BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD

TUESDAY, 26 SEPTEMBER 2023 AT 12:30 HOURS
IN COMMITTEE ROOMS 3 & 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1 **NOTICE OF RECORDING/WEBCAST**

The Chair to advise/meeting to note that this meeting will be webcast for live or subsequent broadcast via the Council's Public-I microsite (please click this link) 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 they must declare all relevant pecuniary and other registerable interests arising from any business to be discussed at this meeting.

If a disclosable pecuniary interest is declared a Member must not participate in any discussion or vote on the matter and must not remain in the room unless they have been granted a dispensation.

If other registerable interests are declared a Member may speak on the matter only if members of the public are allowed to speak at the meeting but otherwise must not take part in any discussion or vote on the matter and must not remain in the room unless they have been granted a dispensation.

If it is a 'sensitive interest', Members do not have to disclose the nature of the interest, just that they have an interest.

Information on the Local Government Association's Model Councillor Code of Conduct is set out via http://bit.ly/3WtGQnN. This includes, at Appendix 1, an interests flowchart which provides a simple guide to declaring interests at meetings.

3 **APOLOGIES**

To receive any apologies.

4 **DATES OF MEETINGS**

To note date of formal meetings of the Board commencing at 1000 hours:-

28 November 2023
30 January 2024
26 March 2024

5 - 12

5 **MINUTES AND MATTERS ARISING**

To confirm and sign the Minutes of the meeting held on the 18 July, 2023.

13 - 14

6 **ACTION LOG**

To review the actions arising from previous meetings.

7 **CHAIR'S UPDATE**

(1235-1240) To receive an oral update.

8 **PUBLIC QUESTIONS**

(1240-1245) - Members of the Board to consider questions submitted by members of the public.
The deadline for receipt of public questions is 3:00pm on 19 September, 2023.
Questions should be sent to: HWBoard@Birmingham.gov.uk.
(No person may (submit more than one question)
Questions will be addressed in correlation to the agenda items and within the timescales allocated. This will be included in the broadcast via the Council's Public-I microsite (please click this link)
NB: The questions and answers will not be reproduced in the minutes.

15 - 52

9 **HEALTH AND WELLBEING BOARD DEVELOPMENT**

(1245-1310) Dr Justin Varney (Director of Public Health, Birmingham City Council) will present this item.

53 - 60

10 **JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) UPDATE**

(1310-1330) Rebecca Howell-Jones (Assistant Director, Public Health, Birmingham City Council) will present this item.

61 - 106

11 **11. DRAFT BIRMINGHAM AND SOLIHULL ENABLING PRIMARY CARE STRATEGY**

(1330-1355) Paul Sherriff (Chief Officer, Partnerships and Integration, BSol ICB) and Dr Sunando Ghosh (Chair, General Partnership Board, BSol ICB)

will present this item.

107 - 224

12 **FAST TRACK CITIES+ UPDATE AND ACTION PLAN**

(1355-1420) Becky Pollard (Assistant Director, Public Health, Birmingham City Council) will present this item.

INFORMATION ITEMS

Item Description

225 - 232

13 **FORWARD PLAN**

233 - 234

14 **CREATING AN ACTIVE CITY STRATEGY CONSULTATION - UPDATE**

15 **OTHER URGENT BUSINESS**

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

16 **EXCLUSION OF THE PUBLIC**

That in view of the nature of the business to be transacted which includes exempt information of the category indicated the public be now excluded from the meeting:-

Exempt Paragraph 3 - Minutes

PRIVATE MINUTES

- Confidential – Other

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD MEETING TUESDAY, 18 JULY, 2023

MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON TUESDAY 18 JULY, 2023 AT 1000 HOURS IN COMMITTEE ROOMS 3 AND 4, COUNCIL HOUSE, BIRMINGHAM, B1 1BB

PRESENT: -

Councillor Mariam Khan, Cabinet Member for Health and Social Care and Chair for the Birmingham Health and Wellbeing Board in the Chair

Dr Clara Day (Vice-Chair) Chief Medical Officer, NHS Birmingham & Solihull ICB
Councillor Karen McCarthy
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Helen Price (on behalf of Sue Harrison) – Director of Education and Skills
David Melbourne, NHS Birmingham and Solihull CCG
Andy Cave, Chief Executive Officer, Healthwatch Birmingham
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Douglas Simkiss, Bham Community Healthcare NHS Foundation Trust
Professor Catherine Needham, Professor of Public Policy, University of Birmingham
Natalie Allen Chief Executive SIFA FIRESIDE

ALSO PRESENT:-

Alexander Quarrie, Programme Officer, Governance
Louisa Nisbett, Committee Services
Jo Tonkin, Assistant Director (KEG), BCC
Maria Gavin, Asst Director, Adult Social Care
Rob Checketts, ICB
Colin Michel, Interim Director of Strategy & Partnerships, BCC
Alison Hurst, WM Police
Kim Madill, West Midlands Police
Mike Walsh, Adult Social Care BCC

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NOTICE OF RECORDING/WEBCAST

709 The Chair advised that this meeting will be webcast for live or subsequent broadcast via the Council's Public-I microsite (please click this link) and that

members of the press/public may record and take photographs except where there are confidential or exempt items.

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

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

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

(See document attached)

DECLARATIONS OF INTERESTS

711 The Chair reminded Members that they must declare all relevant pecuniary and other registerable interests arising from any business to be discussed at this meeting. If a disclosable pecuniary interest is declared a Member must not participate in any discussion or vote on the matter and must not remain in the room unless they have been granted a dispensation.

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Information on the Local Government Association's Model Councillor Code of Conduct is set out via http://bit.ly/3WtGQnN

This includes, at Appendix 1, an interests flowchart which provides a simple guide to declaring interests at meetings.

There were no declarations made.

APOLOGIES

712 Apologies for absence were submitted on behalf of :-

Dr Justin Varney, Director of Public Health
Richard North, West Midlands Police
Dr Anne Coufopoulous. University College, Birmingham
Peter Richmond, Birmingham Social Housing Partnership
Professor Graeme Betts, Director for Adult Social Care
Mark Garrick, Director of Strategy and Quality Development, NHS Foundation Trust
Aiden Hall, Programme Manager

Greg Ward,

DATES OF MEETINGS

713 The Board noted the dates of meetings for the next municipal year commencing at 1000 hours (except where stated)*

26 September, 2023 **(1230 to 1430 hours)***

28 November, 2023

30 January, 2024

26 March, 2024

MINUTES AND MATTERS ARISING

714 The Minutes of the meeting held on 28 March, 2023, having been previously circulated, were confirmed and signed by the Chair.

ACTION LOG

715 No outstanding actions were raised for the Action Log.

CHAIR'S UPDATE

716 Councillor Mariam Khan, Cabinet Member for Health and Social Care updated as follows:-

Since the last meeting a Development Day had taken place and there had been a good turnout with many of Members attending. It had been recommended that there be an Annual Development Day. They had looked at how to work better together.

The Chair and jJustin Varney had attended the Baton of Hope tour. The Baton of Hope was to raise awareness for the prevention of suicide. The tour set of in Glasgow 2 weej journey and ended in Downing Street.

On 4 July the Chair had visited the Well Being Health Centre in Washwood Birmingham's first Heath Diagnostic Centre with Dr Clara Day. One of the biggest Centres in England. Birmingham's first Diagnostic Centre. Open 7 days week. CDC's are part of the national governments investment. Services include many services.

Last week guest local Maternity and Neonatal Services Board meeting and shared own maternity stories with healthcare professionals. Have power to

affect change. Look at how put some experiences into lessons learnt into practive. Visiting Women's and Children's Hospital later this month.

Last week the Chair was honoured to be invited to open a launch event for Compassionate Cities event at the MAC. Bring together a range of partners to support people sickness death and dying.

Offer congratulations to Jonathan Brotherson on his appointment as Chief Executive at University Hospital who did an amazing job as Interim ad look forward to working with him.

The Chair mentioned the extreme financial pressures the Council is under. The Council will do its best to protect the services its residents rely on.

PUBLIC QUESTIONS

717 The Chair advised that the Board welcomed questions, any questions should be sent to HealthyBrum@Birmingham.gov.uk.

There were no questions.

Following a request the Chair varied the order of the agenda.

BETTER CARE FUND - END OF YEAR RETURN 2022/23

Mike Walsh (Adult Social Care, Birmingham City Council) presented this item. To approve the Birmingham Better Care Fund – End of Year Return for 2022/23. Following a brief discussion it was

718 **RESOLVED**:-

That the Health and Well Being Board approve the Birmingham Better Care Fund – End of Year Return for 2022/23.

BETTER CARE FUND PLAN 2023/25

Mike Walsh (Adult Social Care, Birmingham City Council) presented this item. To approve the Birmingham Better Care Fund Plan for 2023-25. Following some comments from Members it was

719 **RESOLVED**:-

That the Health and Well Being Board approve the Birmingham Better Care Fund Plan for 2023-25.

CHILDREN AND YOUNG PEOPLE'S PLAN

Colin Michel (Interim Director of Strategy and Partnerships, Birmingham City Council) presented this item

(See document attached).

Colin Michel updated the Board with progress that Birmingham Children and Young People's Partnership had made to commence work on a strategic programme to deliver the ambition and outcomes of Birmingham's Children and Young People's Plan. The briefing outlines governance, actions, and enabler work that form the core of the Plan, highlighting progress, work in development, and forward plans. It had been agreed hat quarterley reports will be submitted to the Board together with an Annual report. Members commented and welcomed the report. The Chair thanked all of those involved in the plan and the commitment of all partners.

720 **RESOLVED**:-

That the Health and Well Being Board note the progress made by Birmingham Children and Young People's Partnership, and the governance arrangements set out in paragraphs 4.11 to 4.21 of the report.

BIRMINGHAM AND SOLIHULL JOINT ICB FORWARD PLAN

Rob Checketts (Chief Officer for Policy, BSol ICB) presented this item.

(See document attached)

Rob Checketts updated the board on the development of the 5-year Joint Forward Plan and how it linked in with the10 year ICP Strategy and responded to comments from Members.

721 **RESOLVED**:-

That the Health and Well Being Board note the information on the collaborative approach to delivery of the Joint Forward Plan and the engagement to deliver the Plan.

WM POLICE: RIGHT CARE, RIGHT PERSON MODEL

Kim Madill (Chief Superintendant, West Midlands Police) presented this item.

(See document attached)

Right Care, Right Person (RCRP) is a national approach agreed between the Home Office and Health partners to ensure that the right person and agency, with the right skills, training, and experience responds to calls relating to mental health or other concerns for welfare. WMP local analysis showed that West Midlands Police (WMP) currently receive and respond to thousands of calls each year, which include non-crime incidents such as concerns about someone's welfare, vulnerabilities or mental health, when the police are not always the best agency to support the person in need. The purpose of this

document was to share the details of the national approach with local partners to support the journey towards implementation.

In response to a question WMP did not yet have details of the national agreement to be shared. There was an event taking place on 8 September, 2023. They had engaged with the ICB's and welcomed any other suggestions. Concerns regarding Mental Health and substance misuse were raised and Members discussed the sharing of information so that people did not get lost in the system.

722 **RESOLVED**:-

The Health and Well Being Board noted that WMP was working towards implementing the Right Care, Right Person model and recommend a joint approach with key local partners to introduce the model and consider the impacts, opportunities and risks to ensure they were aligned and can collectively deliver the best public service to our communities.

HEALTH AND WELLBEING BOARD DEVELOPMENT 2023-24

Jo Tonkin presented this item on behalf of Dr Justin Varney, (Director of Public Health, Birmingham City Council).

(See document attached)

Jo Tonkin updated the Health and Wellbeing Board following its recent Development Day (May 2023) and sought endorsement and approval for the proposed action plan. Following comments from Members it was

723 **RESOLVED**

i) That the Health and Wellbeing Board (HWB) receive and note the feedback from the Health and Wellbeing Board (HWB) Development Day (May 2023). and note the comments on the proposed action plan and work programme for the year ahead and

ii) That the creation of an Executive Board as set out in paragraph 4.5.1 of the report be agreed in principle.

INFORMATION ITEMS

WRITTEN UPDATES

724 The following written updates were on the Agenda for information only.

((See documents attached)

HEALTH AND WELLBEING BOARD FORUM UPDATES

BIRMINGHAM AND SOLIHULL CHILD DEATH REVIEW TEAM AND CHILD DEATH OVERVIEW PANEL (CDOP) ANNUAL REPORT 2021-22

BIRMINGHAM AND SOLIHULL ICB JOINT CAPITAL PLAN 23-24

725 **RESOLVED**:-

That the written updates be noted.

FORWARD PLAN

726 The Forward Plan was noted.

(See document attached)

OTHER URGENT BUSINESS

727 The Chair thanked Douglas Simkiss, Medical Director and Deputy Chief Executive of Birmingham Community Healthcare NHS Foundation Trust who was due to retire before the next meeting.

EXCLUSION OF THE PUBLIC

728 **RESOLVED**:-

That in view of the nature of the business to be transacted which includes exempt information of the category indicated the public be now excluded from the meeting:-

Paragraph 3

Minutes.

The meeting ended at 1230 hours

……
CHAIR

Action Log 2023/24

Rag rating:

Overdue
In progress
Complete

Index no.	Date of Entry	Agenda Item	Action or Event	Named Owner	Target Date	Date Complete	Outcome/Output	Rag
1	18/07/2023	11. Children and Young People's Plan	Agree a future HWB meeting date for Children and Young People's Plan update.	Aidan Hall	26/09/2023	26/09/2023	Added to the HWB Forward Plan.	
2	18/07/2023	12. Birmingham and Solihull Joint ICB Forward Plan	Agree a future HWB meeting date for 'Joint Forward Plan' for the ICS 10-year strategy.	Aidan Hall	26/09/2023	26/09/2023	Added to the HWB Forward Plan.	
3	18/07/2023	10. Health and Wellbeing Board Development 2023-24	Defer the HWB Development item to the next meeting.	Aidan Hall	26/09/2023	26/09/2023	Item refined and brought back to the following meeting.	
4	18/07/2023	20. Exclusion of the Public	'Private' Minutes will be deferred to the next meeting and HWB will be given access	Louisa Nisbett	26/09/2023	26/09/2023	Private minutes circulated to members via email	

	Agenda Item: 9
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**26th September 2023**
TITLE:	**HEALTH AND WELLBEING BOARD DEVELOPMENT**
Organisation	**Birmingham Health & Wellbeing Board**
Presenting Officer	**Dr Justin Varney, Director of Public Health**

Report Type:	**Discussion**

1. Purpose:

1.1. To update the Health and Wellbeing Board on the proposed actions for development following the Board's Annual Development Day.

2. Implications (tick all that apply):

Creating a Bolder, Healthier, City (2022-2030) – Strategic Priorities	Closing the Gap (Inequalities)	X
	Theme 1: Healthy and Affordable Food	X
	Theme 2: Mental Wellness and Balance	X
	Theme 3: Active at Every Age and Ability	X
	Theme 4: Contributing to a Green and Sustainable Future	X
	Theme 5: Protect and Detect	X
	Getting the Best Start in Life	X
	Living, Working and Learning Well	X
	Ageing and Dying Well	X
Joint Strategic Needs Assessment		

3. Recommendation(s)

That the Health and Wellbeing Board (HWB):

3.1. Note and comment on the proposed action plan, including the Executive Board Draft Terms of Reference.

4. Report Body

Health and Wellbeing Board Development Day – Summary

4.1. The Health and Wellbeing Board (HWB) is committed to continuous improvement to improve the health and well-being of Birmingham's communities. This includes development sessions in addition to formal meetings.

4.2. The HWB Development Day took place on Wednesday 17th May 2023 at The Exchange (University of Birmingham). The session was attended by twelve HWB members and key partners, including the leads of the HWB's Forums (sub-groups).

4.3. Board members discussed their role and purpose, relationships with partners and the Creating a Bolder Healthier City strategy. The feedback and insights generated have been collated and summarised (**Appendix 3**) and used to develop a series of actions for the Board to consider and monitor (**Appendix 2**), including a terms of reference for an HWB Executive Board (**Appendix 1**).

Key Points and Next Steps

4.4. The draft action plan (**Appendix 2**) outlines several next steps for the Board to consider and endorse. Feedback and actions are categorised by theme (adapted from the following Local Government Association (LGA) report):

- Supporting HWB Members
- Communications and Engagement
- Prioritisation and Work Planning
- Relationships and Accountabilities
- HWB Role
- HWB Culture and Style

4.5. Key actions include:

4.5.1. Develop an **Executive Board (EB)** to support the HWB. The aim of the EB will be to provide the whole board membership with more space and time for strategic discussion and thematic agenda items. The EB will also have a role in filtering and organising agenda items. The EB will be made up of a smaller number of existing HWB members and will have representation from the ICB, the Council and others. A Terms of Reference has been drafted for the HWB to consider **(Appendix 1)**.

4.5.2. Undertake at least one **HWB development session** annually. Building on the recent Development Day, there was clear agreement that such sessions need to be ongoing, to allow board members to carry on with mutual learning,

understand and develop the role of the board, and explore ways to maximise their contribution. While it is important for boards to be transparent about their work and to discuss and make their decisions in public, they also need the time and privacy to explore options freely at an early stage before reaching conclusions about which workable alternatives may achieve the best outcomes.

4.5.3. Clarify the **relationships and accountabilities of the HWB** with sub-groups (HWB Forums) and other statutory and partnership boards.

5. Compliance Issues

5.1. HWB Forum Responsibility and Board Update

5.1.1. The roles and responsibilities of HWB Forums are outlined in their Terms of Reference (Health and wellbeing board | Birmingham City Council).

5.2. Management Responsibility

5.2.1. The Health and Wellbeing Board is responsible for its continuous improvement and development.

5.2.2. Governance support will be led by the Service Lead (Governance) with oversight from the Director of Public Health.

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Lack of engagement and buy-in to the proposed changes	Low	High	The proposed changes are the result of feedback from Board Members. Members are receiving feedback and the proposed action plan for comment and discussion before formal agreement.
Actions in the proposed plan are not completed within the indicative deadline	Medium	Medium	The agreed actions will be closely monitored, and resources will be allocated to deliver.

Appendices

Appendix 1 – Draft HWB Executive Board Terms of Reference
Appendix 2 – HWB Development Action Plan
Appendix 3 – HWB Development Day (May 2023) – Feedback

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

Rebecca Howell-Jones, Assistant Director for Public Health, Birmingham City Council
Aidan Hall, Service Lead (Governance), Public Health, Birmingham City Council
Alex Quarrie-Jones, Senior Officer (Governance), Public Health, Birmingham City Council
Avneet Gharial, Senior Officer (Governance), Public Health, Birmingham City Council

Birmingham Health and Wellbeing Board

DRAFT Terms of Reference: Executive Board

Overview

The Birmingham Health and Wellbeing Board is a statutory board established under the Health and Social Care Act 2012. It is also a formal sub-committee of the Cabinet of Birmingham City Council. It has a responsibility to provide a forum for leaders in the health and care system to convene and work jointly to reduce health inequalities and support the integration of services.

Purpose

To better facilitate the responsibilities of the Health and Wellbeing Board, an Executive Board has been established to support the streamlining of decision making by the Health and Wellbeing Board. This Executive Board will consider papers on behalf of, make recommendations to, the full Health and Wellbeing Board.

The Executive Board will allow the Health and Wellbeing Board to allocate more time to major strategic decisions and thematic discussions.

Frequency and Structure of Meetings

There are six annual meetings of the Birmingham Health and Wellbeing Board, which occur every other month. Five of these are full Board meetings and one is an annual development session.

Accordingly, the Executive Board will meet six times a year, approximately six weeks before the scheduled date for the Health and Wellbeing Board meeting. The Executive Board will receive an agenda and papers at least five working days prior to its meeting. The Executive Board can also meet on an extraordinary basis if requested by two or more of the members. If so, Executive Board members will be given at least five working days' notice.

The Executive Board will not be conducted in public. The papers and recommendation summaries from the Executive Board will be published in the subsequent reports to the Health and Wellbeing Board for decision-making and approval.

Recommendation summaries will include:

1. A recommendation from the Executive Board on a particular item
2. A short rationale behind the recommendation
3. A summary of members present at the Executive Board and the date of the meeting
4. A reference to the papers and/or evidence that was considered (these will be published at the full Health and Wellbeing Board as appendices)

If there are no items to be considered by the Executive Board, they will not be required to meet before a full Health and Wellbeing Board meeting.

Scope

The Executive Board will consider reports on behalf of, and make recommendations to, the Health and Wellbeing Board. Items to be discussed by the Executive Board will include statutory and non-priority items. Examples can be found in Appendix 1. The agenda of the Executive Board, and therefore the triaging of reports, will be determined by the Chair of the Health and Wellbeing Board in line with these Terms of Reference.

Membership

The membership of the Executive Board will contain full members of the Health and Wellbeing Board, including those with named positions. The membership is stated below:

- Chair of the Health and Wellbeing Board (also the Cabinet Member for Health & Social Care at Birmingham City Council)
- Vice Chair of the Health and Wellbeing Board
- Opposition Spokesperson on Health and Social Care
- A representative from the local Healthwatch
- Two representatives from Birmingham and Solihull Integrated Care System
- The Director of Public Health
- The Director of Adult Social Care
- The Director of Children's Social Services

This list excludes representatives from West Midlands Police, Department for Work and Pensions, Academic institutions, Birmingham Chamber of Commerce, and community and voluntary sector organisations who are otherwise members of the full Health and Wellbeing Board. However, members of the full Health and Wellbeing Board can request to attend Executive Board meetings.

Quorum

The Executive Board will be quorate with the Chair or Vice-Chair, at least one elected member, and three other statutory members of the Health and Wellbeing Board listed above (i.e. minimum of four people) in attendance.

Voting

Each member of the Executive Board will have one vote on any items to be approved. These votes will be non-binding as all decisions that require approval from the full Health and Wellbeing Board will be presented for approval there.

The Executive Board will be supported by officers from Public Health Governance Team. Other attendees will be permitted at the discretion and agreement of the Chair.

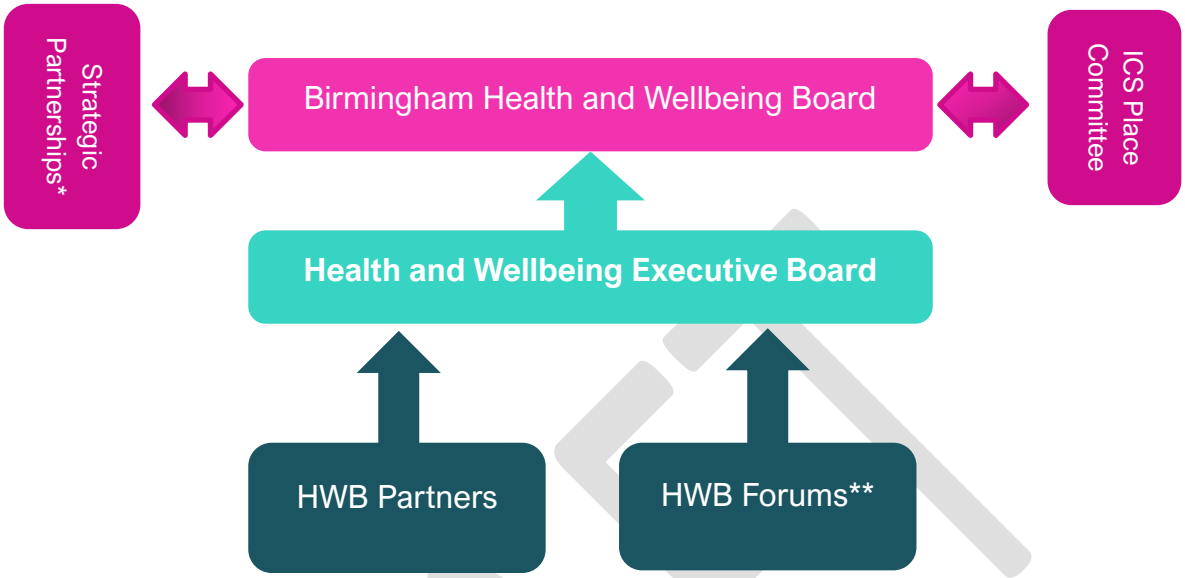
Substitutes

Members of the Executive Board may send substitutes in their place when they are otherwise unavailable. Supporting officers for the Executive Board must be notified of a substitution at least 2 working days before the meeting is scheduled. Notifications should be sent to the email address below:

HWBoard@birmingham.gov.uk

Executive Board Arrangements

Figure 1: Governance structure for Health and Wellbeing Board



* Strategic partnerships in Birmingham include; Children and Young People's Partnership, Adult Safeguarding Partnership Board, Children's Safeguarding Partnership Board, Community Safety Partnership, City Board, and Financial Inclusion Partnership

** HWB Forums include; Creating a Mentally Healthy City Forum, Creating a Healthy Food City Forum, Creating a City Without Inequalities Forum, Creating a Physically Active City Forum, Health Protection Forum

Date of Approval/Next Review

The governance, membership and Terms of Reference of the Executive Board will be reviewed on an annual basis and agreed at the first meeting of the municipal year (July) for the Health and Wellbeing Board.

Appendix 1: Examples of appropriate items for HWB Executive Board

Statutory Items	Non-priority items
• Joint Strategic Needs Assessment Process, Development and Reports • Pharmaceutical Needs Assessments, including supplementary statements • Director of Public Health Annual Report • 'Better Care Fund' End of Year Report • Requests for changes to the HWB Terms of Reference, including membership	• Updates on Indicator Dashboard for JHWB Strategy • Written updates from HWB Forums • Terms of Reference changes for HWB Forums • JHWB Strategy Annual Reviews

Appendix 2 – HWB Development Day Action Plan (presented September 2023)

Feedback/Ideas from Development Day (summarised)	Theme	Proposed Action	Owner	Indicative Deadline (HWB)	Progress
Ensure actions happen between meetings and they appear on an action log	Supporting HWB Members	**Refresh and maintain the Action Log**	Public Health (Governance)	Sep 2023	
Quarterly partner newsletter/bulletin	Communications and Engagement	**Develop a quarterly/partner newsletter and post key updates from Health and Wellbeing Board (HWB) meetings on social media via the Healthy Brum account**	Public Health (Governance/ Comms and Engagement)	Jan 2023	
Shorter meeting papers succinct action points	Prioritisation and Work Planning				
Induction pack for new HWB	Supporting HWB Members	**Create a HWB Induction Pack for new members**	Public Health (Governance)	Nov 2023	
Need to improve awareness of who is a member	Communications and Engagement				
Getting new members up to speed	Communications and Engagement				

Feedback/Ideas from Development Day (summarised)	Theme	Proposed Action	Owner	Indicative Deadline (HWB)	Progress
Clarity of relationships of the HWB board with other boards e.g., ICB, ICP, Place, HOSC	Relationships and Accountabilities	**Create a 'Ways of Working' document/agreement to highlight relationships, responsibilities and roles the HWB has with other partnership boards**	Public Health (Governance)	Nov 2023	
Clarity on governance of corporate strategic partnership	Relationships and Accountabilities				
Define strategic and operational function	HWB Role	**Develop and agree operating principles**	Public Health (Governance) HWB Members	Nov 2023	
Create opportunities for board members to connect	HWB Culture and Style	**Incorporate learning opportunities and reflection into future Health and Wellbeing Board Away Development Sessions** **Run at least one development session annually**	Public Health (Governance)	May 2024	
Reciprocal learning opportunities for HWB organisations	HWB Culture and Style				
Create opportunities for board members to connect	HWB Culture and Style				

Feedback/Ideas from Development Day (summarised)	Theme	Proposed Action	Owner	Indicative Deadline (HWB)	Progress
HWB reflection on success, ways of working and challenges	HWB Culture and Style				
Criteria for taking papers to the board e.g., what if it doesn't meet criteria	Prioritisation and Work Planning	**Establish an Executive Board to support the HWB, providing the board membership with more space and time for strategic discussion and thematic agenda items**	Public Health (Governance) HWB Members	Sep/Nov 2023	
Too many papers (length of reports and time allocated) at each Board meeting	Prioritisation and Work Planning				
Executive Board to sign off reports	Prioritisation and Work Planning				
Is it in the strategy and is it deliverable?	Prioritisation and Work Planning				
Refresh of the Deep Dive programme	Prioritisation and Work Planning	**Add 'Review Deep Dive topics' to the HWB Forward Plan**	Public Health (Governance)	Sep 2023	
We need clear governance, structure and accountability	Relationships and Accountabilities	**Develop Board member roles and expectations**	Public Health (Governance)	Nov 2023	

Feedback/Ideas from Development Day (summarised)	Theme	Proposed Action	Owner	Indicative Deadline (HWB)	Progress
Being understanding and supportive of each other	HWB Culture and Style	**Incorporate the Nolan Principles into a statement or memorandum**	Public Health (Governance) /HWB Members	Nov 2023	
Build relationships with communities	Prioritisation and Work Planning	**Refresh the public question function and process**	Public Health (Governance) /Democratic Services	Jul 2023	
Focus of wider determinants that can be controlled	Prioritisation and Work Planning	**Create a (high level) delivery plan for each of the strategy themes**	Public Health (Governance)	Mar 2024	
Robust action plans e.g., names, deadlines	Prioritisation and Work Planning				
Link between HWB and day job	Prioritisation and Work Planning				
Focus on areas can influence and be creative	Prioritisation and Work Planning				
Accepting realistic time constraints	HWB Culture and Style				

Feedback/Ideas from Development Day (summarised)	Theme	Proposed Action	Owner	Indicative Deadline (HWB)	Progress
Highlight success and failures short and long-term	HWB Culture and Style	**Conduct an independent evaluation of the Joint Health and Wellbeing Strategy**	Public Health (Governance)	May 2024	
Examine other models e.g., Better Care Fund	Supporting HWB Members				
Trust to use resources correctly	Relationships and Accountabilities				
Outside expertise on relationships	Relationships and Accountabilities				
Terms of References need to be agreed for each forum	Relationships and Accountabilities	**Share and review the Terms of Reference for each HWB forum annually**	Public Health (Governance) HWB Forums	Nov 2023	
The membership of the forums may need to be reviewed more frequently	Relationships and Accountabilities				
Forums should have more themed discussions/ presentations to avoid unstructured discussion	Prioritisation and Work Planning	**Explore the options for forums to have thematic sessions and develop actions from these discussions**	Public Health (Governance) HWB Forums	Nov 2023	

Feedback/Ideas from Development Day (summarised)	Theme	Proposed Action	Owner	Indicative Deadline (HWB)	Progress
Forums need to move from a passive role to an active one	Prioritisation and Work Planning				
Better communication methods for forums' members (i.e. not LinkedIn)	Comms and Engagement	**Develop shared mailbox/ email address (or alternative) for each forum with options for regular updates**	Public Health (Governance) HWB Forums	Nov 2023	
Governance structures could better involve Healthwatch and academic sector	Relationships and Accountabilities	**Explore options for representation from Healthwatch and academic sector at relevant forums**	Public Health (Governance) HWB Forums	Nov 2023	
There needs to be better defined accountability between the forums and the HWB	Relationships and Accountabilities	**Explore formal representation (e.g. Board Champions) for forums at Health and Wellbeing Board meetings. Include in refreshed HWB Terms of Reference**	Public Health (Governance) HWB Forums	Nov 2023	
Better representation for the forums at HWB meetings	Relationships and Accountabilities				

Birmingham Health and Wellbeing Board Development Day - Feedback

The Exchange, 3 Centenary Square

Wednesday 17th May 2023

Background

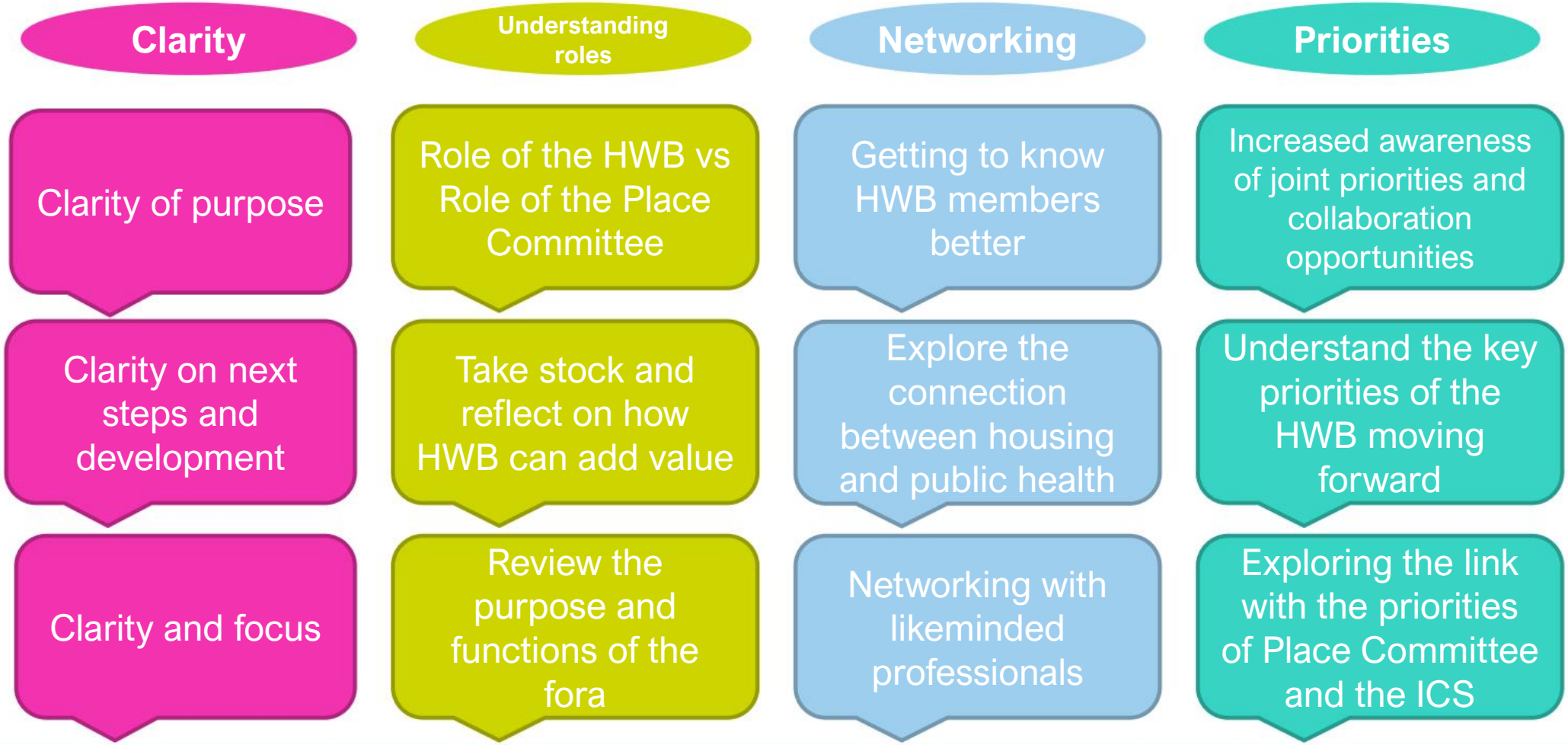
The Health and Wellbeing Board Development Day took place on Wednesday 17th May 2023 at The Exchange (University of Birmingham) building. The Development Day was attended by twelve board members and key partners, including the leads of the Health and Wellbeing Board's Forums.

Board members discussed their role and purpose, relationships with partners and their Creating a Bolder Healthier City Strategy. The ideas generated and feedback provided is summarised on the following sections:

- Role and purpose
- Forums and partners
- Pre-Mortem Exercise (Creating a Bolder, Healthier City Strategy)
- Facing the challenge and actions

The feedback has been used to develop a series of recommendations and proposed actions for the Board to consider.

What did members hope to gain from the day?



BIRMINGHAM HEALTH AND WELLBEING BOARD – OUR ROLE, PURPOSE & PARTNERS

BE BOLD BE BIRMINGHAM

Birmingham City Council

Health and Wellbeing Boards - Drivers and Barriers

Committed leaders, both political and managerial

Collaborative plumbing, often reflecting a history of partnership working

Clarity of purpose, being clear about the primary task of the HWB

A geography that works, or has been made to work

The response to budget changes, which can drive either collaboration or a retreat to silos

A focus on place, with local priorities that drive collaboration

A director of public health, who ‘gets it’

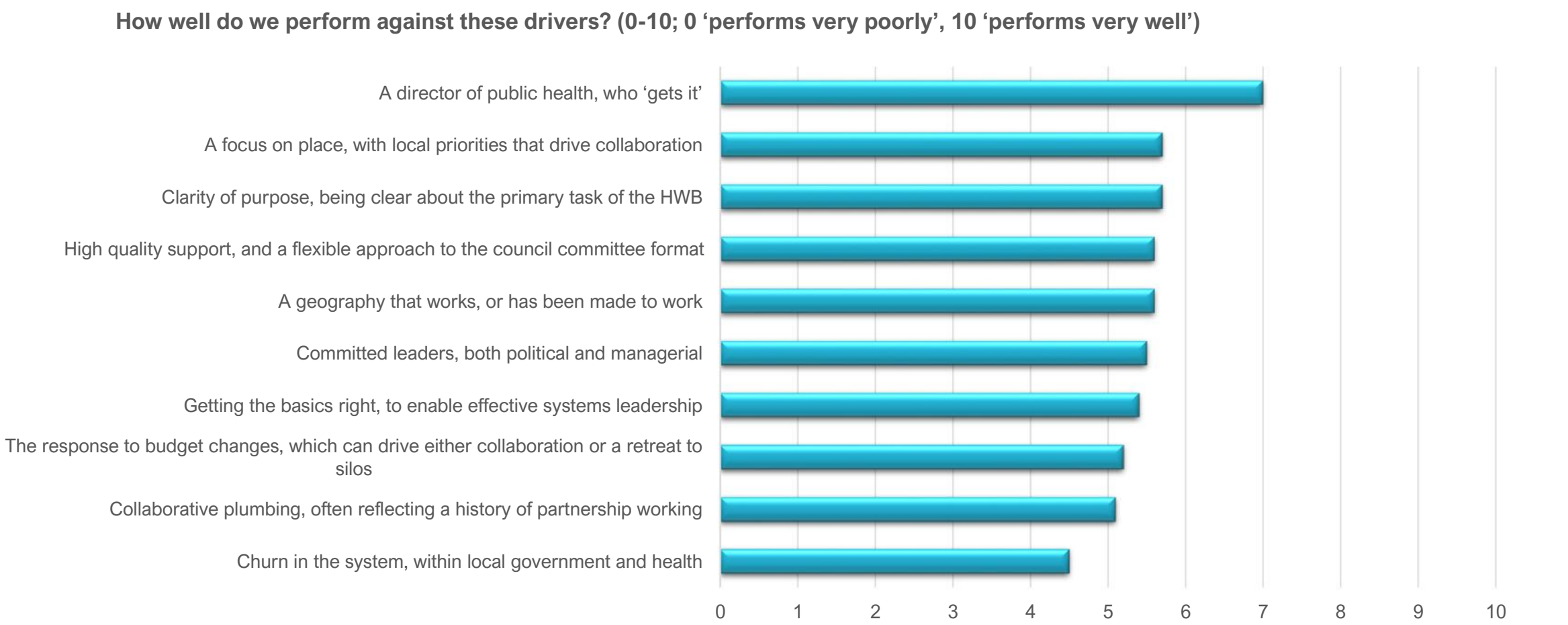
High quality support, and a flexible approach to the council committee format

Churn in the system, within local government and health

Getting the basics right, to enable effective systems leadership

[Effective health and wellbeing boards findings from 10 case studies (local.gov.uk)]

Health and Wellbeing Boards - Drivers and Barriers



Breakout groups: Our role and purpose

- What is the role of the Health and Wellbeing Board?
- What aspects of the Health and Wellbeing Board are working well?
- Which aspects could be improved upon?
- What can I contribute to the Health and Wellbeing Board?
- How can I make my contribution effective?

Feedback: Our role and purpose

What is the role of the Health and Wellbeing Board?

- Leadership and direction-setting
- Collectively deliver the priorities in the HWB Strategy
- Create joined-up working across the health and care system
- Improve health and wellbeing and reduce health inequalities
- To provide accountability and governance
- Place to disseminate and reflect knowledge and experience
- Taking a systems approach with partnership working
- Cross-organisational collaboration

Feedback: Our role and purpose

What aspects of the HWB are working well?

- Functioning and adding value during the Covid-19 pandemic
- Strong public health leadership
- Clarity of purpose from the HWB Strategy
- Helping to achieve greater integration
- Alignment of strategic aims between organisations
- Strong partnership working apparatus
- Helping to identify people who may not be known to other organisations (e.g. DWP)

Feedback: Our role and purpose

What aspects of the HWB could be improved?

- Shorter reports/ briefing details
- Infrequent attendance
- More alignment required with the ICS Place Committee
- Limited opportunity to challenge items before sign-off
- Forums could have greater steer from the HWB
- Improve external communication, especially to communities
- Reduce risk of duplicated work
- Better defined link with Adult Social Care
- Greater focus on localities/wards (e.g. West Birmingham)

Feedback: Our role and purpose

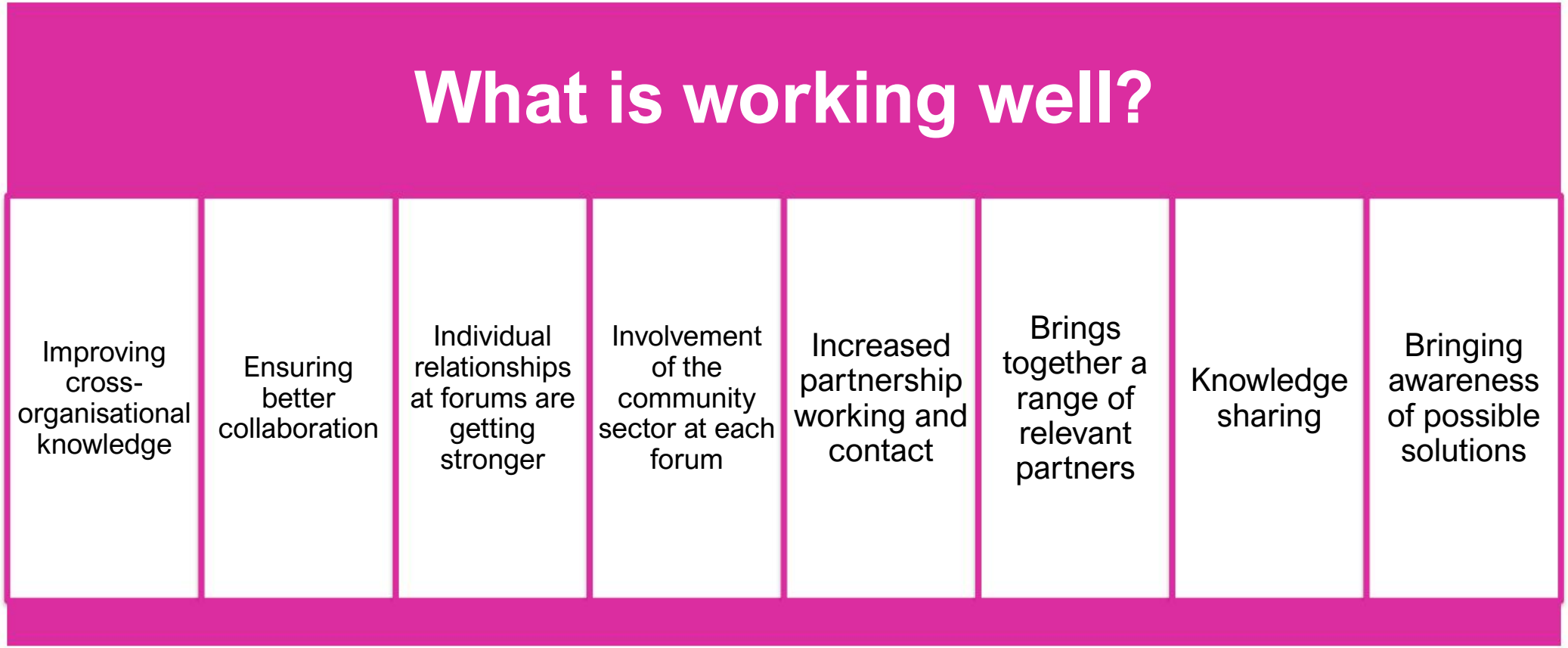
What contribution can I make and how can I make it effective?

- Balance capacity of smaller organisations (e.g. Healthwatch)
- Contribute data, evidence and insight
- Provide scrutiny and keep the HWB accountable
- Establish formal link with other partnerships (e.g. Community Safety Partnership)
- Consistent presence of ASC on the HWB
- Accountability
- Problem-solving
- Providing the crucial link into the activity of the forums

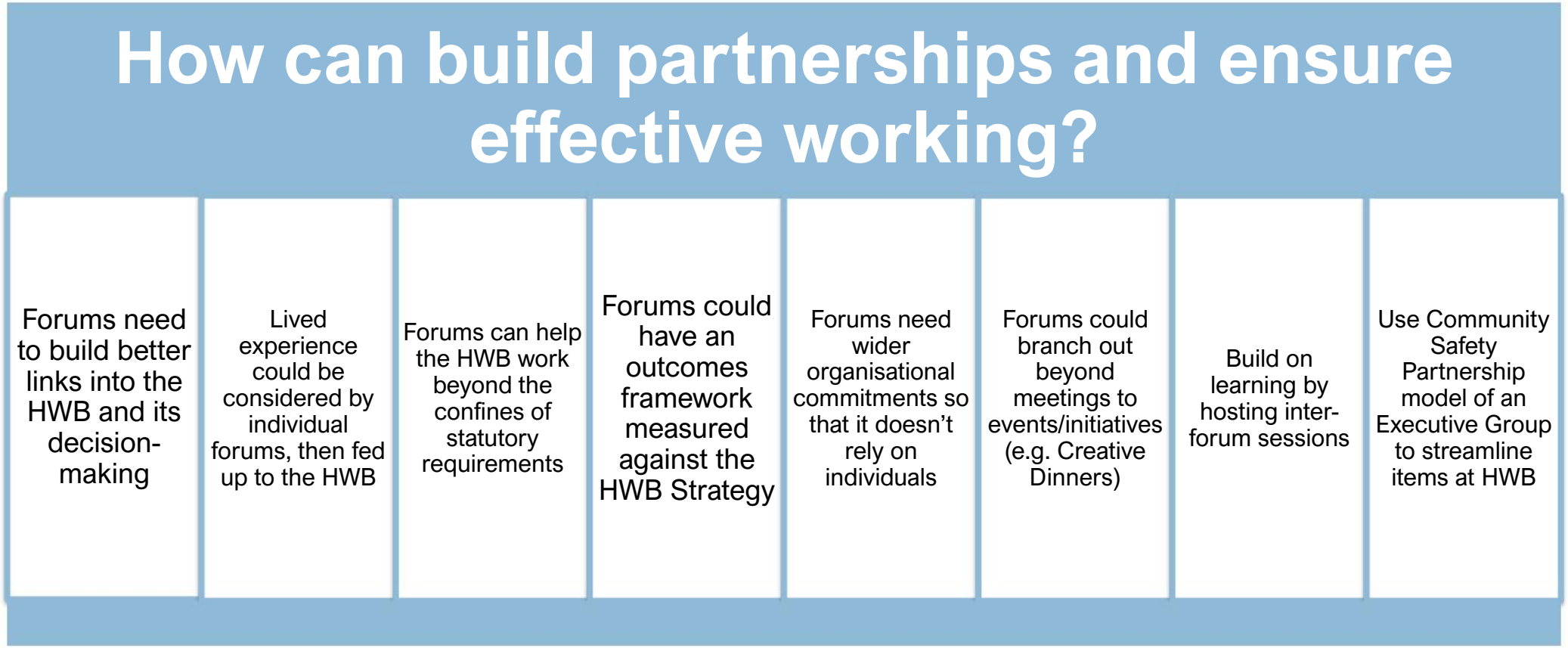
Breakout groups: Our forums and partners

- What is working well across the forums and with our wider partners?
- How do we build partnerships whilst holding ourselves and partners to account?
- How can the HWB enable the forums to be more effective?
- Are the forums fit for purpose? If not, what needs to change?
- Where are the gaps?

Feedback: Our forums and partners



Feedback: Our forums and partners



Feedback: Our forums and partners

Are the forums fit for purpose? Where are the gaps?

Forums should have more themed discussions/ presentations to avoid unstructured discussion	Forums need to move from a passive role to an active one	Governance set-ups could better involve Healthwatch and academic sector	Better communication methods for forums members (i.e. not LinkedIn)	There needs to be better defined accountability between the forums and the HWB	The membership of the forums may need to be reviewed more frequently	Better representation for the forums at HWB meetings

PRE-MORTEM EXERCISE
CREATING A BOLDER HEALTHIER CITY STRATEGY (2022-2030)

BE BOLD BE BIRMINGHAM

Birmingham City Council

Pre-Mortem Exercise

Step One: What went wrong?

a) **Individually** list on post-it notes all of the things that could go wrong. Only list the problems (not the solutions):
- What went wrong?
- Why did the indicators not improve/get worse?

b) Bring together the post-it notes and place into themes.

c) Move around the room with your stickers, vote for the top five potential problems/failures (themes or specific failure).

Step two: Facing the challenge

- Focus on the top problems/failures identified. Write down the top five (most votes) on a new sheet of paper. Start by going further into the problems/failures, asking:
  - What happened to cause that?
  - Keep asking "why has this happened?" to identify logical causes
- Move into solution mode and brainstorm actions needed to avoid/prevent the key problem/failure.

Feedback: (Pre-mortem) - What went wrong?

