BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD

TUESDAY, 27 JULY 2021 AT 15:45 HOURS
IN ON-LINE INFORMAL MEETING, MICROSOFT TEAMS

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 meeting You Tube site (www.youtube.com/channel/UCT2kT7ZRPFCXq6_5dnVnYlw) and that members of the press/public may record and take photographs except where there are confidential or exempt items.

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2 **APPOINTMENT OF HEALTH AND WELLBEING BOARD - FUNCTIONS, TERMS OF REFERENCE AND MEMBERSHIP (15:45 - 15:55)**

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

3 **DECLARATIONS OF INTERESTS**

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

4 **APOLOGIES**

To receive any apologies.

5 **DATES OF MEETINGS**

To note the dates of meetings of the Board for 2021/22 as follows:-
Tuesday 27 July 2021
Tuesday 21 September 2021**
Tuesday 30 November 2021
Tuesday 18 January 2022**
Tuesday 15 March 2022**

All meetings will commence at 1500 hours. The venue for the meetings are to be arranged.

NB: **These meetings are formal meetings and will be held as face-to-face meetings.

5 - 22

6 **MINUTES (15:55 - 16:00)**

To note the Minutes of the meeting held on the 19 May 2021.

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7 **ACTION LOG (1600 - 16:05)**

To review the Actions arising from previous meetings.

8 **CHAIR'S UPDATE**

To receive an oral update.

9 **PUBLIC QUESTIONS**

Members of the Board to consider questions submitted by members of the public.
The deadline for receipt of public questions is 5pm on 10 May 2021. Lines of questioning should be submitted via:
https://www.birminghambeheard.org.uk/place/birmingham-health-andwellbeing-board-questions
(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 via the Council's meeting You Tube site (www.youtube.com/channel/UCT2kT7ZRPFCXq6_5dnVnYlw)
NB: The questions and answers will not be reproduced in the minutes.

10 **CORONAVIRUS-19 POSITION STATEMENT (16:05 - 16:10)**

Dr Justin Varney, Director of Public Health will present this item

11 **CORONAVIRUS-19 VACCINE UPDATE (16:10 - 16:15)**

Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG will present this item

12 **ICS UPDATE (16:15 - 16:20)**

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13 **JSNA DEEP DIVES (VETERANS) (16:20 - 16:35)**

Luke Heslop, Service Lead Evidence, will present the item.

107 - 114

14 **CREATING A MENTALLY HEALTHY CITY FORUM (16:35 - 16:50)**

Natalie Stewart, will present the item.

115 - 134

15 **PUBLIC HEALTH COMMISSIONED ADULT SERVICES (16:50 - 1705)**

Bhavna Taank and Karl Beese, Public Health Division will present the item.

135 - 140

16 **CREATING A HEALTHIER CITY FRAMEWORK (17:05 - 17:15)**

Dr Justin Varney, Director of Public Health will present the item.

17 **OFSTED REPORT (17:15 - 17:30)**

Kevin Crompton Director of Children's Services will present the item.

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18 **FORWARD PLAN (17:30 - 17:35)**

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19 **WRITTEN UPDATES FROM FORUMS (17:30 - 17:35)**

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20 **WRITTEN UPDATES BLACHIR (17:30 - 17:35)**

163 - 168

21 **WRITTEN UPDATE FROM ICS INEQUALITIES BOARD (17:30 - 17:35)**

22 **WRITTEN UPDATE FROM THE LOCAL COVID OUTBREAK ENGAGEMENT BOARD (17:30 - 17:35)**

LCOEB 26052021 Minutes
LCOEB Minutes 30062021

23 **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.

APPOINTMENT OF BIRMINGHAM HEALTH AND WELLBEING BOARD

FUNCTIONS, TERMS OF REFERENCE AND MEMBERSHIP 2021/22

In accordance with paragraph 6.4 of Article B6 (Executive Role, Functions and Procedures) of the City Council Constitution, the board is constituted as a Committee under the chairmanship of the Cabinet Member for Health and Social Care in order to discharge the functions of the board as set out in the Health and Social Care Act 2012, including the appointment of board members as set out in the schedule of required board members in the Act.

Functions

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

The Health and Wellbeing Board will:

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

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

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

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

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

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

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

Terms of Reference

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

The Leader of the Council or their nominated representative to act as Chair of the Board
The Director - Adult Social Care Directorate (Director for Adult Services)
The Director - Education and Skills Directorate (Director for Children's Services)
Nominated Representatives of each Clinical Commissioning Group in Birmingham
The Director of Public Health
Nominated Representative of Healthwatch Birmingham

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

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

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

Membership 2021/22

City Council Appointments to the Health and Wellbeing Board

Cabinet Member for Health & Social Care as Chair: Cllr Paulette Hamilton (Lab)	Cllr Paulette Hamilton
Cabinet Member for Children's Wellbeing: Cllr Kate Booth	Cllr Kate Booth
Opposition Spokesperson on Health and Social Care – Cllr Matt Bennett (Con)	Cllr Matt Bennett
Vice Chair for 2021/2022 to be a Clinical Commissioning Group (CCG) representative (to be advised by the CCGs) - to reinforce the Board as a joint body rather than a solely LA committee	Dr William Taylor
Director - Adult Social Care Directorate	Professor Graeme Betts
Director - Education and Skills Directorate	Kevin Crompton
Director of Public Health	Dr Justin Varney

External Appointments to the Health and Wellbeing Board

Representative of Healthwatch Birmingham	Andy Cave
2 Representatives of Birmingham and Solihull Clinical Commissioning Group	Dr William Taylor and Paul Jennings
Representative of Sandwell and West Birmingham Clinical Commissioning Group	Dr Manir Aslam

Representative of Third Sector Assembly	To be appointed
Representative of Birmingham and Solihull STP (One Care Partnership)	Paul Jennings
Chief Executive of Birmingham Children's Trust	Andy Couldrick
Chair of the Birmingham Community Safety Partnership/WM Police	
Representative of the Department of Work and Pensions	Gaynor Smith
Member of the Birmingham Social Housing Partnership	Peter Richmond
Representative of Birmingham Community Healthcare NHS Foundation Trust	Richard Kirby
Representative from the Education Sector	Professor Robin Miller
Representative from Acute Care	Mark Garrick
Representative from the Integrated Care System	Yve Buckland
Representative from the Chamber of Commerce	

Co-optees

Birmingham Voluntary Services Council	Stephen Raybould
Representative from the Business Sector	To be appointed
Representative from the Birmingham and Solihull Mental Health Trust	Waheed Saleem
Representative from SIFA FIRESIDE	Carly Jones

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD INFORMAL MEETING WEDNESDAY, 19 MAY 2021

MINUTES OF AN INFORMAL MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON WEDNESDAY 19 MAY 2021 AT 1500 HOURS AS AN ONLINE MEETING

PRESENT: -

Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and Chair of Birmingham Health and Wellbeing Board
Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Councillor Kate Booth, Cabinet Member for Children's Wellbeing
Andy Cave, Chief Executive, Healthwatch Birmingham
Andy Couldrick, Chief Executive, Birmingham Children's Trust
Mark Garrick, Director of Strategy and Quality Development, UHB
Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG
Carly Jones, Chief Executive, SIFA FIRESIDE
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Professor Robin Miller, Head of Department, Social Work and Social Care, Health Services Management Centre, University of Birmingham
Dr William Taylor, NHS Birmingham and Solihull CCG
Dr Justin Varney, Director of Public Health, Birmingham City Council

ALSO PRESENT:-

Steven Connolly, BSol CCG Contract Manager
Alan Ferguson, BSol CCG
Aidan Hall, National Management Trainee, Public Health
Maria Gavin, Assistant Director, Quality and Improvement, Adult Social Care
Elizabeth Griffiths, Assistant Director of Public Health, BCC
Stacey Gunther, Service Lead – Governance, Public Health
Harvier Lawrence, Director of Planning and Delivery
Pip Mayo, Managing Director - West Birmingham, Black Country and West Birmingham CCG
Rhy Roper
Douglas Simkiss, Birmingham Community Healthcare NHS Foundation Trust
Errol Wilson, Committee Services

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DECLARATIONS OF INTERESTS

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

APOLOGIES

548 Apologies for absence were submitted on behalf Chief Superintendent Stephen Graham, West Midlands Police and Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS Foundation Trust .

PROPOSED DATES OF MEETINGS FOR BIRMINGHAM HEALTH AND WELLBEING BOARD

549 The Board noted the following meeting dates for the Municipal Year 2021/22:

2021	**2022**
Tuesday 27 July	Tuesday 18 January
Tuesday 21 September	Tuesday 22 March
Tuesday 30 November	

All meetings will commence at 1500 hours. The venue for the meetings will be arranged.

MINUTES AND MATTERS ARISING

550 **RESOLVED: -**

The Minutes of the meeting held on 16 March 2021, having been previously circulated, were noted.

ACTION LOG

The following Action Log was submitted:-

(See document No. 1)

Stacey Gunther, Service Lead – Governance, Public Health introduced the item and advised that there were no outstanding actions on the Action Log.

551 **RESOLVED: -**

The Board noted the information.

CHAIR'S UPDATE

552 The Chair welcomed everyone to the meeting and stated that we have good news with the vaccine rollout which was gathering momentum and she will be doing her bit and will be helping out on Friday with vaccinations.

Queens Speech

We had the Queens speech early this month with some snippets of good news on funding being made available to support health and wellbeing – tackling obesity and improving mental health which was very much welcomed.

However, it was disappointing to see that the promised and much needed urgent social care long term funding solution was missing yet again.
The renewed commitment to social care reform was welcomed, but it would have been great to understand when our Prime Minister will set out when he will fix social care which he boldly pledged to do in his election victory in 2019 – we were still waiting Boris…

It was worrying as a survey for Age UK found the pandemic had significantly increased older people's social care needs, with nearly a quarter (23%) of those aged 60 and over saying their ability to carry out everyday activities had worsened since the first lockdown.

We all understand the immense strains Covid has created on our health and social care sector which desperately needed strengthening.

With lockdown easing – we were beginning to open up and our day centres and care homes were opening to visitors which was crucial for us all. Social Isolation was something that we need to look at addressing.

This morning I attended a meeting to discuss Mental Health Prevention and Promotion and the additional funds will help in supporting our communities affected by Mental Health – which continues to emerge as a key issue.

Community Wellbeing Board

At the LGA Community Wellbeing Board meeting last week we looked at the Dementia Strategy 2021 - 2041 update as the LGA alongside the Alzheimer's Society will oversee the strategy as Dementia Programme Board members.

It will be a three-year strategy. It was proposed that year 1 will be focussed on Covid recovery and issues arising from the pandemic. Years 2 and 3 will look at

issues agreed by the Dementia Programme Board prior to the pandemic. Councils had a key role in delivering/commissioning services for people with dementia in the community. The strategy will need to reflect the diverse needs of communities – particularly around raising awareness, risk reduction and ensuring appropriate support and stigma in this area.

Infant Mortality

Last month at Full Council I responded to a task and finish review of Infant Mortality and I have asked for this to be discussed at Health and Wellbeing Board soon. It was a very hard read – we needed to do more - the preventable loss of life of a baby was the most devasting consequence any family could ever face and the fact that in Birmingham our rates were so high was distressing and makes uncomfortable reading.

I am committed to doing all I could to reverse this – the report highlighted that some of these deaths were preventable through a range of earlier actions and awareness and earlier conversations on lifestyle choices prior to conception and during pregnancy.

There was more we needed to collectively undertake together with our health partners, our communities and with our citizens.

We will be looking for a Chair, to chair that taskforce and we were looking for someone that had the passion and drive. This needed to be someone that could give the overview and push that it needed as the City Council takes this issue seriously. We intended to ensure that the outcomes were met in this area.

PUBLIC QUESTIONS

553 The Chair advised that there were no public questions submitted for this meeting.

CORONAVIRUS-19 POSITION STATEMENT

554 Dr Justin Varney, Director of Public Health introduced the item and advised that as we had the Local Covid Outbreak Engagement Board meeting next week he would not be doing the full slide presentation. Dr Varney then gave the following overview concerning the direction of travel: -

(See document No. 1)

1. Case numbers in Birmingham continues to decline which was good news and reflected all of the hard work of citizens and partners where we were working together to bring the Covid outbreak under control. However, we were not out of the woods yet, and if we look to the north areas like Bolton and Blackburn and Darwen the rapid escalation of the April variant (previously known as the Indian variant) had led to rapid increase in case rate.

2. Unfortunately this had now started to translate into hospitalisation amongst predominantly people who had no vaccine or only one dose of the vaccine. This was a caution to us all.
3. In Birmingham we were seeing a relatively small number of variants of concern of any type, but we were now starting to get data from Public Health England (PHE), but will give a fuller presentation on variants of concern next week.
4. Of those that we were aware of that were the April variant of concern in total up to the 14 May 2021 we had 29 cases in the city. Of those where the contact tracing was completed, over half were either directly travellers themselves or lived and were direct contact with someone who had come from overseas.
5. What we were not seeing in Birmingham was a significant number of cases in the communities where there were no history of travel. Colleagues would be aware that we had in recent weeks ran three Operation Eagles which were around cases of the South African variant, where we identified individuals that were not linked to travel and we had done surge testing to try and see if there were any different pattern or any evidence to more spread in the community.
6. Those operations did not identify any further cases of the variants although they did find a small number of additional cases of people who were positive and did not know it. It was always a benefit when we did these surge testing and we found potentially more cases we can further reduce the transmission of the virus across the city.
7. We had been preparing and running some scenario exercises around what might happen if we saw escalation in a similar picture to what we saw in Bolton.
8. At next weeks' Local Covid Outbreak Engagement Board meeting, there will be a fuller presentation from the learning of Operation Eagles and also some of the work we were doing in preparing for various scenarios looking to the future.
9. It was important to remind everyone that Covid remained a risk and it was important that we continue to follow the guidance – maintaining hands, face and space and now adding in ventilate as the weather had gotten better.
10. As we learned more about the virus it became more important that we keep windows open particularly when we were in an environment with people we did not live with. If you were having people over, under the rule of having six people from different households or two households coming together indoors please ensure that you keep the windows open and the rooms well ventilated, maintain distance and keep washing your hands.
11. The lessons from Bolton and Blackburn showed that these numbers could escalate quickly and the new April variant present a serious risk particularly, because the evidence emerging was that it was more infectious than the Kent variant we had at the beginning of the year.
12. It may or may not be more dangerous in terms of putting more people into hospital, but simply the fact that it was more infectious meant more people would become infected and even if the same proportion ended up in hospital meant more pressure on the NHS.
13. Dr Varney reiterated the importance of getting vaccinated. All of the evidence currently internationally showed that the vaccines we were

using in the UK were effective against the new variants and reduced the risks of hospitalisation and significantly reduced the risk of dying.

14. The situation we saw from Bolton – the vast majority of people who were admitted to hospital were people who were in the priority groups, were eligible for vaccine and had chosen or were unable to take up the vaccine and sadly as this wave swept through Bolton they succumb and ended up in hospital and sadly some of them had died.

15. A small number of them had the first dose but not the second dose. There was one case in an extremely frail individual who had two doses but still became extremely unwell.

16. This reinforces the importance for everyone if you were in those eligible priority groups, particularly individuals who were considered clinically extremely vulnerable, those who were shielding or those considered clinically at risk and those who had the flu jab normally in a year – those were the people who should be taking the extra step to ensure they got their vaccine now as we wanted to close that gap and get those vaccines into you as soon as possible before we saw that wave of new April variant moving down across the country.

17. There was still a way to go and we will still see these challenges around new variants appearing the next year. We were in a good place and were doing everything that was asked of us and had to keep going at it to avoid ending up in a situation that other areas in the country currently found themselves.

CORONAVIRUS -19 VACCINE UPDATE

555 Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG introduced the item and gave the following verbal update:-

a. The vaccine rollout continues and we continue to go down through the age groups. We were now administering the Pfizer vaccine to individuals aged under 40 years old.
b. The supply of vaccines were coming through to allow us to reach our second dose application whether it was the Pfizer or the AstraZeneca vaccine.
c. Probably over this weekend or early next week we will reach the point where we would have administered 1m vaccines across Birmingham and Solihull. Around ¾ of those was through Primary Care and a ¼ through the mass vaccination sites and hospital hubs which was an astonishing achievement.
d. Mr Jennings reemphasised Dr Varney's comments that no one gets left behind on this. If at any point you had chosen not to have the vaccine and/or you did not felt that you could for whatever reason, if at any point you changed your mind, you would be warmly welcomed to have your vaccine and to join those who were taking on a level of protection that worked well against all of the versions of the virus we currently had in circulation.
e. It was a fantastic and mammoth effort and people were working had at this now since we have started just before the New Year. We had been at this for just over five months now. In line with what Dr Varney had stated we were also planning for any potential surge.

f. In Bolton you would have seen the buses with people queuing up to have the vaccine. Most of those were people who could have had the vaccine and did not take it.
g. We will have plans in place, we have a fantastic capacity for vaccines here and working flat out we know that we could do about 120,000 per week. We never had that level of supply, but if we did find ourselves in a surge situation, he was reasonably confident that we had the resources, skill, planning capability ,and the competences and most important a committed workforce most of whom were volunteers to enable us to deliver what was required should it be needed.
h. In the meantime we carry on the vaccine programme as it stands. We will work with the cohorts and get to the point around summer where every single adult would have been offered the opportunity to be vaccinated and protected before we move on into the winter.
i. We have not had our summer yet but we planned to carry out our flu programme and Covid vaccine booster programme that it appeared we would be doing this year too.

Dr Aslam made the following comments:-

i. We had done well and had delivered 1m vaccine, this was much more than we could have hoped for, there was still a challenge. Dr Varney had pointed to it that in Bolton those people who were not vaccinated were suffering and the infection was spreading quickly amongst those people and a significant proportion of those people were becoming unwell.
ii. In West Birmingham, compared to the rest of the Black Country, we were seeing 10% behind on vaccination rates in most of the priority cohorts. Although we had lots of things in place including revamping our community pharmacy offer and making vaccines available in practices and continuing the work that we had done at the city sites that will extend into the winter period.
iii. We will continue to deliver large scale vaccination into the winter period and the vaccination site at Aston Villa and Millennium Point we still had a challenge. Our system was at risk of Covid spreading quickly within our communities and we had a significant portion of people that were not vaccinated.
iv. Although he was excited that we got this far, and it was much better than we ever did with the flu campaign previously, there were more for us to do and we will continue to do that work as Mr Jennings described if you had given up the opportunity to have your vaccination on one occasion that was fine. If you changed your mind we were here as we had the access point for you to get vaccinated.

The Chair enquired what inhibitive ways were you trying to work with communities to make the vaccine more accessible for the communities. Mr Jennings advised that we had mobile vaccine sites, the vans were going around and we had been working with Faith Groups and community groups. We were offering vaccines sessions where specific languages were spoken. We proliferate more sites into pharmacies because these were more local areas that were more trusted by individuals. In the first three months of the campaign we had nearly 80 engagement with communities and leaders etc. This pattern was reflected in the west of the City.

Dr Varney commented that he had access to three different websites that he had logged into to look at the vaccine data, some of which Mr Jennings, Ms Mayo and Dr Aslam had access to and some that displayed the data in a different way. The access to that was restricted to the information about Birmingham residents and the two STP, ICS NHS systems that we work with. Dr Varney added that he could see the data for Birmingham and Solihull, West Birmingham and Sandwell and the rest of the Black Country, but he did not have access to the Bolton data to be able to look at whether their vaccination uptake was particularly different from ours in terms of whether we were less at risk vaccinated than where we were currently.

Dr Varney stated that he could not do that kind of analysis which he thought was what Mr Raybould was hinting at. Where we looked at the uptake we were doing well. We still had some communities that if they changed their minds and come back – there was no blame no judgment here. The reality was that the April variant was posing a real threat now. If you were watching the news and saw people from India and you thought about it and felt you were now ready to have the vaccine, please get in touch with the NHS and book through the NHS website. If you had a medical condition and you wanted to talk it through, please talk with your pharmacist or to your GP practice about your personal circumstances.

In terms of the demographics of our populations, we were not that dissimilar from Blackburn and Darwen which was also doing an uplift. Bolton was slightly less diverse in the way that we were and was slightly older, but we were not radically different. If this was happening in Devon, he would be slightly less concerned than he was about it happening in Greater Manchester.

INTEGRATION AND INNOVATION: WORKING TOGETHER TO IMPROVE HEALTH AND SOCIAL CARE FOR ALL

556 Aidan Hall, National Management Trainee, Public Health introduced the item and gave a brief overview of the Government's Health and Social Care White Paper published in February 2021. Mr Hall then drew the attention of the Board to the information contained in the slide presentation.

(See document No. 2)

Doug Simkiss, Birmingham Community Healthcare NHS Foundation Trust presented the information on behalf of Richard Kirby, Lead for the ICS Inequalities Work. Mr Simkiss then drew the Board's attention to the information contained in the report.

(See document No. 3)

Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG introduced the item and drew the attention of the Board to the information contained on page 58 of the Agenda Pack which highlights the four things the ICS was here to do. Mr Jennings then advised that Harvir Lawrence, Director of Planning and Delivery will give a slide presentation on the item.

Ms Lawrence then drew the attention of the Board to the information contained in the slide presentation

(See document No. 4)

Pip Mayo, Managing Director - West Birmingham, Black Country and West Birmingham CCG made the following statements:-

1. One of the additional components in terms of our journey towards becoming an ICS was that we knew that integrated care worked best when NHS services were well integrated with local authority services. This was well proven with the work we did so far.
2. In the White Paper and the guidance that accompanied that there was a clear expectation that sets out that CCG boundaries and local authority boundaries become aligned to support that integration.
3. We knew that West Birmingham currently sat in a different CCG system to the rest of Birmingham with BSol.
4. The challenge on us as system leaders to work over the coming year to see how we resolved that for the benefit of local people. At the moment we were working closely with Mr Jennings team in BSol to set out what that might mean for us and what our journey might be.
5. This was something that might be useful for us to bring back in more detail at a subsequent meeting. We were on a trajectory to bring the health economies back together in Birmingham for the benefit of integrated care.

Dr Varney commented that he welcomed Ms Mayo's statement and that Mr Jennings and Dr Aslam had both alluded to the way West Birmingham had worked collegiately with BSol through this had demonstrated and had changed a lot of the dynamics around how we deliver to the citizens of Birmingham effectively as a whole city which was positive.

In relation to Ms Lawrence's presentation Dr Varney enquired whether those priorities had gone through the West Birmingham Integrated Care Partnership (ICP) as part of the pre-journey before they came to the Board. He added that one of the key bits he would like to see was West Birmingham was supportive of them. In terms of the request for members to feedback on those eight priorities, Dr Varney suggested that this be done electronically so that a more detailed and thought through approach could be had.

The Chair stated that it would be good for the sake of the Board if we could get a few comments on the points that Ms Lawrence had raised in her presentation and the points that was raised by Ms Mayo. The Chair voiced concerns that as an HWB if we were going to play a significant role going forward particularly around Mr Hall's presentation in relation to the White Paper, we needed to have some strong positive/negative views so that as the ICS was developing, they saw us as a Board that had 'bite'.

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

Professor Robin Miller:-

a. The aspirations that had been set out here today and we also hear about at the Away Day, were inspirational. What was great to see was the health care service that had totally embraced the notion of general wellbeing, inequalities and were trying to work on a more community orientated and a socially friendly way.
b. That he was reassured about the plan for the ICS and if they were to build on the previous relationship that was established with the HWB underlined that.
c. In relation to the West Birmingham question it had always hard as an independent observer to comment on that as there were so many complicated discussions that were on-going with that it was hard to provide any meaningful insight.
d. It was complicated and had a tendency to work to the same boundary and the city one was where people worked to the city boundary where most people live in. It was hard as an external commentator to note that.
e. All of what we were talking about here would require our workforce to behave differently. There were two key elements - our ability to collaborate and the ability to work with communities.
f. This was not unfamiliar to them – we wanted to see a step change up in the way that they do. The question was what their engagement was like with universities.
g. A further question was whether they felt like they understood what was required of a future HWB as social care professionals and were they providing the right development support for you. That the Board come back to a future HWB meeting if it was not the time now.

Stephen Raybould:-
In terms of the priorities with the digital conversation – in relation to West Birmingham it was important that in lots of ways, West Birmingham was in the Birmingham system. It was just the challenges that we had two systems and that did not work for citizens. If the direction was towards merger, the primary experience for the people who were anxious and concern about it and what that might meant, that was experience as a merger rather than a takeover and the absorption of West Birmingham into the BSol system. There were lots that were brilliant and the relationship to the voluntary sector in West Birmingham had historically been excellent. We would like to see that carried into the wider space.

Dr Manir Aslam:-

I. Ladywood had some of the most deprived areas in the country and that he made no apologies for arguing for those people to have better outcomes than they have at the moment.
II. The idea that we managed health and inequalities as their primary driver was exactly what his work was about and not what he would like the work of the HWB to be about.
III. It was important that we listen to local people, that we allowed decisions to be made locally that could be implemented or that those decisions were enacted as close to the point where those decisions were made as possible.
IV. Localism was important here as the best work we had done through Covid was when we were engaged with communities; when GPs had contacted patients about vaccinations because they did fine; when

communities had contacted each other about vaccinations they had done well.

V. It needed to be borne in mind that Ladywood had suffered from poor health and social inequalities for some time over the years. Despite it being in the legislation that we mange health and inequalities they got worst over the last 10 years.

VI. There was something that we needed to do together differently to change the outcome which was an important point to make – we tried and did not got there.

VII. We needed to try again, but this time it cannot be about '*what are you doing and what am I doing*,' it had to be about what we were doing together to achieve those aims.

VIII. We needed to hold ourselves to account in f5 – 10 years' time to say did we set ourselves a set of outcomes that we achieved and if not, why not. If we were all pulling in the same direction there was no reason why we could not make the lives a lot better for those people living in West Birmingham.

IX. In one sense it did not matter which system we were in, what mattered was the work that we do for the people in West Birmingham was beneficial for them and it achieved the outcomes that we set.

