Public Health**

Report Type:	**Information**

1. Purpose:
This report updates the Health & Wellbeing Board on the progress of the Task & Finish group commissioned in November 2016.

2. Implications:		
BHWB Strategy Priorities	Child Health	Yes
	Vulnerable People	Yes
	Systems Resilience	No
Joint Strategic Needs Assessment		No
Joint Commissioning and Service Integration		Yes
Maximising transfer of Public Health functions		No
Financial		No
Patient and Public Involvement		No
Early Intervention		Yes
Prevention		Yes

3. Recommendation
The Health & Wellbeing Board is asked to note the progress made and that a full report will be submitted to October's meeting.

4. Background

4.1 Following a presentation of the evidence of the impact of adverse experiences in childhood on child, adolescent, and adult health and wellbeing in November 2016, the Board asked for a Task & Finish group to consider the implications.

4.2 The Task & Finish group was convened in March 2017. The terms of reference was to scope the opportunities to:

a) Prevent the likelihood of these experiences occurring;

b) Identify children who have already had these experiences at an early stage in order to reduce the medium and long term impacts for the child and the family;

c) Identify children and adults who have already had these experiences resulting in emotional and/or physical illness in order to improve their response to therapy thereby improving their therapeutic outcomes.

4.3 The Task & Finish Group has met three times and a draft report is being compiled to reflect the discussion of the available evidence in the context of our Birmingham communities. This was considered via a final meeting at the end of June and will be ready for discussion at the Board meeting in September.

4.4 Task and Finish Contributors

Alison Holmes	Head of Early Help & Family Support, Birmingham City Council
Alison Moore	St. Paul's Community Development Trust
Andrew Coward	GP and Chair of Birmingham South & Central NHS CCG
Andy Wright	Head of Virtual School, Birmingham City Council
Anna Robinson	New Start programme Manager, Birmingham Education Partnership
Aqil Chaudary	GP and Children Lead Birmingham Cross City NHS CG
Bel Sixsmith	West Midlands Police
Caron Eyre	Nursing & Quality Director, Birmingham Children's Hospital
Catherine Evans	Safeguarding Lead, Birmingham & Solihull Mental Health Trust
Claire Rigby	Partnership Lead, Forward Thinking Birmingham
Doug Simkiss	Deputy Medical Director, Birmingham Community Healthcare NHS Trust
Geoff DeBelle	Designated Doctor, Birmingham CCGs

Liz Webster	Children & Families Division, Birmingham Community Healthcare NHS Trust
Louise Bauer	Birmingham Education Partnership
Maria Jardine	Operational Lead, Think Family Service, Birmingham City Council
Paul Drover	West Midlands Police
Paul Patterson	Digital and Prevention Lead, Forward Thinking Birmingham
Salma Ali	BSIL Programme Lead, NHS England WM
Sandra Passmore	Services for Education
Sian Warmer	Change Grow Live
Simon Inglis	West Midlands Police
Tony Stanley	Principal Social Worker, Birmingham City Council
Dennis Wilkes	Assistant Director of Public Health (Convenor of the Group)

5.	**Compliance Issues**
5.1	**Strategy Implications**
	None
5.2	**Governance & Delivery**
	None
5.3	**Management Responsibility**
	None

6.	**Risk Analysis**
	Not applicable

Appendices
None

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

	Agenda Item: 10
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**4th July 2017**
TITLE:	**Improving the Independence of Adults**
Organisation	**Birmingham City Council/Birmingham Cross City CCG**
Presenting Officer	**Adrian Phillips**

Report Type:	**Decision**

1. Purpose:
To inform the Board of a successful application to NHS England, which will support a strategic objective of Improving the Independence of Adults

2. Implications:		
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		
Prevention		

3. Recommendation
It is recommended that the targets in the Integrated Personal Commissioning adopter programme are adopted by the Health and Wellbeing Board for its strategic objective of improving independence of adults

4.	Background
	Improving the Independence of Adults is an agreed strategic objective of the Board. The accompanying paper describes how a joint initiative between the NHS and Council would help take this forward.

5.	Compliance Issues
5.1	***Strategy Implications***
	It supports the refreshed strategy of the Board
5.2	***Governance & Delivery***
	Through the IPC Board
5.3	***Management Responsibility***
	Accountable Board Member to be agreed

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
That the culture of professionals and organisations will not change	Medium	High	Staff involvement in the process. Development of champions
New financial systems may lead to inappropriate use of public funds	Medium	Medium	Learn from other successful sites in appropriate financial governance

Appendices

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

The following people have been involved in the preparation of this board paper:

Anita Hallbrook – Birmingham Cross City CCG
Adrian Phillips – Birmingham City Council

Detail

NHS England announced the launch of the Integrated Personal Commissioning (IPC) Programme in July 2014. It was described as "radical new option in which individuals could control their own combined health and social care support".

It fits into the Health and Wellbeing Boards' strategic approach to independence for adults as well as promoting more choice. It incorporates Direct Payments, Personal Health Budgets as well as Personal Budgets. However it does not have to involve financial transfer but at its heart is personal choice and control.

The prospectus for the programme, published in September 2014 with LGA, ADASS and Think Local Act Personal, set out the vision and requirements in more detail:#

- People with complex needs and their carers have better quality of life and can achieve the outcomes that are important to them and their families through greater involvement in their care, and being able to design support around their needs and circumstances

- Prevention of crises in people's lives that lead to unplanned hospital and institutional care by keeping them well and supporting self-management as measured by tools such as 'patient activation' – so ensuring better value for money

- Better integration and quality of care, including better user and family experience of care.

It is an ambitious programme that seeks to systematically harness the potential of people needing support and their families to be active co-producers of that support, and of their communities to help keep them independent and well. It works across health, local government and the voluntary sector to pull together the resources available to people, and to work with people to understand and plan how best to use these.

