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, 03 OCTOBER 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 Chairman 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 except where there are confidential or exempt items.

2 **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.

3 **APOLOGIES**

5 - 14

4 **MINUTES AND MATTERS ARISING**

To confirm the Minutes of the last meeting.

5 **CHAIR'S UPDATE**

To receive an oral update. (1505-1510)

15 - 42

6 **HEALTH & WELLBEING STRATEGY UPDATE**

To consider a report on developments related to the Strategy including the identification of potential indicators, targets etc. (1510-1520)

43 - 78

7 **USING THE IMPACT OF CHILDHOOD ADVERSE EXPERIENCES TO IMPROVE THE HEALTH & WELLBEING OF BIRMINGHAM PEOPLE**

To consider a report on a proposed way forward aimed at responding to and reducing the impact of Childhood Adverse Experiences. (1520-1540)

79 - 122

8 **DRAFT BIRMINGHAM HOMELESSNESS PREVENTION STRATEGY 2017+**

To consider a report on the draft Birmingham Homelessness Prevention Strategy and how it relates to the Health and Wellbeing Strategy priorities and ambitions. (1540-1555)

123 - 136

9 **BIRMINGHAM CITY COUNCIL'S VISION AND STRATEGY FOR ADULT SOCIAL CARE SERVICES**

To consider the Council's Vision and Strategy to modernise the Adult Social Care Services which is being submitted to Cabinet on the morning of 3 October, 2017 for approval. (1555-1610)

137 - 202

10 **BIRMINGHAM BETTER CARE FUND PLAN 2017/18/19**

To consider a report on the Birmingham Integration and Better Care Narrative Plan 2017/19. (1610-1620)

203 - 216

11 **CARE QUALITY COMMISSION: REVIEW OF SOCIAL CARE AND HEALTH SYSTEM**

To consider a report on the Care Quality Commission review of the Social Care and Health systems that will be taking place in Birmingham. (1620-1630)

12 **SUSTAINABILITY AND TRANSFORMATION PLAN - SYSTEM CHANGES UPDATE**

To receive an oral update. (1630-1640)

13 **CLINICAL COMMISSIONING GROUPS - CHANGES UPDATE**

To receive an oral update. (1640-1650)

217 - 226

14 **WEST MIDLANDS MENTAL HEALTH COMMISSION BRIEFING PAPER**

For information.

15 **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 of the meeting are matters of urgency may be considered.

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD
4 JULY 2017

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

PRESENT: - Councillor Paulette Hamilton in the Chair; Graeme Betts, Andy Cave, Dr Aqil Chaudary, Councillor Lyn Collin, Dr Andrew Coward, Johnathan Driffill, Professor Nick Harding, Chief Inspector Karen Greasley, Dr Adrian Phillips, Dr Gavin Ralston and John Short.

ALSO PRESENT:-

Margaret Ashton-Gray, Head of City Finance, BCC
Gemma Coldicott, Senior Communications and Engagement Manager, Birmingham CrossCity Clinical Commissioning Group (CCG)
Paul Holden, Committee Services, BCC
Mary Latter, Strategic Commissioning Manager, Birmingham Better Care
Claire Parker, Chief Officer for Quality, Sandwell and West Birmingham CCG
Paul Sheriff, Birmingham and Solihull CCG Transition Programme Lead and Director of Operations and Corporate Development, CrossCity CCG

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NOTICE OF RECORDING

190 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.

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

The following schedule outlining the functions, terms of reference and membership of the Health and Wellbeing Board agreed by Cabinet on 27 June 2017 was submitted:-

(See document No. 1)

191 **RESOLVED:-**

That the re-appointment of the Health and Wellbeing Board with the functions, terms of reference and membership as outlined in the schedule be noted.

DECLARATIONS OF INTERESTS

192 Members were 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.

APOLOGIES

193 Apologies for absence were submitted on behalf of Chief Superintendent Chris Johnson, Councillor Brigid Jones and Tracy Taylor.

DATES OF MEETINGS

The Chair highlighted that it was also proposed to hold two informal meetings.

194 **RESOLVED:-**

That the following proposed dates for formal meetings of the Board be noted: 1500 hours on Tuesday 3 October 2017; Tuesday 16 January 2018; Tuesday 27 March 2018.

MINUTES

195 The Minutes of the Board meeting held on 31 January 2017 were, subject to it being noted that Professor Nick Harding had submitted an apology for his inability to attend, confirmed and signed by the Chair.

CHAIR'S UPDATE

196 In first referring to electoral developments, the Chair reported that she had since the last meeting had the pleasure of attending the launch of the new regional Specialist Haemoglobinopathy Unit at City Hospital. The Chair advised the members that she was really proud to have spoken at the event because for many years she had passionately felt that the client group had not been given the same life chances as others because of where they lived in the country. Moreover, the Chair highlighted that she had been pleased to see organisations such as the Blood Transfusion Service, City Hospital and Public Health England working in a joined-up way.

The Chair reported that she had visited Chicago as part of a social care exchange programme set up 20 years ago involving Birmingham, Chicago and Hamburg and which offered participating cities the opportunity to gain an international perspective of contemporary issues concerning social care and engage in discussions with fellow politicians on policy development. The Tri-City programme had since expanded to include other cities e.g. Casablanca, Durban, Morocco, Osaka, Paris and Shanghai. Members were informed that

her reflections on the exchange trip was that it was important to retain a focus on prevention rather than reacting to 'trauma', a word constantly used in Chicago to refer to such issues as domestic abuse, guns and gangs and mental health, the levels of which were quite shocking.

Reference was also made by the Chair to a joint visit that she had made with Andy Street, Mayor for the West Midlands to the New Specialist Supported Living Scheme in Bartley Green. She informed the meeting that the housing complex had been a joint venture involving a Housing Trust, Birmingham City Council and others and an excellent example of what could be achieved when organisations and people worked together.

In relation to the NHS Confederation conference in Liverpool, the Chair commented that she had been heartened to hear that the focus on social care was still at the forefront of discussions about integration.

In concluding the Chair advised the meeting that Healthwatch Birmingham's Annual Report 2016/17 was now available and undertook to ensure that a copy was sent to all members of the Board.

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) John Short indicated that he was surprised that tackling childhood obesity was not in the Strategy. He also advised the Board that the Mental Health System Strategy Board would be setting the ambition of zero suicide as hundreds of people died through suicide and considered that it would be helpful if the ambition was referenced in the Strategy.

2) Dr Andrew Coward referred to the importance of NHS provider organisations having a commitment to the wellbeing of staff and reported that compared to the average worker in the United Kingdom, NHS staff were 50 per cent more likely to have a debilitating illness which directly related to quality outcomes for patients. Furthermore, he advised the Board that domestic violence was 2-3 times more prevalent amongst nursing staff. He therefore considered that there was much that the NHS could do to put its own house in order. Further to 1) above, the member supported the ambition of zero suicide being included in the Strategy and pointed out that individuals who had 4 or more Adverse Childhood Experiences were 49 times more likely to attempt suicide.

3) The Chair advised the meeting that she was passionate about tackling and bringing down levels of domestic violence and abuse and considered that the issue should be covered within the Strategy.

4) Further to comments made, Dr Adrian Phillips referred to work that had been led by Dr Andrew Coward on childhood obesity and highlighted that work continued to take place on the issue, notwithstanding the fact that it was no longer mentioned in the Strategy. He highlighted that the Board had considered that it would be better to focus on making efforts to perform well in respect of a relatively small number of priorities / ambitions and, in relation to the issue of suicide, referred to the need for the Board to consider how it might work with other organisations to identify and help vulnerable people in crisis. He suggested that a report be brought to a meeting later in the year covering both child obesity and the issue of zero suicide and this was supported by members.

5) In responding to a question from Professor Nick Harding, Johnathan Driffill highlighted that families moving with their children from temporary to permanent accommodation was a big improvement in itself and suggested that the quality aspect could be addressed by referring to appropriate or suitable permanent accommodation.

6) Professor Nick Harding indicated that he would be keen to see metrics in respect of the priorities and ambitions in the Strategy circulated to members of the Board on a regular basis. Dr Adrian Phillips undertook to arrange for this to happen.

7) Further to a request from Dr Adrian Phillips for members to consider what support they might be able to offer in terms of developing targets and implementing the Strategy, the Chair asked that the Director of Public Health arrange for the members to be contacted in this regard.

8) John Short highlighted that one of the functions (Minute No 191 refers) of the Board was to promote a reduction in health inequalities across the City through the commissioning decisions of member organisations. He therefore considered that it would be helpful if there was a simple fact sheet that described what the biggest health inequalities were in Birmingham.

197 **RESOLVED:-**

(a) That the developments related to how the Strategy was relevant to the objectives of members' organisations be noted;

(b) that this Board agrees to:-

(i) support the development of the Operations Group; and

(ii) provide specific leadership to individual objectives.

(c) that a report be submitted to the Board later in the year on the issue of child obesity and the ambition of zero suicide.

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

The following report was submitted:-

(See document No. 3)

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) Dr Andrew Coward placed on record his thanks to Dr Dennis Wilkes, Assistant Director of Public Health for his excellent work in chairing meetings and taking matters forward. The member also referred to an example of where a mother who'd suffered domestic abuse had been re-united with her child. He looked forward to receiving the full report of the Task and Finish Group and highlighted that the work on Adverse Childhood Experiences (ACEs) provided a central platform to improve the health and wellbeing of people in Birmingham.
2) Andy Cave highlighted that learning could be gained by speaking to individuals who'd suffered ACEs in the past and identifying what had helped them.
3) Further to 2) above, Dr Adrian Phillips considered that exposing the problems that adults were experiencing was a big step on the way to tackling them. In relation to children, he highlighted that one of the difficulties faced was how frequently to ask them if they needed help. He confirmed that seeking to identify good and best practice was part of the Task and Finish Group's work.

198 **RESOLVED:-**

That the progress made and that a full report will be submitted to the October meeting, be noted.

IMPROVING THE INDEPENDENCE OF ADULTS

The following report was submitted:-

(See document No. 4)

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) Dr Adrian Phillips indicated that the timescales involved had meant that there'd not been sufficient time to include Sandwell and West Birmingham in the application to be a demonstrator site for the Integrated Personal Commissioning Operating Model.

2) In relation to seeking to ensure that the services were available to meet the needs of individuals with Personal Health Budgets (PHBs), Dr Adrian Phillips considered that focus should be on speaking to service users about what services they required and stimulating rather than controlling the market.

3) John Short, in supporting the comments made in 2) above, underlined that PHBs were something that he had desperately wished to see put in place for a long time. He considered that they were fundamental in terms of seeking to change the relationship between service providers and service users and giving greater power to the latter. Furthermore, he felt that they were the most important step that could be taken structurally to reduce health inequalities. He therefore had concerns that there was no reference to PHBs in the Birmingham and Solihull CCGs' transition update document received (Minute No 202 refers).

4) At this juncture Dr Adrian Phillips referred to an interview involving John Short at The Kings Fund and commented that in the field of mental health the legislation was very powerful and could involve taking away people's liberty; he highlighted that personalisation was the very opposite of this.

199 **RESOLVED:-**

That the targets in the Integrated Personal Commissioning adopter programme be adopted by the Health and Wellbeing Board for its strategic objective of improving the independence of adults.

PROPOSALS FOR THE USE OF THE IMPROVED BETTER CARE FUND

The following report was submitted:-

(See document No. 5)

Graeme Betts, Interim Corporate Director, Adult Social Care and Health, BCC introduced the information contained in the report. It was explained that the following were the main areas being focused upon: providing more nursing beds and rectifying flaws in the system with regard to delayed transfers of care; the importance of 7-day working; using Trust Assessors; investing in the Third Sector; and improving primary and community care and the way people worked in localities. Graeme Betts reported that feedback from the Clinical Commissioning Groups and NHS providers had been positive and he therefore commended the proposals to the Board.

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

1) Graeme Betts indicated that he considered that the idea of one public sector organisation fining another with the objective of improving performance in respect of delayed transfers of care was ill-conceived. He highlighted that it did nothing to bring about better partnership working and only served to reduce the amount of funding available to provide hospital social workers.

2) Members were advised that the Local Authority would be inspected again in the autumn or late spring next year and that the health service would be

inspected at the same time so that the health and social care system was looked at as a whole. Furthermore, Graeme Betts reported that a company would be examining the system from the 'front door' to the 'back door' to identify any pressure points. He indicated that it was believed that the proposals being put to the Board would bring about the improvements that everyone wanted to see.

3) Dr Gavin Ralston very much welcomed that the money would be used to improve the way that the system was working particularly as it was likely to result in long term benefits when the funding ceased. He was also pleased to hear that Trust Assessors would be used and that moves were being made towards 7-day services.

4) Further to 3) above, Graeme Betts considered that 7-day working by social work teams reduced pressures on them as they were not then always trying to catch-up and considerably improved the way that they worked. He would therefore be making efforts to encourage them to move quickly to 7-day working.

5) In responding to comments and a question from Professor Nick Harding, Graeme Betts confirmed that as much flexibility as possible was being retained in respect of the use of the money. He also concurred that there was a need for local targets in relation to delayed transfers of care as it was unrealistic to expect everyone to move at the same pace. Members were advised that there was recently a meeting involving CCG and NHS provider colleagues where it had been agreed that the next step was to add the timelines and metrics to the programme in terms of what it was expected to deliver and over what timescale. In anticipation of the inspection he underlined that a robust improvement plan was being developed.

6) Councillor Lyn Collin considered that there were brilliant hospitals, practitioners, doctors and nurses in the City and that this quality of provision should be matched by social services. The member hoped that in the future the NHS and social services would be able to work effectively together and provide the quality services that residents deserved.

The Chair thanked the Interim Corporate Director, Adult Social Care and Health, BCC for reporting to the meeting.

200 **RESOLVED:-**

(a) That the proposals outlined in section 4.5 of appendix 1 to the report be supported and approved;

(b) that the implementation plan be received at a future meeting.

DEMENTIA FUNDING IN THE BETTER CARE FUND

The following report was submitted:-

(See document No. 6)

Margaret Ashton-Gray, Head of City Finance, BCC and Mary Latter, Strategic Commissioning Manager, Birmingham Better Care introduced the information contained in the report.

The Chair thanked the representatives for reporting to the meeting.

201 **RESOLVED:-**

That approval be given to the transfer of budgets for commissioning third sector dementia services from Birmingham City Council to the BCF Pooled Fund, where they will be match-funded to provide a similar level of support to previous years.

BIRMINGHAM AND SOLIHULL CCGS: TRANSITION UPDATE

The following report was submitted:-

(See document No.7)

Paul Sheriff, Birmingham and Solihull CCG Transition Programme Lead and Director of Operations and Corporate Development, Birmingham CrossCity Clinical Commissioning Group (CCG); Claire Parker, Chief Officer for Quality, Sandwell and West Birmingham CCG; and Gemma Coldicott, Senior Communications and Engagement Manager, Birmingham CrossCity CCG, were in attendance.

The Programme Lead introduced the information submitted and in referring to comments that had been made earlier (Minute No 199 refers) acknowledged that the information presented did very much concentrate on operational form which was not the ultimate purpose of what was trying to be achieved. He advised members that nonetheless the points that had been made at the meeting were very much part of the programme of work to ensure that what a strategic commissioning should look like in the future was captured. It was reported that consultation would commence on 10 July and run for a 6-week period. In addition, at this juncture, Dr Andrew Coward expressed his support for the proposed merger of the 3 CCGs, Joint Strategic Commissioning and a movement towards Accountable Care Systems / Organisations. He considered that the NHS had not at times performed well at addressing the wider determinants of health with its strongly disease orientated approach and medical model of waiting for things to go wrong and then seeking to put them right using vast sums of money. The member felt that one of the reasons for this was that the NHS had been compartmentalised and too strongly hospital-led. However, he believed that if the merger went ahead and there was movement to create an Accountable Care System (ACS) with a split between an Accountable Care Organisation and Joint Strategic Commissioning it would provide the opportunity to home-in on the issues that really mattered for the health and wellbeing of the citizens of Birmingham.

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

1) John Short informed the representatives that the NHS providers believed that it was important that the proposed merger of the 3 CCGs at the same time addressed the West Birmingham issue; referred to Personal Health Budgets (PHBs) and stressed the need for the strong commissioning mentioned in the appendix (fifth slide) to be carried out in partnership with citizens and service users/patients; and considered that it was important that the issue of what balance there should be between collaboration and competition was covered when going out to consultation and moving towards ACSs. He felt that competition was entirely appropriate but believed that there should also be something about collaboration. The Board was advised that the Birmingham and Solihull Mental Health NHS Foundation Trust now had an ACS as the Trust had on 1 April 2017 taken over all the Adult Secure Services for the West Midlands and that their rhetoric was all about competition alongside collaboration. The member considered that this was something that needed to be better reflected in the messages going out particularly given that the consultation would soon start. He had concerns that the public might interpret a strong voice as being the NHS dictating to the public rather than it being concerned with ensuring that ACS had the commissioning skills to bring about the best possible outcomes for the citizens of Birmingham.
2) Professor Nick Harding considered that merging the 3 CCGs was the right thing to do and that there was a need to look at how an ACS could be allowed to develop. The member highlighted that doing the right thing in a diverse place like Birmingham with its different populations was complex and challenging. He considered that an underlying question was how would population care be made better as a consequence of the proposed new structures. The member was not sure that a merged organisation would allow the NHS to get round the commissioner / provider split in the first instance but believed that it would allow the NHS to work together better.
3) The Chair stressed the importance of ensuring that the voices of citizens were heard. Graeme Betts, Interim Corporate Director, Adult Social Care and Health, BCC highlighted the value of the report in terms of opening up the discussion and debate around how to take matters forward, particularly in terms of an integrated commissioning approach. In addition, he reported that he was pleased to hear references at the meeting to the importance of tackling health inequalities as it could be easy not to give them enough prominence when focusing on commissioning issues rather than outcomes.
4) Further to 3) above, Dr Andrew Coward highlighted that the biggest driver of poor health, non-communicable diseases and poor mental health were Adverse Childhood Experiences (ACEs) and that ACEs were three times more likely in the most deprived populations compared to the least deprived. As ACEs were the biggest driver of health inequalities he therefore considered that it was important to focus on the childhood adversity piece and that joint commissioning arrangements would help in this regard.

Members of the Board were thanked for the feedback and Paul Sheriff undertook to take on board issues that had been raised at the meeting as part of the consultation exercise.

The Chair thanked the representatives for reporting to the meeting.

202 **RESOLVED:-**

That the proposed CCG organisational commissioning arrangements be endorsed.

OTHER URGENT BUSINESS: INFORMAL BOARD MEETING – BIRMINGHAM AND SOLIHULL SUSTAINABILITY AND TRANSFORMATION PLAN

203 Dr Adrian Phillips informed the meeting that it was proposed to hold an informal meeting of the Board towards the end of the summer on the Birmingham and Solihull STP and to invite partners to attend. Members supported this approach.

The meeting ended at 1628 hours.

……..…….
CHAIRPERSON

	Agenda Item: 6
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**3 October 2017**
TITLE:	**HEALTH & WELLBEING STRATEGY UPDATE**
Organisation	**Birmingham City Council**
Presenting Officer	**Adrian Phillips**

Report Type:	**Information**

1.	**Purpose:**
1.1	To update the Health and Wellbeing Board of progress in developing and establishing potential indicators and targets and accountable groups across the health and social care economy that have the lead on delivering the ambitions in the Health & Wellbeing Strategy.
1.2	To identify issues that may hinder progress delivering the ambitions of the strategy.

2.	**Implications:** # Please indicate Y or N as appropriate]	
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

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

3.2 Board members report how the strategy relates to their organisational objectives.

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

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

Targets

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

Board Member Involvement

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

4.7 **Next Steps**

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

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

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

Appendices
Health & Wellbeing Strategy Update

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

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

Wayne Harrison
Jade Hussain
Adrian Phillips

Health & Wellbeing Strategy Update

Background

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 key responsibility of the HWBB is to develop a Health and Wellbeing Strategy (HWBS), to inform commissioning decisions across local services such that they are focussed on the needs of service users and communities, to tackle the factors that impact upon health and wellbeing across service boundaries.

In January 2017 the HWBB agree to a set of updated priorities for the HWS around:

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

Subsequently the HWBB has asked the Operations Group to identify potential indicators and targets and accountable groups across the health and social care economy that have the lead on delivering these ambitions.

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

Ambition	Target	Key links/external bodies	Board Lead	Operations Lead
Detect and Prevent Adverse Childhood Experiences	Awaiting recommendations of the Task & Finish Group			
All children in permanent housing	All children in permanent housing	Housing Birmingham	Jonathan Driffill	John Hardy BCC
Increase the control of individuals over their care through Integrated Personal Commissioning (Personal Health Budgets and Direct Payments)	To be agreed with NHSE BCC target 25% by 31/3/18	Integrated Personalised Commissioning Board	tbc	Anita Holbrook CCG Chris MacAdams BCC
Increasing employment/ meaningful activity and stable accommodation for those with mental health problems	8.9% patients with on CPA in paid employment by 2020/21 Accommodation tbc	Mental Health System Strategy Board	tbc	Jo Carney CCG Melanie Brooks BCC
Improving stable and independent accommodation for those learning disability	tbc	tbc	tbc	Melanie Brooks BCC
Improve the wellbeing of those with multiple complex needs	tbc	tbc	tbc	Natalie Allen BVSC
Improve air quality	Halve air pollution attributable mortality by 2030	BCC Air Quality Steering Group	Adrian Phillips	Wayne Harrison BCC

Ambition	Target	Key links/external bodies	Board Lead	Operations Lead
Increased mental wellbeing in the workplace	tbc	tbc	tbc	Tbc

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

A Focus on the Most Vulnerable

The poor health outcomes of people with co-existing mental and physical conditions represent one of the greatest inequalities in health. Mental illness is involved in one in three avoidable deaths every year, while people with severe mental illness die on average 20 years earlier than the rest of the population – a situation described as lethal discrimination by Rethink.

Similarly, people with learning disabilities in England die much younger than the general population (13 to 20 years younger for men with learning disabilities; 20 to 26 years younger for women with learning disabilities). More than three times the number of people with learning disabilities dies than would be expected when taking into account age and sex.

The hard "Hard Edges" report describes the experiences of individuals who are in contact with at least two out of three of the homelessness, substance misuse and/or criminal justice systems. The quality of life reported by these people facing Sever Multiple Disadvantage (SMD) is much worse than that reported by many other low income and vulnerable people, especially with regard to their mental health and sense of social isolation.

In Birmingham it is estimated that there are:

- Over 6,700 affected by 2 forms, and
- Up to 2,500 affected by 3 forms of SMD

SMD creates a significant cost for the rest of society, particularly with respect to disproportionate use of certain public services. There are also significant social costs associated with SMD, not least the potentially negative impacts on the children with whom many people facing SMD live, have contact, or are estranged from;

The effects of inequities can be entrenched through generations. The range of experiences, such as domestic violence, incarceration, mental illness, unemployment and substance misuse can have an adverse effect on the health and wellbeing of our children, Young

People, families, and adults for a lifetime. Single experiences have an adverse impact on the child's future health & wellbeing but multiple experiences have a cumulative impact.

Current position

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

Identified indicators, targets and plans for delivery

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

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

Indicators identified but target and plans not yet determined

- Improving stable and independent accommodation for those learning disability
- Increasing stable accommodation for those with mental health problems

Limited nationally published indicators are available for each of these areas. However, it has been recognised that there are gaps in these areas. It is proposed to prepare a paper for the next Board meeting with more details for potential indicators, targets and the strategic context for these areas. .

Indicators, targets and plans not yet determined

- Detect and Prevent Adverse Childhood Experiences
- Improve the wellbeing of those with multiple complex needs
- Mental wellbeing in the workplace

The HWBB has established a working group on ACEs. However, it is not expected that this work will recommend indicators or targets for the ambition outlined in the strategy. ACES are also a work stream in the Sustainability and Transformation Partnership for Birmingham & Solihull.

Improving the wellbeing of those with multiple complex needs and mental wellbeing in the workplace are both areas that are being addressed in the Public Service Reform programme of the West Midlands Combined Authority. As yet, the indicators and targets for these areas have not been established, nor has the expected contribution of Birmingham to achieving the overall objectives.

Workplace wellbeing is also a work stream in the Birmingham & Solihull STP.

Once these plans are established Birmingham contribution to them can be quantified and delivery mechanisms agreed and assured.

Next steps

Formally agree the indicators and targets for:

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

Establish the accountable group and agree targets for:

- Improving stable and independent accommodation for those learning disability
- Increasing stable accommodation for those with mental health problems

Establish Birmingham indicators, targets and plans for:

- Improve the wellbeing of those with multiple complex needs
- Mental wellbeing in the workplace
- Detect and Prevent Adverse Childhood Experiences

Detect and Prevent Adverse Childhood Experiences

Indicator: tbc
Target: tbc

Current plans to achieve ambition

Awaiting update from ACES Task & Finish Group

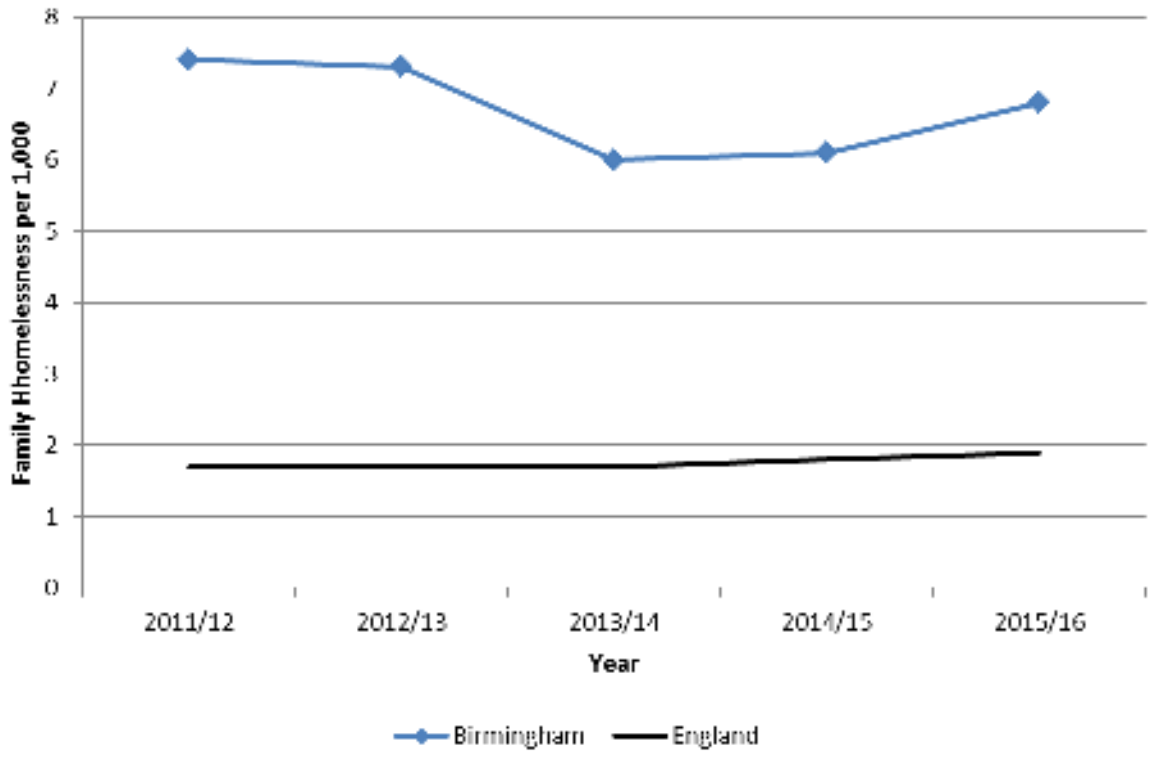
Accountable Group

Secondary indicators

All children in permanent housing

Indicator: Family Homelessness (ChiMat)

Target: tbc



Current plans to achieve ambition

The Birmingham Homelessness Prevention Strategy 2017+ is currently in consultation. The "Positive Pathway Model" sets out five key areas that can be used flexibly to ensure that no matter what stage people enter the pathway; they will be supported as early and as effectively as possible:

1. Universal Prevention
2. Targeted Prevention
3. Crisis Prevention and Relief
4. Homeless Recovery
5. Sustainable Housing

The Homelessness Positive Pathway Programme Board has established five Task and Finish Groups, one for each key area of the pathway. Membership of each group consists of a range of key partners, stakeholders, and crucially citizens as a reference point. The Task and Finish groups will describe what an excellent system looks like. Informed by the public consultation, they will then identify a series of actions, initiatives and opportunities that will be incorporated into the final Strategy Implementation Plan.

Housing Birmingham Partnership is responsible for, and committed to ensuring that Birmingham's vision to eradicate homelessness becomes reality.

Accountable Group

Housing Birmingham Partnership

Secondary indicators

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

Indicator: Personal Health Budgets are the key deliverable for the Integrated Personal Commissioning Programme. As part of the NHSE Early Adopter Programme we have an accelerated target shifting from 2020 – 2022 to 2019 -2020.

Target: There is a need to meet 0.1% by March 2018, and the 0.2% by March 2019. This equates to 1040 PHB's.

Current Plans to Achieve Ambition

The IPC Programme is expected to achieve the following key shifts, which is reflected in each cohort plan and infrastructure planning.

Proactive Coordination of Care:

People proactively or reactively identified and offered information about IPC also demonstrating much greater efficiency.

Community Capacity, Co-production and Peer Support:

Making the most of what's available to 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 people, 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.

IPC Plans focus on several cohorts including Adult Mental Health, Adult Learning Disability, End of Life, Complex Physical Health Care and Wheelchairs. Each of these cohorts has an individualised plan. In addition, there are significant Infrastructure developments in relation to introduction of a Resource Allocation Tool, E-Market Place, Co-Produced local IPC Strategy, Social Media and Training resources.

Accountable Group

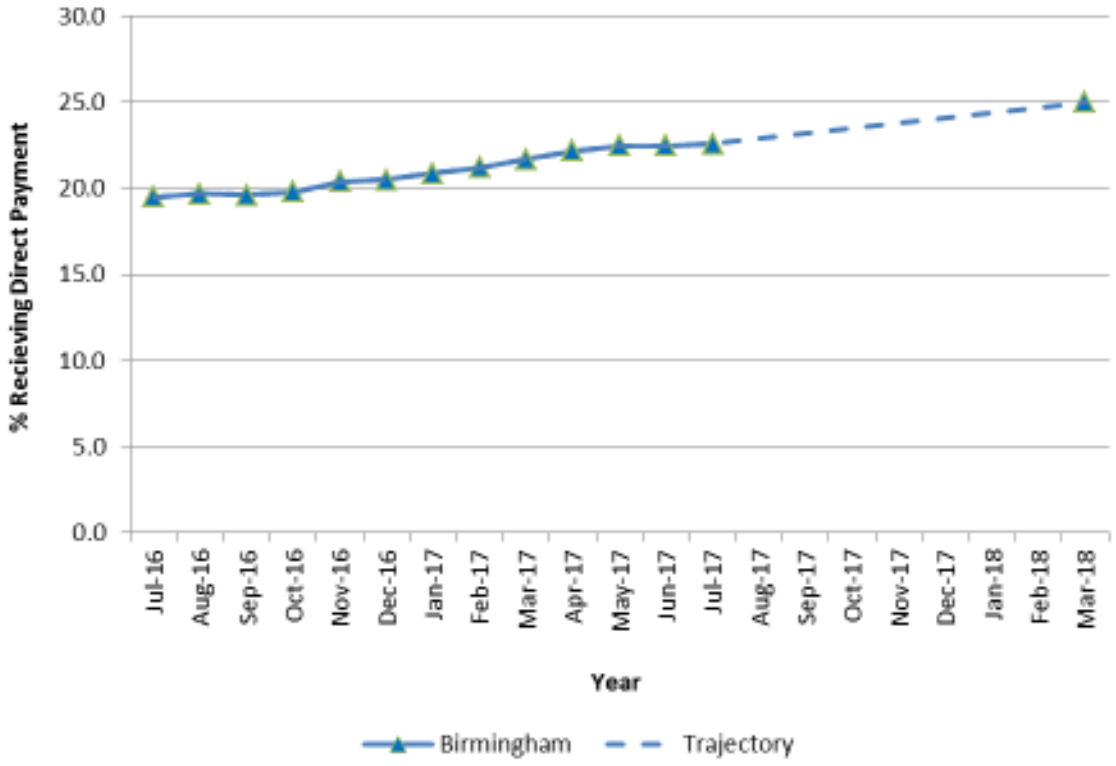
IPC Programme Board

Secondary indicators

NHSE England is currently developing datasets and outcome measures although each cohort is in the process of developing local systems.

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

Indicator: Proportion of clients for whom a Social Care Individual Budget is being taken in the form of a Direct Payment. (Care First)
Target: 25% by 31/3/18



Current plans to achieve ambition

Promoting Direct Payments as being the first choice for citizens

- Direct Payment is the first offer in any conversation with the Council
- Officers feeling confident in being able to deliver key messages
- Targeted support to those officers and those teams which are seen as being pivotal to increasing numbers

- Support to Home Support providers so that they have a clear understanding of Direct Payments

Development of Peer Support and improve joint working across Social Care & Health

- Citizens and patients able to feel that they can communicate with a 'peer' about DP's/PHB's (Direct Payments/Personal Health Budgets)
- Communications Plan that has citizens as its focus and is reaching out beyond the Council
- A meaningful on-line market place that gives citizens information on DP's and what services are available

Change in the way that the Home Support market for children's and adults is managed

- Reduction in numbers of commissioned home support providers from 140 down to between 73 and 97
- Move towards a geographical model for Home Support
- Development of quality ratings and focus on driving up quality

Accountable Group

Direct Payments Project Board.

Secondary indicators

Adult Social Care Outcomes Framework (ASCOF)

The ASCOF is a set of outcome measures, which have been agreed to be of value both nationally and locally for demonstrating the achievements of adult social care. Its key uses span this national and local context:

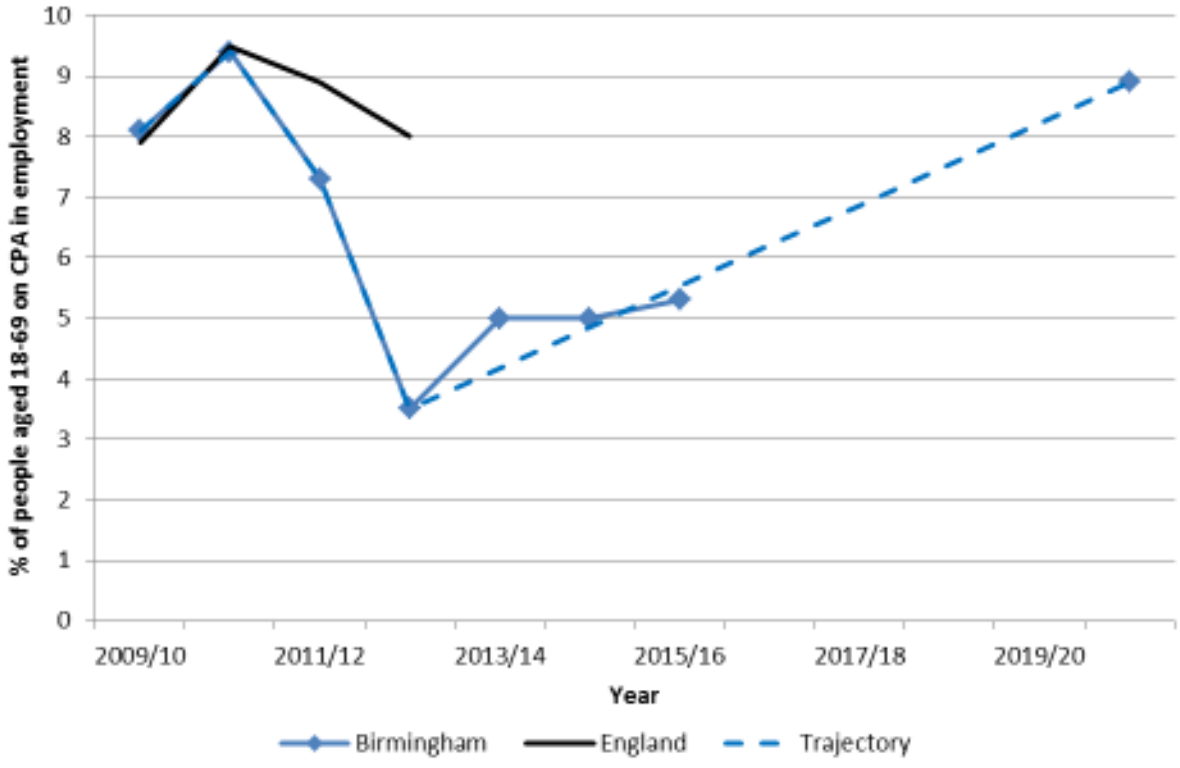
- Nationally, the ASCOF will give an indication of the strengths of social care and success in delivering better outcomes for people who use services. This will support the Government's role in reporting to the public and Parliament on the overall system, and influence national policy development. It will also help local government to understand trends and highlight risks in keeping with its responsibility for improvement in councils.

