Big challenges for health & social care –The Birmingham and Solihull Sustainability and Transformation Plan

1 Why does the Birmingham and Solihull Sustainability and Transformation Plan matter to you?

> *There could not be a more unified and consensual position from across the care and support sector that adult social care is in a perilous position.[1]*

1.1 Health and social care services are facing an unprecedented challenge. Shrinking budgets, especially for adult social care, coupled with ever growing demand, mean that without additional resources, major changes will be needed if the system is to avoid collapse. This is both a national and a local issue. The state of adult social care funding locally needs to be seen in the national context. This was set out in a recent report from the Local Government Association (LGA) which estimates that 'adult social care faces a funding gap of £1.3 billion by the end of the decade as part of the £5.8 billion funding gap facing local government overall.' [2] In describing what he refers to as the existential crisis of care, Richard Humphries, Assistant Director of Policy at the King's Fund, says this when describing the triple challenge of money, service design and workforce to the care system: 'The most obvious is money. Quite apart from past cuts – over £5 billion less in local authority social care budgets over the last five years – it is demography-defying that spending is set to fall further when the number of over 85s will double over the next two decades and adults with a learning disability will increase by at least a third.'[3] It is clear that a key part of the response to these challenges must be a properly integrated health and social care system, one that maximises the value of every pound we spend and prioritises prevention and early intervention.

1.2 Sustainability and Transformation Plans (STPs) have been established by the Government and NHS England as the basis for addressing these challenges. They are intended to be the start of an iterative process which aims to bring about long-term, sustainable change to address key gaps in health and wellbeing, care and quality and finance and capacity.

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[1] Adult social care funding: LGA 2016 state of the nation report: Page 9 Vision, reality and bridging the gap
[2] Adult social care funding: LGA 2016 state of the nation report: Page 6 The state of adult social care funding
[3] Adult social care funding: LGA 2016 state of the nation report: Page 11 The state of adult social care funding: a national overview by Richard Humphries, Assistant Director of Policy, The King's Fund

1.3   As a first step, we agree that there needs to be closer working between NHS providers, NHS commissioners and the local authority. However, bringing about the closer integration of health and social care will require pioneering new models of care to be developed as part of a new local and national health and care service. In order to achieve this, the NHS and social care services will need to succeed in breaking down the barriers which have so far largely prevented them from working sufficiently closely together to deliver a truly integrated health and care service. This presents a huge challenge for both the NHS and for the Council.

1.4   The scale of the challenge faced by the health and care system raises three major questions about the STP.

1.4.1   Firstly, does the STP adequately address the immediate crisis that has emerged in the social care system?

1.4.2   Secondly, does it provide a basis for bringing about the longer term system changes that will be needed?

1.4.3   Thirdly, will it enable the transformational changes in individual behaviour and in the physical and social environments that are necessary to help more people to stay active and healthy over the longer term?

1.5   Clearly this is essential if we are to have any chance of relieving future pressure on the health and care system and preventing an increasing volume of longer term health problems developing, which will cause even greater difficulties for the health and care system in the future.

1.6   Local elected leaders have a key role in shaping how this happens, in influencing what the new models look like and in ensuring that the citizen voice is put firmly at the centre of the plan. To do this, elected members need to be informed and engaged in the debate at an early stage to think about how best to tackle the system challenges and to decide where they want to take health and social care in Birmingham and Solihull over the next five years and beyond. Openness, transparency and public engagement in the STP have been very limited to date and ongoing citizen involvement will be absolutely essential in shaping what the new system looks like. Members have been rightly critical of the process stipulated by NHS England for drawing up the initial version of the STP, which seemed designed to actively exclude the wider public from the discussion. This is both unacceptable and counterproductive. Redesigning the system in order to bring about long term behaviour change cannot be achieved through a process restricted largely to local system leaders. Public input and engagement is essential to ensure that the new models of care are designed from the point of view of the people who access and use the services so that the health and wellbeing of the local population is put at the forefront of the plan and so that the planned changes will have a positive impact on the health and wellbeing of the local population. Birmingham's decision to publish the plan in full is a welcome recognition of this fact.