It is particularly suited to individuals who are "complex", where our current system can't easily accommodate their needs. It is also very useful in instances where promoting independence actually helps an individual. Earlier work showed particular improvements in patients with severe mental health problems and those approaching End of Life. The studies also demonstrated much greater efficiency.

The Integrated Personal Commissioning Model

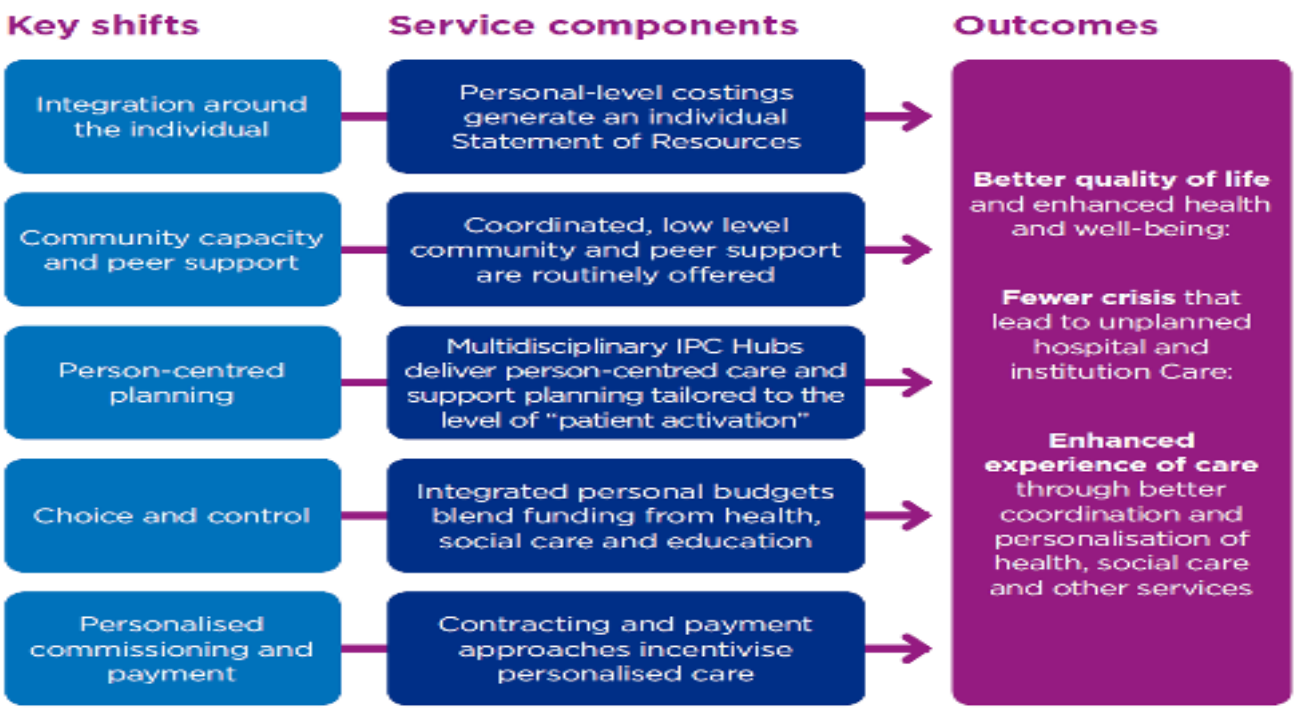
The specific responsibility of all Integrated Personal Commissioning sites is to introduce Integrated Personal Commissioning as the main model of care for 5% of a local system's population, including people with multiple long-term conditions, people with severe and enduring mental health problems, and children and adults with complex learning disabilities and autism. This includes putting in place the Integrated Personal Commissioning Framework to include:

- **Proactive coordination of care:** People proactively or reactively identified and offered information about IPC

- **Community capacity, co-production and peer support:** Making the most of what's available to you through Local Area Coordination and systematic access to peer support
- **Personalised care and support planning:** Having a different or better conversation to identify what matters to you, and capture this in one place.
- **Personal budgets:** A personal budget blends resources to achieve health, wellbeing and learning outcomes
- **Personalised commissioning and payment:** Accessing a wider range of care and support options tailored to individual needs and preferences, through personalised contracting and payment.

The following figure is taken from the reference document and describes the key "shifts" which the approach aims to deliver:

Figure 1: The emerging IPC Framework



Source: Integrated Personal Commissioning Emerging Framework - NHS England (May 2016). https://www.england.nhs.uk/healthbudgets/wp-content/uploads/sites/26/2016/05/ipc-emerging-framework.pdf

Local Relevance

Work was undertaken in 2016 across the NHS and Councils in Birmingham and Solihull (BSOL) to submit an application to be a "demonstrator" site. Approval to submit the application was sought and endorsed through the Local STP governance structures. A partnership approach was undertaken and has achieved programme has sign up from the following organisations:

- Birmingham City Council
- Solihull Metropolitan Borough Council
- NHS Birmingham Cross City CCG
- NHS Birmingham South Central CCG
- NHS Solihull CCG

- Birmingham and Solihull Mental Health Foundation NHS Trust
- MERIT Vanguard

In November 2016, NHS England advised that following an application process, Birmingham and Solihull would become one of seven second wave sites for the early adoption of the IPC Operating Model. Participation in this national programme commenced in December 2016 and will continue until March 2018.

Work undertaken with the existing Demonstrator sites in 2016/17 has helped identify the priority activity to deliver on these shifts, produced the IPC Operating Model and associated guidance and products. Integrated Personal Commissioning Early Adopter sites will need to plan to implement these over the course of the programme and test and further refine the guidance for future areas to implement.