Andy Cave:-

- There were two aspects - firstly, the priorities for the ICS and secondly, West Birmingham.
- One of the challenge for the HWB at this moment in time was that we all had different levels of involvement in the ICS process and different levels of understanding.
- As an organisation that currently was not involved in the BSol ICS conversations (he would welcome in dept conversations about our role and function) and actually how patients and the public were influencing these priorities especially when we got into the finer details of that and how we could work at a locality level within the place of Birmingham and overcome some of the challenges of that.
- In terms of West Birmingham, there was a lot that could be learnt and the ICP across all localities of Birmingham. He would welcome the conversations of learning from the ICP in West Birmingham and how we could move that model and learn from it for the other localities as well.
- There was real involvement from a Healthwatch perspective in the Black Country and West Birmingham. Both NICP level in West Birmingham, but we also had representation at Board level in the Black Country. How we learn to increase involvement with all of the Board members was important.

The Chair commented that the voluntary sectors were saying that they needed a voice.

Andy Couldrick:-

- In relation to Professor Miller's last point there was much more that we should be able to do together to improve the offer that social work students received to prepare them for practice which was something we were keen to work on in the Trust with universities including Birmingham.

- On the wider point about children, what was key, was that we remembered that our focus on early help and intervention did not just meant early years and school readiness etc.
- It meant the earliest point in the beginnings of problems emerging for children and young people and families whether they were five weeks old or 15 years old.
- The second point was that it was only going to work (Professor Miller Was right when he talked about practitioners needed to change the way they practice).
- Leaders equally needed to change the way they led the system in order to make integration felt real and safe for the workforce that felt comfortable in their separate silos if we want integration to be real in the way that we took forward some of these priorities.
- The focus on how our workforce worked together in new and different ways was going to be critical.

Councillor Matt Bennett:-

- In relation to the West Birmingham issue, it could be easy to focus on the structural changes and disappearance of the organisational side of it.
- To people out there this meant absolutely nothing and it should not really mean anything and it should not be terribly important how the various commissioning groups were organised or anything.
- It should be about getting the best possible services. Sometimes organisations could get themselves and devote a huge amount of energy and time to the structural stuff that ultimately did not mean anything to ordinary people.
- He was not dismissing the importance of getting it right, but we should not allow a huge amount of time and energy to be focused on this at the expense of other more important things.

The Chair commented that Ms Lawrence raised eight points in her presentation which were key points. The report was for noting, but the issue of waiting times kept coming back from the doorsteps. People that needed to be seen especially in her Ward felt that others would be given priority before them. The Chair enquired what work the Chief Executives were doing to ensured that we got a level of equality across the system and those that truly needed intervention were not waiting and it then became too late for them.

Ms Lawrence stated that in terms of tackling our waiting times there was a substantial backlog that had built up due to Covid for a variety of reasons. We could take an approach and clinically prioritised these patients and completely ignore the inequalities aspect of it, but we have taken a proactive approach to take account of the index of multiple deprivation into how we were tackling our waiting list.

We were getting into the detail of not just looking at clinical priority, but taking account of that layer of inequalities into how we were delivering our services and were bringing in patients for their treatment. This was novel for us as we had done it in this way. It was new to us but we recognised the importance of doing that and have had good conversations with Richard Kirby, our Systems and Equalities Lead around how you embed inequalities to everything that we do as a system. This was in the fabric of the ICS and we did the hearts and

mind piece of work around that which was not a separate piece of work as it was embedded into everything we do.

In presenting those priorities, what we will be reinforcing was those inequalities thread that runs through all of it.

Mr Jennings started that we were back at levels of waiting not known for a very long time if at all. The first thing to be honest about the challenge and the second was to say that this was driven primarily by our response of clinical prioritisation as well as inequality. Mr Jennings advised that he will be joining a weekly meeting of the medical directors shortly as he had done over the last few weeks, across the system which include primary care where their conversation was entirely about doing the best we could in terms of what we had in terms of resources - how do we prioritise patients, how do we constantly review patients, how do we ensure that we minimise harm as much as we possibly could. Thirdly, we have to start to try to assemble a means of being able to communicate effectively with patients about where they were in terms of their waiting position, but also to be able to hear from those whose situation and circumstances changed and therefore our clinical response to them will need to change.

This was an incredibly complex issue when you have the tens of thousands of people that we have currently on the list. Mr Jennings gave his assurance that the hearts and mind of those clinical leaders were precisely around that prioritisation piece.

Dr Aslam stated that sometimes we look at waiting list as the things that hospitals do and we do not look at the impact we had on Primary Care. Primary Care has been robust, but it was at breaking point. There were lots in the media about general practice having being closed, but we have worked fully throughout this pandemic. We delivered services in a different way, but we were fully engaged with our patients, but it had been difficult. It was difficult for us as a society, but it had been difficult for primary and secondary care. We delivered the largest scale vaccinations than we had ever delivered as a country and we delivered it successfully. It was just a please to say general practice the conversation around general practice and access to general practice will need to be part of that wider conversation around waiting list and the restoration and recovery that we will need to go through.

SOCIAL PRESCRIBING

557 Stephen Raybould, Programmes Director, Ageing Better, BVSC and advised that it was an emerging issue across the sector. There was a substantial meeting involving over 50 organisations at the end of April looking at the challenges around Social Prescribing. There was broad agreement that patients experience needed to be placed at the centre and that the voluntary sector providers needed to exercise some control in developing and managing effective pathways across their provision and that a strategic overview be taken after activity. The broader ask was that this be seen in a wider context that their pathways into the voluntary sector were varied. One of the things that would be of great advantage certainly to the health service and to Primary Care was that

if people could find their way to voluntary sector activity without having to go through Primary Care, it would be quicker for citizens and takes the pressure off Primary Care.

There were a number of strategic priorities which were identified in the paper and some of that was around visibility of service

(See document No. 5)

Stephen Connolly, BSol CCG Contract Manager advised that he came along to the meeting to see if there was anything that the Board needed from a CCG perspective. He stated that his role was the Contract Management for the Social Prescribing Service within the Primary Care Network (PCN). That he supported the PCNs and ensured that they were doing what they were supposed to. The funding for the PCN came through from NHS England to the PCN DES. The PCN had a choice as to how many social prescribers they employed. There was a minimum target of one per PCN. We were at the mercy of the PCN and how they decided to employ their staff.

Mr Raybould commented that there were challenges around social prescribing, but there was a broader challenge around where they were being sent to. Although the prescription had been resourced, the other bit had not been resourced and he did not think that there was a plan around it sufficiently that we could begin to think how we tackle it.

Alan Ferguson, Locality Development Manager advised that his responsibility was to coordinate the social prescribing across the footprint and that he had met with Mr Raybould on a couple of occasions. He stated that he knew that this was one of the questions that had cropped up, but it was around capacity and signposting into the right areas. One of the things that came out of the meeting that Mr Raybould referred to was the agreement that we would start to have a better level of communication across the two areas so that we could try to sort out some of the potential problems that may come about in the coming months. Mr Ferguson stated that he was aware that the providers for these social prescribing via the link workers had also been made aware of this and they wanted to have a dialogue that hopefully could bring some form of solution to that helped the citizens.

Mr Raybould commented that there was general recognition that the approach had been forced upon the local system by the national approach and we had to do the best with it as we could. But this did not take away the challenge of the risk of the huge number of referrals where there is no capacity.

Mr Ferguson stated that unfortunately, the pandemic had hijacked a lot of the initial work that we started to do. One of the key things that came into play at the beginning of 2020 was a joint meeting of the Neighbourhood Networks and the newly appointed social prescribers. This brought a conversation that contributed to some working within BSol that we felt would take us forward. Unfortunately, within a month of that meeting we had the pandemic and we went to virtual working which did not help the situation. This was a real opportunity for us to visit where we were 12 months ago and started to build new plans.

Professor Miller commented that it was recognised that the social prescribing model was brought in at the same time and we agreed with the principles. This was a good case for the HWB asking for a joint commissioning plan across health and social care and how they were going to work together in terms of the way they support our communities and other organisations. A lot of research had shown in the past that organisations had to respond to similar request from different commissioners by providing different source of information, different source of contracts etc. Professor Miller stated that he would like to understand how this was joined up across the local authority and in deed our health colleagues. For the voluntary sector a simple ask was to build the capacity and structure that they needed and to get the financial support that they required to meet the needs of the citizens they had been prescribed to receive.

Maria Gavin commented that it was an excellent opportunity to pick up the work that started with Neighbourhood Networks. Neighbourhood Networks had continued to work at pace throughout the pandemic adjusting their offer through Covid with support. Throughout the pandemic we made joint offer to work with our voluntary sector organisations for children's services with the ambition to have that all age approach to working with the voluntary sector. There were some good established networks build upon and we were working closely with BVSC. There were some positive strong structures with a good sense of local need that could be brought together with the social prescribing approach. There were rules and as colleagues were aware, a number of platforms – social care, users connect support and many organisations used the waiting room, but this integrating the approach into systems and structures which were developing strongly was a good opportunity to pick back up.

The Chair commented that the point that was raised by Professor Robin Miller regarding doing some joint work to see how we could be more inter-linked, for this to be taken away as an action that could be looked at and brought back to a future HWB meeting.

Dr William Taylor commented that we had a gathering storm in many ways because what we have done was started answering the question that health and wellbeing was more than just prescribing a medicine or changing someone's blood pressure, but it was not. It was about the whole person which was what this Board was saying for a very long time. The problem was what we created then was an unmet need which was what was what Mr Connolly was alluding to. Dr Taylor stated that if there was an unmet need, we needed to address that. It had to be positive and that he would support the idea of a collaborative commissioning structure which was a true cross organisation piece which was certainly something we should push for, for our ICS and a real test for our ICS to see if this would be successful.

Mr Jennings undertook to take this up as an action. He added that he was impressed with Professor Miller's comment about having a joint way of doing this making it all simple and straightforward for the voluntary sector. We had to speak with the voluntary sector as he imagined that they had the same level of bureaucratic organisations that we had.

CREATING AN HEALTHIER CITY STRATEGY

558 Dr Justin Varney, Director of Public Health introduced the item and drew the attention of the Board to the information contained in the slide presentation.

(See document No. 6)

Dr Aslam commented that he was in attendance at the Development Session and that the principles that Dr Varney had outlined was good. He added that one of the first HWB he attended one of the question that was raised was how do we get away from strategy fatigue as we had seen a lot of strategies at the HWB but we have not seen any improvements in our city over the last 10 years. Dr Aslam added that he was keen and that this was a new opportunity and we could make good progress. He enquired how we could keep a check on ensuring we were making progress and that things were improving.

Dr Varney advised that one of the pieces being done alongside the work on the strategy was a matrix of indicators that we could track. What we were keen to do was not just look at things that we could measure once a year or only measured once every three year. If we take an indicator like infant mortality, it was published as a three year rate, and was only published once per year. But, actually, we knew about infant deaths through the Child Death Overview Panel in real time.

It was looking at how we create indicators where we track progress. The indicators were going to take time to change like childhood obesity, healthy life expectancy – what were the proxies that we could monitor every year and more frequently to move things forward. One of the things that was done well by the Board in 2016/17 under the previous strategy was a clear matrix of data that they were tracking which was reported back to the Board on a regular basis. We would seek to build on that model moving forward so that we were demonstrating progress as well as having a strategy that we could pull all of this together.

INFROMATION ITEMS

559 The Chair advised that Agenda items 14, 15 and 16 were for information only.

OTHER URGENT BUSINESS

560 No other urgent business was submitted.

DATE AND TIME OF NEXT MEETING

561 To note that the next Birmingham Health and Wellbeing Board meeting will be held on the 27th July 2021 at 1500 hours.

The meeting ended at 1650 hours.

……..……
CHAIRPERSON

BIRMINGHAM HEALTH & WELLBEING BOARD

Birmingham City Council

Action Log 2021

Birmingham Health and Wellbeing Board

Rag rating :
- Overdue
- In progress
- Complete

Index No	Date of entry	Agenda Item	Action or Event	Named owner	Target Date	Date Completed	Outcome/Output	Comments	RAG

Index No	Date of entry	Agenda Item	Action or Event	Named owner	Target Date
	29.01.2019	IPS - Mental Health	To send a letter to all Board members to encourage them to actively promote and support employment opportunities for people with SMI within members' organisations through the IPS programme.	Board Admin	
		JSNA SEND	Remove the recommendations from the report and send them to the SEND Improvement Board as a reference item.	Fiona Grant	19.03.2019
		Sustainability Transformation Plan (STP)	To submit written bi-monthly update reports to the Board, with updates from the portfolio boards.	Paul Jennings	28.05.2019
344	19.02.2019	JSNA Update	Public Health Division to present the JSNA development and engagement plan at the next	Justin Varney	19.03.2019
	29.01.2019	IPS - Mental Health	members to encourage them to actively promote and support employment opportunities for	Board Admin	
362	19.03.2019	Joint Strategic Needs Assessmnet Update	The two decisions that were needed from the Board were: - A volunteer for each of the four deep dives as champions and to hold us account; and a short discussion around where the Board would like us to look in terms of diversity and inclusion.	Elizabeth Griffiths	30th April 2018
	29.01.2019	IPS - Mental Health	The Chair has requested that a member of HWBB volunteer to attend the IPS Employers Forum to support the development of IPS.	All Board	19.03.2019
352	19.02.2019	Substance Misuse	Consideration to be given to partners' involvement and public engagement in the future commissioning cycle, and to the funding position, taking on board comments made at the meeting.	Max Vaughan	Date to be confirmed
IAN8	18/06/2019	Air quality update report	Board members encouraged to participate in Clean Air Day 20 June	All Board	20/06/2019

346	19.02.2019	Childhood Obesity	DPH was asked to reflect on potential for social marketing high profile campaign - similar to the partnership approach to ‘sugar free’ month promoted by Sandwell Council and partner organisations and 'Fizz Free Feb' led by Southwark Council.	Justin Varney	Development day 14.05.2019
351	19.02.2019	NHS Long Term Plan	It was agreed that, as the local 5-year plan was being drafted, consultation should take place with the Health and Wellbeing Board and engagement with key leaders in the City to enable them to give an input to the plan.	Paul Jennings	19.03.2019
IAN6	18/05/2019	Public Questions	All Board members to promote submission of public questions to the Board	All Board members	24/09/2019
IAN9a	18/05/2019	Active travel update	Board to work with their partners to promote active travel away from main roads and along green spaces where possible	All Board members	ongoing
IAN9b	18/05/2019	Active travel update	Kyle Stott, Public Health, to bring mapping of active travel back to the Board	Kyle Stott	24/09/2019
IAN10	18/05/2019	Developers Toolkit update	Board members to encourage the use of the developer’s toolkit in their organisation’s capital build projects as well as retro-build and refurbishments but to include anything in the present	All Board members	ongoing
IAN11	18/05/2019	Feedback on the Health and Wellbeing Board development session	Board members to look at opportunities for LD/MH employment within their organisations	All Board members	ongoing
IAN12b	18/05/2019	Changing places	Board Chair to write to WMCA around transport infrastructure hubs: where there is a full station refurbishment changing places to be included.	Chair/PH	24/09/2019

IAN12c	18/05/2019	Changing places	Board Chair to write to the Neighbourhoods Directorate to support the implementation of changing places in parks.	Chair/PH	24/09/2019
IAN13a	30/07/2019	Live Healthy Live Happy STP update report	Birmingham and Solihull STP to work with local elected members around awareness raising of ICS & PCNs – what they mean and the implications.	Paul Jennings	26/11/2019
IAN13b	30/07/2019	Live Healthy Live Happy STP update report	The Board raised concern that changes to West Birmingham area could cause destabilisation for the system and the citizen experience Commissioners and providers agreed to meet outside of the meeting and report back to Board on how we get to an integrated system – particular reference to equity of provision for West Birmingham.	Paul Jennings	26/11/2019
	23/04/2019	Special Health and Wellbeing Board meeting	To respond individually to public questions received for the April Special Health and Wellbieng Board meeting	Justin Varney/Stacey Gunther	28/04/2020
IAN12a	18/06/2019	Changing places	Maria Gavin to see whether changing places can be a specific requirement for Commonwealth Games new-builds	Maria Gavin	24/09/2019

	23/04/2020	COMMUNITY CONCERN RE COVID-19 AND HEALTH INEQUALITIES IN BAME COMMUNITIES	Set up a Special Health and Wellbeing Board meeting in response to rising concern within the community of health inequalities being experienced in Black, Asian and Minority Ethnic (BAME) communities due to coronavirus-19.	Errol Wilson	23/04/2020
	24/09/2019	NHS LONG TERM PLAN: BSOL CCG RESPONSE	Set up a Special Health and Wellbeing Board	Errol Wilson	08/10/2019
	24/09/2019	PUBLIC QUESTIONS	Increase activity around the comms for Public Questions by liaising with partners	Stacey Gunther	21/01/2020
	08/09/2020		Letter to Secretary of State to express concerns with regards to the shortfall of flu vaccinations that have been allocated to	Justin Varney	14/09/2020

	24/09/2019	SUICIDE PREVENTION STRATEGY	Suicide Prevention Strategy Action Plan	Mo Phillips	26/11/2019

Date Completed	Outcome/Output	Comments	RAG
27.03.2019	The letter has been sent out to all Board Members on the 27.03.2019	Awaiting information from Dario Silvestro regarding the Support available for employers	
		Item in Matters Arising in the minutes	
27.03.2019	been sent out to all Board Members on the	information from Dario Silvestro regarding the	
30-Apr-19			
30-Apr-19		Charlotte Bailey nominated by the Chair	
30-Jul-19		Item on agenda 30 July	
20/06/2019			

11/09/2019	Closed and to be tasked to the Creating an Active City Sub-Forum	Paul Campbell informed Kyle Stott to include as part of the work of the forum.	
24/09/2019		Incorporated into forward plan	
24/09/2019	Complete	All organisations to confirm at HWBB 24/09/2019	
24/09/2019	Complete	All organisations to confirm at HWBB 24/09/2019	
06/09/2019	Closed and to be tasked to the Creating an Active City Sub-Forum	Paul Campbell informed Kyle Stott to include as part of the work of the forum.	
05/09/2019	Closed and forward plan to include quarterly round table update.	Quarterly updates does not tally with current meeting calendar - scheduled for every second Board for Minicipal Years 2019-20 and 2020-21.	
05/09/2019	Closed and to be tasked to the Creating a City Without Inequalities Sub-Forum	Paul Campbell informed Monika Rozanski to include as part of the work of the forum.	
18/09/2019	Letter sent by Cllr Hamilton		

18/09/2019	Letter sent by Cllr Hamilton		
26/11/2019	Presentation item for Board 26 November 2019.		
26/11/2019	Presentation item for Board 26 November 2019.		
28/04/2020	Closed		
30/12/2019	Closed	issue of changing places with the CWG leads. New facilities fall under the Organising Committee not the Council I believe. She has asked to join the accessibility forum which is just starting – and which considers all aspects of accessibility (e.g. access for people with sensory impairments, LD) as well as some of the physical requirements. So we are flagging the need for this wherever we can. Quite a few of the facilities are temporary rather than new build though, so we are also encouraging organisers to	

23/04/2020	Closed. Meeting took place, with almost 200 public questions submitted		
30/09/2019	Closed. Meeting arranged for 11/11/2019, subsequently cancelled due to Purdah. Presentation item for January 2020 Board		
30/06/2020	Closed	Public Health have committed to tweeting and sharing via Forum networks. A new online form for question submission has been introduced and will be trialed for the July meeting.	
14/09/2020	Closed		

26/11/2019	Updated version provided as part of Forum update.	The Birmingham Suicide Prevention Strategy was adopted by Full Council in January 2020. The Suicide Prevention Working Group has continued to meet through covid to progress the Suicide Prevention Strategy Action Plan; progress of the working group is reported to the Creating a Mentally Healthy City Forum and to the Health and Wellbeing Board.	

Birmingham Health and Wellbeing Board

	Agenda Item: 13
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**27th July 2021**
TITLE:	**HEALTH AND WELLBEING OF VETERANS DEEP DIVE REPORT**
Organisation	**Birmingham City Council**
Presenting Officer	**Luke Heslop – Service Lead for Evidence**

Report Type:	**Information**

1.	**Purpose:**
1.1	To present the Board with the completed Veterans Deep Dive Report. This is one of a series of deep dive reports that provided deeper insight to compliment the Joint Strategic Needs Assessment (JSNA).

2.	**Implications:**	
BHWB Strategy Priorities	Childhood Obesity	N
	Health Inequalities	Y
Joint Strategic Needs Assessment		Y
Creating a Healthy Food City		N
Creating a Mentally Healthy City		Y
Creating an Active City		N
Creating a City without Inequality		Y
Health Protection		N

3.	**Recommendation**
	It is recommended that the Health and Wellbeing Board:
3.1	Approve the publication of the Health and Wellbeing of Veterans Deep Dive.
3.2	Board Members report back to the next Board with actions taken based on the findings in the report, for example the NHS could take active steps to support the Veteran Friendly GP Accreditation Scheme in Birmingham.

4. Report Body

4.1 Context

4.1.1 This is the first JSNA Deep Dive to reach completion and is presented today for comment and approval for publication.

4.1.2 The focus is on Veterans living in Birmingham.

4.1.3 Support to the Armed Forces community has received political impetus over recent years - for example, in the Command Paper 'The Nation's Commitment: Cross-Government Support to our Armed Forces, their Families and Veterans (2008)' and in the Armed Forces Covenant (2011).

4.1.4 These documents highlight that service in the Armed Forces is different to other occupations as serving and veteran personnel (and their families) experience unique factors as a result of their time in service. These include not only the risks of injury or death, but also factors related to Armed Forces' lifestyles, such as frequent moves and the disruption this may bring. The Command Paper seeks to ensure that these circumstances are taken into account in commissioning and delivering services. The Ministry of Defence's Strategy for our Veterans (2018) sets out a 10-year plan to address the needs of veterans.

4.1.5 Key themes and aims of the strategy are set out as follows:

1. Community and relationships: veterans can build healthy relationships and integrate into their communities.

2. Employment, education and skills: veterans enter appropriate employment and can continue to enhance their careers throughout their working lives.

3. Finance and debt: veterans leave the Armed Forces with sufficient financial education: awareness and skills to be financially self-supporting and resilient.

4. Health and wellbeing: all veterans enjoy a state of positive physical and mental health and wellbeing, enabling them to contribute to wider aspects of society.

5. Making a home in civilian society: veterans have a secure place to live either through buying, renting or social housing.

6. Veterans and the law: veterans leave the Armed Forces with the resilience and awareness to remain law-abiding civilians.

4.1.6 Inequalities between veterans and the general population have been observed in the literature, particularly in relation to employment, offending and homelessness. However, the view of the Government is that the issues faced by veterans, particularly poor mental health, are overestimated by the public resulting in a perception that military service is harmful.

4.1.7 This Deep Dive seeks to bring together the multi-agency data and evidence of veterans in Birmingham in relation to the six themes identified above. Its aim is to identify where gaps in information exist and will make recommendations to key front-line agencies for improved data collection in the future.

4.1.8 The Evidence Team have reviewed the available evidence and have determined that most of the key issues influencing Veteran health fall within the following social themes:

- Community and relationships
- Employment
- Education
- Finance and debt
- Health and wellbeing
- Housing
- Criminal justice system

4.1.9 Qualitative interviews and focus groups were commissioned to investigate these themes with local Veterans from Birmingham. The views of Birmingham's Veterans helped inform the key findings of this Deep Dive report, which are summarised below.

4.2 Key Findings

4.2.1 Recommendations are detailed in Chapter 7 of the Deep Dive report against the four key findings.

Key Finding 1

There is currently insufficient data to allow a full understanding of the size and composition of the local veteran population.

Key Finding 2

Some veterans' needs are not being sufficiently met due to structural and cultural differences between the Armed Forces and civilian society.

Key Finding 3

Emerging evidence suggests a greater need for supporting Early Service Leavers, young recruits and female veterans.

Key Finding 4

There are specific barriers that need tackling to connect veterans to resources that can support them in times of need.

4.3 Next Steps / Delivery

4.3.1 The document will be published on the Birmingham Council website and advertised widely amongst stakeholders.

4.3.2	Board members are asked to review the recommended actions set out in Chapter 7 and provide feedback on whether these can be taken forward to be presented, adapted or are not suitable for progression by the next Board meeting.

5.	**Compliance Issues**
5.1	**HWBB Forum Responsibility and Board Update**
5.1.1	The development of the JSNA, both core and deep dives, is managed by the JSNA steering group.

5.2	**Management Responsibility**
	Luke Heslop, Service Lead for Evidence

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Further delay in publication	Low	Low	Any changes/updates will have a high priority in officer's work programmes.
Changes suggested at presentations	Low	Low	Any changes/updates will have a high priority in officer's work programmes.

Appendices

Appendix 1 – The Health and Wellbeing of Armed Forces Veterans Deep Dive

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

Luke Heslop, Service Lead for Evidence.
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The Health and Wellbeing of Veterans in Birmingham

Deep Dive Joint Strategic Needs Assessment

JSNA Topic Champion

Dr Peter Ingham	Deputy Chair of Health and Wellbeing Board	Birmingham and Solihull Clinical Commissioning Group

JSNA Topic Lead

Luke Heslop	Service Lead for Evidence	Birmingham City Council

JSNA Topic Reference Group:

Jeanette Davis	Public Health Officer	Birmingham City Council
Susan Lowe	Service Lead	Birmingham City Council
Zoe Wright	Senior Public Health Officer	Birmingham City Council
Natalie Stewart	Senior Public Health Officer	Birmingham City Council
Bethany Parkes	Public Health Officer	Birmingham City Council
Jenny Bell	Senior Veterans Mental Health Practitioner (West Midlands Region)	NHS Veterans Transition, Intervention and Liaison Service (TILS)
Jackie Roberts	Health and Justice lead	Public Health England
David Fairclough	Advice and Information Team Leader West Midlands	The Royal British Legion
Christie Barber-Lally	Health & Justice Commissioning Support Manager	NHS England
Dr Gunveer Plahe	Public Health Registrar	Public Health England

Other Contributors

Jeanette Williamson, CRC; Johanna Comer, WMP; Karen Saunders, Public Health England; Gaynor Smith, DWP; Mike Davis, BCC Neighbourhood Advice & Information Service; Dr Marion Gibbon, BCC; Dr Mary Orhewere, BCC.

Contents

Executive Summary

This deep dive into the health and wellbeing of Armed Forces veterans in Birmingham is part of a series of Birmingham's enhanced JSNA deep dive reviews. We have examined multi-agency data and evidence relating to veterans in Birmingham to inform the Health and Wellbeing Board of the needs of this group. We have used the term *veteran* based on the Ministry of Defence definition in this deep dive. However, it should be noted that the term ex-service is usually preferred by this group. This and other definitions are discussed in more detail in the Introduction chapter.