2   What is the Sustainability and Transformation Plan?

2.1   The Birmingham and Solihull Sustainability and Transformation Plan ('the Plan') is basically a planning tool for delivering a health and social care system that achieves better outcomes across Birmingham and Solihull over the next five years. It is about the health system working more closely with community based services and the social care system to provide more appropriate services for patients who may currently be in hospital. It requires local leaders to work together in a collaborative way to achieve an effective, affordable and sustainable system which will deliver better health and care for local people.

2.2   The health and social care system faces a number of significant challenges driven by a variety of factors including financial and capacity pressures, levels of deprivation and increasing demand, some of which are set out in more detail below. Dealing with these difficulties will require a change to the way care is delivered and a change in the way we work with families and communities. We need to focus on preventing the early onset of disease and other conditions so that the pressure on an already overstretched health and care system is reduced. This is the only way we will be able to stabilise the system and make it sustainable in the longer term.

2.3   An integrated health and social care system is clearly part of the answer to these challenges. However, it will only be achieved through a strong, equal partnership approach between all local NHS organisations (including the providers, clinical commissioning groups and GPs), the two local authorities and a range of other stakeholders including local communities. Unfortunately, we have yet to see evidence that both sides of the system are being treated equally through the STP process, to the detriment of adult social care. We agree with the verdict of Councillor Izzi Seccombe, Chair of the LGA's Community Wellbeing Board: '*For too long the service has too often been seen by decision-makers as an adjunct to the NHS, rather than a service of equal importance. A lack of recognition in terms of profile has combined with a lack of recognition in terms of funding to place our care and support system under enormous pressure.*'[4] This has to change if we are to have any real hope of finding the innovative new models of care and approaches envisaged by the STP and in the NHS Five Year Forward View.

3   Scale of the challenge

3.1   The Birmingham and Solihull STP Footprint (the BSol STP footprint) covers 1.3 million people, 2 local authorities, 7 acute hospitals, 1 mental health trust, 1 community health trust, 3 CCGs and 182 GP practices. The scale of the issues in terms of improving the health and wellbeing of the population are set out in considerable detail in the STP and the executive summary is attached for information. The examples set out below go some way to highlighting the scale of the challenge.

3.2   Health and Wellbeing gap:

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[4] Councillor Izzi Seccombe, Chair, Community Wellbeing Board, Local Government Association, Adult social care funding: LGA 2016 state of the nation report Page 4

- 440,000 or 46% of the footprint population live in the "bottom 10%" most deprived areas of England.

- 1 in 3 children live in poverty.

- Birmingham has a gap in life expectancy of 7 years between the most and least affluent and in Solihull it's 10 years.

- Birmingham and Solihull are in the bottom quartile for emergency admissions from falls.

- All three CCGs have cancer mortality rates that are higher than the national average.

3.3   Care and Quality gap:

- There is a growth in emergency admissions for conditions which would not usually need a hospital admission (currently 940.8 per 100,000 population).

- Delayed transfers of care attributable to the NHS and social care across the STP is 17.39 per 100,000 population which is in the worst performing quartile nationally.

- There are significant challenges with available capacity as well as variability in quality of care in nursing homes and domiciliary care.

- The Birmingham and Solihull CCGs combined have the second lowest ratio of GPs and Practice Nurses per 100,000 population (0.53).

3.4   Financial gap:

- The combined 16/17 forecast position for the health and care economy is an overall deficit of £18m. This is driven primarily by the £46m deficit in social care, with the health sector showing a forecast surplus for 16/17 of £24.5m.

- By 2020/21 all organisations across Birmingham and Solihull will be in deficit and the overall combined health and care sector deficit will be £712m if things don't change, with the single biggest driver in the growth of the deficit being generated by the NHS providers, who will be £307m in deficit.[5]

3.5   Capacity gap:

- Detailed demand, activity and capacity modelling has not yet been done. However if nothing is done to change the way care is delivered and to change the way we work with families and communities to prevent the early onset of disease, the suggestion in the plan is that the system would need a further 430 hospital beds, which equates to almost a new hospital, in five years' time.[6] This is the size of a typical general hospital and there are not sufficient empty beds available to cover this demand. In addition, the required workforce is also not available. This is clearly not a sustainable situation.