Commitment

"Lack of commitment from key players"

Community Voice and Engagement

"Insufficient engagement at a community level"

Strategy Management and Action

"Didn't focus enough on our key outcomes lack of long-term commitment

Accountability Leadership and Ownership

"People moving the problem to another service"

Context

"Service commissioned in silo, payment by outcomes and measured by outputs"

National Government

"National Government pulling in opposite directions"

Wider determinants and root cause/Inequalities

"Focus on economic development didn't impact outside the city centre and widened inequalities"

Data

"Not learning from repeatable errors"

Institutional Learning

"We didn't evaluate what we did to see if it was working"

Short-Term Pressures

"Spent too much time working out where partners/boards instead of enabling action to reduce health inequalities"

Why did the strategy fail? (1)

Lack of Accountability/responsibility

5th Why: No one has named an owner (of action)

- Solution: Link between HWB and day job
- Solution: Robust action plans e.g., names, deadlines
- Solution: Clear Governance structure and accountability

Not converting strategy into action

5th Why: Lack of tangible/action because haven't made the time to do the work

- Solution: Actions that are owned
- Solution: Trust to use resources correctly
- Solution: Articulate benefits for individual and organisation

Lack of system leadership

5th Why: Loyalty to organisation, not community

- Solution: Change performance culture
- Solution: Partnership working with check-points
- Solution: Lead from bottom up

External Influences though National Government/Short-term pressures

5th Why: Easier decision than facing bigger problems

- Solution: Be explicit about external influences so can see own performances
- Solution: Highlight success and failures short and long-term
- Solution: Outside expertise on relationships

Why did the strategy fail? (2)

Neglecting/not focusing on the wider determinants

5th Why

Focus on wider determinants that can be controlled

Solution: Focus of wider determinants that can be controlled

Solution: Focus on areas can influence and be creative

Failure to involve/empower communities

5th Why

Skill draw from a certain pool/ culturally does this attracted those with lived experiences

Solution: Work with experts by experience

Solution: Build relationships with communities

Failure to listen and engage with stakeholders

5th Why

Easier not to do

Solution: ToRs to show commitment

Solution: Being understanding and supportive of each other

Lack of/Insufficient use of Capacity/Resources

5th Why

Lack of culture and leadership

Solution: Examine other models e.g., Better Care Fund

Solution: Accepting realistic time constraints

FACING THE CHALLENGE AND MAKING AN IMPACT

BE BOLD BE BIRMINGHAM

Birmingham City Council

Breakout groups: What changes do we need to make?

Areas to consider:

1. **Role** - Do we need to change or clarify the role of the Health and Wellbeing Board? Do we all agree?
2. **Membership** – Do we need to change the membership to ensure we have the right people in the room? Who else do we need to bring in? And how will we ensure that each member can contribute?
3. **Structures** – What changes do we need to support our sub-structures and how we work with other partnerships? E.g. HWB Forums, ICS Place Committee, HOSC
4. **Prioritisation** – What changes do we need to make to ensure we consider only the most important issues?
5. **Support** – What changes do we need to make to ensure the Board is supported effectively?

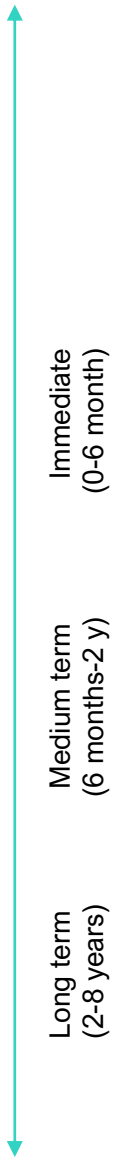
Are these changes:

a) Immediate (0-6 months)

b) Medium term (6 months-2 years)

c) Long term (2-8 years)

Feedback: What changes do we need to make?



Role

- Clarity of relationships of the HWB board with other boards e.g., ICB, ICP, Place, HOSC
- Define strategic and operational function

Membership

- Induction pack for new HWB
- TOR agreed for each forum
- Quarterly partner newsletter/bulletin
- Need to improve awareness of who is a member

Structure

- Ensure actions happen between meetings and they appear on an action log
- Shorter meeting papers succinct action points. March meeting 874 pages. Too much to read
- HWB need structure underneath it that has expertise to scrutinise detail and if been through sub structure don't need to go through HWB meeting
- Clarity on governance of corporate strategic partnership

Prioritisation

- Criteria for taking papers to the board e.g., what if it doesn't meet criteria and still needs
- Is it in the strategy and is it deliverable?
- Refresh of the Deep Dive programme
- HWB reflection on success, ways of working and challenges

Support

- Getting new members up to speed
- Create opportunities for board members to connect
- Reciprocal learning opportunities for HWB organisations

	Agenda Item: 10
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**26th September 2023**
TITLE:	**Joint Strategic Needs Assessment Annual Update**
Organisation	**Birmingham City Council**
Presenting Officer	**Rebecca Howell-Jones**

Report Type:	**Discussion**

1. Purpose:

1.1. To update the Health and Wellbeing Board on the Joint Strategic Needs Assessment (JSNA) for Birmingham, including the live publications and plans for 2023/24.
1.2. To gain support from the HWB for dissemination and stakeholder engagement.

2. Implications (tick all that apply):

Creating a Bolder, Healthier, City (2022-2030) – Strategic Priorities	Closing the Gap (Inequalities)	x
	Theme 1: Healthy and Affordable Food	
	Theme 2: Mental Wellness and Balance	
	Theme 3: Active at Every Age and Ability	
	Theme 4: Contributing to a Green and Sustainable Future	
	Theme 5: Protect and Detect	
	Getting the Best Start in Life	x
	Living, Working and Learning Well	x
	Ageing and Dying Well	x
Joint Strategic Needs Assessment		x

3. Recommendation

3.1. To note the contents of the report,
3.2. HWB to support the continued development, dissemination and use of the JSNA as it contributes to the evidence base for decision making.

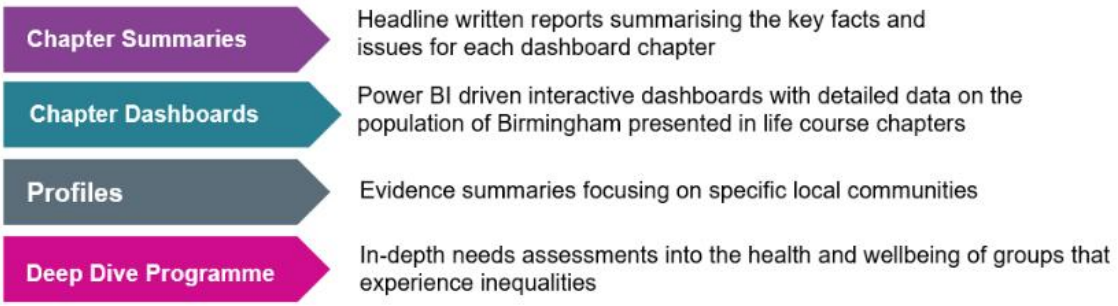
4. Report Body

4.1 Background

The JSNA is an assessment of the current and future health and social care needs of the people of Birmingham; to inform local organisations enabling them to plan services for the future, including informing the Health and Wellbeing Strategy. The JSNA has been developed by Public Health but very much in partnership though the JSNA Steering Committee which includes Adults Social Care, Children and Families Directorate, Birmingham Childrens Trust, Birmingham and Solihull Integrated Care Board and relevant wider Public Health and Council Teams as well as voluntary sector representation.

In developing the latest JSNA, we have moved away from the traditional narrative style, single report to a multi-product, online JSNA 'library' which offers different levels of detail and presentation style to meet the needs of users.

4.2 Structure of the JSNA



4.3 JSNA Current Content

The current content of the JSNA includes:

- JSNA Dashboards and Chapter Summaries:

The JSNA dashboard takes a life-course approach with the following chapters. Each chapter provides a detailed overview of key indicators, bringing together data that are publicly available elsewhere as well as additional local data together and providing local interpretation and context. In addition, a short overview document is provided for each chapter.

  - Children and young people: Conception to Birth
  - Children and young people: Starting Well (0-5)
  - Children and young people: School Years
  - Children and young people: 16-24
  - Children and young people: Vulnerabilities
  - Working Age Adults
  - Older Adults
  - Wider Determinants (in development)

- Profiles

A series of profiles are produced which are included in the JSNA. These profiles provide a focus and deeper understanding of a particular community or geography.

  - 14 community health profiles (published)

- Locality profiles (published)

JSNA Deep Dive Programme Each deep dive provides an in-depth needs assessment of a particular topic area. These reports are evidence-based, capture lived experience and are developed with partners from across Birmingham. The deep dive reports include recommendations for action to improve health and wellbeing and reduce inequalities.

- Health and wellbeing of veterans (published)
- End of Life (published)
- Learning disabilities (publication pending)

4.4 JSNA Publication

JSNA products are published on the City Observatory and on the dedicated Birmingham City Council webpage:

https://www.cityobservatory.birmingham.gov.uk/@birmingham-city-council/joint-strategic-needs-assessment-jsna

https://www.birmingham.gov.uk/info/50268/joint_strategic_needs_assessment_jsna

4.5 JSNA Development and Processes

A multi-agency JSNA steering group was established in December 2022 to oversee the programme of work, improve quality and bring together partners. The purpose of the group is to:

i. involve a wide group of stakeholders from adult and children's health and social care in the identification of indicators and interpretation of those indicators,
ii. agree updates to the JSNA,
iii. disseminate the JSNA for the purposes of decision making, action and inspection.

Terms of Reference for the JSNA steering group are given in appendix. For each chapter a stakeholder sub-group has been developed, which includes representatives of the Steering Group, to take responsibility for agreeing the detailed content. Finally, a JSNA dissemination plan is in development with the JSNA Steering Group.

4.7 – JSNA Plans 2023/24

JSNA Chapter Dashboards
We will develop and publish the wider determinants chapter in 2023/24. Following this, there will be a rolling annual review of each of the chapters (one each quarter). These reviews will aim to gain stakeholder feedback, update interpretation with any additional information and include new data and indicators as appropriate.

Deep Dive work programme for 2023/24 includes;
The work programme for the deep dive programme was previously agreed by the HWBB. The following deep dives are being undertaken this year: .

i. Dual Diagnosis (Substance Use and Mental Health)
ii. Mobility Impairment
iii. Neurodiversity
iv. Work and Worklessness (to commence in 23/24)

Profiles 2023/24
The Locality Profiles are currently being re-developed together with partners, and will be dashboard-based.
There will be an additional 11 community profiles developed. In addition, shorter summaries of existing profiles will be developed using infographics and videos, to make information more accessible.

5. Compliance Issues

5.1. HWBB Responsibility

There is a statutory duty to produce a JSNA. Local authorities and Integrated Care Boards have equal and joint duties to prepare JSNAs through the health and wellbeing board and the responsibility falls on the health and wellbeing board as a whole. Success will depend upon all members working together throughout the process.

Birmingham City Council Public Health Division lead on the JSNA production and development and will report on the JSNA annually to the HWBB to ensure it is fully informed on publication and ongoing development as the statutory duty holder.

5.2. Management Responsibility

Rebecca Howell Jones – Assistant Director of Public Health (Knowledge, Evidence and Governance)
Jenny Riley – Service Lead Public Health (Knowledge)
Luke Heslop – Service Lead Public Health (Evidence)

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Data and understanding of Birmingham's needs are not used to inform decision making in Birmingham.	Medium	High	JSNA is published and disseminated. Efforts are made to ensure the information can be accessed at different levels (e.g. from overview through to detailed understanding). Rolling programme to ensure regular updates.
Partners are not engaged in developing the	Low	High	JSNA steering board has been established to co-ordinate

JSNA and essential insights are missed.			input and provide the forum for development. JSNA is brought to the HWBB annually for discussion. Rolling programme for the JSNA dashboards which enables continued improvement and enhancement.
Due to the size of Birmingham, many information products are launched, leading to confusion.	Low	Medium	Birmingham is a large city with many different communities and therefore there is a requirement for multiple and in-depth considerations of data and intelligence. We aim to provide clarity on our approach and products on BCC website and publish dashboards, and other documents through the City Observatory.
Appendices Appendix 1 - TOR – JSNA Steering Committee			

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

Jenny Riley – Service Lead, Birmingham Public Health
Rebecca Howell-Jones – Assistant Director, Birmingham Public Health

Joint Strategic Needs Assessment Steering Group Terms of Reference

Version 2.0

1. Purpose:

The Joint Strategic Needs Assessment (JSNA) Steering Group for Birmingham City Council aims to ensure that Birmingham has an accurate and up to date view of the health and wellbeing of the population of Birmingham's children, families, adults, and older people.

By:

1) Involving a wide group of stakeholders from adult and children's health and social care in the identification of indicators and interpretation of those indicators.
2) Agreeing updates to the JSNA.
3) Disseminating the JSNA for the purposes of decision making, action and inspection.

2. Membership

The Membership of the group will include those listed below or their representatives:

- Rebecca Howell-Jones, Assistant Director, Knowledge, Evidence and Governance, Public Health Division, Birmingham City Council
- Diane Partridge, Assistant Director Practice Improvement and Development, Birmingham Children's Trust
- David Fallows, Head of Performance, Business and Commissioning Intelligence, Skills and Education, BCC.
- Maria Gavin, Assistant Director, Quality and Improvement, BCC
- Richard Doidge, Commissioning Manager, BCC
- Marion Gibbon, Assistant Director, Children, Young People & Families, Public Health Division, BCC
- Becky Pollard, Assistant Director, Adults & Older Adults, Public Health Division, BCC
- Helen Harrison, Assistant Director, Healthy Behaviours & Communities, Public Health Division, BCC
- Jenny Riley, Service Lead Knowledge, Public Health Division, BCC
- Luke Heslop, Service Lead Evidence, Public Health Division, BCC
- Richard Smith, Head of Insight, Policy and Strategy, Strategy, Equality and Partnerships, BCC
- Richard Wilson, Chief Analyst, Birmingham Solihull ICB
- Sophie Wilson, BVSC
- Stephanie Bloxham, Head of Health & Social Care, BVSC
- Andy Cave, Healthwatch Birmingham

The meeting will be Chaired by: Rebecca Howell-Jones on behalf of Dr Justin Varney.

The Steering Group requires its members to:

- Agree the sub-group membership for the specific JSNA chapter or report, who will:
    - Agree the scope of the JSNA chapter/report.
    - Agree criteria including indicators for publication.
    - Agree indicators for inclusion.
    - Take ownership of the indicators in the JSNA Dashboard and sign off their interpretation.
- Disseminate the findings of the JSNA in their organisations.
- Attend all meetings, or in exceptional circumstances to arrange for a suitable named delegate to attend in his/her place. In case of delegating, the nominee should be appropriately briefed prior to attending the meeting and able to make decisions on behalf of the organisation they represent.
- Represent the views of their nominating organisation, to keep their nominating organisation informed about progress and to communicate the outcomes of the Steering group meetings to their organisations.
- Ensure that there is prompt progress and delivery by their team or nominating body on any actions and strategies agreed by the group.

3. Meetings

The Steering group will meet every month for 1 hour for the first 6 months and two monthly thereafter. Such other meetings may be held as necessary at the discretion of the Chair or should commissioning decisions drive the agenda.

A forward plan which will be used to develop the agenda for meeting.

The agenda for meetings, agreed by the Chair, and all accompanying papers will be sent to members at least 5 working days before the meeting. Late agenda items and/or papers may be accepted in exceptional circumstances at the discretion of the Chair.

Minutes of all meetings of the Steering group (including a record of attendance and any conflicts of interest) will be approved and circulated within 10 working days and submitted for approval to the next appropriate meeting.

5. Review

These terms of reference will be reviewed annually, taking into account views expressed by relevant partner agencies.

	Agenda Item: 11
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**Tuesday 26th September 2023**
TITLE:	**DRAFT BIRMINGHAM AND SOLIHULL ENABLING PRIMARY CARE STRATEGY**
Organisation	**NHS Birmingham and Solihull Integrated Care Board**
Presenting Officer	**Paul Sherriff, Chief Officer Partnerships and Integration** **Dr Sunando Ghosh, Chair General Partnership Board**

Report Type:	**Discussion**

1. Purpose:

The Birmingham and Solihull General Practice Partnership Board (Strategic Advisory Board to NHS Birmingham and Solihull Integrated Care System) is currently asking all key stakeholders for their views on the **draft Enabling Primary Care strategy**, which sets out the shared vision for the future of the sector.

The purpose of this presentation is to seek the engagement and feedback from Bham H&WBB partners on the draft strategy prior to it being presented for approval to the NHS BSol Integrated Care Board in November.

1. Implications (tick all that apply):

Creating a Bolder, Healthier, City (2022-2030) – Strategic Priorities	Closing the Gap (Inequalities)	√
	Theme 1: Healthy and Affordable Food	-
	Theme 2: Mental Wellness and Balance	√
	Theme 3: Active at Every Age and Ability	-
	Theme 4: Contributing to a Green and Sustainable Future	-
	Theme 5: Protect and Detect	√
	Getting the Best Start in Life	-
	Living, Working and Learning Well	-
	Ageing and Dying Well	√
Joint Strategic Needs Assessment		-

2. Recommendation

To receive the draft BSol Enabling Primary Care Strategy for engagement and feedback.

3. Report Body

Background

National and Local Context for Change

Within the last year, there have been major policy drivers to inform change within primary care. The Fuller Stocktake Report establishes a new vision for primary care, and the Hewitt Review supports these recommendations with a focus on system-wide enablement.

Relatedly, the national recovery plans for both primary care access, and urgent and emergency care (UEC) services have driven the way we have structured our ICS operating framework. NHS England and supporting policy has emphasised the importance of joined-up delivery plans across the ICS to drive recovery and resilience across the system, so that any planned changes in secondary care must interface seamlessly with primary care.

Central to the ICS's agenda is the development of partnerships that support innovation and accelerate change. The main vehicle for delivering this transformation is system working and the development of BSoL's provider collaborative programmes. The primary care strategy aims to provide the foundation for primary care collaboration, and therefore scalable planning, delivery and management whilst ensuring direction-setting remains local.

Development of the BSol Enabling Primary Care Strategy

The draft strategy reflects extensive sector engagement and community listening events. Key themes have been identified as the case for transformation as set out below:

- **Meeting demand and integrating care** - A fragmented sector experiencing unprecedented demand must collaborate and integrate to address the factors and pressures that are driving demand pressures.

- **Embedding and allocating resource** - General practice wants to be embedded into the system as an equal provider partner that can influence policy development, inform service change and strategic investment decisions.

- **Leading change and supporting delivery** - Primary care leaders need capacity, opportunities to build capability and a coherent central support offer to deliver effectively.

The sector's biggest challenge, through a range of factors, is meeting increasing demand, whilst attempting to retain a focus on prevention and maintaining continuity of care.

In tackling increasing demand, improving access is not solely an issue for primary care. We have therefore set out the importance of system collaboration at locality and neighbourhood levels with community, secondary care and VCFSE partners.

Measuring success

To date, we have measured used a range key performance indicators (KPIs) as interim metrics. Going forwards, however, we will define a new set of meaningful outcome measures that allow us to evaluate this strategy's success.

4. Compliance Issues

4.1. HWBB Forum Responsibility and Board Update

For information for the HWBB on the key themes as set out within draft BSol Enabling Primary Care Strategy. Following approval of the strategy the HWBB will be kept updated as to progress to deliver the strategy.

4.2. Management Responsibility

Engagement with the sector's strategy is now reaching the final stages of its development. Further system and sector engagement is required to ensure the strategy is clear, is relevant and is reflective of the sector's ambitions and the system's commitments to transformation the way primary care works.

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
-	-	-	-

Appendices

Appendix 1
Summary Enabling Primary Care - A strategy for enabling primary care across BSOL ICB.
Appendix 2
Enabling Primary Care - A strategy for enabling primary care across BSOL ICB.

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

- Paul Sherriff, Chief Officer for Partnerships & Integration
- Ravy Gabrria-Nivas, Head of Operations, GP Provider Support Unit

Birmingham and Solihull
Integrated Care System
Caring about healthier lives

Enabling Primary Care

A summary of the strategy for enabling primary care across BSOL ICS

Working Draft: Version 2.0

JULY 2023

DRAFT

DRAFT

Introduction

1

Where we are now

Understanding the challenges being faced in primary care

2

What we'll do together

Describing what it will take from the system and from general practice to drive change

3

How we'll make it happen

Setting out the roadmap and next steps for how we will transform the sector together

DRAFT

Understanding the challenges faced in primary care

Population growth

The population across BSOL is growing quickly. People are older and more complex than ever, with lots of wider social issues alongside medical ones.

Demand outpacing supply

General practice is putting on over 100,000 more appointments per month that it did before COVID, but demand keeps rising. This means that sector leaders don't have time to transform because of demand in their day jobs.

Financial pressure

There is increased financial pressure and uncertainty, with start-and-stop funding arrangements making service transformation hard to plan.

Fragmentation

General practice doesn't feel like an equal partner within the ICS and its decision-making processes.

Digital and data

It's hard to see patients' records, access their notes and share data between system partners, so providing joined-up care is more difficult than it needs to be.

Patient and staff experience

Patient experience within primary care in BSOL is low, with fewer positive experiences reported. Similarly, high demand, more admin work and less time are also driving low staff morale.

Limited estates

There isn't enough space to serve the growing population, let alone transform services - practices are struggling to cope with their current facilities.

DRAFT

What our vision is for the future of primary care

Better access for patients

Developing appropriate access and capacity to help people get appointments without queuing, renew prescriptions, and work with partners to reduce health inequalities across BSOL.

More time for care

Providing right access first time will free up capacity so GPs and professionals can spend more time on prevention, and more time providing continuity of care for their local population.

Effective resource allocation

Working with the ICS to take a different approach to allocating money, with primary care a constructive partner in system investment discussions.

Common operating model

Laying the foundations to create a sector-led approach with support from the GP Provider Support Unit, and a differentiated offer at practice, PCN and locality level.

Better digital and data

Accelerating ICS investment and support for digital tools, making data sharing easier to improve care, and using emerging technologies like AI to save time and boost productivity.

More space

Developing creative estates solutions and co-locating other services alongside primary care will help use space more effectively and innovatively.

Effective integration

Collaborating to reduce bureaucracy, develop effective culture, and build up ways of working and interfaces between primary care and other care settings.

DRAFT

What we must do to transform together

What we will need from general practice

- Collaboration across the whole sector, aligning around a common vision and integrated operating model for the future
- Commitment to lead and help develop the BSOL 'Right Access First Time' (RAFT) primary care transformation programme
- Ownership to drive, measure and demonstrate improved care outcomes and better value for money for citizens in BSOL

What we will need from the ICB and the wider system

- Central support for the GP Partnership Board and GP Provider Support Unit, change management, and skills development for frontline clinical leaders at PCN and locality level
- Accelerated digital and data support to help practices make best use of existing technologies, and to explore emerging ones
- Comprehensive workforce and estates strategies for primary care, developed in partnership with cross-sector teams and the Community Care Collaborative.

DRAFT

How we'll transform primary care together

1

Year 1

Our first year is focused on bringing 'Team GP' together. It's a call-to-action for general practice in BSOL to align behind a single organisational model. And it has clear next steps to build out the enabling workforce, digital and estates strategies for primary care.

3

Year 3

By our third year, we will have developed clear and specific service strategies and ways to measure success, building on top of the recent clinical strategies that each locality is currently developing.

5

Year 5

By our fifth year, we will have transformed the way primary care is delivered in BSOL. Patients will have better access to integrated and personalised care services in the right place, and professionals will be able to spend more of their time on patient-facing activities.

DRAFT

What the very next steps are for enabling primary care

1

Engage local partners

Listen to feedback and views from all parts of general practice, from system partners, and from citizens and community representatives across BSOL

2

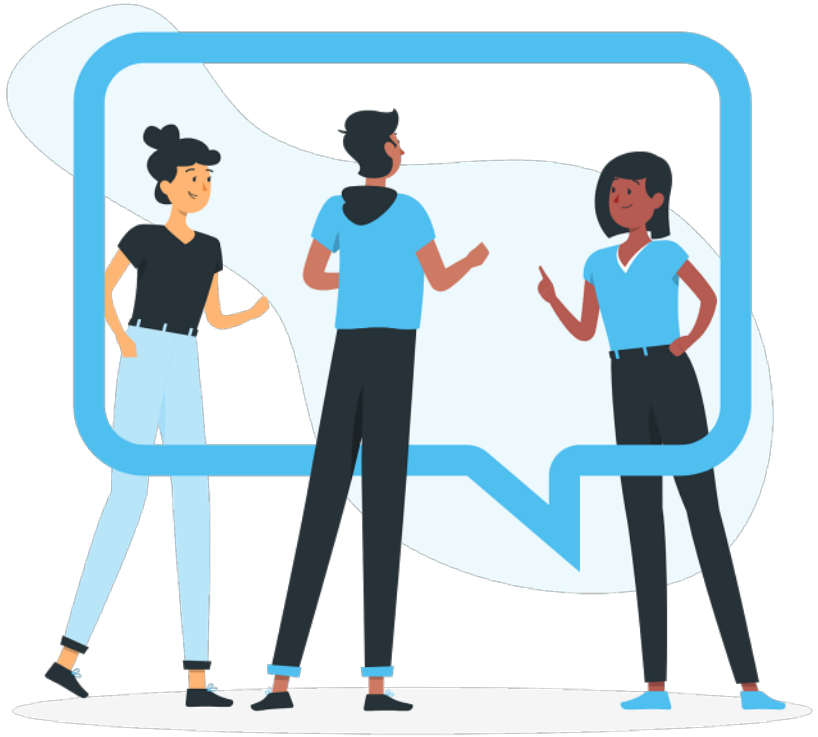
Refine the strategy

Use people's feedback to refine the draft strategy further and build consensus around our direction of travel

3

Define the jobs to be done

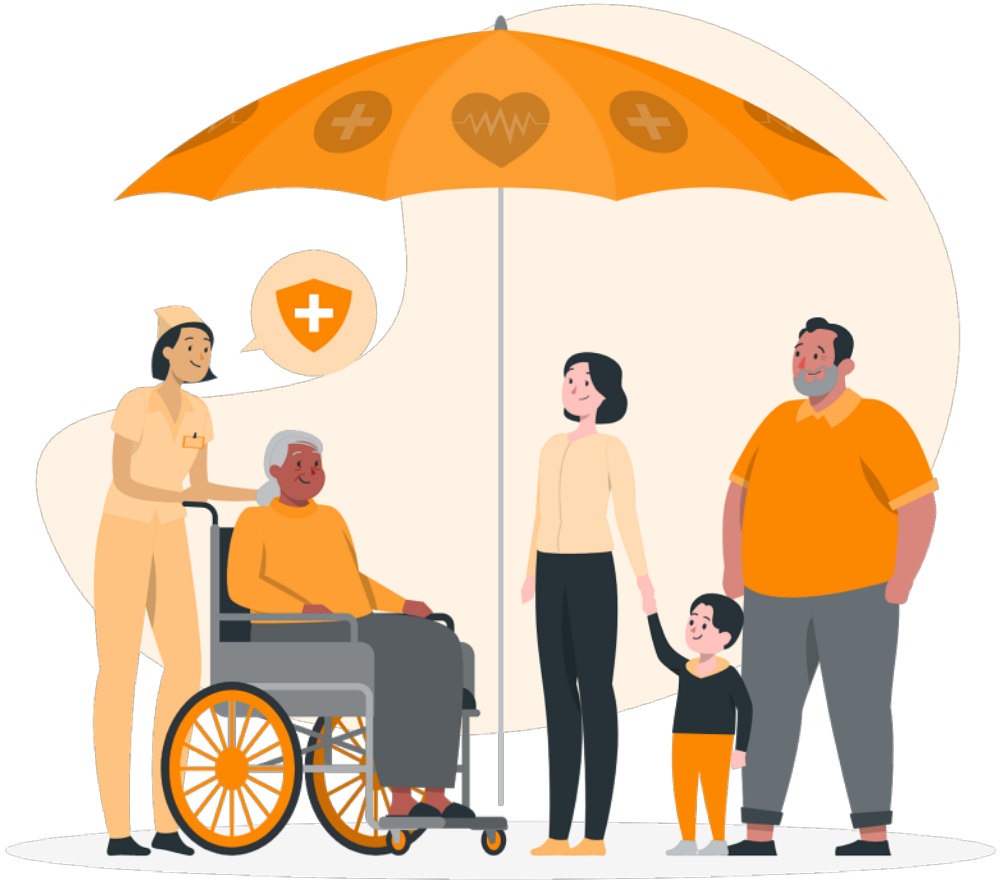
Build out the programmes of work to be delivered in order to make the strategy a reality, including detailed analysis and data-driven implementation plans



Thank you.

Please get in touch with your GP Partnership Board Locality Lead if you wish to discuss this summary further, or for access to a more detailed version.

DRAFT



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Birmingham and Solihull
Integrated Care System
Caring about healthier lives

Enabling Primary Care

A strategy for enabling primary care across BSOL ICB

Working Draft: Version 4.0

JULY 2023

WORKING DRAFT

Table of contents

What this document includes

Birmingham and Solihull
Integrated Care System
Caring about healthier lives

01

The context

What the direction of travel is

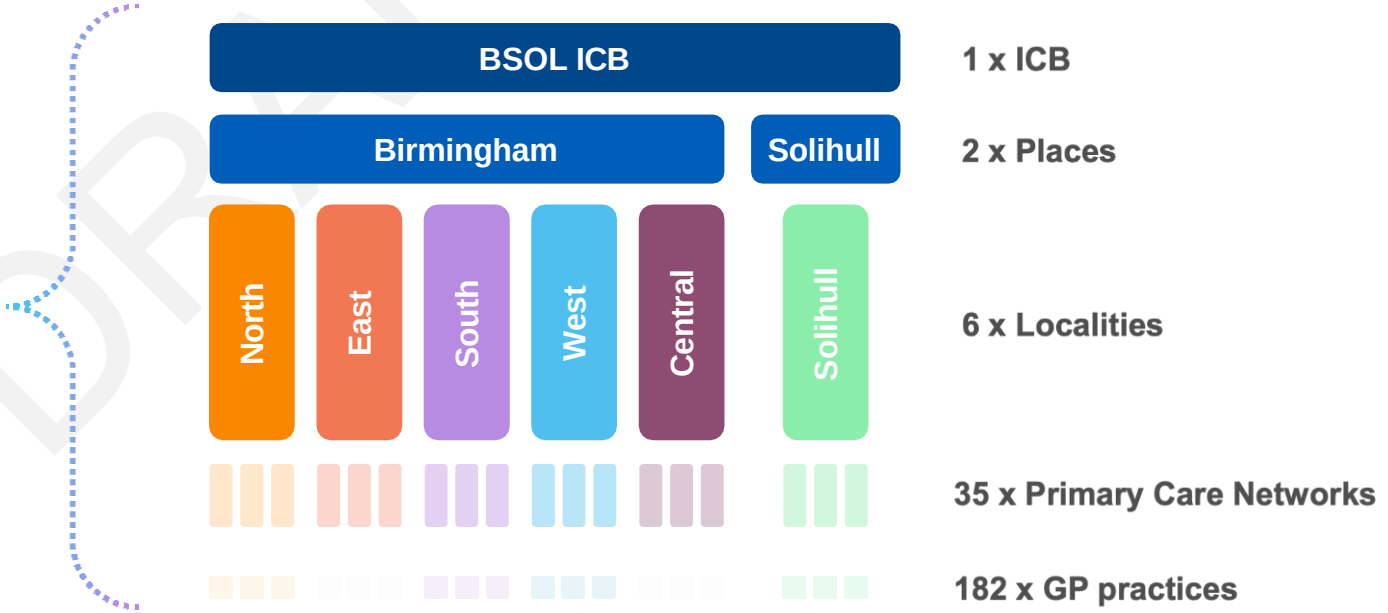
- Introduction to BSOL
- National policy drivers for change
- Local context and transformation

Introduction to BSOL

What our primary care landscape looks like at a glance

BSOL ICS is one of the largest and most diverse geographies in the country, with a population that experiences high rates of health inequalities, disparities in deprivation, and different opportunities to access health and care services. Pertinent trends include changing demographics and an ageing population, workforce recruitment and retention issues, and high post-pandemic waiting lists have all added extra pressure into the system.

Despite this, our vision for the future is for Birmingham and Solihull to be a healthier place to live and work, driving equity in life chances and health outcomes for everyone. The primary care sector has a critical role in realising this vision – it is the anchor that will enable at-scale working across localities and neighbourhoods as the footprints for driving more effective integration between community, hospital, social care and voluntary partners to deliver better outcomes for our citizens.



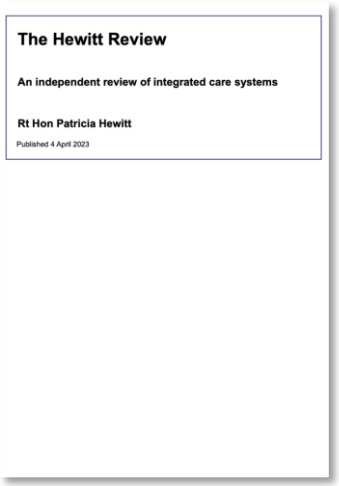
National policy drivers for change

How national policy is driving increased integration, subsidiarity and transformation within primary care

Within the last year, there have been major policy drivers to catalyse change within primary care. The *Fuller Stocktake Report* establishes a new vision for primary care within the NHS, and the *Hewitt Review* supports these recommendations with a focus on system-wide enablement.

FULLER STOCKTAKE REPORT

- The *Fuller Stocktake Report* sets out a new vision for the role of primary care in ICSs as an integral voice in collaboration and integration, with general practice as the bedrock of the NHS and 'the heart of communities'
- One of Dr. Fuller's key recommendations is the development of integrated neighbourhood teams. This will prove critical in providing support to local population health outcomes, promoting the principle of subsidiarity in local decision-making, and driving greater personalisation in the care services offered
- Acknowledging the changes required to make this happen, however, a key priority underpinning this and other recommendations is the need for primary care to become more sustainable, ensuring both its stability and its longevity as a sector
    - This includes **tackling access** to primary care as well as urgent care, which is having a direct impact on general practice's ability to keep up with demand and **offer continuity of care** to patients



HEWITT REVIEW

- The *Hewitt Review* builds on the *Fuller Stocktake Report* and emphasises the importance of collaboration, organisational redesign and cultural evolution within ICSs, with a focus on joint problem-solving
- For primary care, the review also makes clear that models of care will need to shift further 'upstream', with an **increased focus on prevention**; this must also bring the associated resource and investment required to facilitate that shift in a sustainable way

> **"There are real signs of growing discontent with primary care – both from the public who use it and the professionals who work in it."**

National policy drivers for change

How national recovery plans rely on joined-up strategies and delivery across care settings

Relatedly, the national recovery plans for both primary care access and urgent and emergency care (UEC) services have driven the way we have structured our *Operating Framework*. NHS England and supporting policy has emphasised the importance of joined-up delivery plans across ICSs to drive recovery and resilience across the system, so the transformations planned in secondary care must interface seamlessly with our strategy for enabling primary care locally.

PRIMARY CARE RECOVERY PLAN

- The *Delivery plan for recovering access to primary care* also builds on the *Fuller Stocktake Report*, and references system-wide responses to integrated urgent care and neighbourhood teams
- The plan is centred on two key ambitions for access – tackling the 08:00 rush to ensure patients can receive same-day support and guidance from their local practice, and enabling patients to know how their needs will be met when they contact their practice
- To do this, it focuses on four areas to alleviate pressure and drive greater access – **building capacity**, **reducing bureaucracy**, **empowering patients** and **modernising GP access**
- Delivery in these areas includes improving the information, functionality and interoperability of technologies available; expanding the role of community pharmacy; and driving capacity increases through enabling workforce and estates initiatives to better support primary care

UEC RECOVERY PLAN

- Beyond increasing capacity and improving discharge in hospital settings, the *Delivery plan for recovering urgent and emergency care* includes a **core focus on expanding care outside of hospitals**
- This specifically references the importance of the development and improved integration of community services, access to primary care, and more joined-up working and collaboration across settings; these care models will also be underpinned by investment and acceleration of enabling technologies

Local context and transformation

How local policy is driving increased integration, subsidiarity and transformation within primary care

Central to the ICS's agenda is the development of partnerships that support innovation and accelerate change. The main vehicle for delivering this transformation is the development of BSOL's integrator programmes, covering mental health, acute and community services. These will enable scalable planning, delivery and management whilst ensuring direction-setting remains local.

VISION AND OPERATING FRAMEWORK

- BSOL ICS has committed to wider system integration and more joined-up service provision for the public, regardless of where or how our citizens choose to engage with our care services
- To do this, the ICS is using 'integrators' as the vehicles to develop greater integration between different parts of the system in order to:
  - make it easier for patients to **access** the care they need when they need it
  - create the space for our staff to care, and the time for our clinicians to provide the **continuity of care** that is so important to our patients
  - enable a greater future focus on **prevention**
- These three components of access, continuity of care and prevention are critical to becoming a more productive system, enhancing capacity and improving culture in order to deliver better outcomes for our citizens
- This is being driven in practice through three integrator programmes across acute, mental health and community service settings
- Each of these three integrator programmes interacts with primary care in a different way, but **general practice is the common denominator** across them all. This aligns directly with the implementation of Dr. Fuller's recommendations and the piloting of INTs, which will be vital to each integrator programme working well

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02

The case for change

Where we are now, and why we need to transform

- Current situation
- Sector and community engagement
- What we heard

Current situation

What the reality of primary care looks like in BSOL right now

Primary care is currently facing cultural, structural and financial challenges that are making day-to-day life in the sector unsustainable. It has historically low patient satisfaction rates in the latest GP Patient Survey; there is financial instability bred from short-term approaches to resourcing; and the data and estates needed for basic service provision are not consistently fit for purpose. Despite this, general practice is building on foundations of huge success in recent months and years, including stepping up vaccination sites and urgent care hubs, with incredible teams improving service delivery and supporting patients in the face of increasingly challenging circumstances.

Access and patient satisfaction

Increasing levels of demand, greater levels of need and longer waiting lists have all meant that more people are asking to see their GP more often, which is reflected in patient satisfaction rates. The public's unhappiness with access is even more of an issue in deprived areas, which have 17% more demand than those areas with lower rates of multiple deprivation.

Finances

With increasing financial pressures on everyone in the country, GP practices and their staff are no different, with a £6m deficit in primary care funding locally. Practices are having to work harder and for longer to meet contractual targets; many funding streams are inflexible to local needs; and contract changes this year do not include additional investment to counteract the damaging impact of inflation.

Digital, data and technology

GP practices have been at the forefront of the NHS's digital developments, including ePR, e-prescriptions and online booking. However, there is more to be done to support different practices and partners to speak to each other digitally, and to share and use accurate data across organisations. Practices must embrace greater online access and consultation routes for a more digitally-informed public.

Estates

GP practices' estates are extremely variable across BSOL, ranging from modern building to premises unchanged for half a century. New ways of working and connectivity requirements mean the current estates portfolio does not have the capacity to manage increasing demand in the community and the transfers from hospital care. New estates fill up quickly, and yet there is void space that isn't fit for purpose consuming funding that could be used elsewhere.

Sector and community engagement

How this strategy has been informed by the primary care sector and the communities it serves

SECTOR ENGAGEMENT

- Over the last nine months, we've held multiple primary care engagement and clinical leadership events to listen to what's important for over 200 primary care clinicians and practice staff
    - This has included input from elected members, ICP leaders, and BSOL's Health & Wellbeing Board and Health Overview and Scrutiny Committees to ensure engagement and collective alignment across the system
- These roadshows drove engagement have provided the inputs, structure and challenge needed to develop a robust roadmap for transformation, and have helped clarify where our biggest focus areas should be as a sector

COMMUNITY LISTENING EVENTS

- In addition to the sector engagement events, we have also been working closely with multi-agency community engagement leads from both Birmingham and Solihull to promote greater dialogue with seldom-heard communities and understand how best we support their needs
    - These events have included a wide range of representation, from ICS Board members to local citizens who represent their communities and voluntary organisations
- This has helped us shape a community engagement framework, which will ensure we can listen, engage and respond to the needs of our communities more effectively as a sector and as a system

What we heard

From our extensive engagement, there have been six thematic issues that represent the range of views we heard

We've engaged with over 200 GPs and PCN Clinical Directors as part of a series of engagement and listening events across BSOL since November 2022, including clinical leaders from every PCN and almost every GP practice, as well as community representatives across Birmingham and Solihull as places. We have since distilled these conversations into a handful of key themes.

ENGAGEMENT EVENTS

THEMATIC NEEDS

Meeting demand

Demand on BAU activity in primary care is rising. Despite access rates rising with it, practice and PCN teams are left stretched, making future improvement and development unsustainable.

Embedding into the ICS

There is a sense that the sector often feels 'done unto' by the ICS instead of an equal partner, rooted in legacy commissioning arrangements that blurred contracting and development.

Leading change

Primary care leadership has very little surplus capacity nor developmental support. This means leading change locally and collaborating considerately with ICS partners becomes challenging.

Integrating care

The drive for integration out of fragmentation on a locality footprint is well-received, and must connect sensitively into existing work for a system-wide approach that is greater than the sum of its parts.

Allocating resource

Working alongside the GMS contract, a 'boom and bust' approach to resource feeds short-term development; allocations need to be planned and predictable to support sustainable development.

Supporting delivery

The way that central support functions were originally developed has meant that they aren't fit for purpose to support the sector and enable transformation at scale.

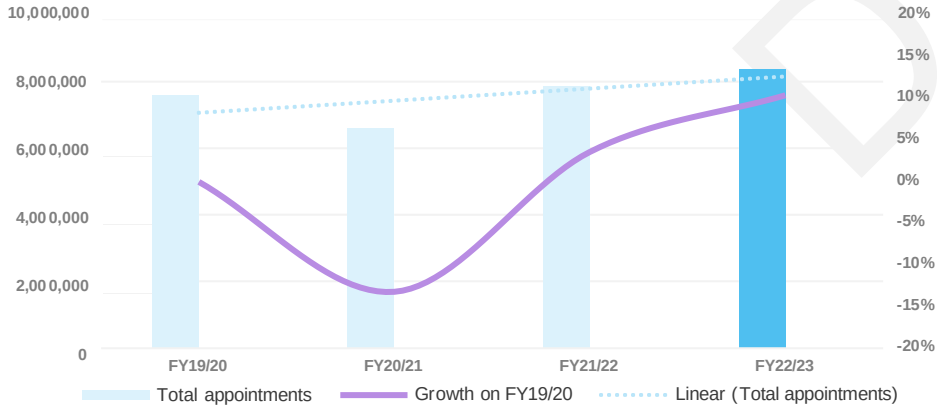
Meeting demand and integrating care

A fragmented sector experiencing unprecedented need must integrate to continue improving access and meeting demand

MEETING DEMAND

- GP practices are seeing **more patients per month** than ever before, and **more of them on the same day**
- Practices delivered **10% growth in appointments** compared to FY19/20 rates, with weighted GP access rates also growing by 16%
- BSOL delivered almost **100k more monthly appointments** in FY22/23 when compared to rolling averages from 2019 to 2022
- Monthly **same-day appointments have increased by 10%**, and BSOL offers 7% more same-day appointments than the national average
- Despite this, public satisfaction surveys show continued dissatisfaction – BSOL recorded the lowest GP Patient Survey score in England with **just 63% patient satisfaction** against a regional average of 79%

Chart showing the absolute and relative growth of annual appointments in BSOL



INTEGRATING CARE

- The sector also experiences **fragmentation and siloed care**, which has built up over time; we have one NHS but many different organisations that work separately within it
- We are building better relationships between these organisations based on patient care rather than contracts, **building a relational discourse** as opposed to a transactional one with patients and system partners
- Wider **societal issues** like the cost of living and loneliness all mean that the NHS needs to work closer with social care and community organisations to address physical and mental health impacts
- Practices have told us that **greater integration is the antidote** when carried out in a considered way, enabling more joined up care across pathways and providers – together we can do so much more

Word cloud showing collective emphasis on the greatest determinants of primary care success

Embedding and allocating resource

General practice wants to be embedded into the system as an equal partner that can influence strategic investment decisions

EMBEDDING INTO THE ICS

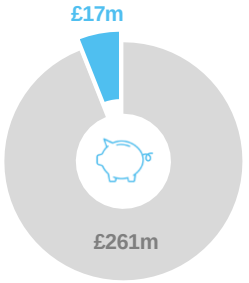
- There is a **lack of structure across the sector** which means it hasn't had a meaningful 'home' in the ICS, and has therefore **struggled to influence and impact** the system
- In order to contribute meaningfully to system development, the sector needs to be **treated as an equal partner** in relation to strategic planning, resource allocation, workforce and digital enablement
- Instead, there should be a **unified voice for primary care** that interfaces with the system and is aligned behind a single vision and strategy
- This need is being addressed by the GP Partnership Board (GPPB), which is the vehicle that enables the sector to interface into the system
- **Localities will also be able to draw influence** from an embedded structure within the ICS, as well as PCNs and providers influencing the system through their locality representatives on the GPPB

Diagram showing the current structure of the GPPB's interfaces with the ICS

ALLOCATING RESOURCE

- **Historical under-investment** in the core contract for primary care needs to be remedied, with funding that should follow the required shift in patient activity further 'upstream', as set out in national policy
- Of the primary care resource available each year**, 94% is fixed on GMS contract and core services**, leaving little flexibility in non-core resource to promote innovation or service development at scale
- The sector has **historically disagreed on how best to use what little flexible resource exists**, with competition leading to small allocations
- The **stop-start nature of incremental resource** undermines the sector's ability to plan and deliver, making investment decisions difficult
- Instead, where there is flexibility on how to use resource, it must be allocated in a way that **has the GP community's sign-off**, and aligns with the ICS's strategic investment decisions

Chart showing how much primary care resource is potentially available for transformation



WORKING DRAFT

Leading change and supporting delivery

Primary care leaders need capacity, opportunities to build capability and a coherent central support offer to deliver effectively

LEADING CHANGE

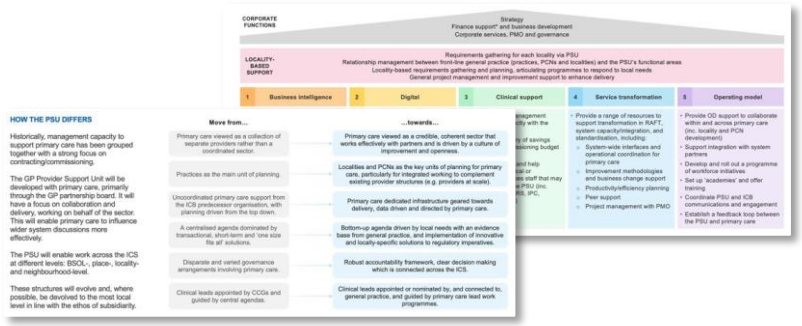
- General practice has often been **left out** of cross-sector planning and decision-making at the system level
- GPs and PCN Clinical Directors **have limited time** to be involved at ICS level, and **have variable experience** to do so effectively
- To do this, the primary care sector recognises it must become 'match fit' in to offer meaningful input and lead change
- There must be a **robust programme of capability development** and associated investment into clinical leadership to ensure change is led through, and owned by, general practice
- Place and locality leads are now **driving transformation from the bottom-up** across primary care, with the GPPB providing strategic direction and support across the ICS

Illustration of the sector's governance, leadership and organisational development plans

SUPPORTING DELIVERY

- Central support for GP practices has been **relatively disorganised** to date, with inconsistent offerings and applications
- Instead, **the sector needs its support infrastructure to be 'match fit'** in order to deliver against its vision, providing the essential capabilities and capacity required for transformation
- The foundation of this delivery support is the GP Provider Support Unit (PSU), which should **bring together the sector's existing expertise and capacity**
- This support must **fit alongside other delivery structures** that already exist, reinforcing the current support mechanisms offered by the ICB and driving development more sustainably across GP providers

Illustration of the GP PSU's future purpose, vision and functions



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03

The road ahead

What we'll do together

- Access and service transformation
- Common operating model
- Winter planning and resource allocation
- Integration
- Central support for delivery
- System enablers

Service transformation

To transform successfully, the system needs to move away from piecemeal approaches and towards a set of clear, cohesive goals

MOVING FROM

In light of the challenges faced by sector colleagues every day, we must move away from **disjointed interventions for alleviating demand**; from uncoordinated and **siloed winter planning**; and from **piecemeal approaches to funding and support** for general practice.

MOVING TO

To navigate the road ahead, we will **evolve the sector's access programme**; we will ensure primary care is **at the table for winter planning**; and we will **promote integration** and collaboration at every level in the ICS through the development of locality hubs, Integrated Neighbourhood Teams (INTs) and more.

Primary care providers will have…

- Sector identity and cohesion
- Sector alignment and collaboration, supported by the GP PSU
- Locality development with focused support and development for key enablers (i.e. workforce, digital and estates delivery plans)
- Bottom-up clinical leadership, resourcing frontline clinicians to network with local practices as the foundation for quality improvement (QI) and transformation
- System-wide transformation activities, driving clarity of focus on a few key priorities and doing them well (e.g. improved access programme)
- Clear infrastructure, governance and processes for partner engagement and whole-system prioritisation

The ICB will have…

- Coherent commissioning strategies that address inequalities and aligning with BSOL's *Operating Framework*
- Strong contract and performance management, with the same degree of quality and assurance oversight as for other providers
- Streamlined enhanced services and alignment of System Development Fund monies (all incentives) with access and integration initiatives across general practice and other settings
- Sponsorship and a refreshed support infrastructure for GPs, including leadership and transformation development resource
- Interfaces with the West Midlands for POD delegation activities

WORKING DRAFT

Responding to the national recovery plan

The sector's single biggest goal is access – and if it improves, then so will continuity of care, prevention and transformation

ACCESS

- Both the sector and the system's **single biggest focus is improving access** to primary care services and meeting demand across the system
- We will address this through a **new transformation programme, Right Access First Time (RAFT)**, which will be the sector's vehicle for change, including the general practice requirements of the national recovery plan
- Improving access **does more than just increase access to care** – by improving access, we are also ensuring clinicians have time to:
  - provide greater **continuity of care** for patients who need it
  - **support prevention** and teach self-management
  - **lead transformation** and integration in line with wider system strategies

QUALITY ASSURANCE AND OVERSIGHT

- Primary care colleagues are committed to **improving quality in general practice** and will commit to developing a new approach to supporting QI
- We will use supportive data to understand the **three key quality domains** for service delivery – clinical effectiveness, patient experience, and patient safety/safeguarding
- We will also commit to **developing a QI framework** to ensure that the three domains of quality are understood and supported through clinical governance structures and external sources, like CQC
- This will ensure **a uniform and fair approach** is taken to managing practice quality across BSOL, and will assist in ensuring strong and **sustainable primary care services that are equipped for the future**

+16% Average GP appointment access rates have increased by 3% since last year, and are **16% higher than they were in 2019**.