The Veterans Strategy (2018) and *Armed Forces Covenant (2011)* reinforce the moral obligation to those who serve or have served in the Armed Forces, their families and the bereaved. Both hold that members of the Armed Forces community should face no disadvantage compared to other citizens in the provision of public and commercial services. Additionally, special consideration is appropriate in some cases, especially for those who have given the most, such as the injured or the bereaved.

In the Opportunities for Action section we have set out the key findings and recommendations as to how local partners can work towards our ambition for Birmingham. These include:

- Improving the capture of data on veterans by local health and care organisations.
- Raising awareness of the *Armed Forces Covenant* and duties for local organisations.
- Sharing best practice across the local area.
- Further work to understand potential high-risk groups.

1. Introduction

1.1. Joint Strategic Needs Assessment (JSNA)

The purpose of a JSNA is to improve the health and wellbeing of the local community and reduce inequalities.[1] The JSNA is not an end in itself but a continuous process of strategic assessment and planning. The aim is to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities. JSNAs are used to determine the actions the local authority, local NHS, and other parties need to take to meet health and social care needs of the local population, and to address the wider determinants that impact on health and wellbeing.

1.2. Why Focus on Armed Forces Veterans?

Support to the Armed Forces community has received political impetus over recent years - for example, in the *Command Paper* '*The Nation's Commitment: Cross-Government Support to our Armed Forces, their Families and Veterans (2008)*' [2] and in the *Armed Forces Covenant (2011)*.[3]

These documents highlight that service in the Armed Forces is different to other occupations as serving and veteran personnel (and their families) experience unique factors as a result of their time in service. These include not only the risks of injury or death, but also factors related to Armed Forces' lifestyles, such as frequent moves and the disruption this may bring. The Command Paper seeks to ensure that these circumstances are taken into account in commissioning and delivering services.

The Ministry of Defence's *Strategy for our Veterans (2018)*[4] sets out a 10 year plan to address the needs of veterans. Key themes and aims of the strategy are set out as follows:

1. Community and relationships: veterans can build healthy relationships and integrate into their communities.
2. Employment, education and skills: veterans enter appropriate employment and can continue to enhance their careers throughout their working lives.
3. Finance and debt: veterans leave the Armed Forces with sufficient financial education: awareness and skills to be financially self-supporting and resilient.
4. Health and wellbeing: all veterans enjoy a state of positive physical and mental health and wellbeing, enabling them to contribute to wider aspects of society.

[1] Local Government and Public Involvement in Health Act (2007) as amended by the Health and Social Care Act (2012). https://www.legislation.gov.uk/ukpga/2007/28/section/221 Accessed 23 April 2021.
[2] Ministry of Defence UK (2008) The Nation's Commitment: Cross-Government Support to our Armed Forces, their Families and Veterans. London. https://www.gov.uk/government/publications/the-nation-s-commitment-cross-government-support-to-our-armed-forces-their-families-and-veterans--2 Accessed 23 April 2021.
[3] Ministry of Defence UK. The Armed Forces Covenant. (2011) London. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/49469/the_armed_forces_covenant.pdf Accessed 23 April 2021.
[4] Ministry of Defence UK, The Strategy for our Veterans (2018) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/755915/Strategy_for_our_Veterans_FINAL_08.11.18_WEB.pdf Accessed 23 April 2021.

5. Making a home in civilian society: veterans have a secure place to live either through buying, renting or social housing.
6. Veterans and the law: veterans leave the Armed Forces with the resilience and awareness to remain law-abiding civilians.

Inequalities between veterans and the general population have been observed, particularly in relation to employment, offending and homelessness. However, the view of the Government is that the issues faced by veterans, particularly poor mental health, are overestimated by the public resulting in a perception that military service is detrimental to the long term health of veterans.[5]

This Deep Dive seeks to bring together the multi-agency data and evidence of veterans in Birmingham in relation to the six themes identified above. Its aim is to identify where gaps in information exist and to make recommendations to key front-line service providers to engage in improved data collection in the future.

1.3. Definitions and Scope

We have used the term *veteran* in this Deep Dive. This decision was backed up by our focus-group participants, most of whom preferred the term *veteran*. However, research also shows that a significant minority of former UK Armed Forces personnel instead prefer to define themselves as *ex-service*.[6] The official definitions are provided below.

Veteran is defined by The Ministry of Defence (MOD) as: "*Anyone who has served for at least one day in Her Majesty's Armed Forces (Regular or Reserve), or Merchant Mariners who have seen duty on legally defined military operations*." Under this definition, veterans are defined as having already left the Armed Forces.[7]

The *Armed Forces Covenant* [8] defines the Armed Forces Community as:

- Regular Personnel - any current serving members of the Naval Service, Army or Royal Air Force;
- Volunteer and Regular Reservists - Royal Naval Reserve, Royal Marine Reserve, Territorial Army and the Royal Auxiliary Air Force, and the Royal Fleet Reserve, Army Reserve and Air Force Reserve, Royal Fleet Auxiliary and Merchant Navy (where they served on a civilian vessel whilst supporting the Armed Forces);
- Veterans - anyone who has served for at least a day in the Armed Forces as either a regular or a reservist;

[5] House of Lords, Veterans Strategy: Background to the Government Policy Debate on 15 November 2018. https://lordslibrary.parliament.uk/research-briefings/lln-2018-0118/ Accessed 23 April 2021.
[6] Burdett et al (2012) ''Are You a Veteran?'' Understanding of the Term ''Veteran'' among UK Ex-Service Personnel. A Research Note. https://www.kcl.ac.uk/kcmhr/publications/assetfiles/veterans/burdett-2012-veterans.pdf Accessed 14 June 2021.
[7] Ministry of Defence UK, The Strategy for our Veterans (2018) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/755915/Strategy_for_our_Veterans_FINAL_08.11.18_WEB.pdf Accessed 23 April 2021.
[8] Ministry of Defence UK. The Armed Forces Covenant. (2011) London. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/49469/the_armed_forces_covenant.pdf Accessed 23 April 2021.

- Families of regular personnel, reservist and veterans - spouses, civil partners and children, and where appropriate can include parents, unmarried partners and other family members;
- Bereaved - the family members of service personnel and veterans who have died, whether that death is connected to their service or not.

Transition is the term used to describe the period of time when personnel leave the Armed Forces to return to civilian life. On joining the Armed Forces, individuals adopt an ethos of selfless service, ready to be moved wherever they are ordered, totally committed to their service and ultimately prepared to give their lives. The national strategies and *Armed Forces Covenant* seek to reinforce the duty that society has to these individuals to ensure that on leaving the military they are integrated successfully into civilian society and suffer no disadvantage as a result of having served. Transition is a holistic experience that can include employment, housing, wellbeing, health, education, children and finances.[9] It is a unique experience for everyone and the length of time involved in this process will depend upon the needs of each service leaver and their families.

Reservists is the term used to describe veterans of volunteer and regular Reserve forces and are a recent consideration. These were added to the definition of veterans in the 2011 Armed Forces Covenant. At the present time there is little evidence available on this group of veterans.

Early Service Leavers (ESL) is a term which describes veterans who leave the Armed Forces either voluntarily before completing an initial four years of service; or compulsorily due to medical or disciplinary reasons. In comparison to other service leavers, ESLs have a higher proportion of younger and female veterans. Research suggests that ESLs are more likely to have served in the Army, to not be in a relationship and to be of lower rank.[10]

Population of interest:
For the purposes of this deep dive, we have focused on veterans of the UK Armed Forces. However, we acknowledge the importance of families and dependents, and have therefore included services for families and the bereaved in our assessment.

There are several reasons why someone may be discharged from the military, including retirement, time expiry, medical, or disciplinary discharge. This deep dive will consider all veterans regardless of the reason for leaving the Armed Forces.

We are aware that there are veterans of foreign forces living in Birmingham. There is little data on this group of veterans, but we have included these in this deep dive where available.

1.4. National Picture of Veterans

Nearly half (47%) of the current UK veterans are aged over 75. These veterans would have served in the Second World War (WW2) and subsequent conflicts (see Figure 1) as conscripts, volunteers and as part of the National Service until 1963. Younger veterans will have served on operational duties at home and abroad including conflicts, peacekeeping

[9] The Army Families Federation. Transition. https://aff.org.uk/advice/family-life/transition/ Accessed 28 June 2021.
[10] Buckman et al (2012), Early Service Leavers: a study of the factors associated with premature separation from the UK Armed Forces and the mental health of those that leave early, European Journal of Public Health. https://pubmed.ncbi.nlm.nih.gov/22539627/ Accessed 23 April 2021.

duties, humanitarian aid, anti-terrorism enforcement and international anti-drug trafficking operations.[11]

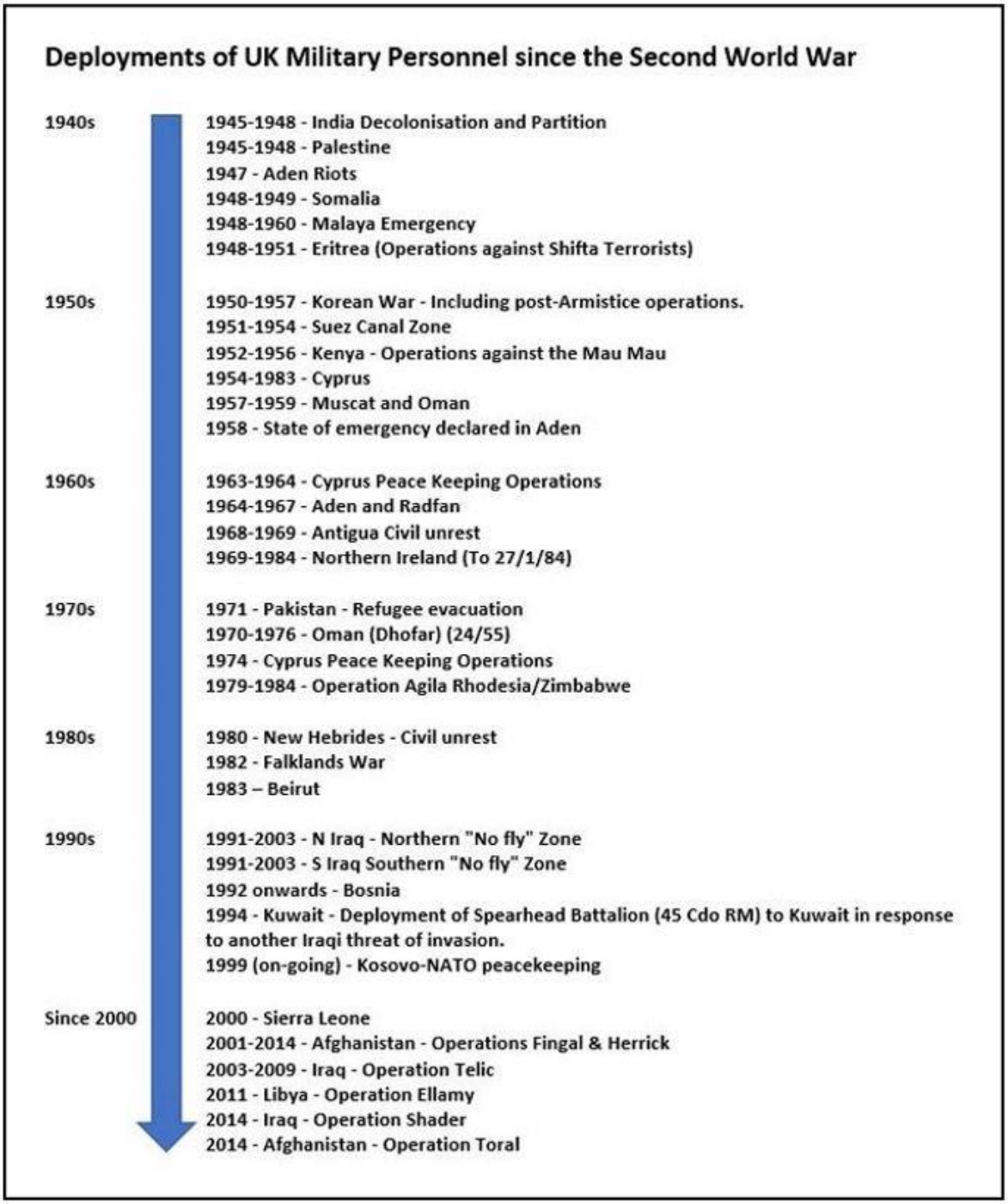

Figure 1: Timeline of the deployments of the UK military personnel since the Second World War. [12]

[11] Annual Population Survey: UK Armed Forces Veterans residing in Great Britain (2017). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774937/20190128_-_APS_2017_Statistical_Bulletin_-_OS.pdf Accessed 23 April 2021.

[12] Britain's Small Wars. http://britains-smallwars.com/deployments Accessed 11th May 2021.

British Armed Forces personnel are presently deployed in sixteen different countries around the world.[13] There are currently 144,650 deployable Armed Forces personnel, many of whom are actively involved in foreign training and peace-keeping operations. Approximately 15,000 trained regulars leave the Armed Forces each year.[14] This can be because they have come to the end of the Armed Service period (time expiry) or because they choose to leave before the end of the Armed Service period (voluntary outflow) or because they are discharged from service.

The average length of service for trained regulars who voluntarily left the Armed Forces[15] between August 2017 and July 2018 was:

- Royal Navy and Royal Marines - 11 years
- Army - 10 years
- Royal Air Force - 15 years

The average age of UK regulars leaving the Armed Forces in 2018 was:

- Royal Navy and Royal Marines - 40 years for officers, 29 years for other ranks
- Army - 41 years for officers, 28 for other ranks
- Royal Air Force - 42 years for officers, 34 for other ranks

1.5. National Strategy and Guidance

The Strategy for our Veterans (2018)[16] sets out the intent for delivery of public services across the UK until 2028. The aim is that "*those who have served in the UK Armed Forces and their families, transition smoothly back into civilian life and contribute fully to a society that understands and values what they have to offer*". This is based upon three principles:

- Veterans are first and foremost civilians and continue to be of benefit to wider society.
- Veterans are encouraged and enabled to maximise their potential as civilians.
- Veterans can access support that meets their needs when necessary, through public and voluntary sectors.

The Armed Forces Covenant (2011)[17] was the re-branding of the earlier Covenant that was introduced in 2000. It is an informal understanding of the mutual obligations between the

[13] The British Army: Operations and Deployments. https://www.army.mod.uk/deployments/ Accessed 7 May 2021.
[14] Ministry of Defence, UK armed forces biannual diversity statistics: 2019 Online. https://www.gov.uk/government/statistics/uk-armed-forces-biannual-diversity-statistics-2019 Accessed 23 April 2021.
[15] Ministry of Defence. Quarterly service personnel statistics: 2018. https://www.gov.uk/government/statistics/quarterly-service-personnel-statistics-2018 Accessed 23 April 2021.
[16] Ministry of Defence UK, The Strategy for our Veterans (2018). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/755915/Strategy_for_our_Veterans_FINAL_08.11.18_WEB.pdf Accessed 23 April 2021.
[17] Ministry of Defence UK. The Armed Forces Covenant. (2011) London. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/49469/the_armed_forces_covenant.pdf Accessed 23 April 2021.

nation and the Armed Forces which encapsulates the moral obligation to those who serve or have formerly served, as well as their families and the bereaved.

The Covenant's twin underlying principles are:

- Members of the Armed Forces community should face no disadvantage compared to other citizens in the provision of public and commercial services.
- Special consideration is appropriate in some cases, especially for those who have given the most such as the injured or the bereaved.

Communities, businesses, and charitable organisations can sign the Covenant and pledge their support to the Armed Forces community. A *Covenant Fund* [18] is available to support projects in line with the Covenant's principles, which can provide small grants for community integration projects and larger grants for more strategic work.

1.6. Birmingham's Strategies and Plans

Community Covenant

Birmingham's Armed Forces Community Covenant [19] was signed in 2012 by the Armed Forces, Birmingham City Council and Birmingham Voluntary Service Council. There are four principles:

- Voluntary statement of mutual support between the civilian community and local Armed Forces community.
- Encourage support, recognise and remember sacrifices made by this Armed Forces community, including in-Service and ex-Service personnel, their families and widow(er)s.
- Provide help and advice to members of the Armed Forces community and build upon existing good work.
- Encourage the integration of service life into civilian life and encourage members of the Armed Forces community to help their local community.

Birmingham has an Armed Forces Covenant Steering Group which meets quarterly and is chaired by the city's Armed Forces Ambassador - Councillor Mike Sharpe BEM (British Empire Medal).

West Midlands Combined Authority

In February 2020, The West Midlands Combined Authority (WMCA) brought together local authorities, homeless charities and Armed Forces organisations and charities to highlight how they can work together to find the best ways to help veterans who don't have permanent homes. This included the release of the *Designing out Veterans' Homelessness Report* which examines the homelessness and housing needs of veterans."

[18] The Armed Forces Covenant Fund Trust. https://covenantfund.org.uk/ Accessed 7 May 2021.
[19] Birmingham City Council, Birmingham Armed Forces Community Covenant. https://www.birmingham.gov.uk/info/50066/moving_to_birmingham/1000/armed_forces_community_covenant Accessed 23 April 2021.

The West Midlands Homelessness Task Force is working with local organisations and councils to ensure that veterans who are homeless, or at risk of homelessness are supported to access the services that will help them to achieve their full potential.[20]

2. Veteran Population in Birmingham

[20] The Best of Birmingham: Calls for Collaboration to Support West Midlands Homeless Veterans. https://www.thebestof.co.uk/local/birmingham/community-hub/blog/view/calls-for-collaboration-to-support-west-midlands-homeless-veterans/ Accessed 11 May 2021.

Birmingham is the largest unitary local authority in Europe and the UK's second city, home to an estimated current population of 1,137,123.[21] According to the *2011 Census*, Birmingham has a younger population than most UK local authorities. The population is more ethnically diverse than the country as a whole and Birmingham also has levels of deprivation that are above the national average.[22]

Birmingham is not a garrison town so there are no barracks housing permanent troops. The Army has Reserve centres in Sparkbrook, Kings Heath, Sheldon and Harborne.[23] The Royal Navy has a Reserve Unit, HMS Forward, located near Birmingham City football ground.[24] There is also a careers office for the Royal Navy, Army and RAF which carries out Armed Forces recruitment in the city centre.

It is not currently possible to determine a robust estimate of the number of veterans in Birmingham because veteran identification is not always asked in service delivery. Furthermore, younger veterans do not always identify as being a veteran, often preferring the term ex-service man or woman. In the absence of reliable routine data, we have used national data to create estimates for the Birmingham population. Nationally, this data provides a good picture of the overall veteran population. However, Birmingham's demographics vary significantly from the national average due to its large ethnic minority population and also having one of the youngest populations in Europe.[25] As a result, this data is less representative of Birmingham and therefore provides us with a less robust estimate.

The following demographic analysis is based on the *2017 MOD Annual Population Survey (APS)*.[26] The Royal British Legion produced a report in 2014, [27] which estimated 10% of the adult population had served in the Armed Forces. It was estimated that in 2016 there were approximately 2.5 million veterans residing in Great Britain, this is projected to decrease year-on-year to 1.6 million by 2028. In 2016, the veteran population represented 5% of household residents aged over 16, this is projected to decrease to 2-3% by 2028. Further

[21] Office for National Statistics, 2017 mid-year population estimates. https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland Accessed 23 April 2021.
[22] MHCLG Indices of Deprivation (2019). https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019 Accessed 23 April 2021.
[23] British Army Jobs, Reserve units in the Midlands, online. https://apply.army.mod.uk/what-we-offer/army-reserve-centres Accessed 20 April 2021.
[24] Royal Navy, HMS Forward. https://www.royalnavy.mod.uk/forward Accessed 20 April 2021.
[25] Census 2011 data finder. https://www.nomisweb.co.uk/census/2011/data_finder Accessed 20 April 2021.
[26] Ministry of Defence UK, Annual population survey: UK armed forces veterans residing in Great Britain (2017). https://www.gov.uk/government/statistics/annual-population-survey-uk-armed-forces-veterans-residing-in-great-britain-2017?utm_source=a55d37ca-8bfa-435a-ab1d-66cf875f2a4c&utm_medium=email&utm_campaign=govuk-notifications&utm_content=immediate Accessed 23 April 2021.
[27] https://www.britishlegion.org.uk/get-involved/things-to-do/campaigns-policy-and-research/policy-and-research/research-and-reports Accessed 23 April 2021.

clarity on the number of veterans in Birmingham is expected from the 2021 Census, which for the first time will include a question about military service.[28]

2.1. Estimated Veteran Population

Due to a lack of current published data, the *2017 MOD Annual Population Survey (APS)* West Midlands region level data has been applied to the most recent Birmingham population data [29] to estimate the potential size of the city's veteran population. In the West Midlands region, veterans account for 8% of 16 to 64 year olds and 9.2% of those aged over 65. Applying these percentages to the Birmingham population gives an estimated veteran population of 31,866 (2.8% of the total population). Improved data collection and reporting would enable a more accurate estimate.

2.2. Gender

In Birmingham, the general population gender split is 51% female and 49% male. Nationally, males account for 89% of the veteran population. Applying this to the Birmingham population would suggest that the city has approximately 28,350 male veterans and 3,500 female veterans.

According to a 2012 study, Early Service Leavers (ESL) are more likely to be female than male.[30] Nationally, the percentage of female members of the Armed Forces had increased from 9.7% in 2012 to 10.6% in 2019.[31]

2.3. Age

The population pyramid below uses the national figures applied to the Birmingham population of veterans to show a comparison between the estimated veteran population and the local population. Nearly half of veterans (49%) are estimated as aged 75 and over and this cohort would have served in WW2 or been conscripted in National Service.[32]

[28] Office for National Statistics. Armed forces community (veterans) question development on the armed forces veterans' community. https://www.ons.gov.uk/census/censustransformationprogramme/questiondevelopment/armedforcescommunityveteransquestiondevelopmentforcensus2021 Accessed 15 June 2021.
[29] Office for National Statistics, 2017 mid-year population estimates. https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates Accessed 23 April 2021.
[30] Buckman et al (2012), Early Service Leavers: a study of the factors associated with premature separation from the UK Armed Forces and the mental health of those that leave early, European Journal of Public Health. https://pubmed.ncbi.nlm.nih.gov/22539627/ Accessed 23 April 2021.
[31] Ministry of Defence, UK armed forces biannual diversity statistics: 2019. https://www.gov.uk/government/statistics/uk-armed-forces-biannual-diversity-statistics-2019 Accessed 23 April 2021.
[32] In house calculations based on ONS Annual Population Survey 2017 data and applied to Birmingham demographics.

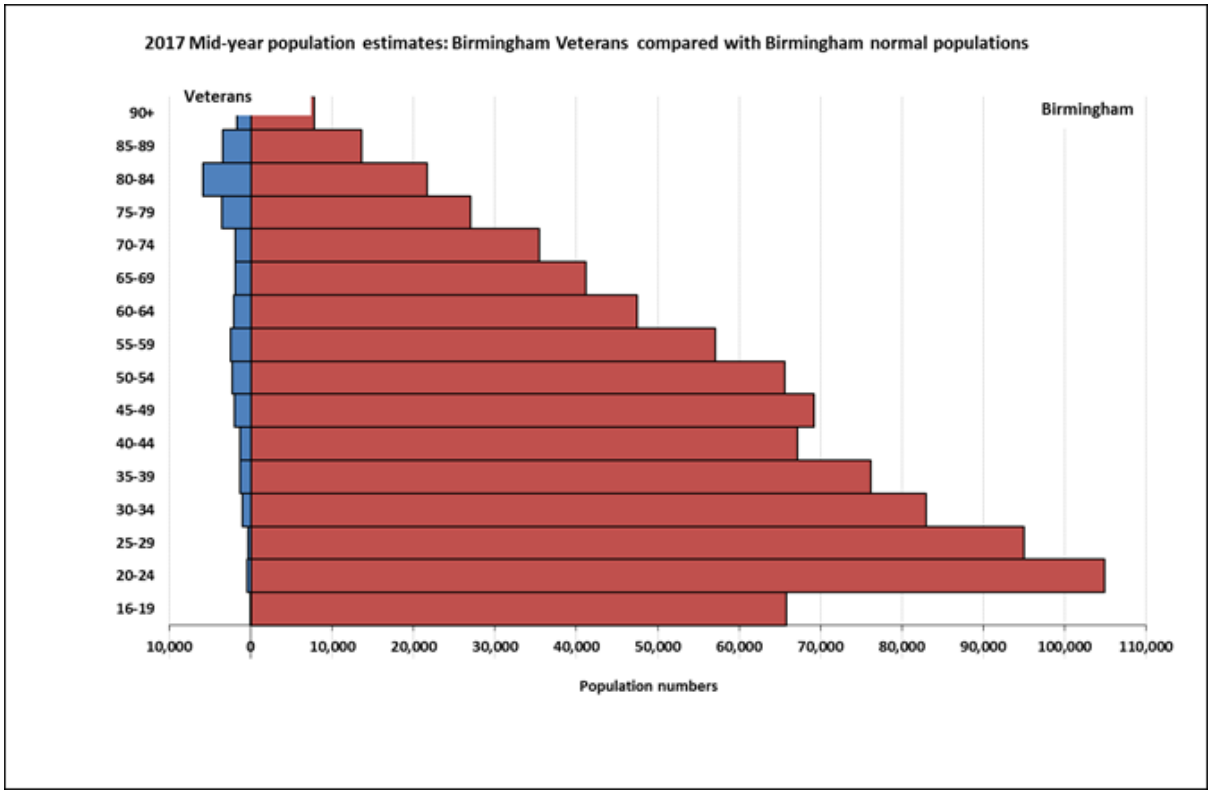

Figure 2: Veteran Age Ranges compared to Birmingham Population (Source: APS 2017)

The age profile of veterans is very different to the non-veteran population in Birmingham as 40% of the city's population is aged under 25 years.[33] Therefore, this data may not provide us with a robust estimate of the number of younger veterans in the area.

The term ex-service is preferred particularly by the younger generation who often view the term "veteran" as relating to older ex-service personnel. This may mean that they may not identify or record themselves as veterans in surveys that use this terminology. To better reflect the younger veterans in the city who identify as ex-service men and women, changes could be made to the wording of questionnaires which may improve the recordings of age estimates.