- Locally, one of the key uses of the ASCOF is for 'benchmarking' and comparison between areas. This is critical to local accountability of councils and reporting to their citizens on a consistent basis. Whilst the ability to compare between areas varies between the measures, overall the framework is one of the most significant supports available to councils themselves in managing their own service

improvement, since it will provide one of the few validated sources of outcome information.

Increasing employment/ meaningful activity for those with mental health problems

Indicator: Proportion of working age adults (18-69) who are receiving secondary mental health services and who are on the Care Programme Approach at the end of the month who are recorded as being employed (ASCOF)
Target: 8.9% patients by 2020/21



The current Public Health Outcomes Framework indicator for the gap in the employment rate between those in contact with secondary mental health services and the overall employment rate shows Birmingham to be performing significantly better than the national average. However, this is a reflection of the low overall employment rate, for which the gap with the national rate widened in 2015/16, rather than good performance for employment of people with mental health conditions.

Current plans to achieve ambition

CCGs are re-commissioning Mental Health 'day services' and learning and work services to provide a redesigned integrated recovery and employment service for people receiving

secondary care mental health services. Employment support will be provided with fidelity to the Individual Placement Support (IPS) model.

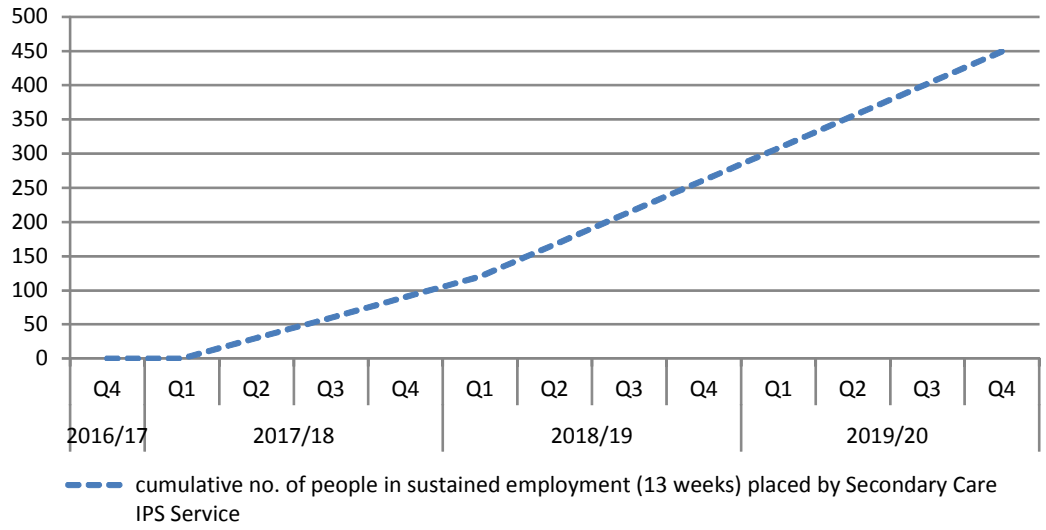
Individual Placement Support is an evidence based model which has been proven to achieve higher numbers of people entering and sustaining employment. IPS workers are integrated into community mental health services and provide open ended support to both employee and employer. A tendering process is currently being undertaken. The service will be established from April 2018.

Accountable Group

Mental Health System Strategy Board

Service Level Key Performance Indicators

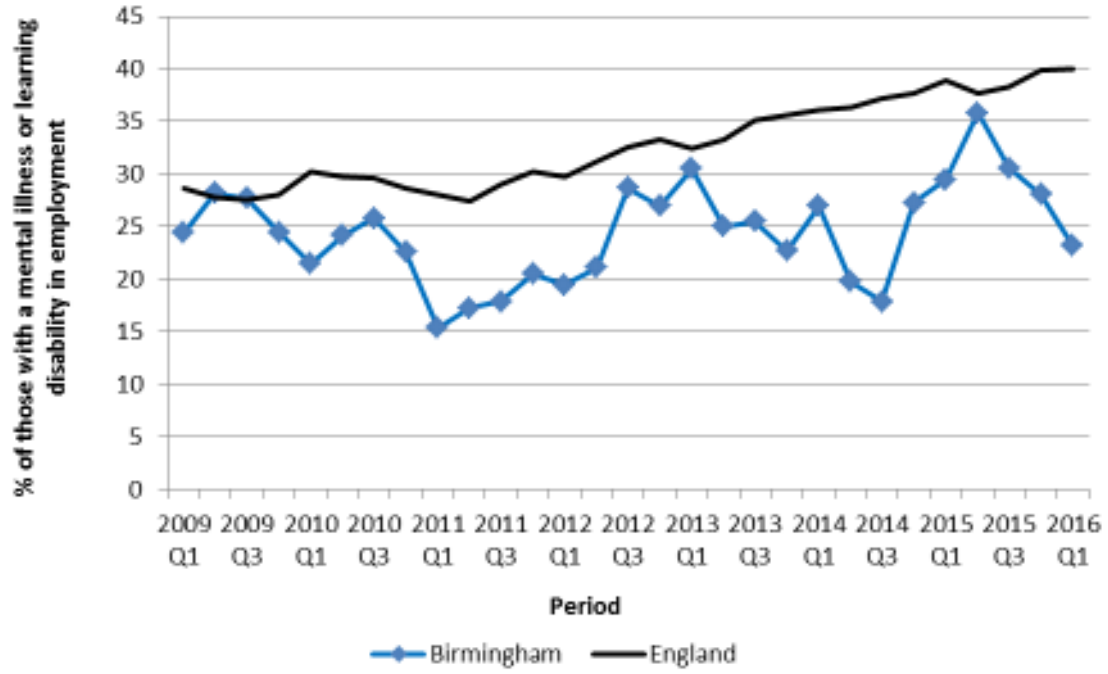
The provider of the IPS service will be set KPIs to monitor performance. Commissioners will monitor the number of people engaged by the service and the number of people who are placed in paid employment which is sustained for 13 weeks.



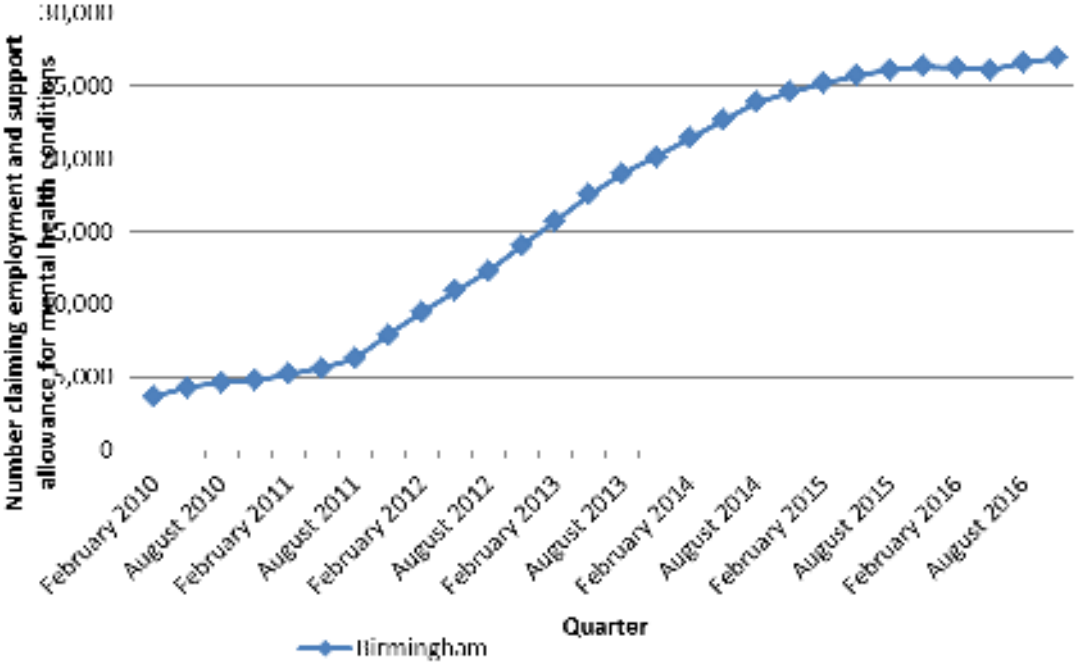
Secondary indicators

It is recognised that employment and meaningful activity affects a much wider population than those on CPA and in contact with secondary mental health services. Therefore a number of other indicators may be considered to give a better overall picture of the situation in Birmingham.

Indicator: Employment of people with mental illness or learning disability: % of those with a mental illness or learning disability (PHE Common Mental Health Disorders Profile)
Target: tbc



Indicator: Number of people receiving Employment Support Allowance for mental health conditions.
Target: tbc



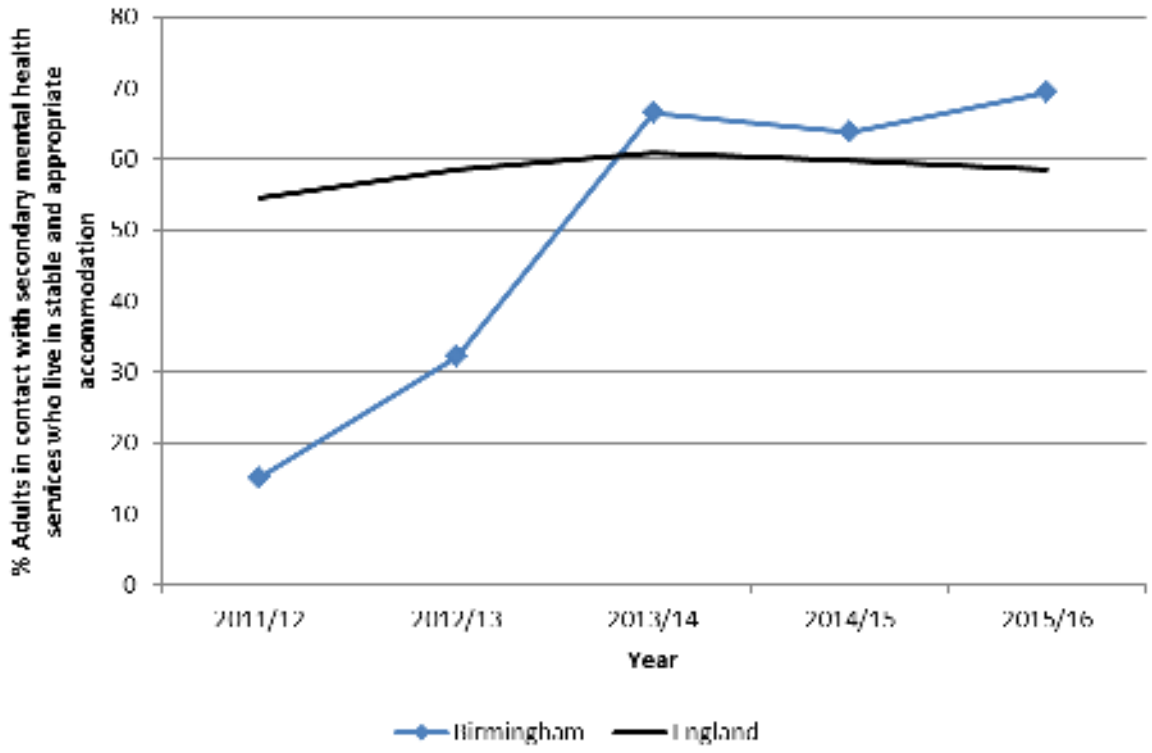
Current plans to achieve secondary ambition

THRIVE West Midlands is the action plan established in response to the West Midlands Commission on Mental Health. One of THRIVEs five key work streams is “Supporting People into Work and Whilst in Work”. As part of this THRIVE is commissioning a large scale RCT trial of Individual Placement Support for long term conditions (including mental health) in primary care. The trail will take place across Birmingham and the Black Country with test sites in South, Central and West Birmingham.

Increasing stable accommodation for those with mental health problems

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

Target: tba



Current plans to achieve ambition

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

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

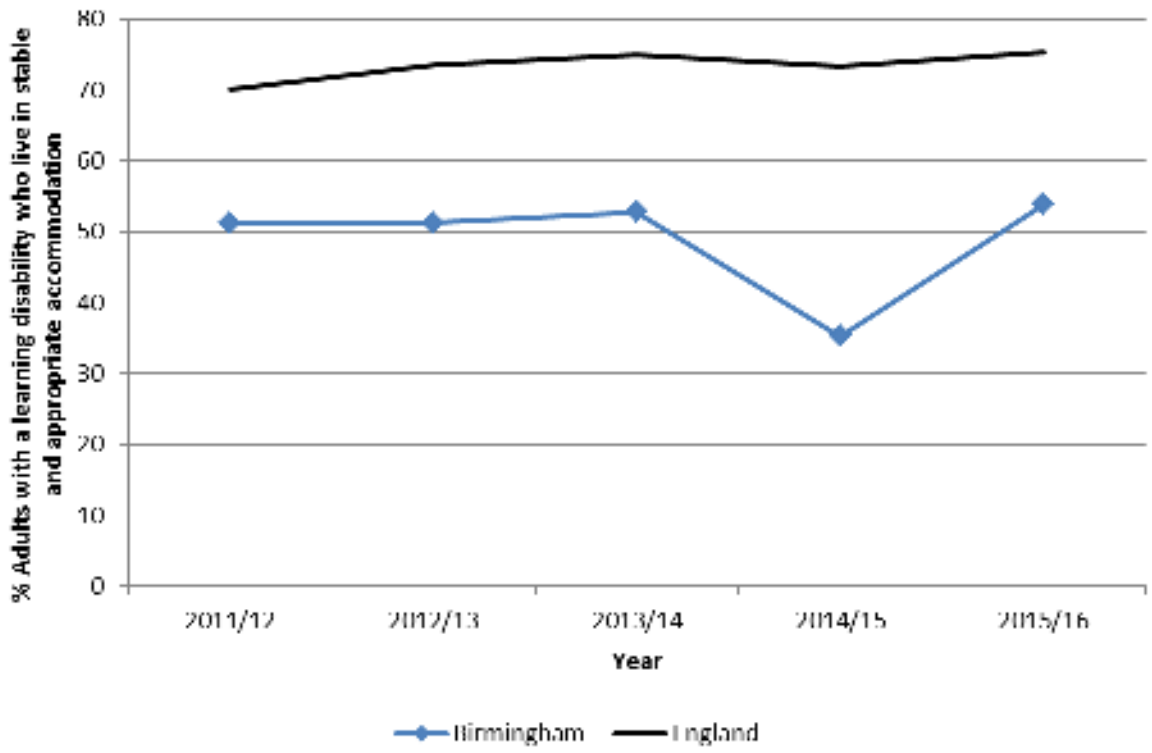
Accountable Group

Secondary indicators

Improving stable and independent accommodation for those learning disability

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

Target: tbc



Current plans to achieve ambition

Accountable Group

Secondary indicators

Improve the wellbeing of those with multiple complex needs

Indicator: tbc
Target: tbc

Current plans to achieve ambition

Birmingham tbc

The West Midlands Combined Authority Public Service Reform programme is focussing on Multiple Complex Needs as one of its four work streams. Their initial definition is "people with two or more of three complex needs relating to offending, homelessness or substance misuse. There are some important gaps in this definition which are currently being explored." This work is still in progress.

Accountable Group

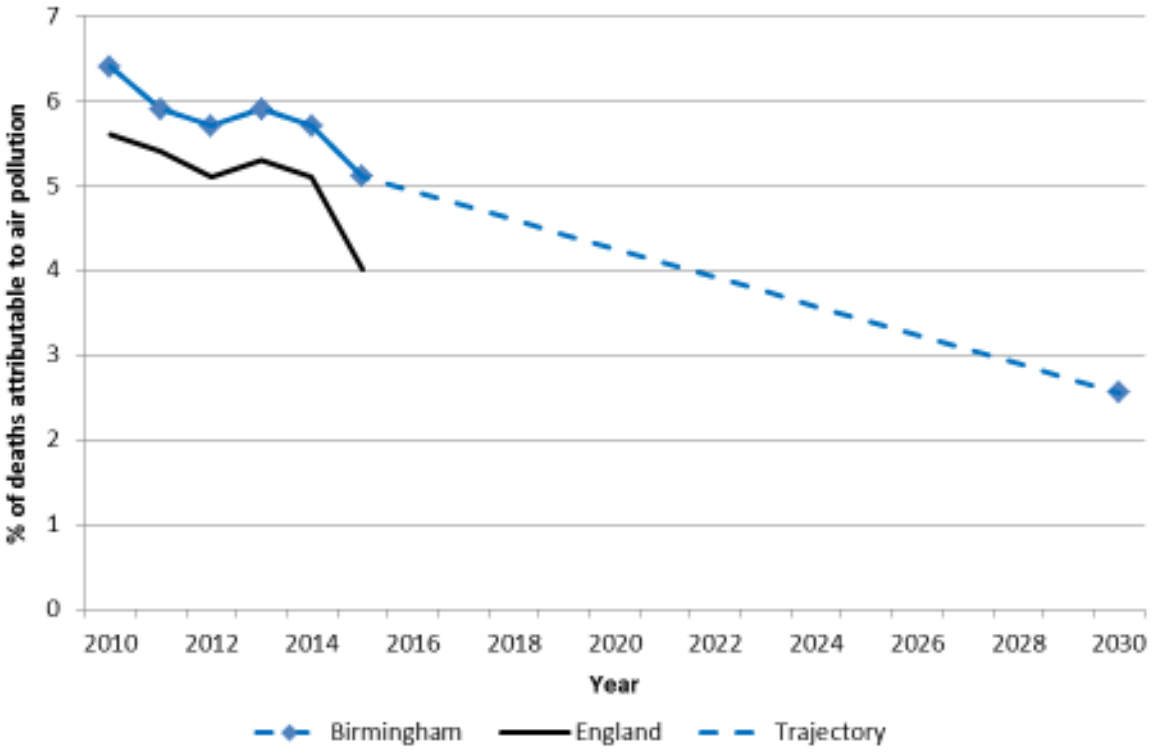
Birmingham tbc

West Midlands Combined Authority

Secondary indicators

Improve Air Quality

Indicator: Fraction of all-cause adult mortality attributable to anthropogenic particulate air pollution (PHOF)
Target: Halved by 2030 (on 2015 baseline)



Current plans to achieve ambition

The whole of Birmingham has been designated an Air Quality Management Area (AQMA) under the Environment Act 1995, which means there is a duty to monitor and report on levels of nitrogen dioxide (NO_2), particulates (PM_{10} and PM_2.5) and sulphur dioxide (SO_2). According to Defra modelling, the concentration of NO_2 in Birmingham's air is up to 50% higher than it should be. If we don't take any action, we will not reach the legal limit until 2027.

As part of a plan to improve air quality in the UK and to meet legal air quality limits in the shortest possible time, the Government has instructed Birmingham to introduce a Clean Air Zone (CAZ). Work is currently underway to develop the extent of the CAZ and to model the impact on health across the population.

It is recognised that to achieve the ambition of halving deaths attributable to air pollution will require changes above and beyond the CAZ and the Director of Public Health is leading this work within the Council.

Additionally the West Midlands Combined Authority has a focus on air quality and is developing an approach across the wider conurbation.

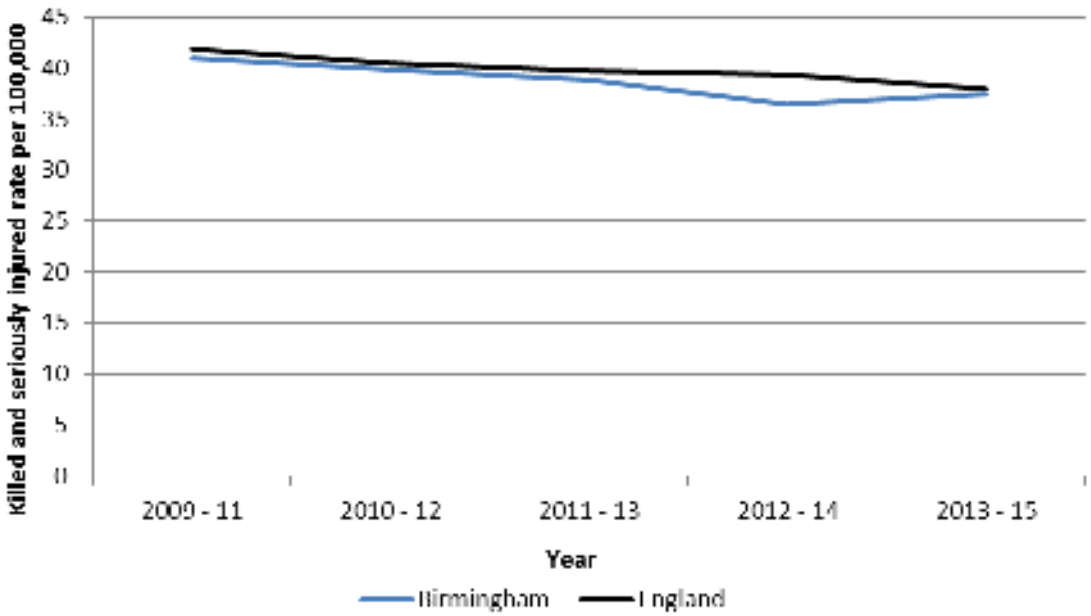
Accountable Group

BCC Air Quality Members Steering Group

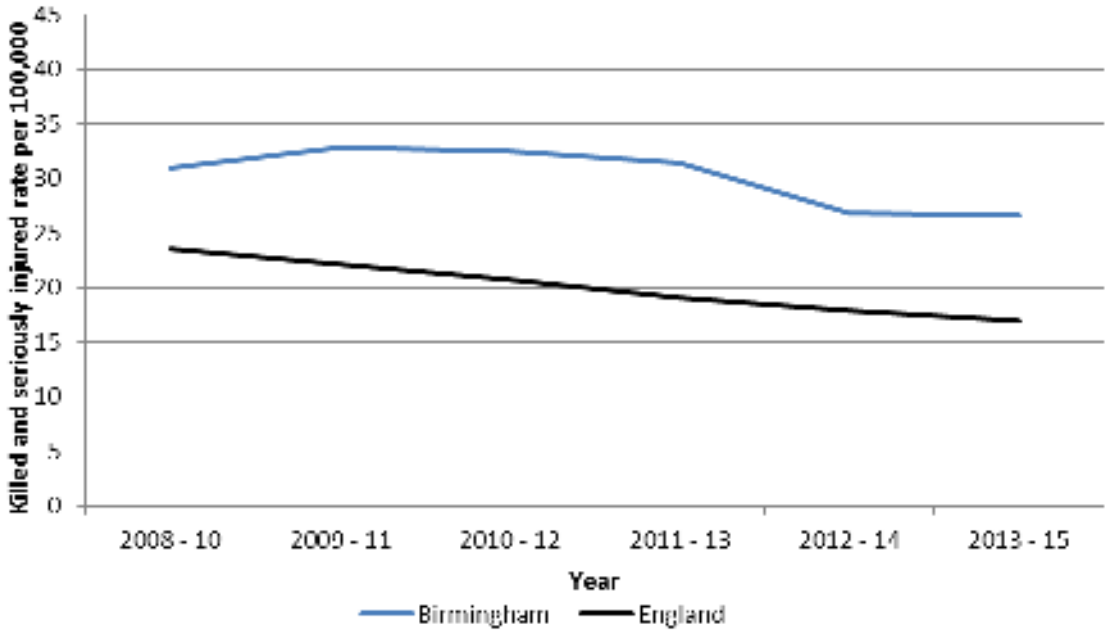
Secondary indicators

In order to ensure that changes to the transport system don't have unintended adverse effect two other indicators have been proposed.

Indicator: Killed and seriously injured casualties on England's roads (PHOF)
Target: No increase



Indicator: Children killed and seriously injured on England's roads (ChiMat)
Target: No increase


Killed and seriously injured rate per 100,000
45
40
35
30
25
20
15
10
5
0
2008 - 10
2009 - 11
2010 - 12
2011 - 13
2012 - 14
2013 - 15
Year
Birmingham
England

Increased mental wellbeing in the workplace

Indicator: tbc
Target: tbc

Current plans to achieve ambition

Birmingham tbc

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

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

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

Accountable Group

Birmingham & Solihull STP

West Midlands Combined Authority Mental Health Commission

Secondary indicators

The Mental Health Commission has set an ambition to recruit 200 organisations from a whole range of sectors within the region to sign up to the Wellbeing Commitment, and for this to move towards 500 by the end of year two.

	Agenda Item: 7
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**3 October 2017**
TITLE:	**USING THE IMPACT OF CHILDHOOD ADVERSE EXPERIENCES TO IMPROVE THE HEALTH & WELLBEING OF BIRMINGHAM PEOPLE**
Organisation	**Birmingham City Council**
Presenting Officer	**Dr Dennis Wilkes** **Assistant Director of Public Health,** **Birmingham City Council**

Report Type:	**Endorsement**

1. Purpose:
This report considers how local agencies and communities can respond to the impact that Childhood Adverse Experiences have on citizens. It identifies some next steps and seeks the Health & Wellbeing Board's support for these.

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

3.	Recommendations
3.1.	The Health & Wellbeing Board should broker the strategic drive for Primary Preventative effort.
3.2.	The Early Help & Safeguarding Partnership should use the evidence to establish a common cultural understanding of the impact of adverse experiences in childhood, especially in schools, and nurture locality multi-agent learning to embed it.
3.3.	The Early Help & Safeguarding Partnership should broker an action learning set of specialist services to identify the opportunities and benefits of using Routine Enquiry of adverse experiences in childhood in their client groups.
3.4.	The Early Help & Safeguarding Partnership should align its outcome work stream to take account of the impact of the preventative focus and its implications.

4.	Background
4.1	The Health & Wellbeing Board discussed the primary research evidence which demonstrates the impact that Childhood Adverse Experiences have singly or in combination. The Board asked that local stakeholders explore the opportunities to respond to these impacts and reduce them in Birmingham.
4.2	The attached report documents the conclusions of these discussions held in Spring 2017. A full list of participants from a range of stakeholders is included in the report.

5.	Compliance Issues
5.1	***Strategy Implications***
	This report helps shape the developing objectives 2017-2020.
5.2	***Governance & Delivery***
	The Health & Wellbeing board and the Early help & Safeguarding Partnership are challenged with further action and have their own governance arrangements.
5.3	***Management Responsibility***
	Dr Dennis Wilkes

6. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**

Appendices
1. Using the Impact of Childhood Adverse Experiences to Improve the Health & Wellbeing of Birmingham People: A Health & Wellbeing Task & Finish group 2017

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

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

Detailed in the Appendix

USING THE IMPACT OF CHILDHOOD ADVERSE EXPERIENCES TO IMPROVE THE HEALTH & WELLBEING OF BIRMINGHAM PEOPLE

A HEALTH & WELLBEING BOARD TASK & FINISH GROUP

Dr Dennis Wilkes

Assistant Director of Public Health

THANKS TO THE CONTRIBUTORS

Alison Holmes
Alison Moore
Andrew Coward
Andy Wright
Anna Robinson
Aqil Chaudary
Bel Sixsmith
Natomie Reid-Lyon
Catherine Evans
Claire Rigby
Doug Simkiss
Geoff DeBelle
Liz Webster
Louise Bauer
Maria Jardine
Paul Drover
Paul Patterson
Salma Ali
Sandra Passmore
Sian Warmer
Simon Inglis
Tony Stanley

Compared with no ACEs, those with 4+ ACEs were:

3x more likely to be a **current smoker**
3x more likely to have had **sex under 16 years**
6x more likely to have **used drugs**
10x more likely to be **problem drinkers**
49x more likely to have ever **attempted suicide**

INDEPENDENT OF POVERTY

If they had no ACEs problems could be reduced by:

Smoking	Early Sex	Drug Use	Problem Drinking	Suicide
22%	21%	36%	51%	83%

Aged 18-25 years

Bellis et al. 2014, n=10,696 individuals

WHAT SHOULD WE DO?

ADVERSE CHILDHOOD EXPERIENCES

PHYSICAL ABUSE

SEXUAL ABUSE

VERBAL ABUSE

PARENTAL SEPERATION

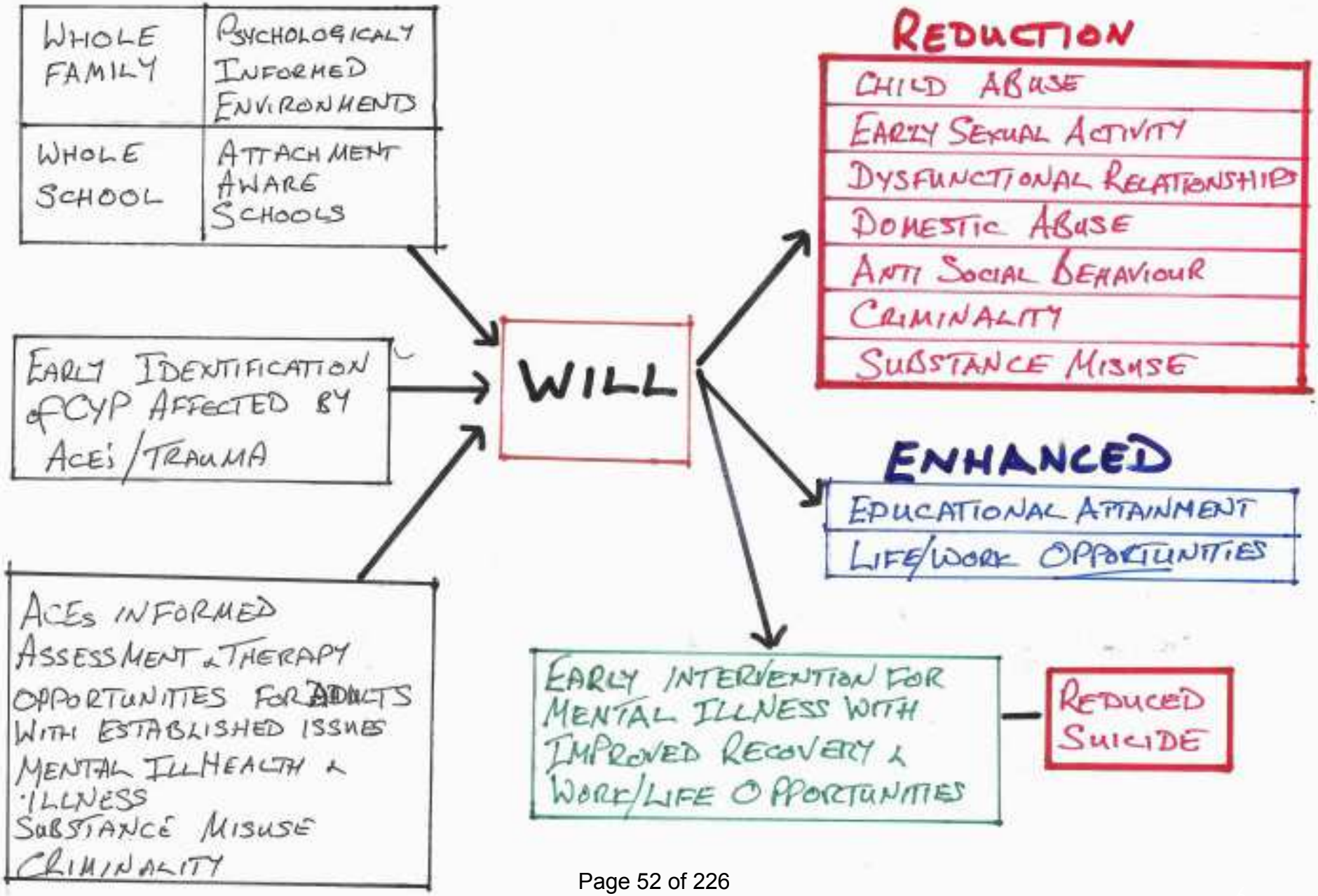
DOMESTIC VIOLENCE

MENTAL ILLNESS

ALCOHOL ABUSE

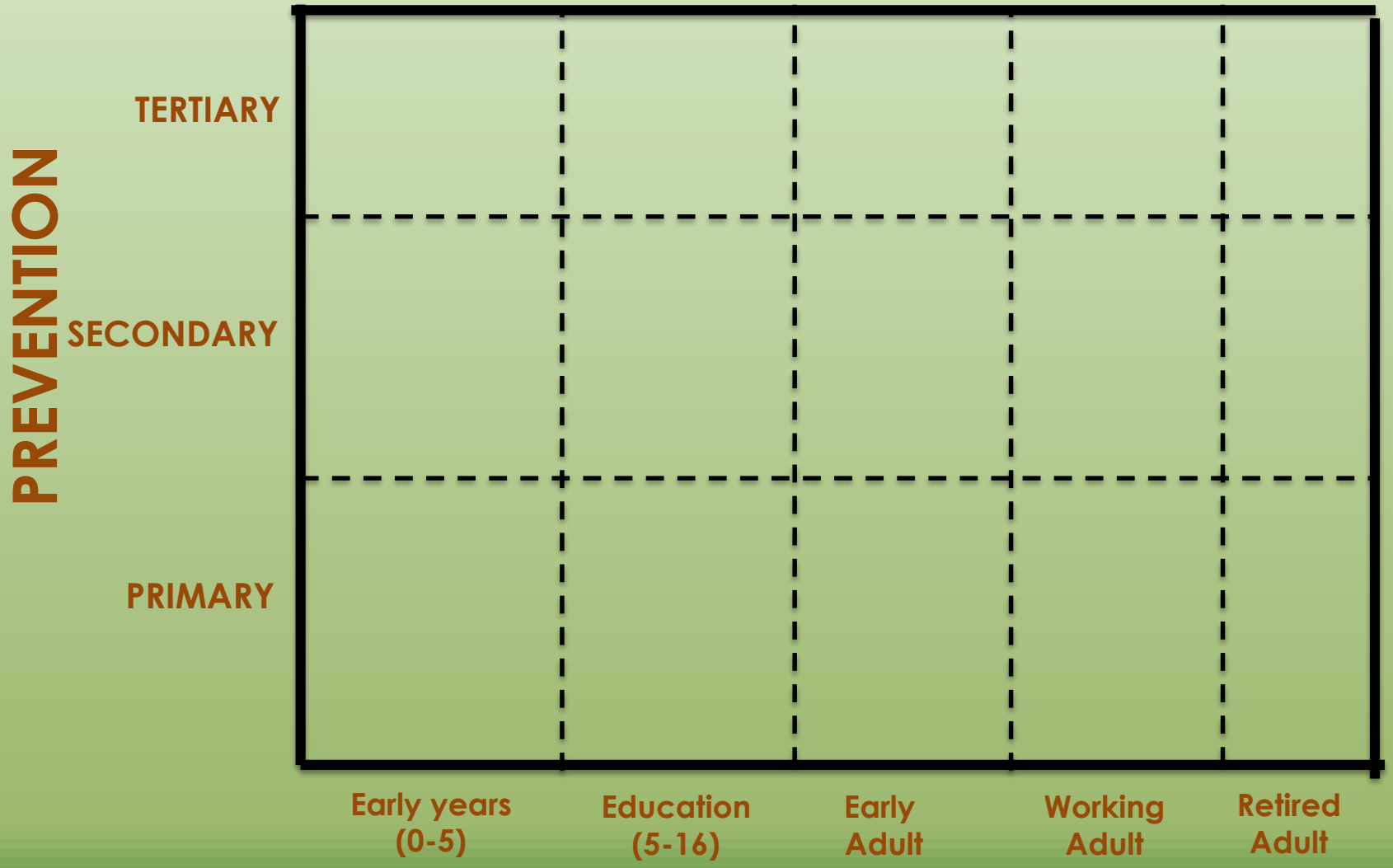
DRUG ABUSE

INCARCERATION


WHOLE FAMILY
PSYCHOLOGICALY INFORMED ENVIRONMENTS
WHOLE SCHOOL
ATTACHMENT AWARE SCHOOLS
EARLY IDENTIFICATION of CYP AFFECTED BY ACE's / TRAUMA
ACEs INFORMED ASSESSMENT & THERAPY OPPORTUNITIES FOR ADULTS WITH ESTABLISHED ISSUES MENTAL ILLHEALTH & ILLNESS SUBSTANCE MISUSE CRIMINALITY
WILL
REDUCTION
CHILD ABUSE
EARLY SEXUAL ACTIVITY
DYSFUNCTIONAL RELATIONSHIPS
DOMESTIC ABUSE
ANTI SOCIAL BEHAVIOUR
CRIMINALITY
SUBSTANCE MISUSE
ENHANCED
EDUCATIONAL ATTAINMENT
LIFE/WORK OPPORTUNITIES
EARLY INTERVENTION FOR MENTAL ILLNESS WITH IMPROVED RECOVERY & WORK/LIFE OPPORTUNITIES
REDUCED SUICIDE