Following the notification by NHS England, we were invited to consider a similar but much smaller process for Looked After Children (LAC) with poor mental wellbeing. We have been successful in becoming an adopter site in this area although it is less well established due to time scales.

The following are projections of people that BSOL expect to take part in the main IPC programme by March 2018.

Site: Birmingham and Solihull Date submitted: March 2017	**Definition**	**Number of people**	**Proportion of population**
Population	Based on CCG populations.	1,300,000	100%
People in the IPC cohort	People within your IPC cohorts and who are in the linked dataset – data to include health, social care and education activity and spend	26,000	2%
People with a care plan/EHC plan	People within your IPC cohorts who have a completed care plan/EHC plan	13,000	1%
People with a personal budget (includes NHS-funding)	People within your IPC cohort who have a completed care plan/EHC plan and personal budget in place. Must include NHS funding.	1,040*	1 in 1,000

*** Based on the total of the individual trajectories of each CCG as supplied by NHS England and will include PHBs both within and outside the chosen IPC cohorts of mental health and learning disabilities.**

Progress to Date

Learning Disability and Mental Health

These thematic projects are focussed on adopting a recovery focused approach to providing services. The aim is to move beyond symptom and risk management to support people to re-establish a meaningful life for themselves. The project focus recognises that recovery requires services to look beyond treatment to consider wider issues such as housing, employment and family relationships. Further, that implementation of Personalisation is seen as a tool that will allow individuals to define their own outcomes and design their own packages of care and support.

Future work is planned in relation to those individuals requiring S117 arrangements or requiring community step-down.

Wheelchairs

This project aims to see 185 individuals access wheelchair provision using their allocated PHB.

Complex and Continuing Health Care

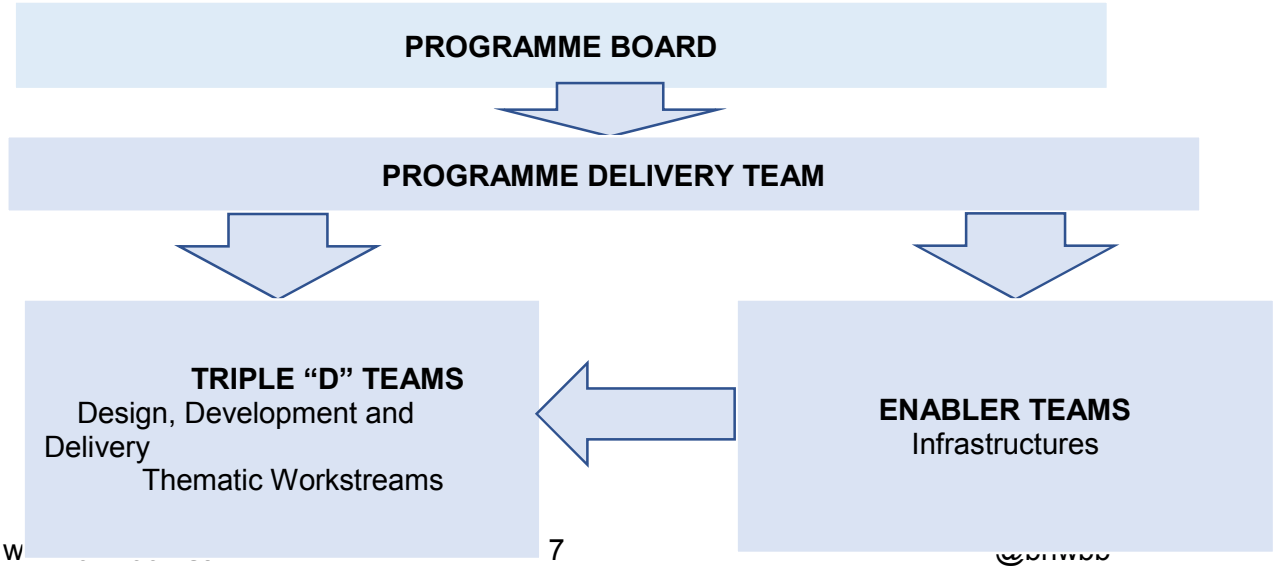
There are currently 87 individuals in receipt of a PHB with a target to stretch this number to 265 during the lifetime of the Programme.
The IPC Programme will be further developed to explore the following areas:

- Long Term Conditions
- Frailty
- End of Life
- SEND

Governance and Programme Team

There is a newly established IPC Programme Board with membership reflective of both the partnership and those organisations responsible for delivery of targets. The Board is supported by a small dedicated Programme Team consisting of a Programme Manager. Personal Health Budget Manager and Evaluation Officer.

Governance Structure



Challenges

The IPC Programme is ambitious and as faces a number of challenges. There is an expectation that Early Adopter sites will work towards achieving a necessary cultural shift, adjustments to existing systems and processes, whilst achieving volume in the uptake of Personal Health Budgets.

Some areas of particular challenge relate to the following:

- The necessity to understand the needs and preferences of individuals and then to ensure that there are a range of providers available to meet those needs. Existing providers express a concern around de-stabilisation but the numbers are so low as to make this theoretical not actual.
- If volume of individuals targeted for PHB's remains low there will be difficulty in de-commissioning elements of existing services, not chosen by individuals, particularly where block contracts are in place.
- Systems are required to manage budget setting, assurance, monitoring, financial and clinical sign off. There are complex health and social care systems that do not "talk to each other" not least lack alignment. It means that the "system" has to change do facilitate this, not just bolted-on.
- The basis for measuring patient-led outcomes and their influence on commissioning not just outputs. Systems currently measure activity as opposed to outcomes.
- Misaligned timescales in particular for the local IPC Programme. Contracts are already agreed and in place with no additional money available or funds to release.
- There is a risk of creating inequality in accessing PHBs as each local area will determine, cost, numbers with differing levels of commitment. This is mitigated to an extent by a learning network instigated by NHS England.
- Cultural attitudes to providing care is challenged by allowing individuals to take control of their care programme and exercise choice in their care options which are likely to be less traditional. A change in thinking and attitude is as critical as systems and processes, there will be a requirement for organisations to become more risk averse. This is probably the biggest barrier.
- The investment and skills required to develop and use technology as a platform to enhancing personalised care.