2.4. Ethnicity

Birmingham's residents represent a diverse range of national, ethnic and religious backgrounds. According to the *2011 Census*, the largest ethnic group in Birmingham was White British (53.1%), which was reduced from 65.6% in 2001 and is substantially lower than the 80.5% average in England. Other large ethnic groups within the city are Pakistani (13.5%) and Indian (6%).[34]

[33] Internal analysis based on Birmingham Census 2011 populations by age and ethnicity downloaded in November 2012 via https://www.nomisweb.co.uk/query/construct/summary.asp?reset=yes&mode=construct&dataset=801&version=0&anal=1&initsel= Accessed 26 April 2021.
[34] Office for National Statistics 2011 UK Census. https://www.nomisweb.co.uk/census/2011/data_finder Accessed 23 April 2021.

In the national survey, 99% of veterans were from a White ethnic background.[35] Applying this to the Birmingham population an estimated 31,500 veterans of White ethnicity and 300 from ethnic minorities. However, these estimates are very different to the non-veteran population in the city and with no local data sources, it is not possible to further confirm this estimate. Whilst local data indicates that the veteran ethnic minority population in Birmingham is larger than the estimate suggests, the older age groups, within which many veterans are found, has a higher proportion of White ethnicity compared to the younger age groups in the city.

Birmingham has a long tradition of welcoming immigrants. These include Irish and Jewish migrants during the 18th and 19th centuries; post-war immigration from Commonwealth countries; refugees fleeing conflict from Somalia, Iraq and Afghanistan in the 1990s and 2000s; and more recent migration from EU member states such as Romania and Poland. According to the *2011 Census*, 22% (238,313) of Birmingham residents were born outside the UK (almost double the England average of 13%), and 9.6% (106,272) of residents had arrived in the UK since 2001. It is likely that some immigrants will have served in the armed services of their countries of origin. Local police custody data [36] confirms that this is the case. However, there is no data to estimate their numbers in Birmingham.

2.5. Projected Population Changes

In 2016, the national veteran population represented 5% of household residents aged over 16; this is projected to decrease to 2-3% by 2028.[37] The percentage of working age veterans is projected to increase from 37% in 2016 to 44% by 2028. The percentage of female veterans is also projected to increase from 10% in 2016 to 13% by 2028.[38]

3. Health and Wellbeing Needs of Veterans

This evidence review focuses upon the main impacts that being a veteran has on health and wellbeing and explores the factors that make veterans more at risk than the general population. These factors include the wider determinants of health.

[35] Ministry of Defence, UK armed forces biannual diversity statistics: 2019. https://www.gov.uk/government/statistics/uk-armed-forces-biannual-diversity-statistics-2019 Accessed 23 April 2021.
[36] Custody data received from West Midlands Police, August 2019.
[37] Ministry of Defence UK, Population Projections: UK Armed Forces Veterans residing in Great Britain, 2016-2018 (published 2019). https://www.gov.uk/government/publications/population-projections-uk-armed-forces-veterans-residing-in-great-britain-2016-to-2028 Accessed 23 April 2021.
[38] Ministry of Defence UK, Population Projections: UK Armed Forces Veterans residing in Great Britain, 2016-2018 (published 2019). https://www.gov.uk/government/publications/population-projections-uk-armed-forces-veterans-residing-in-great-britain-2016-to-2028 Accessed 23 April 2021.

As mentioned previously, there are issues surrounding the availability and reliability of veteran data. At present, there is no single reliable data source of veterans in Birmingham and research is often based on best estimates from survey data. There is no reliable evidence either as to the long-term physical effect of military service. MOD reviews of veterans suggest personnel are likely to suffer the same range of health and welfare issues as the general population and most are generally robust people who do make a successful transition to civilian life, although a small percentage struggle.[39] This veteran minority can experience complex mental and physical issues that are often compounded by wider determinants of health such as social isolation, crime, housing and income.

This review is set out into sections that relate to the *National Veterans' Strategy key themes*.

3.1. Community and Relationships

Research tells us that social interactions and community connections bring value to our lives and the lack of them can affect a person's quality of life.[40] Life transitions such as leaving the Armed Forces can leave a person more vulnerable to experiencing loneliness than others. However, evidence regarding loneliness and social isolation amongst veterans is limited.

In 2018, the House of Commons Defence Committee published the first report of its *Inquiry on Mental Health and the Armed Forces*. A key finding of this report was that the sense of community within the Armed Forces may improve mental health or delay the onset of mental health conditions. This positive effect can be lasting, but the potential loss of support and community when personnel leave the Armed Forces may mean that, for some, military service will have only delayed the onset of mental health issues. UK Government statistics report only those who seek help and may therefore be significantly underestimating how many serving personnel and veterans have mental health conditions. Current research suggests that the number of veterans with mental health conditions that require professional help could be up to three times higher than official statistics, at around 10%.[41]

A 2018 survey of the Armed Forces community found that one in four veterans reported that they feel lonely and socially isolated 'always' or 'often'.[42] An earlier survey [43] found that more than three in ten veterans have just one or no close friends, and more than half admitted that they would be unlikely to discuss any feelings of loneliness.

Focus group findings (see Section 5) support this, with many participants experiencing social isolation in the first year of their transition without the military's strong social network. Some participants reported feeling that their families don't understand what they've been through

[39] NHS Advancing Quality Alliance, North West Military Veterans Mental Health Mapping Project, (2012). https://archive.vsnw.org.uk/static/files/MVreport(6)pg2012.pdf Accessed 23 April 2021.
[40] Ministry of Defence UK, The Strategy for our Veterans (2018). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/755915/Strategy_for_our_Veterans_FINAL_08.11.18_WEB.pdf Accessed 23 April 2021.
[41] House of Commons Defence Committee, Mental Health and the Armed Forces, Part One: The Scale of Mental Health Issues, (July 2018), HC 813 of session 2017-19. https://publications.parliament.uk/pa/cm201719/cmselect/cmdfence/1635/1635.pdf Accessed 20 April 2021.
[42] Royal British Legion, Loneliness and Isolation in the Armed Forces Community, (2018). https://www.britishlegion.org.uk/get-involved/things-to-do/campaigns-policy-and-research/campaigns/loneliness-and-social-isolation Accessed 23 April 2021.
[43] SSAFA, 41 per cent of veterans have felt isolated, research reveals, (23 October 2017). https://www.cobseo.org.uk/41-veterans-felt-isolated-research-reveals/ Accessed 23 April 2021.

and are unable to relate to their experiences. Participants suggested that the military sense of pride often stops people from asking for help and that transition could be improved with the introduction of a support network and timely access to advice and information during the early transition stages.

The *Armed Forces Covenant* addresses the transition to civilian life and recommends a range of services that should be provided to leaving personnel. However, ESLs often receive little specific resettlement provision compared to those with a planned discharge.[44] For example, medically discharged individuals will be offered transition services but may not be able to attend because of their treatment.

Focus group participants (Section 5) believe the disparity in resettlement provision is a factor in how well those leaving the military transition to civilian life. They think that transition support has improved overall but more could still be done.

Military associations exist for those who wish to retain a link to their service. However, recent surveys suggest that these associations do not always provide local integration or the sense of community that is sought.[45]

3.2. Employment

Stable and fulfilling employment is essential for any individual's health and wellbeing.[46] Those who have served in the Armed Forces demonstrate a level of motivation and determination that is valued in civilian employment.[47] Support with civilian employment is offered to veterans through the Career Transition Partnership (CTP), which is provided by Right Management Ltd and contracted by the MOD.

Data from the employment section of the *Annual Population Survey* [48] suggests that there is no difference in proportion between those employed in the working age veteran population compared to the non-veteran population. However, veterans are more likely to be employed in public service (e.g. the prison service, NHS, fire service and MOD), with 12% of veterans compared to 6% of non-veterans employed within this sector.

Those in the veteran focus groups (Section 5) who had specific trade skills, which could apply to areas such as the NHS, said they found it easier to gain employment than those who didn't. Many others struggled to have their skillset understood or valued outside the

[44] Howard League for Penal Reform, Report of the Inquiry Into Former Armed Service. https://howardleague.org/publications/report-of-the-inquiry-into-former-armed-service-personnel-in-prison-2/ Accessed 20 April 2021.
[45] Ministry of Defence, The Strategy for our Veterans (2018). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/755915/Strategy_for_our_Veterans_FINAL_08.11.18_WEB.pdf Accessed 20 April 2021
[46] Norström, F., Waenerlund, A., Lindholm, L. et al. Does unemployment contribute to poorer health-related quality of life among Swedish adults? BMC Public Health 19, 457 (2019) doi:10.1186/s12889-019-6825-y. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-6825-y Accessed 23 April 2021.
[47] HM Government, The Strategy for Our Veterans, (2018).
[48] Ministry of Defence. Annual Population Survey: UK Armed Forces Veterans residing in Great Britain (2017). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774937/20190128_-_APS_2017_Statistical_Bulletin_-_OS.pdf Accessed 23 April 2021.

military and faced barriers to employment. Even when they secured positions, there was culture shock at the different style of communication in civilian life.

The MOD reported differences in employment levels of those who used a CTP service:[49]

- Army leavers were more likely to be unemployed (10%) compared to RAF and naval service leavers (7% each).
- Black, Asian and other ethnic minority leaders were more likely to be unemployed (21%) than White service leavers (8%).
- Those who were medically discharged were less likely to be employed (73%) than those not medically discharged (84%). However, this group may not have had the goal of achieving employment immediately on leaving service.

As previously mentioned, the reliability of this data should be viewed with caution. The Royal British Legion (RBL) have estimated lower employment rates than those in the MOD statistics.[50] This report also highlighted worse outcomes for veterans from ethnic minorities, female veterans, disabled veterans and ESLs.

The way in which veterans approach seeking employment differs to the general population. Figure 3 shows the methods adopted by veterans to access employment compared to non-veterans. Veterans are more likely to use newspapers and journals to find work and are far less likely (less than 5%) to use a Jobcentre than the non-veteran population. The survey data should be viewed with caution, but these differences have been noted in anecdotal evidence from professionals working with veterans in Birmingham.

[49] Ministry of Defence, Career Transition Partnership Annual Statistics: UK Regular Service Personnel Employment – 1 April 2012 to 31 March 2017, (January 2018), pp2-3. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774784/20181203_-_CTP_Bulletin.pdf Accessed 20 April 2021.
[50] Royal British Legion, Deployment to Employment, (2016). https://www.britishlegion.org.uk/docs/default-source/campaigns-policy-and-research/deployment-to-employment.pdf Accessed 20 April 2021.

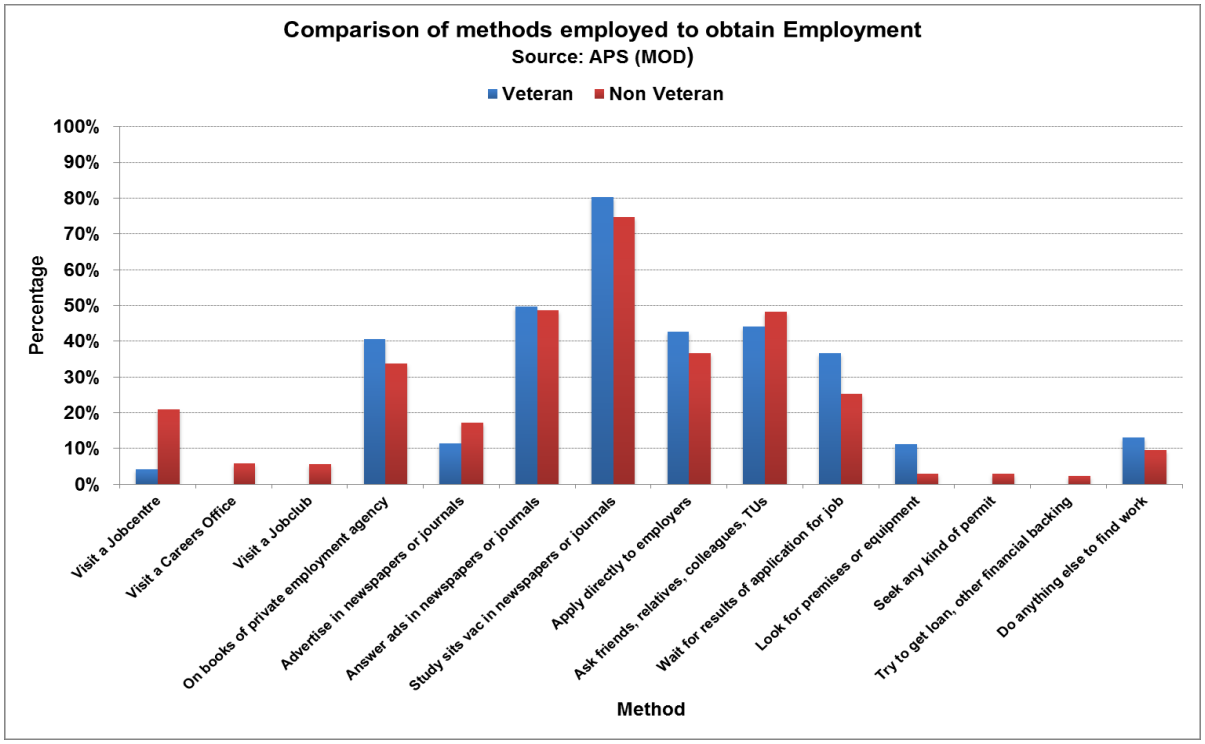

Figure 3: Employment seeking methods. (Source: APS 2017)

Military service is a unique experience and it can be difficult to translate experiences to civilian employment. Some employers have a limited understanding of the skills that veterans can offer meaning that employment options may be restricted to stereotypical roles. Many focus group participants (Section 5) echoed this experience and want dedicated support to help show the value of their skills to companies, and to help combat stigma.

3.3. Education

There is no significant difference between working age veterans and non-veterans who have a qualification (92% and 89% respectively).[51] However, veterans are less likely to have a degree than non-veterans (21% veterans, 30% non-veterans) and are more likely to gain their qualifications through work (60% veterans, 43% non-veterans). The MOD states that this is to be expected as a large proportion of personnel join aged 16-19 years. An RBL report found that lower levels of qualifications can act as a barrier to employment when veterans return to civilian life.[52]

This RBL report called for action to reduce the employment gap and made recommendations to improve the situation. These included: more accurate data on long-term sustainability of jobs; analysis of the disadvantaged sub-groups; improving existing services including

[51] Ministry of Defence. Annual Population Survey: UK Armed Forces Veterans residing in Great Britain (2017). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774937/20190128_-_APS_2017_Statistical_Bulletin_-_OS.pdf Accessed 23 April 2021.
[52] Royal British Legion, Deployment to Employment (2016), pp12-19. https://www.britishlegion.org.uk/docs/default-source/campaigns-policy-and-research/deployment-to-employment.pdf Accessed 20 April 2021.

corporate pledges to the Covenant; and more work to ensure education, training, skills and qualifications gained by service personnel can be translated into civilian employment.

Focus group participants emphasised that there should be training appropriate to the individual that helps with gaining long-term opportunities, i.e. taking into account physical ability when offering training for particular career paths such as plumbing or construction. Career support for military wives was deemed important, too.

3.4. Finance and Debt

The Veterans' Gateway [53] support service reports that finance is continually in the top three areas of need that they are contacted for support.[54] Members of the Armed Forces community can encounter many of the same financial issues as the general population, for non-service related reasons. However, military life, which often starts in very early adulthood, can leave veterans unprepared for balancing the financial demands of civilian life. For serving personnel, especially those living in service housing, many costs are subsidised and may be taken directly from salary, meaning that some people can be unaware and unprepared for the full costs of civilian life. This includes charges for dental treatment, housing repairs or council tax, housing costs (from net rather than gross income) and commuting costs. Veterans can also face disadvantage due to having served in multiple locations, affecting their credit scores.

Focus group findings (Section 5) corroborate that finance is a major issue for veterans and how the lack of experience for the costs of civilian life can lead to substantial financial difficulties. This can have a significant impact on the veterans, their families, their mental health and even lead to homelessness. Others cannot cope and seek unhealthy outlets, such as drinking or gambling.

Central data and evidence for financial hardship and debt are not currently available. Instead, reports by Armed Forces charities who provide support to veterans have relevant findings on the topic. Financial hardship is a near-universal concern for the veterans helped by the Soldiers, Sailors, Airmen, and Families Association (SSAFA). The *SSAFA Voices of Veterans Survey* found that 86% of veterans reported that they face financial challenges, defined as: a problem paying the bills; budgeting and managing finances; dealing with debt; or getting the right benefits.[55] 35% of the survey respondents saw debt as their biggest challenge in civilian life.[39] The average annual net household income of the SSAFA veterans

[53] Veterans' Gateway. https://www.veteransgateway.org.uk/ Accessed 20 April 2021.
[54] The Armed Forces Covenant Fund Trust. Annual report of the usage of the Veterans' Gateway online and mobile directory of services. https://covenantfund.org.uk/wp-content/uploads/2021/02/2020_Veterans-Gateway-Usage-Report.pdf Accessed 20 April 2021
[55] SSAFA The New Frontline: Voices of Veterans in Need (2016). https://www.ssafa.org.uk/media/h2chojc0/the-new-frontline-ssafa-research-report.pdf Accessed 20 April 2021.

was only £13,800[56], compared with £28,200 for all working-age and £31,000 earned by the average family with two children in the general population.[57]

3.5. Health and Wellbeing

General health of veterans

Figure 4 illustrates that the main health issues affecting Birmingham veterans relate to back or neck injuries, followed by cardio-vascular problems and conditions relating to the legs or feet.

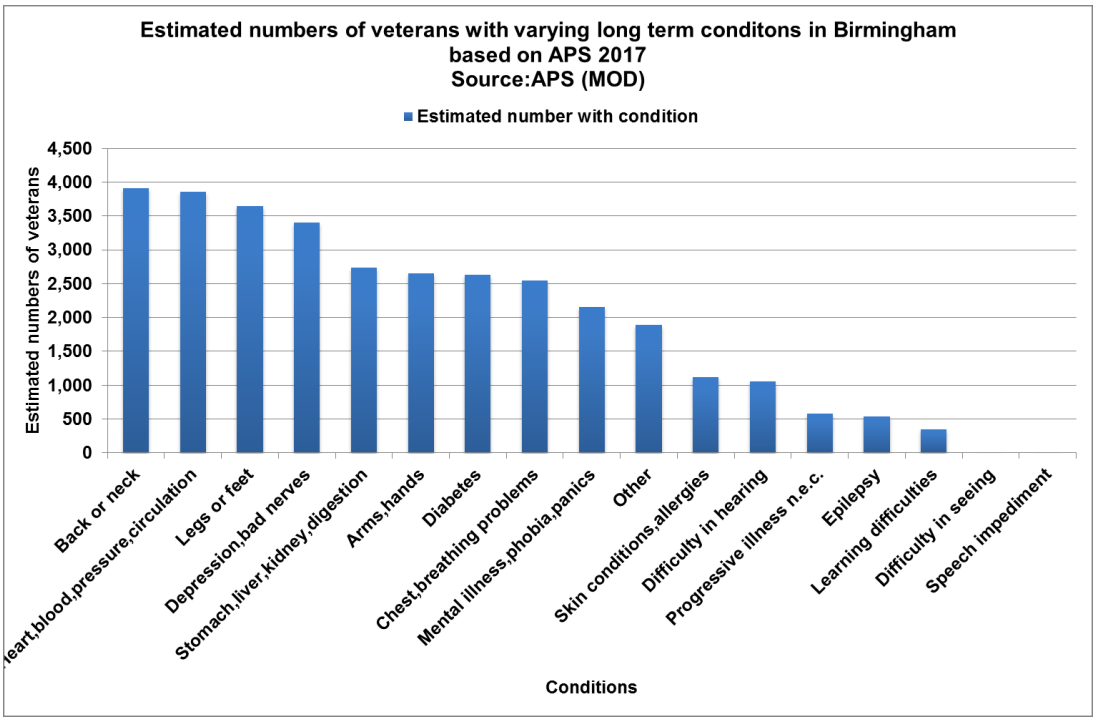

Figure 4: Long term conditions for veterans. (Source: Annual Population Study 2017)

Veterans often experience physical health problems in later life. However, lack of follow-up data means that it can be unclear whether these problems are due to military service or are a feature of the ageing process. Another confounding factor is that Armed Forces recruitment is disproportionately drawn from individuals with deprived backgrounds and poor educational achievement; [58] factors which are each independently associated with poorer health and lower life expectancy. Furthermore, veterans often show reluctance to seek medical help for health problems, leading to under-reporting of veteran health conditions.

[56] A UK Household Survey of the Ex-Service Community in 2014: Royal British Legion (November 2014). https://www.britishlegion.org.uk/get-involved/things-to-do/campaigns-policy-and-research/policy-and-research/the-uk-ex-service-community-a-household-survey Accessed 23 April 2021.

[57] Living Standards: Recent Trends and Future Challenges by Jonathan Gibb, Andrew Hood and Robert Joyce published by The Institute for Fiscal Studies (March 2015). https://www.ifs.org.uk/publications/7615 Accessed 20 April 2021.

[58] CRIN. Conscription by poverty? Deprivation and army recruitment in the UK. (2019). https://home.crin.org/evidence/research/british-army-recruitment-and-deprivation-report Accessed 20 April 2021.

Studies have reported that this is due to a sense of self-sufficiency instilled by the Armed Forces and a need to feel and be seen as 'tough'. [59]

The *2014 Household Survey* by the Royal British Legion (RBL)[60] identified that a quarter (24%) of working age veterans reported a long-term condition compared to 13% of the non-veteran population. The RBL survey identified a higher proportion of veterans reporting with long-term health conditions, including depression, back problems, arms, legs, feet, and sight problems.

It is widely believed that military service is a positive intervention for individuals that can lead to good health in later life, due to the healthy lifestyles that are promoted through training and the high levels of physical exercise experienced during military service. However, some of the more physically demanding activities involving the Armed Forces (e.g. parachuting, marching exercises) have been known to lead to chronic arthritis and musculoskeletal health complaints in old age. Lack of protective equipment has also been associated with some of the long-term health conditions for veterans. Hearing loss as a result of repeated unprotected exposure to loud noises in engine rooms and shooting ranges is a common complaint. Elevated risk of skin cancer is also observed in Armed Forces veterans, believed to be the result of having no sun protection during training exercises or deployment.[61]

Veteran health can often be affected by adverse experiences on the battlefield. Common battlefield injuries can include life-changing damage to eyesight, limbs and the spine. Combat stress is also a significant psychological consequence of the toxicity of warfare, which can affect many veterans, leading to long-term disorders including depression, somatic or sexual dysfunctions, guilt, somatic complaints, addiction[62], distress, alienation, sleep disturbance and aggressive behaviour.[63]

Although the military is considered to be a stressful occupation, there are remarkably few studies that compare the prevalence of common mental disorders between the military and the general population.[64] Mental health was a major concern in the veteran focus groups (Section 5), particularly around PTSD (Post Traumatic Stress Disorder), and addictive behaviours, such as alcoholism and gambling addiction. PTSD is more severe and longer lasting than combat stress and requires working with a mental health professional.[65] Recent research suggests that 6% of current and ex-service military personnel suffered from PTSD

[59] Williamson V., Harwood H. et al. Impact of military service on physical health later in life. https://bmjopen.bmj.com/content/9/7/e028189 Accessed 14 May 2021.
[60] Royal British Legion, UK Ex-service Community: A Household Survey, (2014). https://www.britishlegion.org.uk/get-involved/things-to-do/campaigns-policy-and-research/policy-and-research/the-uk-ex-service-community-a-household-survey Accessed 20 April 2021.
[61] Williamson V., Harwood H. et al. Impact of military service on physical health later in life. https://bmjopen.bmj.com/content/9/7/e028189 Accessed 14 May 2021.
[62] Ustinova Y., et al. Combat stress disorders and the treatment in ancient Greece. https://www.researchgate.net/publication/269035855_Combat_Stress_Disorders_and_Their_Treatment_in_Ancient_Greece/link/55cc39b608aebc967dfe1f1a/download Accessed 14 May 2021.
[63] Reisman, M. PTSD Treatment for Veterans: What's working, what's new, and what's next. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5047000/ Accessed 14 May 2021.
[64] Goodwin, et al, Are common mental disorders more prevalent in the UK serving military compared to the general working population. https://pubmed.ncbi.nlm.nih.gov/25602942/ Accessed 14 June 2021.
[65] U.S. Department of Defense - Military OneSource. Understanding and Dealing with Combat Stress and PTSD. https://www.militaryonesource.mil/health-wellness/wounded-warriors/ptsd-and-traumatic-brain-injury/understanding-and-dealing-with-combat-stress-and-ptsd/ Accessed 18 May 2021.

in 2014/16.[66] A theme across the focus groups (Section 5) was that being on tour, in wars, and seeing action on the frontline, had a major impact on mental health, and could potentially affect anyone. Focus groups recommended that better understanding and early recognition of PTSD is needed in health care services for veterans.

Veteran mortality data has not been routinely captured by the UK Government in the past. Instead, in accordance with their *Strategy for Veterans*, the Ministry of Defence have commissioned studies into the mortality rates of veterans of the Falklands War (1982) and Gulf Conflict (1990-91) and found no evidence that veterans were more likely to take their own lives, when compared to the wider population. Another study focusing on suicide rates for personnel deployed to the Iraq and Afghanistan conflicts (2001-14) has been commissioned more recently and was subsequently extended to ongoing by the Secretary of State for Defence.[67] However, there are contrary reports (both here and abroad) that raise concerns that veteran suicide rates could exceed that of the wider population[68] [69], and that certain veteran groups in particular, including female veterans, younger veterans, and those who have recently been discharged, have an increased risk.[70]

Despite this, the Government has continued to dismiss public calls to gain clarity on the subject by collecting routine data (i.e. instructing Coroners to record veteran status on death certificates).[71] The recent addition of a military service question to the 2021 Census may prove helpful in providing cross-sectional data on veteran numbers in communities. However, this will not extend to providing clarity on outcome measures for UK veterans.[72]

Healthy behaviours

Smoking is one of the biggest causes of death and illness in the UK. Every year around 78,000 people in the UK die from smoking, with many more living with debilitating smoking-

[66] Stevelink, et al, Mental Health Outcomes at the end of the British involvement in the Iraq and Afghanistan conflicts: a cohort study. https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/mental-health-outcomes-at-the-end-of-the-british-involvement-in-the-iraq-and-afghanistan-conflicts-a-cohort-study/E77CCC4B6D0B2A3B6A481C0980D29E93 Accessed 15 June 2021

[67] UK Government Ministry of Defense website. https://www.gov.uk/government/news/new-study-into-iraq-and-afghanistan-veterans-launched Accessed 15/6/2021

[68] UK Independent. MOD confirms more British soldiers commit suicide than are killed in battle https://www.independent.co.uk/news/uk/home-news/mod-confirms-more-british-soldiers-commit-suicide-are-killed-battle-8707958.html Accessed 14 June 2021

[69] Kaplan, et al. Suicide among male veterans: a prospective population-based study, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2465754/ Accessed 14 June 2021.