1. *Prevent the likelihood of these experiences occurring **and the consequences therefore avoided**;*
2. *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;*
3. *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.***

THE TERRITORY FOR CHANGING THE IMPACT OF ADVERSE CHILDHOOD EXPERIENCES

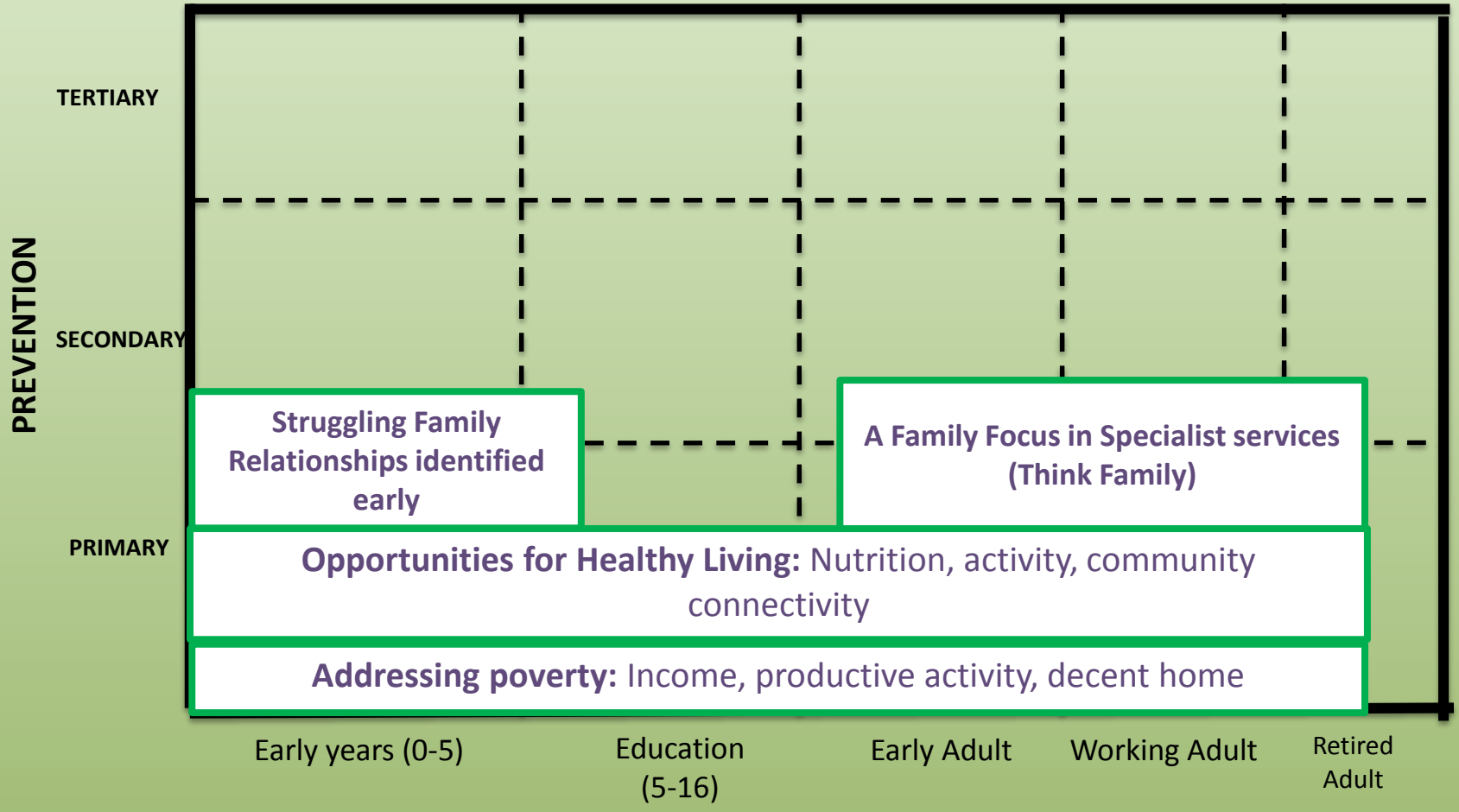


IMPORTANT PRINCIPLES

1) Routine enquiry is not a validated screening tool and should not be used on a general population to identify those with aces

2) Those with 4+ aces should not become a target group for intervention

3) Routine enquiry can be used to improve insight into the genesis of reported concern/difficulties


PREVENTION
TERTIARY
SECONDARY
PRIMARY
Struggling Family Relationships identified early
A Family Focus in Specialist services (Think Family)
Opportunities for Healthy Living: Nutrition, activity, community connectivity
Addressing poverty: Income, productive activity, decent home
Early years (0-5)
Education (5-16)
Early Adult
Working Adult
Retired Adult
LIFE COURSE

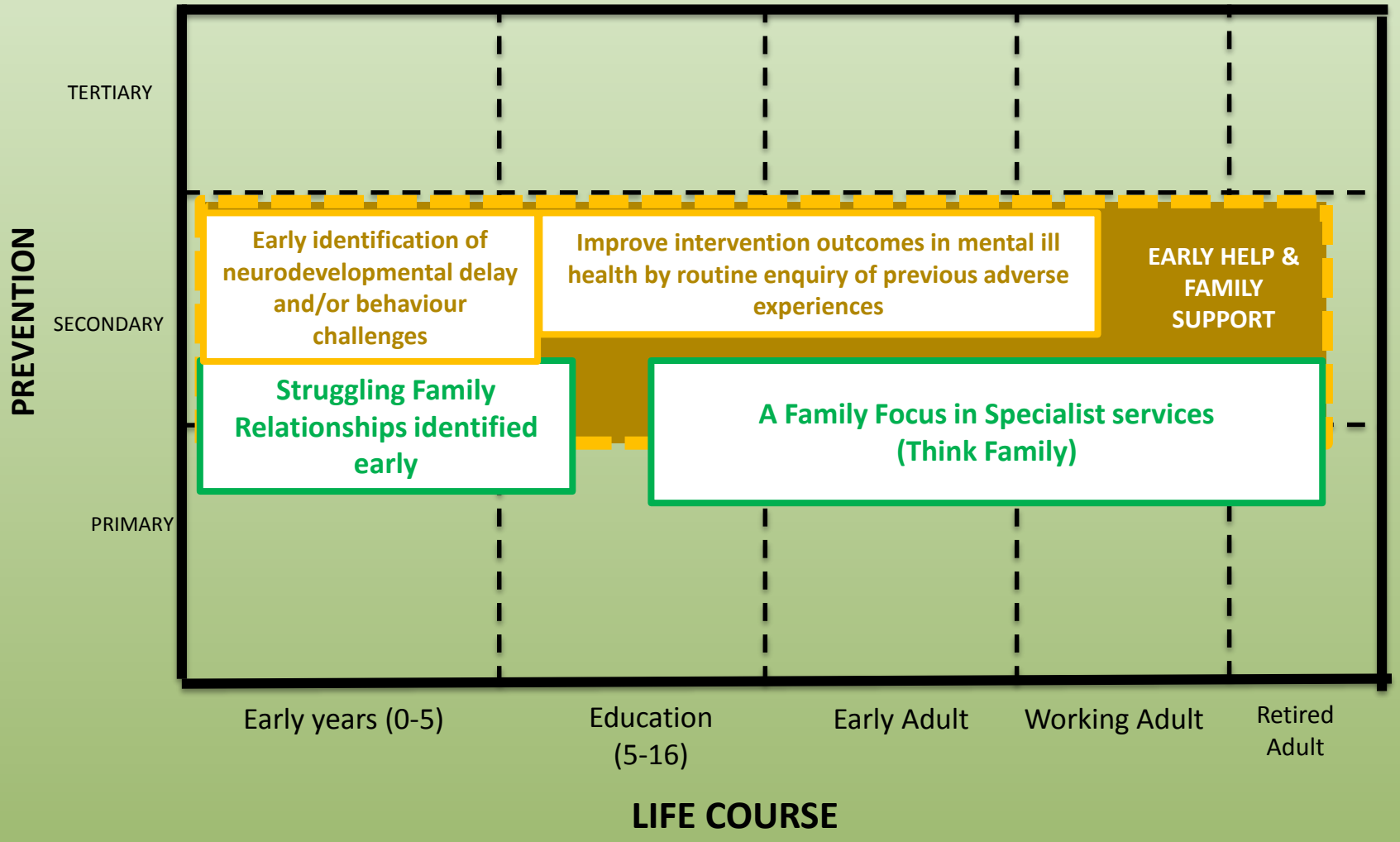
RECURRENT WIDER THEMES

Particularly the combinations of:

Poverty and work

Poverty and housing quality

Poverty and family relationships


PREVENTION
TERTIARY
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Early identification of neurodevelopmental delay and/or behaviour challenges
Improve intervention outcomes in mental ill health by routine enquiry of previous adverse experiences
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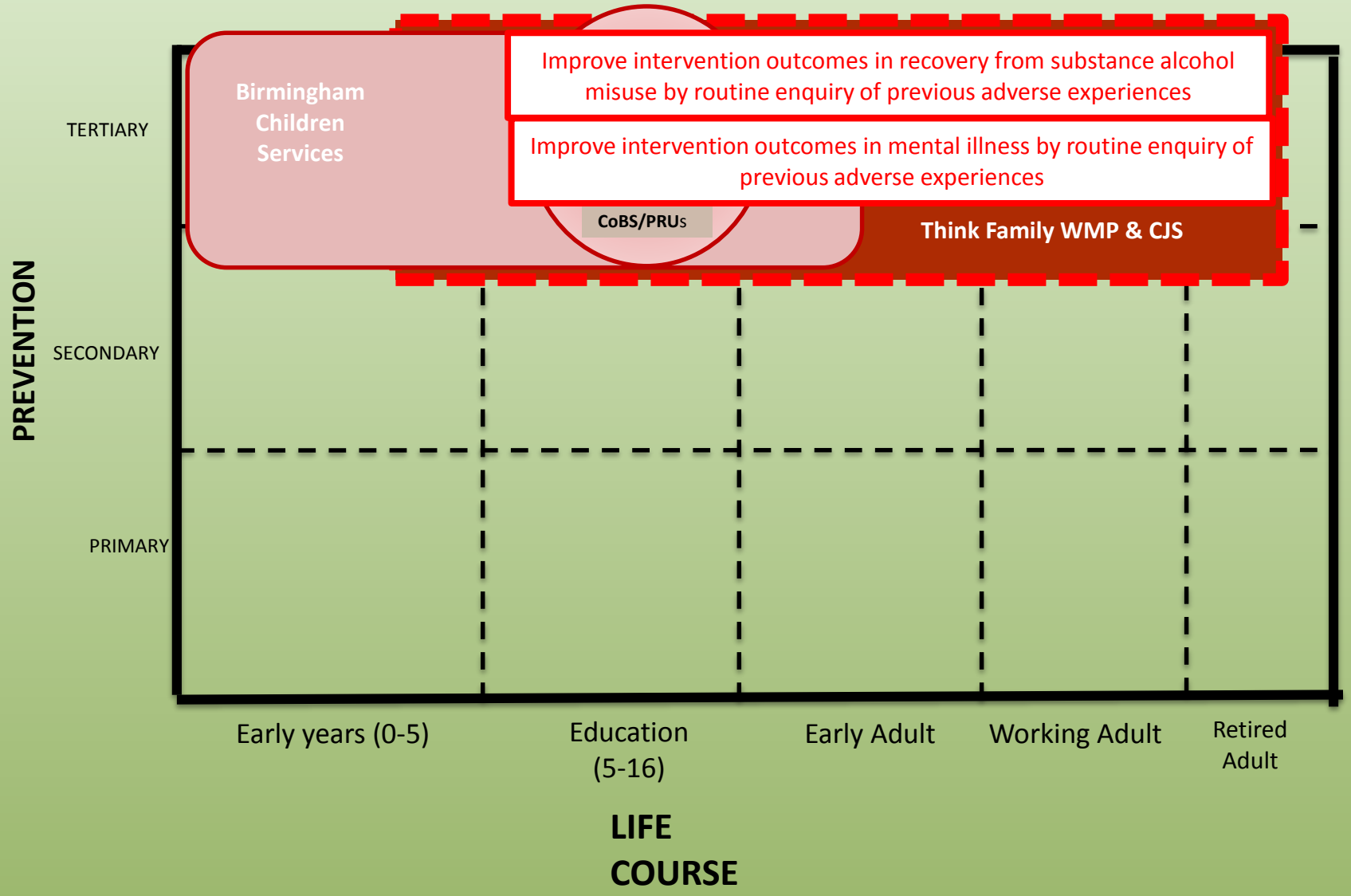
LIFE COURSE


Birmingham Children Services
Improve intervention outcomes in recovery from substance alcohol misuse by routine enquiry of previous adverse experiences
Improve intervention outcomes in mental illness by routine enquiry of previous adverse experiences
CoBS/PRUs
Think Family WMP & CJS
TERTIARY
SECONDARY
PRIMARY
PREVENTION
Early years (0-5)
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Early Adult
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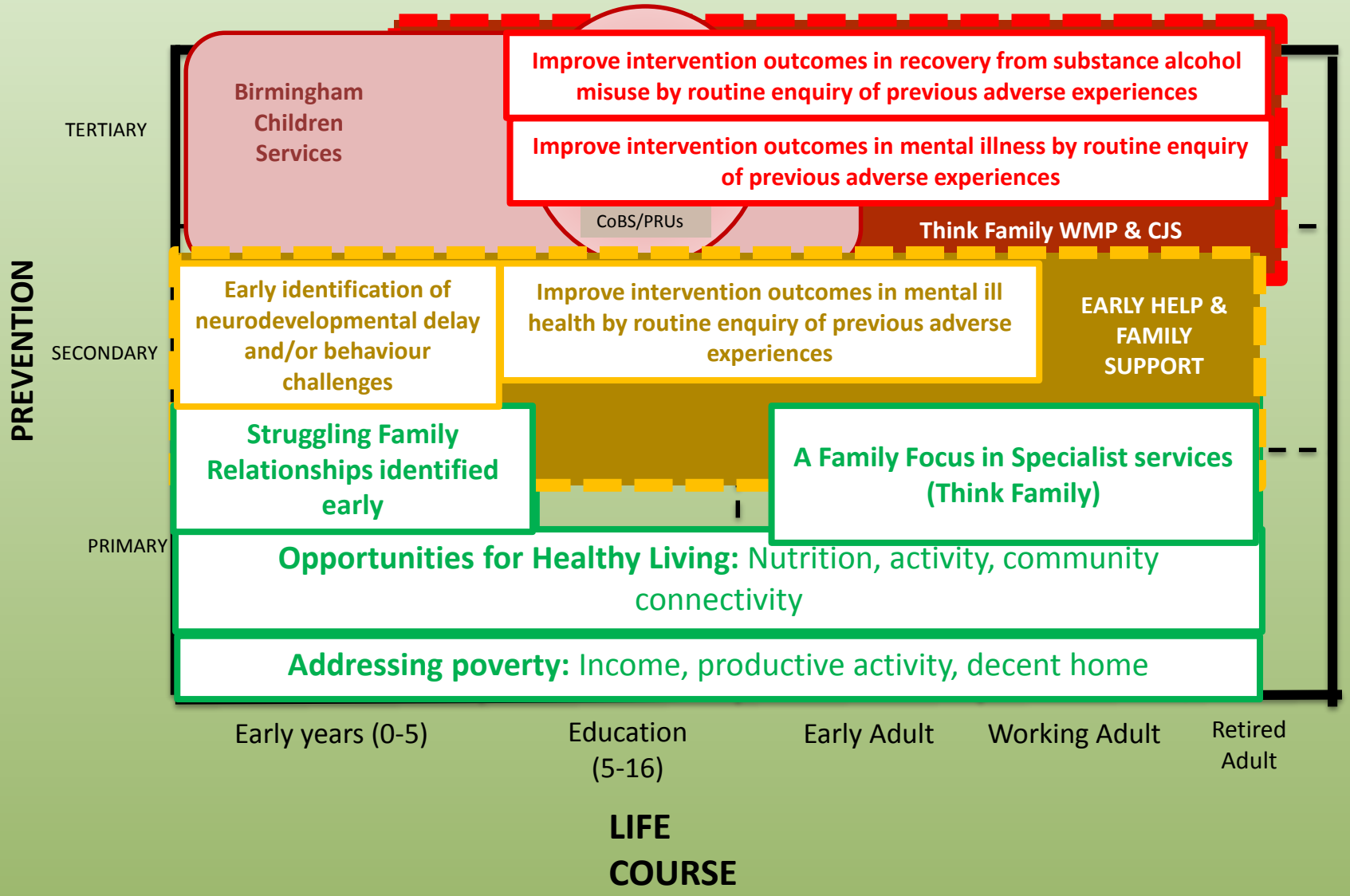
Retired Adult
LIFE COURSE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Working Adult
Retired Adult
LIFE COURSE

ALIGNING OURSELVES SYSTEMATICALLY TO TAKE THESE OPPORTUNITIES TO REDUCE THE IMPACT

5.1: CULTURAL CHANGE

ALIGNING OURSELVES SYSTEMATICALLY TO TAKE THESE OPPORTUNITIES TO REDUCE THE IMPACT

5.1: CULTURAL CHANGE

5.2: PRIMARY PREVENTION

ALIGNING OURSELVES SYSTEMATICALLY TO TAKE THESE OPPORTUNITIES TO REDUCE THE IMPACT

5.1: CULTURAL CHANGE

5.2: PRIMARY PREVENTION

5.3: ALIGN THE LOCALITY EFFORTS FOR EARLY HELP

ALIGNING OURSELVES SYSTEMATICALLY TO TAKE THESE OPPORTUNITIES TO REDUCE THE IMPACT

5.1: CULTURAL CHANGE

5.2: PRIMARY PREVENTION

5.3: ALIGN THE LOCALITY EFFORTS FOR EARLY HELP

5.4: ROUTINE ENQUIRY IN RELATED SPECIALIST SERVICES

ALIGNING OURSELVES SYSTEMATICALLY TO TAKE THESE OPPORTUNITIES TO REDUCE THE IMPACT

5.1: CULTURAL CHANGE

5.2: PRIMARY PREVENTION

5.3: ALIGN THE LOCALITY EFFORTS FOR EARLY HELP

5.4: ROUTINE ENQUIRY IN RELATED SPECIALIST SERVICES

5.5 EVALUATE

USING THE IMPACT OF CHILDHOOD ADVERSE EXPERIENCES TO IMPROVE THE HEALTH & WELLBEING OF BIRMINGHAM PEOPLE

A HEALTH & WELLBEING BOARD TASK & FINISH GROUP

1. INTRODUCTION

The research base for the long term effects of Adverse Childhood Experiences is striking and strong. The evidence is summarised in the report to the Health & Wellbeing Board (29 November 2016[1]). Describing these consequences prompts the response of *"wanting to do something".* This document seeks to create a framework for these responses in Birmingham.

2. THE BACKGROUND

The published research evidence, particularly Felitti[2] (USA) and Bellis[3] (UK), reminds us of the range of experiences which have an adverse effect on the health and wellbeing of our children, Young People, families, and adults for a lifetime (Figure 2.1). Single experiences have an adverse impact on the child's future health & wellbeing but multiple experiences have a cumulative impact.

Figure 2.1: The Adverse Experiences of Childhood

DIRECT EXPERIENCES	PARENTAL CONDITIONS IMPACTING ON THE CHILDREN
PHYSICAL ABUSE	MENTAL ILLNESS
SEXUAL ABUSE	ALCOHOL ABUSE
VERBAL ABUSE	DRUG ABUSE
PARENTAL SEPARATION	INCARCERATION
DOMESTIC VIOLENCE	

Most of the impact is mediated by the hormonal arousal system designed to respond to immediate and short term threats. When the threat becomes persistent or more sustained there is a disruption of that system with physiological consequences. If the change in threat is in our early years there can be a disruption in the development of our basic attachment process. If the changes in the threats occur later, in childhood or adolescence, this can undermine or re-arrange our attachment responses. The disruption or undermining of our attachment responses disrupt our socialisation and relationships with a tendency to leave us

[1] Wilkes D *Adverse Childhood Experiences: An initial strategic direction in the West Midlands Combined Authority area 2016* Birmingham Health & Wellbeing Board paper 26 November 2016

[2] Felitti VJ, Anda RF, et al *Relationship of childhood abuse and household dysfunction to many leading causes of death in adults. The Adverse Childhood Experiences (ACE) study* American Journal of Preventative Medicine 1998 14:245-258

[3] Bellis M, Hughes K, et al *National Household Survey of Adverse Childhood Experiences and their relationship with resilience to health-harming behaviours in England* BMC Medicine 2014 12:72

expecting threats and adversity at all times. We respond accordingly leading to the multiple consequences of the adverse experiences in childhood reported so strongly by Bellis[3].

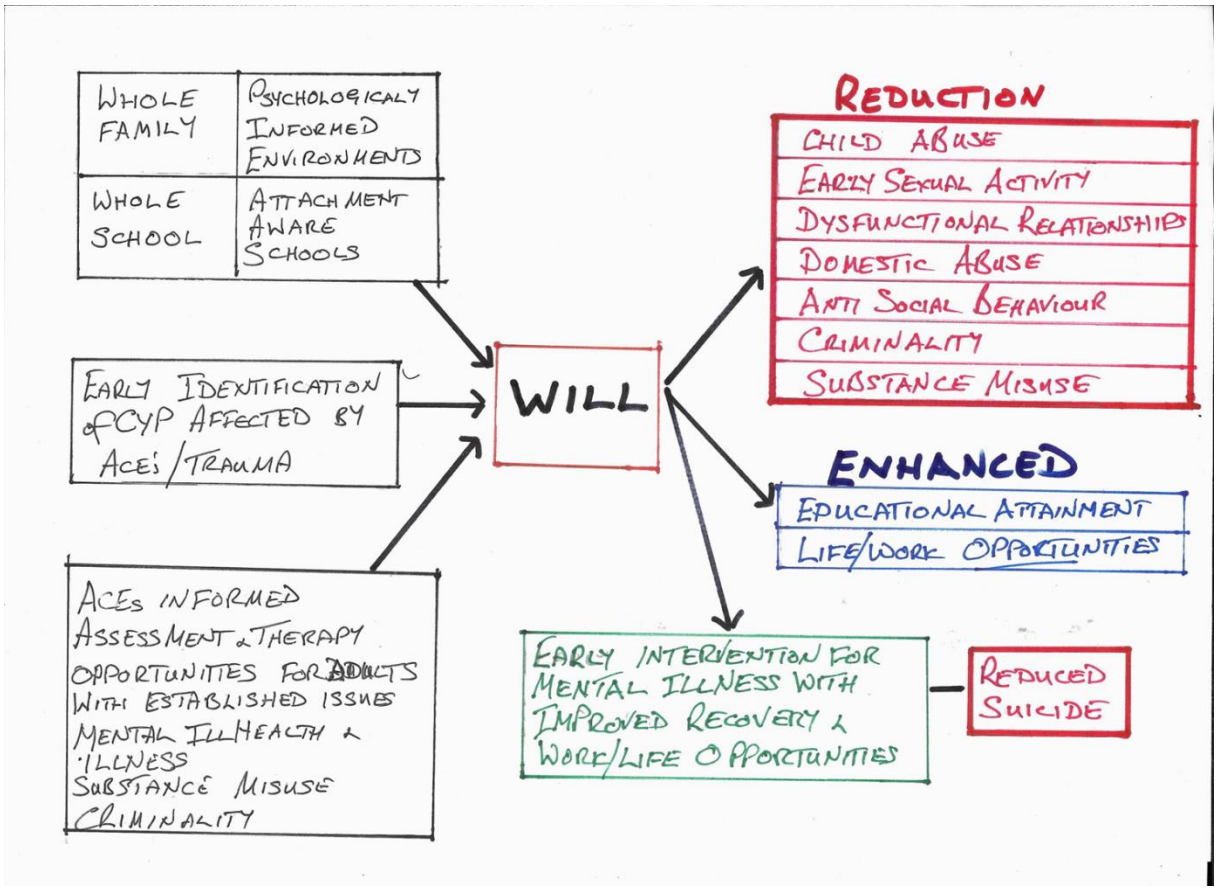
3. **SO WHAT?**

Describing the consequences of adverse experiences in childhood evokes a response of *"wanting to do something"*, but what is the right thing to do?

3.1. **Our collective aim should be to avoid the consequences of these experiences and to be able to promote recovery.** This was the basis of the preventative framework the Task & Finish group developed, which will be described in more detail in section 4.

3.2. In order to act across the preventative spectrum and life course we, collectively, need to develop a common and shared understanding of the mechanism of the impact and the benefits of preventing these experiences. This is summarised in Figure 3.1.

Figure 3.1: The Benefits of Adopting the adverse experiences in childhood Preventative Framework.



This understanding needs its own language which will bring benefits such as:

a) An **understanding we can share** with children, young people and families about the drivers and triggers of difficulties with the possibility of recovery in the present and consequent prevention in future generations.

b) An improved **connectivity** with each other as communities living together, agents on the ground, and local organisations.

c) The establishment of **the role that relationships within the family and with staff** have in the healing of attachment disturbances for individuals to enable recovery. This extends to the use of non-professional relationships of trust (Peers and experts by experience) in that recovery process[4].

3.3 The alignment of our understanding of the impact of adverse experiences in childhood across sectors/agencies and more widely in our communities will develop a wider view of the drivers of the difficulties our children, Young People, and adults have. This will result in:

a) Telling the story differently for the wider community to understand and respond to so that there is;

i. Increased awareness and mutual support; and

ii. Availability of self-assessment and response.

b) A realisation that responding to these issues in this way is not the sole responsibility of public services.

c) A different or changed set of responses to concerns or behaviours by staff or practice pathways.

d) A strong and good reason for aligning our organisational cultures and change in that direction.

4. THE PREVENTATIVE FRAMEWORK

There are three preventative opportunities which can occur along the whole of the Life Course. These are:

a) **Primary prevention,** when the likelihood of these experiences occurring is significantly reduced and the consequences therefore avoided;

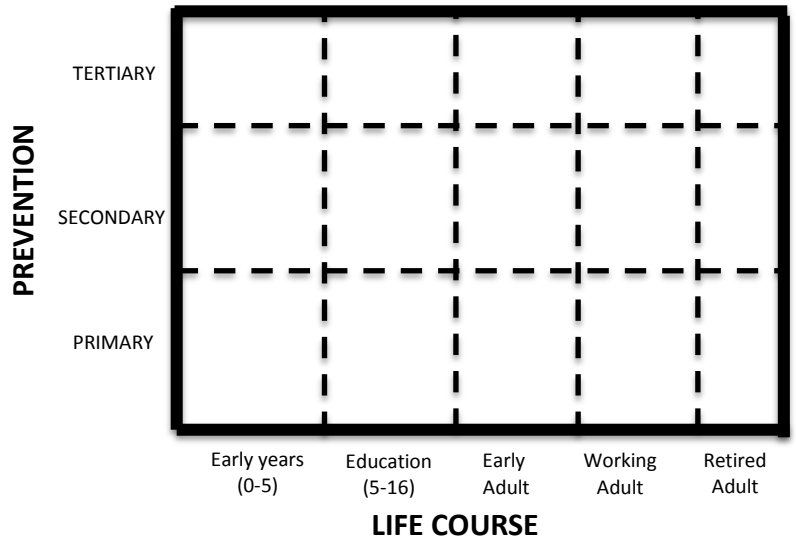
b) **Secondary prevention,** when those who have already had these experiences are identified soon after the experience in order to reduce the likelihood of the medium and long term impacts occurring; and

c) **Tertiary Prevention,** when those who have already had these experiences and are struggling with the longer term impacts on relationships and/or emotional and/or physical illness are identified in order to reduce that impact and aid recovery.

The Task & Finish group composed a simple framework on which to hang their thinking (Figure 4.1).

[4] Luke Rogers (Foster Focus),*The Changing Face of Safeguarding* Birmingham Safeguarding Children Board Practitioners Annual Conference June 2017

Figure 4.1: The Preventative Framework



4.1. **Primary prevention** addresses the socio-economic influences of health & wellbeing as well as identifying the opportunities to avoid the adverse experience in the first place. Ignoring the impact that poverty, and the social implications it has, is to ignore the evidence of decades and most recently marshalled by Marmot[5]. The Task & Finish group summarised the impact from their own experience as:

a) Poverty and being out of meaningful work or in low value/reward work

b) Poverty and housing quality

c) Poverty and family relationships

The opportunities for primary prevention were discussed from many viewpoints and are summarised in Figure 4.2.

Poverty and its drivers is a complex issue that was outside of the group's expertise and focus but it was considered important to identify. Opportunities for healthy living was also not a simple issue but was acknowledged to hold a very positive impact on preventing these adverse experiences by enhancing the family health and relationships.

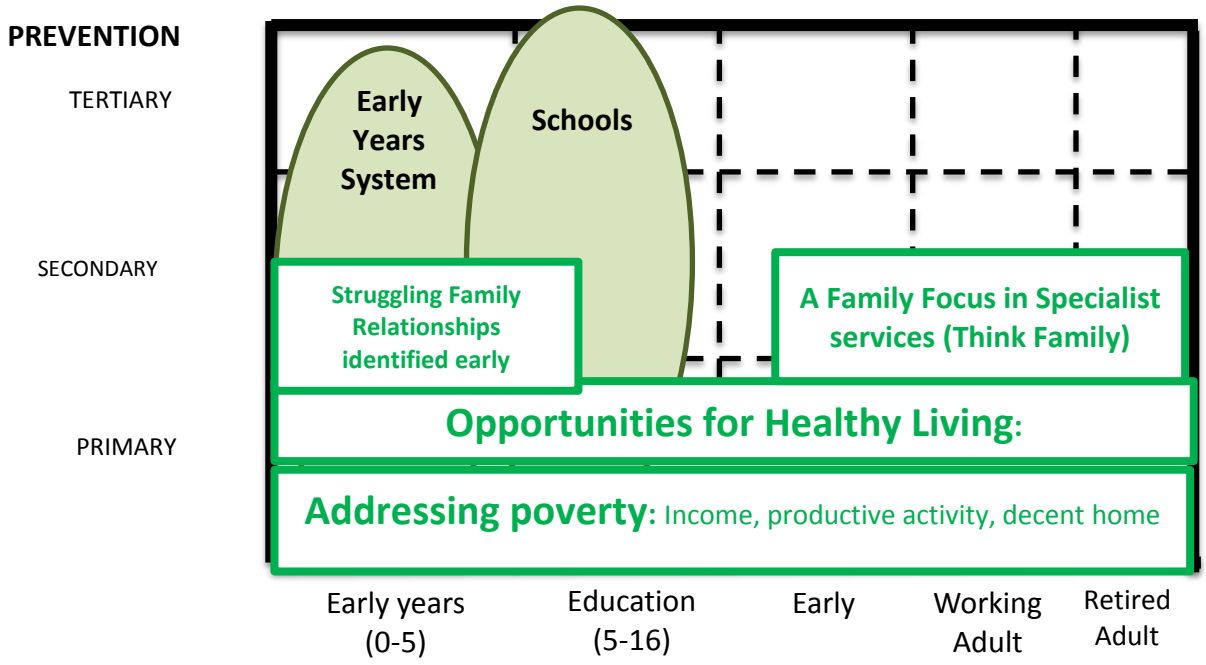
The early avoidance and/or identification of strained/struggling family relationships (parent-parent and parent-child) in the early years of childhood can be addressed by attention to preparation for parenting during pregnancy (especially the first pregnancy) and contact or support in the first year. This is a key characteristic of the developing Birmingham & Solihull Local Maternity System (BUMP) and Birmingham Early Years System.

Likewise there is the opportunity to prevent damage by parental behaviours by adopting Family Centred approaches in adult specialist services, especially due to mental illness and/or recreational or prescribed drug use and/or alcohol misuse.

The group discussion led to the conclusion that preventing the impact of adverse experiences in childhood should become the significant reason for our collective commitment to these Primary Preventative opportunities.

[5] Marmot M, Allen J, et al ***Fair Society, Healthy Lives****: A strategic review of Health Inequalities in England post 2010* London Institute of Health Inequity 2010

Figure 4.2: Opportunities for Primary Prevention of Adverse Experiences in Childhood.



4.2. The opportunities for **Secondary Prevention** seek to identify when an Early Help response will indeed be early enough to reduce the impact of recent adverse experiences in childhood on current health and wellbeing. The intention is to limit the damage to relationships, attachment, and future potential which would require more complex or specialist assistance later.

Figure 4.3 identifies the secondary preventative opportunities the group discussed and particularly highlights the significant role that the Early Help System approach plays. The common understanding of the impact of adverse experiences in childhood, described in section 3, shape these opportunities and the incorporation of routine enquiry of the adverse experiences in contacts or assessments would enhance the opportunity.

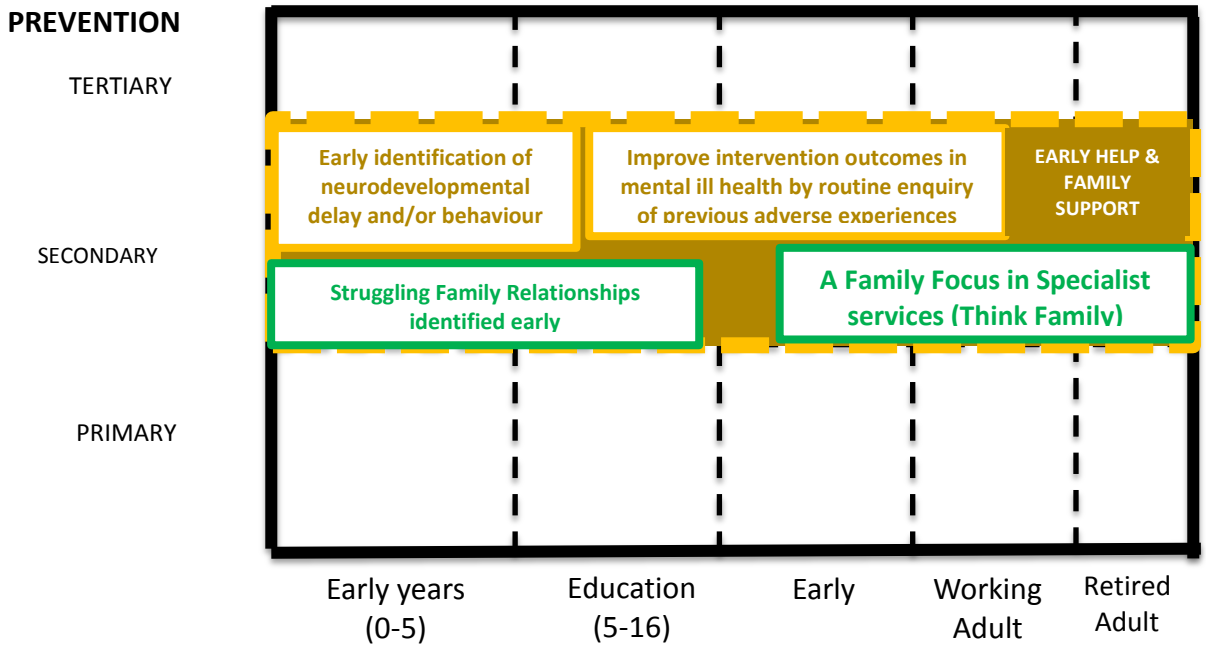
There is strong evidence that using routine enquiry for the adverse experiences opens therapeutic opportunities for swifter and more significant recovery from emotional distress, health harming behaviours, and destructive relationships. The UK research experience has been using a tool based upon the experiences identified by Felitti and Bellis (Figure 2.1).

Identifying the role of adverse experiences in childhood reduces the likelihood of the progression to serious mental illness and speeds recovery, a serious secondary preventative opportunity. There is often a fear that routine enquiry may unleash an uncontrollable maelstrom of suppressed emotions that would also damage the individual. The evidence from the use of routine enquiry in this context does not support this fear. However if routine enquiry is adopted there must be responses in place to deal with such an outcome.

An important feature of all qualitative research into successful features of intervention programmes is the presence of a trusted adult in the relationship dynamics. This applies at a family level, family support, and targeted interventions with children, particularly with

children in care. Whatever the response model, the 'characteristics' of the 'mediator of change' is important in developing trust and thence the opportunities for modelling change.