Opportunities

Personalisation has a place in nearly all aspects of care where care is complicated, long term or independence promotes recovery (and often all three are present such as mental ill-health). It is not the "answer" but another type of commissioning and thus offers more choice. So it offers another option to "system transformation".

The existing demonstrator sites and previous work have shown it can be applied to a vast range of circumstances with good effect. There is a real opportunity to use this approach in other areas locally, such as children's disability, End of Life care, Joint Care Plans for children (EHC) and also scale up existing areas. An obvious area is the BCF, especially frailty (where there is an existing demonstrator site) and EOL. As it is a key issue in the NHS five year plan, it could usefully form a principle for the STP.

Conclusion

The IPC programme is a key part of the NHS “five-year forward view” and a policy supported by the LGA. At its heart is the philosophy of independence, not dependence. This is seen practically as people control their care and having choice on delivery linked to clear outcomes set by them.

It is proposed that the targets in the IPC adopter programme are adopted by the Health and Wellbeing Board with future modifications based upon the LAC work and other possible planned activity.

	Agenda Item:11 (a)
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**4th July 2017**
TITLE:	**PROPOSALS FOR THE USE OF THE IMPROVED BETTER CARE FUND (iBCF)**
Organisation	**Birmingham City Council**
Presenting Officer	**Graeme Betts / Louise Collett**

Report Type:	**Approval**

1. Purpose:
1.1. To outline and seek approval for the proposed use of the iBCF allocation 2017/18 (Appendix 1).

2. Implications:		
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	
	It is recommended that the Board:
3.1	Supports and approves the proposals (outlined in Appendix 1, section 4.5)
3.2	Receives the implementation plan at a future meeting

4. Background

4.1 Through the 2017 Spring budget a significant amount of additional non-recurrent funding was made available to Councils in order to support adult social care over three years. For Birmingham, this represents a £27m in 2017/18, £16m in 2018/19 and £8m in 2019/20.

4.2 This additional funding is the start of the national response to a widely acknowledged crisis in social care and is recognised as being only a partial and short term 'fix' for sustained funding cuts. The funds are to be combined with the existing BCF commitment which, taken together, now represents the Improved Better Care Fund (iBCF).

4.3 Whilst the planning guidance is yet to be confirmed, the published policy framework outlines that the intended use of the iBCF across three priority areas;

- to meet adult social care need,
- to provide support to the NHS (especially through application of the 8 High Impact Changes),
- and to sustain the social care provider market.

4.4 Working with partners (through the BCF Executive) the attached report (Appendix 1) has been developed and provides outline proposals against the three priority areas outlined above. Following approval, a detailed project plan will be completed.

5. Compliance Issues

5.1 Strategy Implications

Health and Wellbeing Board priorities

Vulnerable people:

- Improve the wellbeing of vulnerable people
- Older people to remain independent, reducing hospital admissions

System resilience

- Common NHS and Local Authority approaches: The iBCF still remains as one of the mandatory national policies for the integration of health and social care
- Greater focus on prevention and early intervention
- Greater focus on asset based approach
- Greater focus on the contribution of communities and the third sector

5.2 Governance & Delivery
• Delivery plan will be shared with the H&WBB and regularly reported on • BCF Commissioning Executive Board will oversee delivery with links to • A&E delivery group and BSol STP Board
5.3 Management Responsibility
• Feedback to the H&WB Board through Greame Betts • Delivery programme oversight through Louise Collett, Service Director, Commissioning through to the BCF Commissioning Executive

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
The wellbeing of vulnerable people decreasing	3	3	
Less older people remain independent, hospital admissions increase	3	4	
Decreased system Resilience and stability	3	4	

Appendices
Improved Better Care Fund (iBCF): Birmingham Proposals, May 2017

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

The following people have been involved in the preparation of this board paper:

Louise Collett
John Denley

Improved Better Care Fund (iBCF): Birmingham Proposals June 2017

1. Introduction

1.1. Through the 2017 Spring budget a significant amount of additional non-recurrent funding was made available to Councils in order to support adult social care over three years. For Birmingham, this represents a £27m in 2017/18, £16m in 2018/19 and £8m in 2019/20.

1.2. This additional funding is the start of the national response to a widely acknowledged crisis in social care and is recognised as being only a partial and short term 'fix' for sustained funding cuts. The funds are to be combined with the existing BCF commitment (See table 1) which, taken together, now represents the Improved Better Care Fund (iBCF).

Table 1. Improved Better Care resource for Birmingham

	2017/18	2018/19	2019/20
BCF Commitment (Better Care Grant)	£6.7m	£31.3m	£52.4m
Spring Budget 2017	£27.0m	£16.0m	£7.9m

1.3. The iBCF provides an opportunity to bring some much needed stability across the Health and Social Care system in Birmingham, creating a firm platform for transformation which will focus on improving the health and wellbeing of the city's adults and older people.

1.4. This paper outlines proposals for the allocation of this resource that will deliver improved outcomes for citizens; help to alleviate key system pressures and also compliment/add value to current plans.

2. Background

2.1. The additional funding is significantly different to the initial Better Care Fund (BCF). This is because when the initial BCF was introduced in 2015/16 it comprised largely of redirected resource from existing NHS budgets. The Kings Fund described the initial approach as 'robbing Peter to pay Paul'[1], citing the arrangement as a principle cause of tension in partnership arrangements at local level between the NHS and Local Authorities[2] rather than the intended purpose of promoting partnership and integration.