[70] Kapur, et al. Suicide after Leaving the UK Armed Forces – A Cohort Study. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2650723/ Accessed 16 June 2021.

[71] UK Government and Parliament Petitions – Coroners must be lawfully obligated to statistically record veteran suicides. https://petition.parliament.uk/petitions/300055?reveal_response=yes Accessed 14 June 2021.

[72] Office for National Statistics. Armed forces community (veterans) question development on the armed forces veterans' community. https://www.ons.gov.uk/census/censustransformationprogramme/questiondevelopment/armedforcescommunityveteransquestiondevelopmentforcensus2021 Accessed 15 June 2021.

related illnesses.[73] Historically, smoking was highly prevalent within the UK Armed Forces.[74] Table 1 (below) shows the self-reported smoking status for veterans and non-veterans of working and retirement ages. This illustrates no significant difference between veterans and non-veterans that currently smoke. However, veterans of working age (55%) and retirement age (66%) were significantly more likely than non-veterans to have ever smoked (44% and 56% respectively).

	England Veterans 18-64	England Veterans 65+		England Non-Veterans 18-64	England Non-veterans 65+
Have you ever smoked?					
Yes	55%	66%		44%	56%
No	45%	34%		56%	44%
Do you currently smoke?					
Yes	37%	12%		40%	14%
No	63%	88%		60%	86%

Table 1: Self-reported smoking status. (Source: APS 2017)

Higher levels of alcohol use have been observed in the UK Armed Forces. Evidence suggests that alcohol may be used as a coping strategy when returning to civilian life.[75] Anecdotal evidence from professionals working in the local area is that there has been a culture shift regarding alcohol in the Armed Forces whereby younger veterans are less likely to use alcohol as a coping strategy.

[73] NHS. What are the health risks of smoking? https://www.nhs.uk/common-health-questions/lifestyle/what-are-the-health-risks-of-smoking/ Accessed 20 April 2021

[74] Ministry of Defence. Annual Population Survey: UK Armed Forces Veterans residing in Great Britain (2017). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774937/20190128_-_APS_2017_Statistical_Bulletin_-_OS.pdf Accessed 23 April 2021.

[75] Wigham S., Bauer A., Ferguson J. et al, A systematic review of the effectiveness of alcohol brief interventions of the UK military personnel moving back to civilian life, Journal of the Royal Army Medical Corp, (2017), 163, p.242-250. https://pubmed.ncbi.nlm.nih.gov/28320916/ Accessed 23 April 2021.

Health Inequalities

Divorced and separated veterans were significantly more likely to report suffering from depression and bad nerves (18%) than veterans in all other marital status groups (11%).[76] This reflects other research findings,[77] which suggest that a relationship breakup among the 'ex-service community' is likely to be a 'trigger' of psychological difficulties, including depression. However, it is unknown whether already existing mental health issues may place strain on a relationship, contributing towards divorce or separation.

Diabetes is a serious condition where the blood glucose level is too high.[78] Over a long period of time, high glucose levels in your blood can seriously damage the heart, eyes, feet and kidneys. Male veterans of working age were significantly more likely than female veterans of the same age to report having diabetes (15% and 8% respectively). Prevalence of diabetes is 6% of the total population and whilst men are more likely than women to have the disease, the difference is not as pronounced in the general population.

Male veterans of retirement age were significantly more likely than female veterans of the same age to report having heart, blood pressure and/or circulatory problems (53% and 42% respectively). Male veterans are also more likely to have difficulties with hearing than females (11% and 4% respectively).

The Defence Committee report on mental health [79] discussed evidence that some groups of personnel may be at higher risk of mental health issues. More evidence is currently being sought by the Committee to support these claims. The high risk groups were:

- Those that served in Iraq and Afghanistan
- Early service leavers
- Younger recruits
- Those who suffered physical injury
- Female personnel

Studies on barriers to accessing mental health services have focused mainly on male participants, therefore understanding of experiences by female veterans is limited. Although relatively small, the number of female military veterans in the UK is increasing, with over 1000 women leaving military service each year. Research published in BMJ Military Health found that female veterans face additional barriers accessing mental health support, such as negative gender stereotypes and a lack of recognition of their veteran status.[80]

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[76] Ministry of Defence, APS 2017 Statistical Bulletin. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774937/20190128_-_APS_2017_Statistical_Bulletin_-_OS.pdf Accessed 23 April 2021.
[77] Centre for Social Justice, Military Families and Transition. https://www.centreforsocialjustice.org.uk/core/wp-content/uploads/2016/06/MILITARY-FAMILIES.pdf Accessed 23 April 2021.
[78] Diabetes UK Online. https://www.diabetes.org.uk/diabetes-the-basics Accessed 9 October 2019.
[79] House of Commons Defence Committee, Mental Health and the Armed Forces, Part One: The Scale of Mental Health Issues, 25 July 2018, HC 813 of session 2017, p30. https://publications.parliament.uk/pa/cm201719/cmselect/cmdfence/1635/1635.pdf Accessed 23 April 2021.
[80] BMJ. Anglia Ruskin University. Female military veterans face additional barriers accessing mental health support. https://www.bmj.com/company/newsroom/female-military-veterans-face-additional-barriers-accessing-mental-health-support/ Accessed 19 May 2021.

A literature review around LGBTQ service personnel and veterans found that they have poorer mental health and well-being; report more stigma and barriers to mental healthcare, which reduces uptake of accessed healthcare services; experience more sexual trauma; and have poorer physical health than heterosexual military personnel and veterans. However, the review highlighted that there are substantial gaps in the current evidence for this population group.[81]

In February 2021, Northumbria University announced they are working with the Fighting with Pride charity to carry out research into the health and social needs of LGBT+ veterans, particularly focusing on those veterans who were discharged from the military under a ban, which was only lifted 21 years ago, to assess the impact it had on their lives.

Under the ban, anyone found to be LGBT would be discharged, lose their pensions and have their service medals confiscated and, up until 1994, potentially criminalised.

This research will be building on the work of the *Map of Need Project* and look to find out what type of support is needed and where.[82]

3.6. Housing

There is no significant difference between veterans and non-veterans who have bought their own home and those who rent, even when comparisons are made by age and region. Most UK Armed Forces veterans residing in Great Britain were estimated to either have owned their own property or had a mortgage (76%), which was consistent with the non-veteran population (78%).[83]

For veterans living in social housing, the Ministry of Housing, Communities and Local Government (MHCLG) has introduced a package of measures to ensure that the Armed Forces community have the same access to social housing and are not disadvantaged by the requirement for mobility whilst in Service.[84] In 2016/17, a greater proportion of the UK Armed Forces veterans were estimated to spend less than six months waiting for social housing compared to the non-veteran population (68% and 52% of those aged under 65 respectively, and 67% and 60% of those aged 65+ respectively).

Leaving the Armed Forces is often the first time that veterans will search for a home for themselves. However, they are just as likely to own their own home as the non-veteran population. There is no evidence to suggest that veterans are overrepresented in the

[81] International Review of Psychiatry 31(1):1-20. The health and well-being of LGBTQ serving and ex-serving personnel: a narrative review April 2019. https://www.researchgate.net/publication/332512549_The_health_and_well-being_of_LGBTQ_serving_and_ex-serving_personnel_a_narrative_review Accessed 24 May 2021.
[82] Northumbria University. Strategic partnership to revolutionise support for LGBT+ Veterans. https://www.northumbria.ac.uk/about-us/news-events/news/strategic-partnership-to-revolutionise-support-for-lgbt-veterans/ Accessed 24 May 2021.
[83] Ministry of Defence, Annual Population Survey: UK Armed Forces Veterans residing in Great Britain, (2017). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774937/20190128_-_APS_2017_Statistical_Bulletin_-_OS.pdf Accessed 23 April 2021.
[84] MHCLG. Improving access to social housing for members of the Armed Forces. https://www.gov.uk/government/publications/improving-access-to-social-housing-for-members-of-the-armed-forces Accessed 21 April 2021.

homeless population. However, public perception is that there is a significant problem with homelessness. [85]

Those in the veteran focus groups (Section 5) had differing views on whether homelessness is an issue for veterans. Some thought that veterans would be reluctant to seek help and therefore fail to access the required support. There was concern over the validity of veteran homelessness data, that it wasn't capturing all homeless veterans, and recommended that the data's methodology should be reviewed to make it more robust.

3.7. Criminal Justice System

Prisons

Veterans are 30% less likely to be in prison in England and Wales than the general population. Evidence in 2010 suggested 3.5% of the prison population were veterans.[86] During 2018, the veteran population of prisons was re-assessed, and there were approximately 2,032 veterans in British prisons making up 4% of the population. 1,832 (90%) of these were British, 192 (9%) foreign nationals, and 8 (1%) did not have their nationality recorded.[87] As with other statistics used in this report, there is the issue of reliability and potential underreporting by veterans who do not wish to be recorded as veterans or who do not identify themselves through the term "veteran".

Table 2 shows the offences for which veterans are serving their sentence. Violence against the person accounted for the highest proportion of the veteran prison population which is also the most common offence for those in the general prison population.

Offence Group	Numbers 2010	Number 2018	Percentage 2018
Violence against the person	725	669	32.9%
Sexual Offences	546	502	24.7%
Drug Offences	236	217	10.7%
Robbery	158	146	7.2%
Burglary	87	79	3.9%

[85] Ministry of Defence UK, The Strategy for our Veterans (2018) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/755915/Strategy_for_our_Veterans_FINAL_08.11.18_WEB.pdf Accessed 20 April 2021.
[86] Defence Analytical Services and Advice, Estimating the proportion of prisoners in England Wales who are ex-Armed Forces – further analysis (2010). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/280048/15-september-2010.pdf Accessed 23 April 2021.
[87] Ministry of Justice, Experimental Statistics Ex-service personnel in the prison population, England and Wales (2018). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/750708/ex-service-personnel-prison-population-2018.pdf Accessed 9 July 2019.

Theft and handling	52	49	2.4%
Fraud and Forgery	30	28	1.4%
Motoring offences	15	14	0.7%
Other offences	198	183	9.0%
Offence not recorded	160	148	7.3%

Table 2: Ex-armed forces prison population by offence. (Source: Ministry of Justice 2018)

According to the 2018 figures, 98% of the veteran prisoner population were male as opposed to 95% of the non-veteran prison population[88]. However, the proportion of female veteran prisoners has increased since 2010.

Custody data

Between April 2018 and March 2019, there were a total of 362 Birmingham residents who identified themselves as veterans to West Midlands Police (WMP) following their arrests. The majority of those who were arrested were male (95.6%). The female arrestees were all aged under 50 years. The majority of the recorded veteran arrests relate to veterans who have served since 1990. 64% of those arrested served in the Royal Navy, the British Army or the RAF. 30% served in foreign Armed Forces and 7% didn't state where they had served. The most common offences were for assault (27%). The next most common were drink driving and use of / possession of drugs.[89]

[88] Ministry of Justice. Ex-service personnel in the prison population, England and Wales. (2018). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/750708/ex-service-personnel-prison-population-2018.pdf Accessed 20 April 2021.
[89] In house calculations based on data supplied by West Midlands Police, (2019).

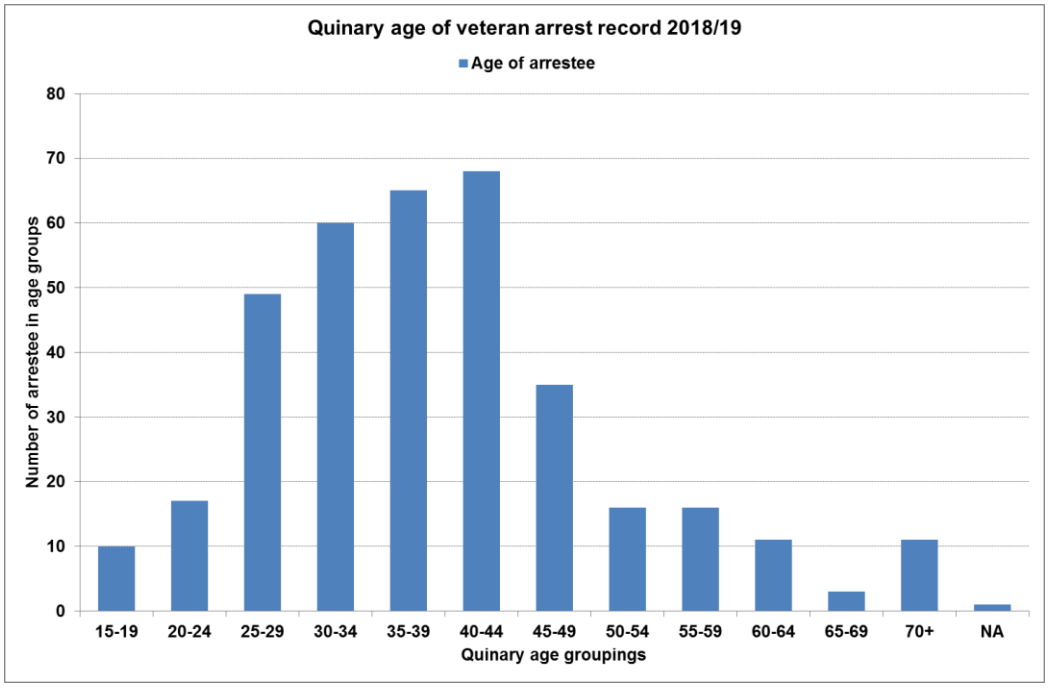

Figure 5: Police custody - veteran age ranges. (Source: West Midlands Police 2018/19)

Veterans Experience & Needs

The National Centre for Children of Offenders (NICCO) undertook a needs assessment of male veteran offenders and their families before, during and after imprisonment to improve the whole families' outcomes in relation to wellbeing and transitions into and out of custody. This included in-depth qualitative research with a sample of veteran offenders and their families, and a desk-based literature review.[90]

The research found that prisoners' ties with their families are "put under immense strain before, during and after imprisonment". The recommendations in this report included early intervention, support with mental health problems and family breakdown, as well as a systemic and cultural change in all services so that veterans and their families receive timely support and the stigma of prison is removed.

There were the following key points:

- Children of veterans in custody are likely to have experienced family breakdown, with only 26% of children identified in their sample living, or expected to live, with both birth parents when their fathers were released from custody.
- A significant number of their sample had been discharged following sanction by the military, which compromised any transition planning and potentially increased their vulnerability.
- Neither the prison, military charities, nor the peer support groups collect information on dependents or family situation, so there was no way to ascertain the nature or scale of needs.

[90] NICCO. A Needs Assessment of Veterans in Custody, their Families & Children. https://www.nicco.org.uk/userfiles/downloads/5e3d905a68926-veterans-assessment-doc.pdf Accessed 24 May 2021.

- Veterans, partners and children all indicated that they are uncertain about what they can say/ask each other, professionals and/or others outside the immediate family, e.g. from concern over upsetting people or showing weakness, to uncertainty of restrictions with regard to contact/communication with children.
- The veteran's military service must be verified to receive specialist support. This can be barrier to receiving support as veterans may not want to inform criminal justice agencies fearing this might have negative repercussions for their relationship with the military.
- Participants would like to see peer support for both veterans inside prison and families outside in the community.
- Feedback is positive when services are accessed in custody but family support is largely absent.
- The greatest challenge is at the point of release from custody. Going from the familiarity of the structure and stability of the prison environment (in relation to military culture), to uncertainty over what happens with release can cause anxiety. And a more planned phased release has shown to help.
- The negative financial impact on the mother working to hold the family together alone also caused negative emotional impact.

4. Services

This section describes the current services that are available for Armed Forces veterans in Birmingham. These are set out in themed areas. Some of the services relate to more than one theme.

4.1. Community and Relationships

The services discussed here relate to social relationships and community connections and are services that help with loneliness, social isolation, and integration into local communities.

Armed Forces Charities

There are 187 Armed Forces charities offering support to veterans locally and nationally.[91] The Royal British Legion (RBL) and SSAFA (Soldiers and Sailors Families Association) have local branches across the city and offer emotional and practical support to members of the Armed Forces, veterans, their families and the bereaved. Both these organisations as well as other charities use the Cobseo (The Confederation of Service Charites) case management system and can share information with the veteran's consent.

Royal British Legion (RBL)

RBL offers a wide range of services and support, from employment and financial support, to expert guidance and physical and mental wellbeing.[92] There is a Pop in Centre in the city centre which offers advice, support and guidance. There is also a helpline and online support available 24 hours a day / 7 days a week.

Local branches are focal points for social activity, remembrance, and for supporting the Armed Forces community. In local communities, the RBL plays a vital role in helping hard-to-reach individuals and tackling problems like loneliness and isolation.

The Battle Back Centre at Lilleshall was established by the RBL in 2011 to support injured personnel returning from Iraq and Afghanistan. It is centred upon adaptive sport and adventurous training activities. Battle Back helps build camaraderie as well as the chance to connect through shared experiences and the centre now offers wellbeing courses to veterans.

Soldiers, Sailors, Airmen, and Families Association (SSAFA)

This organisation exists to relieve need, suffering and distress amongst the Armed Forces, veterans and their families in order to support their independence and dignity.[93] SSAFA has two sites across the city with caseworkers to support their clients. In addition, SSAFA Forcesline is a free, confidential telephone helpline and email service that provides support for serving (regulars and reserves) and ex-service men and women from the Armed Forces and their families.

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[91] Charity Commission for England and Wales, (2017). Military charities: group case report. https://www.gov.uk/government/publications/military-charities-group-case-report/military-charities-group-case-report Accessed 23 April 2021.
[92] Royal British Legion. Local community connections. https://www.britishlegion.org.uk/get-support/local-community-connections Accessed 23 April 2021.
[93] SSAFA Greater Birmingham. https://www.ssafa.org.uk/greater-birmingham Accessed 20 April 2021.

Help for Heroes

This charity provides recovery and support for the Armed Forces community whose lives are affected by their time in service. Available services include physical and emotional rehabilitation and recovery, identifying new career opportunities, financial guidance, and welfare support.

Peer support networks for veterans are offered through the Help for Heroes Band of Brothers network.[94] There is also a Band of Sisters network for close family members. These social networks are available to veterans and service personnel. They are also available to those who have served alongside our Armed Forces and have been wounded, injured or sick during, or as a result of their service, resulting in an ongoing need of support for themselves and their close family members.

Veterans Gateway

The Veterans Gateway [95] has been set up to be a first point of contact and to signpost to the most relevant service. This is funded by the Armed Forces Covenant and is available 24 hours a day, 7 days a week via phone, email, a website, and a recently launched app.

The Northern Hub for Veterans and Military Families Research developed this digital, UK-wide directory of services known as the Veterans Gateway Mobile Application and Local Support website (VG).[96] This app enables veterans and their families to identify appropriate service provision in their local area from a database, including an interactive map. These organisations cover both the Armed Forces sector and wider charity and not-for-profit sectors.

By analysing the app data, the research team are beginning to build a comprehensive picture of ex-service personnel needs. They are gaining a better understanding of where in the UK there is a higher need and will, over time, be able to tell whether veterans' needs are increasing or decreasing. This information is now being used to inform service funding strategies and improve comprehension of user needs.

Combat Stress

This charity helps former servicemen and women from every service and conflict deal with trauma-related mental health problems such as anxiety, depression and post-traumatic stress disorder (PTSD). They provide evidence-based clinical programmes, treatment and support alongside online resources and a helpline.[97] After a period of reduced funding[98], in

[94] Help for Heroes Band of Brothers. https://www.helpforheroes.org.uk/get-support/fellowship-groups/band-of-brothers/ Accessed 26 July 2019.
[95] Veterans Gateway. https://www.veteransgateway.org.uk/ Accessed 23 April 2021.
[96] Northumbria University Newcastle. Mapping the needs of veterans across the UK. https://www.northumbria.ac.uk/research/research-impact-at-northumbria/health-impact/mapping-the-needs-of-veterans-across-the-uk/ Accessed 14th June 2021.
[97] Combat Stress. https://combatstress.org.uk/ Accessed 18 May 2021.
[98] BBC News. Veterans' charity Combat Stress stops new referrals over funding crisis. https://www.bbc.co.uk/news/uk-51243098/ Accessed 19 May 2021.

April 2021, Combat Stress confirmed that they received new funding from the NHS to re-take on new referrals.[99]

Poppy Factory

The Poppy Factory [100] began by offering veterans with mental and physical health conditions a place of employment producing Remembrance products for The Royal British Legion and the Royal Family, including poppies, wreaths, crosses and symbols.

Their aim is to support wounded, injured and sick veterans on their journey into meaningful and sustained employment across a wide range of sectors. The veterans receive personal, tailored support whether as part of pre-employment preparation or within the in-work support programme, such as:

- Application process guidance such as CVs, application forms and interview preparation.
- Identify any required adaptations to support veterans staying in work.
- Liaison with relevant clinicians to ensure veterans have consistent support.
- Training and qualifications where they are a requirement for the role.
- Signposting and referrals to partner organisations with ongoing collaboration.

Carers support

Forward Carers in Birmingham is a carer support service providing help to people caring for an elderly, frail, sick, or disabled family member and includes parent carers.[101] Once registered, carers are offered an assessment. Forward Carers offer a variety of services to all carers including information and advice, wellbeing activities, events and special offer deals and discounts.

Forward Carers ask if either the carer or cared for has ever served in the Armed Forces and approximately 10% of 15,000 clients on their database are ex-service (July 2019).[102] The service signposts clients to RBL, SSAFA and other Armed Forces charities.

Social care

Birmingham Children's Trust (BCT) work with children, young people, their families and carers. This includes working with children in need (CIN), who are defined as children aged under 18 in need of local authority services to achieve or maintain a reasonable standard of health or development; or to prevent significant or further harm to health or development; or are disabled. BCT do not record whether a child has a family member who has served in the Armed Forces.

Birmingham City Council's Adult Social Care (ASC) work with those aged 18 and above in need of social care support. Whether a client has served in the Armed Forces is not recorded on their Carefirst System. When undertaking an assessment, ASC staff use the three conversations approach rather than specific questions, which enables citizens to share

[99] BBC News. Lance Shingler: Iraq veteran with PTSD died after overdose. https://www.bbc.co.uk/news/uk-england-birmingham-57117679 Accessed 21 May 2021
[100] The Poppy Factory. https://www.poppyfactory.org/ Accessed 26 May 2021.
[101] Forward Carers. https://forwardcarers.org.uk/ Accessed 23 April 2021.
[102] In house calculations based on data supplied by directly by Forward Carers.

their background. ASC staff are aware of the Armed Forces charities and the support that those organisations can offer.

Neighbourhood Network Schemes

Neighbourhood Network Schemes are locally based networks that enable the engagement with, and investment in, community assets. This is for the purpose of supporting older people to connect to individuals, groups, organisations, activities, services and places in their neighbourhoods. The aim is to reduce social isolation and prevent the need for more costly health and social care. The schemes are aimed at all older people but are linked up to the local Armed Forces charities.

Independent Veteran Led Support Groups

The focus groups (Section 5) highlighted independent veterans led support groups, associations, and charities in Birmingham that provide a social network platform to bring veterans together to support health and mental wellbeing and reduce social isolation:

- British and Caribbean Veterans Association[103] (Edgbaston, Birmingham)
- The Irish Guards Association[104] (Central Birmingham)
- Chosen Veteran Support Group[105] (Sutton Coldfield)
- Bournville Peer Support Group[106] (An off-shoot group from Combat Stress - South Birmingham)

Despite all this, focus group participants (Section 5) perceived that funding has been reduced for organisations such as Combat Stress, making services more difficult to access, and meaning that drop-in centres are closing.

4.2. Employment, Education and Skills

The Department for Work and Pensions (DWP) offer support to job seekers. This includes training, work academies, Health and Work programme, English for Speakers of Other Languages (ESOL), apprenticeships, and work experience. In addition to this, advisors signpost to specialist provision available to ex-forces personnel and their families.

Service	Description	Link	Detail
X-Forces	Local on-site support	X-Forces Enterprise	Self-employment support for UK Armed Forces (and their families).
Walking with the Wounded	Local on-site support	Walking with the Wounded	A pathway for vulnerable veterans to reintegrate back into society and find work.

[103] British and Caribbean Veterans Association. http://bcva.weebly.com/ Accessed 19 May 2021.
[104] Irish Guards Association – West Midlands Branch. https://midlandsmicks.com/ Accessed 19 May 2021.
[105] Chosen Veteran Support Group. https://www.chosenveteransupportgroup.co.uk/ Accessed 19 May 2021.
[106] Combat Stress. https://combatstress.org.uk/ Accessed 28 May 2021.

Disabled Ex-Servicemen and Women	National	Disabled Ex-Servicemen and Women	Ableize - A virtual library of UK disability resources and support for ex-service people.
Help For Heroes	National & local	Help For Heroes	A national network of support for wounded personnel (and their families).
Pathfinder International	National	Pathfinder International	Ex-army jobs, civilian careers and Armed Forces resettlement in the UK.
Regular Forces Employment Association (RFEA)	National	RFEA	The Armed Forces employment charity.
Remploy	Nationwide & local agreements	Remploy	Support for Armed Forces and Veterans.
Sporting Force	National	Sporting Force	An Armed Forces sports charity also offering routes into paid employment.
Steps Into Health	National	Step into Health	Connects employers in the NHS to people from the Armed Forces community, by offering an access route into employment and career development opportunities.

Table 3: Employment Support Services: (Source DWP July 2019)

4.3. Finance and Debt

Locally based Armed Forces charities RBL and SSAFA offer advice and financial support to Birmingham veterans.

Birmingham City Council's Neighbourhood Advice and Information Service (NAIS) provides financial and benefits advice to Birmingham residents, including:

- When forces personnel leave on health grounds or for other reasons and cannot access alternative employment, neighbourhood advisors can ensure they access welfare benefits and maximise their income if appropriate.
- If ex-forces personnel fall on hard times and have debts, NAIS advisors can provide personal budgeting support and refer for detailed debt advice.