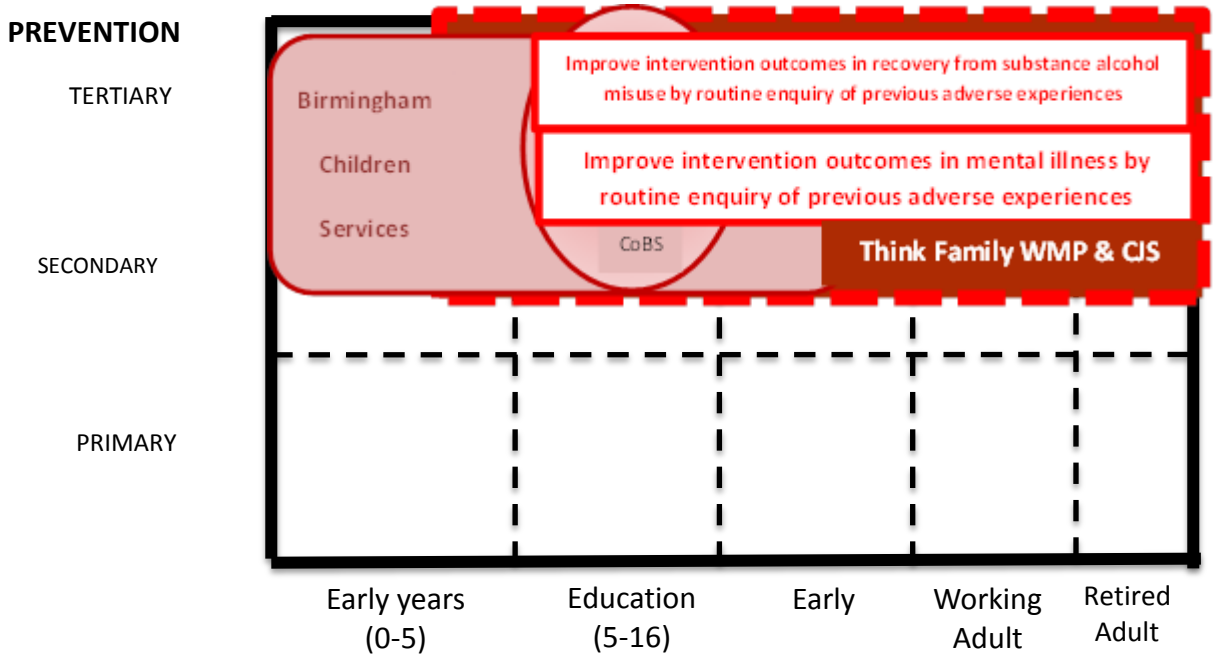
Figure 4.3: Opportunities for Secondary Prevention of Adverse Experiences in Childhood.



4.3. The opportunities for **Tertiary Prevention** seek to identify when complex or specialist assistance can reduce the impact of past adverse experiences in childhood on current ill health and wellbeing.

4.4. Figure 4.4 identifies the tertiary preventative opportunities discussed and particularly highlights the significant role that the specialist adult services, specialist schools (Pupil Referral Units and City of Birmingham School in particular), and the Police and Criminal Justice Service play. The common understanding of the impact of adverse experiences in childhood shape these opportunities and the incorporation of routine enquiry of the adverse experiences would enhance the opportunities.

Figure 4.4: Opportunities for Tertiary Prevention of Adverse Experiences in Childhood.



5. ADOPTING THE PREVENTATIVE FRAMEWORK

The Task & Finish Group developed a commonality of purpose from the use of the evidence of impact of adverse experiences in childhood. They also found adopting the Preventative Framework useful in creating a focus of intent and a common language. This experience prompted a conviction that translating this into a strategic and tactical approach would help the Health & Wellbeing Board (strategic), Birmingham Early Help & Safeguarding Partnership (tactical), and locality agents (operational) to align efforts productively.

This alignment seems to have the following implications:

5.1. Need for cultural change

Section 3 explored the beneficial impacts of an understanding of the impacts of adverse experiences in childhood on understanding concerns and behaviours of individuals. The common language of all partners and the Public has to be based on this common understanding, particularly on our attachment development.

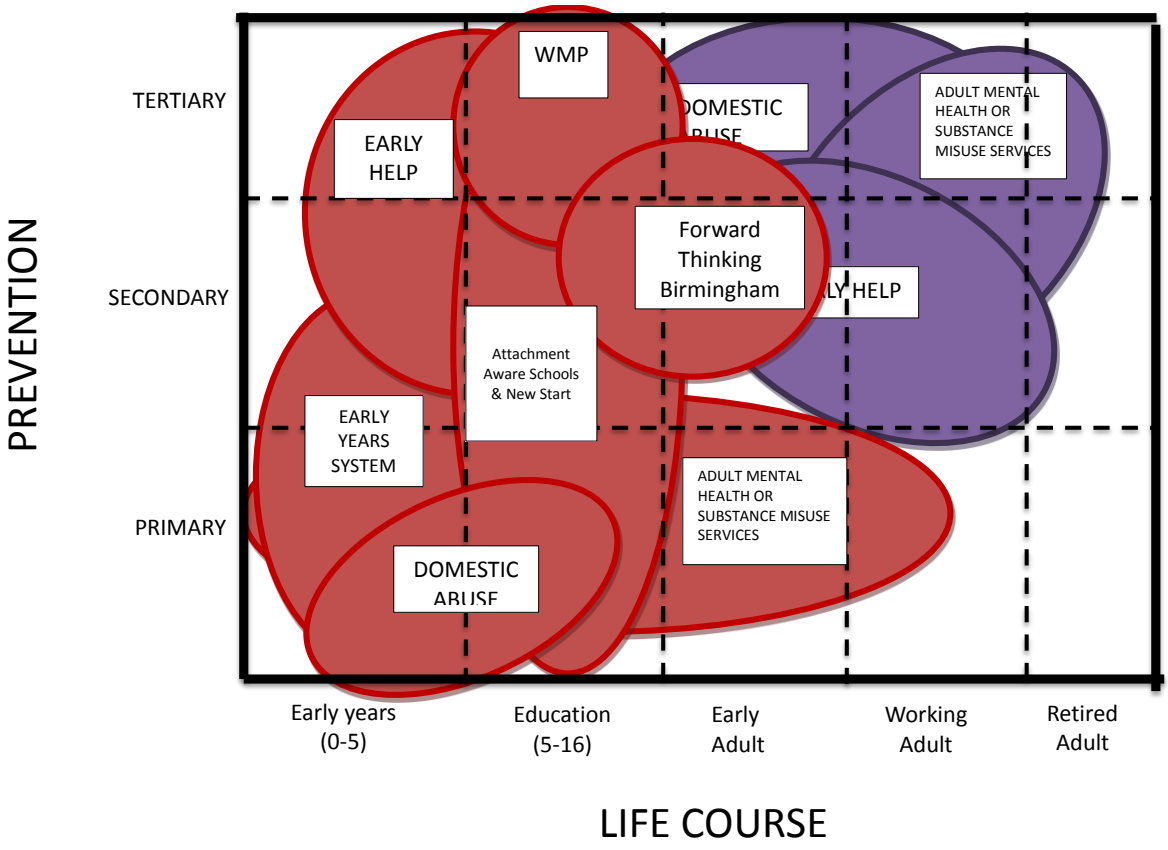
This common language should lead to a change in organisational approaches (Culture) towards individuals (clients and staff) struggling with the established consequences of adverse experiences in childhood. This change has to occur at three levels to be effective and beneficial, namely strategic, managerial, and at the frontline. This requires the senior managers (strategic), middle managers (tactical), and frontline staff (operational) layers of agencies to adapt and adopt the insights. The group returned many times to the impact of

this in the school setting so that an "attachment based" approach, rooted in the insights of the impact of adverse experiences in childhood becomes important and embedded.

However, doing this in isolation within one agency fails to embed the change. This cultural change will be further enhanced by multi-agent learning. However, experience of multi-agency training organised at a city level is not encouraging. The group became committed to the principle of *locality based multi-agent learning* at tactical and operational level. This approach has been found to improve locality relationships and trust in other agent's capabilities and judgments. There are even reports of a consequent improvement in the trust of families in the agents when using this multi-agent learning approach in the Birmingham Think Family programme.

5.2. **Primary Prevention** is clearly wider than the remit of the agencies represented in the Task & Finish group but they did attempt to visualise the different agencies contribution to the Preventative Framework (Figure 5.1).

Figure 5.1: The Agency Opportunities for Preventing Adverse Experiences in Childhood identified in Birmingham

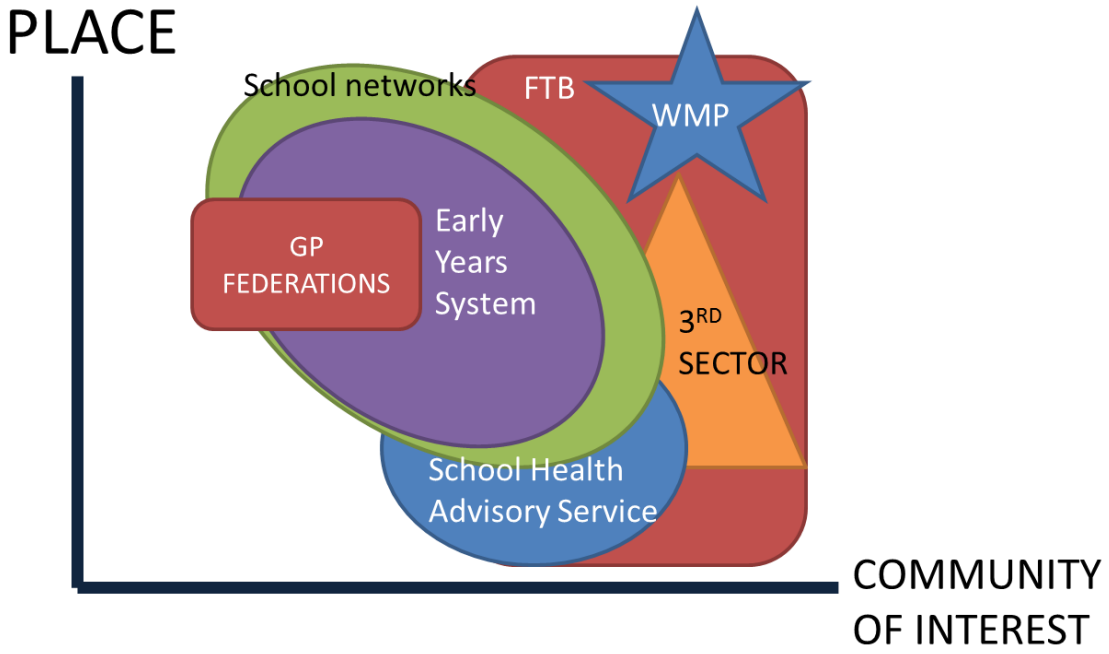


On reflection there may have been an over estimation of the role they play in the Primary Prevention space, compare Figures 4.2 and 5.1. However it was felt to be a legitimate concern of the Health & wellbeing Board as a strategic leader in the City, particularly the issues of poverty and opportunities for healthy living (Figure 4.2). The group did not make any specific recommendations for a future approach other than to lay down the strategic challenge to the Health & Well Being Board.

5.3. It became clear that **the Early Help approach was an overarching influence shaping the opportunities for secondary prevention** and within that **a locality focus** would augment and strengthen the additional benefit of the multi-agent learning approach.

A Locality focus is important in developing local connectivity and trusted relationships between partner professionals and with families. However we were challenged by the complexity of the notion of communities and wanted to avoid a simplistic geographical place based model. There are communities of interest, both socially and professionally focused, which provide a healthy challenging tension with the geographical place based perspective. Some of these are identified in Figure 5.2.

Figure 5.2: Balancing Geographical Place with Communities of Interest



Wherever along that spectrum of geographical place to community of interest an agency finds its self, there were some strong characteristics that emerged in the discussions.

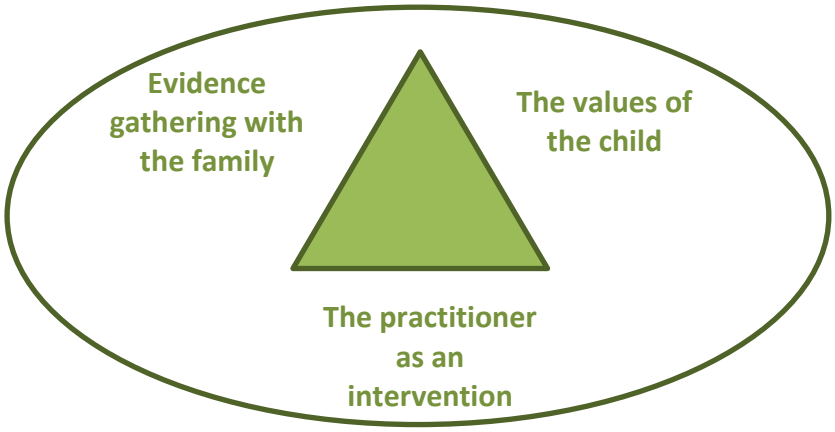
a) Multi-agent learning and the consequent multi-agent family centred and family determined partnering requires **dedicated time** to attain and maintain. The experience of Think Family and Family Nurse Partnership models strongly supports the need for **collective learning and individual supervision time**.

b) Effective family centred and family determined **support** is the 'glue' that holds it all together and is based on **trusted relationships**. The group reflected on the importance of the value of the agent relationship with the family which the multi-agent learning approach can foster. Trusted relationships foster family change. This has been the theme of a number of the effective evidence based programme evaluations[6], perhaps more than the programme theory base or content and especially the licensed ones.

[6] Wilkes D *Early Interventions to Improve the Health & Wellbeing of Children & Young People of Birmingham.* Birmingham Public Health 06 August 2013

c) **Evidence based programmes of interventions** will be important but they are not a panacea or substitute for the relationship support 'glue'. There is a lot of evidence available appraising the effectiveness of programmes (Early Intervention Foundation, NICE, the Attachment literature, Solihull Approach etc.) and a local map of usage was produced for the Early Help Strategy development in 2014. Some of these programmes may need to be commissioned across the City while others are more agency or community specific. This is the focus of the Early Help & Safeguarding Partnership commissioning work stream.

d) There is an importance to **using a common model of practice and assessment.** The *Right Service Right Time* framework has helped and the incorporation of the *Signs of Safety model* to the common assessment has also helped. The group also identified an *evidence based practice model* introduced by the Royal College of Paediatrics and Child Health which draws on the three elements of:



It is important that the Early Help & Safeguarding Partnership continue to develop the common models of practice and assessment.

e) The group were keen to explore how the insights of the impacts of adverse experiences in childhood and /or the use of routine enquiry might strengthen these practice and assessment approaches effectively. They acknowledged that the assessment process is seen by some practitioners as already long and daunting, therefore adding another element could be counterproductive. However the multi-agent learning process might inform the process more effectively as it informs and supports the enquiry/decision making by individuals.

The group concluded that the **Birmingham Early Help & Safeguarding Partnership adopt/adapt/explore the learning from the impacts of adverse experiences in childhood as a framework to enhance the effectiveness of locality partnering through locality multi-agent learning.**

5.4. **Tertiary prevention** seems to relate to specialist services for Children & Young People, especially those children & Young People in or recently left the Care of the Council, and adults (Figure 4.4). The use of the Routine Enquiry tool in this group of people, whose condition is likely to be driven by their adverse experiences in childhood, is likely to improve the journey to recovery by naming these experiences without them having to relive/recount these experiences[4]. The Task & Finish group recommends that **an action learning set be**

convened to consider the opportunities and benefits of collectively adopting this approach.

5.5. **How will we know that we have done good?**

Robust and formal evaluation of both what works and what works here in our localities is important to facilitate change and maintain benefit for our citizens and communities. Its importance should not be underestimated in identifying:

a) the benefits realised; and

b) the assurance to the system of the benefit of the adopted direction of travel.

However, it is not the same as target/indicator driven performance management.

We need to include evaluation as a planned component of any developments we put in place. We must concentrate on outcomes and changes for families, measured as the distance travelled towards their own goals expressed in their terms.

The Task & Finish group recommends that the Birmingham Early Help & Safeguarding Partnership align its outcome work stream to take account of the preventative impact of the approaches in 5.2, 5.3, and 5.4 in order to evaluate and demonstrate change.

6. CONCLUDING SUMMARY

6.1. The evidence of impact of adverse experiences in childhood is strong. Acting on the evidence requires agreement and commitment.

6.2. The impact of sharing the insights from this evidence with families and communities is referred to (3.3) but not further explored here. The potential for accelerating changes in our communities could be an exciting possibility but would require further exploration by a different group of people than this Task & Finish Group.

6.3. A preventative framework approach helps local stakeholders to focus attention and strategic direction to reduce the impact of adverse experiences in childhood on individuals and communities.

6.4. The Health & Wellbeing Board should broker the strategic drive for Primary Preventative effort. (5.2)

6.5. The Early Help & Safeguarding Partnership should use the evidence to establish a common cultural understanding of the impact of adverse experiences in childhood, especially in schools (5.1), and nurture locality multi-agent learning to embed it. (5.3)

6.6. The Early Help & Safeguarding Partnership should broker an action learning set of specialist services to identify the opportunities and benefits of using Routine Enquiry of adverse experiences in childhood in their client groups. (5.4)

6.7. The Early Help & Safeguarding Partnership should align its outcome work stream to take account of the impact of the preventative focus and its implications.(5.5)

Dr Dennis Wilkes
Assistant Director of Birmingham Public Health
On behalf of the Task & Finish Group (Contributing members identified in Appendix A)
16 August 2017

TASK & FINISH GROUP CONTRIBUTORS

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Dennis Wilkes	Assistant Director of Public Health (Convenor of the Group)

	Agenda Item: 8
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**3 October 2017**
TITLE:	**DRAFT BIRMINGHAM HOMELESSNESS PREVENTION STRATEGY 2017+**
Organisation	**Birmingham City Council**
Presenting Officer	**Mike Walsh, Head of Service – Commissioning**

Report Type:	**Information**

1. Purpose:
To present the draft Birmingham Homelessness Prevention Strategy 2017+

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

3. Recommendations	
	The Board is recommended to:
3.1	Note the development of the draft Birmingham Homelessness Prevention Strategy 2017+
3.2	Note how it relates to the Health and Wellbeing Strategy priorities and ambitions.

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4. Background

4.1 The Challenge for Birmingham

4.1.1 The Government recognises that the housing system is broken. Locally this is recognisable as a lack of affordable housing options, particularly for larger households, and increasing difficulties experienced by people under 35 to secure affordable, independent accommodation.

4.1.2 Deprivation and associated poverty / low incomes are key barriers for accessing and maintaining suitable, stable and financially sustainable accommodation. Access to employment is a key mechanism for preventing homelessness. The average household income in Birmingham is relatively low. Combined with relatively high rates of unemployment – this is a driver of housing exclusion.

4.1.3 The growing population in the city continues to put increasing pressure our existing housing stock. Locally there are more than three times the rate of priority homeless households than the national average and double the rate of Core City neighbours.

4.1.4 The difficulties that people experience trying to find and secure suitable housing has a direct impact on their health and well-being. This places increased pressure on health services, particularly in General Practice and mental health services, as people struggle to navigate the housing system in the city. With an estimated 20,000 households in Birmingham each year who are homeless, at risk of homelessness or recovering from their experience – the health and wellbeing of the city is under threat.

4.1.5 Birmingham has a very high level of families who are homeless and/or in temporary accommodation. More than three quarters of applicants accepted as homeless and in priority need have children – either with a lone parent, or as dependants of a couple.

4.1.6 Traditionally the city's approach to recovery has been overly housing focussed, with an emphasis on securing accommodation and not enough attention given to prevent future homelessness by addressing the underlying cause of peoples' experience.

4.1.7 The street homelessness community are the most visible tip of the homelessness iceberg. The number of street homeless people has increased by 53% in the last year, and by 588% since 2012. The complexity of the inter-relationship between multiple needs and the circumstances leading people to sleep rough in the city makes it increasingly difficult for a single agency to address alone.

4.2 Key Drivers for a New Strategy

4.2.1 The Homelessness Act 2002 places a legal requirement on Local Authorities to carry out a review of all forms of homelessness in their district and publish a Homelessness Strategy every five years.

4.2.2 The Birmingham Homelessness Review was undertaken in 2016 and provides part of the evidence base for developing the new Birmingham Homelessness Prevention Strategy 2017+.

4.2.3 The Review noted the need to develop a new Strategy that makes best use of the assets we have in the city. It also highlighted the scale of the challenge and the budget pressures facing the Council as key drivers to fundamentally changing our approach to tackling homelessness in Birmingham.

4.2.4 In October 2016, a Homelessness Summit was held with key partners and stakeholders. Discussions here led to the development of and buy in for the vision for the new strategy (4.3).

4.2.5 Locally, Council Scrutiny Inquiries into Homeless Health (2015), and Rough Sleeping and Prevention (2017) set out key recommendations for addressing homelessness in the city.

4.2.6 Alongside this, the introduction of the Homelessness Reduction Act 2017 will place a legal duty on Local Authorities from 2018 to provide anyone threatened with or at risk of being homeless (within a 56 day period) to be provided with advice and support to prevent them becoming homeless.

4.3 Vision and priorities

4.3.1 The vision for the new Strategy is:

Birmingham is a city where everyone works together to eradicate homelessness.

4.3.2 To achieve this vision, the strategy sets out five key priorities:

- Ensure people are well informed about their housing options,
- Prevent people from becoming homeless,
- Assist people as soon as possible if they do become homeless so that their homelessness can be relieved by securing sufficient accommodation and support,
- Support people to recover from their experience and stay out of homelessness,
- Enable people to secure homes that they can afford and maintain,

4.4 The Approach: The Positive Pathway Model

4.4.1 The Positive Pathway is a whole systems approach built on collaboration, best practice and service integration. First developed by St Basil's and implemented locally with young people at risk of or experiencing homelessness, the Positive Pathway has seen much success and is recognised nationally as a model of best practice.

4.4.2 By embedding the approach at the heart of this strategy, Birmingham will create a comprehensive and consistent approach to homelessness across the life course.

4.4.3 Our approach sets out five key areas that can be used flexibly to ensure that no matter what stage people enter the pathway; they will be supported as early and as effectively as possible. The five key areas are:

- *Universal Prevention* - A wide range of timely, accurate information and advice about housing options and financial issues that is available to everyone to prevent issues with housing occurring in the first place, and to ensure people understand the links between housing choice and their financial and employment circumstances.

- *Targeted Prevention* – Introduces early intervention through trauma informed practice to

understand trauma and how it may lead to homelessness either now or in the future. It focuses on identifying individuals and families who may be at risk of becoming homeless and offering them effective support as early as possible.

- *Crisis Prevention and Relief* - An integrated, co-ordinated response to commissioned accommodation and support where housing options and homelessness services come together with other services including health, education and family mediation etc to ensure the impact of the crisis is limited.

- *Homeless Recovery* - The provision of support to limit the impact of homelessness as well as prevent homelessness recurring. This involves working with people to reduce the risk of secondary trauma or re-traumatisation by encompassing psychologically informed environments; and focusing on improving the overall wellbeing of all adults and children in the household.

- *Sustainable Housing* - The provision of a range of safe, decent, affordable housing options, both shared and self-contained, in the private, social and third sectors. It concerns longer term strategic actions such as improving the supply of suitably affordable housing to make a difference to homelessness.

4.4.4 The Positive Pathway radically changes the way we respond to homelessness in Birmingham; shifting the balance from a reactive crisis prevention response to proactively addressing homelessness in all of its forms throughout a person or family's journey.

4.4.5 The Positive Pathway forms the basis for the Strategy Implementation Plan. The development of the model is being driven by the Homelessness Positive Pathway Programme Board; a multiagency partnership with representatives from across the Council, Health, Housing, Voluntary and Third Sectors.

4.5 Next Steps

4.5.1 The public consultation on the draft strategy is open from 24 August to 05 October 2017.

4.5.2 Approval of the Strategy will be sought at Cabinet in December 2017.

4.5.3 As there is a legal duty for the Local Authority to publish and implement a Homelessness Strategy, a recommendation will be sought from Cabinet for City Council to approve the adoption of the Strategy.

4.6 Further Information

4.6.1 For further information please contact Kalvinder Kohli, Head of Service, Directorate for Adult Social Care and Health at Kalvinder.kohli@birmingham.gov.uk

5.	**Compliance Issues**
5.1	***Strategy Implications***
	Priority 1 - Improving the Wellbeing of Children: - Detect and Prevent Adverse Childhood Experiences

- All children in permanent housing
  Priority 3 - Improving the Wellbeing of the Most Disadvantaged:

- Increasing employment/ meaningful activity and stable accommodation for those with mental health problems

5.2	***Governance & Delivery***
	Housing Birmingham Partnership has delegated responsibility for the development of the Strategy to the Birmingham Homelessness Prevention Positive Pathway Programme Board. The development of the strategy an associated Positive Pathway model is overseen by the Homelessness Positive Pathway Programme Board on a monthly basis.
5.3	***Management Responsibility***
	The Member of the Board accountable for the CQC Review is Graeme Betts, Interim Corporate Director for Adult Social Care and Health. The Manager responsible for day to day delivery is Kalvinder Kohli, Head of Service – Commissioning, Directorate for Adult Social Care and Health

6.	**Risk Analysis**
	A risk assessment cannot be undertaken until the Strategy has been approved by Cabinet.

Appendices
Appendix 1 – Draft Birmingham Homelessness Prevention Strategy 2017+
Appendix 2 – Consultation Summary Document
Appendix 3 – Consultation Questionnaire

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 Homelessness Prevention Strategy 2017+

(Consultation Draft)

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Delivering our Vision 17

Implementation Plan 18

Foreword

Cllr Peter Griffiths - Cabinet Member for Housing and Homes

Welcome to Birmingham's fourth Homelessness Strategy. I would like to thank partners from across the Council, Health, Criminal Justice, Housing Sector, and Voluntary and Third Sectors, who have contributed and committed to its development and success.

Birmingham has a strong history of working together in partnership to tackle homelessness. Despite our success, the scale and extent of homelessness has remained persistent. A radically different approach that drives whole system change is now necessary. In collaboration with our Local Authority neighbours from across the West Midlands Combined Authority area and the West Midlands Mayoral Taskforce, we will work together to eradicate homelessness from our city. Our new strategy focuses preventing people from becoming homeless in the first place and helping people who are homeless to build a more positive future.

The task ahead will be challenging. Increasing pressure on budgets in all sectors and the impact of the Homelessness Reduction Act 2017 are just some of the challenges that we face. I am confident that together with our partners, and in collaboration with our Local Authority neighbours, we will tackle those challenges and make a significant impact on homelessness in Birmingham.

Cllr Sharon Thompson - Birmingham Homelessness Ambassador

The impacts of homelessness are complex and intertwined. The growing number of people living on the street makes visible what may otherwise be unrecognisable to the majority of people in our city. Yet street homeless remains a relatively small proportion of the overall issue and we must not forget those living in precarious housing circumstances, temporary accommodation, hostels and supported accommodation - or indeed those who are taking positive steps to recover from homelessness.

Homelessness can lead individuals and families into a cycle that can have a profound effect on all aspects of life. It is not just a lack of accommodation; homelessness can affect our physical and mental health and wellbeing, educational achievement, ability to gain and sustain employment, and puts pressure on our personal and family relationships. These effects, especially on children, can be life long and can cause repeated homelessness of a generational nature.

No single organisation can prevent homelessness alone; together we must be proactive in working together to intervene earlier and prevent homelessness wherever possible.

I look forward to working with our highly skilled, experienced and innovative partners in the city to deliver this strategy and achieve our vision for Birmingham.

Introduction

Homelessness is caused by a complex interaction between a person or family's individual circumstances and a number of social and structural factors often outside of their own control.

Unless these other factors are addressed, the ability of an individual or family to become resilient and improve their chance of a positive future is greatly reduced, and places them at risk of becoming trapped in a cycle of homelessness.

Tackling all of these issues at the point of crisis is complex and very expensive. Therefore, we must do more to intervene as early as possible, to limit the impact of homelessness, help people to recover from homelessness, and prevent it from happening in the future.

The journey into and through homelessness is different for everyone. People enter at different stages, at different times in their lives, and each with individual support; it is important that our approach is flexible to respond effectively.

Scope

The scope of this strategy recognises:

- Those who are considering their housing options
- Those who are at risk of homelessness
- Those who are deemed statutory homeless
- Those who are deemed non – statutory homeless
- Those who are street homeless
- Children who experience homelessness
- Those who are moving on from homelessness
- The wider population (for the purposes of prevention more broadly)

Our Vision

Birmingham is a city where we all work together to eradicate homelessness

Aims

1. Ensure people are well informed about their housing options
2. Prevent people from becoming homeless
3. Assist people as soon as possible if they do become homeless so that their homelessness can be relieved by securing sufficient accommodation and support
4. Support people to recover from their experience and stay out of homelessness
5. Enable people to secure homes that they can afford and maintain

Defining Homelessness

Statutory Homelessness

The Department for Communities and Local Government (DCLG) defines statutory homelessness as:

"A household is legally homeless if, either, they do not have accommodation that they are entitled to occupy, which is accessible and physically available to them or, they have accommodation but it is not reasonable for them to continue to occupy this accommodation"

Households in priority housing need include families, pregnant women and single people who are particularly vulnerable.

Non-Statutory Homelessness

Non-statutory homeless people are typically single people/childless couples who are not assessed as being in 'priority need' and are only entitled to advice and assistance if homeless.

Some non-priority homeless people are offered access to Local Authority - commissioned housing support services.

Street Homelessness

DCLG define street homelessness as:

"People sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments). People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or "bashes")"

Legal duties

The **Housing (Homeless Persons) Act 1977** requires Local Authorities to prevent as well as respond to homelessness and assist people under imminent threat of homelessness (and classed as 'in priority need') by taking reasonable steps to prevent them from losing their existing accommodation.

The **Homelessness Act 2002** places a specific requirement for Local Authorities to devise and implement a Homelessness Strategy.

The **Homelessness Reduction Act 2017** places a duty on Local Authorities to provide anyone threatened with or at risk of being homeless (within a 56 day period) to be provided with advice and support to prevent them becoming homeless.

Impact of Homelessness

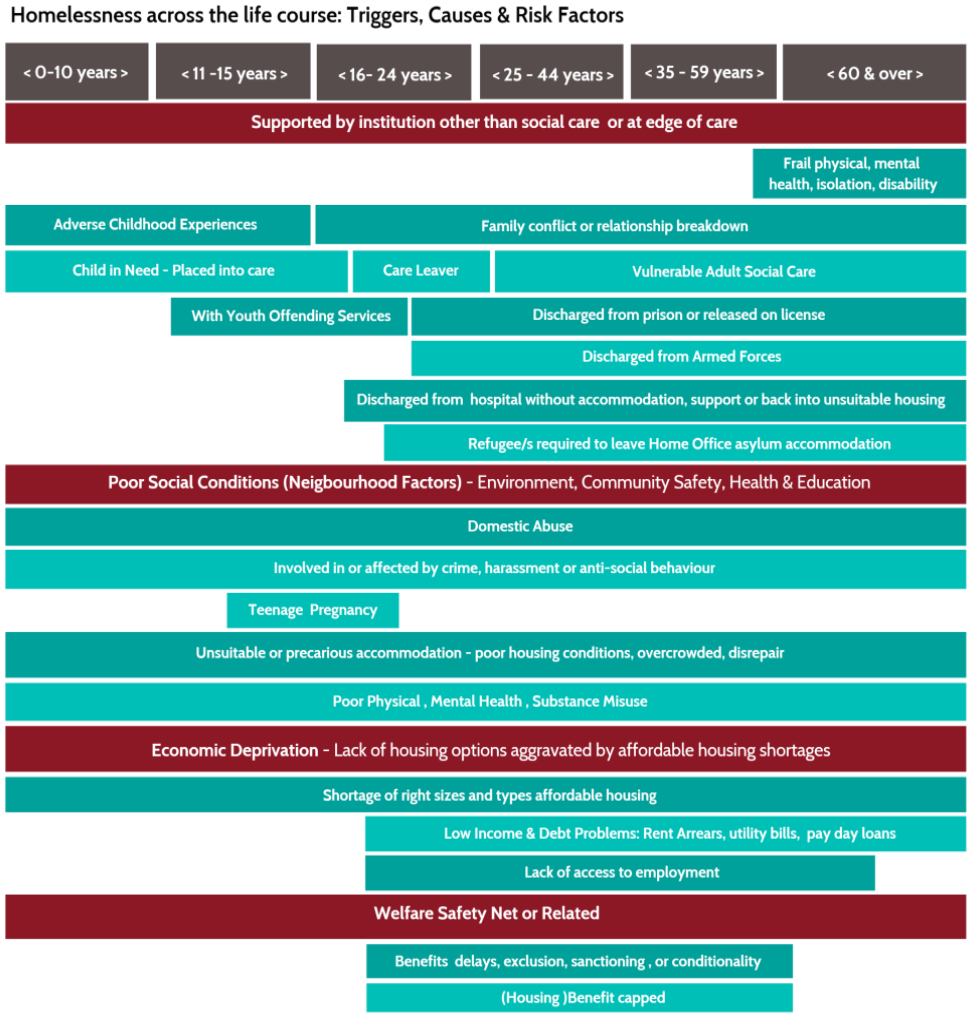
The impact of homelessness begins at birth; children are more likely to be born at a low birth weight and miss their immunisations, and are less likely to be registered with a GP.

Homeless children are three times more likely to experience poor mental health; the impact of which is long lasting. Even after they have a new home, children who experience homelessness remain vulnerable to family breakdown, domestic abuse, maternal mental ill health, and learning and development difficulties.

As a result of their preoccupation with addressing their unstable and unsafe living conditions, a parent's capacity to effectively parent is much reduced.

For many people, homelessness is not just a housing issue. It is closely linked with complex and chaotic life experiences. Mental health problems, drug and alcohol dependencies, and experiences in prison or with the care system are often closely linked to more entrenched experiences of homelessness. Traumatic childhood experiences are part of most street homeless people's life histories.

Homeless households experience severe health inequalities, poorer health and wellbeing, and a lower life expectancy than the general population. It is vital that we can identify and address the impact of homelessness for people at every stage of life.



A Priority for Birmingham

Homelessness continues to be a high priority for Birmingham. Despite our progress, the number of people experiencing homelessness is growing.

The cross cutting nature of homelessness is clear and highlighted by its inclusion as a key contributing factor to the success of the following strategic priorities:

- **Birmingham Housing Strategy Statement (2017)** - Enabling citizens to find, access and sustain housing that meets their needs is a key priority.
- **Birmingham Health and Wellbeing Strategy (2017)** - Tackling homelessness is key to children living in permanent housing, increasing employment or meaningful activity stable accommodation for those with mental health problems, and improving the wellbeing of people with complex needs.
- **Birmingham Financial Inclusion Strategy (2017)** - Financial exclusion exacerbates poverty and can lead to serious debt problems, homelessness, mental health issues and involvement with crime.
- **Birmingham Domestic Abuse Prevention Strategy (2017)** - Domestic abuse as the second highest presenting reason for homelessness households in priority housing need.
- **Birmingham Early Help Strategy (2015-2017)** - Reducing the number of families experiencing homelessness and overcrowding is key to 'a good childhood for the best start in life'.
- The **agreed purpose for Improved Mental Health in Birmingham** (2016) - Supporting people to recover from poor mental health in order to reduce adult and youth homeless.

Homelessness is an issue for the West Midlands as well as the city. We are very aware of the regional aspects of homelessness which include the impact of issues such as standards in the Private Rented Sector, affordability and lack of supply. There is also crossover with potential households who are experiencing homelessness.

We will continue to explore regional opportunities to influence and shape the homelessness agenda across the West Midlands Combined Authority. We will also support activity and services that can afford us better value for money and improved outcomes for our Citizens through models such as Housing First and the combined efforts towards hospital discharge and prison release.

Birmingham is also keen to share its approach to tackling and preventing homelessness with the West Midland's Mayoral

Taskforce on Homelessness, collaborating with our Local Authority neighbours to ensure we are making the greatest impact to achieve our vision.

Our Challenge

Nationally the Government recognises that the housing system is 'broken'. Locally, this market failure is particularly apparent as:

- A lack of affordable housing options for many larger households – Birmingham has higher than average household sizes but a limited supply of 4 bed and larger homes. This is especially difficult for larger households affected by the 'benefit cap',

- Increasing difficulties experienced by people under-35 to secure affordable, independent accommodation – particularly for low-income and unemployed young people. Whilst there is a relatively good supply of accommodation of this type, it is often not affordable for this group. People who are subject to benefit restrictions face additional difficulties. This contributes to a need for additional larger homes as young people are living with their family for longer; representing a new and growing housing need in the city.

Birmingham has a growing population, which is putting increasing pressure on the existing housing stock. Locally there are more than three times the rate of priority homelessness than the national average and double the rate of Core City neighbours. These high rates can also be seen as a direct consequence of a fractured housing system. The statutory homeless system can seem to offer a clear pathway into permanent accommodation, which contrasts with the difficulties that people experience in finding suitable and affordable accommodation.

Increasingly, people are presenting as statutory homeless because an assured short hold tenancy has ended. Domestic abuse and parental exclusion are also significant reasons for why people become homeless in Birmingham; over 40% of homeless applications from outside of the city are associated with homelessness resulting from domestic abuse.