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[5] Understanding the gap – Finance – 15/16 through to 20/21 BSol STP Page 15
[6] Illustrative increase in acute beds required by 2020/21 in the 'do nothing' scenario BSol STP Page 17

4   How has health scrutiny been involved in the process?

4.1   The Health Scrutiny Committee was briefed about the approach being taken to the Plan at an informal session at the start of the municipal year by the Better Care Fund Programme Director and the Strategic Director for the STP. Notably however, we were not informed as to the content of the first draft Plan submitted to NHS England at the end of June 2016. In September, the Committee took formal evidence from the Cabinet Member for Health and Social Care, who set out her detailed concerns in relation to both the Plan and the process.

4.2   After listening to the Cabinet Member and discussing the issues raised, the members decided to devote their October meeting to scrutinising the Plan. At its October meeting the committee invited Mark Rogers, in his capacity as System Lead for the STP, and the work-stream leads, namely Sarah-Jane Marsh (Maternity and Newborn Programme), Dame Julie Moore (Vibrant Secondary and Tertiary Services Programme), John Short (Mental Health Programme) and Les Williams who represented Tracy Taylor (Community Care First Programme). The system and work-stream leads addressed the Committee and answered questions from members about the work being planned, work already in progress, how the public have been involved to date or plans to involve them, problems and issues arising and how the Plan will help to resolve these in relation to their respective work-streams.

5   Cabinet Member response to the Plan

5.1   Just prior to the publication of the Plan the Cabinet Member for Health and Social Care, whilst welcoming the direction of travel represented by the Plan and supporting the development of a fully integrated health and social care system and reiterating her commitment to a collaborative and place based approach, set out her significant concerns about a range of issues arising from the Plan. These concerns were shared with all Birmingham councillors and can be briefly summarised as follows:

- The Plan is focussed on organisations and not people; it fails to take an approach to population health and to the ambitions from citizens for a greater emphasis on positive health outcomes;

- The Plan cannot claim to be place based when 16% of Birmingham is missing from it and there is no cross referencing to the plan for West Birmingham in the Black Country STP;

- Social care is seen as incidental to the issues facing NHS organisations and social care principles and services which are based on supporting people outside of the NHS system have been relegated to an ancillary position;

- Social care thinking is also rooted in a broad appreciation of the wide nature of communities and the plan is weak about how key issues such as housing and other community based services could be deployed;

- There is much hard work through a wider process of public engagement that needs to be done to gain public support for the Plan;

- The Plan doesn't operate as one system covering health and care. Although the social care financial gap is included within the Plan, which is welcome, there is no indication of how this gap will be closed. Indeed some of the assumptions in the Plan to shift more care into the community through fewer hospital admissions and shorter lengths of stay are not accompanied by any change to the level of homecare and social support, and create a significant risk that the Plan will move care and costs from the NHS to the social care system which could actually increase the gap;

- The Plan takes a supply side analysis based on projected demand and needs. It does not start from the point of pulling the needs of the 21st century and current demographic patterns in Birmingham into a clear analysis.

5.2   Our Committee endorses the Cabinet Member's concerns and welcomes the strength and clarity with which she has publicly made her views known. On the positive side, the Cabinet Member recognised the significant advantages of completing a single view of NHS finance with Birmingham and Solihull as a stepping stone for the further work to be done and of bringing about a climate of better governance and improved relationships within NHS partners and beyond.

Findings

6   The financial challenge and the implications for social care

6.1   Many of the concerns raised by the Cabinet Member were echoed by the members of the Health Scrutiny Committee. The most immediate of these is the fact that the Plan does not operate as one plan covering both health and social care, with the result that although the social care financial gap is included in the Plan, there is no indication of how the gap will be closed. The Plan also presents a significant risk in that it will move care and costs from the NHS to the social care system which could actually increase the gap and consequently intensify the financial pressures on the local authority sector.