2.2. The iBCF sets a different tone, and whilst the planning guidance is yet to be confirmed, the associated policy framework for the iBCF[3] does help create better conditions for the promotion of partnership working and integration. The policy framework outlines intended use of the iBCF across three priority areas;

- to meet adult social care need,
- to provide support to the NHS (especially through application of the 8 High Impact Changes),

[1] What now for social care. Kinds Fund, December 2016. https://www.kingsfund.org.uk/blog/2016/12/what-now-social-care
[2] Allocating social care funds: difficult decisions ahead, Kings Fund, April 2017 https://www.kingsfund.org.uk/blog/2017/04/allocating-social-care-funds
[3] Integration and Better Care Fund Policy Framework 2017 to 2019 https://www.gov.uk/government/publications/integration-and-better-care-fund-policy-framework-2017-to-2019

- and to sustain the social care provider market.

2.3. The iBCF still remains as one of the mandatory national policies for the integration of health and social care and this will need to be reflected in decision-making processes, although the decision making relating to the iBCF is no longer subject to the NHS assurance arrangements for the main BCF.

3. Our approach

3.1. Similar to other areas of the country, the initial BCF programme has not had the impact that was initially hoped for. The reasons were well documented.[3,4] These reasons seem to have been heard nationally with the iBCF having added flexibility to the conditions for its use. This offers an opportunity to consider and tackle the broader influences on the outcomes we are trying to improve. For example, considering prevention and early intervention and helping local communities to flourish.

3.2. In addition, the iBCF has been introduced at a time of significant change within the NHS with the introduction of Sustainability and Transformation Partnerships and consideration of an 'accountable care approach'. The iBCF is set within this context and provides additional opportunity to ensure that the stabilisation and transformation is at a system level.

3.3. We also know where improvements at a population and system level need to be made. For example, 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. Birmingham is ranked in the bottom 3% in the country and has been for over 5 years. Progress made against key contributory indicators such as the reducing rates of emergency admissions and reducing Delayed Transfers of Care (DTOC) have not matched expectation; 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 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.

3.4. We are therefore proposing to refresh our approach through the iBCF to ensure the maximum improvements in outcomes are achieved for the people of Birmingham; and to get best value for 'the Birmingham £'. To achieve this, the iBCF governance will be reviewed to ensure a single voice and a unified strategic commissioning approach as a platform for stabilising the current system and fostering a joint approach to transforming the current adult health and social care system in Birmingham.

4 Focus on Outcomes

4.1. Our ambition is to ensure all Birmingham citizens live a good quality life. We will contribute to this by enabling citizens to live independently, and contribute to their community for as long as possible, and, if citizens need care and support to do so, we will ensure it is of high quality, and their experience of the Birmingham health and social care system is good.

[4] Public Account Committee https://www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/news-parliament-2015/integrating-health-social-care-report-published-16-17/

4.2. The ambition fits with the initial collective vision of the Birmingham BCF which was developed with the Experts By Experience - based around the 'Think Local, Act Personal' initiative:

By 2019 in Birmingham we will have integrated health and social care so that:

- The most vulnerable people are identified and supported to improve their health and wellbeing
- We improve the resilience of our health and care system
- We manage crises better only utilising hospitals and long term residential care when needed
- We support people to stay in control and at home for 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 as active members of their communities for as long as possible
- We support communities to help their members to be healthy and well for as long as possible"

4.3. Improvements in key health and wellbeing outcomes for adults and older people will provide the evidence that we are achieving our ambition. These outcomes are well established and are outlined three key documents; Public Health Outcomes Framework[5] (in particular the Healthcare Public Health section), the NHS Outcomes Framework[6] and The Adult Social Care Outcomes Framework (ASCOF).

4.4. To keep a focus on the outcomes, we will put in place a performance framework which will ensure clear links between proposals for each of the three iBCF priority areas, the actions undertaken and the impact on outcomes .

4.5. The iBCF proposals for Birmingham are outlined below in Table 2.

Table 2. Initial proposals for the application of iBCF in Birmingham

Area 1: To meet adult social care need		
Proposal	Rationale	Indicative Investment 17/18 (£m)
• Support communities and community based organisations to develop offers that support diversion and avoidance from social care services.	• Represents a focused commitment to preventing and delaying need • Supports the revised 'offer' and approach to an asset based model. • Also linked to draft BCC Commissioning Strategy for Adult Social Care.	£8.85m (32.8%)
• Policy decision to channel shift all Carers assessments to community based Carers Hub, with associated support embedded within communities.	• Focusing on support being provided through the community, by the community. • Assessments will be undertaken through the 3rd sector with appropriate governance and safeguarding arrangements. • Reduced reliance on social workers/ACAP to undertake assessments	

[5] Public Health Outcomes Framework http://www.phoutcomes.info/

[6] NHS Outcomes Framework indicators - Feb 2017 release https://www.gov.uk/government/statistics/nhs-outcomes-framework-indicators-feb-2017-release

• Develop a more citizen centred approach to social work which develops the community model and alleviates some of the pressure in the health economy	• Creating support networks within communities • Reduces demand and increasing the use of community, family and individual resilience.	
• Reconfiguration of enablement services that focus on those with the greatest reablement potential and align care pathways for both community and out of hospital care	• Would align to revised out of hospital pathways, support DTOC and reducing demand for ASC • Reprofile current savings to allow transformation across the wider system on a targeted basis.	