+100k There have been almost **100k more appointments every month** than there were from 2019 to 2022.

63% Despite this, demand continues to outstrip supply and average GP **patient experience is 63% positive**, which is the lowest in the country; the Midlands average was 79% by contrast.

Developing a common operating model

The RAFT programme will be the new approach for the sector to improve access, increase capacity and lead transformation

We are now refreshing our general practice access work into a large-scale improvement programme called Right Access First Time (RAFT), which is summarised in the depiction below. This will help practices manage workload more sustainably, improve patient care and deliver against the requirements of the GMS contract. Its outcomes will include more access, more capacity, and more change leadership – and specific success metrics of this programme will be agreed by the GPPB and ICB executives in Q3 FY23/24.

AIMS

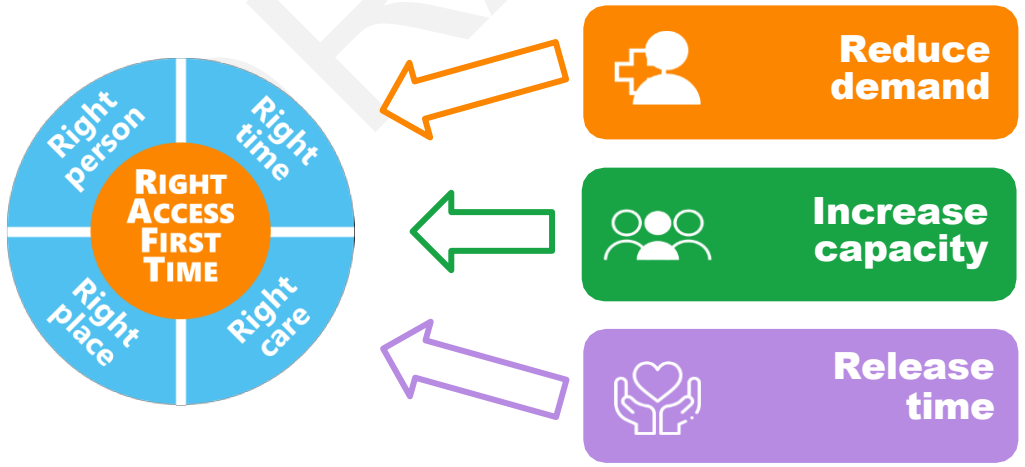
The aims of the RAFT programme are to improve access and to manage workload, to the extent that:

By **Apr-24**, every patient in BSOL will be offered an **assessment of need**, or be **signposted** to an appropriate service, at first contact.

By **Apr-25**, every patient in BSOL will have **consistent access** to the right care from the right person at the right time and in the right place, irrespective of geography, demography, clinical need or registered practice.

MODEL

A holistic approach to optimise the appropriate use of clinicians' time, and an end to the 08:00 rush and 'one size fits all' approaches.



IMPROVEMENT

Wide-ranging actions within and around general practice to drive sustainable improvements.

SUPPORT

Locally-led change projects, with support, advice and coordination from central enabling functions like the GP PSU.

Resource allocation

To drive this impact through RAFT, both the sector and the system must take a different approach to resource allocation together

LONG-TERM FUNDING APPROACH

- Building on GMS, general practice and the ICB must jointly **move away from the 'stop/start' funding approach** that it often ends up relying on; when the ICB has moved away from this approach, the sector has demonstrated benefit and impact
- We will hardwire our commitment for **primary care to be a constructive partner for winter planning** at the outset – this will drive an integrated, whole-system approach to preparations, with additional funding distributed for those cross-sector programmes that will have the biggest impact on system access

FINANCIAL PLANNING

- BSOL will move to **create and enable greater financial flexibility** for general practice's use of existing funding streams for primary care, and ensure all potential resources are accessed and utilised to enable the sector to support the BSOL *Joint Forward Plan* and *10 Year Strategy*
- This will include the **use of enhanced service funding** such as the Universal Patient Offer and Primary Care Commissioning Framework to ensure resource is focussed on the enablement of primary care to support communities and respond to system transformation priorities, including the *Fuller Stocktake*
- We will **bring together existing central funding** for primary care wherever practicable (e.g. SDF, HEE monies), simplify the Universal Offer, and **lobby for a more equitable distribution of system resource** into general practice
- This will drive a **renewed focus on tackling inequalities** as a result of deprivation – BSOL has some of the country's most deprived areas, which adds further pressure to the sector and requires adequate resource to mitigate against unwarranted variation

Example of the impact of consistent funding approaches

When describing the need for consistency approaches to funding and reducing non-recurrent, hand-to-mouth approaches, the Washwood Heath Locality Hub in the East locality exemplifies how more strategic funding can drive impact.

Compared to other locality hubs, the East has:

- ✓ delivered disproportionate activity compared to other localities
- ✓ driven the highest rates of cross-PCN and cross-practice referrals
- ✓ supported the best weighted GP access rates in BSOL
- ✓ offered access to same-day appointments at over twice the rate of those localities asked to stand up hubs on a non-recurrent basis

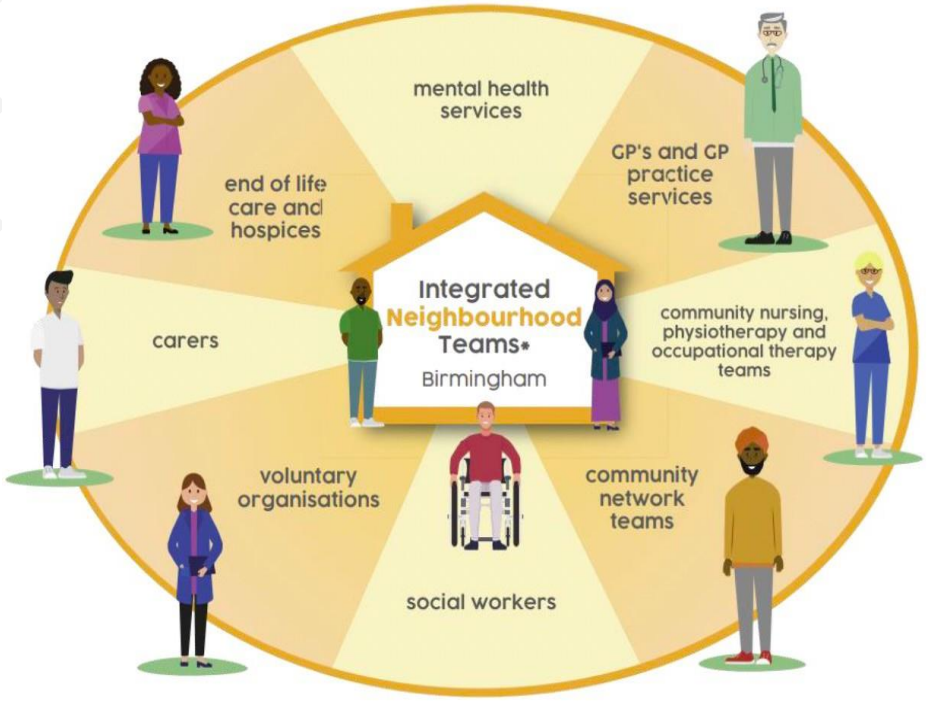
The hub team has attributed this to a more strategic funding approach that has allowed for greater collaboration, improved integration and consistency of delivery across the locality.

Integration

Cross-sector integration is essential to shifting the dial on access, and to enable system transformation in intermediate care and UEC

INTEGRATION AT EVERY LEVEL

- Access is an issue that collectively affects intermediate, urgent and emergency care settings as well as GP practices – and with each part of the system struggling, the **solution necessitates greater integration** across locality and PCN footprints to generate value that is **greater than the sum of its parts**
- We will use **localities as the currency for change**; they will be our wayfinders to drive aligned investment and deliver effective integration across system providers, with **locality hubs as the physical and virtual anchors for integration** at scale
    - This approach is already showing green shoots, with some localities joining up practice and PCN strategies into a coherent, collective locality voice that is driving change and maximising its economies of scale
- We will also **reinforce our commitment to INT development** as part of the Community Integrator Programme which includes GP leadership, driving collaborative service delivery across the acute and mental health Integrator programmes
- As we develop localities and collaborate across primary care, there is also a need to ensure we develop support structures; an engagement model that practices connect with; and a governance approach that **enables and protects inter-PCN working**



STRATEGIC ALIGNMENT

- While improving access and meeting demand is the biggest focus for primary care, **access cannot be an issue for primary care to tackle alone**
- We must therefore **connect into broader system agendas** and strategies, and in this way we're reliant on collaboration with community, secondary care and VCFSE partners

Central support for delivery

We will support primary care by offering dedicated resource to support providers, and giving leadership and organisational development

GP PROVIDER SUPPORT UNIT REFRESH

We are refreshing the functions and the form of the GP PSU so that it is fit for purpose to respond to the sector's needs, and has the corporate stability and capability required to underpin transformation activity.

The GP PSU's future functions and form are being refreshed so that it is better equipped to respond to sector needs, enables work at place, locality and practice level, and is clearly delineated from central contracting and commissioning functions.

The PSU will complement the delivery capability that primary care providers have. It will be the central delivery vehicle for providing the support required to transform services and ways of working through the RAFT programme, supporting the sector as it transforms whilst building trust and confidence throughout.

LEADERSHIP DEVELOPMENT

We are setting up a robust leadership development programme for primary care, providing support, advice and coaching to build capability and confidence across general practice.

To influence and impact the system in a meaningful way, our primary care leaders need a robust programme that offers upskilling opportunities and developmental support. This will connect our primary care leaders at every level of the system, from the GPPB, to PCN CDs and locality leads, to recently-appointed Fuller clinicians.

This support includes developing a Training Hub that meets the needs of all PCNs, as well as a locality-based understanding of training requirements to inform a sustainable development programme. These activities are being delivered as part of the RAFT programme, in line with the national GP recovery plan.

Central support for delivery

The GP Provider Support Unit will complement existing capability and drive transformation through the RAFT programme

FUTURE FUNCTIONAL DESIGN

- The GP PSU's functions have been refreshed so that it aligns more closely to meet sector needs, enables work across the ICS at different levels, and can advocate for general practice appropriately with the ICB's commissioning and contracting function
- We have worked closely with the GPPB, the PSU Steering Group and representative GPs, practice managers and operational leads to reimagine what the PSU's purpose is, and what we're trying to achieve through it
- This has allowed us to agree its key functions and also identify what is out of scope for the PSU; together these will enable delivery of the RAFT programme alongside other strategic imperatives for primary care

FUTURE FORM APPRAISAL

- Relatedly, we have carried out an independent options appraisal to assess where best the PSU should sit in order to add value in the most effective way for primary care and the wider system
- With close consultation from primary care colleagues and ICB executive leadership, we developed a series of assessment criteria and options for the future form, with an independent body developing a recommendation for our consideration and seeking input from relevant cross-sector organisations
- This will introduce a managed transition period for the PSU as it evolves its functions and form, supporting teams to prepare and clarify what it might mean for them

As a primary care sector, we want to…

…drive stability: creating a stable, sustainable and resilient general practice that helps primary care function well as a sector to deliver better access, service quality and experiences.

…create capacity: building the time and thinking space needed to support transformation and service improvement initiatives, with dedicated support to deliver system priorities.

…build clear leadership: developing clear leadership and engagement models for both the sector and its partners to engage with general practice, reducing the degree of fragmentation of the sector's voice and connecting front-line GPs to Board representation.

…influence priorities: working with system partners as equals to influence and impact service improvements, including the development of a clear and concise set of priorities to inform system transformation planning and delivery.

…develop trust: reinforcing the trust and confidence within the sector to have more effective and efficient conversations.

System enablers

We are also giving clear statements of intent for the workforce, digital and estates changes required to enable wholesale transformation

WORKFORCE

We are developing our workforce by retaining the staff we train, reducing our reliance on agency staff, and redistributing system capability into primary care.

Local workforce analysis identifies BSOL's primary care multi-disciplinary team (MDT) profile as an outlier, with a 6% reduction in nurses compared to 11% growth nationally.

We'll continue to work in partnership with the BSOL Training Hub to implement our strategy. This includes an interface education and training providers to ensure a proactive approach for the pipeline of new entrants.

More work is needed to make the sector more attractive by addressing work-life balance and parity with other NHS career paths.

DIGITAL AND DATA

We are accelerating digital enablement by maximising the use of our IT infrastructure and accelerating the adoption and optimisation of new technologies.

Digital, data and technology enablement is integral for general practice and the wider system to realise its vision. A shared patient record, interoperability and system-level data analysis capabilities are essential to planning and delivering service in a coherent way.

We'll continue to plan and set out a programme for digital improvement and innovation, including AI and other products. This will help lay coherent plans for data sharing to improve its understanding of root causes and its service planning to meet the needs of patients and the system.

ESTATES

We are optimising our estates at the locality level by reconciling localities' clinical needs against our estates portfolio, exploring opportunities with civic partners.

BSOL's current estates footprint is inhibiting growth and collaborating across primary care.

To rectify this, there needs to be greater weighting of capital investment to primary care estates, informed by a detailed review of physical space within systems to build a one public estate approach.

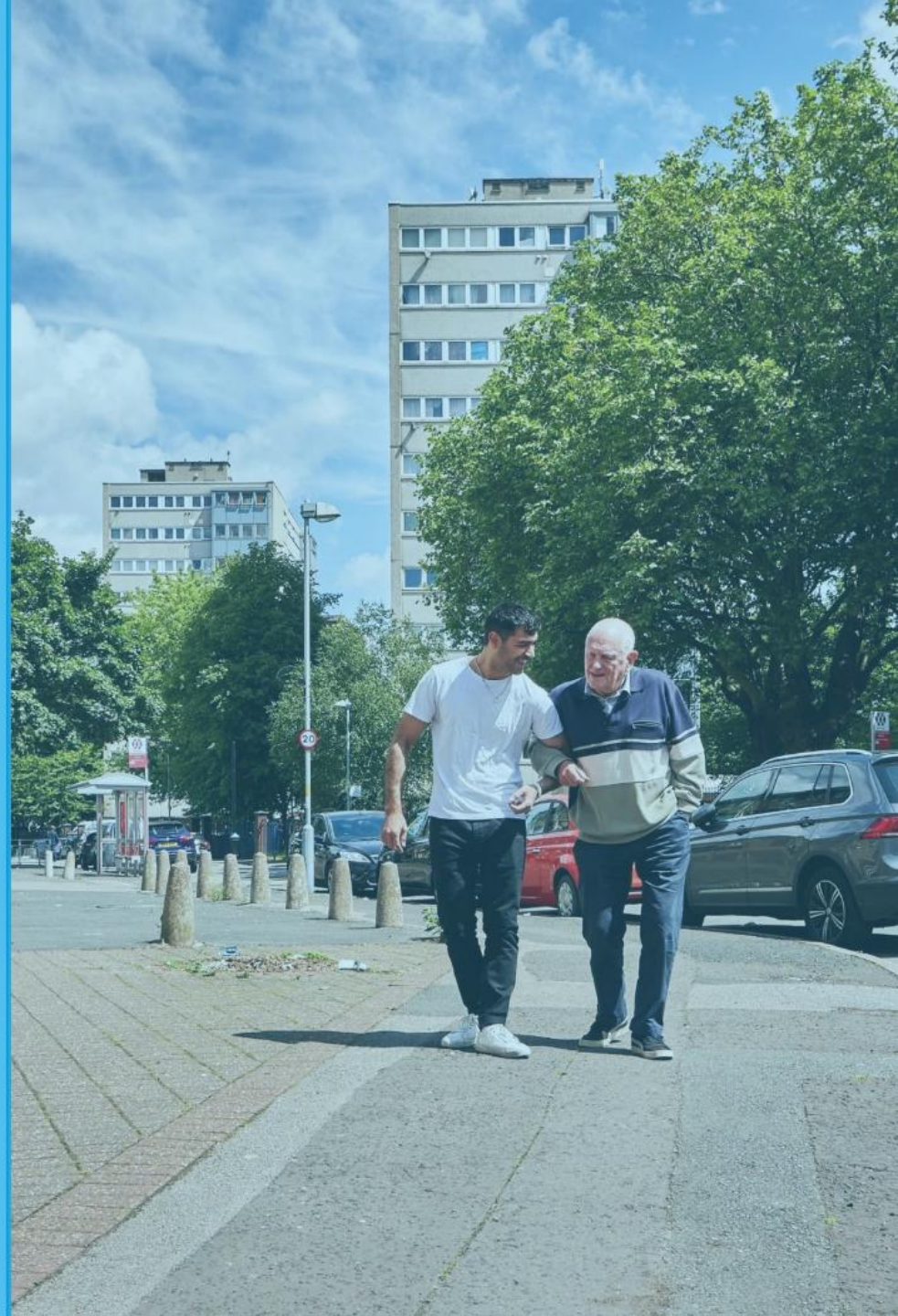
The *Estates Strategy and Condition Analysis* was set out 18 months ago, resulting in funding applications from NHSE to support system-wide, locality-level estates planning that considers deprivation and demographies.

04

The journey

How we'll deliver this together

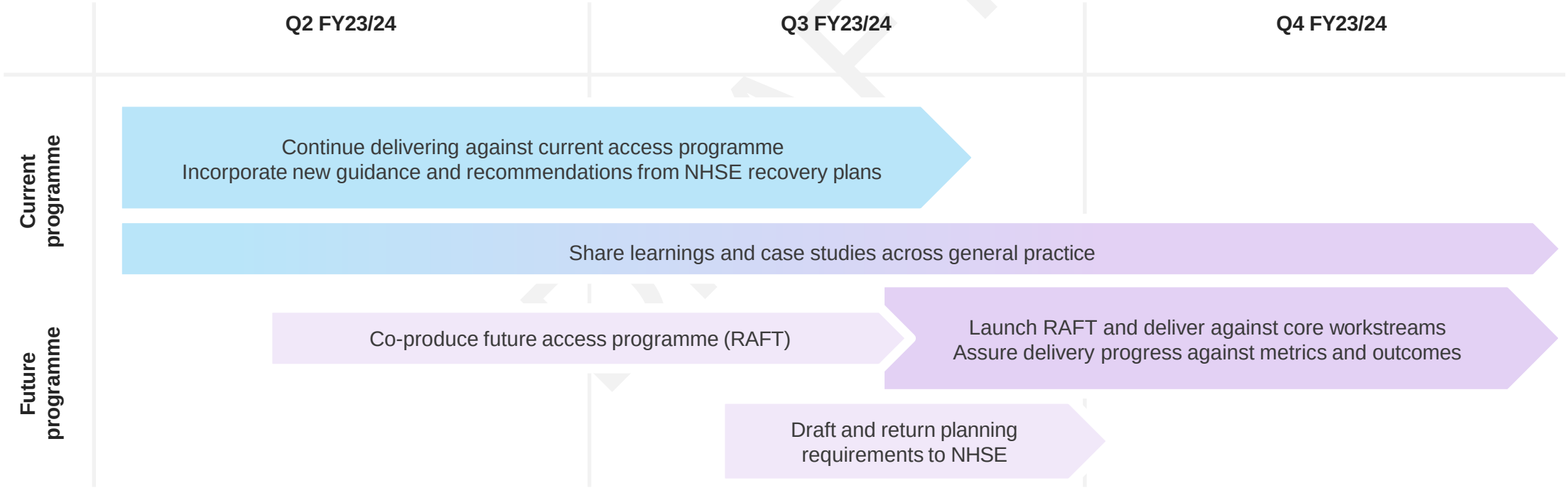
- Transformation programme development
- Workforce delivery plan
- Digital and data delivery plan
- Estates delivery plan
- Success metrics



Transformation programme development

Our current access programme will continue while the RAFT transformation programme is co-produced before it launches in Oct-23

Our existing access programme will continue through Q2 FY23/24 in order to maintain momentum across our core initiatives, and to provide continuity of support to primary care colleagues. This will precede a transition from our current access programme into the future transformation programme, RAFT, which will continue to be co-produced directly with general practice before we launch it in Oct-23.



WORKING DRAFT

Delivery focus for the current access plan

The current programme's activities will continue to reduce demand, improve capacity and tackle variation while co-creating RAFT

	REDUCE DEMAND	IMPROVE CAPACITY	TACKLE VARIATION
AIMS	*Reducing demand in primary care by streamlining activity across the system.*	*Improving system capacity by using alternative flow routes and better forecasting.*	*Tackling variation by understanding root causes with better data and support.*
ACTIVITIES	• Improving access to diagnostics • Refining integrated advice and guidance processes with secondary care • Improving community responses to assist patients who need a quick response (e.g. wound care and SPA) • Doing comprehensive audits to understand why patients contact general practice • Increasing the use of social prescribing • Signposting patients to access support for social issues from appropriate services	• Enhancing escalation processes to trigger system interventions when demand and capacity forecasts indicate mismatches • Working more closely with cross-sector providers to ensure activity isn't 'dumped' inappropriately into primary care services • Using enhanced access and integrated locality hubs to boost capacity • Implementing Community Pharmacist Consultation Services (CPCS) to provide additional capacity through pharmacies • Improving online repeat prescriptions	• Maximising the use of data to understand variation and the root causes driving it • Improving the quality of primary care data to support the design and monitoring of change • Building robust, sector-owned interventions to tackle variation informed by business intelligence and management information • Providing peer support to address variation in working practices and processes • Establishing new locality-based QI teams • Supporting business change to improve telephony and the use of digital solutions

Delivery focus for transformation

The future programme's activities will catalyse our approach to access by reducing demand, increasing capacity and releasing time

	REDUCE DEMAND	INCREASE CAPACITY	RELEASE TIME
AIMS	*Reducing and redirecting demand through work across the ICB with patients and the public.*	*Increasing capacity in all staff roles through training, recruitment and retention initiatives.*	*Freeing up appointments through streamlining access and follow-up processes in practices.*
ACTIVITIES	• Decompress general practice • Enable greater continuity of care and support prevention activities • Enhance single-point-of-access • Streamline information requests and cut bureaucracy • Optimise UEC pathways • Standardise communications • Empower patients with long-term conditions • Optimise self-care and self-referrals	• Retain and recruit GPs and practice nurses • Increase numbers of ARRS staff • Optimise use of ARRS roles in primary care • Develop community pharmacy and online prescription improvement plans • Develop management capabilities • Develop premises and estates • Build transformation and change management capacity through the GP PSU	• Embrace digital communications and automated workflows, modernising GP access and business change • Develop advanced signposting • Streamline appointment systems • Design for continuity • Support frequent attenders • Incentivise efficient follow-ups • Enable proactive long-term condition care

WORKING DRAFT

Workforce delivery plan

How the workforce strategy will be delivered to enable primary care

Workforce capacity remains a huge pressure on primary care. We will ensure a continued focus on recruiting and retaining GPs and the wider primary care workforce, alongside optimising current capacity with a long-term, system-wide workforce strategy that includes primary care. This builds on our Primary Care Workforce Strategy, and is underpinned by a number of practical workforce development schemes across a range of clinical and non-clinical roles.

	Recover net growth	Reduce reliance	Redistribute capability
ACTIVITIES	• Continue retaining and recruiting GPs, practice nurses and the wider workforce to make up for 2% and 7% declines in non-trainee GP and nurse FTEs since 2015 • Create an improved employee value proposition for our staff • Prioritise the delivery of a system-level development offer for primary care, ensuring practice participation • Promote flexibility and support in the creation of new roles, especially for those GPs projected to retire soon	• Use fewer bank/agency staff and overtime international recruitment as compensatory actions, enabled as a result of net workforce recovery • Focus on 'the 4Rs' – recruitment, retention, returners and role allocation, like through the sponsorship of Tier 2 visas • Create the capacity needed for teams to design new ways of working • Enable access to the Fairer Futures Fund to drive investment	• Ensure primary care plays a central role in designing new ways of working to support integrated service delivery • Design and implement practical workforce development schemes across clinical and non-clinical roles, including nursing training programmes for working in primary care • Help cross-sector staff develop the competencies and behavioural change required to make our new integrated models of care work
OUTCOMES	✓ Improved baseline of net staff ✓ Improved retention rates ✓ Attractive employee value proposition	✓ Reduced reliance on bank/agency staff ✓ Improved capacity for existing staff ✓ Greater investment in new ways of working	✓ Improved cross-system capabilities ✓ Greater distribution of AARS roles and relevant competencies across disciplines ✓ Improved MDT composition

WORKING DRAFT

Digital and data delivery plan

How digital acceleration will be delivered to enable primary care

There is room for us to use technology to transform more effectively and more quickly. Our approach to accelerating digital, data and technology centres on maximising existing assets, and then investing in new enabling technologies. There is also a need to develop digital capability across the sector, supporting adoption and usage rates to drive efficiencies through integration – these needs will be informed by locality models of care as they continue to develop.

	Improve data	Drive interoperability and connectivity	Develop digital capabilities
ACTIVITIES	• Enable greater data sharing between partners, with accessible and usable shared care records for patients • Improve the quality of primary care data to measure progress, understand real-time activity and manage change effectively • Develop data linkages to support more advanced MI/BI (i.e. in non-elective, elective and outpatient data covering referrals, attends, waits and admissions) • Build sector-owned success measures	• Support business change processes to improve adoption rates and maximise existing solutions • Bring online other digital solutions, including contractual requirements (e.g. for online consultation) as well as to optimise workflows and create capacity for GPs • Invest in interoperability between partners • Explore joint solutions and opportunities to reduce technological barriers to implementation between providers	• Support innovation with new solutions and emerging technologies • Establish new locality-based quality improvement teams • Provide GPIT support and coaching to practice staff through the PSU, building base capabilities with accessible training • Establish peer support offerings to address service variation across processes, sharing capabilities across all practices
OUTCOMES	✓ Improved data sharing between partners ✓ Improved data analytics and reporting ✓ Robust set of success metrics for primary care transformation	✓ Improved adoption rates ✓ Improved productivity ✓ Improved interoperability	✓ Reduced demand on general practice ✓ Improved usage rates ✓ Greater cross-sector digital capability

WORKING DRAFT

Estates delivery plan

How the estates strategy will be delivered to enable primary care

Our estates strategy will be informed by each locality's clinical strategy for general practice. And to underpin this strategy, we must acknowledge the shift required to move away from new hospital buildings and refocus investment into community and primary care settings to manage demand there. This work will give us a clear view of sector requirements across the system, which can then be reconciled against wider ICS development portfolio and capital allocations.

	Develop clinical strategies	Define strategic requirements	Prioritise the aggregate portfolio
ACTIVITIES	• Carry out work with independent experts to understand the strategic clinical requirements of each locality • Ensure PCN CDs leadership to represent local populations • Use clinical strategies to develop a consolidated view of each locality's space, facility and access requirements • Understand existing opportunities for estates optimisation	• Aggregate each locality's requirements to form a view of the strategic requirements for the ICB as a whole • Understand the existing estates portfolio, including void or partially-used spaces and opportunities to target overheads • Work with civic partners to understand opportunities for collaboration or consolidation, in line with wider integration across the system	• Assess the net system estates portfolio and reconcile against any remaining gaps in ICB estate requirements • Work with civic partners to understand how best to optimise future development projects and add value at scale • Prioritise the portfolio with general practice and develop cohesive plans for flexible, innovative and visionary cross-sector solutions
OUTCOMES	✓ Clarity on locality strategies ✓ Improved understanding of primary care estates portfolio	✓ Defined set of strategic requirements at the locality level ✓ Improved understanding of opportunities for reconciling estates	✓ Improved understanding of gaps in aggregate estates portfolio ✓ Increased confidence in strategic decision-making on capital development

Defining transformation success metrics

We have identified a set of key performance indicators to measure primary care's success in delivering this strategy

We must be able to measure the outputs of our strategy, assess its impact and evaluate its outcomes on our primary care sector and citizens. To date, we have measured a series of key performance indicators (KPIs) as interim metrics. Going forwards, however, we will define a new set of meaningful outcome measures that allow us to evaluate this strategy's success. This will be reinforced by our efforts in generating more granular data across care settings.

CURRENT KPIs

Lead indicators:

- Rates of DNAs per weighted 1,000 list population
- Rates of same-day access
- Number of two-week appointments
- Number of face-to-face appointments
- Rates of CPCS activity
- Rates of social prescribing
- Number of online repeat prescriptions served
- Reported patient experience, concerns and complaints (with a dataset comprising >1m responses)

Impact KPIs:

- Rates of NHS111 activity (in-hours)
- Rates of ED walk-ins (in-hours)
- Rates of activity compared to pre-COVID levels
- Relative distribution of activity across all practices/PCNs

Primary KPI:

- Number of GP appointments per 1,000 list population

Secondary KPIs:

- Number of GP FTEs per weighted 10,000 list population
- Number of DC FTEs per weighted 10,000 list population
- Number of nursing FTEs per weighted 10,000 list population

FUTURE MEASURES

Our future outcome measures will be defined as part of the RAFT programme's development during Q2 FY23/24.

These will go beyond simply measuring access metrics, but rather explore the impact of transformation on patients' care outcomes; on patient and staff experience; on our estates portfolio; on our resource efficiency and productivity, and related measures.

Birmingham and Solihull Integrated Care System
Caring about healthier lives

WORKING DRAFT

Impact and outcomes

What the impact of realising our collective ambitions will be for the sector, system partners, and our citizens

WHAT WE HEARD

- We have a growing population which is more complex than ever before, but we have the same amount of funding
- We don't have the time nor the support to focus on thinking about or leading transformation in a sustainable way
- We don't feel like an equal partner within the ICS and its decisions
- That growth includes many people who need language interpretation, which makes it even harder to do a proper consultation in 10mins
- We can't plan services in a consistent or collaborative way
- We have more financial pressures, with contractual uncertainty and stop/start funding
- Self-help and self-management isn't the starting point for our patients – they come to us instead
- We have to spend more time on admin, often with manual workarounds for inefficient processes
- We struggle to recruit and retain so must rely on locums, which often increases the workload for partners
- We feel growing public and political discontent, including negative media portrayals that undermine morale
- We don't have enough space to serve a growing population, let alone to transform services
- We can't see patients' records, access their notes, or share data

WHAT WE WILL DO

- We will improve access through our current programme by reducing demand, building capacity and tackling variation
- We will co-design and launch RAFT as the sector's transformation programme
- We will set up a robust development programme to support primary care leaders and build skills
- We will commit to using localities and neighbourhoods as the footprints for integration at scale across partners
- We will upgrade the central support provided to general practice by refreshing the GP PSU
- We will reinforce existing governance and appoint GP representatives at each level of our operating model
- We will deliver workforce interventions to retain and recruit staff more effectively, like sponsoring Tier 2 visas
- We will work with system partners to prioritise estate needs and optimise void capacity and spend for new space
- We will invest in digital improvement and innovation, accelerating DDaT strategy roll-out
- We will enable more data sharing and develop advanced analytics and BI for primary care
- We will contribute to system-level investment discussions and support cross-sector winter planning at the outset
- We will develop more flexible and equitable funding models and make use of enhanced service funding

WHAT IT WILL FEEL LIKE

- We have less demand on a consistent basis
- We have more time to work on prevention and provide continuity of care for our patients
- We can devote time to co-designing new ways of working and leading transformation
- We have better working relationships with cross-sector partners
- We are able to offer better services using localities which we couldn't do at the practice- or PCN-level
- We understand local population health trends
- We can plan targeted interventions and service improvements
- We have to do less administrative work
- We can share information between partners effectively, and can see and read patient records and notes
- We can use technology-enabled processes
- We have a more steady pipeline of staff who have more development and learning opportunities
- We have the physical space we need to transform our services
- We have primary care representation at every layer of governance so can trust our voice is being heard in the ICS
- We can contribute meaningfully to ICS investment decisions
- We can use discretionary funding in a way that makes sense locally
- We have more sensible funding allocations and winter isn't a surprise

WHAT OUTCOMES WE WILL DRIVE

- Improved access and increased capacity to support continuity of care and prevention
- Reduced variation in outcomes and inequalities for our local populations
- Improved leadership capabilities embedded within the sector
- Localities have the identity and cohesion to support service integration at scale
- Increased influence in, and impact on, the ICS and its decision-making
- Reduced bureaucracy between the sector and its system partners
- Stable clinical leadership structures in locality and neighbourhood footprints
- Improved staff morale, experience and engagement across the sector
- A fair approach to improving premises and strategic planning that makes best use of system resource at scale
- Improved patient satisfaction and experience with primary care services
- High-quality datasets that inform service planning and collaborative investment decisions
- Shared care records that work and support integrated working meaningfully
- Financial resource is aligned and GPs are engaged to collectively plan and drive transformation activities

Next steps

This strategy continues to be refined, tested and iterated with primary care and relevant system colleagues as it develops

After significant engagement to date, the sector's strategy is now reaching the final stages of its development. Further system and sector engagement is required to ensure the strategy is clear, is relevant and is reflective of the sector's ambitions and the system's commitments to transformation the way primary care works. The next steps to signing this work off are set out below, although this is subject to change while some sections are finalised and further detail is built into the delivery plans.

Birmingham and Solihull
Integrated Care System
Caring about healthier lives

Thank you.

	Agenda Item: 12
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**26th September 2023**
TITLE:	**FAST-TRACK CITIES+ UPDATE**
Organisation	**Birmingham City Council**
Presenting Officer	**Becky Pollard, Assistant Director Public Health (Adults and Older People), Birmingham City Council**

Report Type:	**Information**

1. Purpose:

1.1. The purpose of this report is to provide an update on recent outputs produced for the Birmingham Fast-Track Cities+ (FTC+) programme, a programme that aims to reduce new infections and deaths from human immunodeficiency virus (HIV), Hepatitis B, Hepatitis C (blood-borne viruses (BBVs)) and tuberculosis (TB) in Birmingham by 2030.

1.2. The outputs of note include the Engagement/Needs Assessment Summary, Action Plan and Data Dashboard, which are referenced in the Appendices.

2. Implications (tick all that apply):

Creating a Bolder, Healthier, City (2022-2030) – Strategic Priorities	Closing the Gap (Inequalities)	x
	Theme 1: Healthy and Affordable Food	
	Theme 2: Mental Wellness and Balance	
	Theme 3: Active at Every Age and Ability	
	Theme 4: Contributing to a Green and Sustainable Future	
	Theme 5: Protect and Detect	x
	Getting the Best Start in Life	
	Living, Working and Learning Well	x
	Ageing and Dying Well	x
Joint Strategic Needs Assessment		

3. Recommendation

3.1. The Board is asked to review and note the following outputs produced for the Fast-Track Cities+ programme:
- 3.1.1. Engagement and Needs Assessment Summary (Appendix 1)
- 3.1.2. Action Plan (Appendix 2)
- 3.1.3. Data dashboard (screenshots shown in Appendix 3) to be agreed by the FTC+ Project Board and Director of Public Health

3.2. The Board is asked to note that the FTC+ Project Board now reports to the Health Protection Forum and other appropriate fora to oversee and coordinate efforts to deliver the Action Plan

4. Report Body

Background

4.1. This is the first report to the Health and Wellbeing Board for FTC+ however reports have been made to Birmingham City Council Cabinet as set out at 4.8.

4.2. A key focus of Theme 5 within the Birmingham Joint Health and Wellbeing Strategy is to protect individuals from the harm caused by infectious diseases such as HIV, hepatitis B, hepatitis C and TB through early detection and treatment. For this reason, Birmingham is one of 12 local authorities in the UK and one of 300+ international cities signed up to the FTC programme.

4.3. At its core, the programme aims to reduce health inequalities. Prevalence rates of BBVs and TB are higher for Birmingham than the average for England. Prevalence rates are also higher among certain vulnerable population groups compared to the general population. These include but are not limited to: homeless and rough sleepers, people who inject drugs, sex workers, LGBTQ+ individuals, women of reproductive age, Black African individuals, South Asian individuals, people aged 60+, men who have sex with men, young people aged 13-25, refugees and asylum seekers.

4.4. After the FTC+ Steering Group agreed that Birmingham was equipped to officially sign up to the programme and commit to achieving the targets, Birmingham officially signed up to the programme in October 2022. An in-person Signing Ceremony was held, during which the Lord Mayor and the Vice President of International Association of Providers of AIDS Care (IAPAC), the organisers of the FTC programme, signed the Paris Declaration (Appendix 4), committing to reduce new infections and deaths from BBVs and TB in Birmingham. Stakeholders from the National Health Service (NHS), UK Health Security Agency (UKHSA), Office for Health Improvement and Disparities (OHID), community groups and industry attended due to the joint-working nature of the project.

4.5. A FTC+ Project Board has now been established to oversee the delivery of the programme led by Birmingham City Council's Public Health Team.

4.6. More information about the programme can be found on the Birmingham FTC+ webpage (www.birmingham.gov.uk/ftc). In summary, the aims of the programme are as follows:

- 4.6.1. To strengthen existing programmes and focus resources to accelerate locally co-ordinated, city-wide responses to end HIV/AIDS by 2030.
- 4.6.2. To attain the UNAIDS 95-95-95 targets (page 3, Appendix 1) by 2030 and achieve zero stigma and discrimination.
- 4.6.3. To attain a series of targets for hepatitis B (page 3, Appendix 1), hepatitis C (page 3, Appendix 1) and TB (page 4, Appendix 1).

Key statistics

4.7. Based on currently available data, progress against some of the FTC+ targets are listed below. The full targets and data can be found in Appendix 5. To note that the targets highlighted in red have yet to have baselines sourced and agreed.

Engagement/Needs Assessment, Action Plan and Data Dashboard

4.8. Approval for funding was received from Cabinet during December 2020 (CMIS Decision Details can be found here) and approval was received from Cabinet on an update paper during June 2022, which detailed amendments to the funding (CMIS Decision Details can be found here). Since then, work on the Birmingham FTC+ programme has progressed. To date, activities include:

4.8.1. An Engagement and Needs Assessment exercise conducted during 2021 to establish the views of citizens and stakeholders in Birmingham regarding BBVs and TB and analyse how current data compares to the overall targets. A summary version of the report has been drafted and made accessible. Once noted by the Health and Wellbeing Board, the document will be made publicly available. Please see Appendix 1 for the final version of the report.

4.8.2. Based on the recommendations from the Engagement/Needs Assessment, an Action Plan has been developed to set out the actions required to meet the targets of the programme, and can be seen in Appendix 2. This Action Plan sets out required actions, suggested timescales, resource allocations and responsible teams from the FTC+ Steering Group, where available. The report has been made accessible and remains a working document due to its dynamic nature. Work is ongoing to identify timescales, resources, and delivery partners to achieve all actions set out in the plan. Once noted by the Health and Wellbeing Board, the document will be made publicly available. It is recommended that the actions are reviewed by the FTC+ Steering Group and Project Board quarterly to ensure the programme remains on track.

4.8.3. A key finding of the Engagement/Needs Assessment was the need for a data dashboard to enable stakeholders to measure progress against the targets. Screenshots of the dashboard can be found in Appendix 3. The dashboard will be made publicly available on the Birmingham City Observatory once the Health and Wellbeing Board has noted it. Members of the Board can access the dashboard if they would like to, by emailing Dharini.roula@birmingham.gov.uk.

4.9. The Fast-Track Cities+ ambition is for work to continue and ensure stakeholder budgets are pooled together to ensure the recommendations from the Engagement/Needs Assessment can be actioned.

Upcoming Awareness Days

4.10. Key upcoming priorities will be to deliver local campaigns to amplify national and international awareness days such as:

4.10.1. World AIDS Day on 1st December 2023

4.10.2. HIV Testing Week during early February 2024

4.10.3. World TB Day on 24th March 2024

4.10.4. World Hepatitis Day on 28th July 2024

5. Compliance Issues
5.1. HWBB Forum Responsibility and Board Update
5.1.1. An update on progress of the FTC+ programme will be provided to the Health Protection Forum (as a sub-group of the HWBB) and other appropriate boards, at regular intervals.
5.2. Management Responsibility
Dr Justin Varney, Director of Public Health, Birmingham City Council Becky Pollard, Assistant Director Public Health (Adults and Older People), Birmingham City Council Juliet Grainger, Service Lead (Adults), Birmingham City Council

6. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
The list of actions included in the action plan is extensive and requires strong commitment from the relevant stakeholders. Without this commitment, there is a risk that the actions will not be achieved	Medium	Medium	Named teams and organisations are being assigned to actions in the action plan

Appendices
Appendix 1. Engagement and Needs Assessment Summary
Appendix 2. Birmingham FTC+ Action Plan
Appendix 3. Data dashboard (screenshots)
Appendix 4. The Paris Declaration
Appendix 5. Targets and Corresponding Data – July 2023

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

Becky Pollard, Assistant Director Public Health (Adults and Older People), Birmingham City Council
Lottie Drury, Senior Public Health Officer, Birmingham City Council
Juliet Grainger, Service Lead (Public Health Adults Team), Birmingham City Council
Dharini Roula, Senior Public Health Officer, Birmingham City Council

FAST-TRACK CITIES+

Birmingham City Council

Engagement & Needs Assessment for Birmingham

EXECUTIVE SUMMARY

FAST-TRACK CITIES+ BIRMINGHAM

A BOLDER HEALTHIER BIRMINGHAM

CONTENTS

BIRMINGHAM AS A FAST TRACK CITY

The Fast-Track Cities initiative was launched on World AIDS Day in 2014. It is a world-wide drive towards ending HIV and is partnership between a network of cities and four core partners:

- The International Association of Providers of Acquired Immune Deficiency Syndrome (AIDS) Care (IAPAC)
- The Joint United Nations Programme on HIV/AIDS (UNAIDS)
- The United Nations Human Settlements Programme (UN-Habitat)
- The city of Paris.

Originally the initiative just aimed to target and eliminate HIV but since initiation in Birmingham, Viral Hepatitis (Hepatitis B and Hepatitis C) and Tuberculosis (TB) were added to the initiative as they could be co-targeted with HIV, leading to the Fast-Track Cities+ initiative (with '+' indicating the addition of Viral Hepatitis and TB).

The purpose of this initiative is to:

- Ensure availability and access to effective testing and treatment to significantly reduce and therefore eradicate new cases of blood-borne viruses (BBVs) - HIV, Hepatitis B and Hepatitis C) - and TB.
- Strengthen communities and ensure timely provision of services that support the population living with these conditions, without prejudice and stigma.
- Ensure effective, targeted, and necessary public health interventions are in place for BBVs and TB to enable the delivery of the Fast-Track Cities+ vision by 2030.

The following partners set an intention to address BBVs (HIV, Hepatitis B and Hepatitis C) and TB transmission locally:

- NHS Primary Care
- NHS Secondary Care
- NHS Specialised Commissioning
- BSol ICS
- UK Health Security Agency
- Industry Representatives
- Birmingham Public Health
- Community Partners

Encompassing a whole-city approach, the initiative offers a more joined-up effort to eliminate and eradicate new transmissions of BBVs and TB.

Timeline:

- **December 2020 – March 2021:**
  Tender process to obtain provider to conduct community engagement and needs assessment
- **April 2021 – August 2021:**
  Community engagement and needs assessment data gathering
- **September 2021 – May 2022:**
  Report write-up for community engagement and needs assessment
- **May 2022 – October 2022:**
  Finalising targets and scoping data for monitoring progress
- **October 2022:**
  Birmingham signs the Paris Declaration
- **October 2022 – July 2023:**
  Development of the Data Dashboard and Action Plan, utilisingthe findings from this document
- **July 2023 onwards:**
  Implement the Action Plan and utilise the data dashboard to monitor progress on the targets

TARGETS

The below targets have been developed and adapted from global and national targets to fit Birmingham's context and the data which is available on the local level. They have been informed by local clinicians, epidemiologists and other experts in the field. Progress towards these targets is being monitored using a data dashboard which is available on the Birmingham Observatory.

HIV

These targets are included in the Paris Declaration and are the UNAIDS 95-95-95 targets By 2030:

- 95% of people living with HIV (PLHIV) knowing their status
- 95% of people who know their HIV-positive status on HIV treatment
- 95% of PLHIV on HIV treatment being virally suppressed
- Zero stigma and discrimination

Hepatitis B

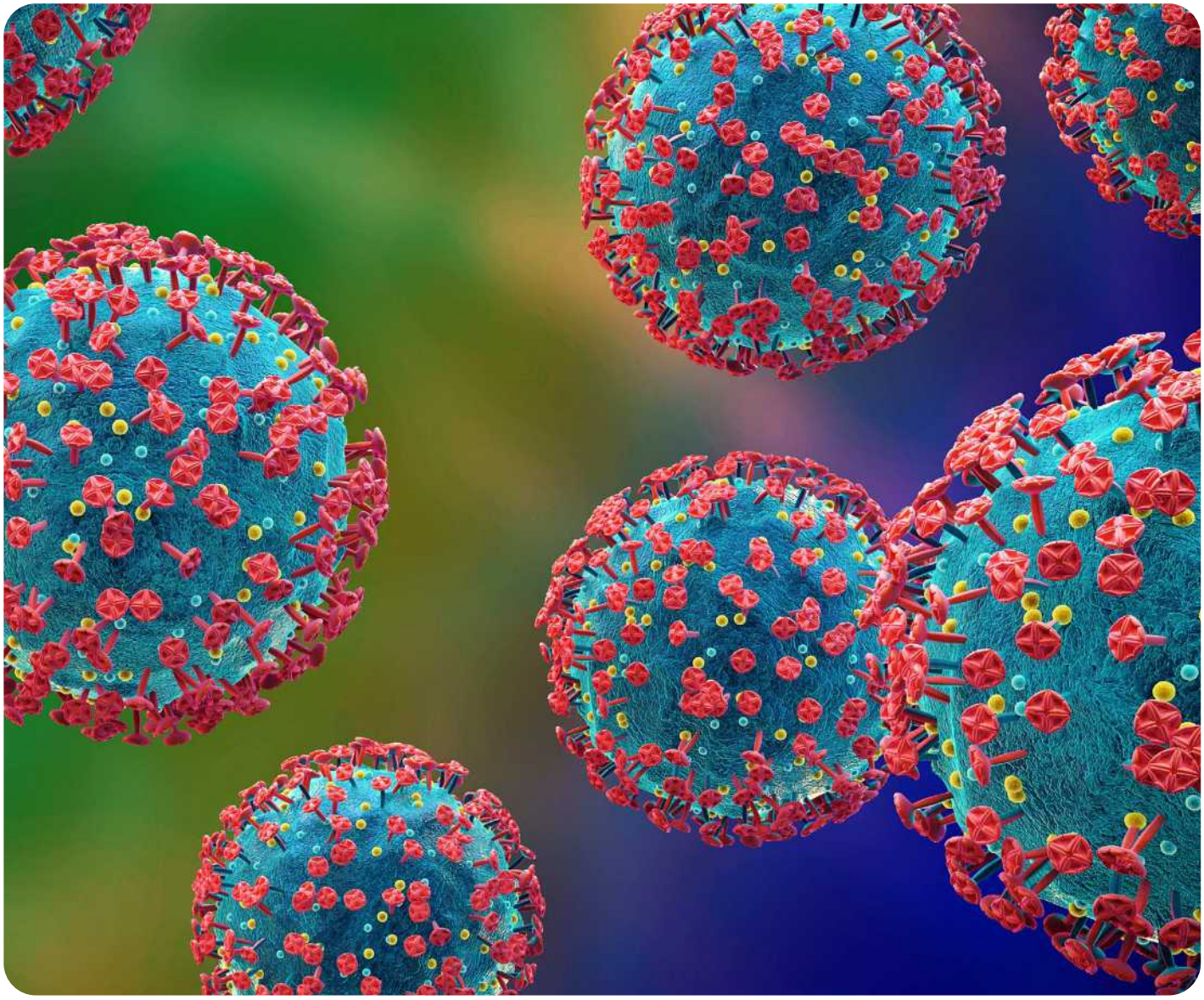
- 90% reduction in new cases of chronic Hepatitis B infections by 2030 (compared to 2015)
- 65% reduction in deaths from Hepatitis B by 2030 (compared to 2015)
- 90% childhood Hepatitis B virus vaccination coverage (3rd dose coverage)
- 100% Hepatitis B virus birth-dose coverage or other approach to prevent mother-to-child transmission
- 90% coverage of vaccination in prisoners, sexual health clinic clients, homeless individuals, sex workers, contacts of Hep B infected cases, asylum seekers, new migrants and people who inject drugs (PWID)

Hepatitis C

- 90% reduction in cases of chronic Hepatitis C infections by 2025 (compared to 2015)
- 65% reduction in deaths from Hepatitis C by 2025 (compared to 2015)
- 100% of injecting drug users report adequate needle and syringe provision for their needs
- 90% of those living with Hepatitis C diagnosed
- 90% of eligible persons with current Hepatitis C infection started treatment

Tuberculosis (TB)

- 90% reduction in TB incidence compared to 2015
- 95% reduction in TB deaths compared to 2015
- Achieve 1358 latent TB infection (LTBI) tests per year in Birmingham
- Achieve 90% treatment completion rates (12 month outcome) by 2026
- 80% Bacillus Calmette–Guérin (BCG) vaccination coverage for all children eligible in the Birmingham local authority (LA)
- 100% of TB cases offered a HIV test



SUMMARY OF THE REVIEW

The review focused on 3 key areas to understand more about BBVs and TB in Birmingham: epidemiological analysis, engagement with service providers and experts and community engagement.

1. Epidemiological analysis

- Overview of Birmingham
- An overview of service activity in Birmingham in relation to BBVs and TB, including epidemiological data and relevant local, regional and national datasets.
- A scoping exercise of current service provision across primary, community and secondary care services with a specific focus on understanding current testing and treatment pathways.
- A desktop literature review covering BBVs and TB.

2. Engagement with service providers and experts

Stakeholder engagement and involvement to bring expert opinion, inform the next phase of the Fast-Track Cities+ initiative and understand how current services for patients diagnosed with these conditions can be improved.
The approach used was semi-structured interviews. Where possible, a Strengths, Challenges, Opportunities and Threats (SCOT) analysis was completed.