Deprivation and associated poverty / low incomes are key barriers for accessing suitable housing and maintaining stable and financially sustainable tenancies. Access to employment is a key mechanism for preventing homelessness. The average household income in Birmingham is relatively low. Combined with relatively high rates of unemployment – this is a driver of housing exclusion. Poor financial management and a failure to maximise household income also limits people's ability to access housing.

Our approach to recovery has been overly housing focussed, with an emphasis on securing accommodation and not enough attention given to prevent future homelessness by addressing the underlying cause of peoples' experience. We need to do more to recognise the impact that the trauma of homelessness can have on both adult and childrens' physical and mental health and well-being.

Homelessness is an adverse childhood experience that can have a long-term negative impact on children's development.

Birmingham has a very high level of families who are homeless and/or in temporary accommodation. It affects social bonding, school performance as well as linked to disadvantage in future generations. More than three quarters of applicants accepted as homeless and in priority need have children – either with a lone parent, or as dependants of a couple.

Young people are the most disadvantaged in the housing market because they are likely to have a low income and are viewed by Landlords as potentially high risk. As Birmingham is a young city, this is a particularly local challenge. There are 4,118 young people facing homelessness in Birmingham, most of whom have been made homeless from their family home (42%). It is common for there to be other underlying factors that could contribute to or increase the risk of a young person becoming homeless, including lack of tenancy experience and mental health issues.

The difficulties that people experience trying to find and secure suitable housing has a direct impact on their health and well-being. This places increased pressure on health services, particularly family doctors and mental health services, as people struggle to navigate the housing system in the city. With more than 20,000 (est.) households in Birmingham each year either homeless, at risk of becoming homeless or transitioning out of homelessness – the overall health and wellbeing of the city is under threat.

Birmingham is at crisis point with rough sleepers at the most visible tip of the homelessness iceberg. The number of street homeless people has increased by 53% in the last year, and by 588% since 2012. The complexity of multiple needs, circumstances and increasing inter-relationship of triggers and reasons leading people to sleep rough makes it increasing more difficult for a single provider or partner to address. At the same time, it is increasingly hard to engage with this group suggesting that our traditional approach is no longer as effective as it used to be.

The Housing Birmingham Partnership's strategy "Birmingham: A Great Place to Live" sets out the challenge we face in terms of ensuring a sufficient supply of sustainable housing options for all citizens. Ensuring that households who have experienced homelessness are able to sustain accommodation in the long-term requires both the availability of suitable housing, and also the household having the capacity and resilience to maintain occupation of their home.

Our Approach – The Positive Pathway

The Positive Pathway is a whole systems approach built on collaboration, best practice and service integration. Successful implementation of our approach will ensure an excellent response to homelessness in the city.

First developed by St Basil's and implemented locally with young people at risk of or experiencing homelessness, the Positive Pathway has seen much success. By embedding the approach at the heart of this strategy, Birmingham will create a comprehensive and consistent approach to homelessness across the life course.

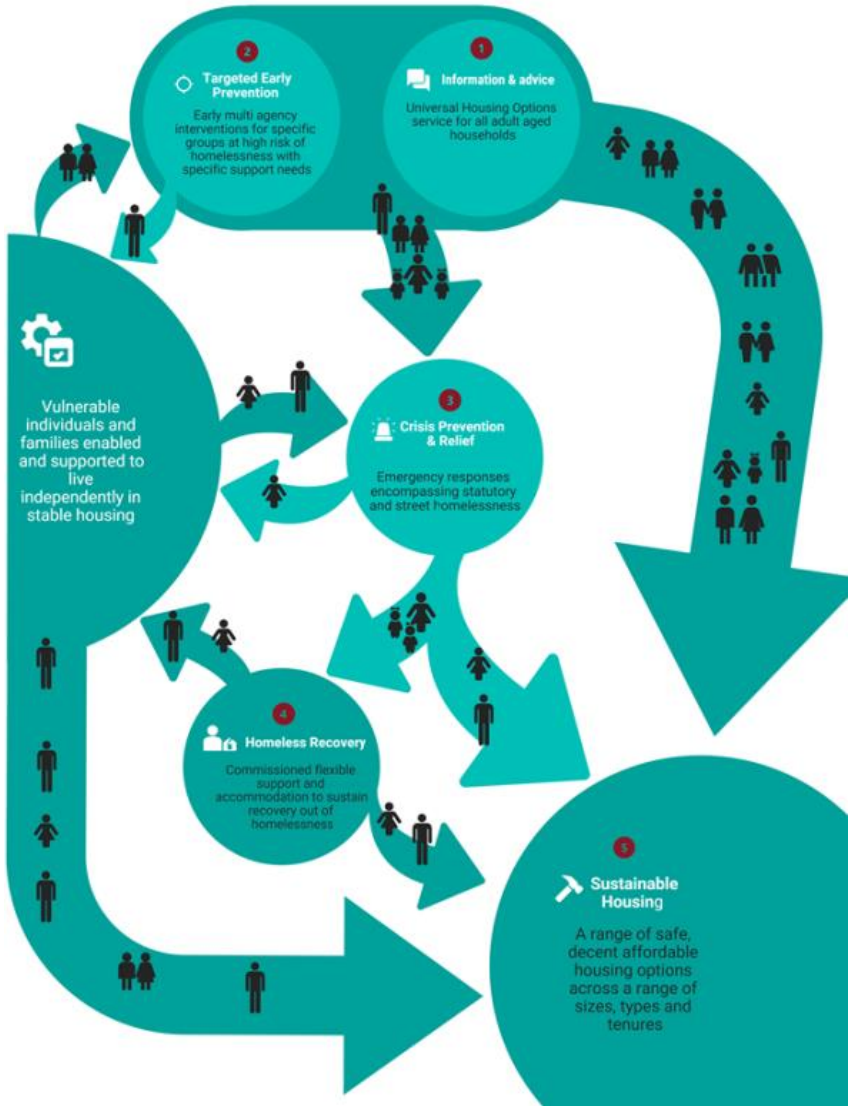
Our approach sets out five key areas that can be used flexibly to ensure that no matter what stage people enter the pathway; they will be supported as early and as effectively as possible.

The five key areas are:

1. Universal Prevention
2. Targeted Prevention
3. Crisis Prevention and Relief
4. Homeless Recovery
5. Sustainable Housing

The Positive Pathway radically changes the way we respond to homelessness in Birmingham; shifting the balance from a reactive crisis prevention response to proactively addressing homelessness in all of its forms throughout a person or family's journey.

The Positive Pathway Model



Universal Prevention

Our Aim

To ensure people are well informed about their housing options.

Our Approach

A wide range of timely, accurate information and advice about housing options and financial issues that is available to everyone to prevent issues with housing occurring in the first place, and to ensure people understand the links between housing choice and their financial and employment circumstances.

This approach is delivered through a variety of ways including online, through schools and universal services, and community networks to reach young people, families and professionals.

It is intended to empower people to successfully live independently without support from specialist services, and ensure they know where to go to seek help if required.

Strategically, this approach links closely to the work of the Birmingham Health and Wellbeing Strategy, Birmingham Financial Inclusion Strategy and the Child Poverty Commission to support reductions in inequality across the city.

Targeted Prevention

Our aim

To prevent people from becoming homeless

Our Approach

Anyone can become homeless. However, it is possible to identify people who are most likely to become homeless. Groups at risk of homelessness includes young people leaving the care of the local authority, those leaving prison, people suffering from domestic violence, those with a mental health problem or suicidal ideation, those with a substance misuse problem, those experiencing bereavement or from troubled families, people on low incomes and those who are in debt. There is a strong overlap between homelessness and deep social exclusion.

This approach introduces early intervention through trauma informed practice – understanding trauma and how it may lead to homelessness either now or in the future.

Linked to the Birmingham Early Help Strategy, targeted prevention focuses on identifying individuals and families who may be at risk of becoming homeless and offering them effective support as early as possible. In a significant number of cases early, effective intervention can prevent homelessness occurring.

To be successful, we must strengthen our collective approach to ensure the right structures, partners, and services are in place. As part of that 'joining-up' process, the development of appropriate and proportionate information sharing protocols with relevant agencies is vital to ensure a holistic response to the prevention of homelessness with people most at risk.

This will also ensure we can improve our understanding of the scale and nature of homelessness in the city, as well as the evidence base of 'what works' to predict and prevent homelessness, understand household strengths and assets, and achieve other related outcomes relevant to people in Birmingham.

Crisis Prevention and Relief

Our Aim

To assist people as soon as possible if they do become homeless so that their homelessness can be relieved by securing sufficient accommodation and support

Our Approach

Whilst we seek to shift the balance to a more proactive, preventative approach, we must ensure there is still an effective response for those who present as homeless in an emergency or crisis situation.

Crisis responses concern those where the threat of homelessness is imminent. Making a homeless application is a crisis response in itself, which may in turn lead to a placement into temporary or emergency accommodation.

Interventions in this area may help reduce the need for someone to make a homeless application to the Local Authority, or to avoid the need for rehousing into social housing.

This approach outlines an integrated, co-ordinated response to commissioned accommodation and support. This means housing options and homelessness services coming together with other services including health, education or family mediation to ensure the impact of the crisis is limited. This means everyone knowing how to answer and how they contribute to the question – 'help I need somewhere to stay'.

This approach is underpinned by a comprehensive, multiagency holistic assessment of need and is a key data collection point to inform ongoing development of the pathway.

Homelessness is prevented wherever possible – whether that is supporting a young person to stay in their family network, preventing the loss of a tenancy, quick access to emergency accommodation including domestic abuse refuge, and immediate and ongoing support where required.

Homeless Recovery

Our Aim

To support people to recover from their experience and stay out of homelessness

Our Approach

People who have experienced homelessness are more likely to have additional needs around their mental, physical and emotional health and may need extra support to make a sustained recovery into stable housing and onward to a positive and healthy future. This is particularly true for children, young people and more vulnerable adults. Providing this support is critical to limiting the impact of homelessness as well as preventing homelessness recurring.

Experiencing homelessness can have a serious, adverse and long lasting impact, particularly in childhood. Understanding that being homelessness can be traumatic, this approach involves working with people to reduce the risk of secondary trauma or re-traumatisation by encompassing psychologically informed environments. This means taking into account emotional and psychological needs alongside continued support to stabilise their accommodation, and focusing on improving the overall wellbeing of all adults and children in the household.

This includes ensuring people have access to a range of support that will enable them to improve their physical and mental health and wellbeing, stabilise the family income, enter and/ or maintain employment, strengthen social networks, and access education or training.

Through building on personal resilience, skills, support and income needed to regain independence and avoid the crises that trigger homelessness this type of preventative action will need to be flexible and right first time.

Sustainable Housing Options

Our Aim

To enable people to secure homes that they can afford and maintain

Our Approach

There is no doubt that homelessness in Birmingham is exacerbated by the lack of supply and access to suitable, settled accommodation.

Recognising the impact of a growing population and increasing pressure on our current housing stock, sustainable housing options are a key part of resolving structural influences on homelessness.

To maintain the momentum of supporting people into independence when they are ready, we must have access to a truly affordable supply of accommodation for people to move into.

Without it, the current situation will remain inevitable: people that are ready for independence are trapped in supported accommodation, potentially blocking others in the system from moving on and getting the help they need.

This approach requires the provision of a range of safe, decent, affordable housing options, both shared and self-contained, in the private, social and third sectors is crucial. Supply, affordability and support are key enablers of tenancy sustainment.

This domain concerns longer term strategic actions such as improving the supply of suitably affordable housing to make a difference to homelessness. Alongside increasing sub-market level housing supply across all tenures, improving the standards and quality of tenure in the private rented sector can also contribute to tackling homelessness in the city.

By enabling this environment, people are economically active and have suitable homes that they can afford and build their future from.

Delivering our Vision

Oversight

Housing Birmingham Partnership is responsible for, and committed to ensuring that Birmingham's vision to eradicate homelessness becomes reality.

Assurance

The Birmingham Health and Wellbeing Board will seek assurance from the Homelessness Positive Pathway Board on the effectiveness of partnership working in the development and implementation of the Strategy Implementation Plan.

Accountability

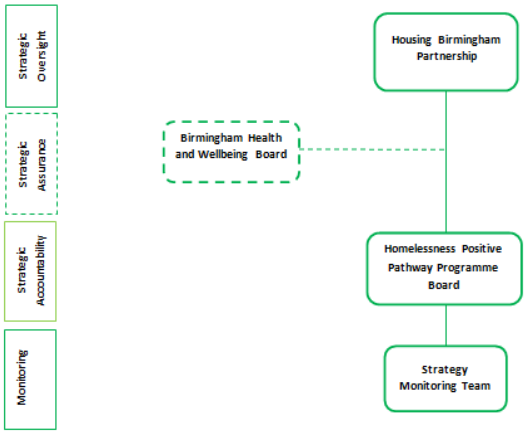
The multi-agency and cross sector Homelessness Positive Programme Pathway Board will be responsible for the successful delivery of the Strategy Implementation Plan.

Monitoring

The Strategy Monitoring Team will report progress against the Strategy Implementation Plan to the Homelessness Positive Pathway Programme Board. The Homelessness Positive Pathway Programme Board will undertake a review of progress against the Strategy Implementation Plan on an annual basis up to and including 2021.

Governance Structure

The strategy will be monitored through the following governance structure:



Equality Duty

The Public Sector Equality Duty (Equality Act 2010) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people when carrying out their activities.

As such, our approach has and will continue to be informed by the latest available intelligence when determining key actions associated with the delivery of our strategy vision.

Implementation Plan

The Positive Pathway Model will be used to shape, inform and drive the whole systems change that is required to achieve our vision.

The Homelessness Positive Pathway Programme Board has established five Task and Finish Groups, one for each key area of the pathway.

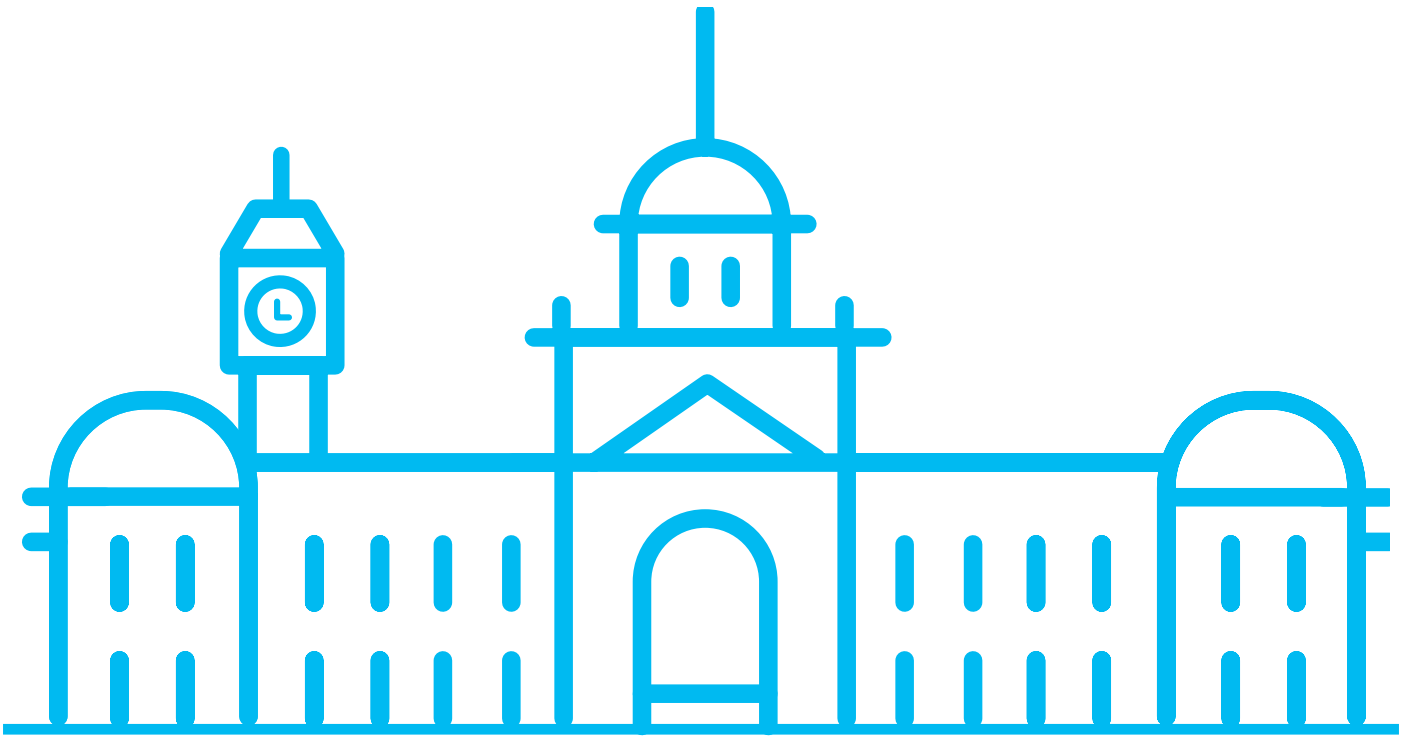
Membership of each group consists of a range of key partners, stakeholders, and crucially citizens as a reference point.

The Task and Finish groups will describe what an excellent system looks like. Informed by the public consultation, they will then identify a series of actions, initiatives and opportunities that will be incorporated into the final Strategy Implementation Plan.

Birmingham Homelessness Prevention Strategy 2017+

24 August - 5 October 2017

Consultation Summary



Birmingham City Council

Birmingham Homelessness Prevention Strategy 2017+

24 August – 5 October 2017

What are we trying to achieve?

Birmingham strives to be a city where we work together to eradicate homelessness. This is our vision for the new Homelessness Prevention Strategy for Birmingham.

Strategic partners from the Housing Birmingham Partnership, and across the City Council, Health, Housing, Voluntary and Third Sectors all recognise that homelessness is an important priority for our city. We have all committed to working together to tackle the issue and prevent it from happening in the future.

Our strategic vision is informed by a number of key drivers including:

- A current and comprehensive review of homelessness in Birmingham;
- The introduction of the Homelessness Reduction Act 2017 due in April 2018;
- The recommendations from inquiries into Rough Sleeping and Prevention and Homeless Health made by the Birmingham Housing and Homes Overview and Scrutiny Committee.

To reduce homelessness we must do more to make sure that people get the early help they need to prevent incidents of homelessness from happening, and also make sure appropriate support is available for those who have experienced homelessness, so that they are able to improve their chance of a positive future.

To achieve this we have identified five key aims:

- Ensure people are well informed about their housing options;
- Prevent people from becoming homeless;
- Assist people as soon as possible if they do become homeless so their homelessness can be relieved by securing sufficient accommodation and support;
- Support people to recover from their experience and to stay out of homelessness;
- Enable people to secure homes that they can afford and maintain.

We will ask Birmingham citizens, including those who have directly experienced homelessness; strategic partners and key agencies to tell us their views on our proposals.

This section supports Question 1 of the Homelessness Prevention Strategy Consultation Questionnaire

What is the scope of our Homelessness Prevention Strategy?

Homelessness is defined by the Government as:

"A household is legally homeless if, either, they do not have accommodation that they are entitled to occupy, which is accessible and physically available to them or, they have accommodation but it is not reasonable for them to continue to occupy this accommodation."

People who are assessed as meeting this definition are referred to as 'statutory homeless' or 'priority housing need'.

People who are assessed and do not meet the Government definition are referred to as 'non-statutory homeless'.

Street Homelessness is defined by the Government as:

"People sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments). People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or 'bashes')."

To ensure that we can effectively tackle homelessness at every stage of a person or family's journey the scope of this strategy recognises:

- Those who are considering their housing options
- Those who are at risk of homelessness
- Those who are deemed statutory homeless
- Those who are deemed non - statutory homeless
- Those who are street homeless
- Children who experience homelessness
- Those who are moving on from homelessness
- The wider population (for the purposes of prevention more broadly).

Why do we need a Homelessness Prevention Strategy?

The Homelessness Act 2002 places a legal requirement on Local Authorities to develop and implement a Homelessness Strategy every five years.

Our Health and Wellbeing Challenge

Homelessness is a significant public health issue that affects the health and wellbeing of our local population.

Whilst we have made good progress in tackling homelessness in the city, we have focused on making sure people have a place to stay. There are now more than 20,000 households in Birmingham each year who are homeless, at risk of becoming homeless or moving out of homelessness. We must do more to support people to address the reasons why they are at risk of homelessness or why they became homeless in the first place to prevent cycles of homelessness negatively effecting both individuals and families.

Experiencing poverty and living on a low income are key barriers for people to access, afford and maintain safe and appropriate places to live. Family income in Birmingham is below the national average and we have a high number of people who are unemployed. Birmingham also has a very high number of families who are homeless and/or have a temporary place to stay.

More than three quarters of people who are accepted as statutory homeless in the city have children. Experiencing adversity in childhood, including homelessness, can have a long-term negative effect on a child's health, development, and emotional wellbeing and we therefore need to better understand how trauma such as abuse or neglect in childhood or living in a dysfunctional home can increase the risk of becoming homeless. We also need to do more to recognise how traumatic the experience of homelessness itself can be to all age groups.

People who sleep on the street are the most visible type of homelessness in our city. Street homeless people have needs that are multiple and complex. When we combine these with the reasons that brought them to sleep on the street in the first place, it makes it very hard for one single agency to provide the right support. We know from our review of homelessness that we need to find more effective ways to engage with the street homeless community.

Our Housing Challenge

The Birmingham Housing Strategy - *Birmingham: A Great Place to Live* - sets out the challenge we face to make sure that there are enough good quality and affordable housing options for everyone in the city. We need to make sure that people who have experienced homelessness are able to continue to live in their new home for as long as they choose.

This means making sure that there are enough suitable homes for people moving on from homelessness to live in. It also means effectively supporting people to gain the knowledge and resilience they need to live independently, either whilst at risk of becoming homeless or after experiencing homelessness.

Birmingham has a growing population that is putting increasing pressure on the availability of our current housing options. While the statutory homeless system may seem to offer a clear pathway into permanent housing, it does contrast with the difficulties that people experience in finding a suitable and affordable place to live. The strategy will look to explore local solutions to this complex issue.

Locally we are seeing an increase in people becoming statutory homeless because a short term tenancy with a private landlord has ended. Domestic abuse and being unable to stay at the family home are also reasons why people become homeless in Birmingham.

The size of families in Birmingham is larger than average and not enough larger homes are available to house those in need. This is especially difficult for larger families who have been impacted by the limit that the government has put on the amount of benefits people can claim.

At the same time, it is becoming more difficult for young people aged under 35 to get a home that they can afford to live in independently. Young people that have a low income or are unemployed are particularly affected and often are living with their family for longer. This is putting further pressure on the need for larger homes - and represents a new and growing need in the city.

This section supports Questions 1 and 2 of the Homelessness Prevention Strategy Consultation Questionnaire

What do we want to do to address homelessness in Birmingham?

We need to change the way we respond to homelessness in Birmingham so that we shift the balance from reactive crisis prevention response to proactively addressing homelessness in all of its forms throughout a person or family's journey.

The Positive Pathway is a whole system approach where all partners work together to tackle homelessness.

This model is already working well with young people at risk of or experiencing homelessness in Birmingham, and by adopting this approach wider the city will have a consistent approach to tackling homelessness.

Our approach sets out five key areas that can be used flexibly to ensure that no matter what stage people enter the pathway; they will be supported as early and as effectively as possible. The five key areas are:

1. Universal Prevention

This means delivering a wide range of timely, accurate information and advice about housing options and financial issues and it will be available to everyone to help prevent issues with housing occurring in the first place. It will also ensure people understand the links between housing choice and their financial and employment circumstances.

This approach is delivered through a variety of ways including online, through schools and universal services and through community networks that reach young people, families and professionals.

It is intended to empower people to successfully live independently without support from specialist services and ensure they know where to go to seek help if required.

Strategically, this approach links closely to the work of the Health and Wellbeing Strategy, Birmingham Financial Inclusion Strategy and the Child Poverty Commission to support reductions in inequality in the city.

2. Targeted Prevention

Anyone can become homeless. However, it is possible to identify people who are most likely to become homeless.

Groups at risk of homelessness include: young people leaving the care of the local authority; those leaving prison; people suffering from domestic violence; those with a mental health problem or suicidal ideation; those with a substance misuse problem; those experiencing bereavement or from troubled families; people on low incomes and those who are in debt.

This approach introduces early intervention through trauma informed practice. This means understanding trauma and how it may lead to homelessness either now or in the future.

It links to the city's Early Help Strategy and is based upon identifying individuals and families who may be at risk of becoming homeless and offering them effective support as early as possible. In many cases, this type of support can prevent homelessness from happening.

It means strengthening our joined up approach to ensure the right structures, partners, and services are in place.

3. Crisis Prevention and Relief

The strategy shifts the balance to delivering a more proactive, prevention approach, however we must make sure that there is still an effective response for those people who become homeless in an emergency or crisis situation.

This part of the pathway approach outlines an integrated, co-ordinated response to commissioned accommodation and support, where Housing Options and Homelessness Services come together with other services including Health, Employment and/ or Childrens Services to make sure the impact of the crisis is limited. This means everyone knowing how to effectively respond to someone who is identified as either at risk of becoming homeless or is homeless.

Effective support in this area may help reduce the need for someone to make a homeless application to the Local Authority, or to avoid the need for rehousing into social housing.

4. Homeless Recovery

People who have experienced homelessness are more likely to have additional needs around their mental, physical and emotional health. They may also need extra support to make sure they can maintain their new home and move on into a positive and healthy future. This is particularly true for children, young people and more vulnerable adults. Providing this support is critical to limiting the impact of homelessness as well as preventing homelessness recurring.

Experiencing homelessness can have a serious and long lasting impact, particularly in childhood. Understanding that being homelessness can be traumatic, this approach involves working with people to reduce the risk of experiencing trauma again.

This means taking into account a person's emotional and psychological needs alongside continued support to stabilise accommodation. It also means focusing on improving the overall wellbeing of all adults and children in the household.

5. Sustainable Housing

The lack of suitable homes makes homelessness in Birmingham an ongoing challenge, and the need to secure more sustainable housing options is a key part of addressing a critical structural influence on the city's homelessness.

To maintain the momentum of supporting people into independence when they are ready, we must have access to a truly affordable supply of housing options for people to move in to. Without it, our situation regards levels and types of homelessness will not change.

People that are ready to live independently may find that they are trapped in supported housing, and it may stop others from moving on and getting the help they need to move towards independent living. This part of the pathway will explore local solutions to expanding the supply of safe, good quality, affordable housing options, and will look across the options for people living alone, with family, or in other forms of shared homes.

This approach focuses on longer term strategic actions such as improving the supply of suitable, affordable housing to make a difference to homelessness, and improving the standards and quality of homes in the private rented sector

This section supports Questions 1, 2 and 3 of the Homelessness Prevention Strategy Consultation Questionnaire

What next?

We are inviting views from all stakeholders interested in tackling homelessness in Birmingham and have developed a questionnaire that lists the things we think will help to achieve our vision for the Homelessness Prevention Strategy.

Please complete the questionnaire and return your views using the FREE postal address below

Alternatively, you can share your thoughts by contacting:

Website: **www.birminghambeheard.org.uk**

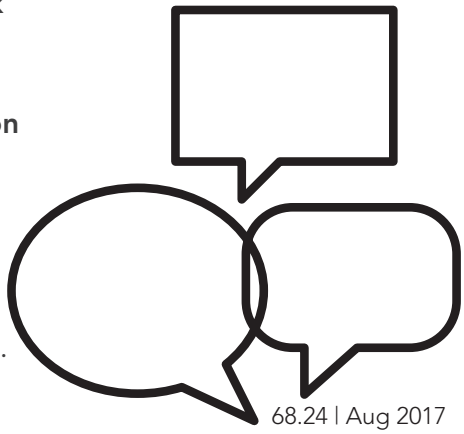
Twitter: **@healthybrum**

Email: **homelessnessconsultation@birmingham.gov.uk**

Telephone: **0121 303 5154**

Write to: **Homelessness Prevention Strategy Consultation**
Freepost Plus RSYS-HKBC-XBLA
PO Box 16465
Birmingham
B2 2DG

Please note that you do not need to use a stamp.



Birmingham Homelessness Prevention Strategy 2017+

24 August - 5 October 2017

Questionnaire

Birmingham City Council

Birmingham Homelessness Prevention Strategy 2017+

24 August – 5 October 2017

Questions we are asking about Birmingham's Homelessness Prevention Strategy 2017+

We are asking people of Birmingham, including those with lived experience of being homeless, key partner agencies and current providers of homelessness prevention services, to let us know your views on our new approach to tackling and preventing homelessness.

The Homelessness Prevention Strategy 2017+ Consultation Summary Document provides supporting information to help outline our ideas.

1. **We propose that the vision for the new Homelessness Prevention Strategy should be that 'Birmingham is a city where we all work together to eradicate homelessness'.**

   (Commentary – See section 'What are we trying to achieve?' in the Summary Document)

   To what extent do you agree or disagree with this vision?
   (Please tick one box only)

   - ☐ Strongly agree
   - ☐ Agree
   - ☐ Don't know
   - ☐ Disagree
   - ☐ Strongly disagree

   Please tell us the reason for your answer:

2. **For Birmingham to eradicate homelessness, we propose that the strategy should focus on the following five aims:**

(Commentary – See section 'What are we trying to achieve?' in the Summary Document)

To what extent do you agree or disagree that these aims are the right ones?

a. **To ensure people are well informed about their housing options** (Please tick one box only)

- ☐ Strongly agree
- ☐ Agree
- ☐ Don't know
- ☐ Disagree
- ☐ Strongly disagree

b. **To prevent people from becoming homeless** (Please tick one box only)

- ☐ Strongly agree
- ☐ Agree
- ☐ Don't know
- ☐ Disagree
- ☐ Strongly disagree

c. **To assist people as soon as possible if they do become homeless so that their homelessness can be relieved by securing sufficient accommodation and support** (Please tick one box only)

- ☐ Strongly agree
- ☐ Agree
- ☐ Don't know
- ☐ Disagree
- ☐ Strongly disagree

d. **To support people to recover from their experience and stay out of homelessness** (Please tick one box only)

- ☐ Strongly agree
- ☐ Agree
- ☐ Don't know
- ☐ Disagree
- ☐ Strongly disagree

e. **To enable people to secure homes that they can afford and maintain** (Please tick one box only)

- ☐ Strongly agree
- ☐ Agree
- ☐ Don't know
- ☐ Disagree
- ☐ Strongly disagree

Please tell us the reason for your answer:

3. **We propose that a new approach called the Positive Pathway model is used to tackle homelessness and prevent it happening in the future. The model will focus on the following five areas:**

1. Universal Prevention

2. Targeted Prevention

3. Crisis Prevention and Relief

4. Homeless Recovery

5. Sustainable Housing

(Commentary – See section 'What do we want to do to address homelessness in Birmingham' in the Summary Document)

To what extent do you agree or disagree that this is the right approach to preventing and tackling homelessness in Birmingham?
(Please tick one box only)

- ☐ Strongly agree
- ☐ Agree
- ☐ Don't know
- ☐ Disagree
- ☐ Strongly disagree

Please tell us the reason for your answer:

4. **We propose that to be successful, a multi-agency approach is needed with key partners from across the Council, Social Care, Health, Criminal Justice, Social and Private Housing Sector, Voluntary and Third Sector, and Education all working together.**

(Commentary – See section 'What do we want to do to address homelessness in Birmingham' in the Summary Document)

To what extent do you agree or disagree that a multi-agency approach is needed to tackle and prevent homelessness in Birmingham?
(Please tick one box only)

- ☐ Strongly agree
- ☐ Agree
- ☐ Don't know
- ☐ Disagree
- ☐ Strongly disagree

Please tell us the reason for your answer:

5. **Please tell us about anything else you think we should consider in our approach to tackling and preventing homelessness in Birmingham:**

6. **There will be an opportunity to inform the development of the Positive Pathway model later in the year. If you would like to be part of this development, please enter your contact details:**

About You

To help us plan our strategy, we would like you to tell us some things about you.

You do not have to tell us if you do not want to, but if you do, it will help us to plan what we should do.

Data Protection Act 1998

The personal information on this form will be kept safe and is protected by law.

You can see more information about data protection on our website at:
www.birmingham.gov.uk/privacy

Are you?

Please tick one box that best describes your interest in the consultation:

- ☐ A member of the general public
- ☐ Someone who is currently homeless or has been affected by homelessness
- ☐ Health or Care professional
- ☐ Housing advisor
- ☐ Homelessness advisor
- ☐ A family member or carer of someone who is or has been homeless
- ☐ Other (please state below)

Which age group applies to you? *(Please tick one box only)*

☐ Under 16	☐ 40 – 44	☐ 70 - 74
☐ 16 - 19	☐ 45 – 49	☐ 75 - 79
☐ 20 – 24	☐ 50 – 54	☐ 80 – 84
☐ 25 – 29	☐ 55 – 59	☐ 85+
☐ 30 – 34	☐ 60 - 64	☐ Prefer not to say
☐ 35 – 39	☐ 65 - 69	

What is your sex? (Please tick one box only)

- [ ] Male
- [ ] Female
- [ ] Prefer not to say

Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more? (Please tick one box only)

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

If yes, do any of these conditions or illnesses affect you in any of the following areas? (Please tick all that apply)

- [ ] Vision (e.g. blindness or partial sight)
- [ ] Hearing (e.g. deafness or partial hearing)
- [ ] Mobility (e.g. walking short distances or climbing stairs)
- [ ] Dexterity (e.g. lifting and carrying objects, using a keyboard)
- [ ] Learning or understanding or concentrating
- [ ] Memory
- [ ] Mental Health
- [ ] Stamina or breathing or fatigue
- [ ] Socially or behaviourally (e.g. associated with Autism, attention deficit disorder or Asperger's Syndrome)
- [ ] Other (please state below)

What is your ethnic group? (Please tick one box only)

White

- [ ] English/ Welsh/ Scottish/ Northern Irish/ British
- [ ] Irish
- [ ] Gypsy or Irish Traveller
- [ ] Polish
- [ ] Baltic States
- [ ] Jewish
- [ ] Other white European (including mixed European)
- [ ] Any other White background (please state below)

Mixed/multiple ethnic groups

- [ ] White and Black Caribbean/African
- [ ] White and Asian
- [ ] Any other Mixed background (please state below)

Asian/Asian British

- [ ] Afghani
- [ ] Bangladeshi
- [ ] British Asian
- [ ] Chinese
- [ ] Filipino
- [ ] Indian Sikh
- [ ] Indian Other
- [ ] Kashmiri
- [ ] Pakistani
- [ ] Sri Lankan
- [ ] Vietnamese
- [ ] Any other Asian background (please state below)

Black African/Caribbean/Black British

- [ ] African
- [ ] Black British
- [ ] Caribbean
- [ ] Somali
- [ ] Any other Black/African/Caribbean background (please state below)

Other ethnic group

- [ ] Arab
- [ ] Iranian
- [ ] Kurdish
- [ ] Yemeni
- [ ] Any other ethnic group (please state below)
- [ ] Prefer not to say

What is your sexual orientation? (Please tick one box only)

- [ ] Bisexual
- [ ] Gay
- [ ] Lesbian
- [ ] Heterosexual or Straight
- [ ] Other (please state below)
- [ ] Prefer not to say

What is your religion or belief? (Please tick one box only)

- ☐ No religion
- ☐ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
- ☐ Buddhist
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ Any other religion (please state below)

- ☐ Prefer not to say

Thank you for taking part in our consultation. Your views are important to us.