Area 2: To provide support to the NHS (especially through application of the 8 High Impact Changes)		
Proposal	Rationale	Indicative Investment 17/18 (£m)
• Review of hospital social worker allocation to ensure sufficient resource is available to meet demand.	• Supports better patient flows through the system • Will provide great link with community development model of social care • Bridged funding gap in current provision	£9.10m (33.7%
• Review effectiveness, impact and scalability of the current Home from Hospital commissioned service as part of wider system	• Supports earlier discharge from hospital • Provides lower end support to help people settle back at home after a hospital stay. • Potential to scale up (through an agreed commissioned process) across the city	
• Fund existing EAB funding gap to ensure current EAB levels are maintained sustained in the short term to enable longer term view	• Provides system stability and a commitment to review • This would allow the necessary transformation to take place in the out of hospital pathways whilst maintaining current capacity.	
• Develop a model of trusted assessors with providers to allow single assessment to take place	• Channel shift and reduce pressure on social work service. • Potentially efficiencies across health, social care and independent provider market with single assessment, speed of discharge and placement.	
• Develop and implement a permanent integrated 7-day social work, brokerage and Emergency Duty Team (EDT)	• Support DTOC, Discharge Hubs provide sustainable cover for evenings and weekend services for the vulnerable in our society • Existing business case has already been developed for social work elements but would need to be reviewed to include the cost of brokerage and EDT services.	
• Development of a structure for Adult Social Care that places social workers and OTs at the 'front door' of acute settings to support diversion from hospital	• the ADAPT model has successfully been rolled out at one of the acute providers and had diverted demand so is seen as a proven solution • There is already an evidence base for this developing at City Hospital	

• Consider hospital social work support extending to cover under 65's in relevant hospital settings	• an invest to save type model, as investment in the Shared Lives services will result in savings in the long term • This has some link to Transforming Care programme (TCP)	
• Supporting system change / diagnostic (Newton)	• Review of Out of Hospital system to inform transformation and improvement	

Area 3: To sustain the social care provider market.		
Proposal	Rationale	Indicative Investment 17/18 (£m)
• Accelerate and bring forward the implementation of the new adult social care framework	• Greater stability to the market • Better quality of services provided for citizens • Reduced variation in quality • Better value for Birmingham £ • Attracts quality providers to work with Birmingham	£9.05m (33.5%)
• Commission an 'Experts by experience/ peer review' function to assist targeted monitoring of quality and safeguarding issues in the care sector.	• Supports an increased focus on quality and outcomes • Greater transparency • Increased safeguarding	
• Additional staff capacity to deliver the required changes at increased pace	• Infrastructure costs to implement the changes required in the form of additional capacity	
• Agree to pay 1 year of CQC registration fees for Gold rated care providers	• Incentivises high quality care provision and clear commitment from BCC about care quality • will assist in driving up quality	
• Purchase additional capacity in the care market	• Aligns to new out of hospital pathways, would enable commissioning of long term nursing dementia capacity which is linked to over 53% of DTOC at present.	
• Accelerate the uptake take up Integrated Personal Commissioning (IPC)	• Increase and accelerate the current IPC programme (Mental Health and LD) • Initiate frailty and children's disability workstream. • Potential impact upon urgent care as well as long term care.	

5 Next Steps

5.1. The proposals outlined will be further developed jointly with our partners via the refreshed BCF Commissioning Executive, and shared with key partners and forums for comment and endorsement. Final sign off will be through the Birmingham Health & Wellbeing Board.

5.2. Detailed delivery plans will be developed to support the expectation of delivery and spend in year. These will be undertaken jointly where relevant.

	Agenda Item: 11b
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**4th July 2017**
TITLE:	**DEMENTIA FUNDING IN THE BETTER CARE FUND (BCF)**
Organisation	**BCC and CCG's**
Presenting Officer	**Margaret Ashton-Gray/Mary Latter**

Report Type:	**Decision**

1. Purpose:
To seek approval from the Health & Wellbeing Board for BCF Commissioning Executive Boards' recommendation to move the current 3rd sector commissioned services specifically for Dementia support to the BCF to allow matched funding and maintain the current services.

2. Implications:		
BHWB Strategy Priorities	Child Health	N
	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		N
Early Intervention		Y
Prevention		N

3. Recommendation
The Health and Wellbeing Board is asked to approve the transfer of budgets from BCC to the BCF Pooled Fund, where they will be matched funded to provide a similar level of support to previous years.

4. Background

4.1 In March 2016 Birmingham City Council proposed to transfer, recurrent funding for previously City Council commissioned dementia specific services, to a ring fenced Section 75 pooled budget for Dementia to be held under the Birmingham Better Care Fund. The cost of these services was £95k, and they were/ are provided by the Alzheimers Society. Transfer from the beginning of April 2016 was proposed. This sum represented the cost of the service after a 50% reduction had been applied at the end of March 2016 and the Birmingham Better Care Fund undertook to 'match fund' (including any annual uplifts) the city council contribution in order to maintain the service.
The services deliver one to one support for people with dementia and their carers and dementia and memory cafes across the city and its provision is seen as critical to the dementia pathway in Birmingham.

4.2 National Context

The first ever national Dementia Strategy (Living Well with Dementia) was launched by the Department of Health in February 2009. Its focus was to improve the lives of people living with dementia and to invest in a network of memory clinics, improve support for people affected by the condition and launch major public awareness campaigns.
The Prime Minister's Challenge on Dementia was launched In March 2012. This focused on delivering major improvements in *dementia care* and *research* by 2015. The three champion groups were set up to focus on the main areas for action: driving improvements in *health and care*, creating *dementia-friendly communities* and *improving dementia research.*[1]
March 2016 saw the launch of the 2020 Challenge and Implementation Plan setting out more than 50 specific commitments, across four core themes of risk reduction, health and care, awareness and social action, and research.