3. Community engagement

A number of engagement and consultation events were held, engaging 358 individuals. The method of engagement included two surveys and eight focus groups.
6 broad topics areas were set:

a. Awareness and knowledge
b. Access to services and barriers
c. Community relationships
d. Access to information and advice
e. Health and wellbeing
f. Beliefs and choices, including prevention.

EPIDEMIOLOGICAL ANALYSIS

This section provides an overview of the outcomes of the epidemiological analysis for Birmingham. The data presented is that which relates to the targets. A full dataset can be accessed separately.

At risk groups

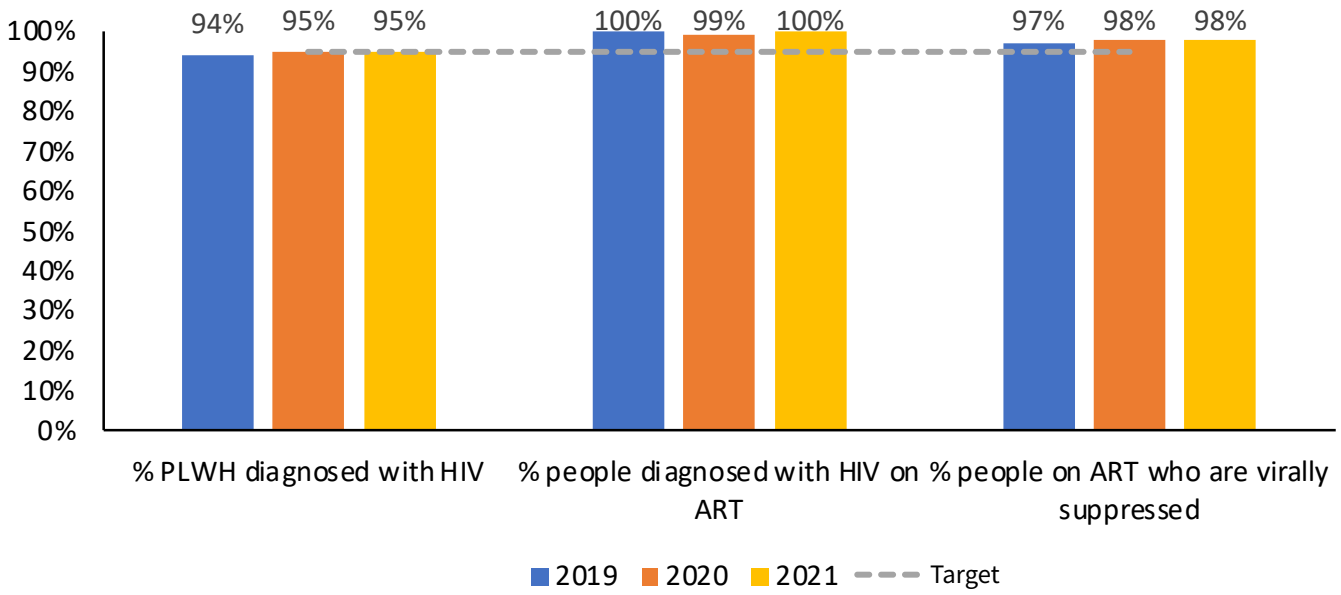
Groups at increased risk of infection	Hep B	Hep C	HIV	Latent TB	TB
People born or brought up in a country with an intermediate or high prevalence of chronic Hep B/C	X	X			
People born or brought up in a country from an area with high HIV prevalence			X		
People born or brought up in a country from an area with high TB prevalence				X	X
Babies born to mothers infected with Hep B	X				
Babies born to mothers infected with Hep C		X			
People who have ever injected drugs	X	X	X		
Men who have sex with men	X	X	X		
Anyone who has had unprotected sex, particularly: • People who have multiple sexual partners • People reporting unprotected sexual contact in areas of intermediate and high prevalence • People presenting at sexual health and genitourinary medicine clinics • People diagnosed with a sexually transmitted disease	X	X	X		
People who are immunocompromised				X	X
Prisoners, including young offenders	X	X			
Immigration detainees	X	X		X	X

Groups at increased risk of infection	Hep B	Hep C	HIV	Latent TB	TB
Close contacts of someone known to be infected with Hep B	X				
Close contacts of someone known to be infected with Hep C		X			
Close contacts of someone known to be infected with TB				X	X
People living in hostels for the homeless or sleeping on the streets	X	X			
HIV-positive men who have sex with men	X	X	X		
People who received a blood transfusion before 1991 or blood products before 1986	X	X	X		
Health care providers and emergency responders	X	X	X	X	X

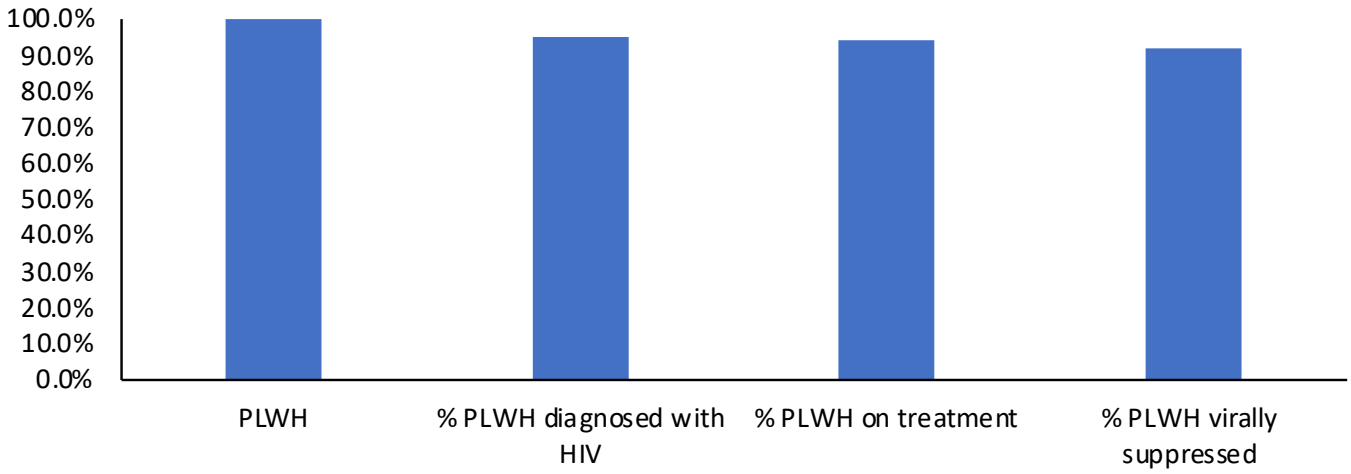
HIV

UNAIDS 95-95-95 Targets

Target	95% of people living with HIV (PLHIV) knowing their status	95% of people who know their HIV-positive status on HIV treatment	95% of PLHIV on HIV treatment with suppressed viral loads
Definition	Proportion of people (of all ages) who are accessing HIV care out of the total number of people estimated to be living with HIV.	Proportion of people (aged 15 years and over) who were prescribed ART out of total number of people (aged 15 years and over) seen for HIV care and living in Birmingham.	Proportion of people (aged 15 years or more) who are accessing HIV care with an undetectable viral load (VL<200 copies/ml).
Raw numbers (2021)	2,247	2,234	2,188
Percentage (2021)	95.0%	99.4%	97.9%



Target	95% of people living with HIV (PLHIV) knowing their status	95% of people who know their HIV-positive status on HIV treatment	95% of PLHIV on HIV treatment with suppressed viral loads
Continuum of care percentage (2021)**	**95.0%**	**94.1%**	**92.2%**



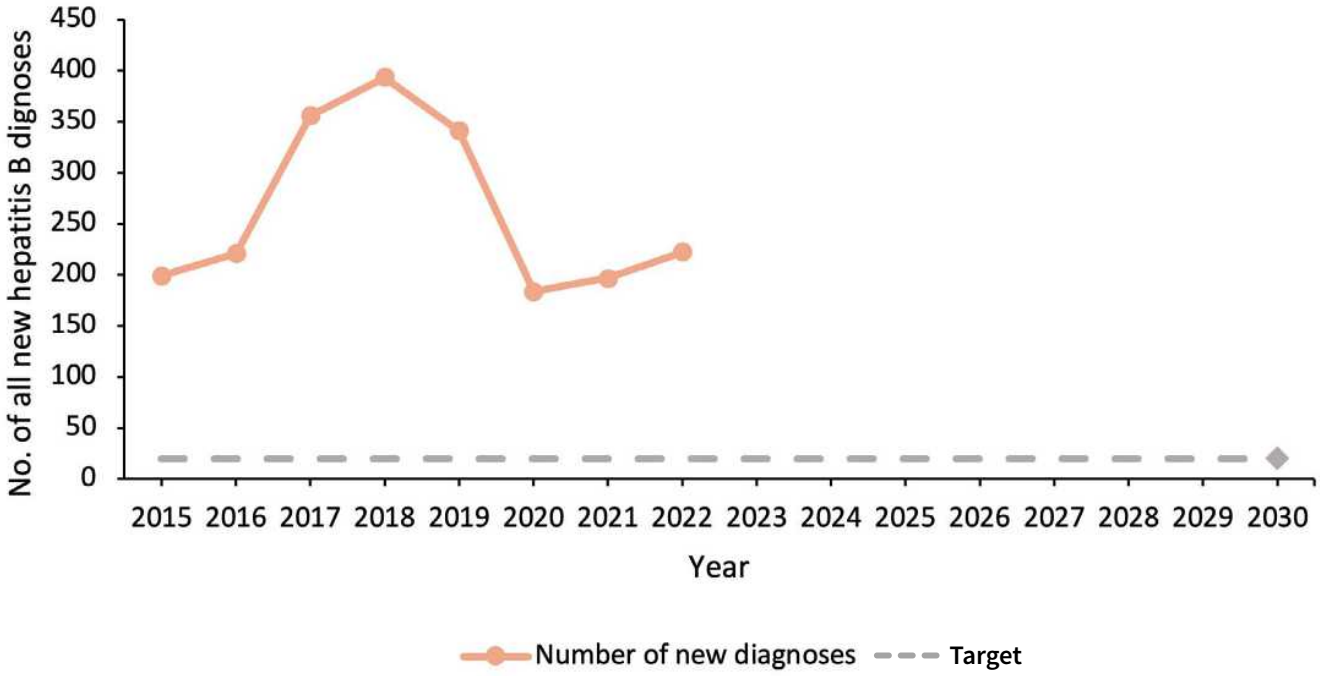
**Estimated number of people living with HIV is based of national estimates and is estimated to be 2,373.*

***The continuum of care percentages show the proportion of people at each stage of the care continuum out of the total number of people estimated to be living with HIV.*

Hepatitis B

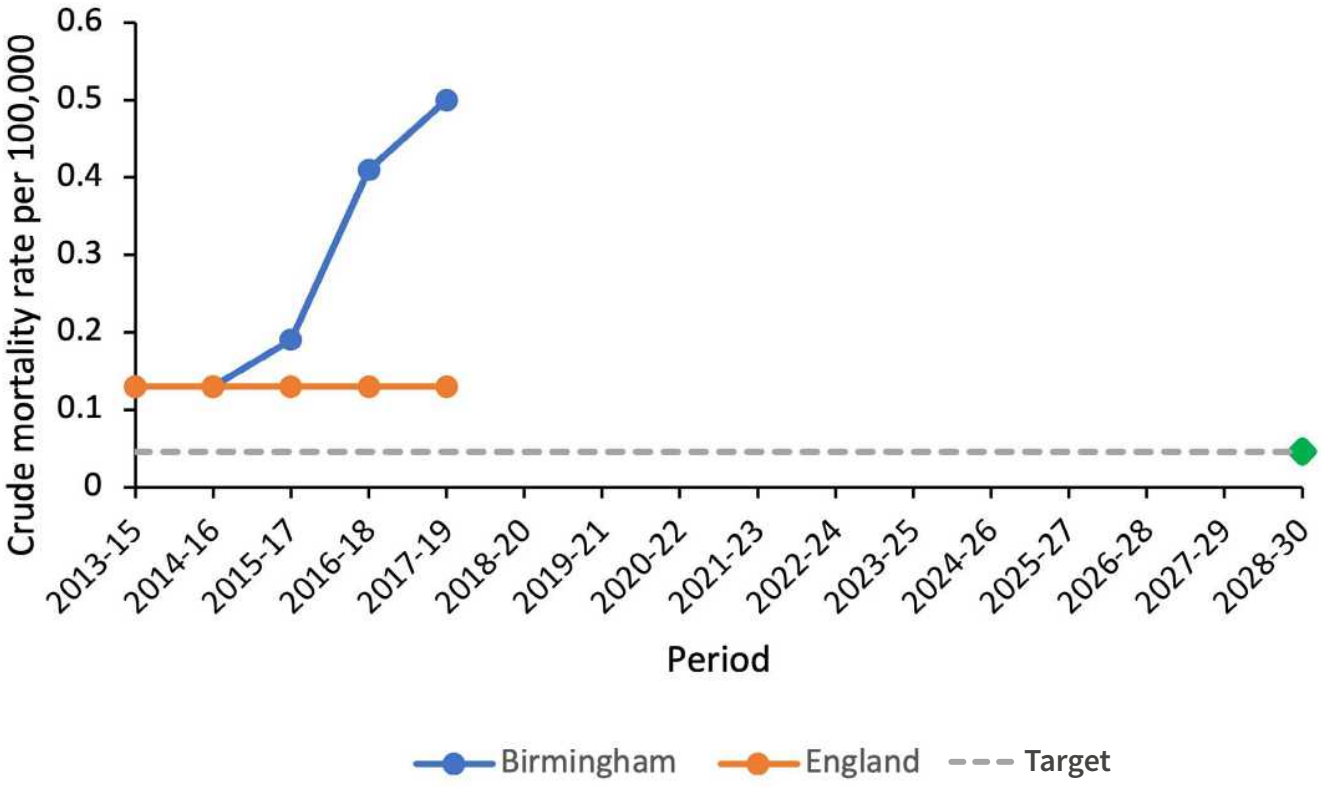
90% reduction in new cases of chronic Hepatitis B infections by 2030 (compared to 2015)

Definition: Number of all new Hepatitis B diagnoses by year of diagnosis resident in Birmingham City, 2015-2022 (Data source: SGSS – provisional data). N.B. the data shown is for all new Hepatitis B diagnoses, not just chronic Hepatitis B infections.



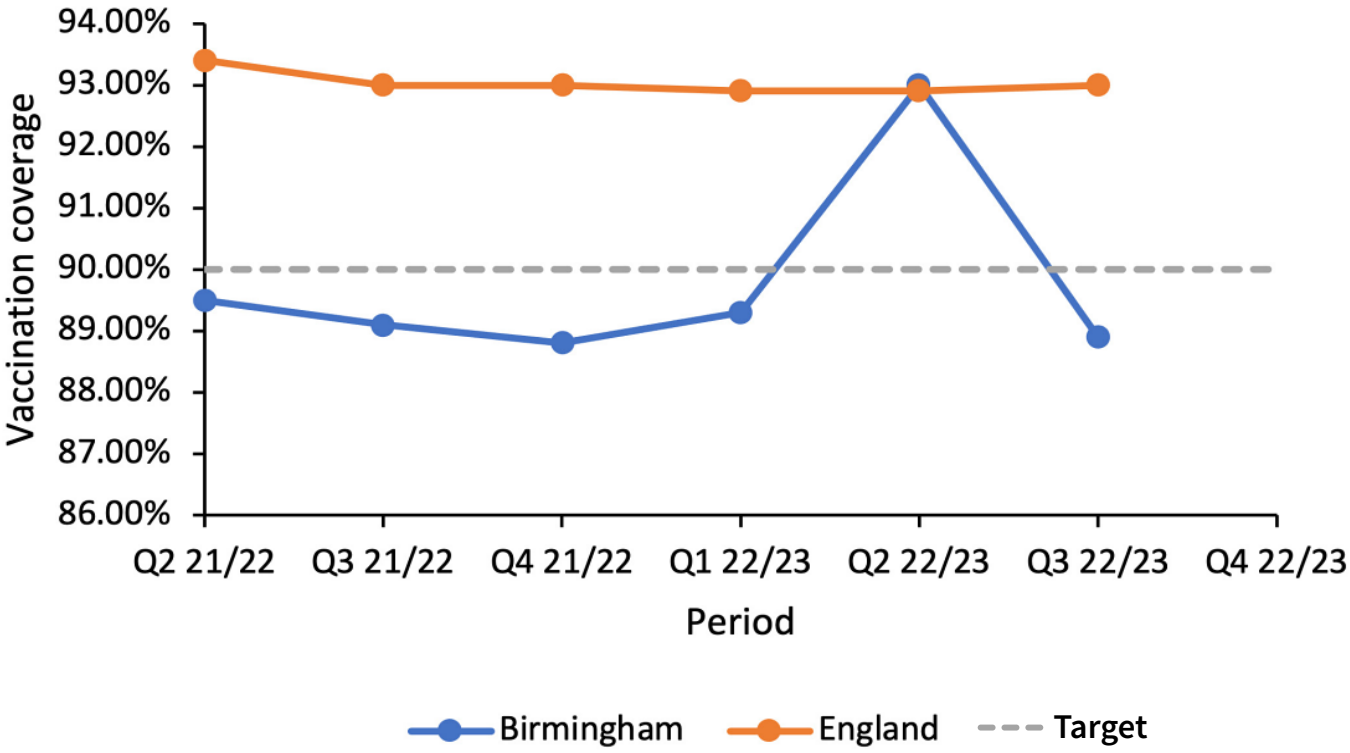
65% reduction in deaths from Hepatitis B by 2030 (compared to 2015)

Definition: Crude rate of mortality from hepatitis B related end-stage liver disease/hepatocellular carcinoma in persons less than 75 years per 100,000 population



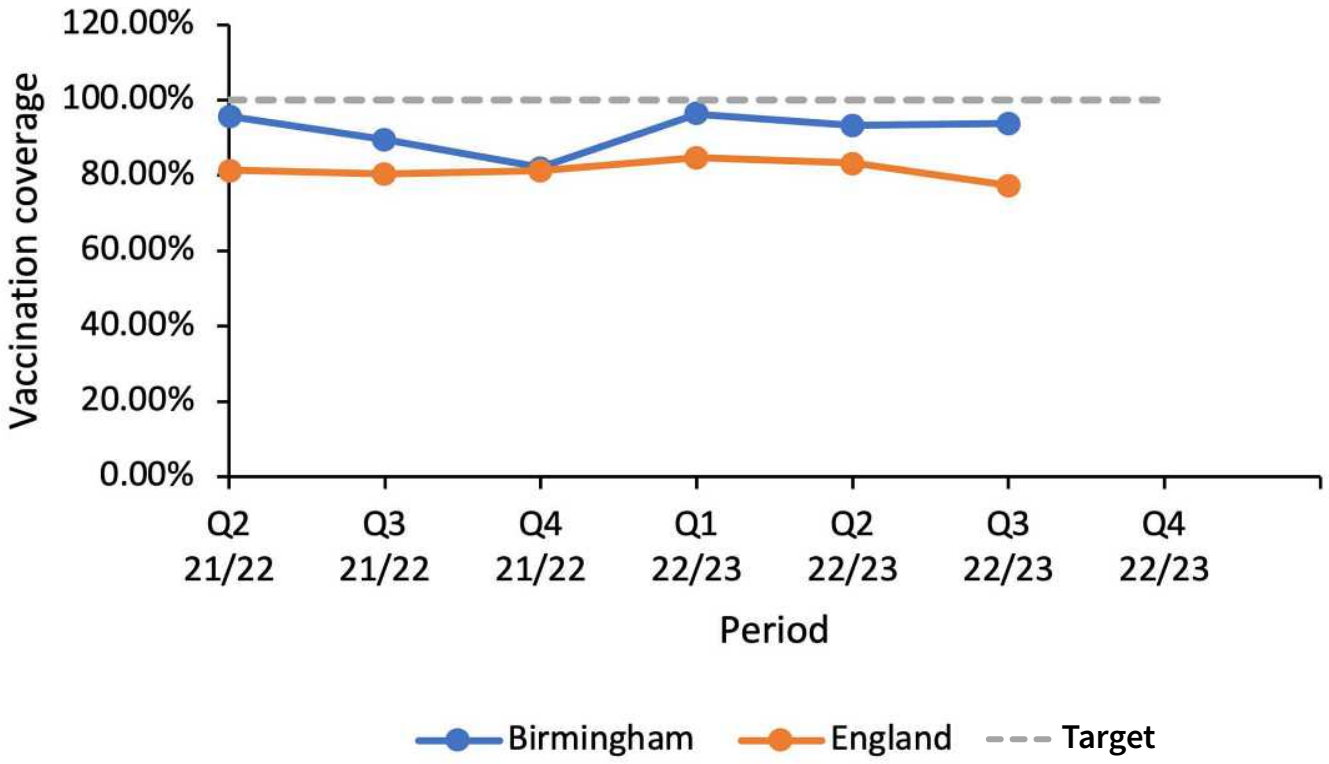
90% childhood Hepatitis B virus vaccination coverage (3rd dose coverage)

Definition: Children for whom the local authority is responsible who received 3 doses of DTaP IPV Hib HepB vaccine at any time by their second birthday as a percentage of all children whose second birthday falls within the time period.



100% Hepatitis B virus birth-dose coverage or other approach to prevent mother-to-child transmission

Definition: Coverage of 3 doses of the 6-in-1 vaccine of a HepB-containing vaccine reported for children who reached 2 years of age in the quarter born to hepatitis B positive women in Birmingham LA (data should be interpreted with caution given the low number of eligible neonates).



90% coverage of vaccination in prisoners, sexual health clinic clients, homeless individuals, sex workers, contacts of Hep B infected cases, asylum seekers, new migrants and people who inject drugs (PWID)

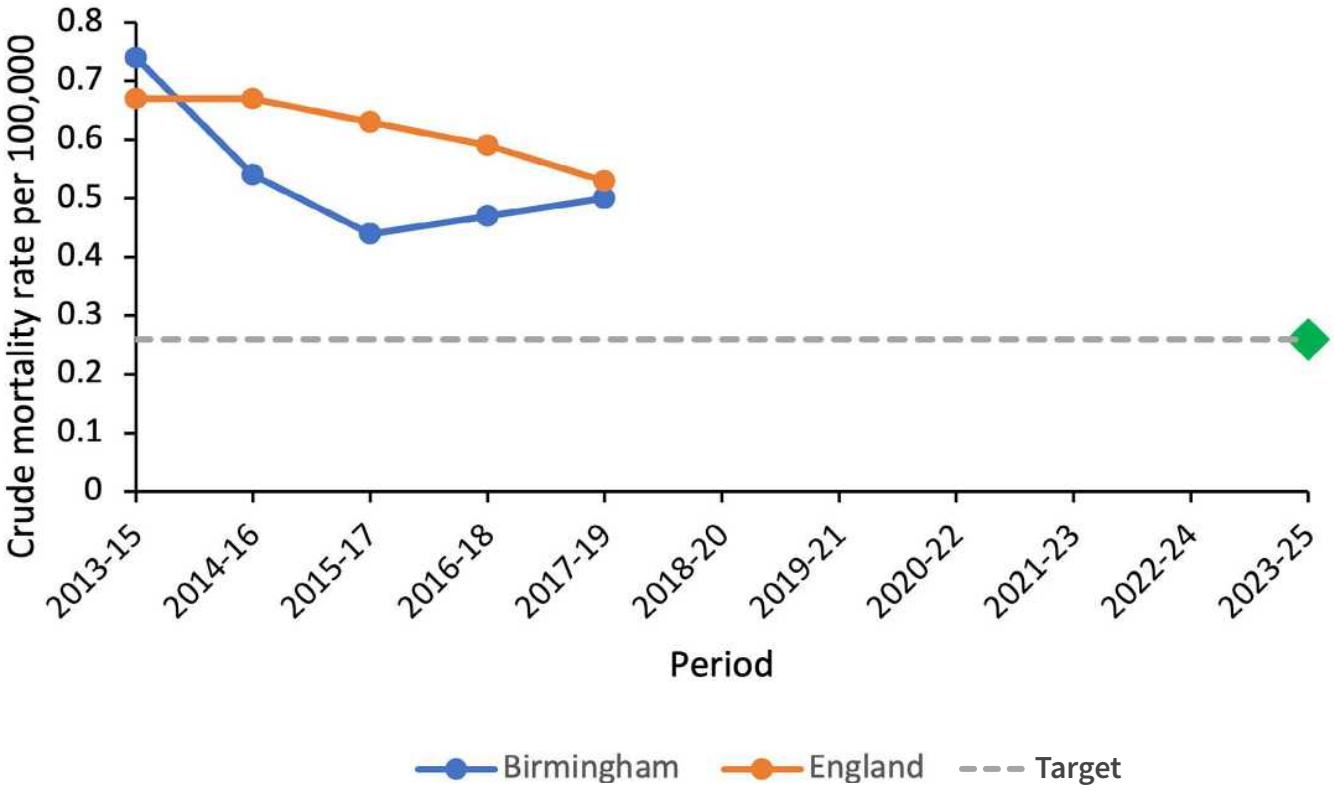
This Needs Assessment has identified that more data collection is required in these target groups.

Hepatitis C

90% reduction in cases of chronic Hepatitis C infections by 2025 (compared to 2015)

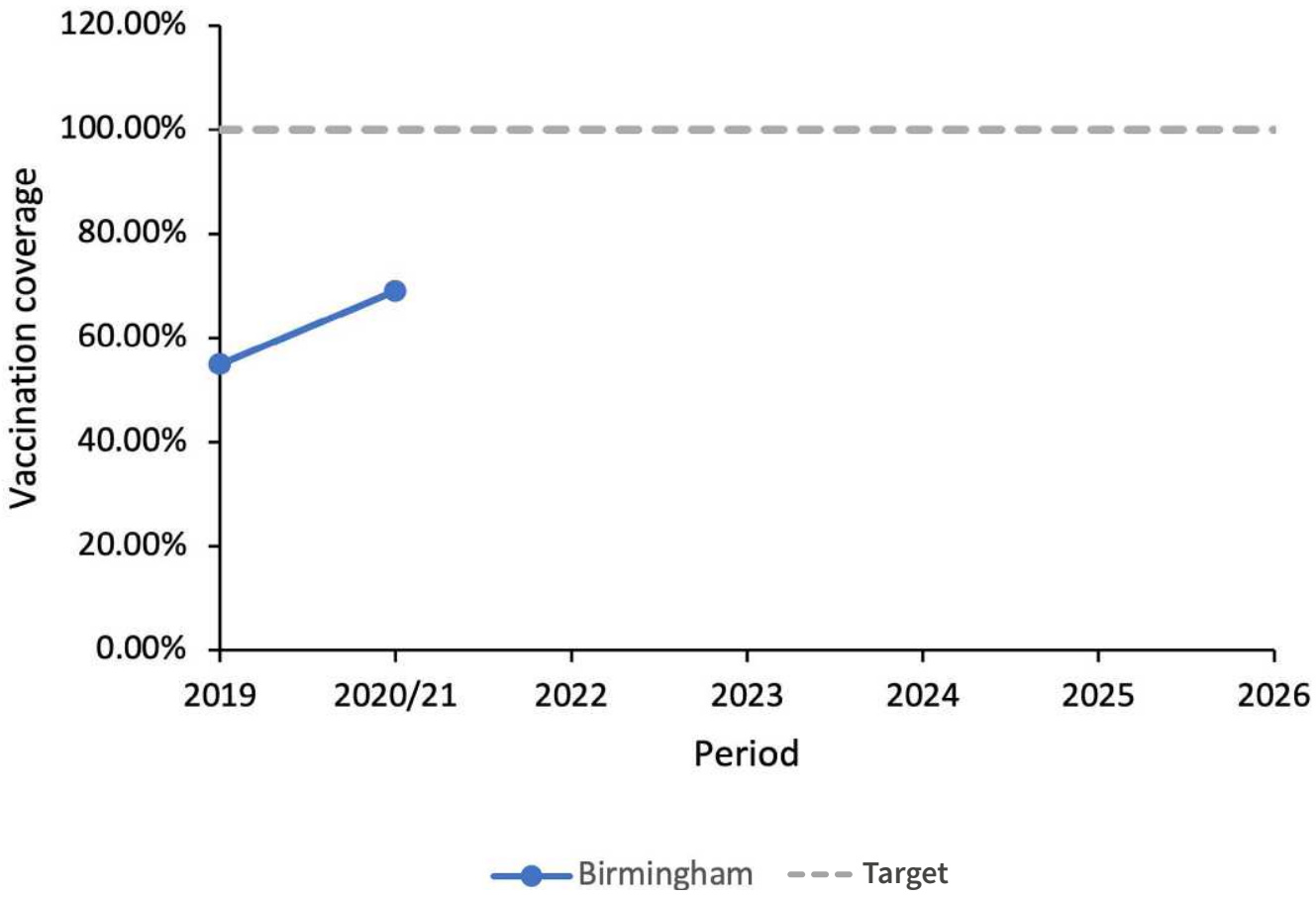
65% reduction in deaths from Hepatitis C by 2025 (compared to 2015)

Definition: Crude rate of mortality from hepatitis C related end-stage liver disease/hepatocellular carcinoma in persons less than 75 years of age per 100,000 population.



100% of injecting drug users report adequate needle and syringe provision for their needs

Definition: The number of people reporting adequate needles to meet their needs out of the number of PWIDs in the UAM survey responding to the question in Birmingham ODN (N.B. due to Covid-19 only 1 survey was conducted to cover the 2020/21 period).

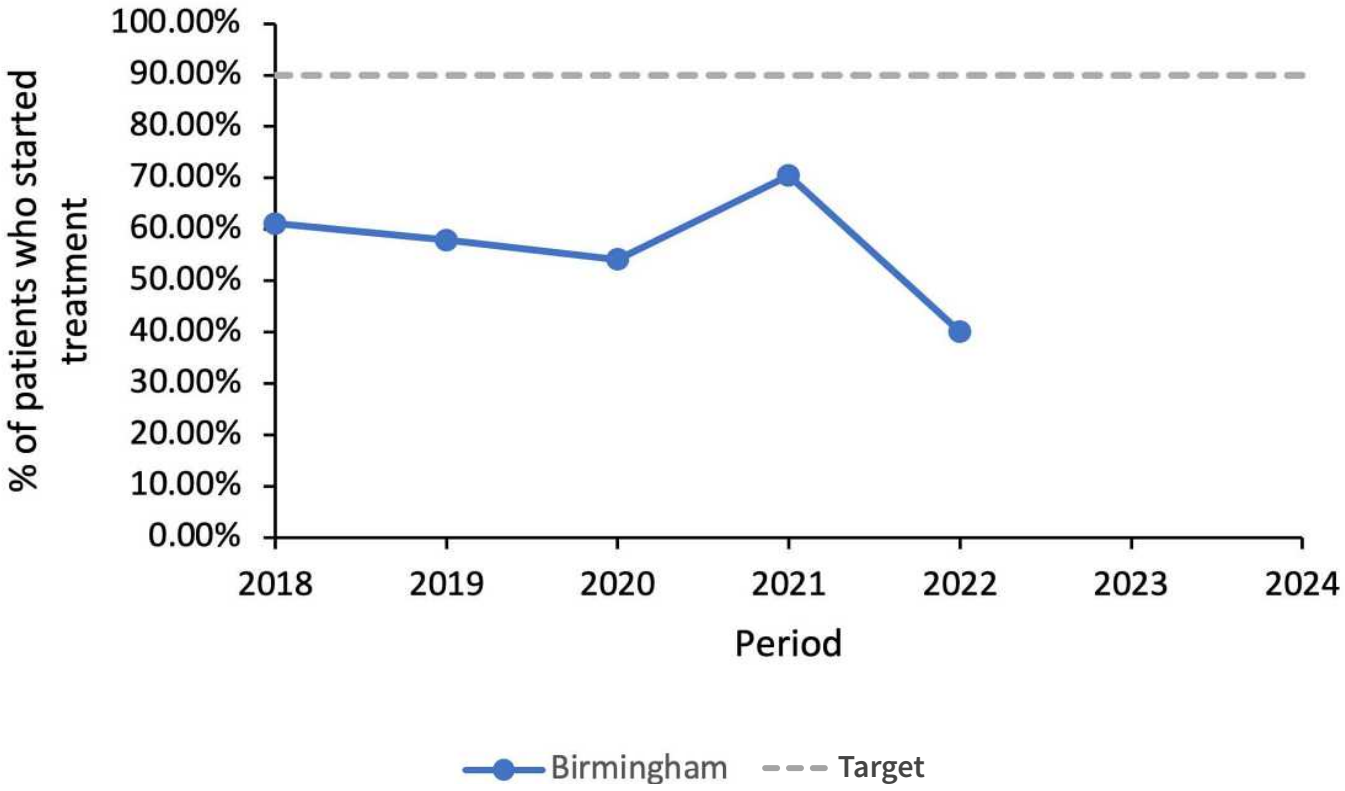


90% of those living with Hepatitis C diagnosed

Model estimates that Hepatitis C prevalence rate with 95% credible intervals is 7300 (6300-8400) in the Birmingham ODN as of 2020.

90% of eligible persons with current Hepatitis C infection started treatment

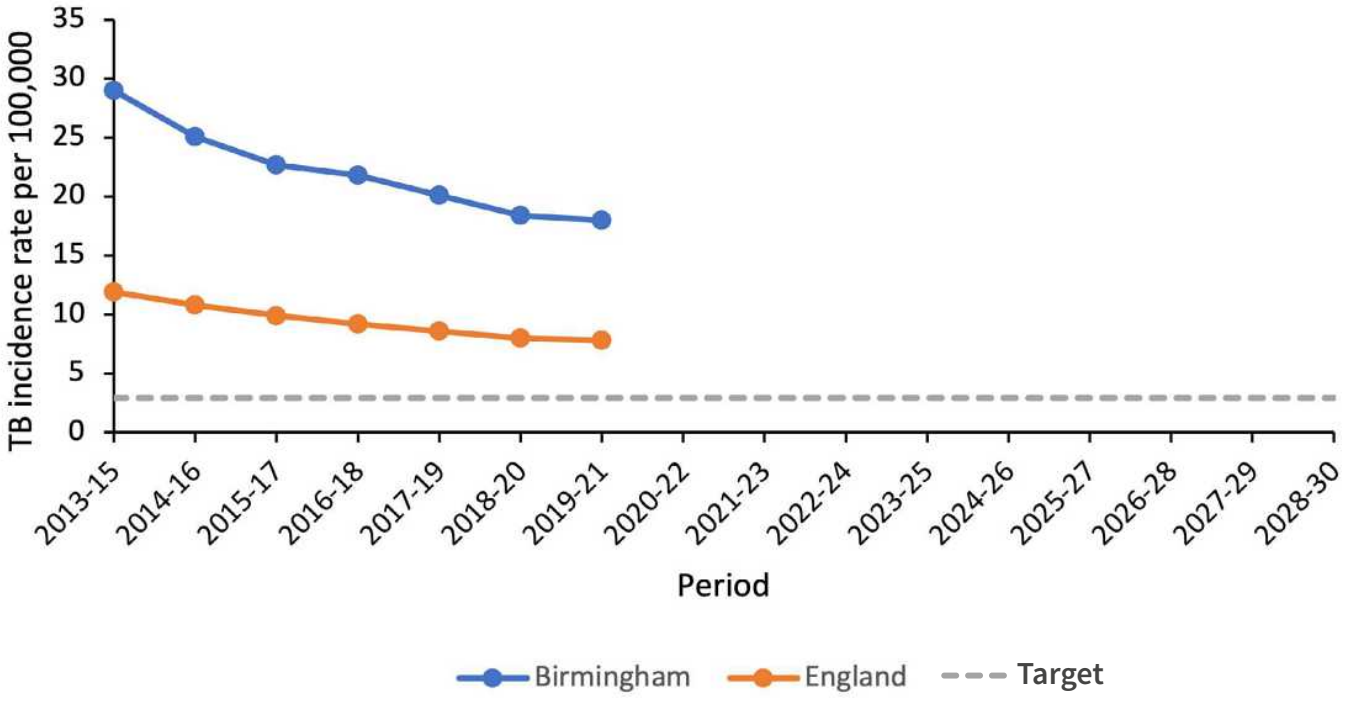
Definition: The number of people starting treatment out of the number of people linked into treatment. *N.B. 2022 data covers Q1-Q3 only.*



Tuberculosis (TB)

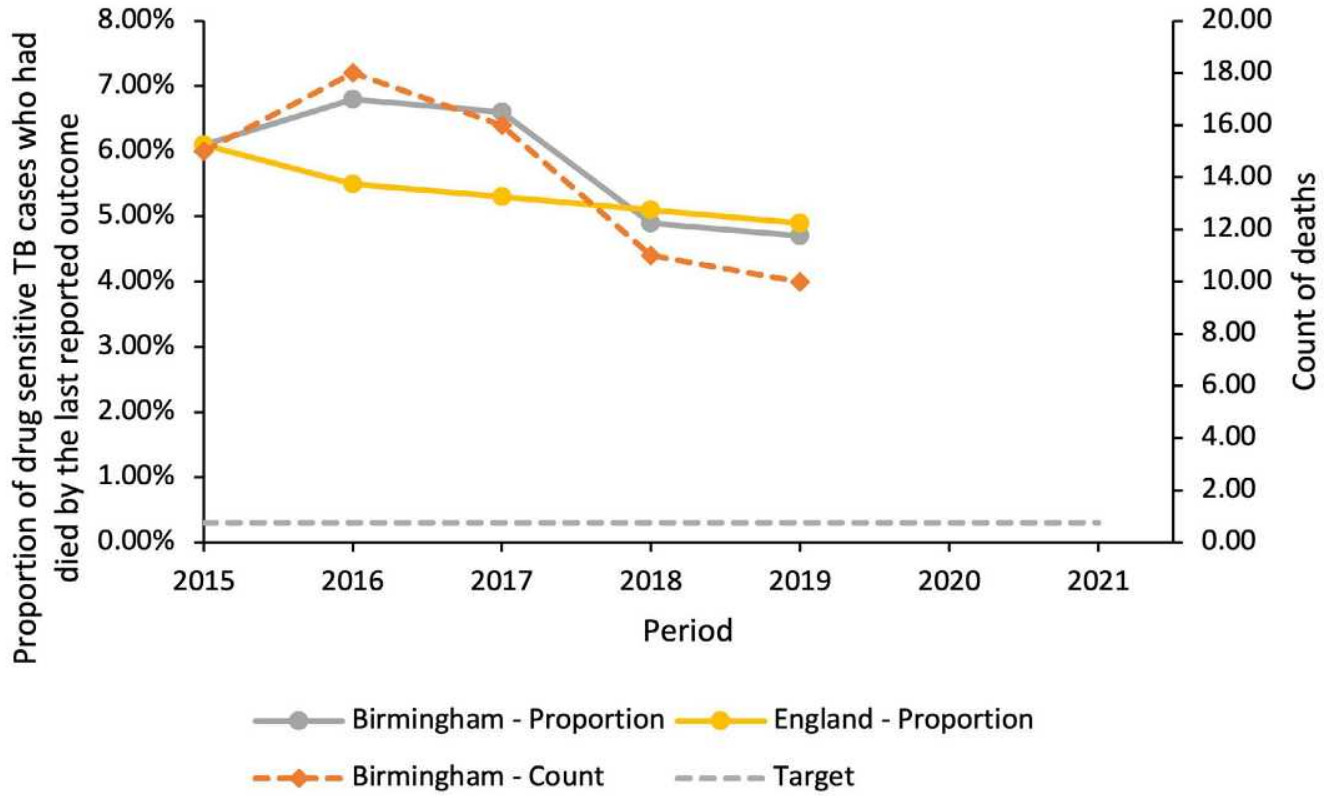
90% reduction in TB incidence compared to 2015

Definition: Three year average incidence per 100,000 population. The numerator (the number of TB notifications in the 3 year period) is divided by the denominator (the sum of the mid-year population estimates for the same 3 year period) and multiplied by 100,000.



95% reduction in TB deaths compared to 2015

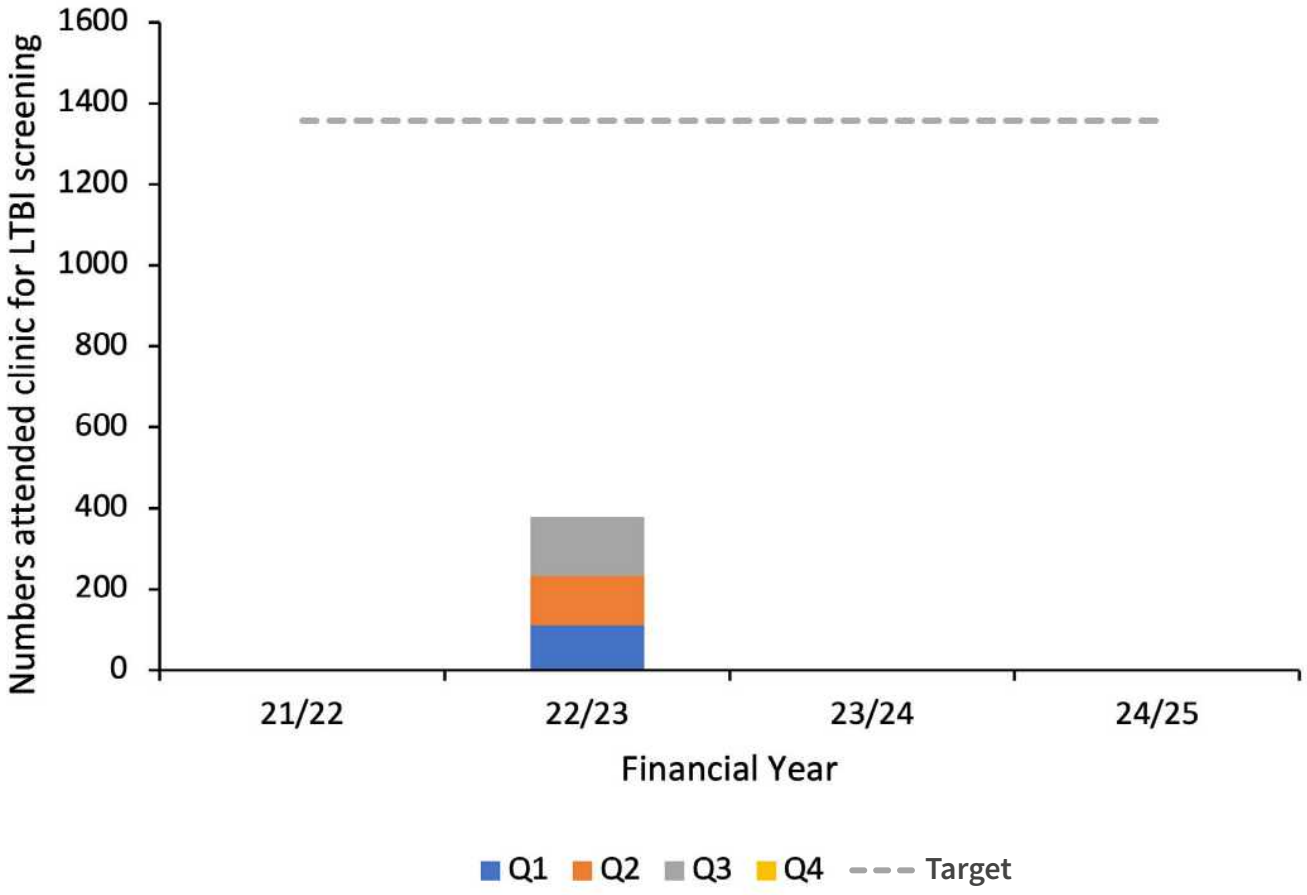
Definition: The annual proportion of drug sensitive TB cases who had died by the last reported outcome (exclusions: TB cases with rifampicin resistance or MDR-TB).



Decrease annually by 5% the proportion of people who develop active TB within 5 years of post UK entry using the 3-year average, 2017 to 2019, as a baseline

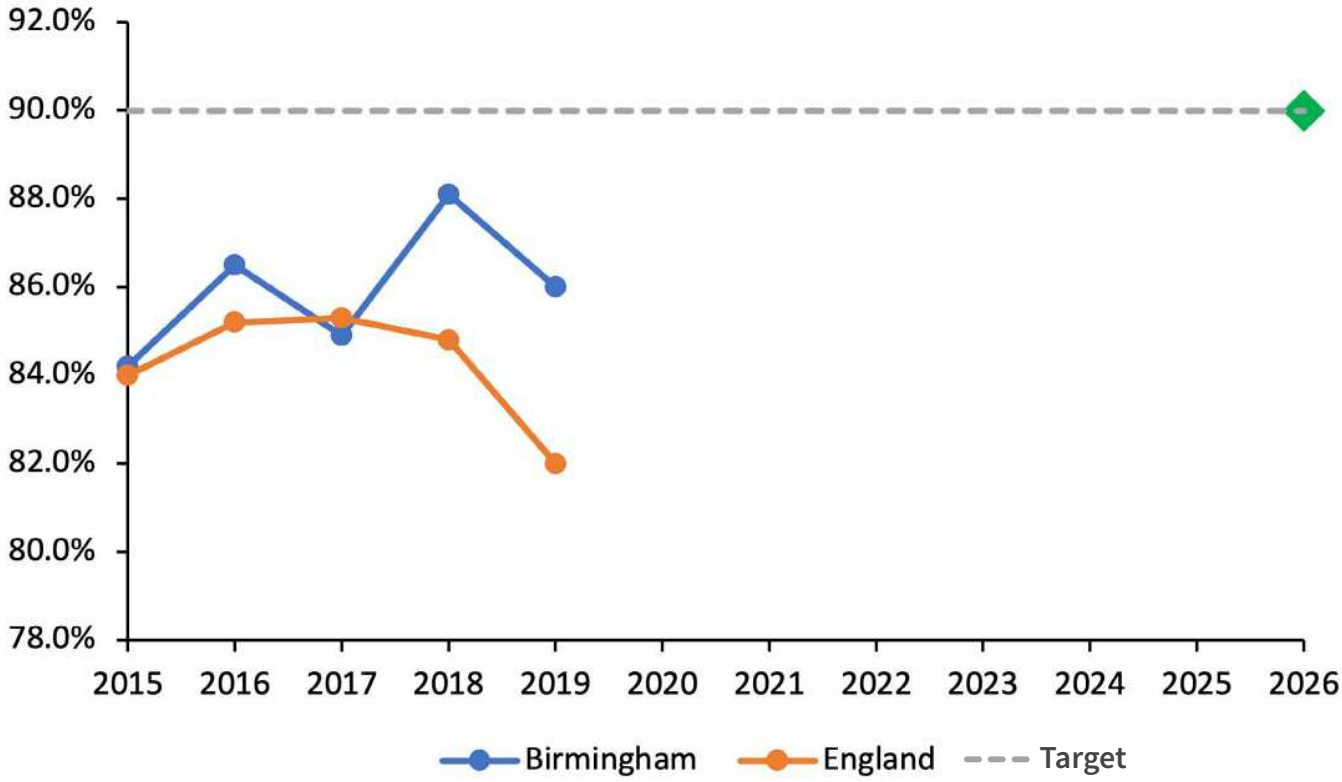
Achieve 1358 LTBI tests per year in Birmingham

Definition: Number of people who have been screened for LTBI in Birmingham and Solihull. This target is provided by NHSE to BSol ICB.



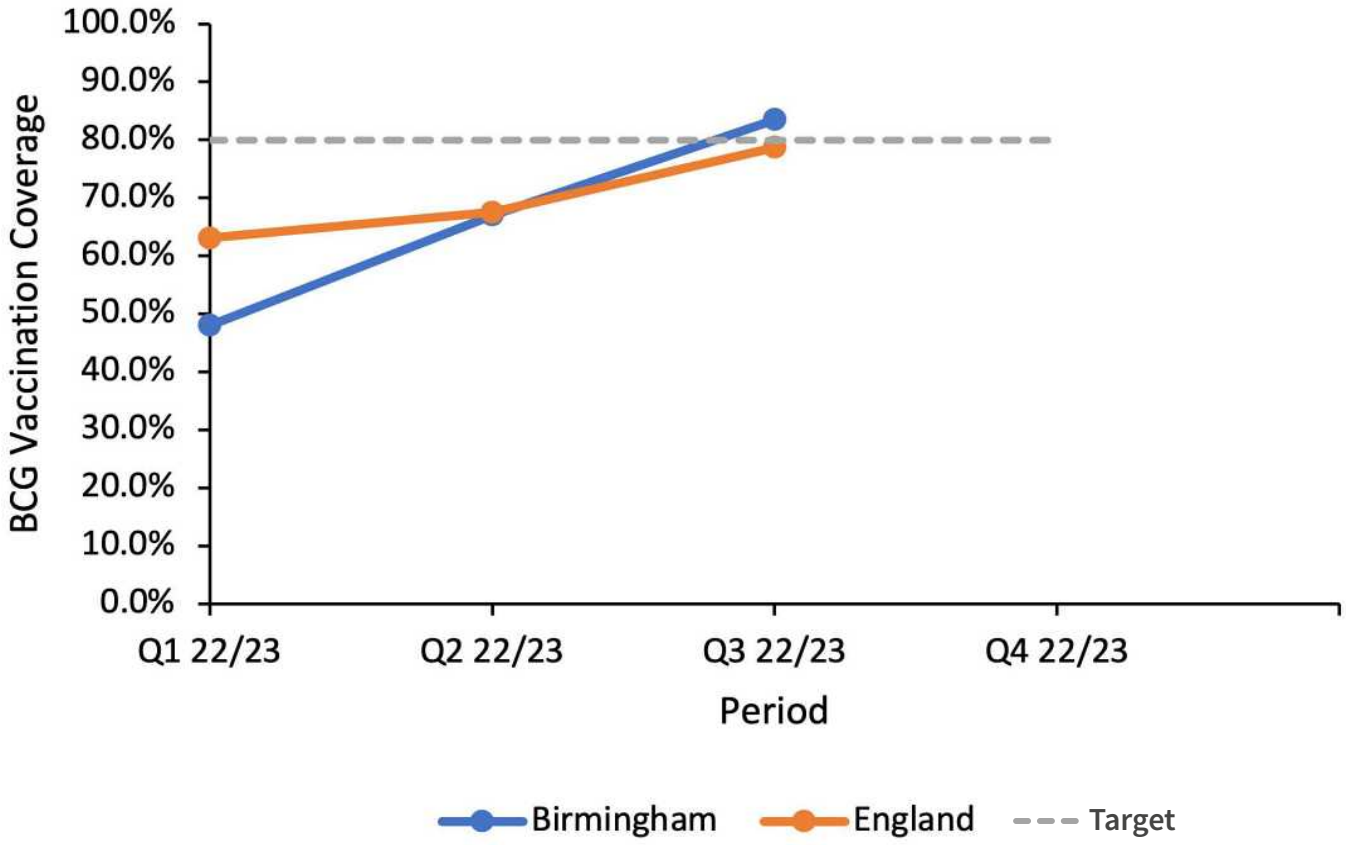
Achieve 90% treatment completion rates (12 month outcome) by 2026

Definition: The annual proportion of drug sensitive TB cases expected to complete treatment within 12 months who had completed treatment within 12 months of treatment start date (exclusions: TB cases with rifampicin resistance or MDR-TB and TB cases with CNS, spinal, miliary or disseminated TB).