Please return this questionnaire to the FREE postal address below – you do not need to use a stamp. If you have any further comments or views on the new Homelessness Prevention Strategy, please contact:

Website: **www.birminghambeheard.org.uk**

Twitter: **@healthybrum**

Email: **homelessnessconsultation@birmingham.gov.uk**

Telephone: **0121 303 5154**

Write to: **Homelessness Prevention Strategy Consultation**
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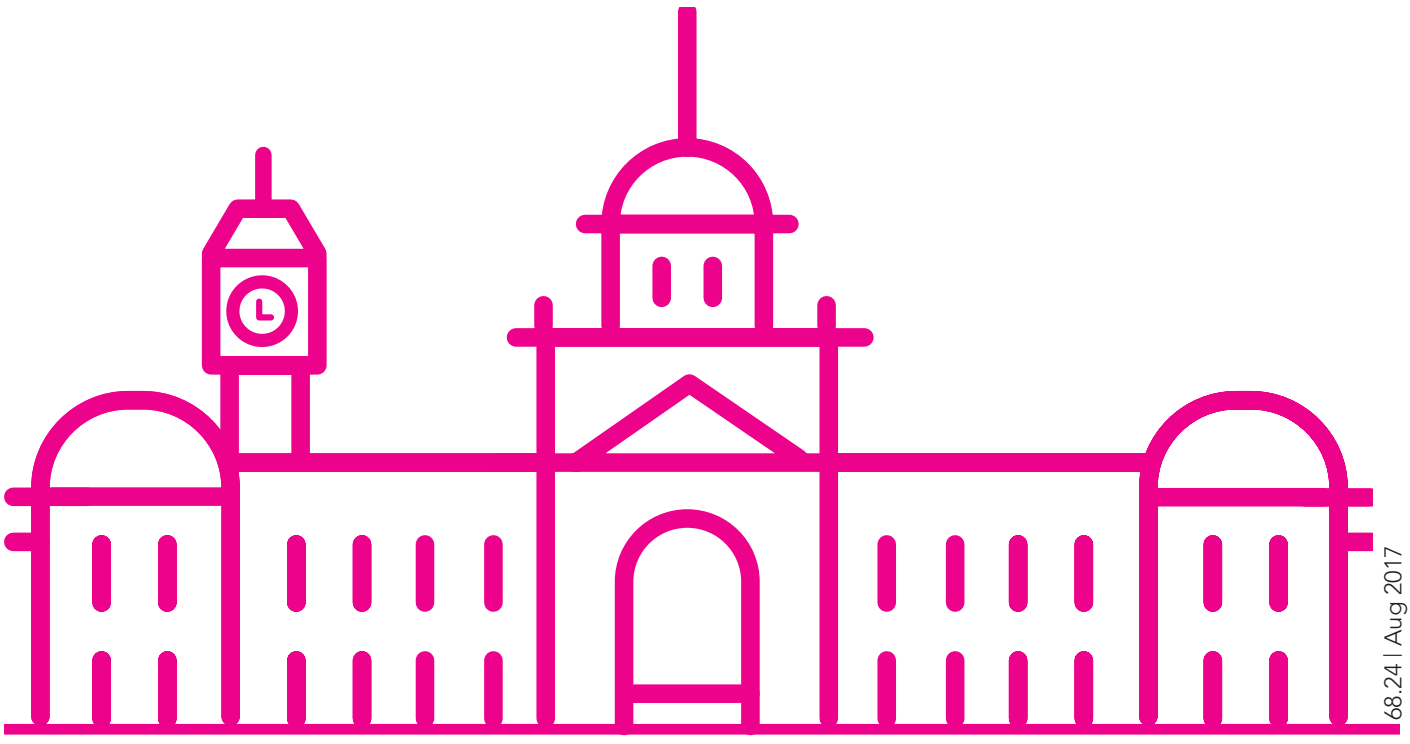


68.24 | Aug 2017

Birmingham City Council

	Agenda Item: 9
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**3 October 2017**
TITLE:	**BIRMINGHAM CITY COUNCIL'S VISION AND STRATEGY FOR ADULT SOCIAL CARE SERVICES**
Organisation	**Birmingham City Council**
Presenting Officer	**Graeme Betts**

Report Type:	**Information**

1.	**Purpose:**
	This is a draft report to seek a discussion on the Vision and Strategy for Adult Social Care services in Birmingham.

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

3.	**Recommendation**
3.1	To discuss the Vision and Strategy for Adult Social Care services in Birmingham

4.	**Background**
4.1	There are a number of challenges facing the Council in supporting adults and older people including: more people living longer with more complex needs; significant numbers of young adults who have disabilities or who suffer from mental illness; people having higher expectations of the public sector; and significantly reduced level of resources. Consequently, changes are needed to the type of services that are arranged and provided, and to the way services are organised and delivered
4.2	The desired outcomes for adults and older people in Birmingham are that they should be resilient, live independently whenever possible, and exercise choice and control so they can live good quality lives and enjoy good health and wellbeing. The Vision and Strategy for Adult Social Care Services addresses potential barriers and obstacles to delivering these outcomes. It also provides a framework for the actions required to modernise Adult Social Care Services in Birmingham.
4.3	There are a number of challenges facing the Council in supporting adults and older people including: more people living longer with more complex needs; significant numbers of young adults who have disabilities or who suffer from mental illness; people having higher expectations of the public sector; and significantly reduced level of resources. Consequently, changes are needed to the type of services that are arranged and provided, and to the way services are organised and delivered
4.4	The desired outcomes for adults and older people in Birmingham are that they should be resilient, live independently whenever possible, and exercise choice and control so they can live good quality lives and enjoy good health and wellbeing. The Vision and Strategy for Adult Social Care Services addresses potential barriers and obstacles to delivering these outcomes. It also provides a framework for the actions required to modernise Adult Social Care Services in Birmingham.
4.5	The Vision and Strategy for delivering the outcomes comprises eight key elements:
•	**Information, advice and guidance** People need access to high quality information, advice and guidance. Whenever possible and appropriate, they need to be able to self-serve, or for their carers and families to do so on their behalf. The range of services that people can access directly will be increased and it will be easier for carers to have their needs assessed.
•	**Community assets** Local groups need to be enabled to provide the wide range of support that helps people to remain in the community. This approach needs to be supported by: a corporate emphasis on locality working; engagement with GP practices; and integrated provision across formal social care services, health services and a diverse range of community assets.
•	**Prevention and early intervention** People need to be able to access prevention and early intervention services

quickly and at any time in their lives to help maximise their independence. A comprehensive ongoing strategy for prevention is required that anticipates potential need and ensures that public sector and third sector organisations are joined up in their approaches. A multi-organisation group needs to take the lead on prevention and there needs to be investment in and development of preventative services.

- **Personalised support**
  Social work and care management services will be re-organised. They will move from assessing people for services to assessing them for the outcomes they want and the assets they have to achieve them.

- **Use of resources**
  It is imperative that resources are used effectively. To deliver this element of the strategy, a review of the use of resources will provide a framework for moving resources to areas that can deliver best value. There will be ongoing monitoring and review of spend to ensure that resources are maximised.

- **Partnership working**
  Services need to be integrated and built on partnership working using multi-disciplinary teams and, where feasible, single points of access. The Council and its partners need to work as a whole system and to embrace locality working.

- **Making safeguarding personal**
  We must 'make safeguarding personal' and understand what outcomes people want from safeguarding enquiries and actions. Safeguarding must be seen as everybody's business and kept in the public eye. The strategy for safeguarding needs to be implemented and the service and its performance regularly reviewed.

- **Co-production**
  All services should be co-produced with users and carers. Ongoing engagement needs to be at the heart of commissioning and service delivery. To deliver this element of the strategy, an approach to co-production needs to be implemented across all services.

4.6 Evaluation of alternative option(s):

Do nothing – This is would not deliver the actions required to modernise Adult Social Care Services. Alternative options for the delivery elements of the strategy will be considered and evaluated through the development of specific programmes and projects.

4.7 The Vision and Strategy provide a framework for the actions required to modernise Adult Social Care Services in Birmingham in order to improve the health and wellbeing of adults and older people.

5.	**Compliance Issues**
5.1.	The Vision and Strategy is consistent with the Council's 'Vision and Priority 2017-2020' and supports the priority of Health – A great city to grow old in. This priority includes: 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; and preventing, reducing and delaying dependency and maximising the resilience and independence of citizens, their families and the community.
5.2	The Vision and Strategy provides an overview of how Adult Social Care Services will contribute towards the corporate priority of Health.
5.3	**Financial Implications**
5.4	Approval of the Vision and Strategy does not commit the local authority to specific expenditure. The importance of using resources effectively is highlighted and changes arising from the Vision and Strategy will be aligned with the development of the Council's long term Financial Plan. This will set the direction for future consideration of savings proposals for Adult Social Care & Health.

6.	***Consultation***
6.1	**Internal** Engagement sessions have taken place on the draft vision and strategy with: Cabinet Members for Children, Families & Schools and Transparency, Openness & Equality; the Chair of the Health and Social Care Overview and Scrutiny Committee; Executive Management Team (EMT); Corporate Leadership Team (CLT); Economy Directorate Management Team; Corporate Director of Place; Health and Wellbeing Board; and the Adult Social Care & Health Directorate Leadership Team. Engagement sessions have also taken place with the Adult Social Care & Health Directorate staff group. Response to the Vision and Strategy by internal stakeholders has been positive.
6.2	**External** Engagement sessions have taken place with: service users; carers; the Citizens Panel; single and multi-faith groups; community groups; Third sector and Supporting People providers; Birmingham Voluntary Service Council (BVSC); care providers and with Clinical Commissioning Groups and trusts in the Health sector.

10.	Risk Analysis
	An Equality Assessment (EA) was carried out in September 2017.The Vision and Strategy is relevant to all protected characteristics. By enabling the outcomes to be delivered the Vision and Strategy will have a positive impact on citizens, service users and carers and we will continue to meet our responsibilities under the Care Act 2014. The Vision and Strategy will potentially have an adverse impact on employees of Adult Social Care Services, arising from re-organisation of social work and care management services with changes to work location. Mitigation of the impacts of specific proposals arising from this Vision and Strategy will be in line with the Council's agreed policies and procedures.

Appendices
Appendix 1- Vision and Strategy for ASCH

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

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

Graeme Betts

Birmingham City Council's Vision and Strategy for Adult Social Care and Health, September 2017

Improving the health and wellbeing of adults and older people in Birmingham

Introduction and context

The goals that Birmingham Council are seeking to achieve for adults and older people are that they should be resilient, living independently whenever possible and exercising choice and control so that they can live good quality lives and enjoy good health and wellbeing.

It is essential to recognise that in order to support people to achieve these goals, the Council has broad responsibility across a range of areas and it is a corporate responsibility to achieve them. For example, the Council has a key role in ensuring there is appropriate housing which offers choice to people with a wide diversity of needs. For people to engage in community activities, there needs to be a wide range of community assets which the Council should ensure are in place including community centres, leisure centres, parks and gardens. People need to feel safe to come out of their homes to enjoy them. These are a few examples of the mainstream services the Council provides or arranges.

Most adults and older people can enjoy access to mainstream services independently or with help and support from their families, friends and social groups. However, for some citizens this is only possible with support from Adult Social Care services and from other public sector agencies such as health services. This report focuses on how Adult Social Care services in Birmingham will work to support adults with disabilities and older people to achieve the desired goals.

The challenges facing the Council to achieve this have never been greater. While it is a great achievement for society that there are more people living longer with more complex needs inevitably this puts pressure on resources. While Birmingham is one of the youngest cities in Europe, the older population is growing rapidly. An estimated 10,000 adults suffer dementia. Further, there are significant numbers of young adults who have disabilities or suffer from mental illness. The resources previously available have been significantly reduced making the use of available resources more important than ever. The public have higher expectations of the public sector, standards are constantly rising and it is increasingly recognised that people want support to enable them to exercise independence, choice and control.

Consequently, the Council has to change and adapt to these new circumstances which means that the type of services arranged and provided and the way they are organised and delivered has to change. The structures and organisation all need to be revisited to ensure they are fit for purpose and it is essential that the staff have the right skills to meet the challenges they face today.

Putting in place a strategy for delivering the outcomes

In order to deliver the desired goals for adults and older people, it is necessary to put in place a strategy that addresses potential barriers and obstacles and puts in place a framework to make the outcomes achievable.

The narrative behind this strategy is that on the whole, people want to lead happy, fulfilled lives in touch with their families, friends and communities. They cherish their independence and prefer to live at home or in the community with support if necessary. The vast bulk of people do not want to be dependent on others but will accept one-off support or ongoing support if it helps them to maintain their independence. For most people, this is achievable and it is only those people with disabilities or who lose their abilities with age that require interventions from adult social care services. And of course, for some people, because of disability, placements in residential and nursing settings are the best way in which these people can lead good quality lives.

Therefore, the ***strategy*** which will enable these outcomes to be delivered contains eight key elements.

Information, advice and guidance

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

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

In order to deliver this element of the strategy, adult social care will continue to promote its services and how people can contact them. The first point of contact which can be through the internet or through a telephone contact centre will be

continuously improved. The number of calls that are abandoned because of long waits will be reduced and more experienced workers will be based in the centres. The range of services that people can access directly will be increased and it will be made easier for carers to have their needs assessed.

Community assets

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

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

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

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

This approach needs to be supported by a broad corporate approach which ensures there is an emphasis on locality working. Similarly, GP practices need to be engaged as do community based health services and mental health services. NHS England has funded Vanguard test sites in England to pilot new models of care that integrate health and care services around the patient. Learning from the Vanguard pilots can be brought into the approach to locality working ensuring there is a partnership of integrated provision across formal care and health services and a diverse range of community assets.

Prevention and early intervention

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

It is important to have a comprehensive ongoing strategy for prevention to ensure that organisations in the public sector and in the third sector are joined up in their approaches and maximise the available resources. Much can be done through making every contact count and there are a wide range of partners who are keen to work in this area such as the fire brigade.

One of the weaknesses of the public sector is that it is poor at anticipating demand. Too often, organisations wait until there is a crisis until services click into gear but by then it is high cost, acute services. That is why there needs to be a strategic approach to prevention which anticipates potential needs and intervenes early before they become a crisis. For example, people often fall several times before they break a hip. Intervening early in low cost solutions and preventive actions can prevent the fall which is then very costly and can lead to poor long-term outcomes.

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

Other preventive services need to be developed and invested in. This will include assistive technology, aides and equipment, support for carers and easy access to reablement programmes.

Personalised support

People require and respond better to personalised services. The approach that works most effectively always puts users and carers at the centre and builds support round them rather than fitting people into rigid services. Essentially, there needs to be a strength-based approach to assessing people's needs – building on the assets people, their families, friends and communities can offer to support them. Direct Payments will continue to be offered as an option for delivering support. They are the

preferred option for delivering support because they maximise the opportunity for people to exercise choice and control.

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

Further consideration will be given to the delivery of safeguarding and the model for learning disability services and mental health services. New roles will be considered which can address the need to link the formal assessments of people's needs with the resources available in the community which contribute to the quality of people's lives.

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

Use of resources

Underpinning all of this is the imperative to use all available resources effectively. Every pound that Birmingham spends on care must represent a pound well spent. The pressures on the City Council's resources are enormous and it is essential that resources are maximised.

In order to deliver this element of the strategy, a review of the use of resources will provide a framework for moving resources from areas where best value is not being delivered to areas where it can. So, for example, areas of service will receive investment such as the development of community assets and Shared Lives while other poorly performing services will have their resources reduced. This is not a one-off exercise and there will be on-going monitoring and review of spend to ensure resources are maximised. This will work alongside the Council's long-term budget planning and management processes.

This will set the direction for future consideration of savings proposals for Adult Social Care and Health.

Partnership working

People's needs are often complex and require support and interventions from a range of organisations. Therefore, services need to be integrated and built on partnership working utilising multi-disciplinary teams and where feasible single points

of access. This approach needs to be developed at all levels – quite simply, care and health services are a whole system and if one part of the system is not working then the system as a whole isn't and the people that suffer are the residents of Birmingham.

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

In order to deliver this element of the strategy, the Council and its partners need to work as a whole system and need to support each other to achieve their separate and joint goals. In some areas care and health services need to be open to changes in processes and to investing in areas to support their partners and the system as a whole. Care and health partners need to embrace locality working and invest their resources in working successfully in local areas, developing community assets and the means for accessing them.

Making safeguarding personal

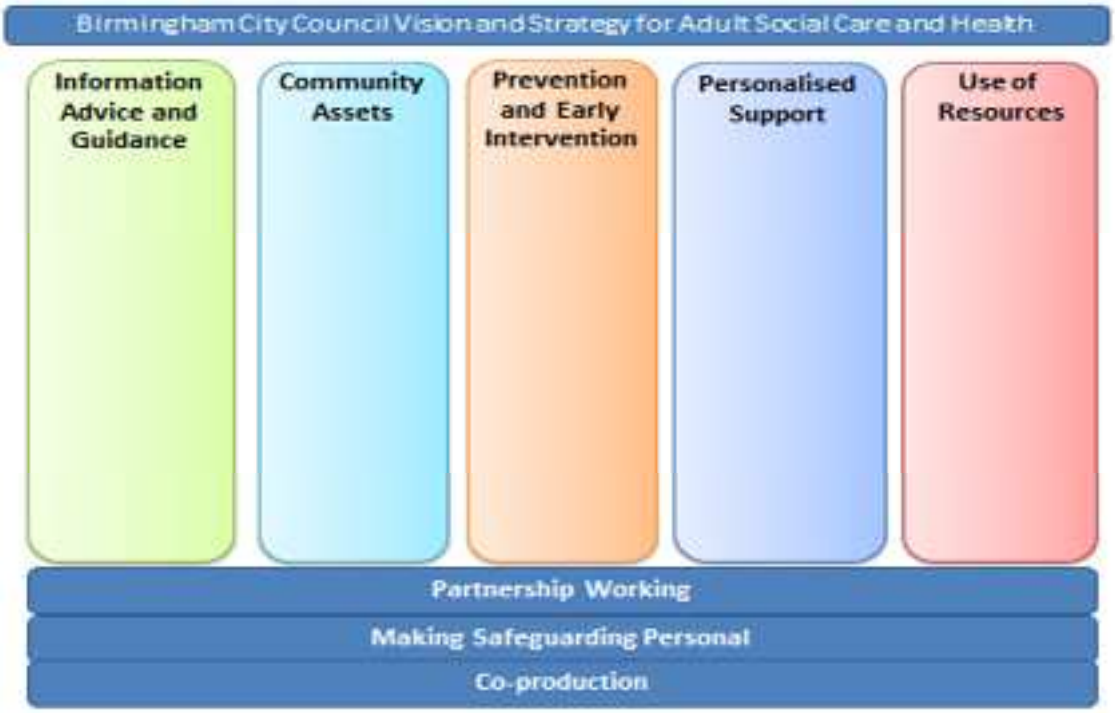
While recognising that for some people there is a need to protect them, it is essential that we ensure we "make safeguarding personal". It is essential that we understand what outcomes people want from safeguarding enquiries and actions. In this area, there is a balance to be achieved. It is essential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

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

Co-production

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

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



Graeme Betts

	Agenda Item: 10
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**3 October 2017**
TITLE:	**BIRMINGHAM BETTER CARE FUND PLAN 2017/18/19**
Organisation	**Birmingham Better Care Fund**
Presenting Officer	**John Denley**

Report Type:	**Decision**

1. Purpose:

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

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

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

1.4 The Integration and Better Care Fund plan for 2017-18 and 2018-19 is a requirement of the policy framework agreed by the Department of Health (DH) and the Department for Communities and Local Governments (DCLG), developed in partnership with the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS) and NHS England.

1.5 This is the third Better Care Fund plan for Birmingham. It builds on the plans and progress of the previous two years and has been agreed by the Birmingham BCF Commissioning Executive, Birmingham and Solihull Sustainability and Transformation Plan (STP) Board and Sandwell and West Birmingham Strategic Commissioning and Redesign Committee.

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

3.	**Recommendation**
	Board members are asked to approve the narrative plan and planning template.

4.	**Background**
	The plan includes:
4.1	Information about the national planning requirements and how Birmingham plans to meet them.
4.2	Details of local financial allocations including CCG and Local Authority contributions to the pooled budget and additional iBCF allocations.
4.3	Information about those National Metrics BCF will be measured against.
4.4	Clear planning reflecting integration and alignment of BCF with 'Out of Hospital' work-streams
4.5	A description of developing governance and accountability arrangements

5.	**Compliance Issues**
5.1	***Strategy Implications***
	Health and Wellbeing Boards have overall responsibility to ensuring the

	integration of health and care functions within their localities and it is a requirement of the BCF that local plans are agreed by Health and Wellbeing Boards.
5.2	***Governance & Delivery***
	Governance arrangements link firmly with the Bsol STP plan, Adult Social Care Transformation and NHS Commissioning Reform. For this reason, the BCF will complement the refreshed approach to the BSol STP and its governance. This is a significant move from the previous BCF programme and governance arrangements, which was set separately to the other system programmes. This is described below.
5.3	***Management Responsibility***
	Louise Collett Service Director Commissioning John Denley Assistant Director – Commissioning

6.	**Risk Analysis**
	A detailed Risk Assessment is included in the narrative plan.

Appendices
Birmingham Integration and Better Care Narrative Plan 2017/19

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

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

Mary Latter,
Programme Manager BCF

BIRMINGHAM BETTER CARE

Birmingham Integration and Better Care

Narrative Plan - 2017/19

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1. Approval and Sign Off

KLOE

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

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

1.1. Summary of plan

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

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

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

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

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

1.2 Budget/Pooled funds

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

KLOE

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

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

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Planned Funding Analysis for 2017/18 & 2018/19

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Local Authority Contribution	**14,103,000**	**11,392,294**	**12,019,620**
iBCF Contribution	**0**	**33,792,214**	**47,327,714**
Minimum CCG Contributions			
Birmingham Cross City CCG	*47,735,704*	*48,590,174*	*49,513,387*
Birmingham South & Central CCG	*16,411,906*	*16,705,679*	*17,023,087*
Birmingham South & Central CCG Practice Transfer Adjustment	*0*	*468,694*	*468,694*
Sandwell & West Birmingham CCG	*11,792,306*	*12,003,388*	*12,231,453*
Sandwell & West Birmingham CCG Practice Transfer Adjustment	*0*	*(468,694)*	*(468,694)*
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1.3. Approval and Signatures

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

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

KLOE

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2. Our vision

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

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

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

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

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

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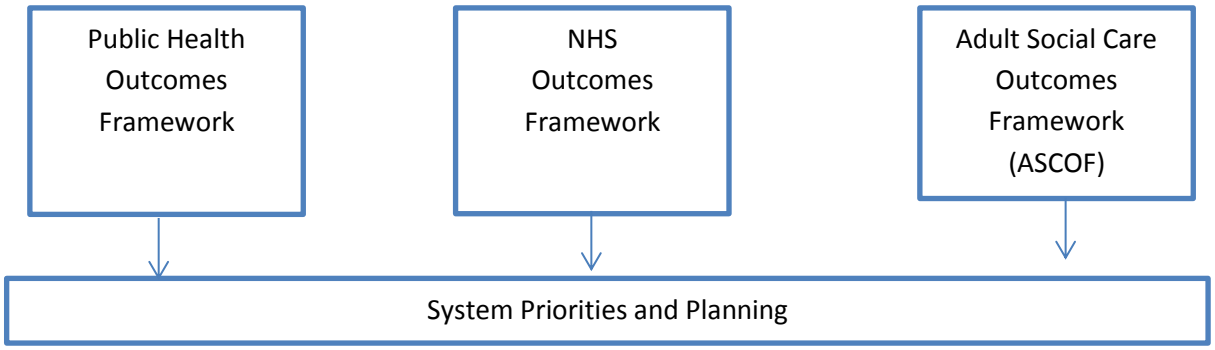
- It remains underpinned by the Birmingham JSNA function which provides a useful oversight and comparison of how the Birmingham health and social care 'system' is performing now, utilising nationally set indicators. The indicators are brought together in the form of three key national frameworks which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



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

3. Background factors and context to the plan

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

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

4. Health and Social care integration

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

KLOE

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

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

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

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

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

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

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

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

KLOE

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

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

5. Understanding Birmingham

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

5.1. Health and Wellbeing

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

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

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

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

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

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

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

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

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

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5.2 Quality Gaps

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

PRIMARY CARE – ACUTE CARE – POST ACUTE CARE INTERFACES

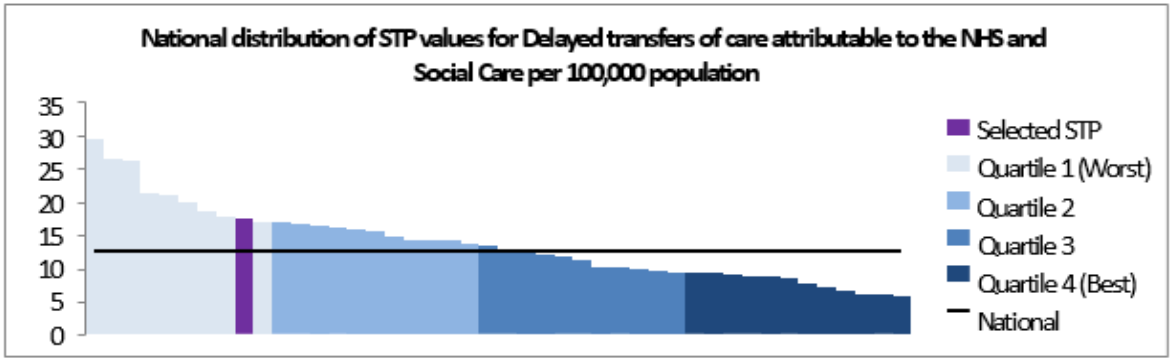
This relates to key 'touchpoints' or hand-off's between the sectors e.g. primary care to the acute sector or from the acute sector to community or social care. Analysis on total spend shows that 8% of the over 65s account for 62% of total spend - which reflects the significance of these touch points.

A & E ADMISSIONS

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

DELAYED TRANSFERS OF CARE (DTOC)

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



A AND E ATTENDANCES

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

CHC AND DOMICILIARY SERVICES

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

PRIMARY CARE

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

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

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

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

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5.3 Financial Gap

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

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

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

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

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

KLOE

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

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

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

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

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

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

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

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

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6 Our approach

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

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

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

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

6.1. The Contribution of the BCF

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

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

2

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

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

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

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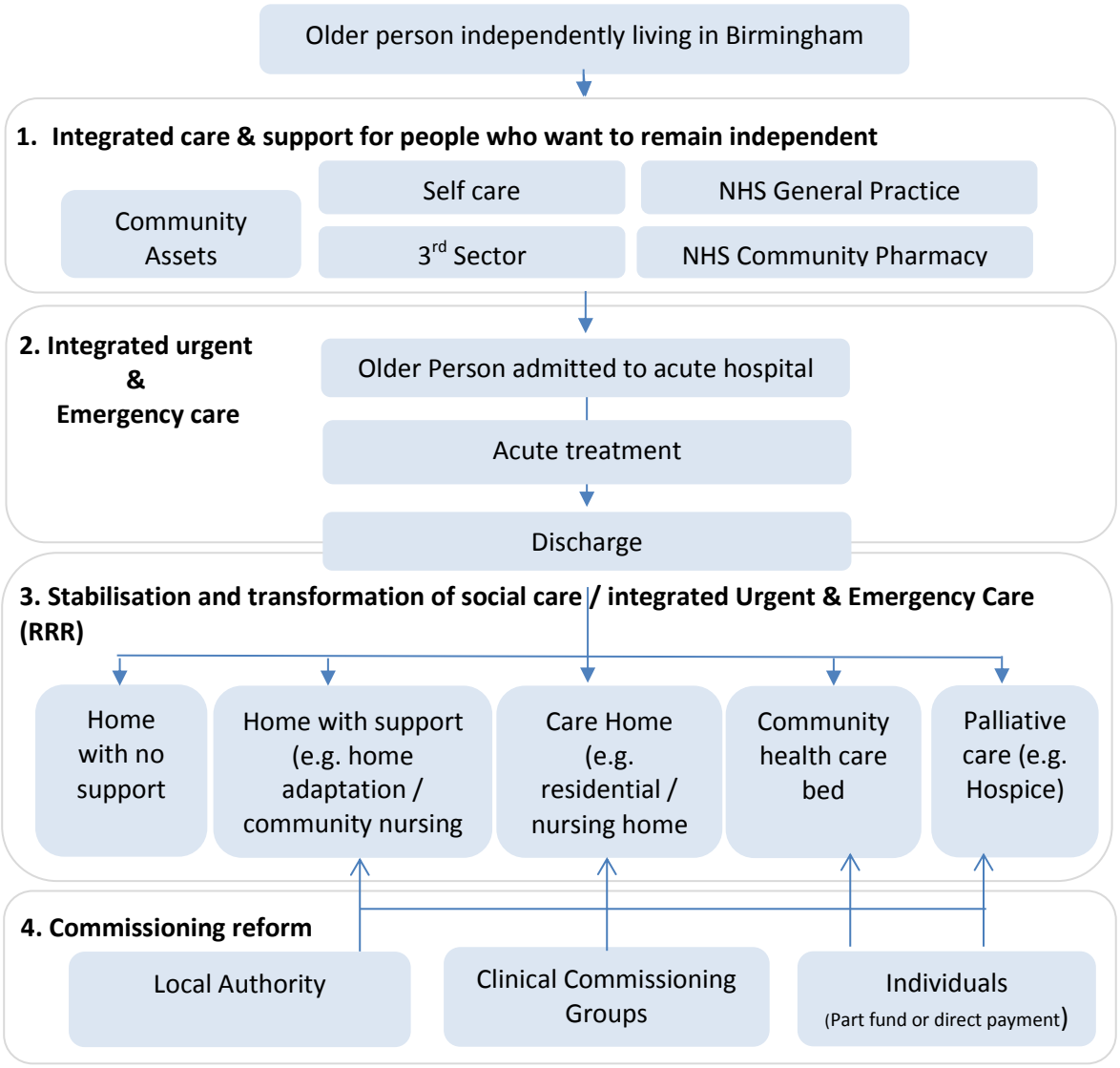
- Our approach will focus on the Birmingham citizen, keeping them as independent for as long as possible. If citizens require support to retain or regain independence, they will be able to find this support in their own community. If further support is required from our health and social care system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



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

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

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

7 What will success look like?

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

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

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8. Local Area Performance Metrics

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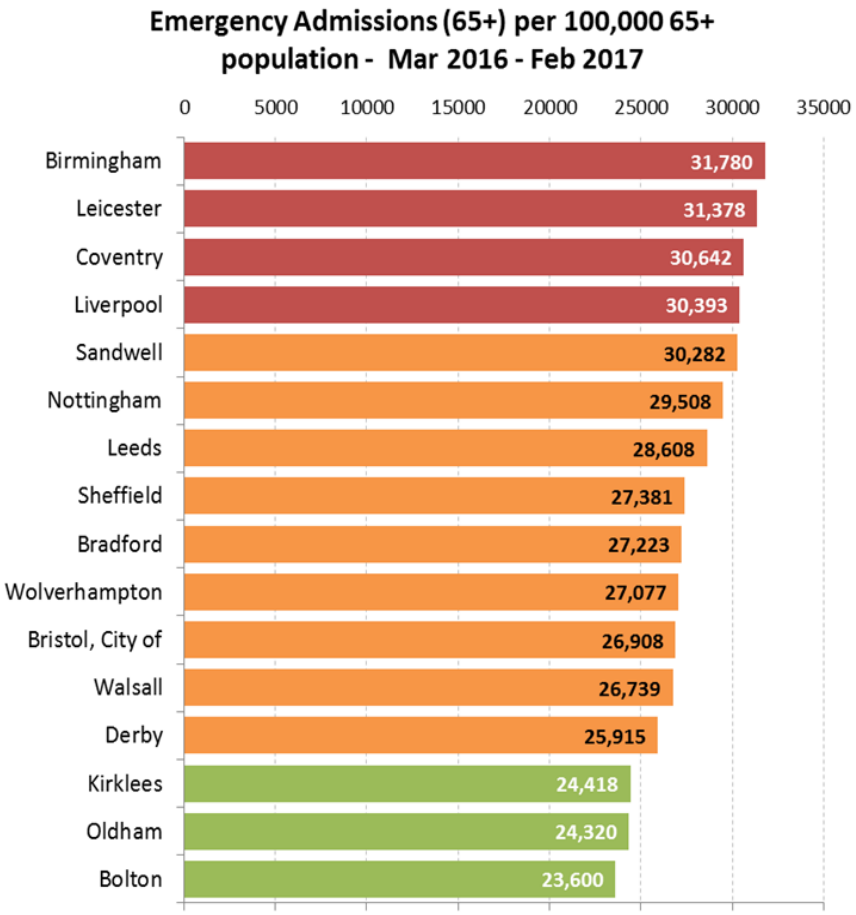
- The BCF policy framework establishes that the national metrics for measuring the progress of integration through the BCF will continue as they were set out for 2016-17. With the exception of measuring Patient satisfaction.

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

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

8.1. Emergency Admissions



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

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

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

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

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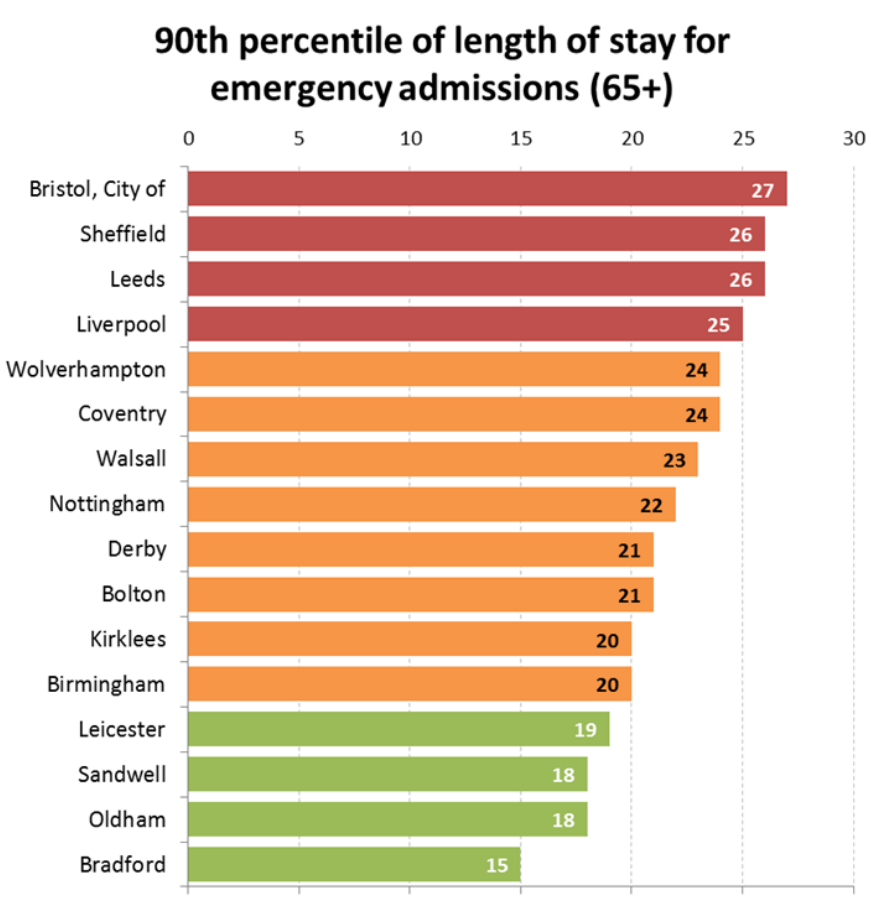
integrated across the system. The *'Hospital to Home'* element of this programme is one of the foundations of the 17/19 BCF and there will be links into the work being undertaken with Newton.