- If ex-forces personnel need help registering an application for accommodation in Birmingham, NAIS advisors can assist or, if homeless, refer on to the Newtown Home Options Team.
- Neighbourhood advisors may be able to assist ex-forces personnel or their immediate families with charity applications such as via SSAFA.

4.4. Health and Wellbeing

Veteran Responsibility

MOD Service Leaver guidance[107] shows that the responsibility is on the service leaver to let their GP know their veteran status, and for the GP to record this.

When in the Armed Forces, personnel register with a Military doctor and the MOD take responsibility for their medical healthcare. Military personnel can only register with an NHS GP as a temporary resident – although special arrangements are possible for extended temporary registration.[108] In both cases, the NHS GP should liaise with the patient's military doctor. The service leaver is told to register with an NHS GP, given a personal copy of their summary medical record when they leave the Services, together with information on how to obtain their full Service medical record if they need it.[109]

When registering with a GP, veterans are advised to fill in the GP registration form's optional section that asks if they are a veteran, and to hand over any medical paperwork to ensure all their military medical records are transferred over. The GP Practice should then flag in the patient's note that they have served.

Primary Care

Clinical commissioning groups (CCG) are responsible for the commissioning of health services for veterans, reservists and service families registered with NHS GPs in their area. However, GPs are often unsure of how many of these individuals are registered within their practices, which suggests that the self-reporting registration system (outlined above) has historically under-reported veteran registrations. It is not currently possible to obtain any data on numbers from the local CCGs (Birmingham & Solihull CCG and Sandwell & West Birmingham CCG).

To address this issue, the Royal College of General Practitioners (RCGP) is working with NHS England and NHS Improvement to accredit GP practices as *veteran friendly*. As of May 2021, there are 20 GPs who have achieved this accreditation within Birmingham, and their locations are displayed in Figure 6. Overall, there are 37 *Veteran Friendly Accredited*

[107] Ministry of Defence. Service Leavers' Guide. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/928535/SLG_Oct_Edition_FINAL.pdf Accessed 28 May 2021.
[108] Royal College of General Practitioners. NHS healthcare for the Armed Forces community in England. https://northeast.devonformularyguidance.nhs.uk/documents/Referral-documents/Veterans/689_NHS-England-Military-veteran-aware-accreditation-A5-GP-top-tips-LEAF.pdf Accessed 4h June 2021.
[109] NHS. Veterans: health FAQs. https://www.nhs.uk/nhs-services/armed-forces-and-veterans-healthcare/veterans-health-faqs/ Accessed 28 May 2021.

Practices registered across all of Birmingham and Solihull, and Sandwell and West Birmingham CCGs[110].

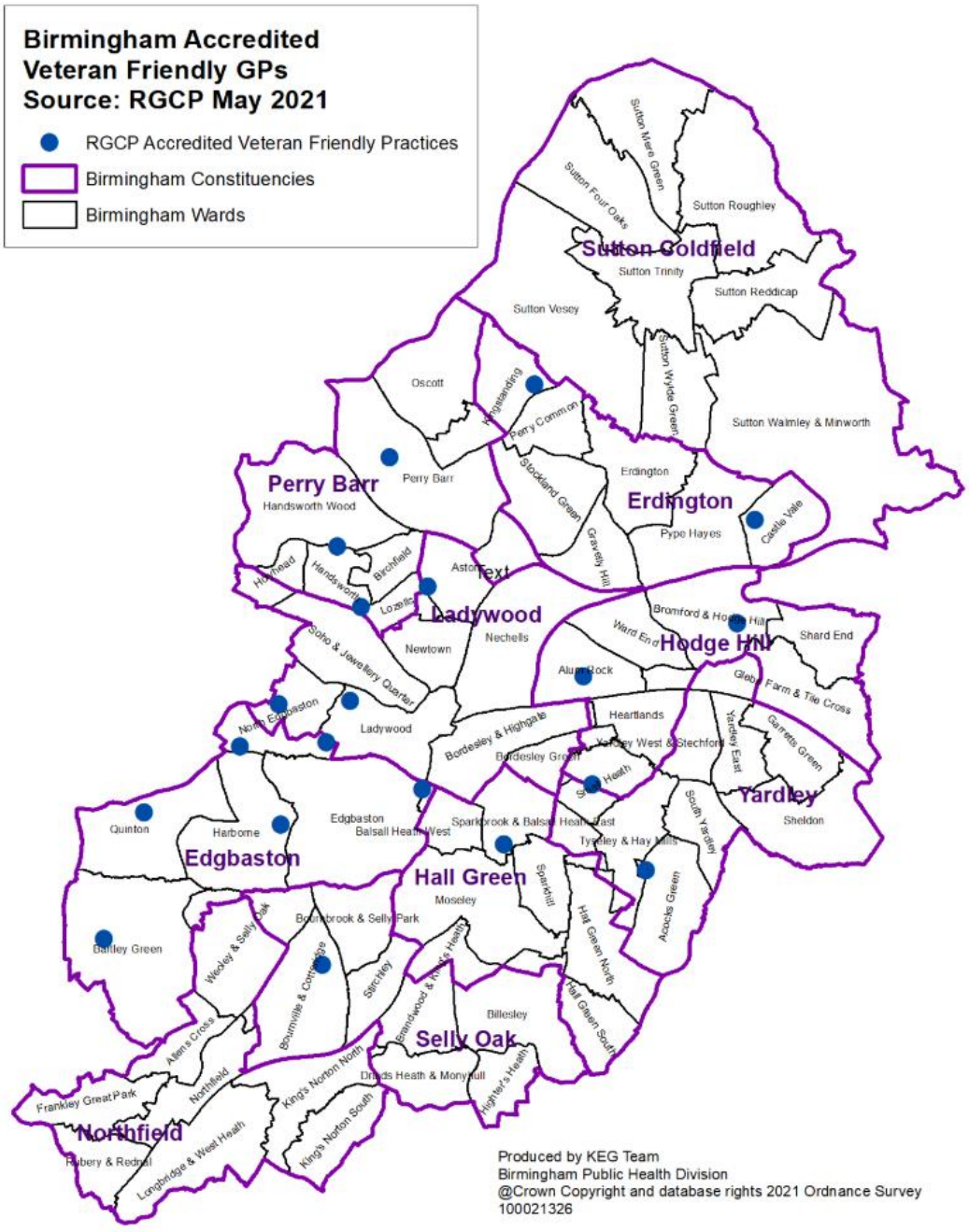

Figure 6: Veteran friendly GP practices in Birmingham (Source: Royal College of General Practitioners)

A random sample of GPs in the city were asked whether they used the recommended Read Code Xa8Da: '*History Relating to Military Service'*. Results suggested very few GPs were

[110] RCGP Veteran friendly GP practices. https://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/Veteran-friendly-gp-practices.aspx Accessed 28 May 2021

using this code. When asked if the GPs were aware of the RCGP Veteran Friendly practice accreditation, only one reported that they had heard of this.[111]

Further to this, the veteran focus groups (Section 5) discussed having numerous issues with getting access to GPs and the inconsistency in having complex mental health issues, such as PTSD, taken seriously by frontline healthcare professionals.

This is supported by a House of Commons report[112] that discussed how the availability of mental health care varies significantly depending on where veterans live and whether they are "*fortunate enough to have a GP who is aware of veterans' mental health needs and services*" and requested an "*urgent need for clarity over how the Covenant's principle of priority care is implemented in practice across the UK*".

Secondary Care

All veterans are entitled to priority access to NHS care (including hospital, primary or community care) for conditions associated with their time within the Armed Forces (service-related). This is always subject to clinical need and doesn't entitle queue jumping ahead of someone with a higher clinical need.[113] There are also dedicated services for physical and mental health conditions.

Veterans Trauma Network

The Veterans Trauma Network is hosted by NHS England to provide specialist care for patients with service-related traumatic injuries. The network comprises 10 major trauma centres across England including a centre in Birmingham.

The network acts as a regional hub for veteran care, linking with NHS veterans' mental health services, national centres of expertise, and key service charities to provide a complete package of care. Patients referred to the service have a personalised treatment plan, developed and provided by a specialist team of military and civilian experts in trauma. The care package extends to the needs of families and carers are also considered.

Veteran's Mental Health Transition, Intervention and Liaison Service (TILS)

This specialist service seeks to increase the access to mental health services for veterans and members of the Armed Forces who are approaching discharge. TILS consists of three elements:

- Transition: the service works with the MOD to offer mental health support for Armed Forces veterans approaching discharge.
- Intervention: personnel approaching discharge will have an assessment within two weeks of a referral, providing access to treatment and support from a care coordinator.

[111] In house survey and analysis carried out by Public Health Team K. Source: K. Lee (personal communication, June 2019).
[112] House of Commons Defence Committee. Mental Health and the Armed Forces, Part Two: The Provision of Care. https://publications.parliament.uk/pa/cm201719/cmselect/cmdfence/1481/1481.pdf Accessed 20th May 2021.
[113] NHS, Veterans; priority NHS treatment. https://www.nhs.uk/using-the-nhs/military-healthcare/priority-nhs-treatment-for-veterans/ Accessed 23 April 2021.

- Liaison: patients that may benefit from NHS care will be referred to the services where they will receive appropriate support or treatment.

The NHS Veterans' Mental Health Complex Treatment Service (VMH CTS)

The NHS Veterans' Mental Health Complex Treatment Service (VMH CTS) is a specialist community mental health service providing additional support for armed forces veterans. It is for those experiencing complex mental illness related to their time in the military and is here to help veterans regardless of when they left the Armed Forces. It is a national service and in the West Midlands it is provided by Birmingham and Solihull Mental Health NHS Foundation Trust at the Barberry Centre.

During 2018/19, there were 321 patients referred to mental health services within Birmingham that were recorded as either a veteran or family member of a veteran (see Table 4).[114]

Flag	Number of patients	Percentage
Dependent of an ex-services member	30	0.08%
Ex-services member	291	0.76%
Unknown (Person asked and does not know is not sure)	615	1.62%
Not stated	3,174	8.34%
NULL	6,083	15.98%
Non-veterans or their dependents	27,882	73.34%
Total referrals	38,075	100%

Table 4: Summary of mental health referrals in Birmingham & Solihull 2018/19 (Source: BSOL CCG Intelligence)

Veterans' Physical Disabilities

Birmingham West Midlands Rehabilitation Centre is one of nine Disablement Service Centres (DSCs) across England that provide enhanced services to veterans who have lost a limb as a result of their service in the Armed Forces. There is also a Blesma Support Officer working in the Midlands, who is dedicated to assisting serving and ex-service men and women who have suffered life-changing limb loss or the use of a limb, an eye or loss of sight in the service of our country.[115]

[114] Mental health data supplied directly by Birmingham & Solihull CCG.
[115] Key support agencies for elderly veterans of UK Armed Forces. https://www.warwickshire.gov.uk/armedforcescovenant Accessed 16 June 2021.

Veterans' Elderly Care

The Royal British Legion works with Dementia UK to provide Admiral Nurses – a service that supports the carers of RBL beneficiaries who have dementia. The focus is to maintain independence and improve the quality of life for carers and families and provide the practical advice that they need. Admiral Nurses operate in communities across the West Midlands. The Royal British Legion also provides long-term nursing and personal care at the six care homes that it operates in the West Midlands. Four of the homes also provide specialist dementia care. Respite care can also be provided.

Substance Misuse Services

Change Grow Live

Change Grow Live (CGL) Birmingham is a substance misuse service that has been commissioned by Birmingham Public Health to provide drug and alcohol assistance for adults in Birmingham.[116] In June 2019, CGL were treating 33 veterans for drug / alcohol addiction (0.5% of total clients in treatment).

Alcoholics Anonymous

Alcoholics Anonymous (AA)[117] is an independent, self-supporting fellowship concerned solely with the personal recovery and continued sobriety of individual alcoholics. All meetings are completely confidential, and personal anonymity is assured.

In terms of service personnel/veterans:

- There are many established AA members who are current or former service personnel. AA is also able to put newcomers in touch with such members.
- AA has a 12-step service specifically for the armed services. This service uses a database of established AA members who also have armed services experience. They found that similar biographical experience can help to overcome obstacles to joining AA.
- AA can provide pamphlets and materials tailored to service personnel or veterans.
- Armed Services Liaison Officers ('ASLOs') can present to professionals to explain what AA can offer and how problem drinkers can access AA. In areas where there are no local ASLOs in role, Public Information/Health Liaison Officers are also equipped to provide that service.
- Volunteers can be coordinated by ASLOs to hold informal AA meetings in facilities or settings where problem drinkers are seeking help (either on an inpatient or an outpatient/drop-in basis), to hold brief, informal presentations or to talk one-to-one to problem drinkers.

4.5. Housing

Fry Accord provide veterans accommodation at a communal establishment in Selly Oak, with a facility consisting of 12 beds, some of which are on the ground floor to address

[116] Change Grow Live. Drug and Alcohol Service - Birmingham. https://www.changegrowlive.org/content/reach-out-recovery-birmingham Accessed 23 April 2021.
[117] Alcoholics Anonymous (AA) - special focus on service personnel and veterans https://www.alcoholics-anonymous.org.uk/Professionals/Social-Sectors/Armed-Services/Armed-Services-Professionals Accessed 26 May 2021.

disability and mobility issues. The scheme encourages peer support from fellow veterans and is close to a range of community-based support services. Veterans are provided with a starter pack and there is wraparound support regarding routes into employment and wellbeing.[118]

In June 2020, the Royal British Legion received a grant from the West Midlands Combined Authority (WMCA) to help Armed Forces veterans who are either homeless or at risk of homelessness. The £20,000 grant was for supporting veterans, with up to £750 each, who may have built up arrears and faced other difficulties as a result of the recent pandemic. The individual grants will help to pay for essential items such as a deposit for accommodation or a first month's rent, travel passes to find work, and basic furnishings.[119]

Haig Housing is a charity that provides housing assistance for ex-service people and their dependents. They do this by letting general needs homes at affordable rent prices to the veteran community, and providing tailored housing solutions to suit specific and individual needs of the service user.

Stoll is a leading veterans' charity and housing association that has been helping ex- service personnel since 1916. Stoll provides safe, high quality housing, and access to services that enable vulnerable and disabled veterans in need of support to live fulfilling, independent lives. Stoll also provides a Veterans Nomination Scheme to find housing through other Housing Associations and Local Authorities. Nominations need to come from one of the main military charities e.g. SSAFA, RBL, Help for Heroes. The Cobseo Housing Cluster have developed a Directory of Housing Support Services for Veterans, which is also available in the Midlands. The lists supported accommodation, general needs housing, floating support and day provision for ex-service personnel.[120]

4.6. Criminal Justice System

Prisons

There are currently 12 prisons located within the West Midlands region. It is not possible to identify which inmates would usually be resident in Birmingham.[121]

HMP Birmingham is located in the Winson Green area of the city. In July 2019, 22 inmates were recorded as being veterans (less than 0.1%). HMP Drake Hall is the only female prison in the region. In July 2019, there were four veterans recorded there. The reliability of the data relating to veterans is questionable due to inaccurate self-reporting or not identifying as a veteran. It is possible that this data may also include veterans of foreign Armed Forces from overseas, it is not possible to differentiate this using the current data.

[118] Impact Pathways. Organisation: Fry Housing Trust. https://www.ipwm.org.uk/Fry-Housing-Trust/Pathway-Services/ Accessed 22 April 2021.
[119] WMCA. Armed Forces Day marked by post pandemic support for West Midlands homeless veterans. https://www.wmca.org.uk/news/armed-forces-day-marked-by-post-pandemic-support-for-west-midlands-homeless-veterans/ Accessed 14 June 2021.
[120] Key support agencies for elderly veterans of UK Armed Forces. https://www.warwickshire.gov.uk/armedforcescovenant Accessed 16 June 2021.
[121] Prison Oracle. Prisons: West Midlands. https://prisons.org.uk/prison_group/west-midlands/ Accessed 27 April 2021.

Prison	Population % recorded as veterans
HMP Birmingham	0.1%
HMP Brinsford	1.7%
HMP Dovegate	4.0%
HMP Featherstone	4.9%
HMP Hewell	4.3%
HMP Long Lartin	1.9%
HMP Oakwood	5.0%
HMP Stafford	5.9%
HMP Drake Hall	1.3%
HMP Swinfen Hall	1.0%
HMPYOI Werrington	0%
HMPYOI Stoke Heath	Data not available

Table 5: Veteran prison population 2019. (Source: NHS England) [122]

Probation

The probation service is currently being re-organised with a move to bring all offender management under the National Probation Service (NPS). HM Prison and Probation Service will transfer to the new model in June 2021.[123]

Police

West Midlands Police (WMP) is the local force covering Birmingham and the surrounding West Midlands metropolitan areas. WMP have been active in their support for the veteran community in the local area. As a result of the work that WMP has done with the Veterans Peer Support Network, Veterans Champions, and Local Authority partnerships, they have been asked to share their working practices and information with police forces regionally and nationally as far afield as Devon and Cornwall Constabulary.[124]

[122] Information supplied by NHS England and NHS Improvement – Midlands Health & Justice Business Support Manager via email (July 2019).
[123] Her Majesty's Prison and Probation Service and National Probation Service Guidance. Strengthening probation, building confidence. https://www.gov.uk/guidance/strengthening-probation-building-confidence Accessed 27 April 2021.
[124] WMP Press release: West Midlands Police Helps Troubled Veterans Turn Their Lives Around. https://emergency-services.news/west-midlands-police-helps-troubled-veterans-turn-their-lives-around/ Accessed 23 April 2021.

Good Practice Case Study (West Midlands Police)

WMP has been actively recruiting, training and developing ex-servicemen and women who are now police officers or police staff within the organisation to be part of a Veterans' Support Network. This is a caring and active staff association of men and women who want to give back to their community, and specifically give their time and attention to fellow veterans who are struggling and are in contact with, or who are at risk of coming into contact with the criminal justice system. This may mean a visit to prison, developing a plan together on how to move forward, a call to the custody block, or just making sure staff within our current structures understand what it is to be a veteran, and what support services both statutory and from the third sector are available.

In addition to the Veterans Peer Support Network, WMP has also identified and trained over 60 Veterans Champions in key areas of business where vulnerable veterans may come into contact with WMP. These are generally colleagues who are not veterans themselves but work in key roles in the Public Contact Centre, as Vulnerability Officers in Partnership teams, Prisoner Intervention and Prevention Teams, and Street Intervention teams.

There is currently training in place to ensure every member of WMP custody teams, over 250 staff from six sites, has a three hour input on Veterans awareness. This ensures that veterans' questions are always asked, that the member of staff has the requisite understanding to ensure veterans receive a gold standard of care from WMP and that colleagues know where they can find the right expertise and ongoing support for veterans.

Through this training WMP have identified, supported and maintained ongoing relationships with:

- Veterans about to leave prison.
- Veterans who would have been charged with minor criminal offences who are now being supported through conditional cautions.
- Veterans who have engaged with our mental health triage team and have been referred onto veteran-specific secondary MH services.

These referrals and alternative ways of helping veterans may not have been accessed without this awareness training.

WMP cover seven local authority areas and work closely with local authority colleagues to reduce crime, keep the people of the West Midlands safe, and to promote community cohesion. WMP recognise that as signatories of the Armed Forces Covenant, there is a duty to work together to promote the wellbeing and the provision of services to serving and ex-armed forces personnel. A veteran's champion lead has been identified in each of the seven policing areas with the appropriate partnership team. They are charged with ensuring WMP are working with the local authority to establish and develop the Community Covenant Partnership working group. These groups are well established and productive in Coventry, Warwickshire and Solihull, newer but no less productive in Birmingham, and a work in progress in the Black Country.

4.7. Potential Services

In this section we consider services for veterans that are not already provided in the city. These have been introduced in other areas and recommended as best practice.[125]

Housing

Wigan Council employs a key worker for ex-service personnel and their families, who is able to navigate the public services landscape which can appear overwhelming and confusing to many veterans. Veterans in Wigan with medical needs related to service are given priority on the housing waiting list and spouses going through divorce will also be given priority.[126]

Glasgow has a veterans' Helping Heroes Hub.[127] This includes a housing expert post that is funded by Glasgow Housing Association, the city's largest RSL (registered social landlord). Housing is one of the greatest pressures on the Armed Forces Community in Glasgow and having a professional directly employed by the city's largest RSL means that the steps which many have to go through in order to get to the right advice are significantly reduced.

Leon House is a project supported by Invisible Wounds[128] based in Prestwich, Greater Manchester. It offers care and support free of charge to ex-service personnel referred by GPs, Armed Forces charities and other professionals. Its services are offered as a priority to ex-servicemen, women and first responders. Facilities include 23 en-suite rooms, a restaurant and a training kitchen. Group therapy sessions and education are provided at the facility to improve health and wellbeing and assist with acquiring employment and permanent housing.

Employment

Glasgow has a Veterans Employment Programme which assists veterans resettling in Glasgow in finding employment and integrating into local communities. It supports local businesses and creates new jobs for unemployed veterans in Glasgow. This is part of the holistic support for veterans that Glasgow offers through its Helping Heroes organisation.[129]

Health and Wellbeing

In Bradford, veterans have priority access to social care if their social care needs relate to their service. Where this criterion is not met, the council will signpost them on to other services. Bradford Council is also updating its adult social care assessments, whereby the public facing member of staff will be required to ask if the person has ever served in the Armed Forces. NHS partners also have questions in their surveys about people's service

[125] Forces in Mind, Our Community – Our Covenant, (2016). https://www.fim-trust.org/wp-content/uploads/2016/08/Our-Community-Our-Covenant-Report-30.08.16.pdf Accessed 23 April 2021.
[126] https://www.wigan.gov.uk/Council/Armed-forces/Getting-support/Health-wellbeing.aspx accessed 23 April 2021.
[127] Glasgow's Helping Heroes. https://sites.google.com/site/glasgowshelpingheroes/ Accessed 23 April 2021.
[128] Leon House Private Clinic on Facebook. https://www.facebook.com/pg/LeonHousePrivateClinic/about/ Accessed 23 April 2021.
[129] Glasgow's Helping Heroes. https://sites.google.com/site/glasgowshelpingheroes/ Accessed 23 April 2021.

history, and a Bradford Council information officer is currently undertaking research to understand the size, need and location of Bradford's Armed Forces community.[130]

In Glasgow, there is the Coming Home Centre, set up by Community Veterans Support in Govan as a space for veterans to go and meet up and talk with other veterans. This set-up allows them to receive informal, word of mouth advice, and support from people with similar experiences who understand their issues better. [131] This informal signposting approach means veterans can seek advice discreetly without having to formally present themselves to any organisation.

Children's Services

A community organisation in Bradford, SHAPE UK, provides activities for young people from disadvantaged backgrounds. Activities include sport and health activities, as well as basic vocational skills. The organisation employs a team of veterans and reservists and has good connections with the local brigade. Another community organisation, the IMPACT project, set out to create a link through heritage to identify commonalities within the diverse communities in Bradford. Part of this project involved visiting two local schools to help show not only what the Armed Forces has done for Bradford, but what Bradford has done for the Armed Forces.[132]

Community Cohesion

Bradford implemented its Armed Forces Covenant with consideration to the diversity within the city. The council engages people from different communities by identifying similarities rather than differences and uses Armed Forces events as a chance to celebrate every community and their impact on the Armed Forces, and vice versa. This has led to Bradford being able to reach out to the harder-to-reach groups in the community.

Veteran Champions

Oxfordshire County Council has more than one single elected member military champion. In order to strengthen the level of engagement between the council and the Armed Forces, each of the five bases in Oxfordshire has a designated military champion. This has the effect of strengthening the links between the Armed Forces and the council; the champions take it upon themselves to be the link between an individual base and the county. This requires that they develop and maintain relationships with relevant officers. It also means having and maintaining presence, such as through attending events on base.

Birmingham has less military presence than Oxfordshire and the bases within the city are all reservists, therefore this approach would not be as relevant compared to Oxfordshire.

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[130] Bradford District Council. Bradford District's commitment to the Armed Forces Community. https://www.bradford.gov.uk/your-community/armed-forces-community-support/bradford-districts-commitment-to-the-armed-forces-community Accessed 23 April 2021.
[131] Glasgow Helps. Coming Home Centre. https://www.glasgowhelps.org/listing/coming-home-centre/ Accessed 23 April 2021.
[132] Our Community – Our Covenant. Improving the delivery of local Covenant pledges. https://www.fim-trust.org/wp-content/uploads/our-community-our-covenant-improving-delivery-local-covenant-pledges.pdf Accessed 27 April 2021.

5. Lived Experience

5.1. Introduction

Birmingham Council commissioned focus groups for this deep dive because it is important to involve the local population whose needs are being assessed. The targeted focus groups were to discuss experiences of ex-service personnel, help inform the understanding of citizen views, and engage citizens in the challenges faced by veterans in the city. The council commissioned Age Concern and Enigma Consulting to run these focus groups.

The providers were expected to cover the following themes for discussion:

- What is a veteran?
- Community and relationships
- Employment, education and skills
- Finance and debt
- Health and wellbeing
- Housing

A full list of the focus group questions can be found in 5.4 **Error! Reference source not found.**.

The following summary reflects the participants' views on these themes, and includes direct interview quotes (in italics)

5.2. Age Concern Birmingham

The original aim for Age Concern was to run one targeted focus group with veterans who have been discharged more than 10 years, using a weekly veterans' group.

Due to lockdown restrictions, instead of a focus group, there were distanced 1:1 interviews conducted with eight participants via online channels, phone, or email. This happened between March to September 2020.

The interviews were structured and focused on the specified key themes for discussion. The interviewer had the questions listed to prompt discussion. Different sections were of interest for the participants, prompting stories and quotes.

Veteran Definition

There were mixed views on whether participants wanted to be defined as a veteran, with half identifying as veterans, and a further half preferring either ex-service man or ex-service personnel.

Community and Relationships

In terms of attitudes towards veterans, most felt they were treated normally and experienced no negative bias because of their service.

It was difficult to gauge community networks as responses were mixed and very individual. Several mentioned positive community interactions, one through a club, another through neighbours, and another through the veterans' community. Two mentioned the need for a more locally accessible veterans' group.

Over half of the veterans had not been supported by Armed Forces charities, social care or the voluntary sector. Those who were aware of SSAFA (Soldiers, Sailors, Airmen and Families Association) had not sought support from it.

However, all participants stated that family and/or friends were the main support networks, although sometimes it was difficult for them to understand veterans' issues – they "*did not get it*".