80% BCG vaccination coverage for all children eligible in the Birmingham LA

Definition: Eligible children are those born in areas where the TB (tuberculosis) incidence is greater than or equal to 40 per 100,000 or who were born to parents or grandparents from TB endemic areas, who should be offered the vaccination at 38 days. Coverage is measured at 3 months of age for this selective immunisation.

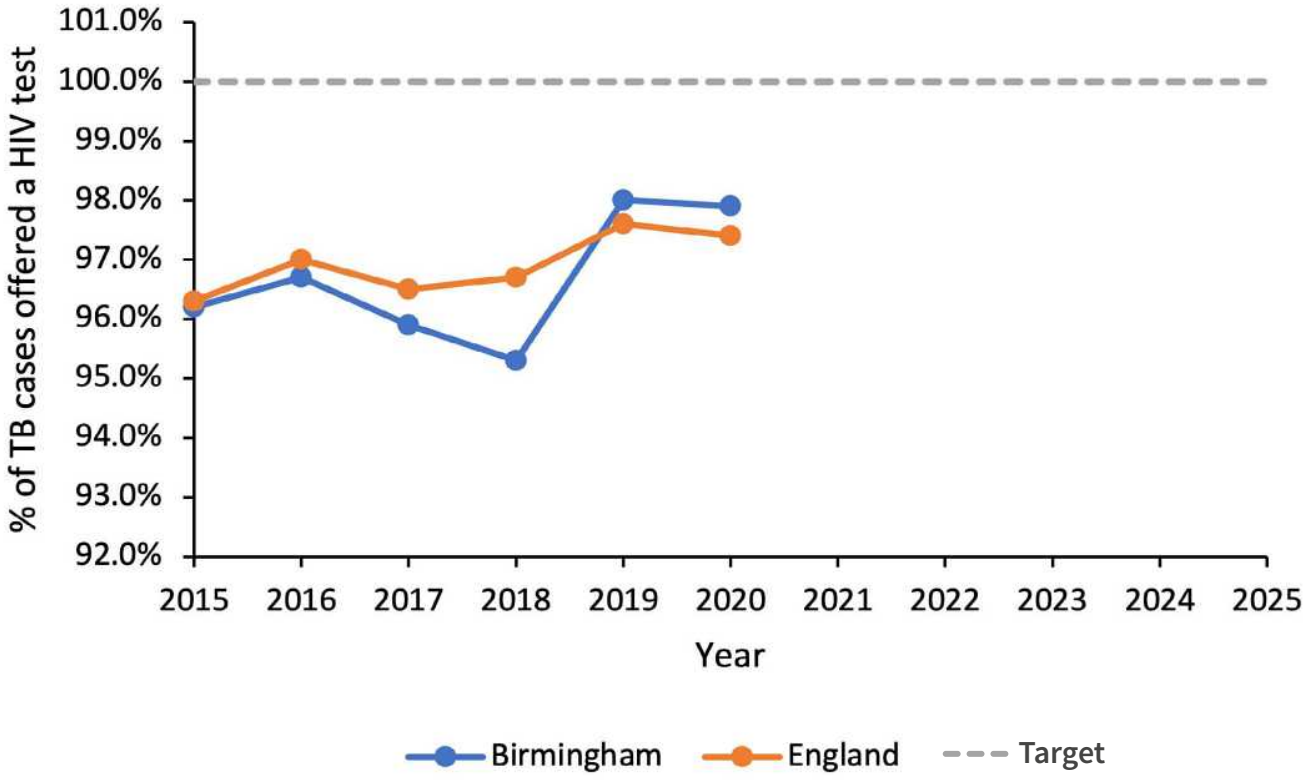


Reduce the average delay in diagnosis in people with pulmonary TB by 5% per year

[Data for this indicator is being sourced and will be updated when it is made available.]

100% of TB cases offered a HIV test

Definition: The proportion of people diagnosed with TB (where HIV testing status is recorded and the patient does not already know their HIV status) who are offered a HIV test.



ENGAGEMENT WITH SERVICE PROVIDERS & EXPERTS

A semi-structured interview approach was used to gather local views from the BBV and TB service providers, healthcare professionals, commissioners and support services involved in this needs assessment. In addition, where possible, a Strengths, Challenges, Opportunities and Threats (SCOT) analysis was completed.

The following charts provide a summary of the key themes and ideas that emerged from the SCOT analysis.

HIV	
Strengths: •Specialist drug and alcohol providers have good links with those at high risk of HIV. •Providers can complete outreach work with their clients in relation to HIV testing. •There is a commissioned pathway for sexual exploitation and sexually abused children. HIV and other infections can be identified. •HIV testing is routine for those with active TB.	**Challenges:** •Patients with HIV have a stigma disclosing a positive diagnosis. •Transitioning from a young person to adult service, especially if young person is used to receiving health interventions as part of a family group. •For children and young people, there is stigma from teachers. •During COVID-19, HIV practitioners were sent to work on other wards. •Some young people with HIV are not told that they are HIV positive by parents.
Opportunities: •Provision of more information to teachers regarding facts about HIV. •The U=U campaign is a good opportunity to promote positive messages about HIV. •HIV education can be taught in schools.	**Threats:** •Backlog of cases for those who do not engage in treatment. •Funding threats. •Data collection not accurate. •Young people born with HIV can lose motivation to continue taking medication.

Hepatitis	
Strengths: •Specialist drug and alcohol services can complete outreach testing with vulnerable groups. They already have a relationship with hard-to-reach patients. •Testing in pharmacies was introduced, although take up was low. •Hepatitis C Trust have a team in place to meet health needs. •There is specific post focussed on the needs of sex workers in the Hepatitis C Trust. •Pop-up clinics can be set up quickly. •Close working relationships with other commissioners. •Outreach services in place (St Phillip's Cathedral/ Salvation Army). •Testing at police custody suites.	**Challenges:** •The substance misusing cohort are difficult to get into treatment. •For the substance misusing cohort, it is difficult to keep patients engaged in treatment. •It was difficult to continue face to face treatment during the pandemic. •The Hepatitis C Trust are dealing with a very stigmatised and marginalised community. •There is not much contact with male sex workers. •Data collection from partners is difficult. •Practitioners must be trained to encourage people to engage in treatment (motivational interviews). •Redeployment of staff/clinicians over the pandemic.
Opportunities: •More testing can be completed with the substance misusing cohort. •Opportunities to upskill drug and alcohol specialist staff. •Dry blood spot testing will allow point of care testing. •More engagement with South Asian communities. •Enable key players to work together - creative thinking resolves issues. •Opportunities for new partnerships/ branch out into Sandwell/Solihull. •Hepatitis C patient forum. •GPs Hepatitis C testing. •Custody suite pilot.	**Threats:** •Backlog of cases for those who do not engage in treatment. •Changes in laws relating to drug use and drug policy - work is made more difficult. •There are always threats due to non-recurrent/ limited funding. •Social distancing measures vital, however have limited number of clients throughput/flow seen via mobile bus.

Tuberculosis	
Strengths: •High treatment completion rates. •Outreach work undertaken. •Accessible service, home screening where appropriate. •Agreement for video observed therapy. •Good relationship with prison, symptomatic investigation. •TB nurse link worker for prison, funding for screening received from Queens's Nursing Institute to fund prison screening. •Innovative testing events, e.g. ESOL classes. •Screening homeless, sex workers, those with socially challenging lifestyles.	**Challenges:** •No patient support fund to cover bus pass/ food to ensure treatment compliance. •Patient support fund essential to transport infectious patients in taxis. •The system for screening sex workers is broken. •Services stood up and down during the COVID-19 pandemic, this impacted TB treatment. •Diagnosis is difficult, primary care isn't back up and running and patients default to the hospital. Patients are spending longer with TB and there is more chance of it spreading. •Can screen in prison but patients can leave or be released from prison. What happens to them? •Would be beneficial to have a repository of locations/assistance of what help is available where.
Opportunities: •More multiagency working- in conjunction with LA and Public Health England. •More focus needed on Prevention measures - West Birmingham, higher incidence prevalence and social risk factors, deprivation. •Too many agency involvements in screening projects/ disjointed with third sector. •TB Patient Forum required, this should not be a standard as we are dealing with different communities and a standard forum will not suit everyone.	**Threats:** •COVID-19 – As patients cannot access their GP, they are going to accident and emergency (A&E). •People newly arrived (refugees and migrants) don't know the screening system for TB. •Large numbers of organisations, directly not aware of what others are doing. •Some people have limited access to healthcare as they move location during treatment. It is not known where in the system, and if, they will present again. •TB patients often lose their jobs and housing.

COMMUNITY ENGAGEMENT

Below provides a summary of the findings arising from the community engagement exercises.

A. Awareness and knowledge

- Significant lack of awareness and knowledge of BBVs and TB in general.
- Lack of knowledge and limited awareness of the Fast-Track Cities+ initiative across most target groups.
- A need for improved communication was expressed frequently.
- Improving education and awareness within the general public was perceived as a main requirement to achieve zero transmissions.
- There is a need to break down barriers and for myth-busting; the discussions highlighted that there are mixed views, myths, and stereotypes amongst different communities of 'who is and isn't impacted.
- Some people shared that they gained knowledge of HIV through social media programmes which could be helpful in raising people's awareness of HIV.
- A short survey conducted with homeless people, PWIDs and sex workers showed a lack of knowledge of hepatitis C amongst these target groups.

B. Access to services and barriers

- There are a range of barriers for testing, treatment, and support for BBVs and TB which need to be addressed to reduce the risk of transmission.
- Some people struggled to access TB services via their GP practice and felt they are at a disadvantage as not all GP practices are signed up to the new entrant LTBI testing and treatment programme.
- Participants fed back that the HIV pathway in Birmingham is fragmented and is split across three aspects which means PLHIV experience multiple touchpoints.
- Some respondents felt that accessing services (such as sexually transmitted infection [STI] and obtaining condoms) was prohibited by postcode.
- Targeted groups felt more could be done to meet individual needs and improve accessing to services, such as addressing barriers to care and reducing gaps in social needs.

C. Community relationships

This topic covers issues raised around stigma-related beliefs and myths, and community social isolation.

- Stigma can manifest itself in many ways and there are different levels of stigma, including;
  - stigma from within the system because of knowledge, attitude, behaviours and experiences of care
  - stigma experienced within communities and amongst the public
- There are a range of beliefs and myths circulating or held within the community linked to the words HIV, hepatitis C, TB and sexual health – there is a need to address these and a need for cultural change.
- Feedback from participants suggests that some communities think HIV is a "White" thing and other think it's an "African" thing.
- There is a lack of awareness around hepatitis; people think those with hepatitis are "untouchable" or are drug addicts.

D. Access to information and advice

- There is variation in where and how people would like to access information and advice about BBVs and TB, in relation to preventative measures, testing, treatment, support.
- There is a need to map existing communication channels and resources as part of improving communication and access to information, as well as to inform future public campaigns.
- There is a need for information to be disseminated via religious communities and centres.
- Information source is important; some sources, such as nurses, clinic staff and websites, are seen as reliable, whereas social media and other internet sources are not always seen as that reliable.
- Different communities, target groups and ages have varying information needs so equality, diversity and cultural sensitivities should be considered in relation to information and advice.
- Access to the right information and point of contact is important, especially if newly diagnosed as those who are newly diagnosed are not always aware of who to ask or where to seek support.

E. Health and wellbeing

Discussions around health and wellbeing formed part of the community engagement exercise.

- Mental health, stigma, access to mental health and counselling support and social aspects, such as housing and financial support, are major causes of concern for those diagnosed with a BBV or TB.
- Delays in accessing mental health support were reported.
- There was a view that there is a lack of support for people with an initial diagnosis, especially HIV.
- Many people disengage with services because they do not feel they are fully understood by the practitioner.
- Health and wellbeing needs for individuals with BBVs and TB, and those they have close relationships with, are not being met.

F. Beliefs and choices including prevention

- There is a need to change conversations about BBVs and TB amongst both the public and the workforce. In particular, awareness needs to be raised about the advancements in treatment for HIV/AIDS in terms of patients having normal life expectancy and viral suppression.
- The general consensus is that higher risks exist where there is a predominance of people in multi-generational living, where there is poverty and deprivation.
- People from abroad with language difficulties tend to congregate in pockets of Birmingham and connect with their own communities, whom they trust and engage with in their own language.
- Better engagement with the gay community is needed, which is more difficult now most gay venues have closed down.

HIGH-LEVEL FINDINGS

A range of key findings were developed through the Needs Assessment. The following section provides an overview of the themes covering the key findings. The full suite of findings can be found in the full Needs Assessment.

Theme 1: News ways of working and structural approach

- Fragmentation of commissioning, pathways, and funding.
- Lack of integration and joint working makes it difficult to incorporate new ways of working and new models of care.
- Individual elimination programmes in place with different reporting lines, and the difficulty in tracking impact.
- Population changes and increase in projections of priority groups impacting capacity and contracting levels.
- Implementation of the National Institute for Health and Care Excellence (NICE) guidelines is patchy across all settings.

Theme 2: Prevention

- Lack of awareness of preventive interventions amongst communities.
- Lack of awareness of pre-exposure prophylaxis (PrEP)/post-exposure prophylaxis following sexual exposure (PEPSE) amongst public and priority groups.
- There are barriers to care/access to PrEP/PEPSE for services.
- Lack of awareness and knowledge of BBVs and TB within communities and health care professionals.
- Different types of stigma are encountered.
- Lack of awareness of vaccinations amongst general public.
- Risky behaviours amongst priority groups including chemsex.
- For the vaccination coverage of hepatitis B (for both 1-year-olds and 2-year-olds) the rate in Birmingham (90%) is higher than the Nearest Neighbours (84%) and England (88%).
- There are 3 indicators relating to viral hepatitis which Birmingham is classified as "requires improvement / worse 95% in comparison to England":
  1. Under 75 mortality rate from hepatitis B related end-stage liver disease/hepatocellular carcinoma (2017-19).
  2. Persons entering drug misuse treatment - percentage of eligible persons completing a course of hepatitis B vaccination (2016-17).
  3. Persons in drug misuse treatment who inject drugs - percentage of eligible persons who have received a hepatitis C test (2017-18).

Theme 3: Testing and diagnosis

- Inconsistency of testing across BBVs and TB.
- Different types of late diagnosis and inconsistency in testing across the acute sector.
- Testing of BBVs and TB is patchy across General Practices and there is variation in GPs skills and knowledge.
- Variation in testing approaches across BBVs and TB and usage of point-of-care testing (POCT).
- Hidden unmet need and undiagnosed population amongst priority groups - testing to align with BBVs and TB NICE guidelines, as currently not necessarily reaching undiagnosed population and addressing unmet need.
- Variation of views in terms of enhancing and incentivising testing.
- A range of commissioned organisations undertaking testing, silo-working and disjointed reporting.
- A backlog in testing for elimination programmes as a result of COVID-19.
- Lack of awareness of testing services and access to testing.
- Key statistics:
    - For HIV testing coverage, between 2013 and 2019, there was a general upward trend in the count of those accepting a test. 2020 saw a significant decrease as a result of COVID-19. In terms of coverage, the 65% in Birmingham is high compared to England (46%) and the Nearest Neighbours (37%).
    - The number and rate of new HIV diagnosis in Birmingham shows a general decrease since 2015 particularly in 2019 and 2020. The rate per 100,000 population is similar to England and to the Nearest Neighbours. The target of 21 by 2025 equates to a reduction of 64% on 2020 figures.
    - For HIV late diagnosis, the actual count report year-on-year decreases between 2014-16 to 2018-20, however the rate for late diagnosis has remained at a similar level to previous years. The rate is lower than the average for the Nearest Neighbours and slightly lower than the England average.
    - The rate for repeat HIV testing in gay, bisexual and other men who have sex with men is significantly lower than the Nearest Neighbours and England average.
    - The number and rate of TB incidence in Birmingham has seen year-on-year (three-year average) decreases since 2011-13. At 18.4 per 100,000 population, this is higher than England and the Nearest Neighbours average.

Theme 4: Treatment

- Lack of awareness of treatment changes.
- Perception and attitude towards treatment (e.g., "Testing is simpler, now a finger prick blood test rather than taking bloods, treatment was tablets and a weekly injection, now just tablets which you can take whilst still being a user.")
- Social deprivation and affordability and the impacts on accessing treatment.
- Multiple appointments and touchpoints for PLWH.
- 89% of adults in Birmingham newly diagnosed with HIV started ART within 91 days of diagnosis. This is higher than the average for the Nearest Neighbours (84%) and the average for England (83%).
- ART coverage for Birmingham is 99% which is similar to the Nearest Neighbours and England.

Theme 5: Support Services

- Lack of support services.
- Inconsistency of Peer Support models across BBV and TB pathways.
- Access to mental health support and counselling.
- Lack of standardisation of patient support forums across BBVs and TB.

RECOMMENDATIONS

The following recommendations are informed by the findings of this needs assessment. From October 2022 – July 2023 the recommendations were fully reviewed by a range of subject matter experts, and where appropriate they have been revised to develop the Birmingham FTC+ Action Plan. The Action Plan is a working document which has a clear set of actions and deliverables required to meet the targets of the initiative and the needs of the population.

Theme 1: New ways of working and structural approach

1. Services and more joined up collaborative working

- Increase the number and awareness of support groups for people with BBVs & TB. (E.g., there is no hospital support group for people with TB)
- Reinstate ESOL for health so new migrants understand health needs and how to access services.
- Create new partnerships for mutual joint delivery of services at grass-root level.
- Give a voice to younger cohort of how they want services delivered and where.
- Instigate joint delivery of testing with community partners such as charities, community centres, Public Health and Integrated Care Boards (ICBs).
- For TB, focus on GP services to provide a more holistic service and provide patient choices and new pathways.
- Operate multi-disciplinary teams to pool together skills and resources to provide a comprehensive service to end users.
- A continuum of care across BBVs and TB, a more personalised and holistic approach across the workforce.

2. System leadership and unity

- A tough stand on homophobic and transphobic language and bullying. "General public/society need to be more accepting of lesbian, gay, bisexual and transgender (LGBT) people."
- Community leaders to take an LGBT affirmative stand.
- Community leaders encouraged to promote testing, vaccination, and treatment for BBVs.
- More of a proactive than reactive approach to TB across the board, through a higher level of awareness amongst communities.
- Nominated leaders to champion the cause through close liaison with ICB, GP, community and faith leaders.

3. Communication

- Promote the referral pathways for GPs, health and social care teams, local authorities and organisations, for signposting and directing service users appropriately.
- Consider the role of social prescribing models, Health Exchange and Choose and Book.
- Consider use of community, media, radio and TV platforms.
- Health professionals to provide more information to parents and guardians regarding the hepatitis B vaccination given to babies.

- Offer training and awareness sessions for different groups; for example, professionals, volunteers and community participants.
- Ensure that campaign information is accessible to individuals who have additional learning/ accessibility needs.

4. Confidentiality and information sharing

- Improve communication links and sharing of information across A&E, GP and ICB as part of effective service delivery.
- Train health professionals in confidentiality to prevent disclosure of status of a BBVs and TB to non-service users.
- Health professionals to ask patients at their first meeting how they would prefer to be communicated with to assure confidentiality. For example, there may be privacy concerns in shared addresses for university students and people in sheltered accommodation.

5. Technology

- Review the effective use of digital technology and make it accessible to all communities, taking into consideration language and barriers to information and making information bilingual where warranted.

6. Monitoring

- Consideration should be given to an overarching Fast-Track Cities+ dashboard to measure the impact of the initiative's plans, inform actions to address unmet need and service gaps and to inform future commissioning decisions.

7. Alignment with national policies

- Consideration should be given to aligning Fast-Track Cities+ with wider national policy, as these are driving current improvements locally across BBVs and TB.

Theme 2: Prevention

8. Information and awareness amongst the general public and workforce

To increase awareness of the Fast-Track Cities+ Initiative programme, more education and information on BBVs and TB is recommended. Opportunities include:

- **In schools:**
  - Development of an age-appropriate educational awareness programme for the Fast-Track Cities+ Initiatives. Its main aims are to develop knowledge and increase awareness around BBVs and TB in children and young people.
  - Children and young people can inform family members, extended family members, older generations and members of the community, helping to dispel stigma and myths.

- **In colleges and universities:**
  - BBVs & TB awareness workshops.
  - Health champions: train volunteers about BBVs and TB so they can inform others, using a peer-on-peer education approach.
  - Advocates to talk about their experiences to raise awareness.
  - Increase signposting to services.
  - Refreshers and workshop for information dissemination.
  - Target key areas for impact, such as fresher's fairs, and make it 'seamless' and part of current processes.

- **In at-risk communities:**
  - Develop Fast-Track Cities+ Champions from targeted audiences to raise awareness of the programme, of BBVs & TB, and to signpost to services.
  - Advocates to discuss experiences in community settings.
  - Greater level of education to understand what latent TB and active TB are and what actions need to be taken.
  - Utilise established pathways to cascade good information to impact on behaviours and engagement.
  - Greater understanding of how culture impacts on acceptance and action.
  - Make education and training available, free and easy to access.
  - Increase awareness of undetectable equals untransmittable (U=U). Education will decrease stigma, prejudice, and discrimination for those living with HIV/AIDS. These are the main barriers that would discourage people from testing and treatment.

- **Across healthcare workforce**
  - Better education within all Birmingham health care services to improve awareness, testing and treatment opportunities for BBVs and TB.
  - Training around who is at risk, what the risks are and prevention methods.
  - Education for healthcare and pharmacy staff on viral hepatitis.
  - Education for people at risk of viral hepatitis on treatment, to help dispel stigma and myths about old treatment.

- **Across the general public**
  - Consider education and awareness campaigns.
  - More education and messaging about hepatitis C. For example how hepatitis C affects your body, i.e., it can cause liver cancer, especially if treatment is not completed.
  - Increase awareness of preventive treatment for HIV, and hepatitis B vaccinations.
  - Increase awareness of services that support safe exchange of needles and offer support for drug addiction.

9. Targeted promotional campaigns

Below shows areas which the Local Authority can help to support. Targeted promotional campaigns:

- Should be aimed at different age ranges and cohorts (for example international students may have limited information on BBVs & TB).
- For communities who are more at risk of BBVs and TB; e.g., Asian communities are more at risk of TB; men who have sex with men and black African communities are more at risk of HIV; PWID are more at risk of viral hepatitis.
- At different physical locations, such as GP surgeries, on public transport, pubs, nightclubs.
- Campaigns on social media covering where to get information, testing locations, prevention methods.
- Use local influencers such as local celebrities, community leaders, faith leaders, to deliver awareness campaigns.
- Use world health days to raise awareness, i.e., World Aids Day, Hepatitis C, Mental Health and TB Days.
- Advertising and messaging to be appropriate. Use simple advertising – consider literacy foreign language diversity.
- Use advertisements in the media, with a positive image encouraging people to get tested for hepatitis C.
- Use cards (like the sexual health concertina leaflet) that fit in your wallet. These are discreet, which is important as there is stigma in having this diagnosed.
- Use important lifesaving messages alongside media campaigns to reduce stigma around condition using radio and TV.
- Promote more services to support people with drug addiction.

10. Prevention activities including vaccination programmes, PrEP and needle and syringe programmes

- Better information on vaccination programs available for hepatitis B and who should get vaccinated.
- Better information on PrEP. This should be promoted for high-risk groups as a lot of people still don't know about it.
- Improve access to needle and syringe programmes over the weekend, so clean equipment is available to people, every day of the week, therefore reducing the need and risk of people sharing.
- Consider best practice from other countries. For example, it was suggested introducing injecting booths like those in Holland, obtaining heroin from chemists.
- More should be done to find out about the sex workers in Birmingham and include them under the Safe Project, to assess their needs in relation to access to services.

Theme 3: Testing and diagnosis

11. Increase awareness of the importance of testing

- Having sexual health and BBV services, charities and organisations at large public gatherings such as festivals, sporting events and concerts.
- Advertisements on highway billboards, public transport, stations, airports, national awareness campaigns like those for COVID-19 and discussion on TV programmes. "Something big and bold like a bus campaign promoting awareness."
- Increase information prevalence in the media such as TV (news and magazine style programmes), radio, newspapers and magazines. Consider use of national HIV figures championing the cause, who would be willing to be interviewed to increase awareness of the importance of testing.
- Ensure conversations are focussed on increasing testing rates for BBVs and TB, giving factual information on how the tests are completed. Discuss how it is a finger prick test, not intravenous; how some who test positive do not expect to; the ease of access and engagement within treatment Mention that extreme side effects are less common now.
- More testing and more promotion of testing across BBVs and TB with a public campaign to all residents of Birmingham. This should highlight the prevalence of BBVs and TB within Birmingham communities, raise awareness and inform people of testing opportunities.
- Increase access to testing at venues such as community centres, local health centres, universities and workplaces.

12. Testing as part of current outreach services in community

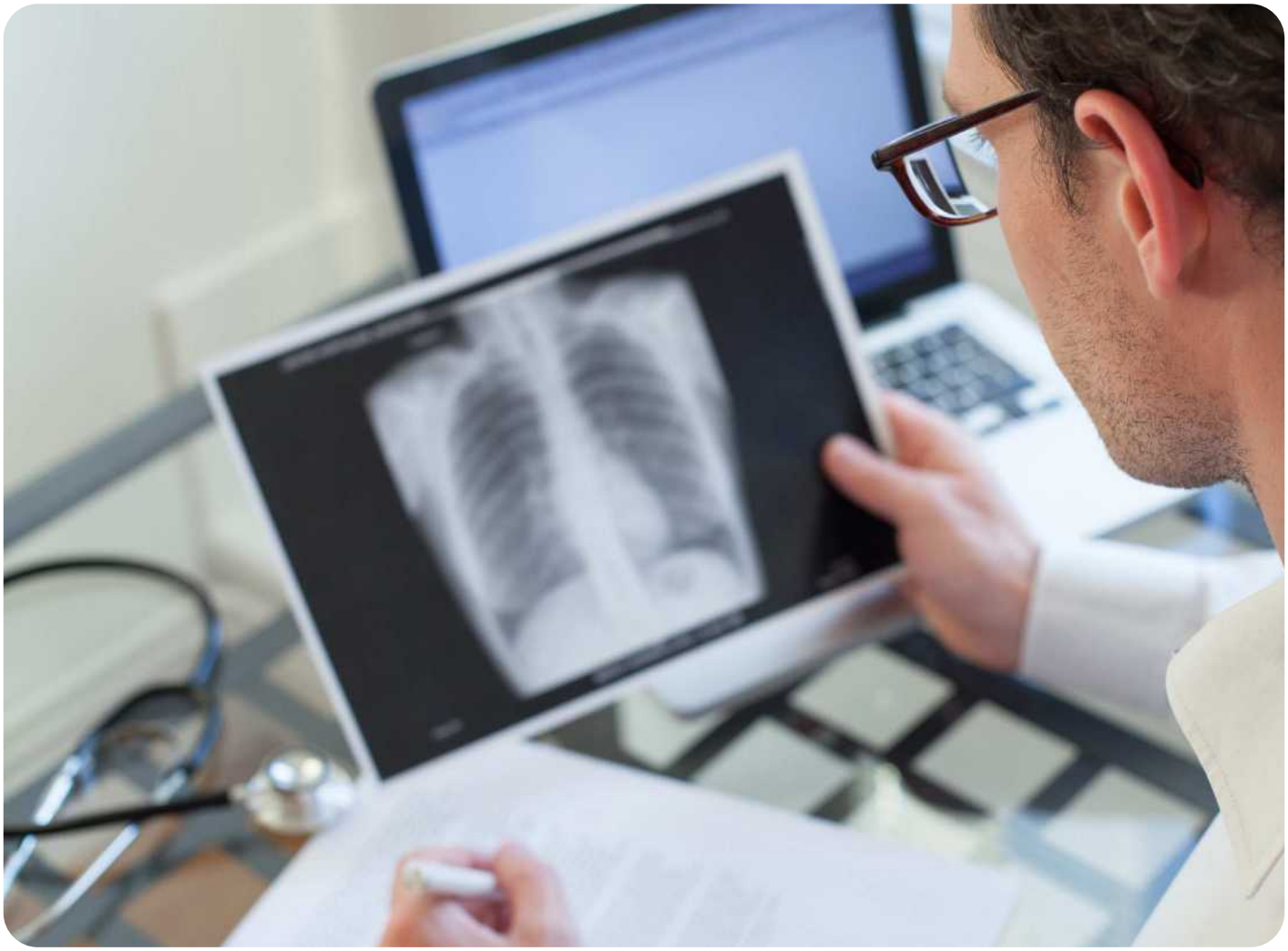
- More promotion of testing and treatment opportunities within services already supporting people at higher risk of contracting BBVs and TB, so that everyone using those services has the opportunity to get diagnosed and supported.
- Ensure services who do offer testing opportunities deliver this provision in a way that allows people to be tested on request, on the same day.
- Specific community intervention and outreach targeting particular communities such as the LGBT community.
- Develop a programme of outreach service in retail space, so you can have a walk-in for screening and testing and serve diverse communities.
- Easy access and walk-in services in the community that operate a good range of hours including outside of normal office working hours and pop-up testing sites.
- Develop home test kits similar to COVID testing for TB, so the ease and effectiveness of service is increased.
- Provide free test kits available to pick up at pharmacies or GP surgeries with details of where to get support to talk about the test or to get help with the test.
- More access to rapid testing or home testing with quick results for BBVs and TB.
- Increase access to BBV and TB testing within GP surgeries, allowing people to be potentially diagnosed in services that are local and convenient.
- Introduction of testing opportunities within pharmacy-based needle syringe programmes, to increase testing opportunities.
- More instant testing with quick results in lots of different places like barbers, libraries and community centres.

- Easy access for booking appointments and getting tested such as an app or website with instant access to booking, testing and information.
- GPs to provide patients with a list of recommended testing and vaccinations.

13. Testing as part of opt-out system

Opportunities for testing as part of an opt-out system include:

- GP routine blood tests - GPs to be educated/re-educated on symptoms, especially when presented with more than one. This should be incentivised in the same way that the influenza vaccination is.
- When a patient presents at A&E with a condition that requires a blood test, provide BBV TB opt-out testing, as late diagnoses often present here with pneumonia, epilepsy and encephalitis symptoms.
- Consider testing people for BBVs and TB at pre-op stage so that the hospital knows who is infectious. Testing at pre-op appointments can help reduce stigma and discrimination, ensuring that people are treated fairly.
- At cervical smear screening, practice nurses to discuss sexual health and testing for BBVs and TB.



Theme 4: Treatment

14. Treatment

- Increase the numbers of peer workers and volunteers to support people accessing testing and treatment.
- Ensure people who are diagnosed in communities are enabled to access or continue treatment in the event that they are imprisoned.
- Increase awareness of changes and improvements in treatment options available, amongst health care professionals and patients.
- Offer multiple appointments and touchpoints for people living with BBVs.
- Offer TB treatment to those aged 65 or under with latent TB.

Theme 5: Support services

15. Stigma

- Stigma and isolation should be dealt with through communication and educational development programmes and workshops.
- Encouragement from other health providers for people to access testing, giving a list of where people could go for testing, vaccination, or PrEP.
- Media campaign to reduce stigma around these conditions using radio and TV.

16. After care and health and wellbeing support

- Counselling services to be more readily and promptly available for individuals with BBVs and TB.
- Improve access to mental health services and support services to reduce social isolation.
- Access to a peer mentor or volunteer with lived experience early in the process, when you are diagnosed with a BBVs or TB, increasing volunteering and paid employment opportunities.
- Establish peer-to-peer support in community, with case studies for positive outcomes.
- Peer support and LGBT-specific services and groups.
- Create feeder groups for improving service provision in all areas of TB testing and medication.
- Make effective use of community networks and be sensitive to the needs of diverse communities.

17. Social support and accommodation

- Ensure that the social and health inequalities that affect the lives of those at higher risk of contracting BBVs are addressed; e.g., safe and secure housing, access to mental health services, access to health care.
- Measures to be taken by the government or local authority to increase the asylum seeker allowance or to supplement it respectively for individuals with BBVs and TB.
- The Government or the Council needs to consider sole accommodation for asylum seekers with BBVs and TB.
- The Council/statutory sector needs to ensure there is social support for people with BBVs and TB.

GLOSSARY

A&E = accident and emergency
AIDS = acquired immune deficiency syndrome
BBVs = blood-borne viruses
BCG = Bacillus Calmette–Guérin
ESOL = English for speakers of other languages
GP = general practitioner
HIV = human immunodeficiency virus
IAPAC = International Association of Providers of AIDS Care
ICB = integrated care board
LA = local authority
LGBT = lesbian, gay, bisexual and transgender
NHS = National Health Service
NICE = National Institute for Health and Care Excellence
ODN = operational delivery network
PEPSE = Post-Exposure Prophylaxis Following Sexual Exposure
PLHIV = people living with HIV
PrEP = pre-exposure prophylaxis
PWID = people who inject drugs
SCOT = strengths, challenges, opportunities, threats
TB = tuberculosis
UAM = unlinked anonymous monitoring
UNAIDS = United Nations Programme on HIV/AIDS
U=U = undetectable equal untransmittable

A BOLDER HEALTHIER BIRMINGHAM

Birmingham City Council

FAST-TRACK CITIES+

Birmingham City Council

ACTION PLAN

FAST-TRACK CITIES+ BIRMINGHAM

A BOLDER HEALTHIER BIRMINGHAM

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FTC+ ACTION PLAN

Project overview

Birmingham has signed up to the Fast-Track Cities+ (FTC+) Initiative. FTC+ aims to strengthen existing programmes and focus resources to accelerate locally coordinated, city-wide responses to end blood-borne viruses (BBVs) including HIV and viral hepatitis (Hepatitis B and C), as well as Tuberculosis (TB), as major public health threats by 2030 and 2035 respectively. The initiative also aims to strengthen communities and ensure timely provision of services that support the population living with these conditions, without prejudice and stigma.

Project objectives and targets

The main objectives of the programme are to:

- Strengthen existing programmes and accelerate locally coordinated responses to end blood-borne viruses including HIV/AIDS and viral hepatitis (Hepatitis B and C), as well as Tuberculosis (TB), as major public health threats by 2030.
- Strengthen communities and ensure timely provision of services that support the population living with these conditions, without prejudice and stigma.

The project aims to target the following groups:

- Young People aged 13 to 25
- Women of reproductive age
- BAME Communities (particularly individuals from African, Caribbean and South Asian ethnic backgrounds)
- Older people aged 50+ years
- LGBT Communities
- Men who have Sex with Men (MSM)
- People Who Inject Drugs (PWID)
- Sex workers (both male and female)
- Homeless people, including rough sleepers and those living in temporary accommodation
- Refugees and asylum seekers

Encompassing a whole-city approach, the initiative offers a more joined-up effort to eliminate and eradicate new transmissions of BBVs and TB.

DISEASE SPECIFIC TARGETS

HIV

- 95% of people living with HIV (PLHIV) knowing their status
- 95% of people who know their HIV-positive status on HIV treatment
- 95% of PLHIV on HIV treatment being virally suppressed
- Zero stigma and discrimination

Hepatitis B

- 90% reduction in new cases of chronic Hep B infections by 2030 (compared to 2015)
- 65% reduction in deaths from Hep B by 2030 (compared to 2015)
- 90% childhood Hep B virus vaccination coverage (3rd dose coverage)
- 100% Hep B virus birth-dose vaccination coverage or other approach to prevent mother-to-child transmission
- 90% coverage of vaccination in prisoners, eligible sexual health clinic clients, homeless individuals, sex workers, contacts of Hep B infected cases, asylum seekers, new migrants and people who inject drugs (PWID)

Hepatitis C

- 90% reduction in new cases of chronic Hep C infections by 2025 (compared to 2015)
- 65% reduction in deaths from Hep C by 2025 (compared to 2015)
- 100% of injecting drug users report adequate needle and syringe provision for their needs
- 90% of those living with Hep C diagnosed
- 90% of eligible persons with current Hep C infection started treatment

Tuberculosis (TB)

- 90% reduction in TB incidence compared to 2015
- 95% reduction in TB deaths compared to 2015
- Achieve 1358 LTBI tests per year in Birmingham
- Achieve 90% treatment completion rates (12-month outcome) by 2026
- 80% BCG vaccination coverage for all children in the Birmingham LA
- 100% of TB cases offered a HIV test

PROJECT BENEFITS

Measure	Impact
Increase in number of people knowing their HIV/ Hep B/Hep C/TB status.	Increase in number of people receiving treatment for each disease area Reduction in rate of transmission.
Reduction in number of new infections of HIV/ Hep B/Hep C/TB.	Increase in quality of life for those affected. Reduction in health inequalities . Reduction in NHS spending in these areas.
Increase in number of people receiving treatment for HIV/ Hep B/Hep C/TB.	Increase in quality of life for those affected. Reduction in health inequalities . Increase in number of people with supressed viral loads (for HIV).
Reduction in number of deaths from HIV/ Hep B/Hep C/TB.	Reduction in health inequalities.
Reduction in number of patients with HIV/ Hep B/Hep C/TB who feel discriminated against, or have their disease stigmatised.	Increase in number of people receiving treatment for each disease area. Reduction in rate of transmission.
Reduction in number of people losing housing due to TB infection.	Increase in quality of life for those affected. Reduction in health inequalities.

PROJECT MANAGEMENT

Project manager: Juliet Grainger/Dharini Roula

Project sponsor: Becky Pollard

The project will be managed within the Public Health Adults Team. It will be led by the Service Lead, managed by a Senior Officer and supported by a Programme Officer. Support will be obtained from the Service Lead for Health Protection, Commissioning Manager and Commissioning Senior Officer, throughout the Commissioning and Performance Management processes. Furthermore, a Steering Group and Project Board have been established to ensure crucial stakeholders are involved at every stage of the project. Full membership can be found in the Appendix 1 and 2 and includes individuals from the NHS and BCC involved in the delivery and commissioning of BBV and TB services, UKHSA, community pharmacy, pharmaceutical company representatives and community organisations.

Action plan

The actions are based on the recommendations produced by the Community Engagement and Needs Assessment. A RAG rating system will be used to monitor how the actions are being progressed with red meaning it has not begun, amber in progress and green complete.

An overarching action is to create a 'Community of Interest' group for FTC+ Birmingham, which will sit alongside the FTC+ Steering Group and the FTC+ Project Board to inform the delivery of the Action Plan. The 'Community of Interest' group will be formed through contacting relevant groups already set up in Birmingham, such as Positive Peers.

The action plan is divided into five themes, each of which set out a number of ambitions, including:
1. New ways of working and structural approach
2. Prevention
3. Testing and diagnosis
4. Treatment
5. Support services

THEME 1: NEW WAYS OF WORKING AND STRUCTURAL APPROACH

1.1 Services and more joined up collaborative working

Ambition: A clear continuum of care across all stages of the care pathway, ensuring relationships between organisations, so patients can be signposted and utilise the multi-disciplinary team.

Current position:

- Fragmentation of commissioning, pathways, and funding.
- Lack of integration and joint working makes it difficult to incorporate new ways of working and new models of care.
- Previous retendering processes & national reconfiguration of sexual health services (separation of HIV services from sexual health services) has resulted in a messy service delivery.
- Individual elimination programmes in place with different reporting lines, and the difficulty in tracking impact, for example the ODN does not always test for HIV, even though PWID have higher rates of HIV.
- Population changes and increase in projections of priority groups impacting capacity and contracting levels.
- Most of the testing for HIV is through the sexual health service, but this does not include the other BBVs.

Required actions	Timescale/resource/ budget	Responsible team and organisation
Create multi-disciplinary teams and new partnerships for mutual joint delivery of services. 1. Map service user journey & the services/teams involved, for each condition pathway. 2. Build pathways around the service user and include the voice of service users in designing interventions. 3. Agree the approach for the required pathway improvements.	Person(s) capacity to map the pathway.	Clinical services for HIV, hep B, hep C and TB.
Build KPI's around BBV and TB testing, treatment and care into all commissioning contracts related to these conditions.	Timescale will be determined by when services are recommissioned.	Commissioners in the ICB, BCC and NHSE.
Instigate joint training and delivery of testing with community partners such as charities, community centres, Public Health and ICBs.	Testing kits, staff to conduct testing.	Whole system – ICS.
Ensure a robust implementation of the TB 'new entrant' and referral pathway for GPs which was reviewed in 2022.	Person(s) to monitor implementation.	ICB commissioners & GPs.
Ensure strong alignment of BBV/TB testing and treatment with BCC's re-commissioned sexual health service and drugs and alcohol service.	March 2024.	BCC commissioning teams.
Align Birmingham's priorities with those across the West Midlands. Scope the different groups that exist across the West Midlands for sexual health and HIV. Utilise the West Midlands Office for ICB's as a collective way into the ICB's in the West Midlands.	Ongoing action.	UKHSA to co-ordinate.

1.2 System leadership and unity

Ambition: Leaders within communities and healthcare systems to proactively raise awareness of BBVs and TB, reducing stigma and increasing testing levels in communities.

Current position:

- There is a lack of awareness about BBVs and TB, particularly among certain community groups.

Required actions	Timescale/resource/budget	Responsible team and organisation
Engage with community organisations and champions through existing forums to raise awareness and recruit support for community delivery of the FTC+ comms plan.	Budget for the community organisations to engage.	BCC.
Develop a champion support pilot with either a community organisation or FTC+ partner, to include training, supervision and networks to share best practice and challenges.	Budget to run a pilot.	BCC and a local community organisation.
Identify underserved communities (as part of comms and testing approaches to utilise in the action plan), understand how partners ensure they provide a culturally competent service (e.g., through audits, CQC measures, policies and regulations).	Ongoing.	Whole system – BCC, ICS and providers.

1.3 Communication

Ambition: Improved knowledge and links between healthcare services so patients can be appropriately referred and signposted to services, including supporting diagnosed patients to be referred to additional healthcare services.

Current position:

- Patients need better access to either the Sexual Health Service or GPs & knowledge and power to access these services.
- Organisations not commissioned to test for BBVs often do not know where to refer patients to for testing.

Required actions	Timescale/resource/budget	Responsible team and organisation
Understand and promote the referral pathways for GPs, health and social care teams, local authorities and other organisations, for signposting and directing service users appropriately. Test an approach through the current social prescribing models, Health Exchange and Choose and Book. Enhance training and awareness sessions on communication for different groups (e.g. professionals, volunteers, community participants). Scope what training already exists for different groups. Identify where there are gaps in training delivery and/or attendance. Identify a plan to fill any gaps.	Person(s) to collate referral pathways & promote to necessary partners.	ICS.
Enhance training and awareness sessions on communication for different groups (e.g. professionals, volunteers, community participants). Scope what training already exists for different groups. Identify where there are gaps in training delivery and/or attendance. Identify a plan to fill any gaps.	Person(s) to scope training, identify gaps & develop a plan.	BCC in partnership with NHS training providers.

1.4 Confidentiality and Information Sharing

Ambition: For necessary information to be shared across organisations whilst maintaining patient confidentiality.

Current position:

- Service users lack assurance regarding confidentiality and are afraid of their health status being disclosed (especially applies to those living in shared or temporary accommodation.
- Outcome & date of testing in prisoners is often not documented or shared with drug & alcohol services or GP practices upon release.

Required actions	Timescale/resource/budget	Responsible team and organisation
Assurance that FTC+ providers have agreements in place and comply with data sharing agreements.	Timescales to fit recommissioning of sexual health services.	BCC and ICS commissioners.
Obtain feedback from service users on experiences and report to the Steering Group/ Project Board annually.	Timescales to coincide with contract review meetings.	BCC, ICS and service providers.
Ensure service specifications and monitoring of services provides patients with a range of communication methods.	TBC.	Those writing service specifications.

1.5 Technology

Ambition: Ambition: Utilise developments in technology to raise awareness and improve systems functions, ensuring accessibility requirements are met.

Current position:

- Celebrities & TV programmes are influential in educating people & raising awareness about BBVs & TB.

Required actions	Timescale/resource/budget	Responsible team and organisation
Services and commissioners review the effective use of digital technology and make it accessible to all communities, taking into consideration language, barriers to information and making things accessible where warranted.	Comms budget to be agreed with partners.	BCC/ICB commissioning teams. Digital teams within services.
Service specifications to stipulate the use of technology to ease access for booking appointments and getting tested e.g., through an app or website.	Timescales to fit recommissioning of sexual health services.	Commissioning teams. Digital teams within services.

1.6 Monitoring

Ambition: To create a system whereby all elements of the initiative can be monitored (including those that are not currently measured/collected) as close to real time as possible.

Current position:

- Current data collection may not provide the 'full picture' & contain inaccuracies.
- Not every target is currently monitorable – e.g., 90% coverage of vaccination in prisoners, sexual health clinic clients, homeless individuals, sex workers, contacts of Hep B infected cases, asylum seekers, new migrants and people who inject drugs (PWID)

Required actions	Timescale/resource/budget	Responsible team and organisation
Consideration should be given to an overarching FTC+ dashboard to measure the impact of the initiative's plans.	Utilise pre-existing dashboards e.g., FTC+ Global Dashboard, the City Observatory.	BCC.
Develop ways to monitor the targets where data is currently not collected or monitored.	Ongoing as part of City Observatory dashboard development.	BCC, supported by clinical teams & epidemiologists.
Develop targets and monitoring for testing (HIV, Hep B & Hep C) and treatment (Hep B).	Budget for testing and treatment to be explored.	BCC and ICS commissioners with support from wider steering group.

1.7 Alignment with National and local Policies

Ambition: For all healthcare settings and broader relevant settings to be aligned with and follow national policies and regulations, such as the NICE guidelines.

Current position:

- Implementation of NICE guidelines is patchy across all settings.
- The needs assessment findings suggested the implementation of NICE guidelines on HIV testing in GP practices is lacking.

Required actions	Timescale/resource/budget	Responsible team and organisation
Target testing at those who meet the testing criteria which is outlined in national testing guidelines. - Audit of HIV testing in the West Midlands adherence to NICE guidelines provide information on barriers to testing and understandings of why people decline tests in different settings.	Resource & budget to expand testing to those outlined in guidance.	ICS/community organisations. Audit by UKHSA.
Engage primary care to support GP testing for HIV, according to the NICE guidelines. 1. Better understand the GP contract for testing for BBVs and facilitators for BBV testing at GPs. 2. Understand data available on delivery of the NICE recommended services and analyse to identify gaps.	TBC.	GPs/ICS.
Align Fast-Track Cities+ activities with wider national policy. - HIV Action Plan for England. - HIV Action Plan for the West Midlands. - TB Action Plan for England . - Hepatitis Elimination Strategies.	Ongoing. Resource required includes updates from partners when new strategies/plan are released.	BCC & key stakeholders.
Develop better communication channels for sharing good practice and conduct a review of good practice. - Review effectiveness of projects/programmes conducted using the HIV innovation fund.	TBC.	BCC & UKHSA.

THEME 2: PREVENTION

2.1 Information and awareness amongst the general public and workforce

Ambition: For increased awareness about BBVs and TB in schools, colleges & universities, at-risk communities, across the healthcare workforce and in the general public.

Current position:

- There is a lack of awareness among the public about what the FTC+ initiative is & knowledge and awareness about BBVs & TB varies widely.
- People's knowledge was mainly around HIV & there is limited knowledge about hep B, hep C & TB.
- Mixed views, myths & stereotypes impact upon who will tested & access other support services.
- There is a broad view that individuals do not die from HIV anymore and therefore it is not taken seriously.
- There is a lack of knowledge about the testing procedure for hepatitis.
- Late diagnoses are happening after multiple touchpoints with the healthcare system because healthcare professionals are not testing.
- The changes to the BCG vaccination programme & the effect of these need to be considered and planned for.

Required actions	Timescale/ resource/budget	Responsible team and organisation
Consider whether comms campaigns should focus of raising awareness of Fast-Track Cities+ as an initiative or focus on the conditions the initiative aims to tackle. - Actions will be detailed in a comms plan under development.	Specific comms budget.	Comms teams in various partner organisations.
Develop a regional HIV communications toolkit and share national resources for local use.	TBC.	UKHSA.
In schools: Review adoption of age-appropriate awareness programmes & provide more information to teachers about HIV & TB.	TBC.	Schools and universities, e.g., nurses/health advisors.
In colleges and universities: BBV & TB awareness workshops with BBV & TB health champions.	TBC.	Wellbeing staff at colleges and universities.
At-risk communities: Develop FTC+ community testing bid to include a champions programme to raise awareness of BBVs & TB, and to signpost to services (e.g., needle and syringe programmes).	TBC.	TBC.

Required actions	Timescale/resource/ budget	Responsible team and organisation
Across the healthcare workforce: 1. Understand what training healthcare providers currently receive on BBVs and TB. 2. Identify gaps. 3. Work with Health Education England (HEE) to promote training available via the ICS (e.g., on testing and treatment opportunities for BBVs and TB, key groups at higher risk, prevention methods etc.) and provide cultural competence training.	Training packages developed by other FTCs e.g., Manchester, Bristol.	Trainers in NHS (HEE) & other healthcare organisations.
Across the general public: Education and awareness campaigns (see comms plan).	Ongoing. World health days/weeks/months.	Comms teams in various partner organisations.