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

8.2. Length of stay



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

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

Overall Rank **55th**
20 days

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

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

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

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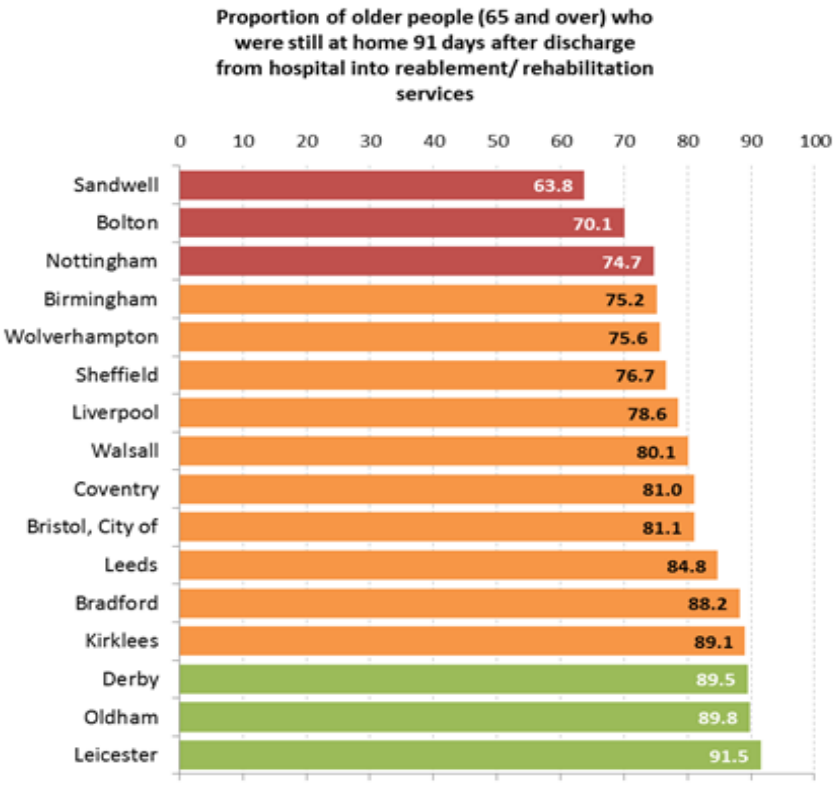
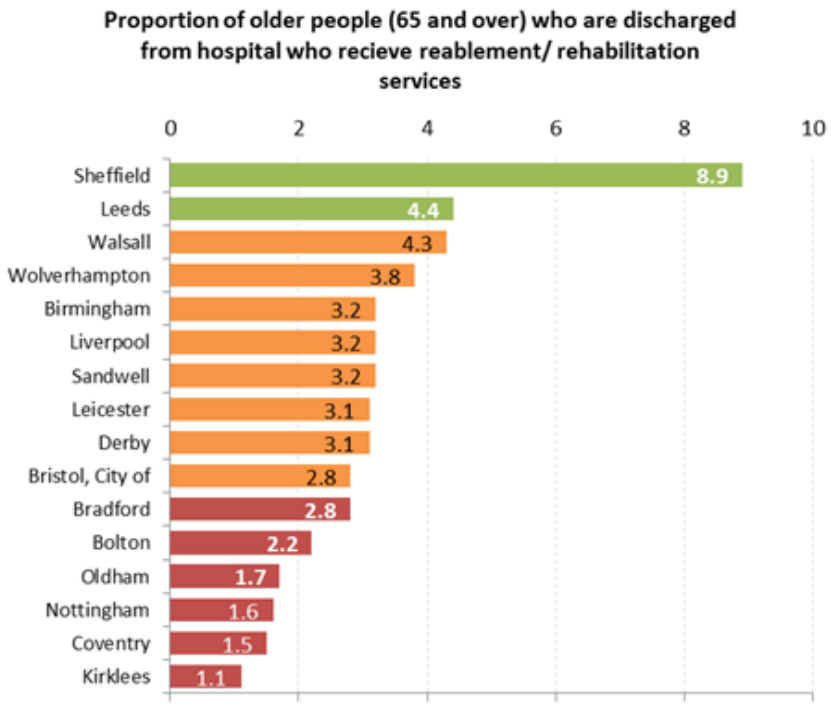
8.3. Reablement



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

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



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

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

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

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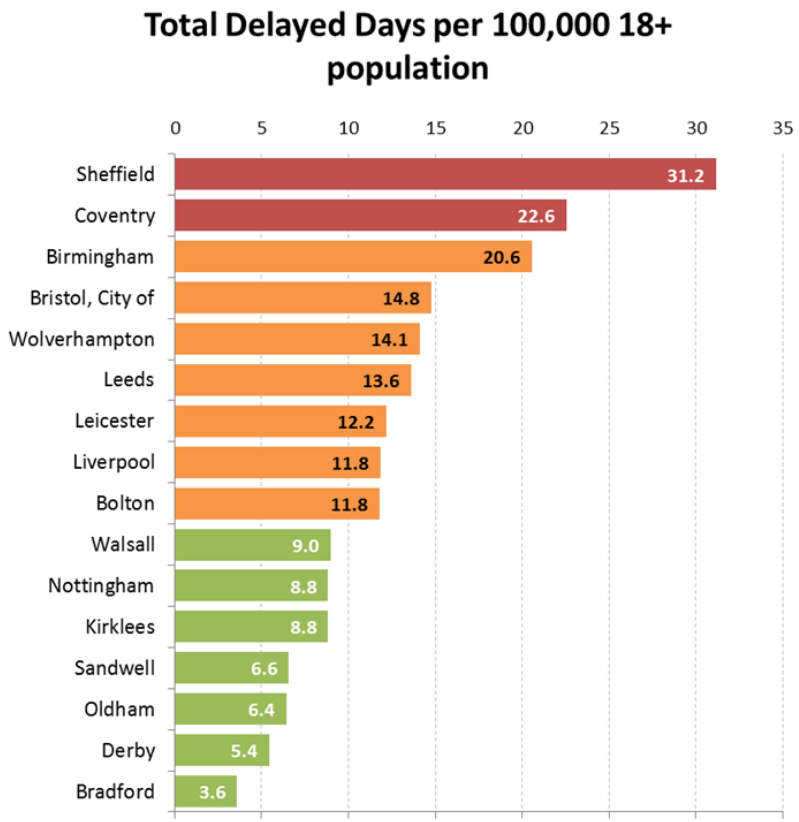
8.4. Admissions to residential and care homes

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

8.5. Delayed Transfer of Care



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

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

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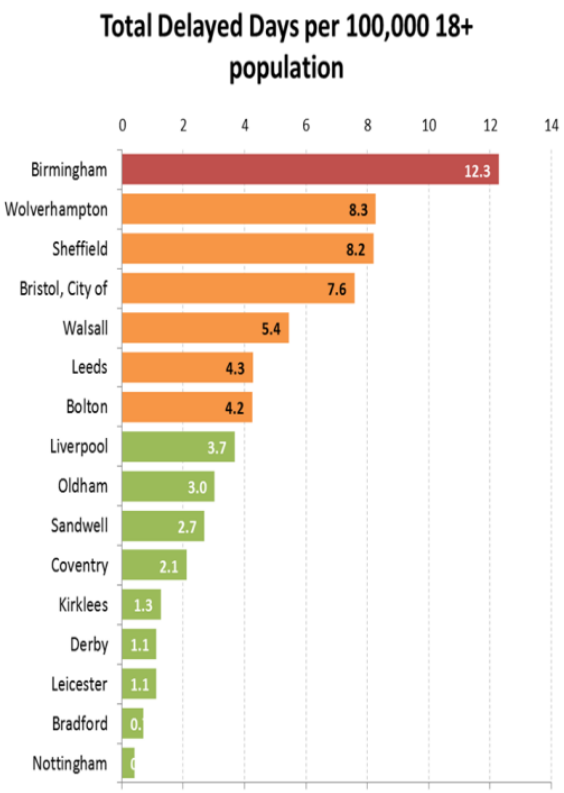
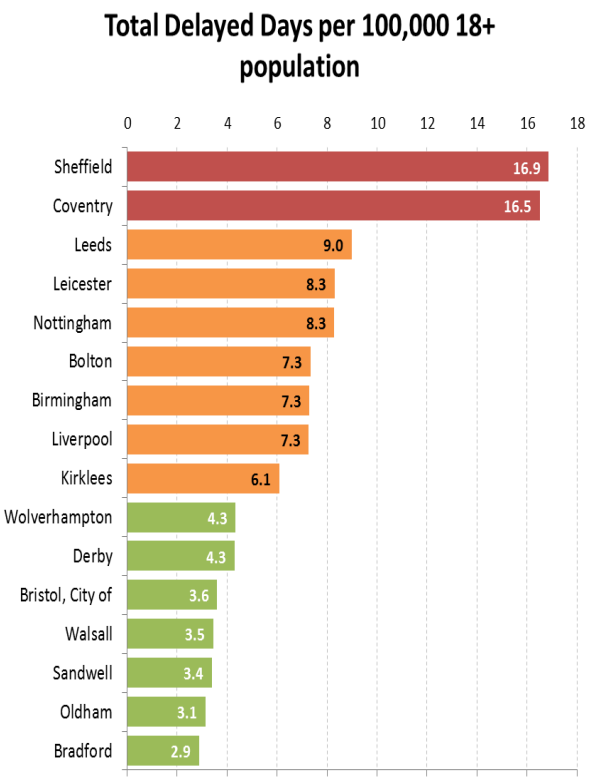
- **Birmingham Performance:** In 2016/17, Birmingham residents experienced a total of 58,379 delayed days. The majority of these delays occurred in five Trusts: UHBFT, BSMHT, HEFT, BCHFT, and SWBFT. The charts below show performance split between Social Care and NHS Delays. Birmingham is a considerably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

Social Care Delayed Transfer of Care



NHS Delayed Transfer of Care



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

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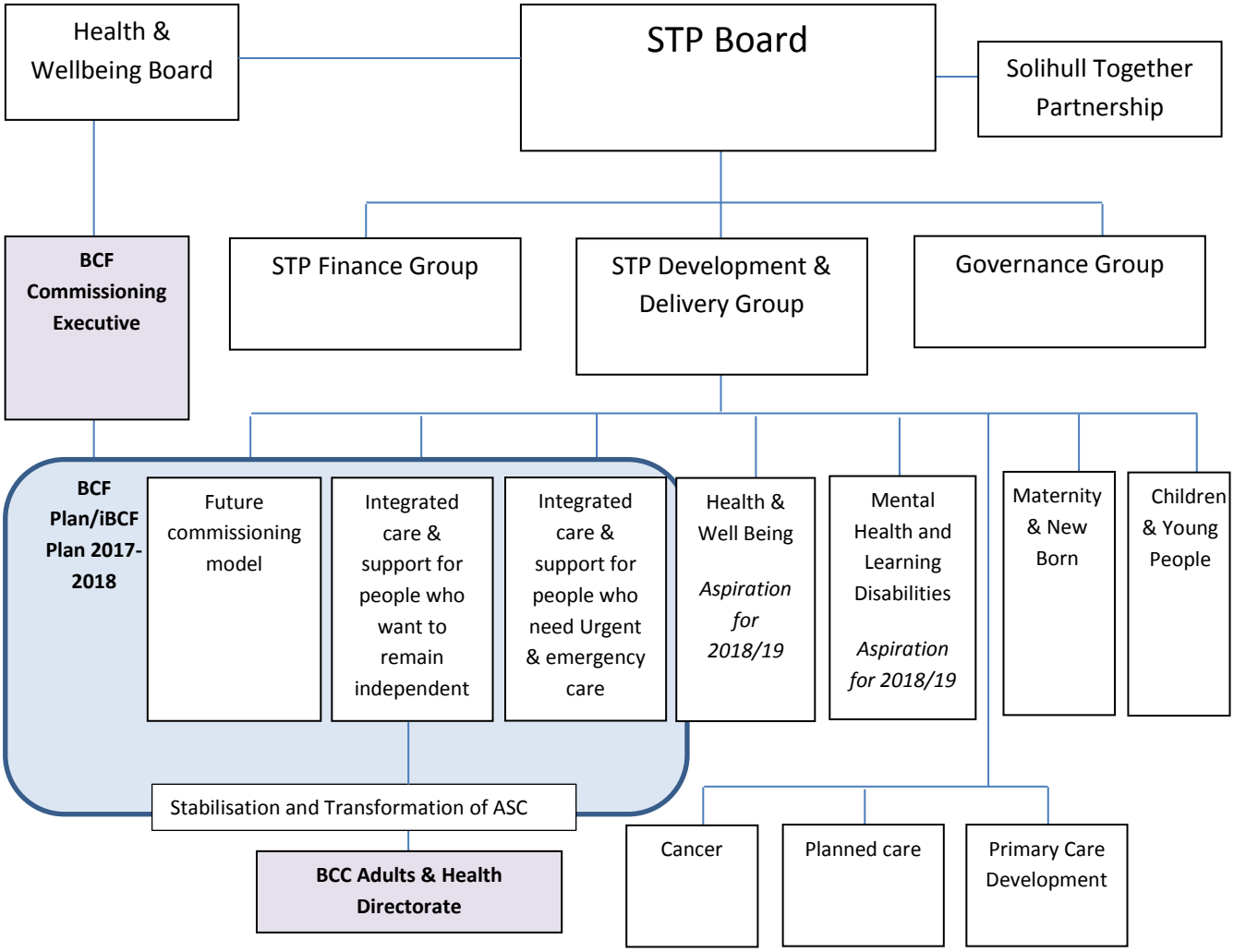
9. Governance

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

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



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

10. Better Care Fund plan 17/19

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

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

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

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

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

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

BCF Programme areas

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

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

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

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

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

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

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

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

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

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

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

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11. Key Programme initiatives

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

11.1. System Diagnostic (Newton) Crisis and Recovery Strategy

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

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

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

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

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

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

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

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

13, 14, 17, 18,

11.2. Clinical Utilization Tool Implementation

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

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

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

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

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

11.3. Carers

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

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

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

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

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11.4. Dementia Strategy

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

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

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

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

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

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

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

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

11.5. Supporting Communities

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

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11.6. Multi Disciplinary Teams (MDTs)

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

11.7. Care Homes

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

11.8. Virtual beds

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

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

11.9. Disabled Facilities Grant (DFG)

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

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

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

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

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

11.10. iBCF priorities

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

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

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

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

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

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

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

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

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

12.1. Information, advice and guidance

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

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

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

12.2. Personalised support

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

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

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

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

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12.3. Community assets

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

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

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

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

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

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12.4. Prevention and early intervention

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

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

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

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

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

12.5. Partnership working

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

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

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

12.6. Making safeguarding personal

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

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

12.7. Co-production

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13.2. Commissioned social care

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

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

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

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

- The approach has been consulted on with implementation from April 2018.

13.3. Prevention First: An integrated Approach

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

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

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

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

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

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

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

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

14.Focus on Delayed Transfers of Care (DTOC)

14.1. Background

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

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

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

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14.2. Current Position

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

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

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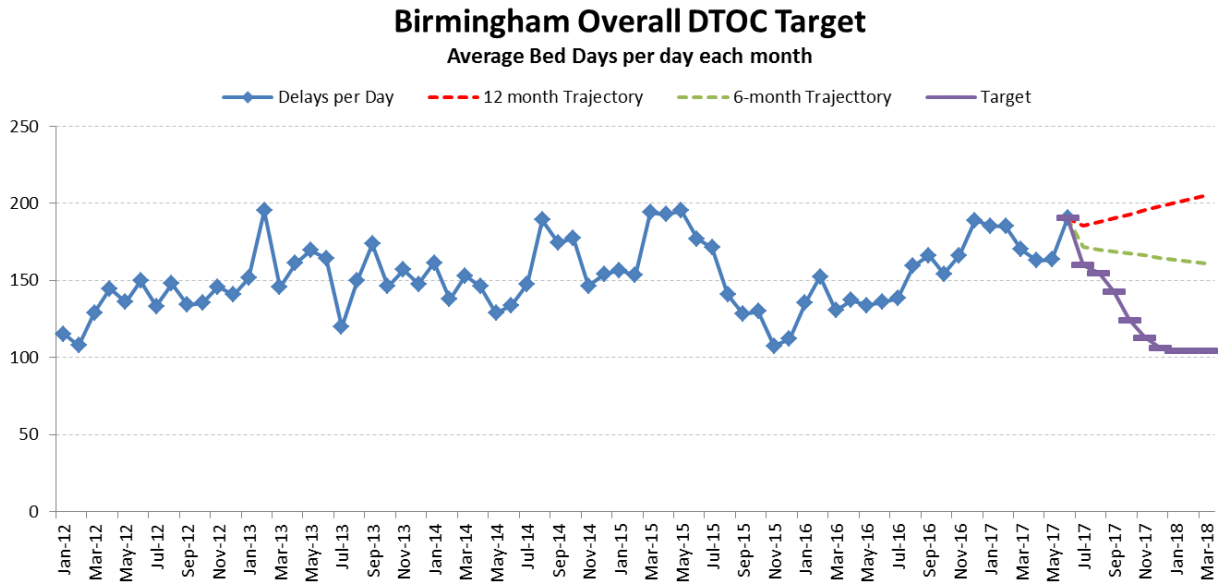
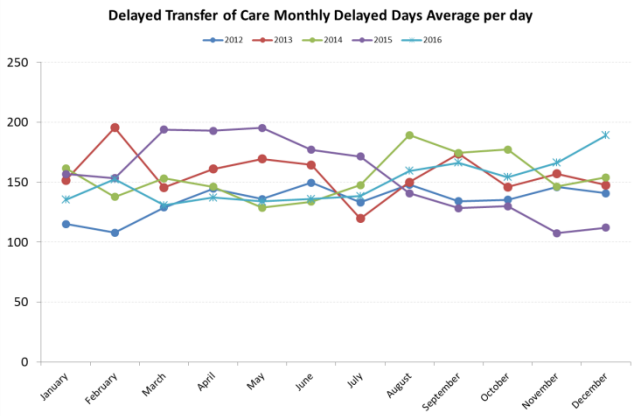
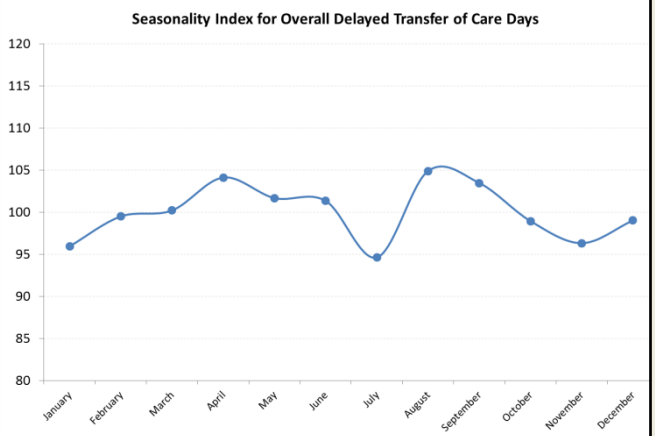
	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
NHS attributed delayed days	1956	1840	1673	1508	1393	1440	1440	1300	1440
Social Care attributed delayed days	2675	2644	2317	2078	1737	1587	1526	1378	1526
Jointly attributed delayed days	329	316	290	269	253	262	262	236	262
Total Delayed Days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



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





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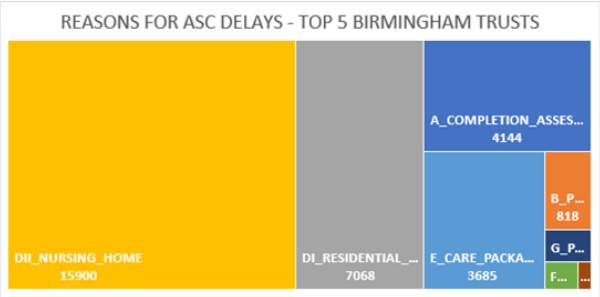

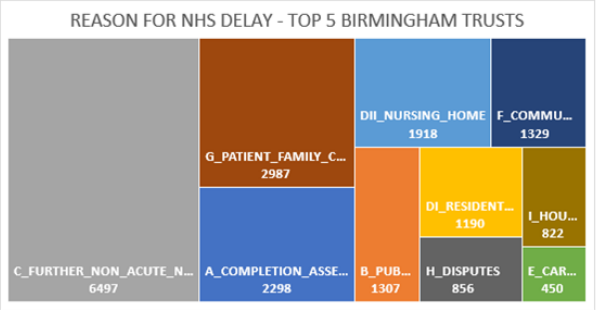

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Monthly Delayed Transfers of Care 'SitRep' returns provide further information about the reasons Birmingham residents have been delayed in hospital and provide some insight into the improvement effort and capacity requirements in the Birmingham system.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

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

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

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

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

12

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

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

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

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

14.5. Longer term Activity

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

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

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

National Milestones	Local Deliverables	KLOE
Early Discharge Planning: In emergency/ unscheduled care, robust systems need to be in place to develop plans for management and discharge and to allow an expected date of discharge to be set within 48 hours	**HEFT:** LOS reduction programme - supported by relevant task and finish groups	12
	UHB: Unscheduled Care Board	
Systems to monitor patient flows: Robust patient flow models for health and social care, including electronic flow system, enable teams to identify and manage problems and to plan services around the individual	Newton Review	11
	Developing an integrated service which appropriately supports ED and short stay units – capacity and flow modelling, systems and processes	12
	Data sharing agreement, integrated IT systems and processes tested at UHB as part of trusted assessor project	
Multidisciplinary/ multi agency Discharge Teams including the voluntary and independent sectors: Co-ordinated discharge planning based upon joint assessment processes and protocols, and on shared agreed responsibilities, promotes effective	Newton Review	12
	Developing an integrated service (including CHC) which appropriately supports ED and short stay units - this will be a consistent service over 7 days and will include BCHC rapid response and mental health requirements to support those in crisis	

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

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

15.Review of National Conditions

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

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

- The following section outlines how these conditions have been met

15.1. National Condition One: A jointly agreed plan

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

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

15.2. National Condition 2: Social Care maintenance

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

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

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

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

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

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

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

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

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

8

- No contingency fund has been allocated against BCF

10

15.4. National Condition 4: Managing Transfers of Care

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

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16. Finance

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

17.Assessment of Risk and Risk Management

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

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

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

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

The risks and Risk assessment is described below

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

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

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

Appendix 1

Birmingham Better Care Plan - Key Lines Of Enquiry

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

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

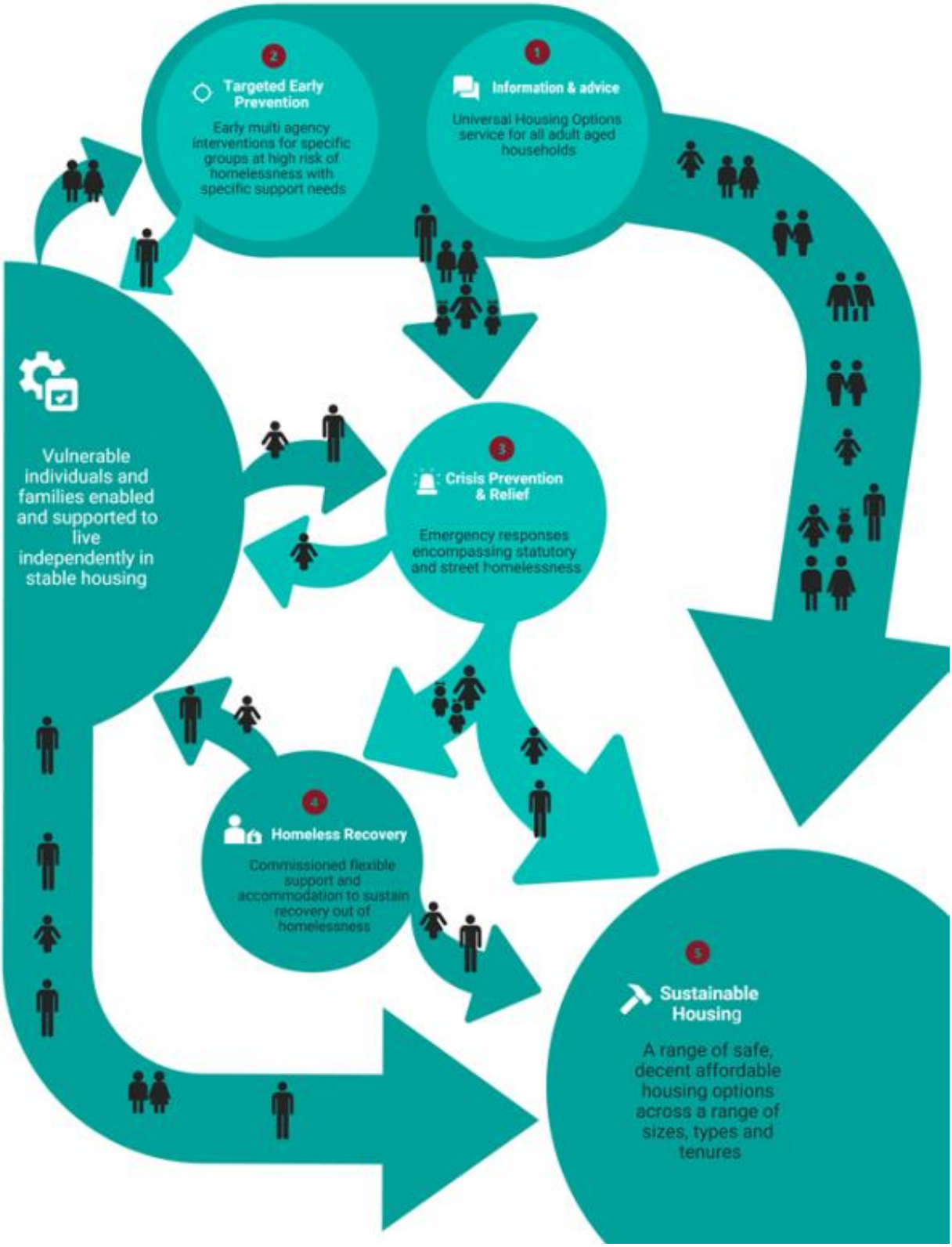
Approach to programme delivery and control	**8.Is there a clear, jointly agreed approach to manage the delivery of the programme, identify learning and insight and take timely corrective and preventive action when needed?**	18. A description of the specifics of the overarching governance and accountability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

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

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

Appendix 2

Homelessness Prevention Positive Pathway



	Agenda Item: 11
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**3 October 2017**
TITLE:	**CARE QUALITY COMMISSION: REVIEW OF SOCIAL CARE & HEALTH SYSTEM**
Organisation	**Birmingham City Council**
Presenting Officer	**Graeme Betts, Interim Corporate Director**
Report Type:	**Information**

1.	**Purpose:**
	The purpose of this report is to provide the Health and Wellbeing Board with information about the forthcoming Care Quality Commission review in Birmingham – including requirements - early in the process.

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

3.	**Recommendations**
	The Board is recommended to
3.1	Note the contents of this report.
3.2	Note the intention to provide a progress report to the Health and Wellbeing Operations Group in November.
3.3	Agrees to promote the CQC Review across the Adult Social Care and Health system.

4. Background

4.1 Care Quality Commission Review in Birmingham

4.1.1 The Care Quality Commission (CQC) has announced that it will be reviewing Adult Social Care and Health systems across the country. Birmingham has been selected as one of the 12 Localities to be reviewed in the first phase. The review of the Birmingham Social Care and Health system is currently scheduled to commence on 04 December 2017 (subject to confirmation) for a period of 14 weeks.

4.1.2 The CQC review programme was announced at the same time as the publication of a written ministerial statement from the Secretary for Health, the publication of an integrated Social Care and Health scorecard and the release of planning requirements for the Better Care Fund (BCF).

4.1.3 This co-ordinated release reinforces a clear message that the government is expecting that increased levels of funding for Local Authorities through the Improved Better Care Fund (IBCF) will translate into significant reductions in the level of delayed transfers of care (DTOCs).

4.1.4 The BCF planning requirements include a requirement on Localities to put in place plans to meet the expected targets for Adult Social Care DTOCs. The CQC review will be used to test the effectiveness of the planning and activity to address these targets.

4.1.5 We anticipate that delayed discharges of medically fit people from hospital to social care are likely to be a key area of scrutiny. The implications of being judged as 'poorly performing' or 'lacking the leadership to improve' could result in a reduction in Better Care Funding.

4.2 Focus of the Review

The review will focus on:

'How well do people move through the Health and Social Care system, with a particular focus on the interface between the two, and what improvements could be made?'

4.3 How has Birmingham been selected?

4.3.1 The integrated Social Care and Health scorecard has been used as the basis for selecting the first group of localities to be reviewed. The scorecard is based on 6 measures that are weighted and then combined to create an overall national ranking (Appendix 1).

4.3.2 The six measures used can each give an indication about how aspects of the Adult Social care and Health system are performing:

- Emergency admissions (1) can indicate how good collaboration is in the system in supporting good management of long term conditions.
- The 90th percentile length of stay of emergency admissions (2) can indicate poor patient flow out of hospital and can then highlight downstream blockages.
- Total delayed days (3) and proportion of weekend discharges (6) are indicators of how

effective the interface is between health and adult social care and joint working of local partners seven days a week.

- The proportion of older people still at home 91 days after discharge (4) and proportion of older people receiving reablement services (5) captures the joint working of social services, health staff and commissioned services to keep people at home.

4.3.3 Birmingham has been selected because the Adult Social Care and Health system that includes NHS trusts, Clinical Commissioning Groups, Birmingham City Council and Care Providers, has been identified as one of the 'most challenged' nationally based on the ranking provided by the integrated Social Care and Health scorecard (Table 1).

Table 1: Most Challenged Local Authorities

Local Authority	National Rank	Included in CQC Review
Oxfordshire	135	Yes
Birmingham	136	Yes
East Sussex	137	Yes
York	138	Yes
Coventry	139	Yes
Plymouth	140	Yes
Hartlepool	141	Yes
South Tyneside	142	No
Bracknell Forest	143	Yes
Manchester	144	Yes
Sheffield	145	No
Halton	146	Yes
Trafford	147	Yes
Northamptonshire	148	No
Stoke-on-Trent	149	Yes
Cumbria	150	No

4.3.4 The performance of Birmingham's system relative to Local Authorities that are similar to our population mix and socio-economic factors etc can be seen in Appendix 2.

4.4 Methodology of the CQC review

4.4.1 Full details of the methodology for the review were presented to the CQC board on 19 July 2017 (http://www.cqc.org.uk/about-us/board-meetings/care-qualitycommission-board-meeting-19-july-2017). The published methodology should be viewed as provisional as it is likely to evolve as CQC learn from the experience of the first reviews in the phase.

4.4.2 The methodology highlights a number of **key elements** which require all partners of the system to engage with and contribution to during the pre-preparation and preparation phase of the review. These include:

- System Overview Information Request (self - assessment)
- Relationship Audit Tool.

4.4.3 The scope of the review is defined in the CQC's **Key Lines of Enquiry** (KLOEs). These are:

- Safe
- Effective
- Caring
- Responsive
- Well-led*
- Resource Governance

* Please note the focus on the '**Well-led'** KLOE. Further detail can be found in Appendix 3.

4.4.4 Further to the KLOEs, CQC have also identified **key system pressure points** that they will explore. These are:

- Maintenance of people's health and well-being in their usual place of residence
- Multiple confusing points to navigate in the system
- Varied access to GPs/urgent care centres/community care
- Varied access to alternative hospital admission
- Ambulance interface
- Discharge planning delays and varied access to ongoing Health and Social Care
- Varied access to re-enablement
- Transfer from re-enablement

4.5 Timetable for the Review

4.5.1 As per 4.1, the review of the Birmingham Social Care and Health system is currently scheduled to commence on 04 December 2017 (subject to confirmation) for an extensive period of 14 weeks.

4.5.2 The activities which need to be undertaken are as follows:

Weeks 1-6	Completion of self-assessment, information requests, data profiles, preparation meetings with review teams, initial meeting of reviewers with local partners and service users and survey to test relationships within the system.
Week 7	Review team analyse documents and data that have been provided.
Week 8	'The Review' (week commencing 22 January 2018)

Day 1: Focus groups with staff, service users, carers and third sector representatives
Day 2-3: Interface pathway interviews. Focus on individual people's journeys through the system using scenarios, case tracking and dip sampling
Day 4: Well-led interviews – interviews with senior leaders across the system
Day 5: Final interviews, mop-up and feedback

Week 9 Report writing

Weeks 10-12 Quality Assurance of the content

Weeks 12-14 Communications: feedback report/letter of advice for the system and a local summit with improvement partners

4.6 The Review Team

The review team will consist of a team of 2 CQC Inspectors supported by 2-3 Specialist Advisors (drawn from a selection of 40 Chief Executive Officers and Director of Adult Social Services. CQC are also intending to supplement this with advisors with Health and Commissioning experience.

4.7 Further Information

For further information please contact Mike Walsh, Head of Service, Directorate for Adult Social Care and Health at Michael.walsh@birmingham.gov.uk or call 0121 464 2186.

5.	**Compliance Issues**
5.1	***Strategy Implications***
	HWB Priority 2: Improve the Independence of Adults
5.2	***Governance & Delivery***
5.2.1	The CQC Review preparations for the whole system are being overseen by the Wider Systems Board chaired by Graeme Betts, Interim Corporate Director for Adult Social Care and Health. Membership of this Board includes senior representatives from across the Health and Social Care system.
5.2.2	Day to day progress is being monitored against the CQC Review Action Plan using robust project management methodology. Progress is reported to the BCC CQC Bi-Weekly Meeting, and onward to the Wider Systems Board on a monthly basis.
5.2.3	It is proposed that a progress report is presented to the Health and Wellbeing Operations Group in November 2017.
5.3	***Management Responsibility***
	The Member of the Board accountable for the CQC Review is Graeme Betts, Interim Corporate Director for Adult Social Care and Health.

The Manager responsible for day to day delivery is Louise Collett, Service Director – Commissioning, Directorate for Adult Social Care and Health

6. Risk Analysis

Risk analysis will be ongoing throughout preparation for the Review. An early analysis identifies the following:

Identified Risk	Likelihood	Impact	Actions to Manage Risk
There is a risk that the outcome of the CQC review will be poor which may lead to a reduction in Better Care Fund funding for the city.	Medium	High	• Undertake an early draft of the SOIRE with all partners to understand Birmingham position, • Communicate key messages to all partners who are required to complete the Relational Audit Tool, • Implement priority actions to tackle and improve Delayed Transfers of Care.
There is a risk that key systems partners may not be effectively engaged in the preparations for the review process that may impact on the position of the system presented in the Systems Overview Information Request submission and Relational Audit Tool.	Medium	High	• Ongoing briefing and engagement of all key systems partners.

Appendices

Appendix 1 – Scorecard Measures
Appendix 2 – System Performance
Appendix 3 – Key Lines of Enquiry (KLOEs)

Signatures

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

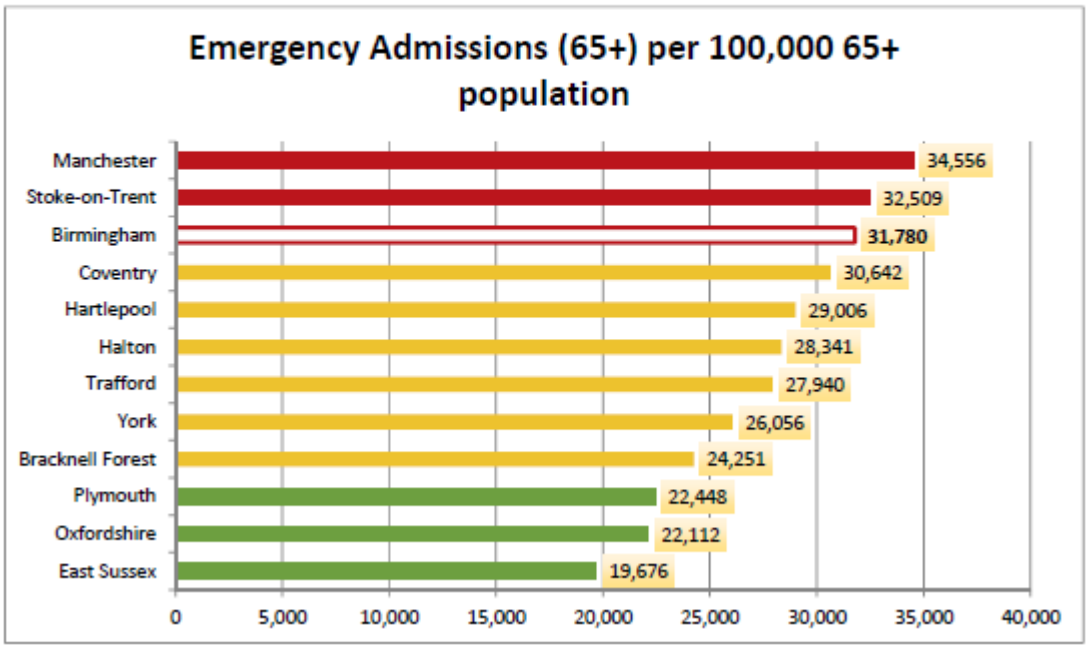
The following people have been involved in the preparation of this board paper:
Mike Walsh, Head of Service, Directorate for Adult Social Care and Health
Michael.walsh@birmingham.gov.uk and 0121 464 2186.