Impact of increasing pressures on adult social care

6.2   The drivers which are putting increasing pressure on adult social care services are well known and include a range of factors, of which demographic changes are the most pronounced.. Between 2015/16 and 2016/17 the level of client need attributable to demographic pressure has been forecast to increase by £12.5m, of which only £6.5m is funded, placing increased pressure on the system.[7]   In addition to population growth, there are demographic pressures from an ageing population who often have a number of co-morbidities and more complex needs. There are other factors such as poverty and sickness which are widely accepted as drivers which lead to the earlier onset of the need for social care, and the growth in the number of younger adults with complex care needs. There are increasing pressures also in the care market with rising costs leading to care

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[7] Stabilisation and Transformation of Social Care, BSol STP Page 57

market failure because councils cannot afford higher fees, which in turn causes more upward price pressure for councils when they have to find more expensive alternative placements. All of these have combined to create more intense demand on the adult social care system. This has a knock-on effect of causing increasing difficulties for the NHS in the form of patients being unable to be discharged promptly from hospital due to inadequate social care provision.

6.3 The impact of these pressures on the adult social care budget has been growing over recent years. These, taken in conjunction with the failure to realise what were probably unrealisable savings in adult social care and assumptions about savings to be made in the NHS which would be utilised to support adult social care which never materialised for a variety of reasons, have all led to a rising overspend culminating in the current, substantial budgetary shortfall.

Council's overall financial position

6.4 The adult social care financial gap needs to be understood in the context of the Council's overall financial position. This is set out explicitly in the latest letter from the Birmingham Independent Improvement Panel to the Secretary of State for Communities and Local Government dated 9th November 2016. The letter says in relation to the Council's financial position :'*The Council's monitoring of its 2016/17 revenue budget position has revealed that there is likely to be a significant overspend for the year, predicted in the Council's report to be in the region of £49m. The Council has now acknowledged that a significant number of the budget reduction proposals recommended to the Budget Council meeting in March 2016 were unrealistic and many previously undeliverable proposals were carried forward into the 2016/17 budget. There was insufficient understanding and ownership of the Council's 2016/17 budget and lack of comprehensive and robust delivery plans for the budget reduction measures that were required to balance the Council's budget.'*

6.5 The letter then goes on to say that '*the 2016/17 budget situation has made the management of the 2017/18 budget much more difficult, with reduced lead-in times for proposals which will inevitably affect very sensitive services, making it much harder to manage the impact on residents.'*

Adult social care budget position

6.6 Specifically in relation to the adult social care budget the letter says: '*Birmingham, in common with all-purpose authorities across England, faces severe financial pressure, particularly on its adult social care budget as a result of demographic changes and growth in demand. The Council is actively engaged in the early stages of working with its health partners to develop a more integrated approach to commissioning and delivering health and social care services to residents. While clearly the right approach in that the focus is on collaborative working to achieve the best possible health and social care outcomes for the city's residents, these developments are unlikely to deliver financial savings for the Council in the short term. The Council recognises this now. The late recognition has made the Council's financial challenge much greater.'*

6.7 This paragraph is referring to the fact that, in relation to the Council's 2016/17 expenditure on adult social care, it had been planned originally that approximately £28m in NHS savings which were to be made through the Better Care Fund by reducing non-planned emergency hospital admissions, would be made available in 2016/17 to be used by the local authority to alleviate some of the financial pressures in adult social care. This never happened due largely to increasing numbers of patients ending up at A&E departments leading to increasing unplanned admissions and a lack of available capacity to deal with the increasing demand. Subsequently it was planned to utilise the retained 1% CCG contingency (an estimated £13m) to alleviate identified financial gaps in the system. It is now clear that this will not happen. This means that these significant pressures will have to be met by the local authority for the current financial year and very probably also for 2017/18 and 2018/19. The fact that there will be no NHS money available to support the adult care system for the next two years, contrary to what had previously been anticipated by the City Council, was acknowledged by the System Lead, Mark Rogers, in his evidence to the Committee.