Employment, Education, and Skills

Responses were positive overall in terms of looking for employment. All successfully found work through different means and timescales. Most did not need any support to do so. There were no barriers in transferring their skills over to civilian jobs.

Finance and Debt

Finance was a much less positive experience for the veterans, learning how to cope with everyday budgeting. There was little preparation and help given to adjusting to the costs of civilian life, especially around accommodation. However, no one had major issues with debt.

"*The main issues for the ex-service personnel were to settle in the civil setup, find a suitable job, a suitable accommodation and to control your expenditure to keep within your limited income*."

Health and Wellbeing

None of the participants had experienced any issues accessing health systems.

The main health issue was around mental health, particularly PTSD, especially after experiences on the front line. They said it could happen to anyone – "*Right person at the wrong time*."

Improving health centred on establishing a routine, including good diet and exercise, with one participant suggesting paid access to a gym would help.

Housing

This tied back in with the earlier issues around difficulties with the costs of accommodation and lack of support for it. Experiences included: difficulty getting social housing, not being able to get on the housing ladder, being a permanent renter, or relying on family support. They didn't believe that social housing difficulties were due to bias against veterans.

None of them had used the *Help to Buy Scheme*, with one participant unaware of it.

The participants strongly believed that one homeless veteran was one too many and that no veteran should be homeless. At least one of the participants had witnessed veteran homelessness due to lack of support for mental health issues, especially PTSD, and for older veterans who didn't have networks when they were discharged.

"'*There are a substantial amount of ex-forces on the street. I have witnessed myself, 9 times out of 10 this is due to dealing with PTSD and not having the correct access to help*."

Conclusions and Recommendations

The participants generally said they just "*got on with it*" as they had to adjust to support themselves and their families.

Employment & skills were not a key issue. However, all participants seemed unprepared for living costs in the world outside of the armed Forces. They felt the Armed Forces could have prepared them better.

Access to health systems was not a problem for the veterans. However, they felt that mental health support could be an issue for those veterans who were homeless with PTSD.

The question about homelessness caused the most conversation. When it was discussed that there was no evidence to show veterans were over-represented, one participant said "*even one was too many*".

This all suggests that the key issues to focus on are support and guidance around living costs, improved mental health access and support for more vulnerable homeless veterans.

The Age Concern focus group was composed of veterans who had left service 10 or more years ago. Some issues or barriers may have changed, although accommodation costs were an ongoing issue for some participants.

5.3. Enigma Consulting

Enigma Consulting carried out targeted community focus group discussions and semi structured interviews on the health and wellbeing of veterans in Birmingham. This included a range of citizen groups with those who were armed forces, ex-service personnel, or a member of a military family.

There were five focus groups and nine semi-structured interviews from February to September 2020, using an expanded set of the discussion themes and questions. These involved a total of 31 citizens with a mix of characteristics and discharge dates. Findings from these discussions were then grouped into the following key themes:

- Definition
- Transition
- Community and relationships
- Loneliness and social isolation
- Employment, education, and skills
- Finance and debt
- Health and wellbeing
- Discussion on mental health
- Housing
- Homelessness

What is a Veteran?

This discussion was on whether participants identified with the MOD definition of "veteran" (for definition, see **Error! Reference source not found. Error! Reference source not found.**) or whether they preferred alternative terminology.

<u>The Value of the Veteran Identity and Community</u>

- Being identified as a veteran still mattered to people. "*Know what a veteran is, prefer veteran, and understand it!*" Participants said they were proud to be a veteran and even today, they abide and live by military values. All agreed with the MOD definition of a veteran and wished for the phrase 'Armed Forces' to remain within the current definition.
- More needs to be done to recognise the contribution of ex-service personnel and make people feel valued. More positive media coverage and stories are needed to showcase the positive outcomes of what the Armed Forces can achieve
- Historically, there was a perception that the term veteran refers to someone older. There is a whole age range of veterans out there in the community, including aged veterans in care home settings. "*Veterans come in all shapes and sizes*."
- For many, the Armed Forces community, the regiment or branch they served in was their military family and for some people, this still is the case today.
- Over and beyond the Armed Forces breakfast clubs, many disparate, independent led, veteran support groups, associations, and charities have surfaced. These being self-sufficient organisations, operating as close-knit family support networks inclusive of ex-service personnel and military families, supporting each other and giving back to the community in many ways.

Transition

This discussion was on understanding challenges in transition faced by those who have served in the Armed Forces, their views and lived experiences.

<u>Preparation for Transition</u>

- There is a huge difference in what constitutes as 'transition' into civilian life 10 years ago and the present time. A MOD transition service in now in place, which was not available to service leavers over a decade ago. However, there is still room for improvement.
- Many people were not well prepared for transition in any form and struggled to make the lifestyle changes. People were faced with many barriers, i.e. accommodation, managing PTSD, relationships, financial support, life skills, employment, etc.
- They had trouble with basic things such as knowing how to get a GP and dentist, paying a cheque, cooking and feeding themselves. They felt lost. The Armed Forces had previously taken care of everything and the skills people needed in civilian life were different.
- The lifestyle in the Armed Forces, the humour and banter, are completely different to civilian lifestyle. In the Armed Forces, there were laws and rules that included "*how you behave and where you could travel to and not.*" People felt lost without a formal structure. *"…Joined at 16, knew nothing about civilian life. Which left me not prepared in anyway shape or form.*"
- Some were fortunate to have a better experience due to their ranking. People left the Armed Forces with different resettlement packages, and therefore different levels of support.
- Some struggle with the lifestyle change and re-join the forces as reservist.

<u>Networks and Hubs to Help Transition</u>

People said their main barriers with transition were finding suitable employment, accommodation, and financial support. Having some form of support network and timely access to advice and information in the early stages of transition can make a big difference to people's experience and mental wellbeing, and support a smooth transition into civilian life.

This could include:

- A more coordinated and streamed service, such as a dedicated support and focal point at the council, where Armed Forces leavers can visit. For example, someone to talk to, such as a council recruiting officer, who can direct people to the right place, first-time.
- A veterans' hub where people can feel comfortable, safe, and interact with other ex-service personnel.
- Life skills training or workshops to develop different life skills/ interpersonal skills to support transition into civilian life.
- The military providing resettlement support for those coming to the end of their service.
- Events/gatherings for veterans to obtain information and support.

Community and Relationships

There was discussion on community and relationships to understand how the civilian population treated ex-service personnel when they came out of the Armed Forces.

Treatment and Bias in Civilian Life

People's experiences were mixed:

- Some people found it positive and were treated with respect, appreciation and shown gratitude. "*Being ex-military does sometimes aid and open doors*."
- Whereas others stated they were badly treated, and did not otherwise feel respected or that they benefited from serving in the Armed Forces. Many people encountered some form of prejudice and faced challenges, especially after the last two Gulf Wars.
- Others felt they were treated "*no different to anyone else*", "*just another person*".
- Experience varied in different parts of the country, with a few participants saying that they were treated much better in places like York, Staffordshire, and Plymouth, than they were in Birmingham.

Many participants experienced bias in various areas of civilian life due to their services background, such as:

- Housing
- Employment/work
- Education and skills
- Social services/ benefits
- Communication style (military banter)
- Welfare associations
- Service entitlements

"*Left military, went to Washwood Heath Centre and said these are the services we are entitled to - refused them, laughed in the face*."

- A few people stated they did not feel Armed Forces charities were supportive towards them because of their ethnic background.
- A few felt that they had been fortunate because of their education, training, or skills, particularly if they had a trade background in areas such as engineering or nursing.
- Stigma still exists in disclosing that they are a veteran or ex-military. Many ex-servicemen choose not to say or bring it up. Participants felt more needed to be done to address stigma, in the workplace and in the community, to enable people to seek support.

Community Involvement & Engagement

Many participants told us they were actively involved in their local communities:

- Many were involved in a range of community activities. Examples included: breakfast clubs, youth work, church groups, Royal British Legion and similar organisations, other charities, etc.
- "*For a period of two years, I didn't want to get engaged and just find my feet. I now give back to community, work with aspiring young black people, am the soldier mentoring in military career*."
- Some participants were active veteran connectors or in a position of responsibility, taking the lead in running and managing a veteran support association, charity, or group.
- Those supporting other veterans through work or support groups requested information on services. "*It would be good to know about point of referral and in addition, knowing about various services and signposting individuals*."

Those who weren't actively engaged in their local communities:

- Struggled with civilian life, choosing to distance themselves from the community.
- Took a while until they felt ready to connect.
- Found organisations were not receptive and welcoming, especially to ethnic minorities.
- Wanted to be left alone to rebuild their own life.
- Were not aware of what was available in their local community.

Most participants who were not actively engaged in their local community thought that they couldn't be encouraged to engage. However they did still want to be made aware of what was available and to have that choice

Loneliness and Social Isolation

A discussion followed on loneliness and social isolation to determine who the participants turned to for support, and to understand any experiences that they had with Armed Forces charities, social care, or the voluntary sector for that support.

Social Isolation and Connections

- This ties in with difficulties around transition, where an effective support network is key, and social isolation has a negative impact on transition to civilian life.

- Without a good social network in place, veterans tend to experience social isolation and loneliness within the first 6 to 12 months of their transition. “I was *left quite isolated, and it was hard to maintain close relationships outside military, having been away for long periods*.”
- Some struggled to reconnect with their families and talk about their military experience – “*what they have been through and seen*.” Some even experienced relationship breakdown.
- Employment and social connections can help reduce social isolation and loneliness. More proactive and better coordinated support is needed, including for military wives and families. “*Civilians don’t understand what you have been through, husband away and bringing kids up alone.*”
- In terms of positive experience, some were able to talk to a range of health and voluntary sector organisations, associations, including their veteran peer support network or group. Some had established support networks with friends who were also veterans or still serving.

Fragmented Networks

- The veteran community is diverse and disconnected. More is needed to bring the community together as a whole to reduce fragmentation.
- The military system is also very fragmented. The Armed Forces and local authorities need to improve interfaces and communication with each other.

Community and Organisation Support

- Experience and use of Armed Forces charities and voluntary organisations is varied.
- Barriers still exist amongst the veteran community in asking for help. “*Pride is stopping people*”.
- There is a perception that drop-in support centres are “*all closing*.” Combat Stress have had their funding stripped and are not taking on new referrals. Veterans are struggling to access the service and refer ex-service personnel. There is not enough government funding helping relevant charities and support groups - “*people are having to raise funds themselves.*”
- There should be work done to connect organisations, Armed Forces charities, social care, council, voluntary sector, and veteran network groups so they have integrated communication.
- Recommendations for tackling social isolation were very similar to those for tackling transition, with an emphasis on one-stop hubs and websites for guidance and support, support for learning life skills, more positive media coverage, and events to bring veterans together and raise awareness.

Employment, Education, and Skills

This discussion was about participants’ experience of looking for work on leaving the Armed Forces, and what support they accessed for it.

Experience of looking for work varied. A minority secured jobs easily, especially those with skills suitable for specific trades, but this was not the case for everyone. Many people faced several barriers with employment and transition, trying numerous jobs before they found a

suitable match or trade. Some retrained to have better career prospects but found this does not always guarantee employment.

Barriers and Issues

- Military skills and qualifications are not always easily transferable or understood, and are often undervalued. "*Left military. All military qualifications not valued in civilian life*."
- Struggling to fit in with the work culture, not being able to be themselves, as it was so different from their military culture, such as different senses of humour.
- Stigma and negative perceptions from being in the military.
- Complex mental health issues, including PTSD.
- Support varies depending when ex-service personnel left the Armed Forces, with different resettlement packages based on service length. "*Younger recruits not getting help*."
- Not enough support for ex-service personnel to network, to seek employment opportunities, and be made aware of what is available. Government funding cuts impacted not just community support but employment, too.
- Some people told us they did not access any support, were not offered any, or didn't even know about it.

Tailored Career Support and Raising Awareness

- Transition support has improved, but individuals still need dedicated and tailored career support. There should be appropriate training that helps with gaining long-term opportunities. "*Some 60-year olds are being trained in plumber trade, short term*." Career support for military wives was important, too.
- Employers need more awareness and appreciation of veterans' transferable skills. "*Make civilian aware what military bloke have to offer and vice versa, i.e. graft skills. Communication and mutual respect.*"
- Another suggestion was for the council to run job fairs focused on helping ex-military, inviting companies to guide and advise. Some veterans may be better suited to getting support in setting up their own business.

Even if they secured a job, some struggled with managing the cost of civilian life on a lower income than what they had been used to. This will be further discussed in the Finance and Debt section.

Finance and Debt

This discussion was to understand how prepared people were for managing the costs of civilian life (i.e. housing repairs, commuting, and dental treatment).

Transition Issues

- As with the other aspects of transition, many people were not well prepared for managing the cost of civilian life and struggled. Suitable employment and accommodation came up as critical success factors when it comes to civilian life and health and mental wellbeing.

- Lots of participants faced many challenges in leaving a secure military environment and having to fend for themselves. Putting food on the table for their families and surviving. Many did not have previous experience in even basic budgeting and were overwhelmed with the complexity of daily living costs, from paying rent to dealing with house repairs, to the cost of travel and taxes. "…*Taken me 15 to 16 years to be on my feet again*."
- They struggled to budget on less money compared to their military salary and housing provision, and some veterans went into deep debt.
- A small proportion didn't struggle financially with the transition to civilian life.

Impact of Debt

- Debt has had a significant effect on ex-service personnel, their families and their health and mental wellbeing. Participants have experienced family breakdowns, divorce, unhealthy habits, mental ill health, and even homelessness.
- There are some who cannot cope and develop alcohol, drug, gambling addictions; behaviours which impact both their mental health and their finances. "*Employment came out low wage, and rubbish jobs, and then drinking, and so hard for budget*."
- Participants mentioned that some ex-service personnel are in denial over their debt issues – they "*run away from it or ask for help rarely*."

Government and Charity Support

- There is a lack of information and awareness of what support is available for veterans to access and what to expect when leaving the Armed Forces. Advice is fragmented and inconsistent across the system and regions. "*No consistency, post code lottery of what you access, different across different regions i.e. Coventry, Birmingham, or up north.*"
- Some participants are aware of Armed Forces charities supporting veterans with debt and financial issues, including the Combat Stress and SAFFA organisations.
- Some participants believe that there is more of a support system in place to help asylum seekers, migrants, and refugees, than veterans.

Awareness and Access to Advice

- More work is required to raise awareness and streamline advice, support, and information so veterans can more efficiently access services when they need it, such as dedicated support for war pension claims, or a one-stop shop to provide support with getting work.
- Support Armed Forces leavers (in advance) to think about and prepare for key aspects of civilian life, e.g. renting or buying a property, living on a tighter budget.
- Support financial upskilling by providing more training on budgeting. The Armed Forces could consider a budgeting service as part of the transition pathway.

Health and Wellbeing

This discussion was aimed at understanding participant experiences accessing health systems, e.g. GPs and hospitals. As with all topics, participant experiences of accessing the

health system varied. A minority of participants experienced no major issues, but most struggled and found it difficult.

Health Issues

Many participants reported that they had faced some form of health issue(s) since leaving the Armed Forces. A few people mentioned service-related injuries and having multiple co-morbidities. "*Knee, right knee, asthma caused by military. In military any issues get you sorted and get you back on your feet. Suffering because of that*." Types of health issues included:

- Mental health, e.g. stress, anxiety, depression, complex PTSD.
- Drinking, drugs, and gambling addictions.
- Physical issues including asthma, musculoskeletal problems, limb injuries, hearing difficulties, etc.

Access to GPs

The Armed Forces Covenant is not working in terms of access to healthcare with GPs:

- GP appointments proved difficult to obtain. Some veterans struggle when registering with a GP and seek support from fellow veterans in order to do so. Other veterans go straight to hospital instead.
- "*Struggled with GP access, conflict with GP…. Four months later refer to mental health psychologist in the surgery upstairs. GP wasn't aware within the surgery. Refer to mental health TILS complex team. GP doesn't know how to do to referrals for mental health.*"
- The priority code for GP access does not always work for Armed Forces veterans. This can lead to a delay in accessing the services that they're entitled to. Increasing awareness of the priority code amongst GPs will help veterans to access care more effectively.

Accessing Mental Health & Other Services

Participants reported having trouble accessing other health services too, such as mental health, dental, trauma and addiction services, hearing loss, and armed forces organisations for treating combat stress.

- Accessing mental health service issues included long waiting times, difficulty booking counselling, and not being able to have enough sessions due to lack of funding. People are "*falling through the cracks*". Those with complex PTSD and addiction problems need more support.
- There were similar issues with access for hospital appointments.
- The complexity of processes for accessing health services means more conversations are needed with veterans and military families so they have more knowledge and feel safer.
- The health system is fragmented and confusing. A tick box process with too many forms and bureaucratic processes. Participants suggested multiple touch points for veterans to access services and provide a more streamlined service.

- Relevant organisations need to improve interfaces and strengthen partnership working.

As with other key themes, a central council-run point, hub or 'one stop shop' with information for veterans was recommended.

Discussion on Mental Health

Part of the Health & Wellbeing key theme, Enigma's analysis had a separate section on mental health, looking at whether participants believe that certain groups are more at risk and why this may be happening.

Impacts on Mental Health

- There are certain groups within the Armed Forces at greater risk of poor mental health. These include those who have been on tours, on the frontline engaging in close action and who have seen live action/war. "*A lot of things happen on tours, not hear about it, not reported, see and hear a lot. Being bombarded is going to have an effect and no rest on tour*."
- Other groups who are vulnerable include those in prison, or who work in prison or emergency services, those with injuries, younger veterans who were early leavers. People felt that suicide is an issue for younger veterans, who have less experience in dealing with and processing negative experiences.
- Many veterans' mental health has been impacted during the pandemic due to: lack of a support network, social isolation and loneliness; being unable to go out; family conflict/tension; being furloughed.

PTSD and Other Mental Health Issues

- As well as PTSD, many veterans have also experienced sleep issues, suicidal tendencies, self-harm, and alcohol abuse related issues.
- Access to mental health services is problematic. More proactive care and support in the community is required. Those with PTSD and other mental health issues are often falling through gaps in the system and missing out on treatment.
- Early recognition of PTSD is needed. There is variation in healthcare professionals' understanding, recognition, and management of PTSD. Not all take it seriously enough. Prejudice exists within services; people feel let down and do not trust easily.

Mental Health Stigma

- The Armed Forces culture is getting better at speaking about PTSD. Historically, this was not the case.
- It is important to address the stigma around asking for help with mental health in order to encourage people to reach out. "*It is OK to be not OK!"* There needs to be proactive care in the community to raise awareness and intervene earlier, rather than relying on individuals to reach out: "*Make them aware, we can help*."

Supporting Veterans with Their Mental Health

Several improvements are mentioned that could support veterans and military families to support their mental wellbeing and feel safe, such as:

- A central point, hub or one-stop shop that is a safe space, "*a sanctuary*".
- A dedicated website with advice and guidance.
- A booklet with relevant contacts.
- A veteran ambassador or spokesperson.
- Meaningful voluntary and community work.

Housing

This discussion was based on participant experiences of finding housing after leaving the armed forces.

Different Experiences of Housing

Participants reported a varied experience of housing choices upon leaving the Armed Forces, which impacted their direction in life, including:

- Renting private accommodation.
- Living with family either in Birmingham or elsewhere in the country.
- Relying on family or partner to arrange social housing for them as they didn't know how.
- Traveling for some, or finding work abroad.
- Buying their own house

Veterans' experiences of housing is dependent on individual circumstances, such as: suitable employment, family, relatives, relationship breakdown, social networks and financial support entitlement based on their years of service. Many didn't have financial reserves to place a deposit for temporary accommodation or put towards a mortgage.

A minority had no problems with housing on leaving, some did not prepare well but eventually secured accommodation, and others found it a stressful and challenging experience. A number of people didn't have the relevant knowledge or support to secure accommodation, such as finding references.

Social Housing

- Some veterans had to rely on other options when they could not get social housing, and others are still having issues with social housing. The process to obtain council housing is difficult: "*the council has a point system in place, which requires you to get points and bid against others*."
- Many people told us they have faced issues in accessing social housing because of their service and some still do.
- More support should be provided to Armed Forces personnel with proving who they are, to help with references for council housing, obtaining a mortgage, or renting.

Government & Council Support

- The Armed Forces covenant is not working, and veterans should be given priority housing.
- There is a perception that communication is poor between the council and military and needs to be improved.
- Many veterans were unaware of the *Armed Forces' Help to Buy scheme* and they wanted more information. A different scheme was in place when they transitioned.
- As discussed in Finance & Debt, people believe that there is more of a support system in place to help asylum seekers, migrants, and refugees in comparison to veterans.

Homelessness

This discussion was about the public perception of homelessness being a major issue for veterans and whether homeless veterans are over-represented.

Are Veterans Over-represented?

- There were differing views on whether veterans are over-represented in homelessness or not, including some participants feeling they had no idea either way.
- Some thought it was likely those who weren't military would claim to be, whereas actual military would "*feel too embarrassed*" to seek support.
- Others thought that veterans' lack of willingness to ask for help, or not knowing where to go for support, would make it more likely for them to experience homelessness when vulnerable. Too many veterans fall through gaps and fail to access the required support.
- The issues that veterans face transitioning to civilian life (finances, relationship breakdown, finding work) also contribute to being over-represented for homelessness.
- Some thought that veterans were over-represented in terms of suicide because of issues with homelessness and unemployment.
- Participants reported concerns over the validity of the data used to measure veteran homelessness, with a potential undercount. Many are being missed as they are not on the streets but are still homeless, such as those couch-surfing or being supported by other veteran families or independent veteran peer support groups. Methodology and classification of homelessness data should be reviewed, making it more robust, open, and transparent.
- Recording statistics specifically on veterans in terms of suicide and mental health would help identify veterans' needs in this area.

Support for Homeless Veterans

- Raise awareness of support available to homeless veterans. The council needs to identify them earlier in the process and help navigate them towards support.
- There is no support system in place or any follow-up checking on veteran welfare. Consider a follow-up 6 to 12 months after the veterans have left the Armed Forces.

- Several options on how to make appropriate housing available for veterans to help prevent or relieve homelessness were offered by participants:
    - Use surplus military or council properties
    - Take US best practice and "*use hotels and camps, camps are being converted for those that are homeless*."
    - Provide a transition living area/camp that provides tailored, structured advice and guidance.
- Provide a list of key contacts to signpost people to independent veteran-led support organisations, associations, charities and groups: "*To point in the right direction, then go from A to B.*"

Suggestions were made on how to identify homeless veterans – they look tidy, are much cleaner, and are mainly younger men living under bridges where it's "*safe*", with women veterans tending to couch surf.

Conclusions and Recommendations (from Enigma Consulting)

People do identify themselves as a veteran and are proud and happy to be a veteran. However, there are many challenges faced by veterans and military families in the city.

Transitioning to civilian life has caused many issues. Social housing, finances, adequate employment, suitable employment trades and skills, and mental health, are all still a challenge. More is required to tackle the cultural issues and address stigma both in the workplace and the community. Many people struggle with adapting to civilian life and as a result, some join back with the forces as a reservist.

There is a strong view among participants that the *Armed Forces Covenant* commitment has not been upheld in Birmingham and that more awareness is needed across the whole system around the Priority Code.

Communication, interfaces and partnership working across the Armed Forces, the council, and other public sector organisations needs to be improved. People want more clarity on what the council are offering in terms of veteran support. Participants reported that the main barriers were around access to timely information, support and advice. They reported not knowing where to go to access support, and not knowing what support and social benefits are available to veterans from the council. Other challenging aspects included accessing health services, i.e. GPs, dentists, and other health systems, (including getting mental health support for PTSD and addictions).

Primary care providers and others on the frontline of healthcare should be given education on the process of transition and how to help, including understanding what veteran support is available. This would help veterans to access the relevant services and address their mental wellbeing and physical health matters more promptly.

There are psychological barriers that prevent veterans from accessing services, particularly related to pride. Seeking support from Armed Forces charities is not seen as a military behaviour. Also, many choose not to identify as a veteran due to fear of being stigmatised.

Participants did not feel they were given priority or valued for their contributions. More appreciation is needed across the system, such as priority access to services, schooling,

housing, and employment opportunities. Also, more community wellbeing events and training are needed to educate and empower this community around life skills, health, and mental wellbeing.

A central point, hub, or single point of access (SPA) at the council could make it easier and more efficient for people to access advice, support, and information. There are many charities and organisations across Birmingham - information needs to be more coordinated and streamlined to prevent people from being passed around several organisations, reducing multiple touch points.

When commissioning and designing services for veterans, their family's perspective should be taken into account so that their needs can also be focused upon.

More proactiveness in terms of early intervention and community support is required to tackle veteran homelessness and suicide. The system should navigate people towards accessing support much sooner and earlier in the process, instead of waiting until it gets to the sectioning stage. However, there is recognition that many choose not to come forward which means that mental health issues are often undetected.

Work is required to build trust and bridges with the veteran community. Several suggestions include:

- Establishing a local forum for veterans to come together to support the Armed Forces Champion. Roles could include informing policy and contributing to service re-design.
- Running an annual or bi-annual veterans welfare exhibition and conference in the city.
- Establishing a tri-services veteran centre within the city centre, providing a permanent presence within the city for those veterans in immediate need and a friendly place to meet, eat and have a coffee.
- Creating a permanent point of contact in the council for veteran welfare matters.

Participants felt let down and frustrated, but there is broad recognition that things have advanced in terms of transition support for current Armed Forces leavers, when compared to what was received by those who left service ten years ago or more. However, there is still considerable room for improvement to make the transition smoother and easier.

5.4. Engagement Questions

<u>What is a veteran?</u>

- Do you identify with the MoD definition of "*veteran*"?
- Do you prefer the term ex-service personnel or something different?

<u>Community and relationships</u>

- How did the civilian population treat you when you came out of the Armed Forces?
- Have you experienced any bias because of your service?
- Are you involved with your local community? If so, how? If not, what would make you more likely to engage?

<u>Exploration of loneliness and social isolation.</u>

- What makes a good support network?
- Who can you talk to?

- Have you used Armed Forces charities, social care, or the voluntary sector for support? If so, what was your experience?

Employment, education, and skills

- What was your experience of looking for work on leaving the Armed Forces?
- What support (if any) did you access?
- Did you have the support you needed?
- Did you find that your skills were valued by civilian employers? What would improve this?