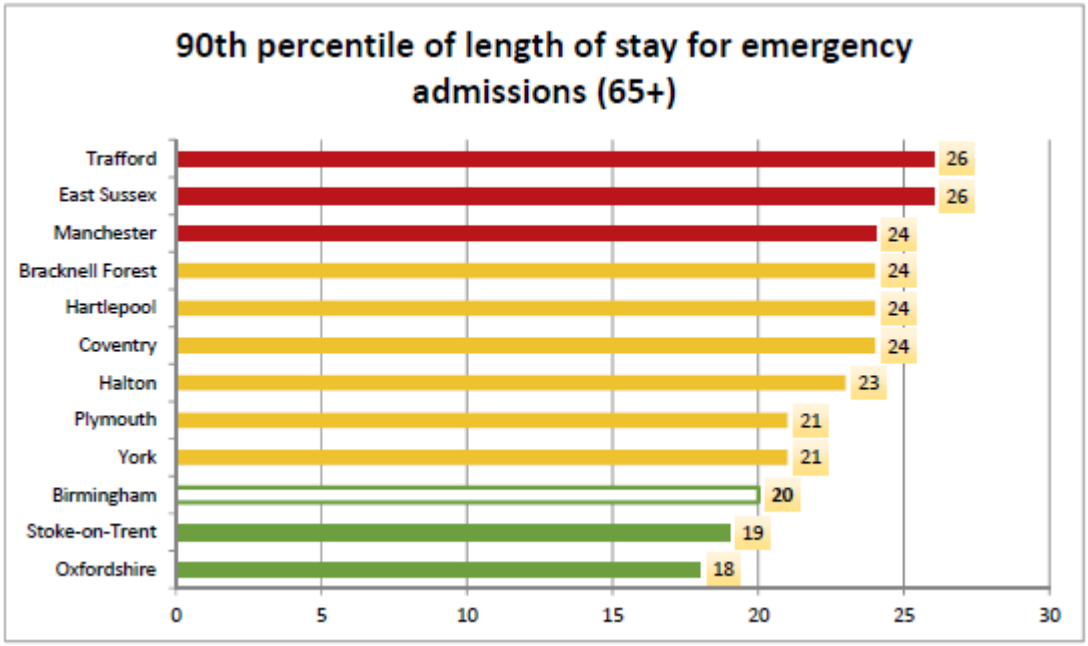
Appendix 1 - Scorecard Measures

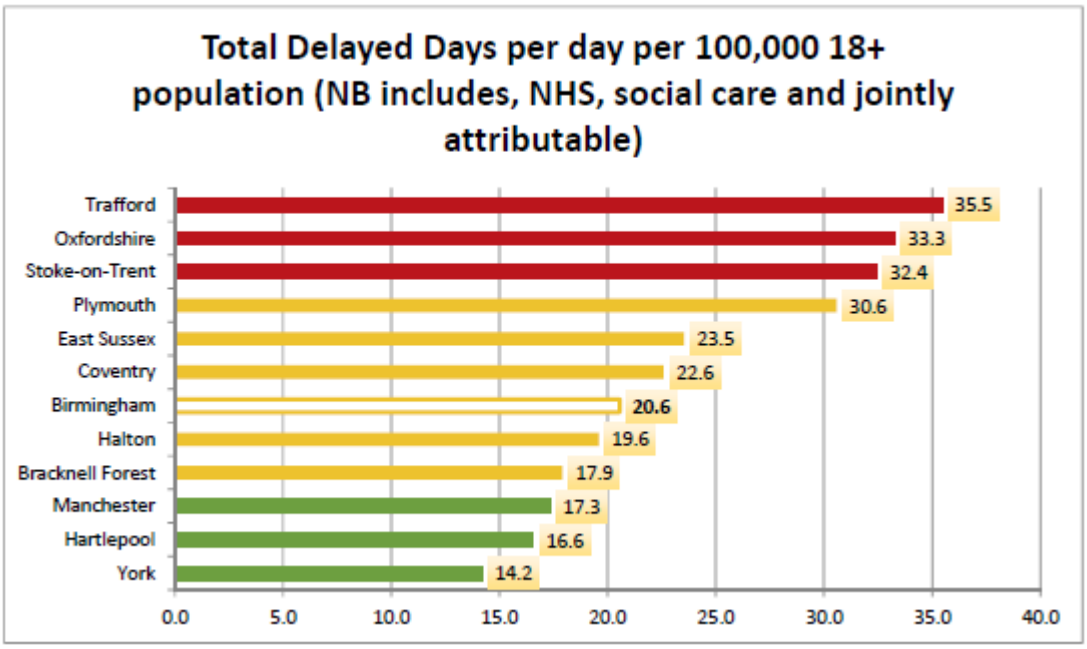
ID	Indicators	What this indicates about the system	Full definition
1	Emergency Admissions (65+) per 100,000 65+ population	Can indicate how good collaboration across the health and care system is to support good management of long term conditions	(Emergency admissions for those with identified age (65+) resident in a local authority) divided by; (Local authority population 65+/100,000)
2	90th percentile of length of stay for emergency admissions (65+)	Longer lengths of stay can indicate poor patient flow out of hospital and hence downstream blockages	The 90th percentile length of stay following emergency admission. e.g. 10% of patients within a local area have a length of stay longer than X days.
3	TOTAL Delayed Days per day per 100,000 18+ population	This indicates how effective the interface is between Health and Social Care and joint working of local partners	Average number of monthly delayed days (ALL) per day Divided by; (Local authority population 18+/100,000
4	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	This captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement. Reablement services lead to improved outcomes and value for money across the health and social care sectors.	The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital
5	Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation services		The proportion of older people aged 65 and over offered reablement services following discharge from hospital.
6	Proportion of discharges (following emergency admissions) which occur at the weekend	This can indicate successful, joint 24/7 working leading to good flow of people through the system and across the interface between Health and Social Care	Percentage of discharges (following emergency admission) at the weekend

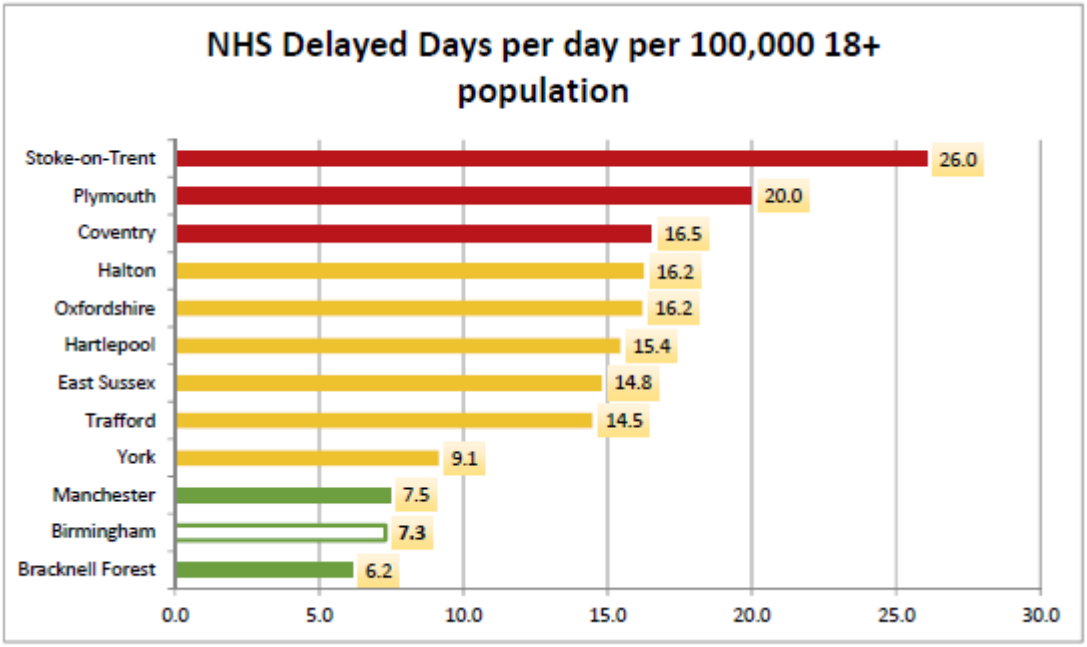
Appendix 2 – System Performance

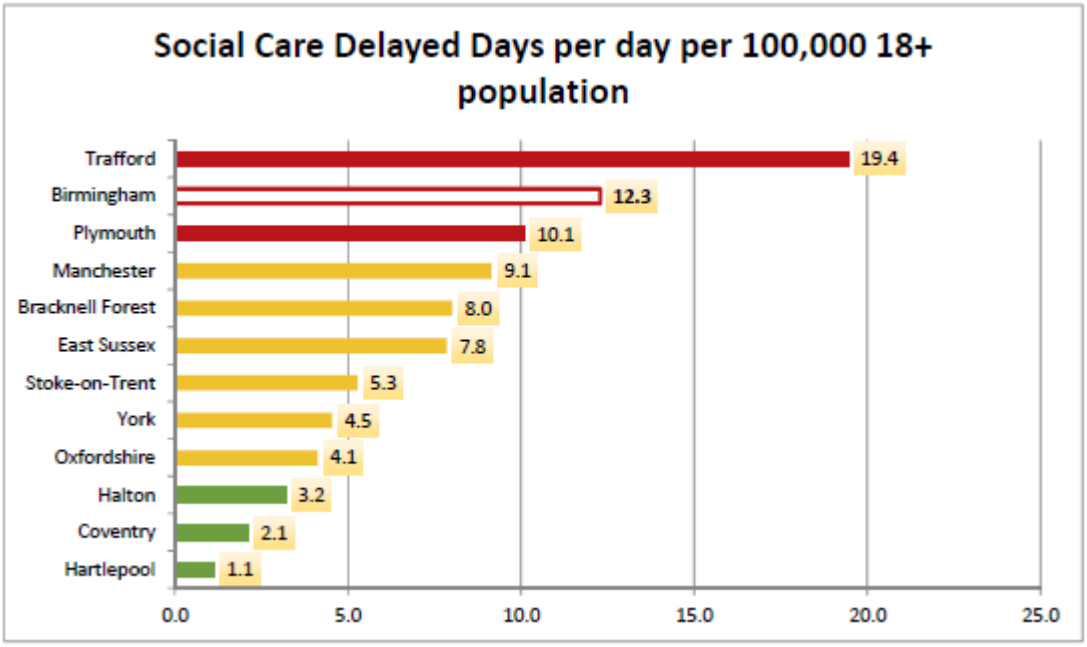
CQC Dashboard (12 Systems to be Reviewed)

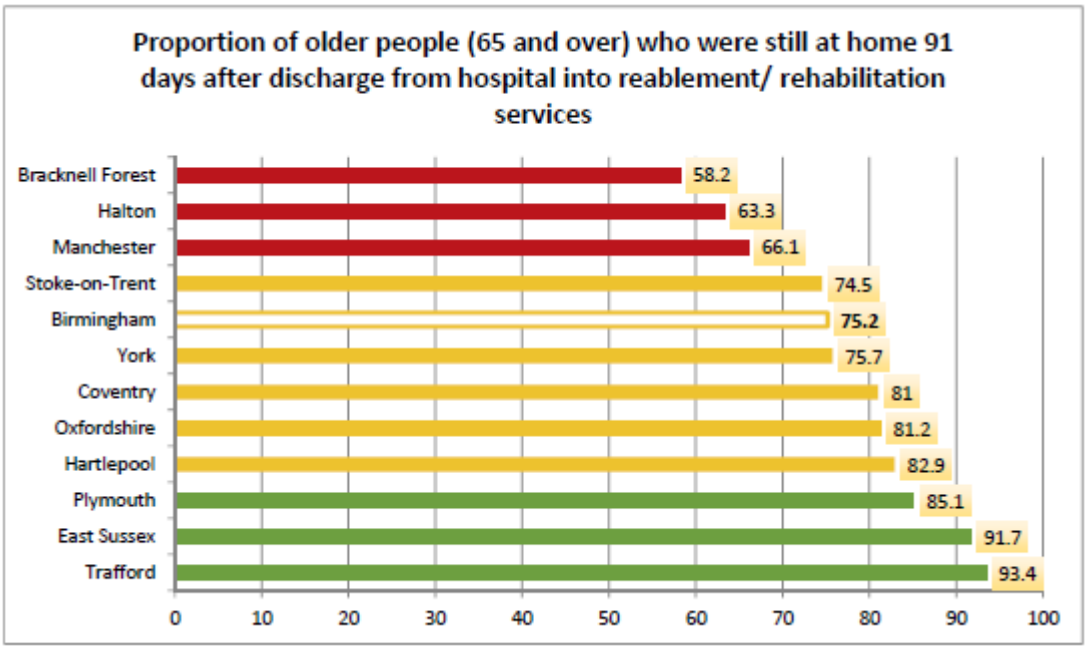


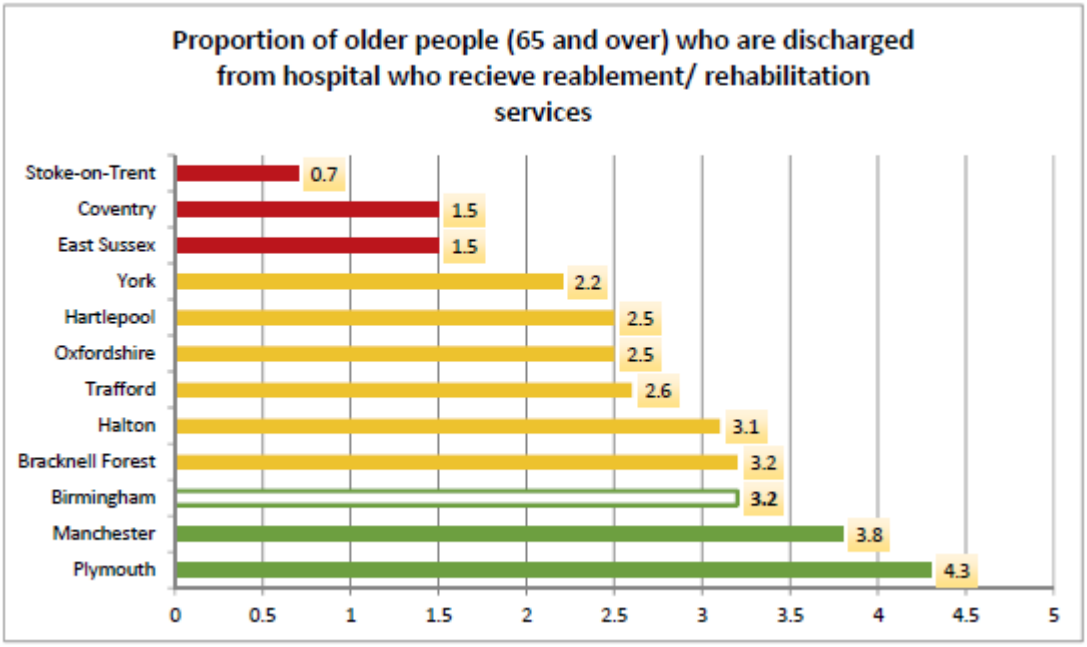


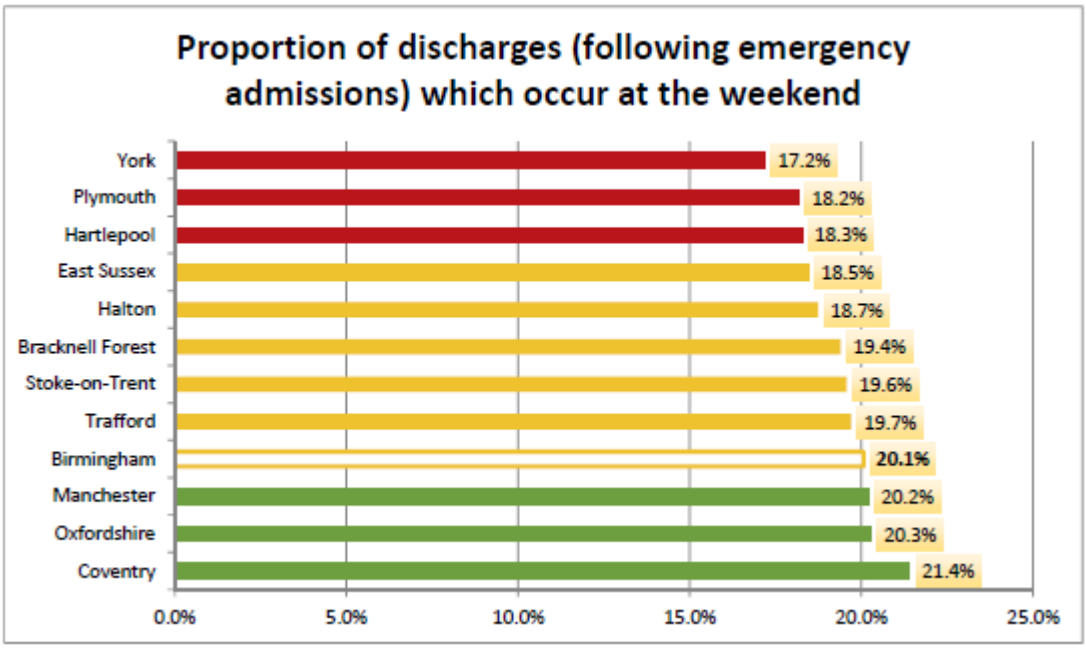

Total Delayed Days per day per 100,000 18+ population (NB includes, NHS, social care and jointly attributable)
Trafford 35.5
Oxfordshire 33.3
Stoke-on-Trent 32.4
Plymouth 30.6
East Sussex 23.5
Coventry 22.6
Birmingham 20.6
Halton 19.6
Bracknell Forest 17.9
Manchester 17.3
Hartlepool 16.6
York 14.2
0.0 5.0 10.0 15.0 20.0 25.0 30.0 35.0 40.0


NHS Delayed Days per day per 100,000 18+ population
Stoke-on-Trent 26.0
Plymouth 20.0
Coventry 16.5
Halton 16.2
Oxfordshire 16.2
Hartlepool 15.4
East Sussex 14.8
Trafford 14.5
York 9.1
Manchester 7.5
Birmingham 7.3
Bracknell Forest 6.2
0.0 5.0 10.0 15.0 20.0 25.0 30.0


Social Care Delayed Days per day per 100,000 18+ population
Trafford
Birmingham
Plymouth
Manchester
Bracknell Forest
East Sussex
Stoke-on-Trent
York
Oxfordshire
Halton
Coventry
Hartlepool
19.4
12.3
10.1
9.1
8.0
7.8
5.3
4.5
4.1
3.2
2.1
1.1
0.0
5.0
10.0
15.0
20.0
25.0


Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services
Bracknell Forest
Halton
Manchester
Stoke-on-Trent
Birmingham
York
Coventry
Oxfordshire
Hartlepool
Plymouth
East Sussex
Trafford
58.2
63.3
66.1
74.5
75.2
75.7
81
81.2
82.9
85.1
91.7
93.4
0
10
20
30
40
50
60
70
80
90
100


Proportion of older people (65 and over) who are discharged from hospital who recieve reablement/ rehabilitation services
Stoke-on-Trent 0.7
Coventry 1.5
East Sussex 1.5
York 2.2
Hartlepool 2.5
Oxfordshire 2.5
Trafford 2.6
Halton 3.1
Bracknell Forest 3.2
Birmingham 3.2
Manchester 3.8
Plymouth 4.3
0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5


Proportion of discharges (following emergency admissions) which occur at the weekend
York 17.2%
Plymouth 18.2%
Hartlepool 18.3%
East Sussex 18.5%
Halton 18.7%
Bracknell Forest 19.4%
Stoke-on-Trent 19.6%
Trafford 19.7%
Birmingham 20.1%
Manchester 20.2%
Oxfordshire 20.3%
Coventry 21.4%
0.0% 5.0% 10.0% 15.0% 20.0% 25.0%

Appendix 3 – Key Lines of Enquiry (KLOEs)

Safe KLOE 1: How are people using services supported to move safely across Health and Social Care to prevent avoidable harm?

S1 How do systems, process and practices in place across the Health and Social Care interface safeguard people from avoidable harm?
S2 How are risks to people assessed and mitigated, and their safety monitored and managed so they are supported to stay safe?
S3 What system is in place for providers to identify people who are frail, with complex needs or who are at high risk of deterioration in their health or social situation?

Effective KLOE 1: How effective are Health and Social Care services in maintaining and improving health and wellbeing and independence?

E1 To what extent are people's needs and choices assessed holistically to promote independence and communicated effectively across the system
E2 To what extent are services designed to improve flow through the Health and Social Care system evidence based?
E3 Does the workforce have the right skills to support the effective transition of people between Health and Social Care services?
E4 How effectively does the workforce collaborate and share information to meet the needs of the local population?

Caring KLOE 1: Do people experience a compassionate, high quality and seamless service across the system which leaves them feeling supported and involved in maximising their wellbeing?

C1 Are assessments of need and care co-ordinated effectively to ensure that the person is at the centre of their care and support planning when moving between Health and Social Care services?
C2 How well are people supported to be actively involved in making decisions about their care, support and treatment when moving through the Health and Social Care system?
C3 How well does the system inform and involve carers, families, advocates and their representatives to make informed choices about future plans?

Responsive KLOE 1: To what extent are services across the interface between Health and Social Care responsive to people's individual needs?

R1 How does the system ensure that people are moving through the Health and Social Care system are seen in the right place, at the right time, by the right person?
R2 How are services designed to meet the needs of the local population?
R3 How timely and effective is the process for reviewing people's support needs to ensure that these continue to remain appropriate as they move through the Health and Social Care system?
R4 How do services ensure that people can make informed choices to access the support they want, in a way that promotes independence?

Well Led KLOE 1: Is there a shared clear vision and credible strategy which is understood across the Health and Social Care interface to deliver high quality care and support?

WL1 How well do partners involve service users, their carers and their families in the strategic approach to managing the quality of the interface between Health and Social Care?
WL2 How well do leaders ensure effective partnership and joint working across the system to plan and deliver services?
WL3 Interagency working: how do leaders ensure that the respective agencies work together to enable people to move seamlessly across the Health and Social Care system?
WL4 Multi-disciplinary working: how do leaders ensure that professionals / front line staff work together to plan and deliver services to people?
WL5 What is the strategic framework that brings the interagency and multidisciplinary work together across Health and Social Care?
WL6 What is the operational planning framework that converts the strategic framework into deliverable plans and how do they shape what operational managers do?
WL7 To what extent is learning and improvement shared across the Health and Social Care system when things go wrong?

Well Led KLOE 2: What impact is governance of the Health and Social Care interface having on the quality of care across the system?

G1 Are governance arrangements across the system supporting partners to collaboratively drive and support quality of care across the health and care interface?
G2 Are effective information governance arrangements in place to enable information sharing to facilitate integration of Health and Social Care?
G3 Are effective risk sharing arrangements in place between partner organisations that support the Health and Social Care interface?

Well Led KLOE 3: To what extent is the system working together to develop its health and social workforce to meet the needs of its population?

CM1 Is there a strategic approach to commissioning across the Health and Social Care interface, informed by the identified needs of local people (through the JSNA) and in line with the Outcomes Frameworks for NHS and Adult Social Care?
CM2 How is commissioning promoting a diverse and sustainable market to support the interface between Health and Social Care?
CM3 How well do commissioners procure services at the interface of Health and Social Care and work with partners with whom they have contracts?
CM4 Do commissioners include standards in their contracts for services at the interface of Health and Social Care, and what do they do if the standards are not met?
CM5 Do local commissioners have a programme to assure them that service reviews across the interface of Health and Social Care are in place to ensure they are getting value from the resources used?

Resource Governance KLOE 1: How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting people's independence?

RG1 How do system partners gain assurance that there is effective use of cost and quality information to identify priority areas and focus for improvement across the Health and Social Care interface?

RG2 Are systems in place to gain assurance that integrated commissioning arrangements are being used to drive improvement across the Health and Social Care interface?

RG3 How are local partners actively developing and managing the provider market to ensure the system has the capacity to ensure quality services and match demand?

	Agenda Item: 14
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**3 October 2017**
TITLE:	**WEST MIDLANDS MENTAL HEALTH COMMISSION BRIEFING PAPER**
Organisation	**West Midlands Mental Health Commission**
Presenting Officer	

Report Type:	**Information**

1.	**Purpose:**
	This report is to provide an update on the current position of the West Midlands Mental Health Commission Action Plan and the work undertaken since the launch of the programme on 31st January 2017.

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

3.	**Recommendation**
	It is recommended that Birmingham Health and Wellbeing Board note this report update

4. Background

4.1 The implementation of the Action Plan has focused on a number of key strands of work which have enabled the delivery model to develop into formal activity. This report will describe the first 6 months of activity and the plan to move the programme forward.

4.2 Wider WMCA Implications

4.2.1 It is proposed that a number of the programmes will be developed with partners across the West Midlands Combined Authority footprint. We will actively seek to engage non constituent members to support the Treasury approach for effective evaluation of national scalability.

4.2.2 The WMCA were allocated a further £7m in the budget of May 2017 to be available for two years from 2018/19 and 2019/20. This funding was ring fenced to support mental health wellbeing in the workplace across the Midlands Engine footprint and was to be used to translate the learning from the Mental Health Commission. Work is now ongoing with the Midlands Engine team and central Government Departments to ensure that the delivery model and approach is agreed in principle to enable to wider roll out of the Mental Health Commissions learning.

4.3 Progress

4.3.1 Employment and Employer - Thrive into Work – Individual Placement Support (IPS) Trial

The Thrive into Work programme, which aims to test whether IPS works in primary and community settings, continues to move on at a pace towards its formal implementation launch on 20 October 2017. The total funding obtained from the Work and Health Unit Innovation fund for the pilot has been finalised as £8.335m over three year programme. Over this period, the programme aims to deliver services to approximately 3,346 people who are out of work with a health condition across the four sites. It aims to engage a further 3,313 to be part of a control group. The providers will refer these individuals to existing employment services in their local areas.

Significant progress has been made in the following areas over the last six months: The trial has been submitted to the Health Research Authority (HRA) for ethical approval. It will be formally considered by the Research Ethics Committee on 19 September 2017 with a view to the programme obtaining ethical clearance for the trial.

An extensive procurement process to appoint employment providers has taken place during August with the scoring, evaluation and moderation of high quality tender submissions. The final bidders will be notified on Monday 11th September following formal sign off from the WMCA Board on 8th September 2017.

In readiness for the launch and the implementation phase of the programme two interim managers (programme manager and delivery manager) have been engaged to advance clinical engagement and manage the provider

contracts which will be in place. Recruitment is about to commence for a small permanent team of staff to manage the programme.

The programme is in the process of concluding a formal legal agreement between WMCA and Wolverhampton CCG to host and provide back office support to the programme. This is due to be completed in the week commencing 11th September 2017.

4.3.2 Employment and Employer - Fiscal incentive

This is the development of a model to test the tipping point at which an employer would initiate wellbeing programmes into the workforce. It seeks to work with 100 small and medium enterprises across the WMCA footprint and works on the premises of a Randomised Control Trial. The programme will focus on key enablers in the company as well as developing wellbeing across mental health, musculoskeletal and obesity linking it to the wider WMCA wellbeing and physical activity strategies. The pilot will take place over two years.

Key partners at local and national level have assisted in the design of the incentive programme which will be submitted to the Work and Health Unit Innovation Fund in mid-September. The original funding proposal was for approximately £2m however, reshaping of the programme has occurred which will be seeking approximately £1.4m.

It is anticipated that recruitment of the business for the pilot will occur in late November / early December and seek to commence in January 2018. These will need to be from across the wider WMCA footprint to support the approach of scalability and also ensure we test across a host of different business sectors.

The programme will be formally evaluated by an academic partner and will seek to support wider discussion with Government Departments in 2019/2020.

4.3.3 Employment and Employer- Wellbeing Charter

Developing support for this programme with existing provision occurring within the local landscape has commenced. Local Authority employer engagement leads and Directors of Public Health have supported the continued promotion of the approach. A number of public and private sector bodies have commenced the approach with a Coventry City Council taking a leading role in the recruitment of business and organisations. All Chambers of Commerce and LEPs have also supported the promotion of this approach. A further strong commitment has been shown by West Midlands Fire Service and Jaguar Land Rover to this agenda by both completing the Wellbeing Charter accreditation. Work is ongoing with other bodies to mainstream this approach.

It is anticipated that the Midland Engine work stream funding will support the wider roll out of the programme. It is expected that this will create some additional resource to enable delivery and scalability.

4.3.4 Employment and Employer – Social Value Procurement approach for wellbeing

As part of the Action Plan a concept to create a ripple effect of improved employer/ employee wellbeing was proposed. The WMCA have taken this forward to develop the principles and process for delivery. It is hoped that once this process has been developed it can be shared more widely across the WMCA and Midlands Engine Footprint to support the cultural shift in increased employee wellbeing as a means to improving productivity.

4.3.5 Housing First work stream

The WMCA mental health commission action plan identified housing as a key area in the promotion of improved mental health. The development of Housing First, an emerging model of housing and support provision, was one of its recommendations.

In June 2017 a small project group was established, comprised of representatives of the WMCA PSR team, local housing association providers, the local branch of the National Housing Federation and the community and voluntary sector. The group has met twice, once in June and again in August.

The focus of its work thus far has been to gather evidence on existing models of Housing First and a review of the evidence and literature is being prepared and will be completed by mid-September. The group also developed a set of key questions for local commissioners and providers in councils and housing associations across the region. These questions formed a 'call for information' and were designed to establish the likely level and type of need. Initial response rates were poor, in part due to the summer holiday period. Follow-up contact has been made and the information should be complete by mid-September.

From this data and the evidence, the group will shortly develop a proposed model of Housing First, and in an effort to test the concept, seek willing partners to pilot it. In developing the model, the group is mindful of current work taking place in various councils, notably in the Black Country and in Birmingham. Discussions have taken place between the project lead and the Implementation Director with those areas and where opportunities exist to partner or join up our work, this will be taken forward. The group is also linked in to the work of the Mayor's Homelessness Taskforce to ensure there is connectedness with their work, and to avoid duplication.

The group is also liaising with the national body with expertise in this field, Housing First England and with the Centre for Mental Health. Work is also in train to establish the viability of funding sources, with particular focus upon the potential for the use of Social Impact Bonds and the appetite for that type of approach as well as exploring other potential sources of funding from outside the public sector.

4.3.6 Criminal Justice - Engager Programme

The WMCA Mental Health Commission Action Plan identified criminal justice as a key area in the promotion of improved mental health. The development

of Engager Intervention model, a psychological intervention to support prisoner leaving prison, was one of its recommendations. The programme is moving along steadily.

HMP Featherstone has been identified as the host prison with the cohort of detainees to be engaged with the programme will be located from within the Wolverhampton Metropolitan Council area.

Funding has been agreed from the Police and Crime Commissioner (£80k), with an agreement for funding the be released at the start of the programme (giving us 12 months to run the programme)

All core stakeholders have now been engaged and are contributing to the designing of outcome measures for the programme to ensure that the programme complements local priorities.

Moving forward, the legal and procurement teams at the West Midlands Combined Authority are supporting the design the service specification and identify the procurement options. The team are currently adapting the academic test pilot Engager model protocols and practitioner manuals for use in the West Midlands pilot.

It is anticipated that the programme will commence in January and to start see the first interventions in early 2018.

4.3.7 Criminal Justice - Mental Health Treatment Requirements

The West Midlands has now been identified as one of five national Test Bed sites. Work is ongoing in Birmingham with key stakeholders to develop the model of delivery which will give courts a sentencing option of a Mental Health Treatment Requirement.

The programme in Birmingham has been developed with NHS Offender Health, Birmingham Cross City CCG and the Health Exchange to enable delivery of primary care interventions for low level offending behaviour. Birmingham will be a wave one site seeking to go live in October with Wave two sites (Black Country and Coventry) seeking to be developed in the next financial year.

Funding for this project has come from NHS England and the Police and Crime Commissioner. It is hoped that further discussions with partners will unlock additional funding for the wave two sites.

4.3.8 Improving Care - Primary Care Mental Health

The aim is to provide a blueprint for the development of the compassionate and effective management of people with mental and emotional health difficulties in primary care. The lead GPs are working with a range of clinical, commissioning and academic partners including STPs, Universities, Academic Health Sciences Network, Public Health and NHS England.

There are many interesting examples of approaches around the country which aim to deal with various parts of this rich and complex area of care, and

an emerging collaboration between public and personal health as well as the social and medical models of health care and support. Colleagues across the country are actively developing ways of working to address a range of issues, using creative methods and inter-disciplinary working to achieve improvements in some of the following:

- prevention of mental illness particularly in people who have suffered significant adversity in childhood;
- managing crisis in ways which allow a range of coordinated alternatives and to reduce the harm caused by mistreatment of people in acute distress;
- more efficient and holistic navigation for primary mental distress;
- better management of people with long term conditions compounded by mental health problems;
- the management of people with complex difficulties who often fall between services;
- the unnecessary attendance at A&E of many people with mental distress;
- people with medically unexplained persistent symptoms;
- the life-expectancy discrepancy between people with severe and enduring mental illness and the rest of the population.

The operational group are actively involved in sifting through literature regarding primary care mental health, looking at local, national and international examples of good care, and aim to provide a series of suggestions within the next month, with the intention that exemplar sites will be found around the region to take these ideas forward, in conjunction with STP and the Five Year Forward View (FYFV), in order to demonstrate tangible ways in which parity of esteem and value can be achieved for people with mental health problems.

This will involve something of a sea change in approaches for some people, changes in how people manage, communicate and share risk and the involvement of service users, people with lived experience in the development and evolution of systems of care. This represents a significant social challenge for us- underpinning all health with good mental health is a brilliant strapline but we need to make it an increasing reality rather than a pipedream.

As part of the above specific thought is being given to the following: Peer support, Social prescribing, the development of an emotional Trauma network around the region-fostering trauma-awareness and good practice, Complexity work with public health- work on an understanding of how some of the people whose care (or lack of care) often costs our society vast sums of money but who are often not recognised or offered help which actually meets their needs.

Links with clinical STP developments for general practice as well as the WMCA work streams of criminal justice, housing, employment and schemes/aspirations like zero suicide are fundamental to trying to ensure that we don't end up with a system full of gaps.

The backdrop of uncertainty in the future of general practice (projected vastly reducing numbers of GPs over the coming years), the push-me-pull-you of

STPs trying to bring their budgets in line, the role of accountable care organisations and Federations, and the alignment of health and social care are all factors which will inevitably influence this work, and stiffen the challenge of making universally acceptable proposals.

To develop further the team are planning separate workshops with the West Midlands Mental Health Commissioning network, NHS England and Health Services Management centre in October to look at the clinical, commissioning and academic ramifications of our proposals

4.3.9 Improving Care - Merit Vanguard (Mental Health Provider approach) – Collaboration is ongoing with the five Mental Health providers in the WMCA metropolitan areas and wider connectivity through the NHS England Mental Health Alliance across the four regional STPs. Out of area placements, restraint in Mental Health units and work on early access for psychosis is in development. It is anticipated that by winter 2017 out of area placements will only be undertaken in exceptional circumstances when specialist care is not available locally.

Further work on the equality agenda is being developed with specialist support from Dr Karen Newbigging (University of Birmingham) and Jacqui Dyer who sat on the national Mental Health Task Force. The focus is seeking to understand equality of access and equality of outcomes and will seek to support the wider development of service redesign across the region.

4.3.10 Community Engagement - Zero Suicide ambition

In May 2017, the “Walking out of Darkness” event took place in Birmingham with approximately 550 people taking part in an 8 mile walk along the canal network of Birmingham. Led by “CLASP” Suicide prevention charity and supported by many regional stakeholders including WMCA, Public Health England, Kaleidoscope plus and Birmingham Mind. The event was launched for year one and is seeking to grow year on year.

The Second year event is planned for Sunday 6th May 2018. A planning event is due to take place in late October or early November. The event will seek to start and finish in Birmingham City Centre with an ambition to recruit at least 1500 participants. To support this it is requested that this event is promoted wherever possible.

4.3.11 Community Engagement -Supporting the drive to prevent suicide.

A paper is being presented to the Directors of Public Health in the region in September 2017 which seeks to develop the wider narrative around zero suicide. The position should be that suicide is not inevitable, it is preventable. Within the WMCA, our approach should be to make suicide prevention everybody’s business as well as developing a personal asset based approach which gives people hope. This approach will build on the existing work in the region and support by creating a regional strategic approach with oversight to embed this cultural shift.

4.3.12 Community Engagement - Mental health literacy programme

Work is ongoing to develop a mental health literacy programme which would be delivered across four levels. The approach would seek to deliver a digital universal programme to 300,000 people with focus on students and employees and communities. This model would be similar to the dementia friends approach. The second tier wold be to support line managers and champions and seek to develop wider awareness and navigation to support with the next two tiers targeting key individuals and groups across the region. Work is ongoing with Mental Health First Aid England to support the programme with a programme development manager. This approach would also fit into the wider Midlands Engine agenda and support the overarching ambition to train 500,000 people in mental health awareness in ten years.

4.3.13 Community Engagement - Citizen Jury Crisis Cafes

The original citizen jury group have developed into a cooperative and are now starting to develop a crisis café model in two localities in the region. Birmingham Wellbeing Board have agreed to test a district model of this approach and the Black Country Mental Health Partnership are supporting this in the Black County

The approach will seek to learn from national best practice and will work alongside provider Recovery College models. For sustainability support will be garnered from the Third Sector and peer support networks. The WMCA MH Commission are designing the pilot programmes to devise a sustainable model.

It is anticipated that within 12 months the initial model will be tested and a scalable model will be ready to share across the wider WMCA. To support the resource element, the programme will seek to recruit volunteers from the mental health literacy programme to develop a volunteer network building on the community asset based approach.

4.3.14 Community Engagement - Global City Network

As part of the THRIVE West Midlands approach there is an opportunity to develop the global cities network. A conference is taking place in Philadelphia and New York in September to align the THRIVE Cities and create a learning event for wider development. We have been invited to send representatives to this event to share the good practice and systems leadership approach as well as maximising our opportunity to market the West Midlands Combined Authority and THRIVE West Midlands on a global platform.

The current THRIVE into Work programme is in the final stage of design. The WMCA have Ministerial approval for the programme. The Memorandum of Understanding from the Department of Work and Health has arrived and work is being conducted week commencing 11th September 2017 with Wolverhampton CCG as the host organisation to complete the due diligence on behalf of the WMCA.

5.	Compliance Issues
5.1	***Strategy Implications***
5.2	***Governance & Delivery***
5.3	***Management Responsibility***
	West Midlands Mental Health Commission

6.	Risk Analysis		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
#	#	#	#
#	#	#	#
#	#	#	#

Appendices

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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