6.8 Page 57 of the STP document spells this out in stark terms: *'A significant level of savings (£28.4m) was apportioned to be achieved in 2016/17 via whole system reform plans with health. On the 4th July 2016 a strategy was supported by BSol partners to seek to gain NHSE support to utilise the retained 1% CCG contingency (estimated at £13m) if this were possible to alleviate identified financial gaps in the system……It is now clear that given a thorough review of system finances and NHS pressures the utilisation of the £13m will not be possible under the current NHS priorities.'*

6.9 The loss of these anticipated resources puts our adult social care services in an extremely precarious position. It also raises a number of questions over the budgetary assumptions the Council had made in previous years, with regard to both its own savings proposals and the belief that NHS contributions will be coming across to maintain the adult social care system which have subsequently not been realised. Lessons need to be learned about the consequences of making unrealistic assumptions when dealing with the current adult social care financial challenge and when making decisions about the current Council budget.

7   Prioritising prevention and early intervention

Public health and prevention

7.1 Prevention and the promotion of wellbeing will be vitally important if both the NHS and social care are to succeed in addressing the financial challenges and increased demand set out in the previous paragraph. Prevention, and in particular public health initiatives and interventions aimed at facilitating and encouraging longer-term behaviour change, will be critical in closing the care gap and achieving the transformation needed to make the available resources go further while still delivering quality care. Maintaining health and wellbeing need to be at the forefront of the Plan so that people are helped and enabled to take action to make a difference in their own lives to have any hope of closing the gap.

7.2   The importance of prevention and the promotion of wellbeing across the system is recognised in the Community Care First work programme and in particular through the 'Improving Health and Wellbeing' strand of work. It aims to address the gap in life expectancy, quality of life and life chances across the life course to enable people to achieve 'active, meaningful and independent lives'. Six priorities have been identified and it is explicit that in order to be effective, these all need to be an inherent part of all the STP work programmes, not just the improving health and wellbeing work-stream. One of the top five milestones in this area is a radical upgrade in prevention and promotion of wellbeing across the system with a focus on vulnerable groups, physical activity and across the life course. This is to be commended as an objective but the Plan also identifies the major risk that the prevention agenda is not integrated within pathways and across all the STP work-streams and that the infrastructure will not be funded to implement the technological change required to modify public behaviour in seeking help and promoting activity. Both of these pose a major threat to the delivery of this objective.

General medical practice and prevention

7.3   Another vitally important aspect of the prevention agenda is covered by the 'Stabilised and Enhanced General Medical Practice' work-stream which aims to develop an enhanced general medical practice offer aligned to long term conditions priorities and preventative interventions. This recognises the importance of general medical practice in reducing health inequalities and improving the health and wellbeing of the population, the need to support member practices to achieve improved quality outcomes and the need to extend access to general medical practice. However, the Plan also highlights the significant risk that if secondary and tertiary providers fail to support the Community Care First model then the funding will not be released from the STP to support the preventative initiatives outlined in the Community Care First work-stream.

Prevention and non-statutory Council services

7.4   Another important area of preventative services which are sometimes forgotten are the non-statutory or discretionary Council services. The current budget position has immediate and obvious implications for Council statutory care services but we also need to be clear about what this means for the resources available to support non-statutory or discretionary services. Much of this money is directed at the type of preventative and early intervention work that is needed to alleviate pressures elsewhere in the health and care system. If services that are supporting people to stay well and to live independently in their own homes are no longer available then the inevitable consequence will be more people needing more intensive interventions, more hospital admissions and increased demand for more intensive social care at an earlier stage than would otherwise be the case. This all means more pressure on hospitals and on the care system.

7.5   Whilst the Community Care First work-stream has a strong focus on public health and wellbeing issues, it is less focused with regard to prevention. In particular, it does not take account of interventions that support people on the edge of crisis and help people to achieve or to maintain stability and independence, which in turn prevents escalation into the care and health systems. An

obvious example of this would be interventions that support people who are homeless, especially given the links to other complex needs, many of which rely on funding from the Supporting People programme, which is one of a number of areas of Council funding currently being reviewed.

7.6   Supporting People funding is used to fund accommodation related support, particularly supported housing. Supported accommodation in Birmingham provides the most vulnerable citizens in the city with a wide spectrum of support packages. The main categories include homeless young people aged 16-25, care leavers, adults with support needs, people with mental health problems, people with learning disabilities, victims of domestic violence, ex-offenders and those at risk of re-offending, individuals with drug and/or alcohol dependencies and homeless people. The main aim of this support provision is to recognise the individual needs of vulnerable people and to support those people to optimise their independence and to remain within the community. For many, the support provided will also facilitate a transition out of intensive supported housing and into the general needs housing with the prospect of living independently. Increasingly, accommodation and support are used as prevention responses to people on the edge of care for either children's services or adult social care, preventing the need for higher tariff responses.