4.3 Local Context

In 2014, the Birmingham & Solihull Dementia strategy (2014/17) was developed in Partnership between the local authorities, CCGs, NHS Trusts and Citizens. The Strategy covers five main parts of the dementia pathway:

1. Prevention & Health Promotion
2. Recognition & Identification
3. Assessment & Diagnosis
4. Living Well with Dementia
5. Increasing Care (including End of Life Care)

The Maximising the Independence of Adults agenda also sets plans to reduce the increasing demand for complex services against significant financial gaps.

Citizens with dementia can cost the Health and Social Care system £8.8billion[2].

5.	Compliance Issues
5.1	***Strategy Implications***
	This will continue to be funded via the joint arrangement of the BCF pooled fund.
5.2	***Governance & Delivery***
	The funding will form part of the BCF Governance arrangements, any changes to the funding will need to be recommended by the BCF Commissioning Executive to the health and Wellbeing Board for decision
5.3	***Management Responsibility***
	This funding will be part of the joint arrangements between the Birmingham CCG's and Birmingham Local Authority

6.	Risk Analysis
	None

Appendices

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

The following people have been involved in the preparation of this board paper:

Margaret Ashton-Gray - Head of City Finance – BCC
Mary Latter – Strategic Commissioning Manger (NHS Birmingham Cross City CCG)

	Agenda Item: 12
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**4 July 2017**
TITLE:	**BIRMINGHAM AND SOLIHULL CCGS: TRANSITION UPDATE**
Organisation	**NHS Birmingham CrossCity Clinical Commissioning Group (CCG); NHS Birmingham South Central CCG; and NHS Solihull CCG.**
Presenting Officer	**Dr Andrew Coward – Birmingham South Central CCG Paul Sherriff – Birmingham CrossCity CCG**

Report Type:	**Endorsement**

1. Purpose:
This presentation outlines the alternatives for future arrangements of the Birmingham and Solihull NHS commissioning organisations.

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

3.	Recommendation
	The Health & Wellbeing Board is recommended to endorse this proposal; the Board's input and involvement is also requested throughout the process.

4.	Background
	• To discuss the Birmingham and Solihull CCGs proposal for progressing STP objectives, in particular objective one: *Creating efficient organisations and infrastructures;* • To share the timeline for this process; • To test and refine our thinking on the possible alternatives, particularly the alternative we prefer at this stage; • To engage, in an open and transparent way; • To recognise the need for formal governance around the process and robust decision making; and • To ensure the Health and Wellbeing Board is consistently and meaningfully contributing to the process; with this insight being used to influence our decisions on which proposals to put to the public.

5.	Compliance Issues
5.1	***Strategy Implications***
	Refer to presentation
5.2	***Governance & Delivery***
	Refer to presentation
5.3	***Management Responsibility***
	Refer to presentation

6.	Risk Analysis
	Refer to presentation

Appendices
Presentation – Birmingham and Solihull CCGs Transition Update Pre Consultation Engagement Briefing

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

The following people have been involved in the preparation of this board paper:

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Birmingham and Solihull CCGs: transition update

Health and Wellbeing Board

Pre-consultation engagement briefing

Introduction

The NHS commissioning partners in the Birmingham and Solihull Sustainability and Transformation Partnership (STP) are:

- NHS Birmingham CrossCity Clinical Commissioning Group (CCG);
- NHS Birmingham South Central CCG; and
- NHS Solihull CCG.

During this presentation, we will outline the alternatives for future arrangements of the Birmingham and Solihull NHS commissioning organisations.

We request your input and involvement throughout the process.

Purpose

- To discuss our proposal for progressing STP objectives, in particular objective one: *Creating efficient organisations and infrastructures;*

- To share the timeline;

- To test and refine our thinking on the possible alternatives, particularly the alternative we prefer at this stage;

- To engage, in an open and transparent way.;

- To recognise the need for formal governance around the process and robust decision making; and

- To ensure the Health and Wellbeing Board is consistently and meaningfully contributing to the process; with this insight being used to influence our decisions on which proposals to put to the public.

Birmingham and Solihull STP

The Sustainability and Transformation Plan (STP) is about local leaders working together to deliver better health and care for local people. The NHS and social care are addressing significant financial challenges and increased demand, so both need to work together to make resources go further whilst ensuring that we can still deliver the quality of care people need.

The Birmingham and Solihull (BSol) CCGs leaders have been working together to think about how this issue is tackled.

The STP is an iterative process, and this is the start of a longer transformation journey. It's not a short term plan - this is for long-term, sustainable change over 5 years and beyond.

The three overarching objectives for the Birmingham and Solihull STP are:

- *Creating efficient organisations and infrastructures;*
- *Transformed primary, social and community care; and*
- *Fit for future secondary and tertiary care.*

The case for change

A strong strategic commissioner

- Working at scale in big partnerships - NHS commissioning will be stronger, more efficient, more consistent and more credible. We will be able to partner more closely with the LA in order to achieve our shared goals.
- Working at scale - gives the best opportunity to improve experience and health outcomes for local people, reduce unacceptable health inequalities, improve provider performance and reduce complexity.
- Recent mergers/planned mergers in hospital and primary care providers means a need for a strong NHS commissioner to balance the system.
- More efficient working means we can make best use of the £1.7bn we have to spend on healthcare for 1.2m people in Birmingham and Solihull.

The case for change

A move toward accountable care systems

- A single commissioning organisation would provide consistent view across both Birmingham and Solihull regarding the principles and development of new models of care.
- The CCGs would become a single strategic, stronger commissioner, speaking with one voice, in line with the development of accountable care systems.
- In the case of the NHS, ACOs and ACSs compromise three elements:
  - First, they involve a provider or, more usually, an alliance of providers that collaborate to meet the needs of a defined population.
  - Second, these providers take responsibility for a budget allocated by a commissioner or alliance of commissioners to deliver a range of services to that population.
  - And third, ACOs work under a contract that specifies the outcomes and other objectives they are required to achieve within the given budget, often extending over a number of years.