2.2 Targeted promotional campaigns

Ambition: Increase awareness, prevention methods and testing in communities of different ages and those most at-risk.

Current position:

- Heterosexual, middle-aged individuals are most likely to present late with HIV.
- Those who present late are more likely to have multiple issues, such as drug use, mental health and social problems.
- Gay Pakistani men are the most difficult population to access in terms of testing.
- New arrivals (refugees & migrants are unlikely to understand the screening programme for TB.

Required actions	Timescale/resource/ budget	Responsible team and organisation
Aimed at different ages and those more at-risk - Actions will be detailed in a comms plan under development .	Ongoing.	Comms teams in various partner organisations – regional comms team for the UKHSA.

2.3 Prevention activities including vaccination programmes, PrEP and needle and syringe programmes

Ambition: Improved knowledge, awareness and take-up of prevention activities, and ultimately a reduction in new infections.

Current position:

- PEPSE is required within 72-hours but is only available in sexual health services (and A&E in out of hours), making it difficult for clinicians to access.
- TB requires higher prevention efforts, particularly in West Birmingham where there is higher incidence, social risk factors & deprivation.
- There is a lack of information given to pregnant women/mothers of young babies about the Hep B vaccination.
- STI testing & condom provision is prohibited by postcode if collecting in person.
- More support is required to prevent risky behaviours e.g., drug taking, Chemsex.

Required actions	Timescale/resource/budget	Responsible team and organisation
Improve information on vaccination programmes available for Hep B and BCG and who should get vaccinated: - Health professionals to provide more information and improved information to parents/guardians regarding the Hep B vaccination given to babies. - Maternity services to MECC, regarding hep B and BCG vaccination. - Ensure the robust implementation of neonatal pathways for BCG, following the evaluation of screening babies for severe combined immunodeficiency in 2021.	Information leaflets/flyers.	NHSE Childhood immunisation team/NHSE commissioners.
Improve information on PrEP and uptake in diverse communities.	National information on PrEP.	Sexual Health Services.
Improve access to needle and syringe programmes. - Audit of current provision & gaps in provision.	To be incorporated into the re-commissioning of the Drugs/ Alcohol Service.	Commissioners of the needle and syringe programmes.
Assess the needs of sex workers and include them under the Safe Project.	Outcomes/findings of the Sex Worker Needs Assessment.	Sexual Health Service providers.

THEME 3: TESTING & DIAGNOSIS

3.1 Testing as part of an opt-out system

Ambition: To create a more unified/systematic approach to testing, using a triple BBVs and TB footprint to meet the unmet need within the undiagnosed population.

Current position:

- Late diagnosis of HIV (and co-infections) is an issue in Birmingham, particularly in older people, heterosexual men & people from a Black African background.
- Testing currently takes an opportunistic approach.
- Not all organisations are testing on a triple BBVs and TB footprint.
- GPs should be testing as part of the General Medical Services (GMS) contract, but implementation of this is patchy across Birmingham.
- Some departments at the QE hospital (including the AMU) routinely screen for HIV and are supported by HIV consultants, however this is not the case in the A&E department.
- Not all GPs are signed up to deliver the LTBI screening programme.

Required actions	Timescale/resource/ budget	Responsible team and organisation
Learn from other areas that previously had high levels of late diagnosis, such as Lambeth and Croydon, and consider where learning can be used to make improvements in Birmingham.	Ongoing.	BCC to make connections & partners to implement improvements.
GP routine blood tests (incentivised in the same way as the influenza vaccination or using a QOF or equivalent scheme).	Funding as an incentive.	Primary Care commissioners in the ICB.
When a patient presents at A&E with a condition that requires a blood test, provide BBV/TB opt-out testing. - Opt-out testing to be made a priority in all associated organisations.	Buy-in from hospitals labs. Funding.	ICS/UHB/UKHSA/Regional Director of Public Health (sits between OHID & NHSE).
Consider testing people for BBVs and TB at pre-op stage.	Buy-in from hospital staff. Evidence behind effectiveness of this.	Birmingham hospitals.
Adopting MECC, at cervical smear screening, practice nurses to discuss sexual health and testing for BBVs and TB.	Primary and care providers.	Clinical staff.

3.2 Testing as part of current outreach services in community

Ambition: To address stigma and engage hidden populations within local communities, testing interventions and approaches will be made culturally competent and utilise pre-existing links into communities.

Current position:

- Lack of engagement with those who are not engaged with the healthcare system.
- Outreach for TB testing is a particular gap in Birmingham.
- There is a lack of engagement about BBVs and TB in some communities, such as the South Asian community.
- The screening system for sex workers has gaps meaning many fall through the system.
- There are mixed perceptions regarding who is impacted & at risk.

Required actions	Timescale/resource/ budget	Responsible team and organisation
Promotion of testing and treatment within services already supporting those at higher risk of BBVs and TB • Specialist drug and alcohol providers who have good links with those at high risk of BBVs. • Ensuring Sexual Assault Referral Centres (SARCs) are carrying out the required testing.	Training on testing methods. Test kits.	Commissioners of these services.
Develop a programme of outreach service in the community that operate a range of hours, including evenings & weekends, and develop pop-up sites, e.g., in retail spaces, barbers, libraries & community centres. - Facilitate rapid testing. - Promote and offer home testing.	Test kits which produce rapid results. Staff. Use of spaces.	As part of specification design.
Develop home test kits similar to COVID and testing for TB, so the ease and effectiveness of service is increased.	Organisations to develop kits.	National TB services.
Increase testing opportunities in primary care and in local communities 1. Provide free test kits at pharmacies, GP surgeries or community sites with details of further support. 2. Introduce testing in pharmacy-based needle and syringe programmes.	Test kits. Vending machines. Training for GP and pharmacists.	Primary care commissioners/ commissioners of needle and syringe programmes.
Improve information provided at GPs & pharmacies 1. Explore what leaflets are sent to GPs (blue bag scheme) & pharmacies (OHID healthy living literature).	TBC.	TBC.

THEME 4: TREATMENT

4.1 Treatment

Ambition: Increased awareness of changes/improvements in treatment and increase retention in care.

Current position:

- There are a number of people, in particular the substance misuse cohort, diagnosed with a BBV or TB who are not engaged with treatment and at risk of lost to follow-up.
- The decommissioning of the HIV and TB support service has led to fragmentation across services, meaning people have to access separate organisations for each problem, resulting in increased risk of lost to follow-up.
- Transitioning from a young person to adult services for HIV can be challenging & young people born with HIV can lose motivation to continue taking treatment.
- There is a lack of knowledge and awareness of the changes and improvements to treatment for hepatitis C.
- There is no patient support fund to taxis patients to TB treatment.
- Some people with TB have limited access to healthcare, especially if they move location during treatment.

Required actions	Timescale/resource/ budget	Responsible team and organisation
~Part of comms plan~ Increase awareness of changes and improvements in treatment options available, amongst health care professionals and patients.	Ongoing.	Commissioners.
Understand the commissioning process for treatment in prisons and the activity relating to Birmingham residents. 1. Work with the Hepatitis C ODN prison clinical nurse specialist to improve the release plans/ pathways.	TBC.	Prison services.

Required actions	Timescale/resource/ budget	Responsible team and organisation
Increase retention in care: 1. Offer a flexible and responsive service that offers walk-in and booked appointments in multiple locations via different modalities (F2F or telephone) at different times/days with information communicated in English and other commonly spoken first languages. 2. Increase number of peer workers & volunteers to support people accessing testing & treatment. 3. Train those supporting individuals through treatment in motivational interviewing and other methods to help them increase adherence. 4. Maximise any touchpoint to discuss BBV and signpost back to care.	Funding for peer workers. Time for training.	Clinical treatment services & commissioners of support organisations.
Improve understanding of why Hep B death rates in Birmingham are increasing, whilst national rates remain stable, i.e., through a death audit.	Staff time to undertake an audit.	BCC and service providers, epidemiologists with access to detailed deaths data.

THEME 5: SUPPORT SERVICES

5.1 Stigma

Ambition: To eliminate stigma surrounding BBVs and TB in Birmingham.

Current position:

- Patients with HIV have a stigma disclosing a positive diagnosis.
- Some children & young people may not be told they're HIV positive by their parents & can receive stigma from teachers.
- PLWH experience stigma in healthcare settings, e.g. being given the last appointment.

Required actions	Timescale/resource/ budget	Responsible team and organisation
Research levels of stigma among the healthcare and wider workforce through a mass questionnaire, using methodology tested in other FTCs, and identify causes of stigma.	TBC	Comms teams in various partner organisations.
Scope a pilot with partners, such as positive peers and FTC leads, to address causes of stigma.	TBC	Healthcare providers across the board (and their trainers).
Assess and develop occupational policies around HIV stigma.	TBC	OHID/NHSE (Regional Director for Public Health).

5.2 Aftercare and health and wellbeing support

Ambition: To ensure those who have been diagnosed with any condition are supported to live healthy, happy lives.

Current position:

- For HIV, independent support groups are not joined up with healthcare services and are not engaged.
- Muslim men living with HIV are more likely to be isolated and require support with accepting diagnosis, adherence to medicine and coping strategies.

Required actions	Timescale/resource/ budget	Responsible team and organisation
Enhance counselling services for individuals with BBVs and TB 1. Scope provision of NHS & third sector counselling services. 2. Strengthen communication between services.	TBC	Hospital trusts/ Hep C trust.
Improve peer support: 1. Scope current peer support programmes available. 2. Identify gaps in peer support programmes. 3. Address gaps in peer support programmes, including levels of inclusiveness, potentially through better utilising community networks, such as faith organisations. 4. Encourage patients to access a peer mentor/ volunteer early in the process.	Willing volunteers to provide peer support or budget to pay them.	Positive Peers/Hep C Trust/ BCC Adult Social Care.

5.3 Social support and accommodation

Ambition: Provide individuals with the support required (external to healthcare support), including social support, to allow them to live a healthy life.

Current position:

- For HIV, independent support groups are not joined up with healthcare services and are not engaged.
- Muslim men living with HIV are more likely to be isolated and require support with accepting diagnosis, adherence to medicine and coping strategies.

Required actions	Timescale/resource/ budget	Responsible team and organisation
Better understand the offer of social support, such as housing, for those diagnosed with BBVs and TB and for new arrivals/asylum seekers and migrants.	Ongoing	BCC and whole system
Link with asylum seeker/migrant health services and strategies to support their delivery surrounding BBVs and TB.	TBC	BBV/TB services in partnership with refugee/ migrant/asylum seeker services.
Enhance social support for people with BBVs and TB. 1. Scope the current social support available. 2. Identify users' needs and priorities for social support services. 3. Collect ongoing user feedback on experiences of social support. 4. Facilitate and implement actions to address these needs and priorities.	TBC	TBC
Implement a patient forum for Hepatitis C and TB and a peer support programme for testing for HIV.	TBC	Partners.

GLOSSARY

A & E = accident and emergency
LGBT = lesbian, gay, bisexual and transgender
BBV = blood-borne virus
LTBI = latent TB infection
BCC = Birmingham City Council
NHS = National Health Service
BCG = Bacillus Calmette-Guérin
NHSE = NHS England
ED = emergency department
NICE = National Institute of Clinical Excellence
FTC+ = fast-track cities+
ODN = operational delivery network
GP = general practice
PLHIV = people living with HIV
HIV = human immunodeficiency virus
PrEP = pre-exposure prophylaxis
ICB = integrated care board
PWID = people who inject drugs
ICS = integrated care system
QoF = quality outcome framework
LA = local authority
TB = tuberculosis

APPENDICES

Appendix 1 -
FTC+ Steering Group Membership

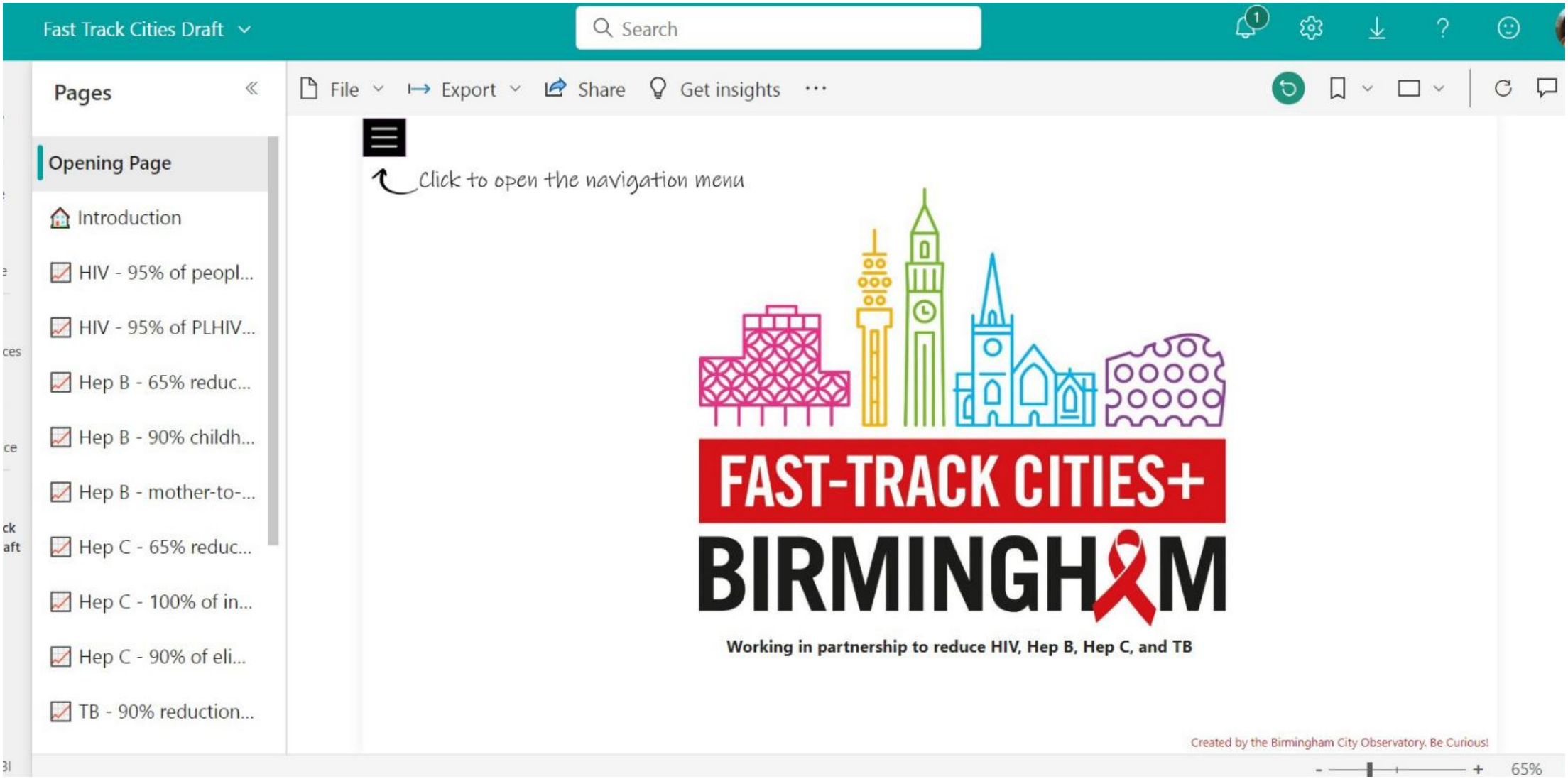
Birmingham City Council (BCC), Commissioning Manager, Adult Social Care
BCC, Public Health Service Lead for Adults (Chair)
BCC, Public Health Service Lead for Health Protection
BCC, Public Health Senior Programme Officer for Adults
BCC, Public Health Programme Officer for Adults
BCC, Senior Commissioning Officer (Adult Public Health Services)
Birmingham and Solihull Local Pharmaceutical Committee, Chief Officer
Cepheid, Community Diagnostic Solutions Sales Manager
Change, Grow, Live – Midlands Cluster Lead Nurse for Birmingham
Gilead, Midlands Regional Market Access Manager
Hep C Trust, Midlands & West Regional Manager
MSD, Local Account Manager for HIV
MSD, National Engagement Lead (Specialised Commissioning)
MSD, National Hep C Elimination Programme Lead
NHS England and NHS Improvement – Midlands, Commissioning Lead – Acute Specialised Commissioning, Specialised Commissioning (West Midlands),
University Hospitals Birmingham (UHB) NHS Foundation Trust, Consultant Physician in Sexual Health and HIV Medicine, Umbrella
UHB, Lead HIV Consultant at Birmingham's Heartlands Hospital (Co-chair)
UHB, Consultant Transplant Hepatologist
UHB, Hepatitis ODN nurse/manager,
UHB, Liver Unit Consultant, Blood-borne Virus Specialist
UHB, TB lead for Birmingham and Solihull
UHB, TB Lead Nurse Specialist and Chair of the RCN Public Health Forum, Birmingham and Solihull TB Service
UK Health Security Agency - West Midlands Health Protection Team, TB Programme Manager
UK Health Security Agency - West Midlands Sexual Health Facilitator

Appendix 2 - FTC+ Project Board Membership

Birmingham City Council (BCC), Director of Public Health
BCC, Assistant Director of Public Health Adults & Older People (Chair)
BCC, Commissioning Manager Adults Social Care
BCC, Programme Officer, Public Health (Adults)
BCC, Senior Programme Officer, Public Health (Adults)
BCC, Service lead for Adults & Chair of the FTC+ Steering Group
Birmingham & Solihull Integrated Care Board (BSol ICB), Head of Prevention and Long Term Conditions,
BSol ICB, Inequalities Programme Director
NHS England and NHS Improvement, West Midlands Commissioning Lead – Acute Specialised Commissioning, Specialised Commissioning
University Hospitals Birmingham NHS Foundation Trust, Chief Innovations Officer
UK Health Security Agency, West Midlands Consultant in Communicable Disease Control

A BOLDER HEALTHIER BIRMINGHAM

Birmingham City Council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Introduction
HIV - 95% of peopl...
HIV - 95% of PLHIV...
Hep B - 65% reduc...
Hep B - 90% childh...
Hep B - mother-to-...
Hep C - 65% reduc...
Hep C - 100% of in...
Hep C - 90% of eli...
TB - 90% reduction...
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FAST-TRACK CITIES+
BIRMINGHAM
Working in partnership to reduce HIV, Hep B, Hep C, and TB
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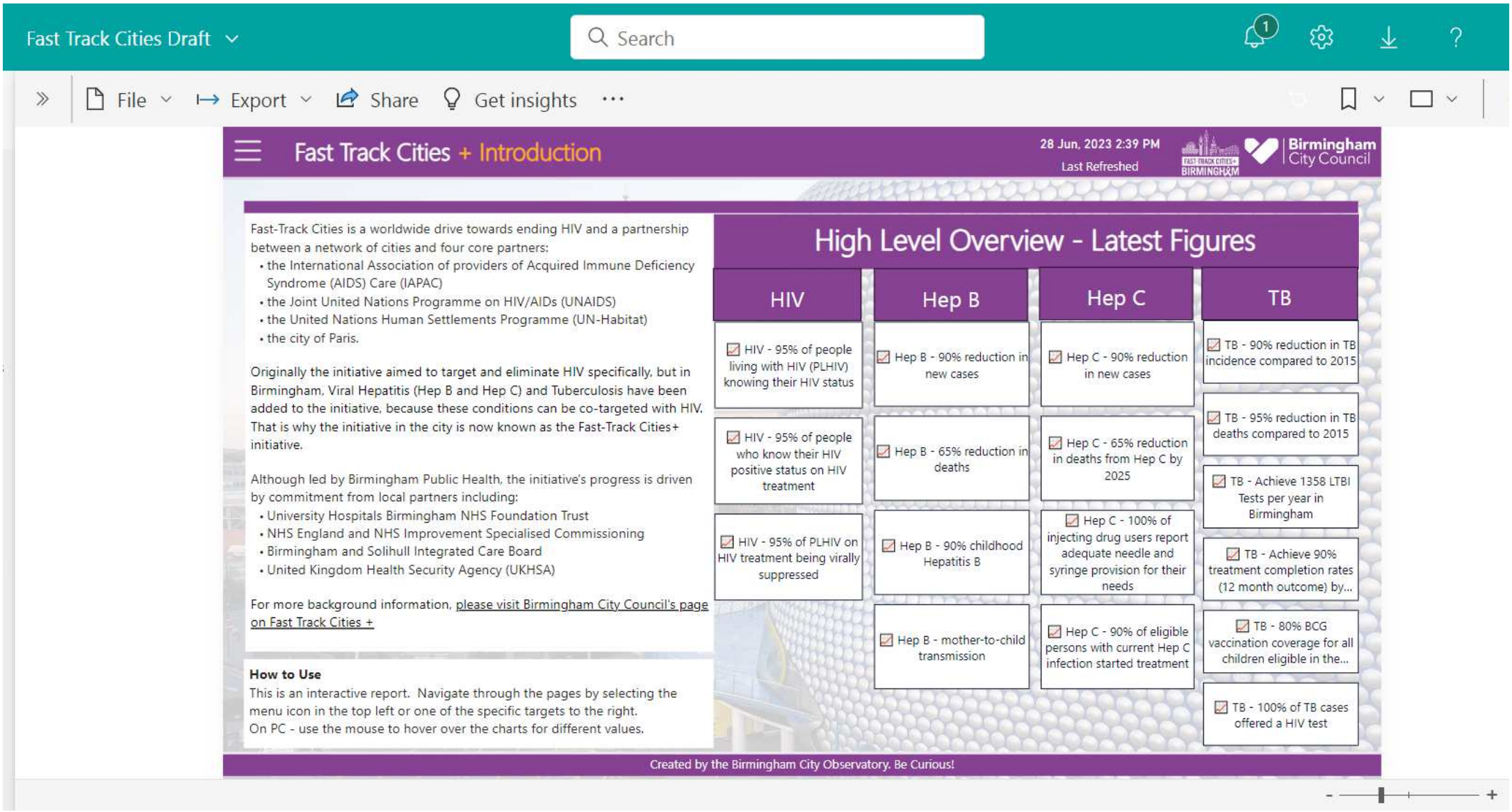
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Fast Track Cities + Introduction
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Last Refreshed
Birmingham City Council
Fast-Track Cities is a worldwide drive towards ending HIV and a partnership between a network of cities and four core partners:
• the International Association of providers of Acquired Immune Deficiency Syndrome (AIDS) Care (IAPAC)
• the Joint United Nations Programme on HIV/AIDs (UNAIDS)
• the United Nations Human Settlements Programme (UN-Habitat)
• the city of Paris.
Originally the initiative aimed to target and eliminate HIV specifically, but in Birmingham, Viral Hepatitis (Hep B and Hep C) and Tuberculosis have been added to the initiative, because these conditions can be co-targeted with HIV. That is why the initiative in the city is now known as the Fast-Track Cities+ initiative.
Although led by Birmingham Public Health, the initiative's progress is driven by commitment from local partners including:
• University Hospitals Birmingham NHS Foundation Trust
• NHS England and NHS Improvement Specialised Commissioning
• Birmingham and Solihull Integrated Care Board
• United Kingdom Health Security Agency (UKHSA)
For more background information, please visit Birmingham City Council's page on Fast Track Cities +
How to Use
This is an interactive report. Navigate through the pages by selecting the menu icon in the top left or one of the specific targets to the right.
On PC - use the mouse to hover over the charts for different values.
High Level Overview - Latest Figures
HIV
HIV - 95% of people living with HIV (PLHIV) knowing their HIV status
HIV - 95% of people who know their HIV positive status on HIV treatment
HIV - 95% of PLHIV on HIV treatment being virally suppressed
Hep B
Hep B - 90% reduction in new cases
Hep B - 65% reduction in deaths
Hep B - 90% childhood Hepatitis B
Hep B - mother-to-child transmission
Hep C
Hep C - 90% reduction in new cases
Hep C - 65% reduction in deaths from Hep C by 2025
Hep C - 100% of injecting drug users report adequate needle and syringe provision for their needs
Hep C - 90% of eligible persons with current Hep C infection started treatment
TB
TB - 90% reduction in TB incidence compared to 2015
TB - 95% reduction in TB deaths compared to 2015
TB - Achieve 1358 LTBI Tests per year in Birmingham
TB - Achieve 90% treatment completion rates (12 month outcome) by...
TB - 80% BCG vaccination coverage for all children eligible in the...
TB - 100% of TB cases offered a HIV test
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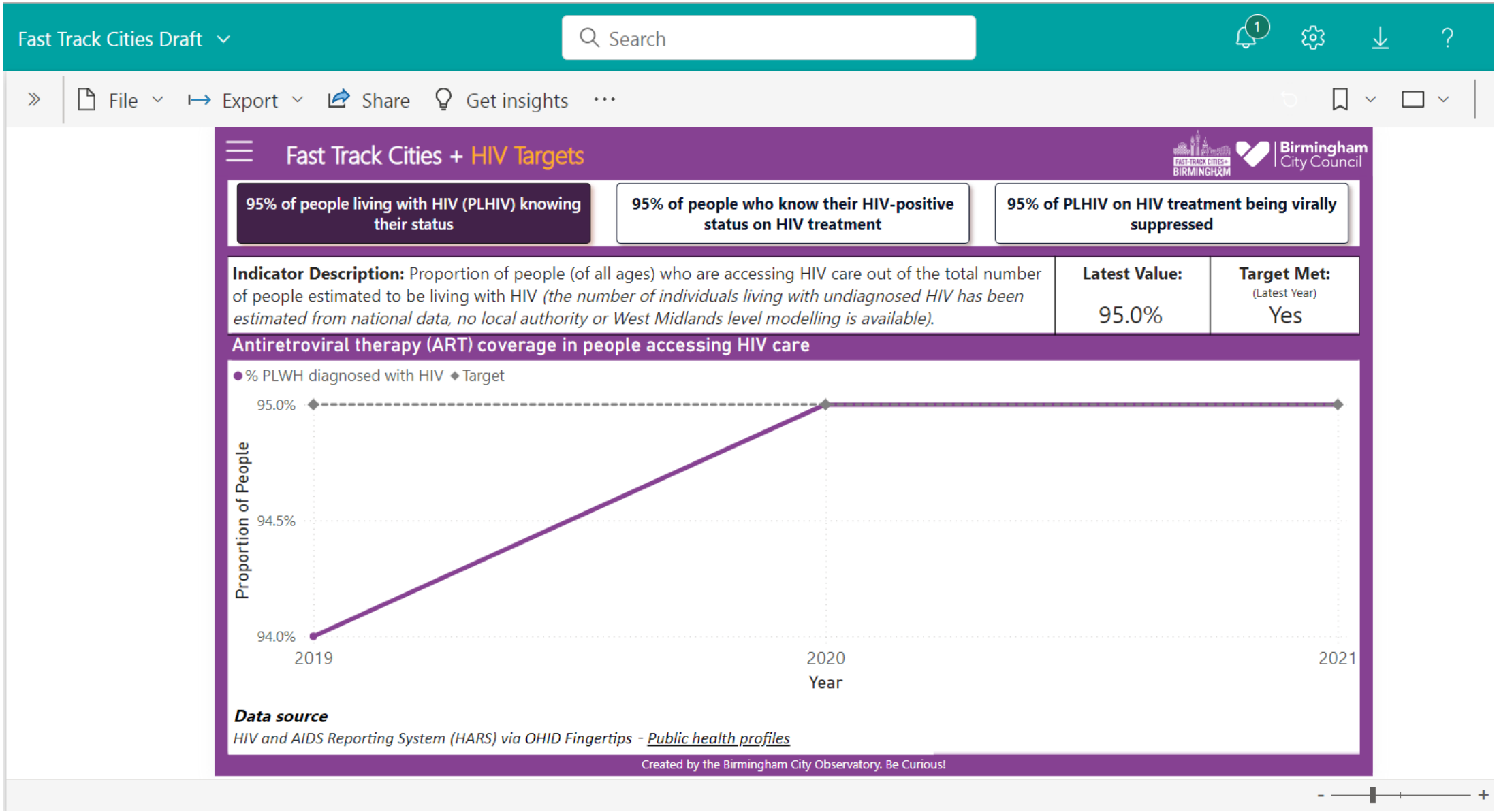
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Fast Track Cities + HIV Targets
Birmingham City Council
95% of people living with HIV (PLHIV) knowing their status
95% of people who know their HIV-positive status on HIV treatment
95% of PLHIV on HIV treatment being virally suppressed
Indicator Description: Proportion of people (of all ages) who are accessing HIV care out of the total number of people estimated to be living with HIV (the number of individuals living with undiagnosed HIV has been estimated from national data, no local authority or West Midlands level modelling is available).
Latest Value:
95.0%
Target Met:
(Latest Year)
Yes
Antiretroviral therapy (ART) coverage in people accessing HIV care
% PLWH diagnosed with HIV
Target
95.0%
94.5%
94.0%
Proportion of People
2019
2020
2021
Year
Data source
HIV and AIDS Reporting System (HARS) via OHID Fingertips - Public health profiles
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Fast Track Cities + HIV Targets

Birmingham City Council

95% of people living with HIV (PLHIV) knowing their status

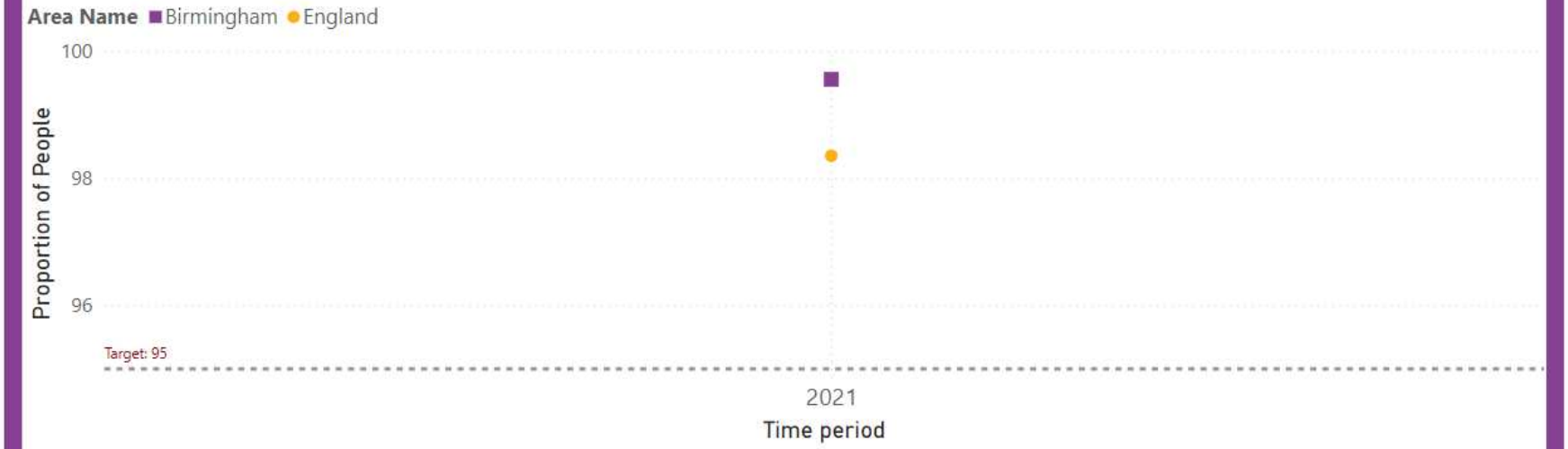
95% of people who know their HIV-positive status on HIV treatment

95% of PLHIV on HIV treatment being virally suppressed

Indicator Description: Proportion of people who were prescribed ART out of the total number of people seen for HIV and living in Birmingham.

Latest Value:	Target Met: (Latest Year)
99.6%	Yes

Antiretroviral therapy (ART) coverage in people accessing HIV care



Data source

HIV and AIDS Reporting System (HARS) via OHID Fingertips - Public health profiles

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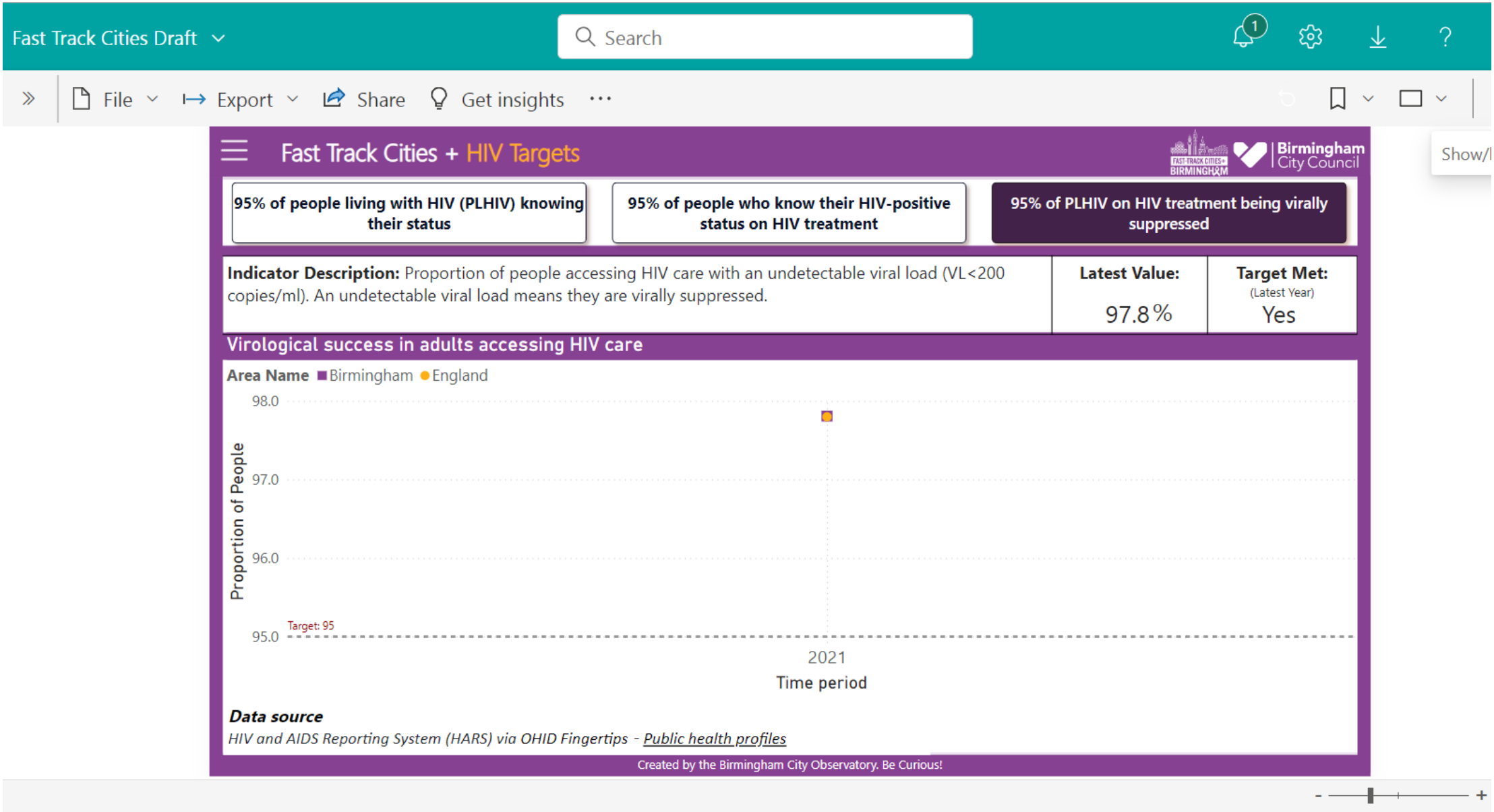
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Birmingham City Council
95% of people living with HIV (PLHIV) knowing their status
95% of people who know their HIV-positive status on HIV treatment
95% of PLHIV on HIV treatment being virally suppressed
Indicator Description: Proportion of people accessing HIV care with an undetectable viral load (VL<200 copies/ml). An undetectable viral load means they are virally suppressed.
Latest Value:
97.8%
Target Met:
(Latest Year)
Yes
Virological success in adults accessing HIV care
Area Name Birmingham England
98.0
97.0
96.0
95.0
Target: 95
Proportion of People
2021
Time period
Data source
HIV and AIDS Reporting System (HARS) via OHID Fingertips - Public health profiles
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Fast Track Cities + Hepatitis B Targets

Birmingham City Council

90% reduction in new cases of chronic Hep B infections by 2030

65% reduction in deaths from Hepatitis B by 2030 (compared to...

90% childhood Hepatitis B virus vaccination coverage (third dose...

100% Hep B virus vaccination coverage to prevent mother-to-...

Indicator Description: Number of all new Hepatitis B diagnoses by year of diagnosis resident in Birmingham City, 2015-2022. *(N.B. the data shown is for all new Hepatitis B diagnoses, not just chronic Hepatitis B infections.)*

Latest Value:	**Target Met:** (Latest Year)
222	No

New Hepatitis B Diagnoses in Birmingham

Data source

SGSS – provisional data

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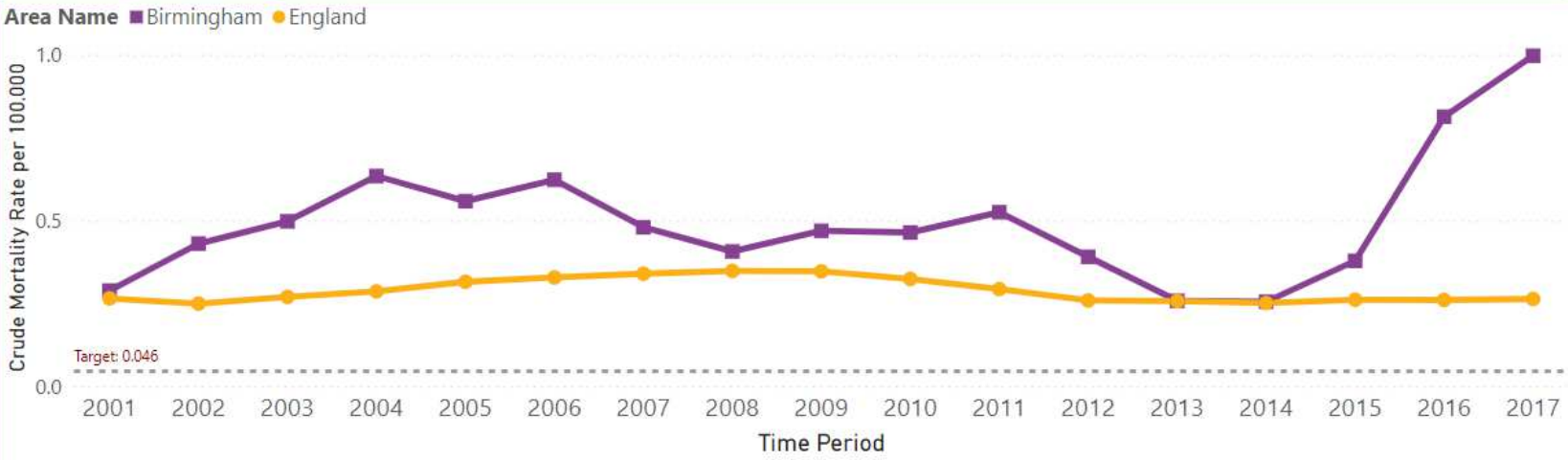
Fast Track Cities + Hepatitis B Targets

Birmingham City Council

90% reduction in new cases of chronic Hep B infections by 2030	**65% reduction in deaths from Hepatitis B by 2030 (compared to..**	90% childhood Hepatitis B virus vaccination coverage (third dose...	100% Hep B virus vaccination coverage to prevent mother-to-...

Indicator Description: Crude rate of mortality from hepatitis B related end-stage liver disease/hepatocellular carcinoma in persons less than 75 years per 100,000 population. 3 year time period range (i.e. 2017 = 2017-19).	**Latest Value:** 1.0	**Target Met:** (Latest Year) No

Under 75 mortality rate from hepatitis B related end-stage liver disease/hepatocellular carcinoma



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OHID Fingertips - Public health profiles

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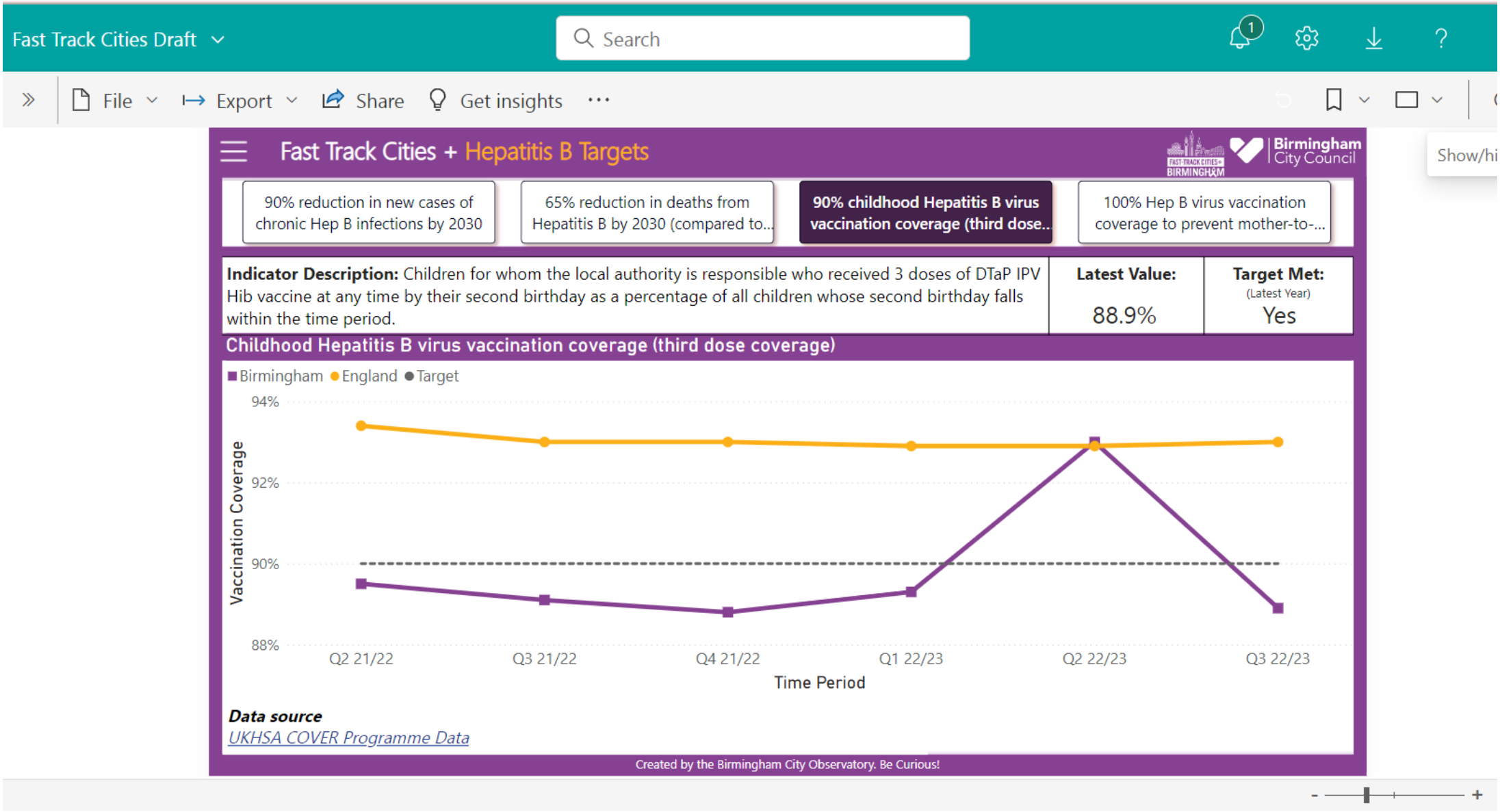
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Birmingham City Council
90% reduction in new cases of chronic Hep B infections by 2030
65% reduction in deaths from Hepatitis B by 2030 (compared to...
90% childhood Hepatitis B virus vaccination coverage (third dose..
100% Hep B virus vaccination coverage to prevent mother-to-...
Indicator Description: Children for whom the local authority is responsible who received 3 doses of DTaP IPV Hib vaccine at any time by their second birthday as a percentage of all children whose second birthday falls within the time period.
Latest Value:
88.9%
Target Met:
(Latest Year)
Yes
Childhood Hepatitis B virus vaccination coverage (third dose coverage)
Birmingham
England
Target
94%
92%
90%
88%
Vaccination Coverage
Q2 21/22
Q3 21/22
Q4 21/22
Q1 22/23
Q2 22/23
Q3 22/23
Time Period
Data source
UKHSA COVER Programme Data
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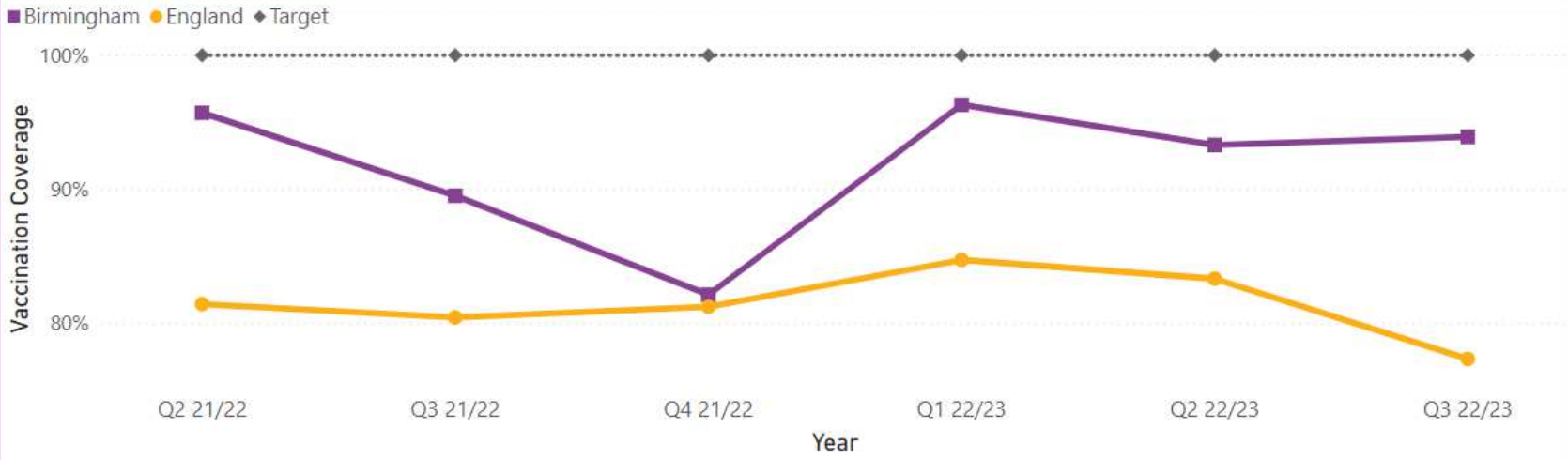
Fast Track Cities + Hepatitis B Targets

Birmingham City Council

90% reduction in new cases of chronic Hep B infections by 2030	65% reduction in deaths from Hepatitis B by 2030 (compared to...	90% childhood Hepatitis B virus vaccination coverage (third dose...	**100% Hep B virus vaccination coverage to prevent mother-to-...**

Indicator Description: Coverage of 6 doses of a HepB-containing vaccine reported for children who reached 2 years of age in the quarter born to hepatitis B positive women in Birmingham LA (data should be interpreted with caution given the low number of eligible neonates)	**Latest Value:** 93.9%	**Target Met:** (Latest Year) No

Hep B virus vaccination coverage to prevent mother-to-child transmission



Data source

UKHSA COVER Programme Data

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Fast Track Cities + Hepatitis C Targets

Birmingham City Council

90% reduction in new cases of chronic Hep C infections by 2025..

65% reduction in deaths from Hep C by 2025

100% of injecting drug users report adequate needle and syringe...