7.7   Urgent consideration needs to be given to how the Council budget process can be better aligned with the STP, given the key emphasis that the STP places upon prevention. The Council's discretionary services represent an important element to delivering this preventative agenda – from supported housing through to wider community-based activities. Given the significant risks previously highlighted above in relation to public health initiatives and interventions aimed at longer-term behaviour change and the risks to developing an enhanced general medical practice aligned to preventative interventions, there is a very real risk that we will undermine the whole basis of the Plan unless we align our budget process and enter into a proper discussion about the future funding of these services, which have a direct impact on STP objectives and outcomes. There are examples of local authorities using their Supporting People funding to co-commission with adult social care and health and children's services to provide more creative 'edge of care' and 'edge of crisis' prevention services, thus reducing pressure on their higher tariff services and contributing more effectively to their STPs, which could and should be explored in collaboration with the NHS.

8   Lack of openness, transparency and public engagement

8.1   There has been widespread concern among Councils about the lack of openness, transparency and public engagement in the STP process as set out by NHS England which has caused some considerable tensions with Councils. To date, there has been very limited public engagement around the BSol STP. At the date of writing this report, there had been three informal stakeholder reference group events on 27th and 29th September and 14th October, with only a few dozen members of the Birmingham and Solihull community involved.

8.2   There are references throughout the Plan to the importance of workforce, stakeholder, patient, service user, family, carer and public engagement and consultation. However the engagement and

communications strategy which is included on one page near the end of the Plan would appear to be very much an afterthought and needs a considerable amount of work to strengthen it and to ensure that decisions taken are made with the engagement and agreement of local communities. The part of the Plan setting out the immediate next steps up to the end of March 2017 refers to further developing a communications strategy and commencing a programme of activities to support wider engagement, but this needed to be done much earlier in the process. As it is, due to a lack of engagement to date, the Plan runs a high risk of failure to engage and persuade both patients and professionals about the new health and care models.

8.3   On a positive note, we warmly welcome the decision to publish the draft BSol STP plan in its entirety on 24th October 2016, despite the apparent desire on the part of NHS England to avoid full publication. The Plan was one of only a handful nationally that were published earlier than the timeline that NHS England sought to impose on the process. This demonstrates an important, albeit belated, understanding of the necessity for wider public and political engagement in the Plan.

8.4   There is clearly a lot of work that needs to be done to put patients and the public at the heart of the Plan. This has to be about more than a traditional, one-off consultation process. We want to see the views and perspectives of citizens and service users actively shaping the Plan in the immediate and longer term. This approach, rooted in the principles of co-production and the actual experiences that patients have of services, is missing at the moment. This needs to be addressed as a matter of urgency using a consistent approach across the different work-streams.

Involvement of local Healthwatch

8.5   It is part of the statutory function of local Healthwatch organisations to gather the views of and understand the experiences of patients and the public and to make these views known. They also promote and support the involvement of people in the commissioning and provision of local health and social services. They have developed expertise in gathering the views of and listening to patient, public, service user and carer experiences and in using these to drive improvement in health and social care. They could provide support, advice and assistance about the best ways of promoting community engagement and supporting the involvement of people in the commissioning and provision of local health and social care services to ensure that the views of patients, the public, service users and carers are at the heart of changes and decisions that are being made about these services.

8.6   Consideration should be given to liaising with and working with Healthwatch about how they collect evidence and about some of the tools they have available to promote community engagement, such as their Feedback Centre and the new Birmingham Healthwatch Quality Standard, which is currently being piloted and tested as part of the NHS England West Midlands assurance process and is due to be launched in early 2017. This uses patient and public insight, experience and involvement to reduce health inequality and drive improvement and could be a useful tool to provide the maximum opportunities for people to share their experiences and to shape the changes that are happening.

8.7   There is also a continuing role for health scrutiny in looking at the operational plans and taking an overview of the engagement and consultation processes as they develop across the system.