Background

June 2016:

The BSol CCGs decided to work towards aligning strategy and commissioning functions to deliver the STP outcomes.

September 2016:

CCGs considered a range of alternatives and decided to form a joint commissioning committee, the Birmingham and Solihull Health Commissioning Board (HCB).

Summer 2017:

The joint commissioning committee is creating a single staff team to support its functions.

The CCGs are further considering the alternatives for the future and begin a period of engagement and plan for public consultation of the options.

The alternatives

Currently, the CCGs operate a joint health commissioning board.

Alternative 1: Return to three separate CCGs/historic arrangements;

Alternative 2: Form a federation; continue with three separate CCGs, but establish shared management team, governance and decision making;

Alternative 3: A single CCG for Birmingham and a single CCG for Solihull, establish joint working arrangements with Solihull CCG with single management teams, joint processes and committees; and

Alternative 4: Full functional organisational merger – one single Birmingham and Solihull commissioning approach and management team.

On balance, we prefer Alternative 4 at this stage.

Key issues/considerations so far

During pre-consultation engagement, stakeholders have raised issues which we are noting and addressing. The following two are prominent and recurrent:

Finance

Birmingham CrossCity and Birmingham South Central both have cumulative surpluses of combined of £36.2million as at 31 March 2018 (assuming delivery of current plans). Solihull CCG has a cumulative deficit rising to £8.3million by 31 March 2018 (assuming delivery of current plans).

West Birmingham

Part of Birmingham is not covered by the Birmingham and Solihull STP. Responsibility for commissioning NHS services for the people of West Birmingham lies with Sandwell and West Birmingham CCG and the Black Country STP.

Retaining localism

Ensuring that Solihull ‘place’ is not lost in the bigger picture.

Stakeholder criteria to benchmark our alternatives against

- Overall improved health and better outcomes for patients;
- A more sustainable local NHS; both financially and able to support new ways of delivering care e.g. accountable care systems;
- Better integration with the local authorities, especially for social care and preventing poor health outcomes;
- Consistency for patients across Birmingham and Solihull;
- Ensuring that all patients can access the same high quality service, regardless of where they live in the area;
- A strong and strategic NHS commissioning voice to match that of the provider organisations and local authority;
- A larger and stronger pool of clinical expertise; and
- Maximising on the existing partnerships the three CCGs currently have.

Alternatives 1

Return to three separate CCGs/historic arrangements.

- The first possibility is to return to three separate organisations, which we feel would be a move backwards, undoing the progress made on partnership working.
- Returning to three organisations, although the structures are familiar to stakeholders, does not address the issues that have been identified:
  - There would be three commissioning voices with three sets of commissioning priorities, and three sets of relationships for providers and stakeholders.
  - Perpetuates the Birmingham city council VS Birmingham NHS boundary non-alignment issue
  - No economies of scale

Alternative 2

Form a federation; continue with three separate CCGs, but establish shared management team, governance and decision making.

- The second possibility , to federate, has slightly more advantages than alternative one. The CCGs could benefit from more of a collective voice and it would allow alignment with the Birmingham and Solihull boundary.
- It may also be possible to retain the setting of locally focussed objectives, incorporate shared governance standards and there may be little disruption for staff.
- However, it could create limitations to the extent of planning, as any of the CCGs could withdraw from the arrangements at any time.
- There would also be unrealised potential economies of scale, no address of the West Birmingham issue, and the financial challenge would not be fully addressed.

Alternative 3

A single CCG for Birmingham and a single CCG for Solihull (establish joint working arrangements with Solihull CCG with single management teams, joint processes and committees).

- The third possibility to create a CCG for Solihull and a CCG for Birmingham, offers further advantages than 1 and 2.
- This would partially addressees the co-terminosity issue, but not West Birmingham, and aligns to existing local authority, scrutiny and health & wellbeing board arrangements, and of course the Birmingham and Solihull partnership.
- This could be a good building block for future models of commissioning, however the resources and attention required to make formal application process for legal change to governance structure would be the same as a BSol CCG, with less of the advantages.
- There may be a risk that Solihull becomes a junior partner, in a world where large provider organisations have much power.

Alternative 4 *(our preference)*

Full functional organisational merger – one single Birmingham and Solihull commissioning approach and management team.

- This is our preference, as we feel it offers the most advantages of the four possibilities. It will be permanent and stable; allowing for consistent planning and approach to commissioning. The CCG would have one strong and strategic NHS commissioning voice to match that of the provider organisations and local authority;
- It would support the longer transformation journey. It's not a short term option, it's for the long-term, sustainable change for the BSol health system five years and beyond.
- It will match the Birmingham and Solihull boundary, and can provide potential efficiencies and the economies of scale are fully realised.
- Whilst the resources and attention required in the upcoming year may be more, the long term sustained benefits will support our healthcare system for the future.

Summary

The risks we have identified of all four alternatives are:

- Potential to lose some clinical leadership
- Potential to lose some staff talent
- Boundary issue of West Birmingham not resolved

In our assessment:

- **Alternative 1** offers significant disadvantages to our current arrangements.
- **Alternative 2** offers no significant advantage over our current arrangements.
- **Alternative 3** offers some advantages over our current arrangements.
- **Alternative 4** offers significant advantages over our current arrangements.

Involving stakeholders

Our phased approach to involving stakeholders observes good engagement practice, general election purdah, and democratic expectation for a public consultation on significant changes:

- **Phase one – May/June 2017:** Engage strategic stakeholders
- **Phase two – June 2017:** Engage wider stakeholders
- **Phase three – 10 July - 18 August 2017:** Formal consultation
- **Phase four – August/September 2017:** Consultation data analysis and reporting. Scrutiny by NHS England and decision on whether to authorise proceeding with preferred option.