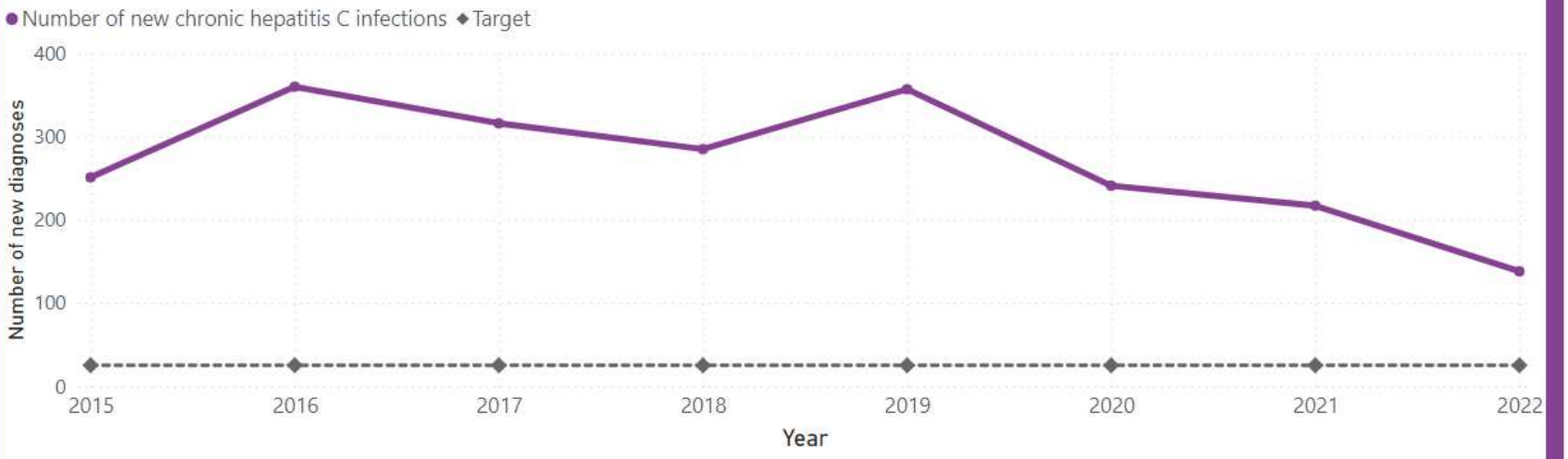
90% of eligible persons with current Hep C infection started treatment

Indicator Description: Number of all new Hepatitis C diagnoses by year of diagnosis resident in Birmingham City, 2015-2022. (*N.B. the data shown is for all new Hepatitis C diagnoses, not just chronic Hepatitis C infections)*

Latest Value: 138

Target Met: (Latest Year) No

New Hepatitis C diagnoses



Data source

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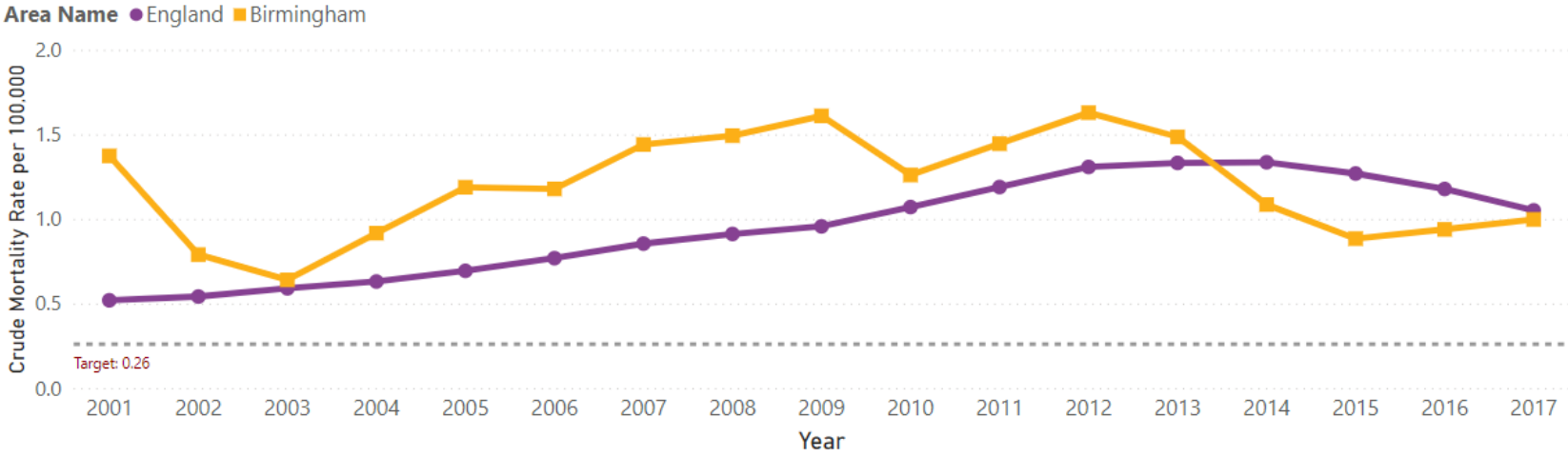
Fast Track Cities + Hepatitis C Targets

Birmingham City Council

90% reduction in new cases of chronic Hep C infections by 2025...	**65% reduction in deaths from Hep C by 2025**	100% of injecting drug users report adequate needle and syringe...	90% of eligible persons with current Hep C infection started treatment

Indicator Description: Crude rate of mortality from hepatitis C related end-stage liver disease/hepatocellular carcinoma in persons less than 75 years of age per 100,000 population. 3 year time period range (i.e. 2017 = 2017-19).	**Latest Value:** 1.0	**Target Met:** (Latest Year) No

Under 75 mortality rate from hepatitis C related end-stage liver disease/hepatocellular carcinoma



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OHID Fingertips - Public health profiles

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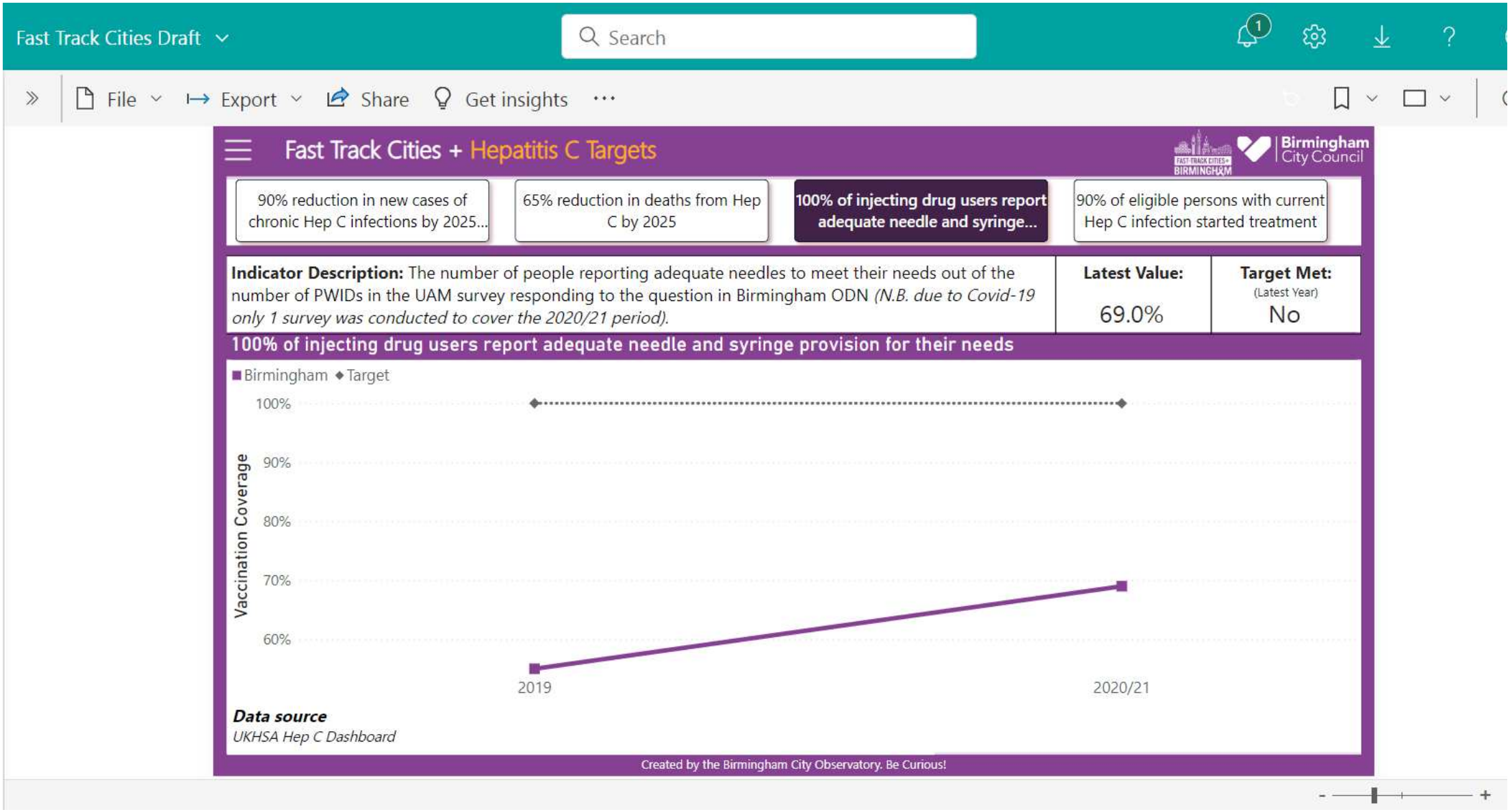
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Fast Track Cities + Hepatitis C Targets
Birmingham City Council
90% reduction in new cases of chronic Hep C infections by 2025...
65% reduction in deaths from Hep C by 2025
100% of injecting drug users report adequate needle and syringe...
90% of eligible persons with current Hep C infection started treatment
Indicator Description: The number of people reporting adequate needles to meet their needs out of the number of PWIDs in the UAM survey responding to the question in Birmingham ODN (N.B. due to Covid-19 only 1 survey was conducted to cover the 2020/21 period).
Latest Value:
69.0%
Target Met:
(Latest Year)
No
100% of injecting drug users report adequate needle and syringe provision for their needs
Birmingham
Target
100%
90%
80%
70%
60%
Vaccination Coverage
2019
2020/21
Data source
UKHSA Hep C Dashboard
Created by the Birmingham City Observatory. Be Curious!

Fast Track Cities Draft

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Fast Track Cities + Hepatitis C Targets

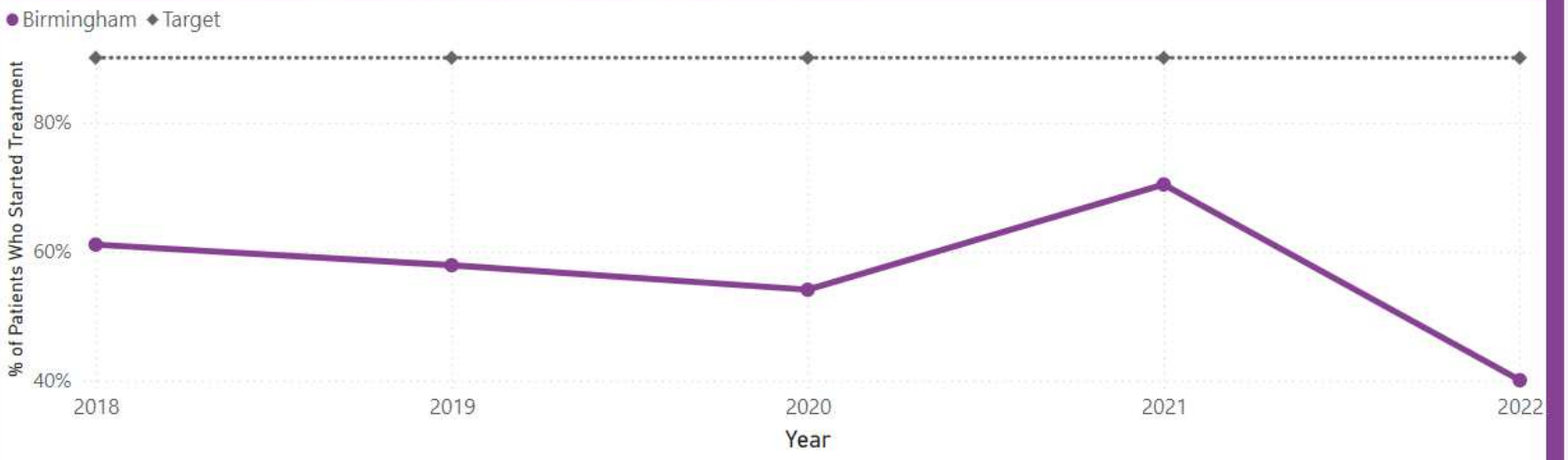
Birmingham City Council

90% reduction in new cases of chronic Hep C infections by 2025...	65% reduction in deaths from Hep C by 2025	100% of injecting drug users report adequate needle and syringe...	**90% of eligible persons with current Hep C infection started...**

Indicator Description: The number of people starting treatment out of the number of people linked into treatment.

Latest Value:	**Target Met:** (Latest Year)
40.1%	No

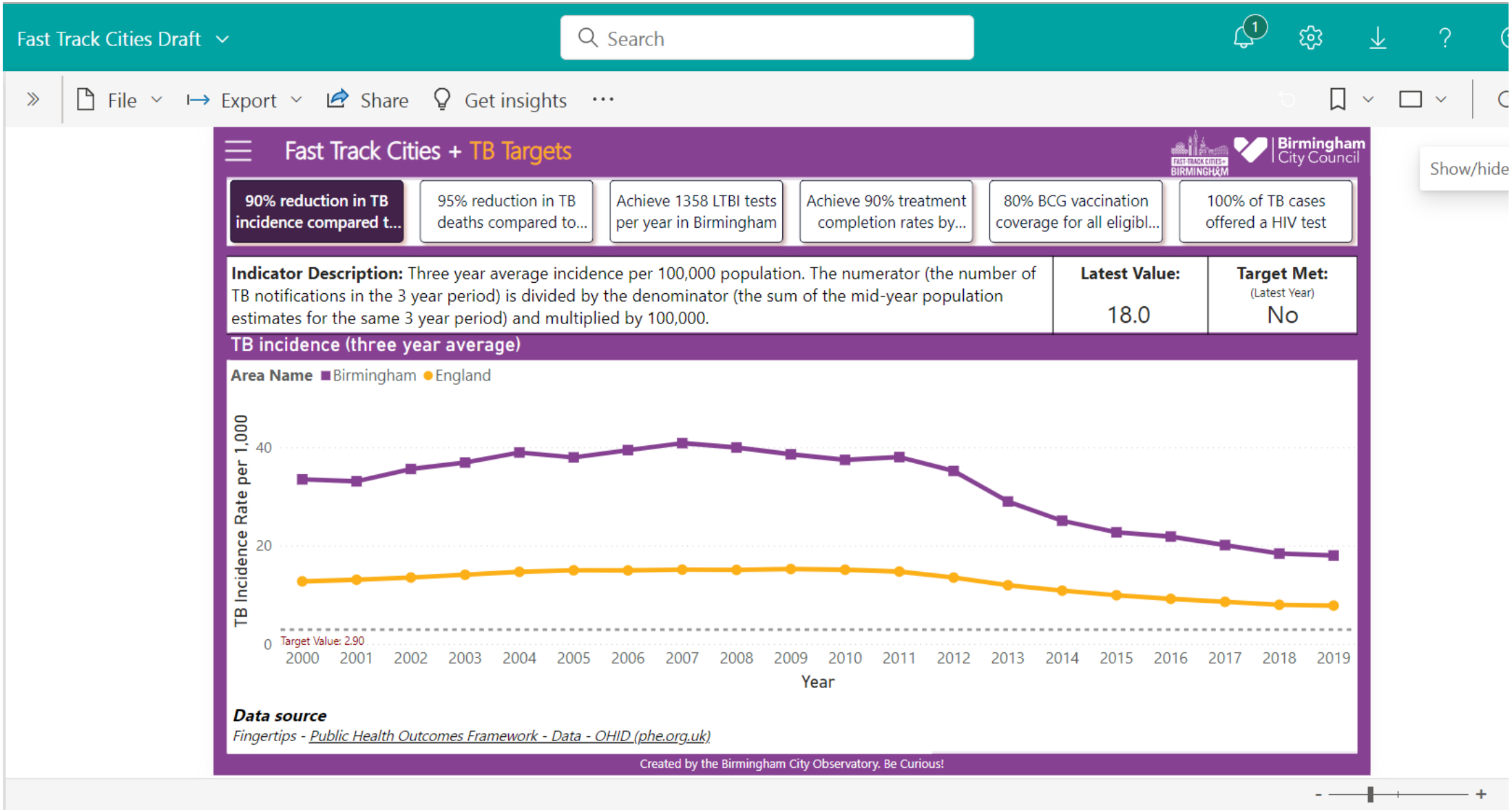
% of eligible persons with current Hep C infection who started treatment



Data source

UKHSA Hep C Dashboard

Created by the Birmingham City Observatory. Be Curious!


Fast Track Cities Draft
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Get insights
Fast Track Cities + TB Targets
Birmingham City Council
90% reduction in TB incidence compared t...
95% reduction in TB deaths compared to...
Achieve 1358 LTBI tests per year in Birmingham
Achieve 90% treatment completion rates by...
80% BCG vaccination coverage for all eligibl...
100% of TB cases offered a HIV test
Indicator Description: Three year average incidence per 100,000 population. The numerator (the number of TB notifications in the 3 year period) is divided by the denominator (the sum of the mid-year population estimates for the same 3 year period) and multiplied by 100,000.
Latest Value:
18.0
Target Met:
(Latest Year)
No
TB incidence (three year average)
Area Name Birmingham England
TB Incidence Rate per 1,000
40
20
0
Target Value: 2.90
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019
Year
Data source
Fingertips - Public Health Outcomes Framework - Data - OHID (phe.org.uk)
Created by the Birmingham City Observatory. Be Curious!
Show/hide

Fast Track Cities Draft

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Fast Track Cities + TB Targets

Birmingham City Council

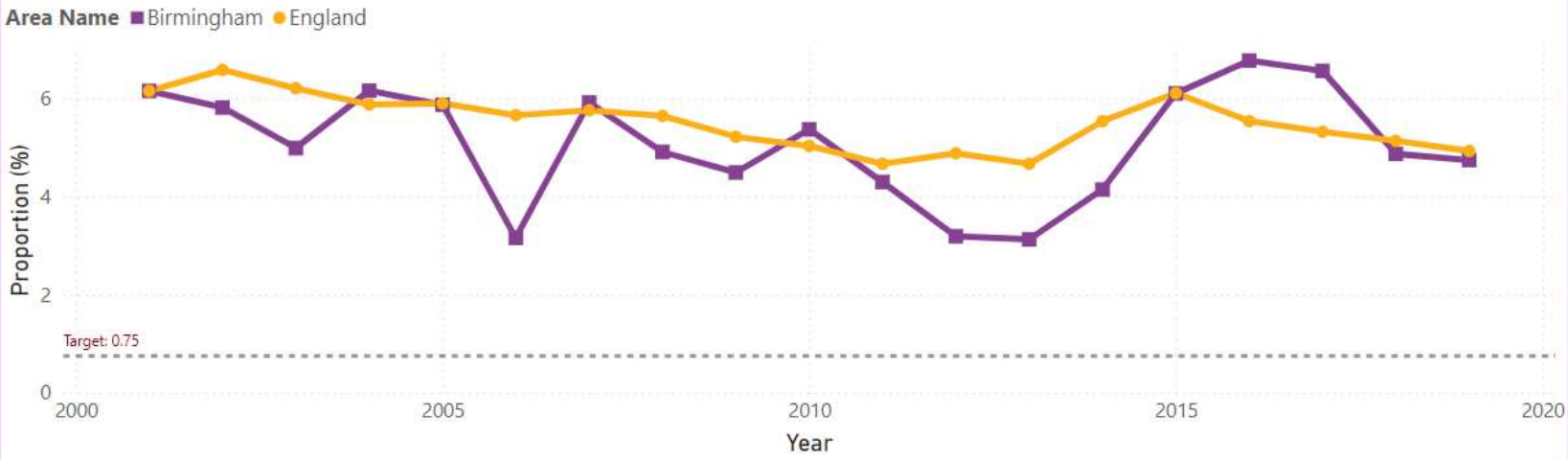
90% reduction in TB incidence compared to..	**95% reduction in TB deaths compared to...**	Achieve 1358 LTBI tests per year in Birmingham	Achieve 90% treatment completion rates by...	80% BCG vaccination coverage for all eligibl...	100% of TB cases offered a HIV test

Indicator Description: The annual proportion of drug sensitive TB cases who had died by the last reported outcome (exclusions: TB cases with rifampicin resistance or MDR-TB).

Latest Value: 4.7 %

Target Met: (Latest Year) No

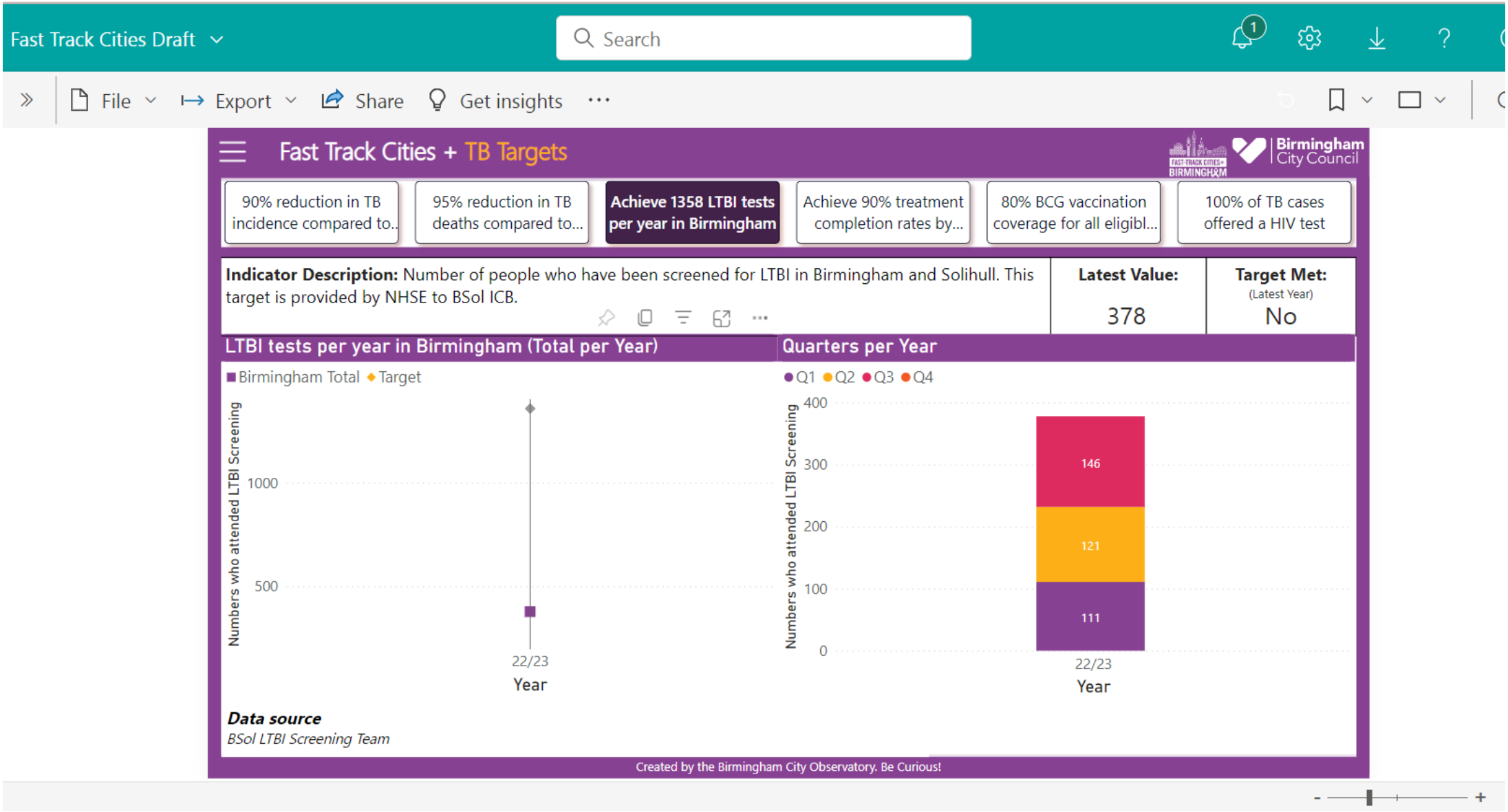
Proportion of drug sensitive TB cases who had died at last reported outcome



Data source

Fingertips - Public health profiles - OHID (phe.org.uk)

Created by the Birmingham City Observatory. Be Curious!


Fast Track Cities Draft
Search
File
Export
Share
Get insights
Fast Track Cities + TB Targets
Birmingham City Council
90% reduction in TB incidence compared to..
95% reduction in TB deaths compared to...
Achieve 1358 LTBI tests per year in Birmingham
Achieve 90% treatment completion rates by...
80% BCG vaccination coverage for all eligibl...
100% of TB cases offered a HIV test
Indicator Description: Number of people who have been screened for LTBI in Birmingham and Solihull. This target is provided by NHSE to BSol ICB.
Latest Value:
378
Target Met:
(Latest Year)
No
LTBI tests per year in Birmingham (Total per Year)
Birmingham Total
Target
Numbers who attended LTBI Screening
1000
500
22/23
Year
Quarters per Year
Q1
Q2
Q3
Q4
400
300
200
100
0
146
121
111
22/23
Year
Data source
BSol LTBI Screening Team
Created by the Birmingham City Observatory. Be Curious!

Fast Track Cities Draft

Search

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Fast Track Cities + TB Targets

Birmingham City Council

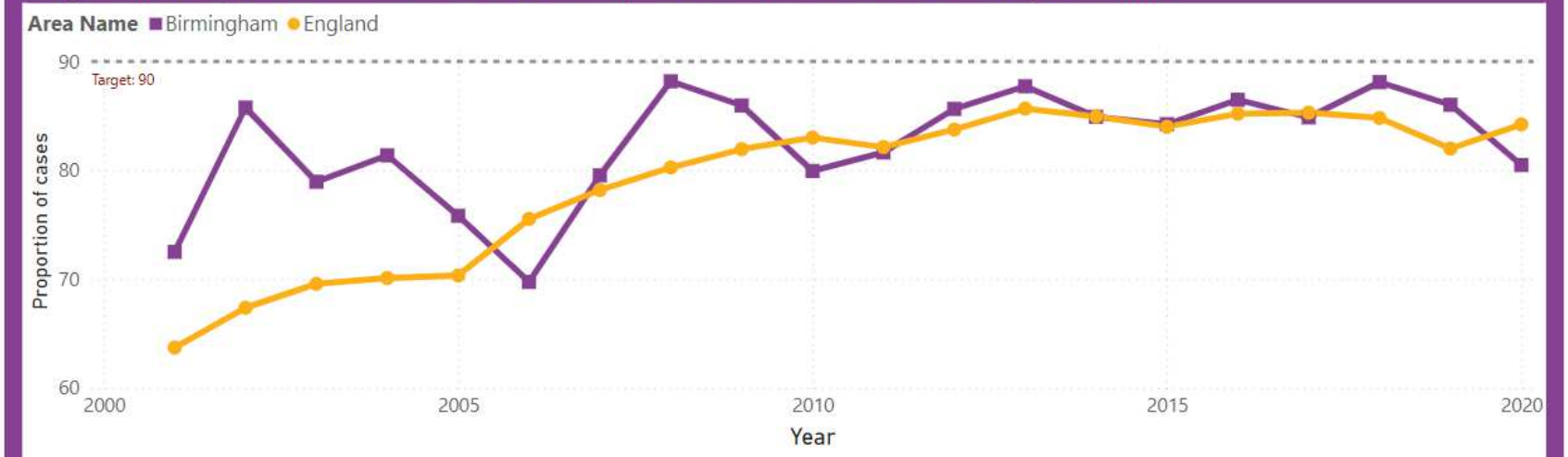
90% reduction in TB incidence compared to..	95% reduction in TB deaths compared to...	Achieve 1358 LTBI tests per year in Birmingham	**Achieve 90% treatment completion rates by...**	80% BCG vaccination coverage for all eligibl...	100% of TB cases offered a HIV test

Indicator Description: The annual proportion of drug sensitive TB cases expected to complete treatment within 12 months who had completed treatment within 12 months of treatment start date *(exclusions: TB cases with rifampicin resistance or MDR-TB and TB cases with CNS, spinal, miliary or disseminated TB).*

Latest Value: 80.5%

Target Met: (Latest Year) No

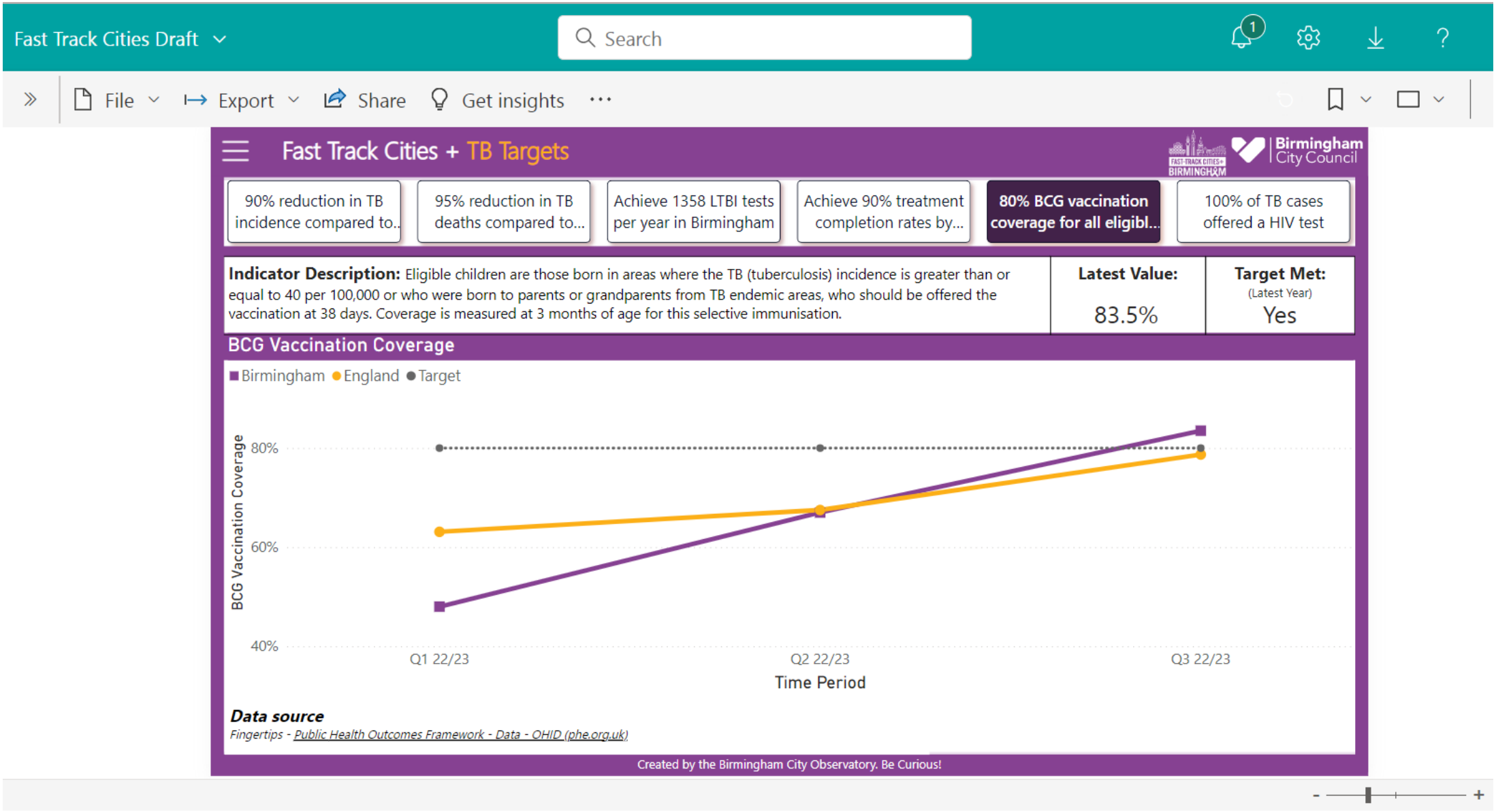
Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months



Data source

Fingertips - Public Health Outcomes Framework - Data - OHID (phe.org.uk)

Created by the Birmingham City Observatory. Be Curious!


Fast Track Cities Draft
Search
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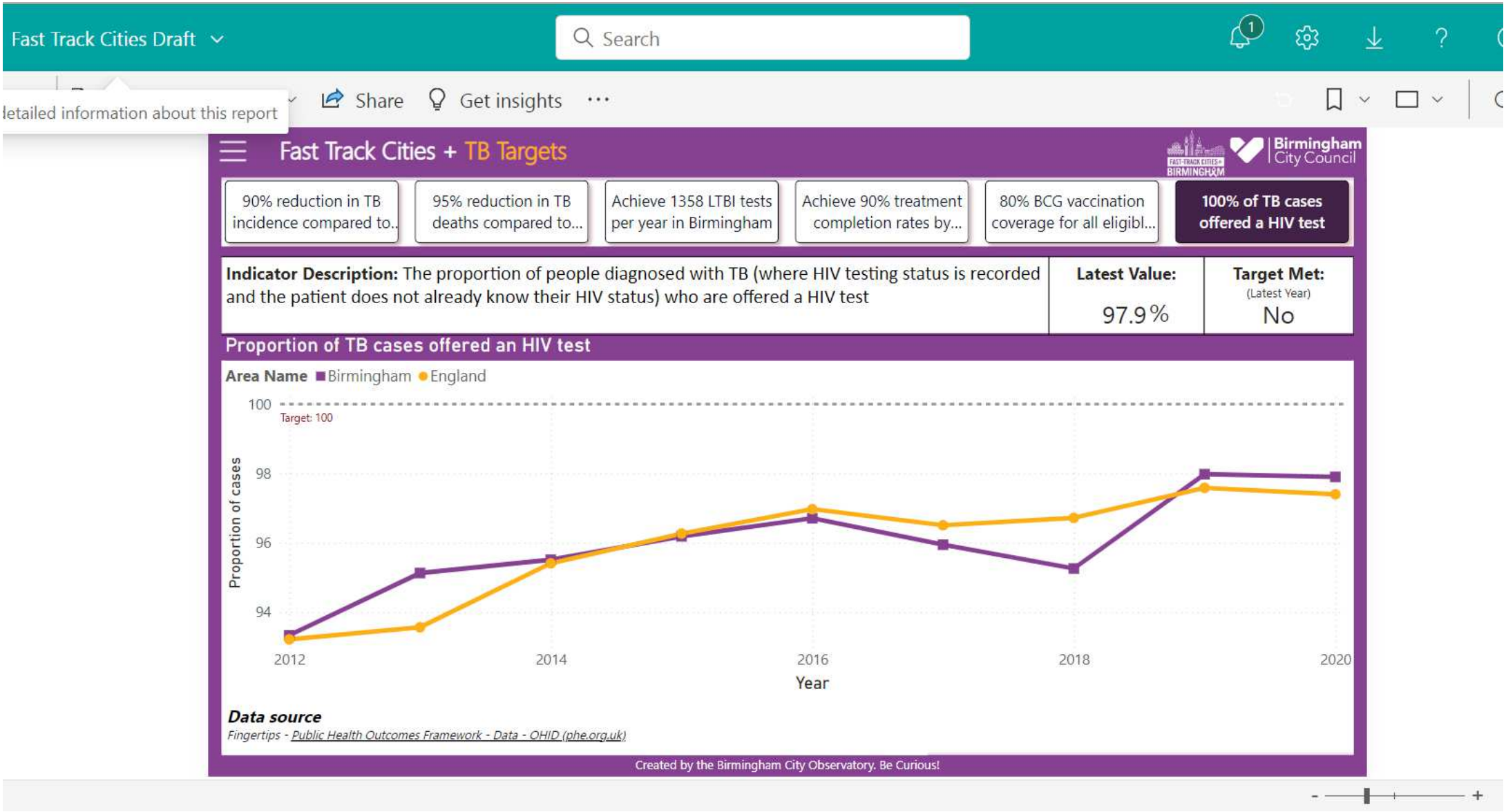
Get insights
Fast Track Cities + TB Targets
Birmingham City Council
90% reduction in TB incidence compared to..
95% reduction in TB deaths compared to...
Achieve 1358 LTBI tests per year in Birmingham
Achieve 90% treatment completion rates by...
80% BCG vaccination coverage for all eligibl...
100% of TB cases offered a HIV test
Indicator Description: Eligible children are those born in areas where the TB (tuberculosis) incidence is greater than or equal to 40 per 100,000 or who were born to parents or grandparents from TB endemic areas, who should be offered the vaccination at 38 days. Coverage is measured at 3 months of age for this selective immunisation.
Latest Value:
83.5%
Target Met:
(Latest Year)
Yes
BCG Vaccination Coverage
Birmingham
England
Target
BCG Vaccination Coverage
80%
60%
40%
Q1 22/23
Q2 22/23
Q3 22/23
Time Period
Data source
Fingertips - Public Health Outcomes Framework - Data - OHID (phe.org.uk)
Created by the Birmingham City Observatory. Be Curious!


Fast Track Cities Draft
Search
Share
Get insights
detailed information about this report
Fast Track Cities + TB Targets
Birmingham City Council
90% reduction in TB incidence compared to..
95% reduction in TB deaths compared to...
Achieve 1358 LTBI tests per year in Birmingham
Achieve 90% treatment completion rates by...
80% BCG vaccination coverage for all eligibl...
100% of TB cases offered a HIV test
Indicator Description: The proportion of people diagnosed with TB (where HIV testing status is recorded and the patient does not already know their HIV status) who are offered a HIV test
Latest Value:
97.9%
Target Met:
(Latest Year)
No
Proportion of TB cases offered an HIV test
Area Name Birmingham England
100
Target: 100
98
96
94
Proportion of cases
2012
2014
2016
2018
2020
Year
Data source
Fingertips - Public Health Outcomes Framework - Data - OHID (phe.org.uk)
Created by the Birmingham City Observatory. Be Curious!

PARIS DECLARATION
1 December 2014
(amended 13 April 2021)

FAST-TRACK CITIES+
BIRMINGHAM

FAST-TRACK CITIES: ENDING THE HIV EPIDEMIC

Cities and Municipalities Achieving Zero HIV-Related Stigma and the 95-95-95 Targets on a Trajectory towards Getting to Zero New HIV Infections and Zero AIDS-Related Deaths

95% of people living with HIV knowing their HIV status

95% of people who know their HIV-positive status on antiretroviral therapy (ART)

95% of people on ART with suppressed viral loads

City:
Birmingham, UK

Signing date:
5 October 2022

PARIS DECLARATION ON FAST-TRACK CITIES

We stand at a defining moment in the HIV response. Due to scientific breakthroughs, community activism, and political commitment, we have an opportunity to achieve Sustainable Development Goal 3.3 of ending the HIV epidemic by 2030. Cities and municipalities have been heavily affected by the epidemic and have been at the forefront of responding to HIV. Cities and municipalities are uniquely positioned to lead Fast-Track action towards achieving the United Nations (UN) 95-95-95 and other relevant targets. Attaining these targets will place us on a trajectory towards getting to zero new HIV infections and zero AIDS-related deaths.

We recognize that ending the HIV epidemic requires a comprehensive approach that allows all people to access quality life-saving and -enhancing prevention, treatment, care, and support services for HIV, tuberculosis (TB), and viral hepatitis. Integrating these services into sexual, reproductive, and mental health services is critical to achieving universal access to health care.

We can eliminate stigma and discrimination if we build our actions on scientific evidence. Understanding that successful HIV treatment and viral suppression prevents HIV transmission (Undetectable=Untransmittable) can help reduce stigma and encourage people living with HIV to initiate and adhere to HIV treatment.

Working together, cities and municipalities can accelerate local actions towards ending the HIV, TB, and viral hepatitis epidemics globally by 2030. As called for by the New Urban Agenda, we will leverage our reach, infrastructure, and human capacity to build a more equitable, inclusive, prosperous, and sustainable future for all our residents, regardless of age, gender, sexual orientation, and social and economic circumstances.

WE COMMIT TO:

1. **End HIV epidemics in cities and municipalities by 2030**
   We commit to achieve the 95-95-95 and other Fast-Track targets, which will put us firmly on the path to ending the HIV, TB, and viral hepatitis epidemics by 2030. We commit to provide sustained access to quality HIV testing, treatment, and prevention services, including pre-exposure prophylaxis (PrEP), in support of a comprehensive approach to ending the HIV epidemic that also addresses TB, viral hepatitis, sexually transmitted infections, mental health, substance use disorders, and comorbidities associated with aging with HIV. We will eliminate HIV-related stigma and discrimination.

2. **Put people at the centre of everything we do**
   We will focus our efforts on all people who are vulnerable to HIV, TB, viral hepatitis, and other diseases. We will help to realize and respect the human rights of all affected people and leave no one behind in our city and municipal HIV, TB, and viral hepatitis responses. We will meaningfully include people living with HIV in decision-making around policies and programmes that affect their lives. We will act locally and in partnership with our communities to galvanize global support for healthy and resilient societies and for sustainable development.

3. Address the causes of risk, vulnerability, and transmission

We will use all means, including municipal ordinances, policies, and programmes, to address factors that make people vulnerable to HIV and other diseases, including laws that discriminate against or criminalize key populations. We will ensure that people affected by HIV enjoy equal participation in civil, political, social, economic, and cultural life, free from prejudice, stigma, discrimination, violence, or persecution. We will work closely with communities, clinical and service providers, law enforcement and other partners, and with marginalized and vulnerable populations, including slum dwellers, migrants and other displaced people, young women, sex workers, people who use drugs, gay men and other men who have sex with men, and transgender individuals, to foster social equity.

4. Use our HIV response for positive social transformation

Our leadership will leverage innovative social transformation to build societies that are equitable, inclusive, responsive, resilient, and sustainable. We will integrate health and social programmes to improve the delivery of services, including for HIV, TB, viral hepatitis, and other diseases. We will use advances in science, technology, and communication to drive the social transformation agenda, including within the context of efforts to ensure equal access to education and learning

5. Build and accelerate an appropriate response reflecting local needs

We will develop and promote services that are innovative, safe, accessible, equitable, and free from stigma and discrimination. We will encourage and foster community leadership to build demand for, and to deliver, quality services that are responsive to local needs.

6. Mobilise resources for integrated public health and sustainable development

Investing in the HIV response together with a strong commitment to public health and sustainable development is a sound investment in the future of our municipality that will yield increased productivity, shared prosperity, and the overall well-being of our citizens. We will adapt our municipal plans and resources for a Fast-Track response to HIV, TB, viral hepatitis, and other diseases within the context of an integrated public health approach. We will develop innovative funding strategies and mobilise additional resources to end the HIV epidemic by 2030.

7. Unite as leaders

We commit to develop an action plan to guide our city and municipal Fast-Track efforts, embrace the transparent use of data to hold ourselves accountable, and join with a network of cities and municipalities to make the Paris Declaration on Fast-Track Cities a reality. Working in broad consultation with everyone concerned, we will regularly measure our results and adjust our responses to be faster, smarter, and more effective. We will support other cities and municipalities and share our experiences, knowledge, and data about what works and what can be improved. We will report annually on our progress.

Cllr Maureen Cornish
Lord Mayor of Birmingham

Tanja Dittfeld
Regional Director for Europe, IAPAC

Anne HIDALGO
Mayor of Paris

Winnie BYANYIMA
UNAIDS

Maimunah Mohd SHARIF
UN-Habitat

José M. ZUNIGA
President of the Fast-Track Cities Institute/IAPAC

FAST-TRACK

CITIES

MAIRIE DE PARIS

UNAIDS

UN HABITAT
FOR A BETTER URBAN FUTURE

IAPAC
INTERNATIONAL ASSOCIATION OF PROVIDERS OF AIDS CARE

Current position

Targets & Data Update

Final Targets - Overview

HIV

- 95% of people living with HIV (PLHIV) knowing their status
- 95% of people who know their HIV-positive status on HIV treatment
- 95% of PLHIV on HIV treatment being virally suppressed
- Zero stigma & discrimination

Hep B

- 90% reduction in new cases of chronic Hep B infections by 2030 (compared to 2015)
- 65% reduction in deaths from Hep B by 2030 (compared to 2015)
- 90% childhood Hep B virus vaccination coverage (3rd dose coverage)
- 100% Hep B virus birth-dose vaccination coverage or other approach to prevent mother-to-child transmission
- 90% coverage of vaccination in prisoners, sexual health clinic clients, homeless individuals, sex workers, contacts of Hep B infected cases, asylum seekers, new migrants and people who inject drugs (PWID)

Hep C

- 90% reduction in new cases of chronic Hep C infections by 2025 (compared to 2015)
- 65% reduction in deaths from Hep C by 2025 (compared to 2015)
- 100% of injecting drug users report adequate needle and syringe provision for their needs
- 90% of those living with Hep C diagnosed
- 90% of eligible persons with current Hep C infection started treatment

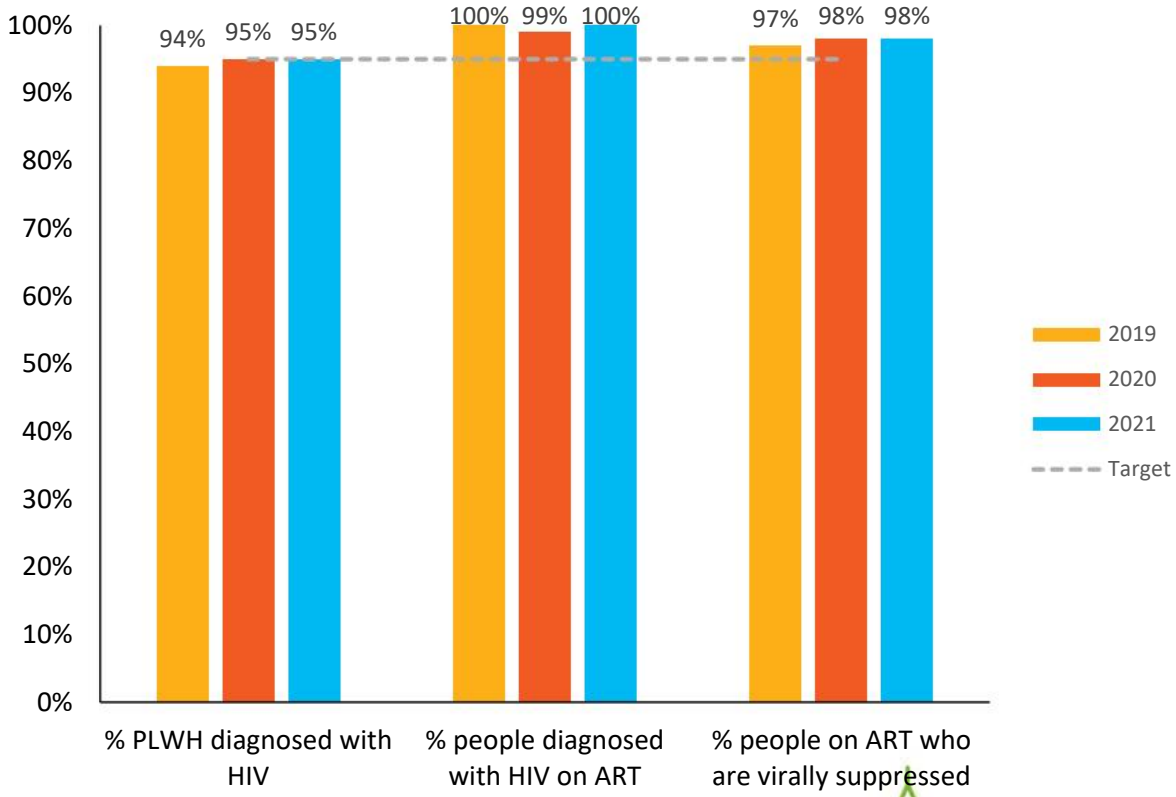
TB

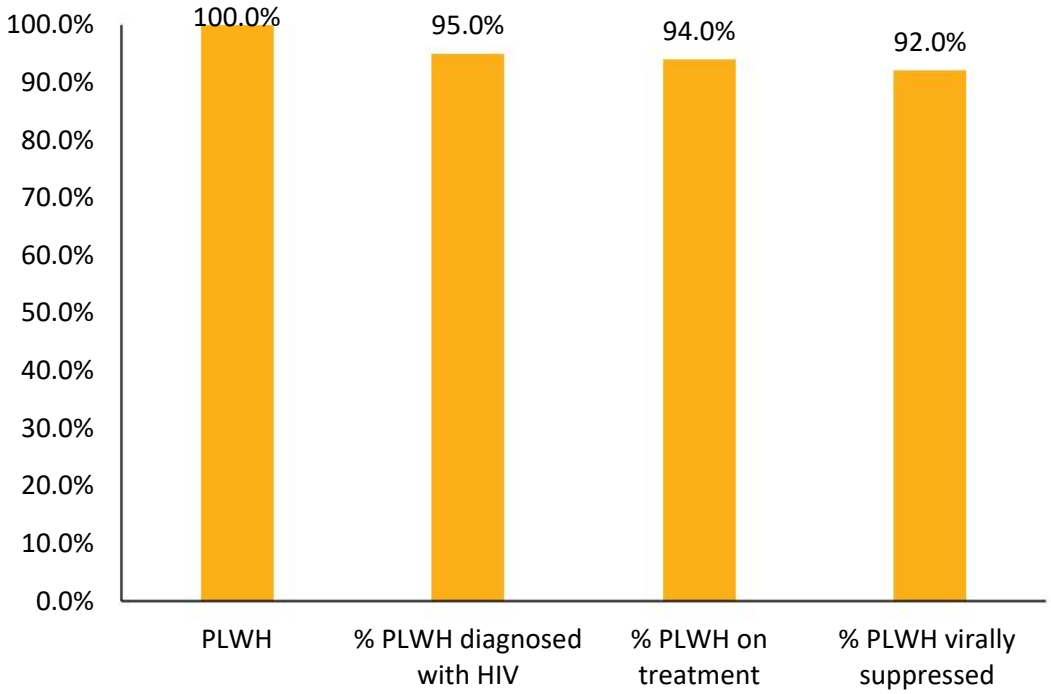
- 90% reduction in TB incidence compared to 2015
- 95% reduction in TB deaths compared to 2015
- Decrease annually, by 5% the proportion of people who develop active TB within 5 years of post UK entry using the 3-year average, 2017 to 2019, as a baseline
- Achieve 1358 LTBI Tests per year in Birmingham
- Achieve 90% treatment completion rates (12 month outcome) by 2026.
- 80% BCG vaccination coverage for all children eligible in the Birmingham LA
- Reduce the average delay in diagnosis in people with pulmonary TB by 5% per year.
- 100% of TB cases offered a HIV test

FAST-TRACK CITIES+ BIRMINGHAM

Birmingham City Council

HIV: 95-95-95 UNAIDS Targets

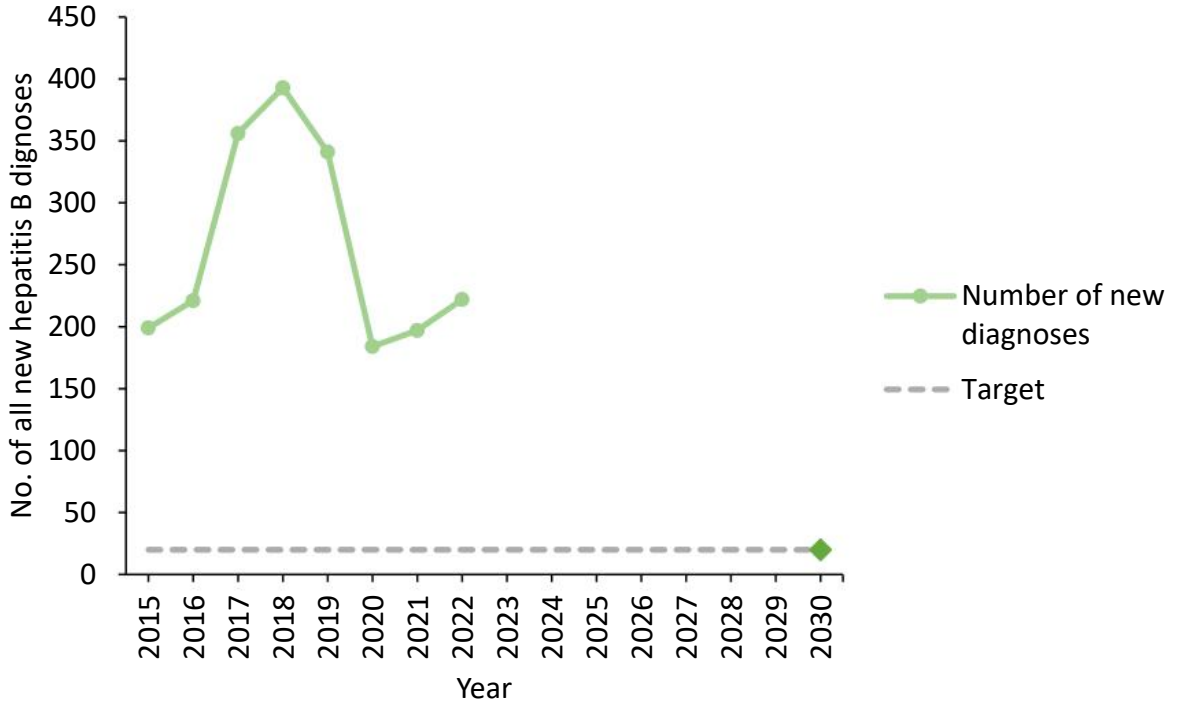




Hep B: 90% reduction in new cases of chronic Hep B infections by 2030 (compared to 2015)

Definition: Number of all new Hepatitis B diagnoses by year of diagnosis resident in Birmingham City, 2015-2022 *N.B. the data shown is for all new Hepatitis B diagnoses, not just chronic Hepatitis B infections.*

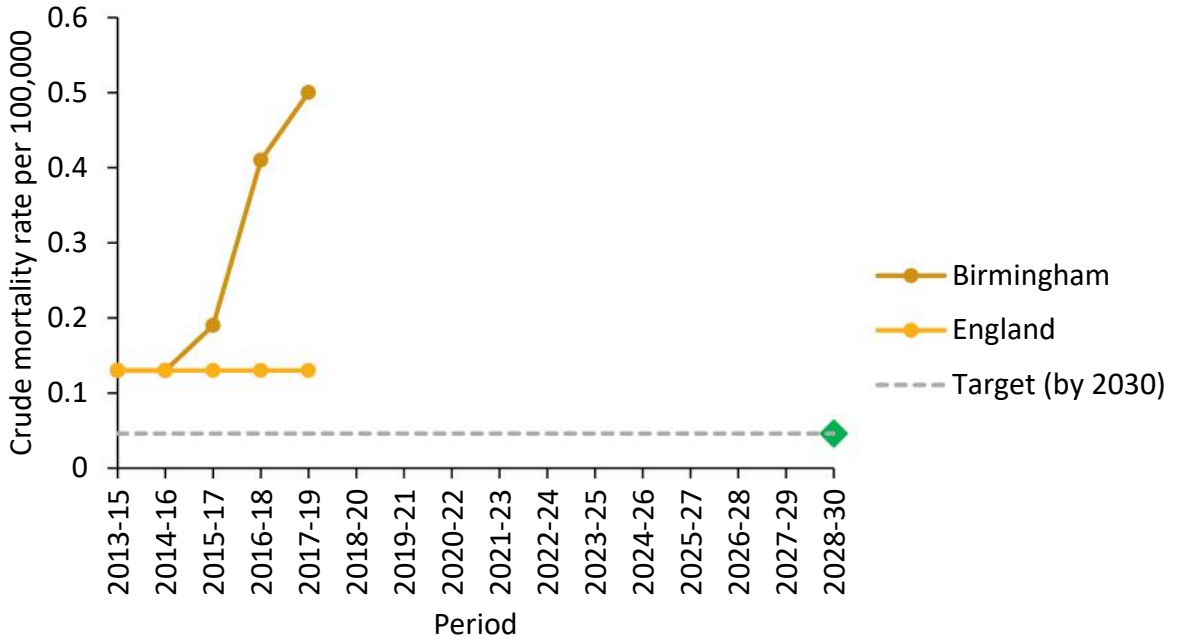
Data source: SGSS – provisional data



Hep B: 65% reduction in deaths from Hepatitis B by 2030 (compared to 2015)

Definition: Crude rate of mortality from hepatitis B related end-stage liver disease/hepatocellular carcinoma in persons less than 75 years per 100,000 population

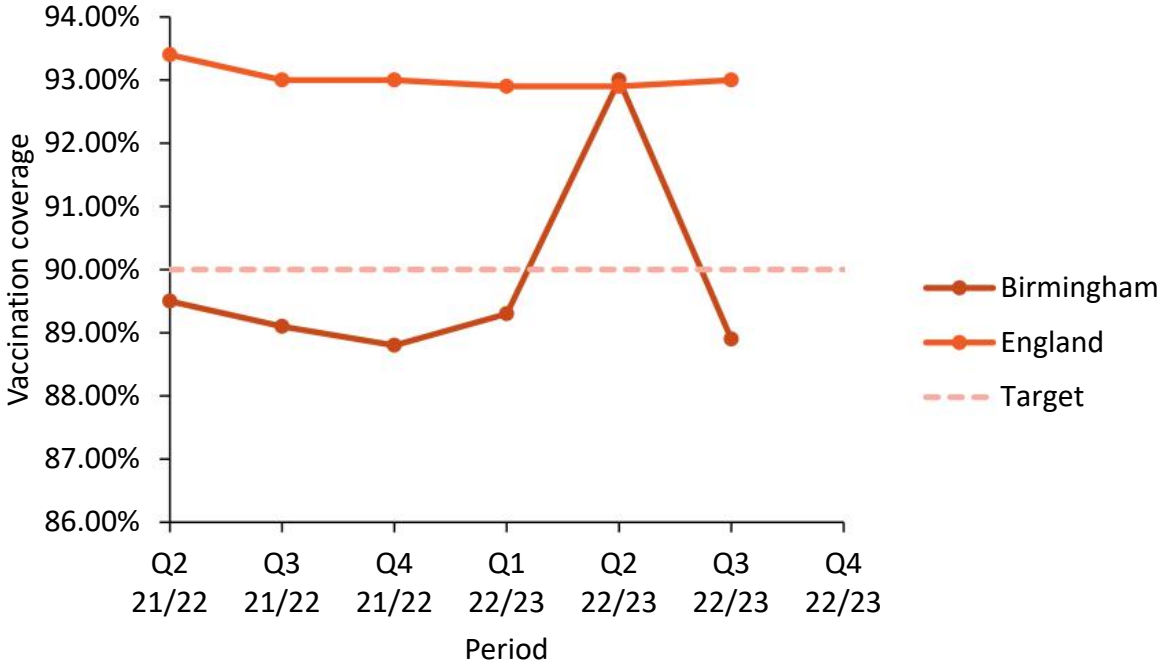
Data source: Fingertips - Public health profiles - OHID (phe.org.uk)



Hep B: 90% childhood Hepatitis B virus vaccination coverage (third dose coverage)

Definition: Children for whom the local authority is responsible who received 3 doses of DTaP IPV Hib vaccine at any time by their second birthday as a percentage of all children whose second birthday falls within the time period.