9   'The West Birmingham Question'

9.1   The boundaries of the geographical area covered by the Sandwell and West Birmingham Clinical Commissioning Group are not co-terminous with the local authority boundaries. This has resulted in the anomalous situation where parts of West Birmingham, which represents approximately 16% of the Birmingham population and includes areas such as Ladywood, Handsworth and Perry Barr, are part of the Black Country STP and are not included in the BSol STP. BSol and Black Country representatives are associate members of each STP and attend each other's STP meetings but otherwise there is a lack of connectivity and a lack of cross-referencing between the BSol STP and the Black Country STP.

9.2   Maintaining health and wellbeing needs to be at the forefront of this Plan and responsibility for Public Health sits with the Council. Having two plans covering different parts of the city and taking account of what is happening in Solihull and Sandwell will make the essential preventative public health aspects of the transformation difficult for Birmingham City Council to plan and deliver.

9.3   Scrutiny already has Joint Committees (HOSCs) with both Sandwell and Solihull to scrutinise cross-boundary issues. There is clearly a role for both the Joint HOSCs in scrutinising the BSol and Black Country STPs. However there remains a question about the best way to look at the overall picture covering what is proposed through the two STPs in Birmingham, Solihull and West Birmingham.

9.4   There is another issue in relation to the STP footprint which was raised by the work-stream leads. All of the Birmingham trusts deliver also some specialised services across a larger geographical area outside of the STP footprint on a wider regional or national basis. The fact that some services are delivered across a wider footprint needs to be given consideration in the discussions and decisions to be made about the plan.

9.5   Consideration may need to be given as to the best way to ensure that the overall picture is looked at in detail and about whether both of these aspects might necessitate some form of wider regional or sub-regional oversight.

10   Conclusions

10.1   At the outset of this report, we posed three key questions. Firstly in the short term, does the STP meet the immediate crisis in social care? Given that the Plan is not yet a single entity covering both health and social care and that whilst it mentions the social care financial gap, it gives no indication as to how the gap will be closed, the answer to this question must be no. Worse than this though, the Plan also presents a significant risk that, through fewer hospital admissions and shorter hospital stays, it will move care and costs from the NHS to the social care system without

making any provision for increased homecare or social care resources, which could actually increase the gap and thus worsen the immediate crisis in social care.

10.2   Secondly and thirdly, taking a longer view, does the Plan provide a basis for bringing about the longer term system changes that will be needed and will the Plan bring about the kind of changes in behaviour and the environment needed to support more people to stay healthy for longer to relieve pressure on the health and care system in the future? The answer to this seems to be that whilst it provides a potential basis for achieving this, it has a long way to go before it can deliver. We can only reiterate what was said by the Cabinet Member about the Plan. There is general agreement that the concept of integrating health and social care is the right way to go but at the moment social care is seen by the NHS as incidental to the issues facing the NHS. This needs to change if the Plan is to succeed. The inter-dependent relationship between the NHS and the social care system needs to be at the centre of the Plan to bring about a more level playing field and a more equal relationship between health and social care for the Plan to succeed.

10.3   Whilst recognising the not inconsiderable achievement of bringing together a single view of NHS finance in Birmingham and Solihull, and in drafting a medium-term plan, the concerns about the Plan expressed by the Cabinet Member in relation to a lack of openness, transparency and public engagement in the process to date were fully endorsed by Health Scrutiny Committee members. This has caused some considerable concern and unease within the local authority. There has been very limited public engagement in the Plan to date and the risks of not gaining public support are highlighted in the Plan. Members are aware that some of this was due to the guidelines for the process set out by NHS England but the Plan has been largely drafted to date with no significant input or engagement from staff, patients, the public or local government and this needs to be remedied urgently. Members welcomed the decision to publish the Plan earlier than the required timeline but much more is needed. The consultation plan which is set out in the STP is not adequate and needs strengthening considerably. Organisations such as local Healthwatch can also provide additional experience and support in this area but they need to be properly engaged in the process to enable them to do this.