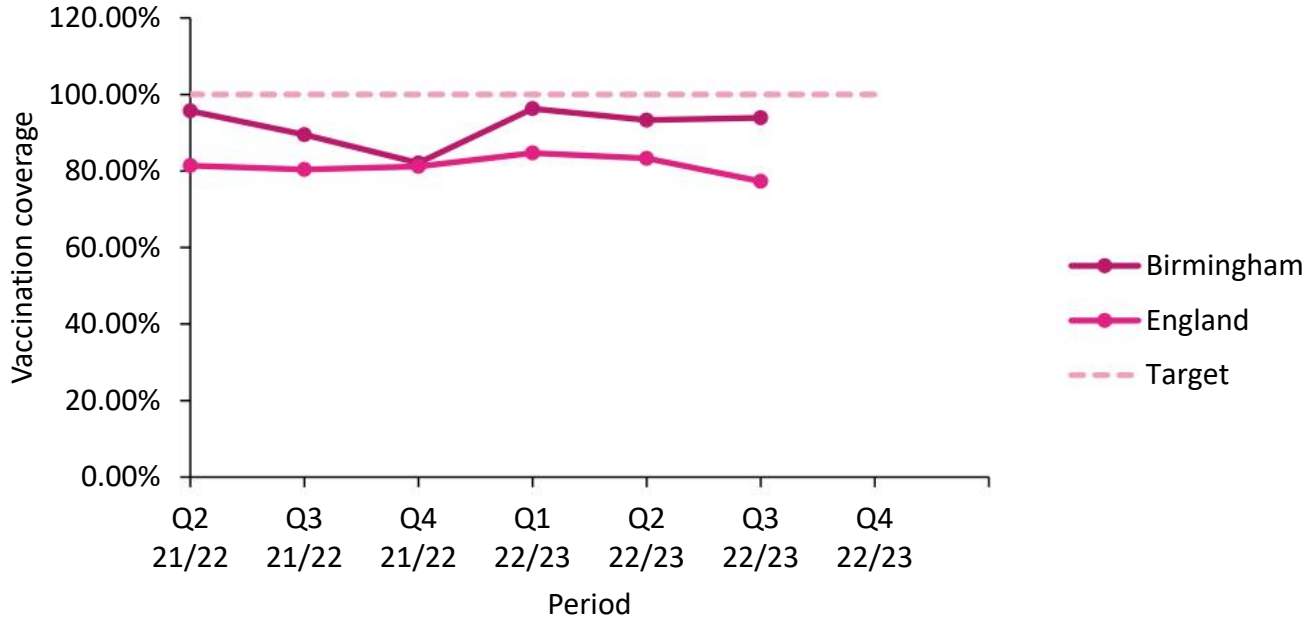
Data source: COVER Data - Cover of vaccination evaluated rapidly (COVER) programme 2022 to 2023: quarterly data - GOV.UK (www.gov.uk)



Hep B: 100% Hep B virus vaccination coverage to prevent mother-to-child transmission

Definition: Coverage of 6 doses of a HepB-containing vaccine reported for children who reached 2 years of age in the quarter born to hepatitis B positive women in Birmingham LA (data should be interpreted with caution given the low number of eligible neonates)

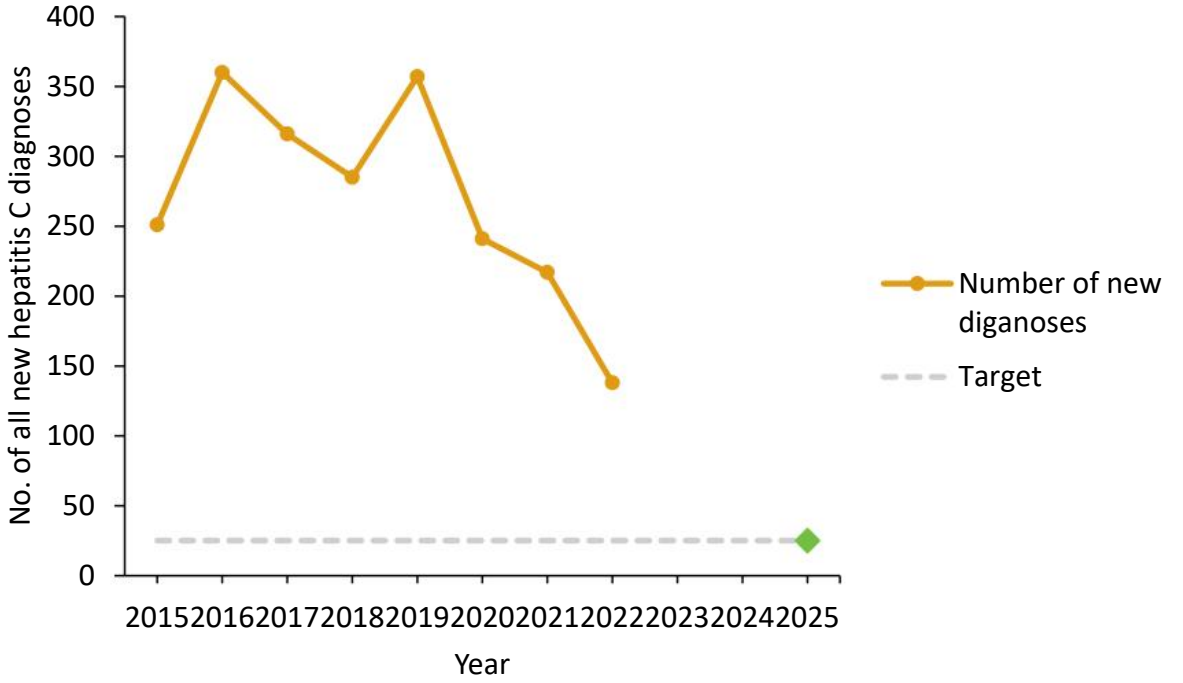
Data source: COVER Data - Cover of vaccination evaluated rapidly (COVER) programme 2022 to 2023: quarterly data - GOV.UK (www.gov.uk)



Hep C: 90% reduction in new cases of chronic Hep C infections by 2025 (compared to 2015)

Definition: Number of all new Hepatitis C diagnoses by year of diagnosis resident in Birmingham City, 2015-2022. *N.B. the data shown is for all new Hepatitis C diagnoses, not just chronic Hepatitis C infections.*

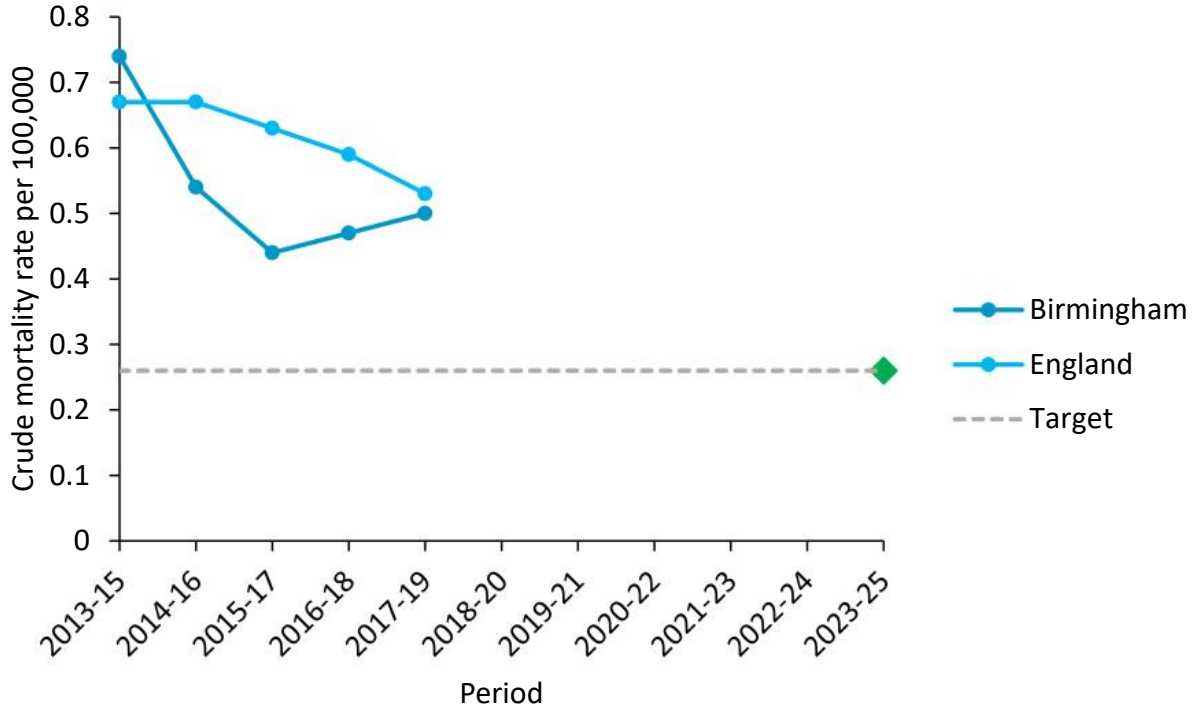
Data source: SGSS – provisional data



Hep C: 65% reduction in deaths from Hep C by 2025 (compared to 2015)

Definition: Crude rate of mortality from hepatitis C related end-stage liver disease/hepatocellular carcinoma in persons less than 75 years of age per 100,000 population.

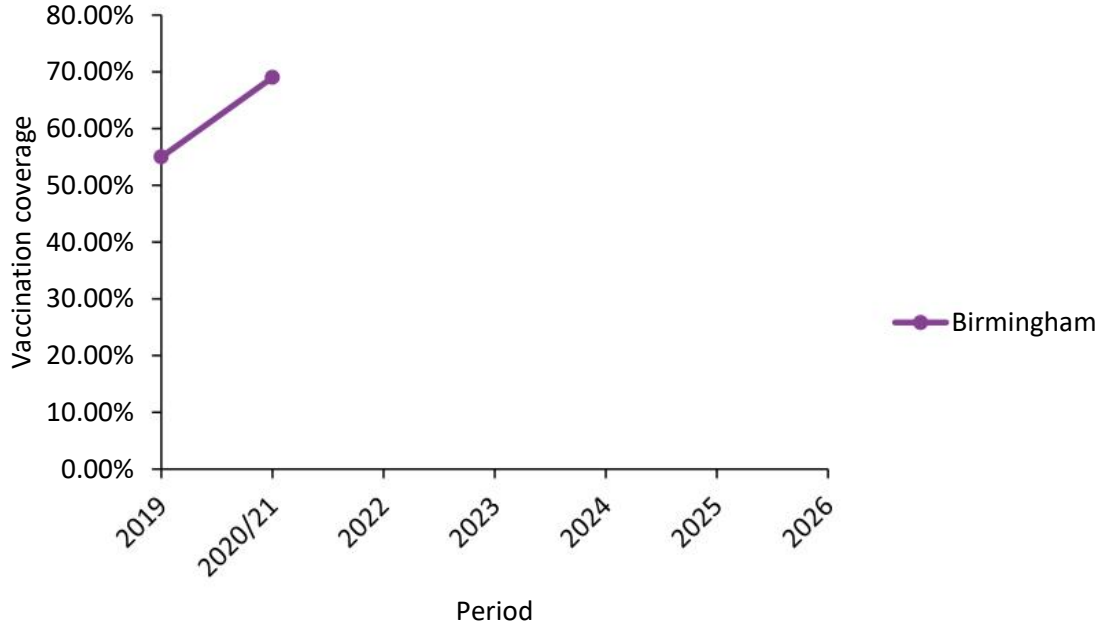
Data source: Fingertips - Public health profiles - OHID (phe.org.uk)



Hep C: 100% of injecting drug users report adequate needle & syringe provision for their needs

Definition: The number of people reporting adequate needles to meet their needs out of the number of PWIDs in the UAM survey responding to the question in Birmingham ODN *(N.B. due to Covid-19 only 1 survey was conducted to cover the 2020/21 period).*

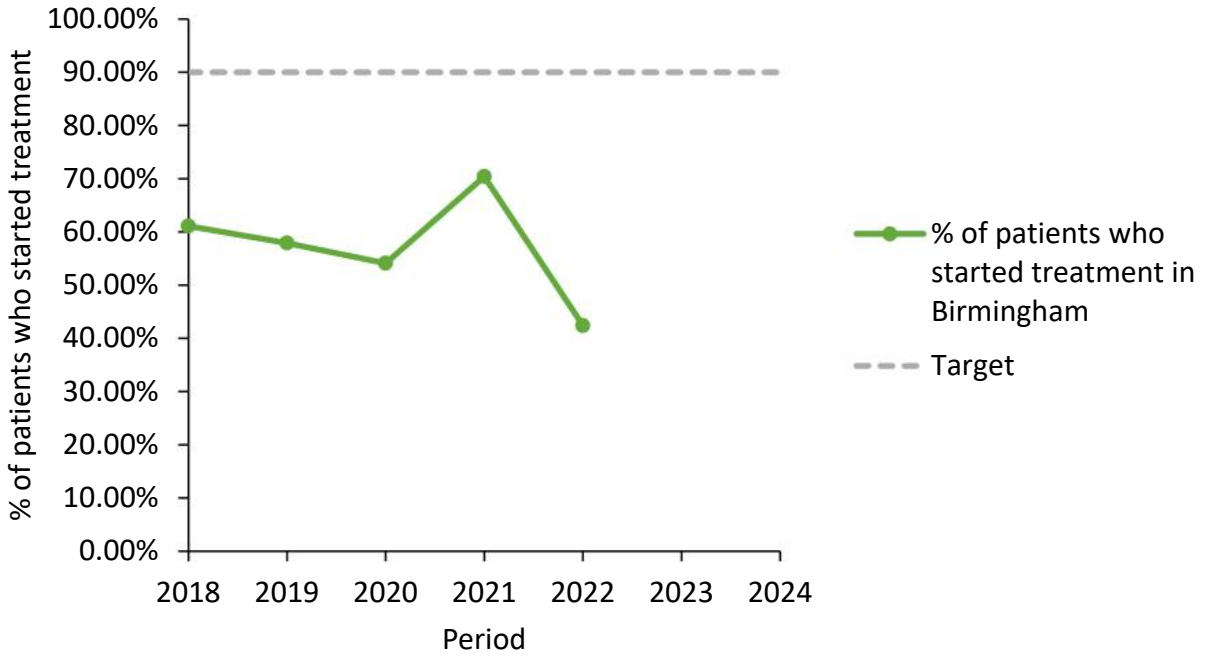
Data source: UKHSA Hep C Dashboard



Hep C: 90% of eligible persons with current Hep C infection started treatment

Definition: The number of people starting treatment out of the number of people linked into treatment. *N.B. 2022 data covers Q1-Q3 only.*

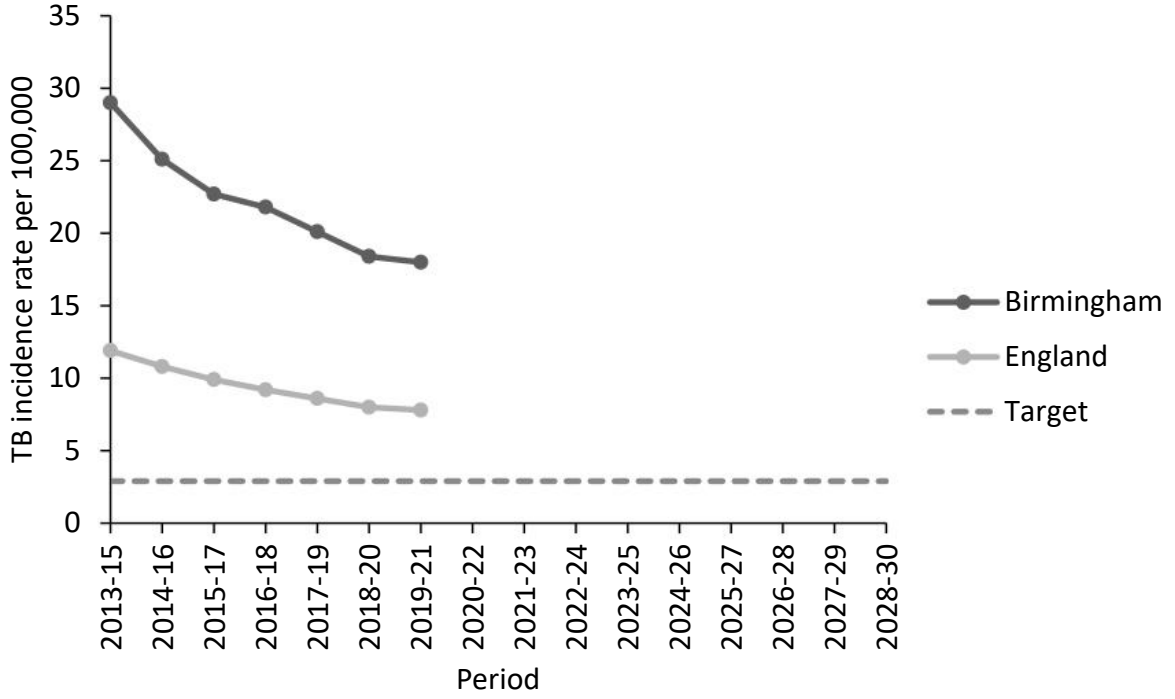
Data source: UKHSA Hep C Dashboard



TB: 90% reduction in TB incidence compared to 2015

Definition: Three year average incidence per 100,000 population. The numerator (the number of TB notifications in the 3 year period) is divided by the denominator (the sum of the mid-year population estimates for the same 3 year period) and multiplied by 100,000.

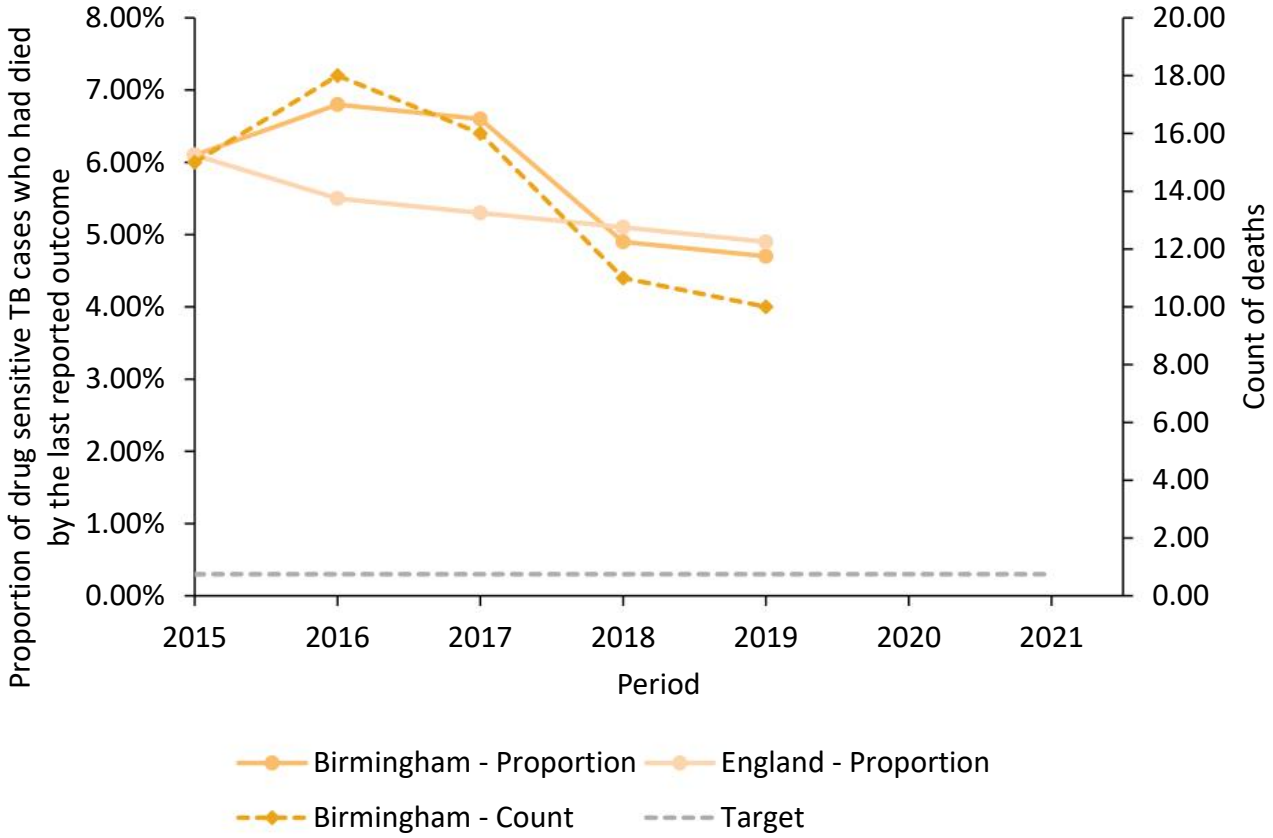
Data source: Fingertips - Public Health Outcomes Framework - Data - OHID (phe.org.uk)



TB: 95% reduction in TB deaths compared to 2015

Definition: The annual proportion of drug sensitive TB cases who had died by the last reported outcome (exclusions: TB cases with rifampicin resistance or MDR-TB).

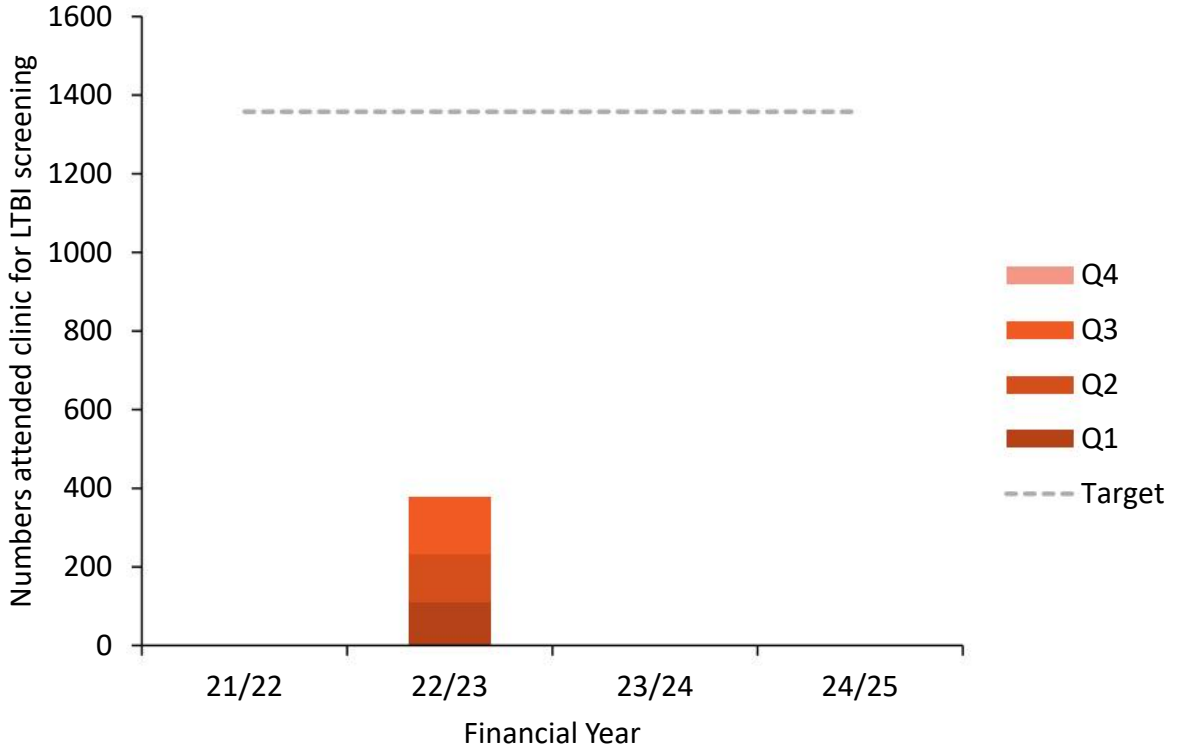
Data source: Fingertips - Public health profiles - OHID (phe.org.uk)



TB: Achieve 1358 LTBI tests per year in Birmingham

Definition: Number of people who have been screened for LTBI in Birmingham and Solihull. This target is provided by NHSE to BSol ICB

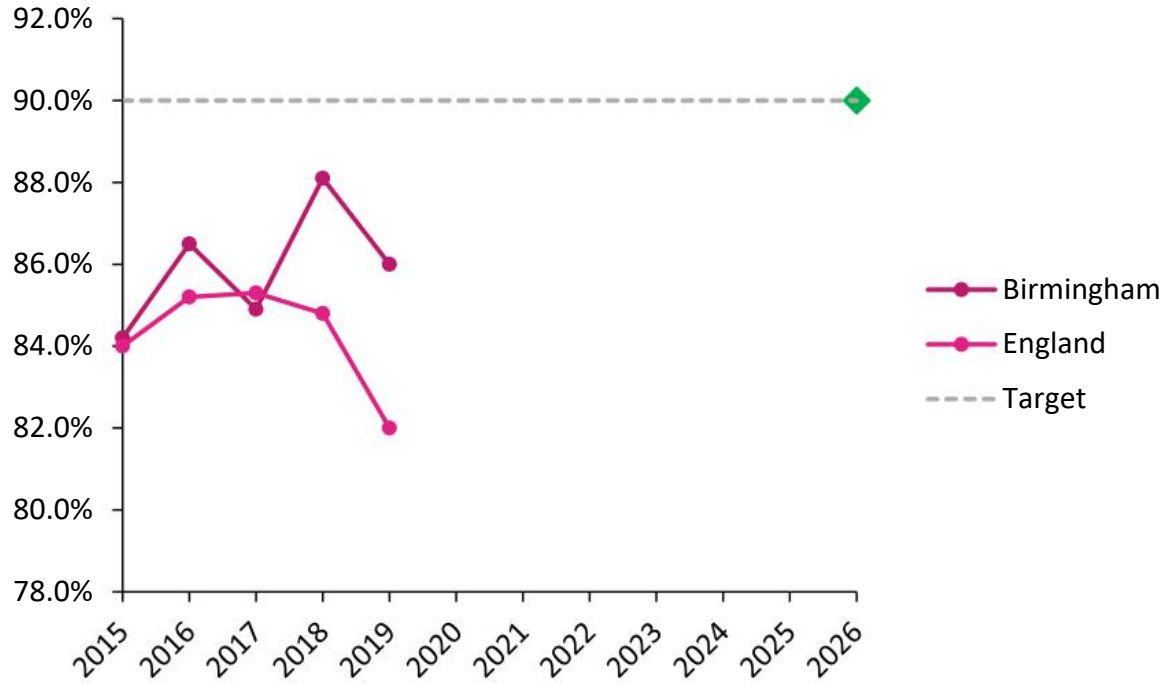
Data source: BSol LTBI Screening Team



TB: Achieve 90% treatment completion rates (12 month outcome) by 2026

Definition: The annual proportion of drug sensitive TB cases expected to complete treatment within 12 months who had completed treatment within 12 months of treatment start date (exclusions: TB cases with rifampicin resistance or MDR-TB and TB cases with CNS, spinal, miliary or disseminated TB)

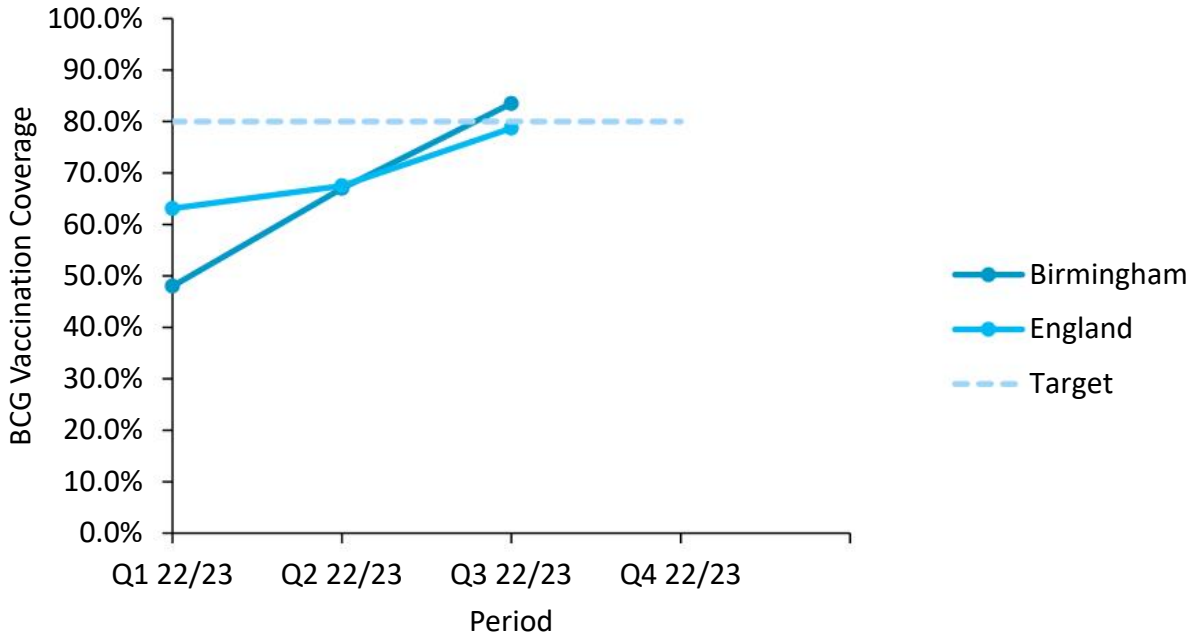
Data source: Fingertips - Public Health Outcomes Framework - Data - OHID (phe.org.uk)



TB: 80% BCG vaccination coverage for all children in the Birmingham LA

Definition: Eligible children are those born in areas where the TB (tuberculosis) incidence is greater than or equal to 40 per 100,000 or who were born to parents or grandparents from TB endemic areas, who should be offered the vaccination at 38 days. Coverage is measured at 3 months of age for this selective immunisation.

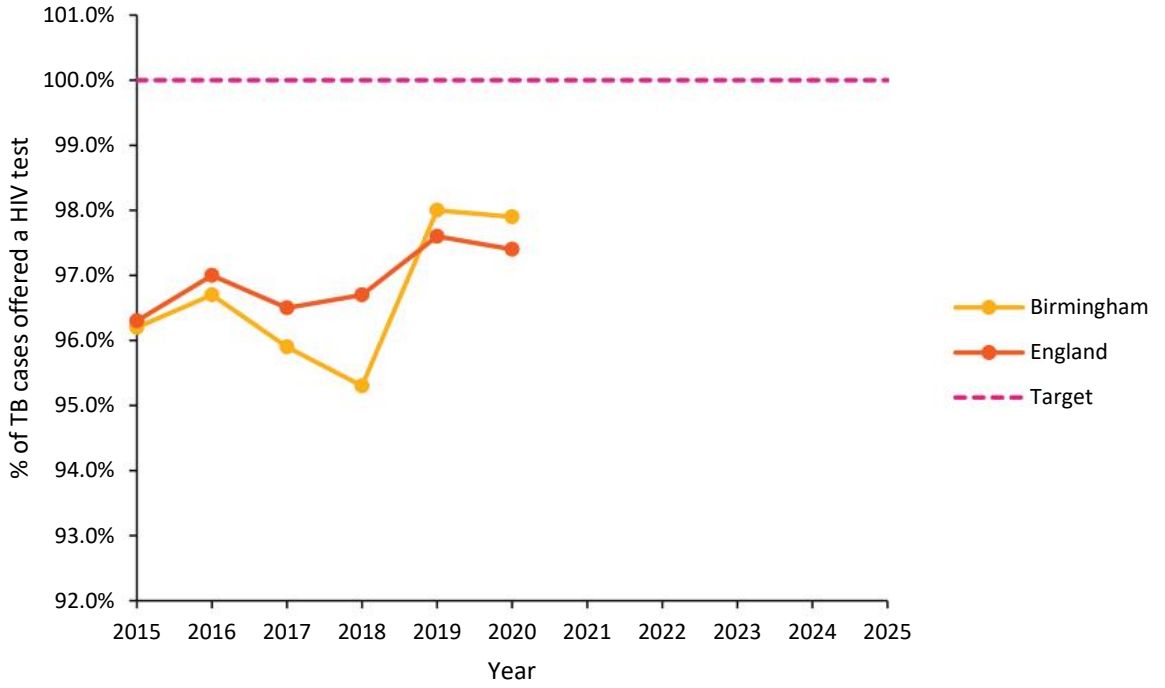
Data source: COVER Data - Public Health Outcomes Framework - Data - OHID (phe.org.uk)



TB: 100% of TB cases offered a HIV test

Definition: The proportion of people diagnosed with TB (where HIV testing status is recorded and the patient does not already know their HIV status) who are offered a HIV test

Data source: Fingertips - Public health profiles - OHID (phe.org.uk)



Birmingham Health and Wellbeing Board
Board Membership and Work Programme 2023-24

Board Members:

Name	Position	Organisation
Councillor Mariam Khan (Board Chair)	Cabinet Member for Adult Social Care and Health	Birmingham City Council
Dr Clara Day (Vice Chair)	Chief Medical Officer	NHS Birmingham and Solihull Integrated Care Board (ICB)
Councillor Karen McCarthy	Cabinet Member for Vulnerable Children and Families	Birmingham City Council
Councillor Matt Bennett	Opposition Spokesperson on Health and Social Care	Birmingham City Council
Dr Justin Varney	Director of Public Health	Birmingham City Council
Professor Graeme Betts	Director for Adult Social Care	Birmingham City Council
Helen Price	Director - Strategy, Commissioning and Transformation Children and Families	Birmingham City Council
David Melbourne	Chief Executive	NHS Birmingham and Solihull Integrated Care Board (ICB)
Richard Beeken	Chief Executive	Sandwell and West Birmingham NHS Trust
Andy Cave	Chief Executive of Healthwatch	Healthwatch Birmingham
Andy Couldrick	Chief Executive of Birmingham Children's Trust	Birmingham Children's Trust
Anne Coufopoulos	Executive Dean (School of Health, Sport and Food)	University College Birmingham
Professor Catherine Needham	Professor of Public Policy and Public Management	University of Birmingham

Richard Kirby	Chief Executive	Birmingham Community Healthcare NHS Foundation Trust
Dr Douglas Simkiss	Medical Director and Deputy Chief Executive of Birmingham Community Healthcare NHS Foundation Trust	Birmingham Community Healthcare NHS Foundation Trust
Jonathan Brotherton	Chief Executive	University Hospitals Birmingham NHS Foundation Trust
Chief Superintendent Richard North	Chief Superintendent	West Midlands Police
Joanna Statham	Inclusion and Engagement Partnership Manager	Department for Work and Pensions
Peter Richmond	Chief Executive of Birmingham Housing Trust	Birmingham Social Housing Partnership
tbc	tbc	Birmingham Chamber of Commerce
Co-optee		
Natalie Allen	Chief Executive of SIFA Fireside	SIFA Fireside
Patrick Nyarumbu	Executive Director Strategic Partnership	Birmingham and Solihull Mental Health Trust
Stephen Raybould	Programmes Director (Ageing Better)	Birmingham Voluntary Services Council
Karen Creavin	Chief Executive of TAWS	The Active Wellbeing Society (TAWS)

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Forward Plan: 2023/24

Date	Strategic Priority	Item	Lead	Purpose	Format	HWB Lead
HWB Meeting: 18 July 2023 Draft paper deadline: 21 June 2023	Getting the Best Start in Life	**Children and Young People's Plan 2023-28 - Update**	Colin Michel	Discussion	Report	Helen Price
	HWB Development	**HWB Development Day Feedback and Next Steps**	Dr Justin Varney	Discussion	Report	Councillor Mariam Khan
	Ageing and Dying Well	**Better Care Fund End of Year Plan**	Mike Walsh	Approval	Report	Prof Graeme Betts
	Ageing and Dying Well	**Better Care Fund Plan 2023-25**	Mike Walsh	Approval	Report	Prof Graeme Betts
	HWB Development	**ICB 5 year Joint Forward Plan**	Rob Checketts	Discussion	Presentation	David Melbourne
	Mental Wellness and Balance	**WM Police: Right Care, Right Person Model**	Chief Superintendent Kim Madill	Discussion	Presentation	Chief Superintendent Richard North
	Getting the Best Start in Life	**CDOP Annual Report 2021-22**	Mel McKenzie	Written Update	Report	Dr Clara Day
	Forum Themes	**HWB Forum Written Updates**	Aidan Hall	Written Update	Briefing	Dr Justin Varney
	HWB Development	**BSol Joint Capital Resource Plan**	Karen Kelly	Written Update	Report	David Melbourne

Date	Strategic Priority	Item	Lead	Purpose	Format	HWB Lead
HWB Meeting: 26 September 2023 Draft paper deadline: 29th August 2023	JSNA	**Joint Strategic Needs Assessment (JSNA) Update**	Rebecca Howell-Jones	JSNA Update	Report	Dr Justin Varney
	Protect and detect	**Fast Track Cities+ Update**	Becky Pollard	Update	Report	Dr Justin Varney
	HWB Development	**HWB Development Day Feedback and Next Steps**	Dr Justin Varney	Discussion	Presentation	Councillor Mariam Khan
	Mental Wellness and Balance; Protect and Detect; Ageing and Dying Well	**11. Draft Birmingham and Solihull Enabling Primary Care Strategy**	Paul Sherriff / Dr Sunando Ghosh	Discussion	Report	Dr Clara Day
Executive Board – EB October 2023						

Date	Strategic Priority	Item	Lead	Purpose	Format	HWB Lead
HWB Meeting: 28th November 2023 **Draft paper deadline: 31st October 2023**	Active at Every Age and Ability	**Draft Physical Activity Strategy and Consultation**	Humera Sultan	Update	Presentation	Dr Justin Varney
	JSNA	**Learning Disabilities Deep Dive (JSNA)**	Rebecca Howell-Jones	Approval	Report	Dr Justin Varney
	Healthy and Affordable Food	**Creating a Healthy Food City Forum Annual Update**	Sarah Pullen	Update	Presentation	Dr Justin Varney
	Closing the Gap	**BLACHIR Update**	Ricky Bhandal	Update	Presentation	Dr Justin Varney
	HWB Development	**Midlands Met Hospital Update**	Richard Beeken	Update	Presentation	Richard Beeken
	Active at Every Age and Ability	**Draft Physical Activity Strategy and Consultation**	Humera Sultan	Update	Presentation	Dr Justin Varney
	Getting the Best Start in Life	**CYP Plan Quarterly Report**	Colin Michel	Written Update	Report	Helen Price

Date	Strategic Priority	Item	Lead	Purpose	Format	HWB Lead
Executive Board - EB Date TBC						
HWB Meeting: 30th January 2024 **Draft paper deadline: 2nd January 2024**	Mental Wellness and Balance	**Creative Public Health Programme**	Rhys Boyer/Ricky Bhandal	Approval	Presentation	Dr Justin Varney
	Mental Wellness and Balance	**Creating a Mentally Healthy City Forum Annual Update**	Jane Itangata	Update	Presentation	Dr Justin Varney
Executive Board - EB Date TBC						
HWB Meeting: 26 March 2024 **Draft paper deadline:** 27th February 2024	Getting the Best Start in Life	**Annual accountability report from BCYPP Board to HWB**	Colin Michel	Discussion	Report	Andy Coldrick
	Closing the Gap	**Creating a City without Inequality Forum Annual Update**	Monika Rozanski	Update	Presentation	Dr Justin Varney
	Closing the Gap	**BLACHIR Update**	Ricky Bhandal	Update	Presentation	Dr Justin Varney
Executive Board - EB						

Date	Strategic Priority	Item	Lead	Purpose	Format	HWB Lead
Date TBC						
HWB Meeting: DEVELOPMENT DAY May 2024 **Draft paper deadline:** April 2023						

Standard Agenda

1. Notice of Recording
2. Notice of Potential for Public Exclusions
3. Declaration of Interests
4. Apologies
5. Minutes and Matters Arising
6. Action Log
7. Chair's Update
8. Public Questions
9. Presentation Items (see detail above)
10. Information Items (see detail above)
11. Forward Plan Review
12. Finalise Agenda for next Meeting
13. Date, Time and Venue of next Meeting
14. Notice of Recording Ceased
15. Private Items (see detail above)

Notes

Any agenda change request must form part of prior HWBB information item with as much lead in as possible but no later than the HWBB immediately prior to the agenda change request, including requests from sub-groups (see below).

Public Questions

Public questions are to be submitted in advance of the meeting. Questions should be sent to: HWBoard@birmingham.gov.uk

	Agenda Item: 14
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**26th September 2023**
TITLE:	**Creating an Active City Strategy Consultation - Update**
Organisation	**Birmingham City Council**
Presenting Officer	**Dr Justin Varney/Lynda Bradford**

Report Type:	**Information**

1. Purpose:

1.1. To inform Health and Wellbeing Board members of the intention to seek approval to consult on the Creating an Active City Strategy.

2. Implications (tick all that apply):

Creating a Bolder, Healthier, City (2022-2030) – Strategic Priorities	Closing the Gap (Inequalities)	X
	Theme 1: Healthy and Affordable Food	
	Theme 2: Mental Wellness and Balance	
	Theme 3: Active at Every Age and Ability	X
	Theme 4: Contributing to a Green and Sustainable Future	
	Theme 5: Protect and Detect	
	Getting the Best Start in Life	
	Living, Working and Learning Well	
	Ageing and Dying Well	
Joint Strategic Needs Assessment		

3. Recommendation

3.1. To note the update which outlines the intention to seek approval to consult on the Creating an Active City Strategy.

4. Report Body

Background

4.1. The Creating an Active City Strategy (previously known as the Physical Activity Strategy) aims to set out a vision for Birmingham to be more active. It proposes a framework for collective action working with a wide range of partners and communities to help local people to build physical activity into their everyday lives and break down the barriers which prevent individuals and communities being active every day.

4.2. From autumn 2022 until to date, a Physical Needs Assessment has been gathering information about the activity of the people in Birmingham, taking a life course approach. The findings of the Needs Assessment are being assimilated and will inform the Strategy.

4.3. Active People; Active Society; Active Environments; and Closing the Gap are five emerging Themes for the Creating an Active City Strategy and are currently being shared with Stakeholders for their views.

4.4. The Creating an Active City Strategy will be taken to the November Cabinet for permission to consult with the public with a plan for consulting with the population of Birmingham.

4.5. Full details of the Consultation plan will be shared with the Health and Wellbeing Board at the November meeting.

5. Compliance Issues

5.1. HWBB Forum Responsibility and Board Update

The Creating an Active City Forum will lead on the consultation and development of the Strategy. Full details of the consultation plan and the draft Strategy will be shared with the Health and Wellbeing Board at the November meeting.

5.2. Management Responsibility

Dr Justin Varney, Director of Public Health, Birmingham City Council
Humera Sultan, Consultant in Public Health, Birmingham City Council
Lynda Bradford, Interim Service Lead, Physical Activity, Public Health, Birmingham City Council

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk

Appendices

The following people have been involved in the preparation of this board paper:
Lynda Bradford, Interim Service Lead, Physical Activity, Public Health, Birmingham City Council