10.4   The fact that the relationship between the health and social care system is currently less than equal is graphically illustrated by the fact that there is nothing in the Plan about closing the financial gap currently faced by the social care system. It is no exaggeration to say that the combination of pressures outlined in this report mean that the social care system is in danger of collapse. This will only add to the strain on hospitals and GPs unless the funding gap in social care is prioritised. Prioritising investment in social care will have the added benefit of relieving the demand pressure on the NHS.

10.5   If both the NHS and social care are to succeed in addressing the financial challenges and increased demand set out in this report then initiatives and interventions encouraging longer-term behaviour changes to support prevention need to be prioritised. Public health initiatives and interventions, enhancing the general practice offer and access to general practice and the Council's discretionary services represent an important element in delivering the preventative agenda – from supported

housing through to wider community-based activities. Much of this money is directed at the types of preventative and early intervention work that is needed to alleviate pressures elsewhere in the health and care system. If these services that are supporting people to stay well and to live independently in their own homes are no longer available then this will lead to more people needing more intensive interventions, more hospital admissions and increased demand for more intensive social care at an earlier stage than would otherwise be the case. This all means more pressure on hospitals and on the care system. The plan is weak about how key issues such as housing and other community based services could be deployed.

10.6   What has been called 'the West Birmingham Question' is another issue that needs to be considered. As was succinctly pointed out by the Cabinet Member, the Plan cannot claim to be place based when a significant part of the Birmingham population in the west of the city are not covered by the plan and there is no cross referencing between the BSol STP and the Black Country STP.

10.7   The STP process stipulated by NHS England means that all Plans, including Birmingham and Solihull's, are medium term strategies focused on the next five years. However the ability to look strategically beyond the current budgetary period to the longer term is important in the interests of dealing with the longer term pressures on the system and achieving stability and sustainability in the system. There remains a need for a much longer-term focus, looking ahead over the next 20 years with a particular view to ensuring that the preventative work currently being done produces results in 20 years. 'STP Plus' may need to build on the STP to take a much longer-term focus over this more extended timeframe.

10.8   Through the STP, local authorities have become involved with NHS agencies to an extent hitherto unprecedented. This is a vital step if a truly integrated health and care system is to be developed at local level. However, local authority engagement should come alongside the essential conditions that are fundamentally intrinsic to the uniquely democratic and accountable governance structures of local authorities. Our committee believes that Birmingham City Council should boldly set out the democratic 'red lines' that constitute the essential conditions for our continuing engagement in the STP. For example:

10.8.1   The City Council will act as an equal partner, not a junior partner, within the STP.

10.8.2   We will not accept proposals that leave social care services to pick up the negative consequences of under-resourced NHS services.

10.8.3   Our continued participation in the STP is conditional on it working to standards of excellence in genuine and participatory forms of public engagement, consistent with the City Council's universal consultation strategy. This will be rooted in extensive, inclusive and open and democratic forms of local community engagement involving elected members, staff, patients and residents groups across the city.

11 Next Steps

11.1 The purpose of bringing this report to Members in full Council was to raise awareness among all elected members in Birmingham about the scale and importance of the changes that are happening and planned across the health and social care system under the remit of the BSol STP. It was also to highlight the importance of elected members engaging in the debate to decide where they want the health and social care system to go over the next five years and over the longer term into the future. The changes that are taking place and the new models of care that are being and will be developed will have a huge impact on the health and care for the people of Birmingham and Solihull.

11.2 The Health, Wellbeing and the Environment Overview & Scrutiny Committee is also seeking a mandate from the Council to continue to focus its efforts in scrutinising the Plan including the operational plans with a view to bringing a further report to Council on developments in 6 months-time. The Health Scrutiny Committee will be seeking meaningful progress on the issues flagged up in this report.

11.3 The range of organisations involved in the Plan is extensive and the importance of the changes that are happening and will be happening across the health and social care system cannot be over-stated. It is therefore of paramount importance that Members are informed, engaged and approach the process knowing the implications and issues and with a realistic understanding of the position of social care within the health and care system. There can be no more pressing priority than tackling the inadequate social care provision which causes disabled, frail elderly and vulnerable people to suffer by being denied the care they need.

Councillor John Cotton

Chair, Health, Wellbeing & the Environment Overview & Scrutiny Committee