Finance and debt

- How prepared were you for managing the costs of civilian life? e.g. housing repairs, commuting and dental treatment.
- What was your biggest challenge with budgeting?
- Have you, or any ex-service personnel you know, had difficulty with debt following transition? What effect did this have?

Health and wellbeing

- How have you found accessing health systems e.g. GPs, hospitals?
- What are the main health issues you and fellow ex-service personnel have faced since leaving the Armed Forces?
- Do you believe certain groups are more at risk of poor mental health?
- What have been the main causes of poor health for you or other ex-service personnel?
- What would help you to stay healthy?

Housing

- What was your experience of finding housing after leaving the Armed Forces?
- Have you, or other ex-service personnel, found it difficult to access social housing because of your service?
- Have you used the Forces *Help to Buy* scheme? If so, what was your experience?
- There is a public perception of homelessness being an issue for ex-service personnel but there is no evidence to suggest that veterans are overrepresented. What do you think about this?

6. Gaps in Provision/Unmet Need

In this section we discuss the gaps and unmet needs that have been identified through the deep dive process.

6.1. Veteran Data

The main gap is the lack of data on veterans in the city, which is also a nationwide problem. An accurate representation of the population and their health and wellbeing needs is not fully known. Improved data collection should develop our access to relevant data in the future for better insight. Enhanced data collection has been a cross-cutting factor in the 2018 Veterans Strategy and the development of the veteran friendly GP accreditation scheme. However, health professionals still rely upon veterans being willing to self-report in order to be registered correctly and it's also possible that organisations may be using the wrong terminology because many young veterans may not identify themselves as veterans, due to believing the term to refer to older ex-personnel.

Focus group discussions highlighted that vulnerable veteran groups, such as those who are homeless, and/or living with mental health issues, needed improved data collection to identify the scale of their needs and to tackle their issues more effectively.

6.2. Housing

Social housing is available to veterans, including those at risk of offending.[133] This service also provides wrap-around support relating to wellbeing and routes into employment.

Focus group research noted that data on homeless veterans needs to be developed further in order to identify the full scope of homelessness needs and to plan for more effective services in the future.

6.3. Healthcare

There is a lack of awareness within primary care about the healthcare needs of veterans. A random sample of GPs in the city were asked whether they used the recommended Read code *'History Relating to Military Service*': Xa8Da in their computer systems. The survey found that very few GPs were using this code. Only 20 practices in Birmingham are registered as Veteran Friendly.

Mental health service access and treatment overall was an issue with focus group participants, with concerns over lack of funding and cuts to services, as well as attitudes towards veterans' specific issues. Participants with PTSD commented that there was an inconsistent approach and understanding of the disorder in the healthcare system, with issues around prejudice and lack of trust.

The *House of Commons mental health report* [134] highlighted that some veterans who need mental health care are facing barriers to seeking help or receiving low standards of care. Availability of care varies depending on where they live. There was a concern in this report

[133] Impact Pathways. Organisation: Fry Housing Trust. https://www.ipwm.org.uk/Fry-Housing-Trust/Pathway-Services/ Accessed 22 April 2021.
[134] House of Commons Defence Committee. Mental Health and the Armed Forces, Part Two: The Provision of Care. https://publications.parliament.uk/pa/cm201719/cmselect/cmdfence/1481/1481.pdf Accessed 20th May 2021.

that outreach centres are too "*city centric*" in places like Birmingham, and that veterans in more remote areas struggle. Beyond that, there is no Birmingham-specific analysis on the quality of veteran-centred care.

Health officials and clinicians reported that "*insufficient capacity*" was a key reason why some veterans were having to wait longer than they should for assessment and treatment.

Lack of resources may be impacted by: "*no clear and agreed understanding across the sector of what the full scale of the mental health problem is across serving personnel and veterans*" and therefore "*the Government is unable to determine the resources required to care for those who need it*."

This shows how overall issues around lack of veteran data (as discussed in 6.1) impacts specifically on mental health funding and priority in provision.

6.4. Transition and Community Services

There is a potential lack of a joined-up approach and co-ordination between MOD, relevant charities and the public sector. Veterans in focus groups showed concern over this failed offering which delays access to key services for managing housing, employment support and education, budgeting, counselling, etc. and may impede their long-term transition to civilian life.

The *House of Commons Mental Health Report* discussed a similar theme, showing inconsistent experiences with Armed Forces charities. Whilst some found it positive, some veterans also had negative experiences, particularly in accessing care. This was deemed due to the charity's limited capacity and subsequent limits on the treatment they could provide.

7. Opportunities for Action

This section identifies 'areas of need' to address through commissioning or other actions by local organisations.

7.1. What Would We Like to Achieve?

We would like to see the vision and principles of the *Veterans Strategy* implemented across the city. The city should understand and value the contribution made by those who have served in the UK Armed Forces, and their families. The transition back into civilian life should be smooth and take into account the unique nature of service in the Armed Forces.

We would like to ensure that the promise of the *Armed Forces Covenant* – '*that all those who serve or who have served in the Armed Forces, and their families, are treated fairly'* - is understood and implemented across the city.

We recommend that the *Birmingham's Armed Forces Community Covenant* should be refreshed in line with the recommendations of this deep dive.

7.2. Key Findings and Recommendations

Here we set out the findings from the JSNA deep dive and make recommendations as to how local partners can help us achieve our local ambitions.

Key Finding 1: There is currently insufficient data to allow a full understanding of the size and composition of the local veteran population.

Most data on veterans is available only at a national or regional level and it is not believed to be entirely reliable. The current data is cross-sectional and fails to give a robust estimate of the number of veterans in the Birmingham area. The reason for this is that routine data (e.g. GP records) is incomplete due to under-reporting. This is caused by the question not always being asked in service delivery, lack of self-reporting by veterans, and that younger veterans do not always identify as being a veteran, sometimes preferring the term ex-service man or woman. The veteran population is changing with national trends showing the number of older age veterans decreasing. However, without robust data sources on the demographic and protected characteristic information, it will be difficult to provide relevant services to meet their needs.

Recommendations:

In order to improve our understanding of the local veteran population. We recommend:

- GPs be proactive in identifying veterans within their practice population.
- Organisations capture data on employees and service users by asking and documenting "*have you ever served in the Armed Forces or Reserves?"*
- Protected characteristic information be collected and retained on veterans e.g. age, gender, disability, sexual orientation.
- Using local organisations and specialist veteran funded projects to collate aggregated data on veterans for a centralised database, e.g. such as British Royal Legion's work with veteran's homeless, in line with data protection guidelines.

Key Finding 2: Some veterans' needs are not being sufficiently met due to structural and cultural differences between the Armed Forces and civilian society.

Evidence suggests that veterans are likely to suffer the same range of health and welfare issues as the general population and most do make a successful transition to civilian life. However, service in the Armed Forces is different to other occupations, and serving and veteran personnel, as well as their families, experience unique factors as a result of their time in service. This experience is often misunderstood by the civilian population leading to difficulties. A minority experience complex issues that are often compounded by wider determinants of health such as social isolation, crime, housing and income.

Recommendations:

In order to provide services that meet the needs of the local veteran population, we recommend:

- Local GPs are encouraged to achieve accreditation as "*Veteran Friendly*" practices through the *Royal College of General Practitioners (RCGP) scheme*.
- The findings of this JSNA Deep Dive be used to inform the refresh of *Birmingham's Armed Forces Community Covenant*.
- Health and care professionals are made aware of the *Armed Forces Covenant* and understand their duties arising from this.
- Examples of best practice are shared e.g. West Midlands Police peer support network.
- A performance measure that relates to Birmingham's covenant aims is set.

Key Finding 3: Emerging evidence suggests a greater need for supporting Early Service Leavers, young recruits and female veterans.

A House of Commons[135] report highlighted early service leavers (ESLs), young recruits under the age of 18, and female personnel as potentially more vulnerable to developing mental health conditions as other veterans and research has also suggested that these veteran groups also have an elevated risk of suicide.[136] Anglia Ruskin University undertook research[137] on whether there were gender differences in barriers to mental healthcare support and found that more women reported facing additional barriers accessing mental health support due to their gender. The focus groups believed that early service leavers were more vulnerable to mental health issues, including suicide, due to lack of support, life experiences, and that homeless female veterans were more likely to be invisible and therefore not receive support due to couch-surfing instead of rough sleeping. However, more data is needed to gain insight into these groups' needs.

[135] House of Commons Defence Committee. Mental health and the Armed Forces, Part One: The Scale of mental health issues: Government Response to the Committee's Eleventh Report. https://publications.parliament.uk/pa/cm201719/cmselect/cmdfence/1635/1635.pdf Accessed 21 May 2021.
[136] Kapur, et al. Suicide after Leaving the UK Armed Forces – A Cohort Study. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2650723/ Accessed 16 June 2021.
[137] BMJ. Anglia Ruskin University. Female military veterans face additional barriers accessing mental health support. https://www.bmj.com/company/newsroom/female-military-veterans-face-additional-barriers-accessing-mental-health-support/ Accessed 21 May 2021.

Recommendations:

In order to more effectively understand the level of need amongst potential high-risk groups of veterans, we recommend:

- Local surveys and qualitative work to understand the health needs of Early Service Leavers, young recruits and female veterans.
- Action to understand the possible barriers and inequalities faced by these and other potentially high-risk groups.
- Connecting with relevant support groups to consult on their needs and concerns, such as the Women's Royal Army Corps (WRAC) Association.
- Investigating how safe spaces for these veterans have been or can be created to share their concerns and/or access specialist resources.

Key Finding 4: There are specific barriers that need tackling to connect veterans to resources that can support them in times of need.

This was a strong theme across the focus groups discussion (Section 5). The barriers include the military culture that leads to some veterans being unwilling to seek help or being unable to recognise when they need help/support, and so not reaching out for services early enough or at all. There is also the issue of whether all veterans are aware of and have help accessing the resources available to them to deal with specific issues, such as job training, budgeting support, discounts, specialist health services and relevant veterans support groups.

Another aspect is that the relevant organisations may not always have the capacity to effectively connect with and support all veterans who need their help. This may be due to a lack of joined-up services across the military and public sector, or due to funding and resource issues.

Recommendations:

To sufficiently connect veterans with the services that can best meet their needs, we recommend:

- Ensuring there are clear lines of communication between MOD transition services and the council regarding military leavers locating to or residing in Birmingham.
- Creating a unified, centralised hub or service with a holistic approach that provides information about potential services to interested veterans without them having to reach out to multiple, disparate organisations.
- Establishing a more pro-active and preventative approach to veteran's mental health issues, navigating people towards accessing support much sooner and earlier in the process.
- Ensuring that key information about specialist veteran support is made available to veterans when they contact public services for different types of support (e.g., employment opportunities, housing support).

Birmingham Health and Wellbeing Board

	Agenda Item: 14
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**27th July 2021**
TITLE:	**CREATING A MENTALLY HEALTHY CITY FORUM**
Organisation	**Birmingham City Council**
Presenting Officer	**Natalie Stewart, People Team Service Lead, Public Health**

Report Type:	**Presentation**

1.	**Purpose:**
1.1	To provide an update on delivery to date, and current and planned activity on selected workstreams within the context of Creating a Mentally Healthy City Forum and the wider mental health portfolio.

2.	**Implications:**	
BHWB Strategy Priorities	Childhood Obesity	
	Health Inequalities	Y
Joint Strategic Needs Assessment		
Creating a Healthy Food City		
Creating a Mentally Healthy City		Y
Creating an Active City		
Creating a City without Inequality		
Health Protection		

3.	**Recommendation**
3.1	The Health & Wellbeing Board is asked to note the contents of this report

4. Report Body

4.1 Background

4.1.1 The Health and Wellbeing Board established the 'Creating a Mentally Heathy City Forum' (CMHC) to focus on action on improving mental wellness across the City. The focus of this Forum is on upstream prevention; creating a City where everyone, at every age, and in every community can achieve their potential and prosper

4.1.2 The forum met on 17th June 2021 for the first time since June 2020. The Forum meetings were placed on hold due to the need for Public Health to focus resources on the various activities being taken against COVID-19 in Birmingham.

4.1.3 Whilst the Forum itself has been on hold various projects have been progressed and this report will provide updates to the Board as requested on:

- Terms of Reference
- Prevention Concordat
- Peer Mentoring/Mental Health Champions
- Better Mental Health Fund
- Suicide Prevention

4.1.4 The full agenda of the recent Creating a Mentally Healthy City Forum can be seen as **Appendix 1.**

4.2 Current Circumstance

4.2.1 Terms of Reference

The Terms of Reference has been in place since 2019 and is now due to be refresh after being in place for two years. It will expire in September 2021. A draft document will be ready in time for the next Forum meeting scheduled for 19 August. The Chair and Director of Public Health will be asked to review and feedback after which it will be presented to the Forum membership for their comment. New members are currently being nominated to fill gaps left by original members due to changes in job roles and/or organisations.

4.2.2 Prevention Concordat

The Prevention Concordat for Better Mental Health was due to be signed in 2020 but was delayed due to the lockdown and having to step down the Forum due to other Covid-related priorities. The Concordat was relaunched in December 2020 to include the effect of Covid-19 on good mental health and wellbeing and seeks to find the actions that will be put in place as we work alongside our community and partner organisations to reduce inequalities and mental health issues across the life course. It also wants to find out how we prioritise and engaged with the most vulnerable citizens in our City for better physical and mental health. The Concordat has been drafted and reviewed by Public Health England as part of the new process and the document revised in

accordance with their feedback. It will now be sent to the Director of Public Health and the Chair of the Creating a Mentally Healthy City Forum for their comments after which it will be presented to Forum members. We are aiming to achieve Commitment Level on application to Public Health England.

4.2.3 Peer Mentoring/Mental Health Champions

This is a joint initiative between Public Health Children and Young People Team and the Mental Health Team. Progress has been made on the design of this project that will support children and young people on building good mental health and wellbeing. We are working with Birmingham Education Partnership (BEP) and through their support we have a Focus Group made up of volunteers who work in mental health, children and young people services, education/educational psychologist, young people with lived experience, service provider for children services, academics, and community workers. We are about to use the feedback to write a draft specification and will be sending to the Focus group for their feedback. Another meeting is in the pipeline. We are hoping to commission this service by August 2020.

4.2.4 Better Mental Health Fund

This fund forms part of the government's Mental Health Recovery Action Plan 2021/22 to ensure the mental health impacts of COVID 19 are rapidly addressed; it is also part of the government's levelling up agenda. Funding must be spent in year.

Funding has been allocated to the top 40 most deprived local authorities using the Indices of Multiple Deprivation 2019 (Ranking of average rank).

We have been successful in securing funding from Public Health England (PHE) following approval of our proposed plan for prevention and promotion of better mental health.

Birmingham has selected a range of interventions for this funding to address mental health and wellbeing needs across the life-course: for example, support for children, young people and families, working age and older age groups. The range includes universal programmes that are available across the city as well as interventions that are targeted to specific ethnicity, faith groups and populations by identity or behaviour so that we can address key areas of inequality as evidenced by local and national research, community engagement and stakeholder consultation.

We have prioritised interventions that will have a lasting legacy beyond the fixed-term funding, that are evidence based, that build upon established work programmes, that focus on skills development and resource development and where there is a clear evidence of need.

4.2.5 Suicide Prevention

The last Suicide Prevention Advisory Group took place on 10th June 2021 for the first time since June 2020. The Forum meetings were placed on hold due to the need for Public Health to focus resources on the various activities being taken against COVID-19 in Birmingham.

Collaborative cross-sector working is evident with a number of service providers and stakeholders swapping details so they can find new ways in which to work together to ensure services are provided consistently and as widely as possible.

The Action Plan now mirrors the Health and Social Care Overview and Scrutiny Committee Progress Report.

Despite to the ongoing pandemic, good progress is being made against actions with most being either, In Progress or Achieved.

We are now working on moving the two Year 2 Actions forward with plans underway to ensure progress is achieved and bids received as part of the Better Mental Health Fund will help toward this.

5.	**Compliance Issues**
5.1	**HWBB Forum Responsibility and Board Update**
5.1.1	All work within the remit of the Forum will be reported to the Board as either a presentation (similar to today) or as part of the information updates detailing all Forum activity as per current governance arrangements. Day to day responsibilities are managed: • Internally via regular weekly team meetings in line with agile project management principles (monthly updates as a minimum), and regular updates to the Cabinet Member for Health and Wellbeing through the Public Health Cabinet Member Briefing sessions (as requested). • With partners through the Creating a Mentally Healthy City Forum, as well as multiple interfaces on shared work packages, objectives, and outcomes.

5.2	**Management Responsibility**
	Natalie Stewart, People Team Service Lead, Public Health Division Mo Phillips, People Team Service Lead, Public Health Division Dr Maria Rivas, Interim Assistant Director of Public Health

6. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Delivery of the Better Mental Health Fund	Low	Low	Contract management and regular communication with commissioned organisations

Appendices
Appendix 1 – CMHCF May agenda

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

Natalie Stewart, People Team Service Lead, Public Health

Andrea Walker-Kay, People Team Programme Senior Officer

CREATING A MENTALLY HEALTHY CITY FORUM GROUP

Thursday 17 June 2021 10.00-12.00

Meeting will be held via Teams – log on information included in meeting invitation

AGENDA

This is not a public meeting but may be recorded for accuracy on Action Notes

1.	Welcome and introductions of members of the 'Creating a Mentally Healthy City' Forum Sub-Committee, along with apologies received	Cllr Paulette Hamilton	5 mins
2.	Briefing from Chair	Cllr Paulette Hamilton	5 mins
3.	Action Notes from meeting 10 June 2020	Mo Phillips – Service Lead People	5 mins
4.	Suicide Prevention Action Plan update	Mo Phillips – Service Lead People	15 mins
5.	Mental Health Team Delivery Plan update	Mo Phillips – Service Lead People	20 mins
6.	Relaunch of the Prevention Concordat	Dr Justin Varney - DPH	10 mins
7.	Health and Wellbeing Board – Creating a Healthy City Framework	Stacey Gunther – Service Lead Governance	20 mins
8.	Prevention and Promotion Fund for Better Mental Health – Expressions of Interest	Dr Justin Varney - DPH	10 mins
9.	Update on the Birmingham Mind Helpline	Helen Wadley – CEO Birmingham Mind	10 mins
10.	Any other business (AOB)	Cllr Paulette Hamilton	5 mins
11.	Dates identified for future meetings, subject to agreement by the Forum: ○ Thursday 19 August 2021 1000-1200 ○ Thursday 14 October 2021 1000-1200 ○ Thursday 16 December 2021 1000-1200		

Birmingham Health and Wellbeing Board

	Agenda Item: 14
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**27th July 2021**
TITLE:	**PUBLIC HEALTH ADULTS COMMISSIONED SERVICES UPDATE**
Organisation	**Birmingham City Council**
Presenting Officer	**Bhavna Taank – Public Health Service Lead (Adults)** **Karl Beese – Commissioning Manager, Adult Public Health Services**

Report Type:	**Information**

1.	**Purpose:**
1.1	This report is to provide a progress and operational summary of the following Public Health contracts; Health Checks, Smoking Cessation, Sexual Health and Adults Substance Use.

2.	**Implications:**	
BHWB Strategy Priorities	Childhood Obesity	
	Health Inequalities	x
Joint Strategic Needs Assessment		
Creating a Healthy Food City		x
Creating a Mentally Healthy City		x
Creating an Active City		x
Creating a City without Inequality		x
Health Protection		x

3.	**Recommendation**
3.1	The Board is asked to note the progress detailed in the report.
3.2	Board members are asked to continue to work to mitigate the effects of COVID in the delivery of these services.

3.3	The Board is asked to note that services are operating differently due to COVID.

4.	**Report Body**

4.1 The paper summarises progress made in the delivery of Sexual Health, Substance Misuse, Health Checks and Smoking Cessation. Key themes covered include:

- Progress and performance
- Performance During COVID
- Delivery Measures implemented and payment arrangements
- Post COVID Delivery of services
- Re-procurement intentions

4.2 Sexual Health

In addition to the service overview the update includes details on the proposed contract extension, the sexual health needs assessment and Fast Track Cities Plus. These can be found in section 1.4 of the attached report.

4.3 Substance Use

The substance use overview includes details on the Triple Zero City Strategy that aims to identify how we should tackle drug and alcohol addiction across Birmingham, in addition to details around contract re-procurement. These can be found in section 2.4 of the attached report.

4.4 Health Checks

The health check service overview includes an overview of the last 3 years to demonstrate the local performance of Health Checks. The update also highlights the new ways of working post COVID, commissioning and uptake from patients of service delivery. These can be found in section 3 of the attached report.

4.5 Smoking Cessation

In addition to the service overview the update details performance over the last 3 years to provide an overview of Smoking Cessation with GPs and Pharmacies. The update also highlights new ways of working during and post COVID, including Quit with Bella, commissioning intentions and uptake from patients including appropriate campaigns to promote services further and increase uptake. These can be found in section 4 of the attached report.

5.	Compliance Issues
5.1	**HWBB Forum Responsibility and Board Update**
5.1.1	The impact and mitigation of the disproportioned risk of Covid-19 on the delivery of these services will continue to be monitored though the performance management processes within the Public Health Adults and Older Peoples Team.
5.1.2	The impact and mitigation of commissioning risk on the re-procurement of these services will continue to be monitored through the closely monitoring of the project pan between the Commissioning Team and Public Health Adults Team.

5.2	**Management Responsibility**
	Dr Justin Varney, Director of Public Health, Birmingham City Council

6.	**Risk Analysis**		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Services cease delivery and provide inequity and inequality. Risks of COVID on these groups are also increased	Low	High	Continue partnership working and promote continuation of delivery of all services and increase activity where resources allow

Appendices
Appendix 1 – Full Update Report

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

Dr Justin Varney, Director of Public Health
Dr Marion Gibbon, Assistant Director Population
Bhavna Taank, Service Lead – Adults
Karl Beese, Commissioning Manager – Adult Social Care

UPDATE REPORT – COMMISSIONED SERVICES

1. Sexual Health

1.1 Introduction

Sexual health is an important area of public health. Most of the adult population of England are sexually active and access to quality sexual health services improves the health and wellbeing of both individuals and populations. Sexual health is not equally distributed within the population, strong links exist between deprivation and sexually transmitted infections (STIs), teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), trans community, teenagers, young adults and black and minority ethnic groups. Similarly, HIV infection in the UK disproportionately affects MSM and Black African populations. Some groups at higher risk of poor sexual health face stigma and discrimination, which can influence their ability to access services.

1.2 Local Provision

Local authorities are mandated to commission comprehensive open access sexual health services, including free STI testing and treatment, notification of sexual partners of infected persons and advice on, and reasonable access to, a broad range of contraception and advice on preventing unplanned pregnancy

In Birmingham the Sexual Health service has been delivered by Umbrella, led by University Hospitals Birmingham NHS Foundation Trust (UHB), who commenced a 5-year contract in August 2015. The contract was extended for a further 2 years under delegated authority until August 2022 with a yearly contract value of £14,038,586.90.

1.3 Service Delivery from March 2020 to May 2021

Since the start of the COVID-19 pandemic in March 2020, Public Health Commissioners have been in continuous contact with Public Health Service Leads and Service Providers in order to receive Business Continuity Plans and subsequent updates, Operational Updates/Positions and details of any newly identified risks. In conjunction with this, UHB's Operational Team comprising of Umbrella Senior management meet daily and any risks/issues are communicated to Commissioners. The Public Health Contracts Board initially met weekly, then bi-weekly and now monthly in order to be briefed on the operational status of all Public Health Contracts and a monthly public health contracts operational update detailing these statuses is produced and circulated to Cllr Hamilton and key partners.

The Birmingham Umbrella Sexual Health service has continued to operate throughout COVID and Birmingham citizens have still been able to access the service albeit in a different way and without major disruption.

Initially the biggest impact of COVID-19 was the need to reduce face to face interaction with patients as during the early stages of the pandemic Umbrella were forced to cease all clinical visits. To mitigate against the issue of restrictions to the "open access" Service, Umbrella were still able be contacted

via telephone and were able to triage patients, signpost and if required offer a telephone/video consultation. The Umbrella website https://umbrellahealth.co.uk/ was and is continually updated and details how and where services can be accessed as well as offering Coronavirus information for patients.

Telephone Calls and Telephone and F2F Consultations

The number of telephone calls taken by Umbrella from March 2020 to May 2021 was 118,481, of which 81,069 people were signposted (Umbrella website/GP/Pharmacy) and 37,412 people received a telephone consultation. Of the 37,412 telephone consultations, 10,386 people were offered a face to face consultation, following COVID-19 social distancing guidance.

Video Consultations

As well as offering telephone consultations and face to face appointments when necessary, where appropriate Umbrella have also been offering video consultations since May 2020. This addition to the Umbrella service offer has seen 1,421 people taking up the offer which is approx. 109 people per month utilising this service.

Postal Medication Service

A postal medication service was also introduced in April 2020 and up until May 2021 a total of 1,304 medications had been dispensed; 733 for genitourinary medicine (GUM - predominantly sexually transmitted infections (STI's) and HIV testing) and 571 for reproductive sexual health (RSH – predominantly contraception). This addition to the Umbrella service offer negates the need for a face to face visit to a Clinic or Pharmacy.

Umbrella Clinical Activity

From 4th May 2020 Umbrella re-opened their Complex Clinic at Whittall Street which offered referral-based face to face appointments for complex procedures such as difficulties in removing a coil and the need for a scan/removal by a consultant. For the period May 2020 to May 2021 Umbrella have seen a total of 21,134 patients face to face; 14,976 for GUM, 4,830 for RSH and 1,328 for Integrated (a combination of GUM & RSH).

Due to the initial and subsequent COVID-19 lockdowns Umbrella had to continually revise and review their service offer based on government guidance and taking into account social distancing. Following the last lockdown Umbrella developed a phased recovery plan which commenced on 19th April 2021 with the final stage enacted on 1st June 2021, so presently all Umbrella clinics are open and back to the pre-COVID-19 position, albeit with social distancing guidance.

Long Acting Reversible Contraception (LARC)

Long acting reversible contraception (coils and subdermal contraceptive implants (SDI's)) have been available throughout COVID-19. For the period April 2020 to May 2021 a total of 924 coils were fitted in Umbrella clinics and

599 removed and 1,039 SDI's fitted and 1,187 removed. In addition to the Umbrella clinical activity, Umbrella GP's have for the period April 2020 to March 2021 fitted a total of 2,623 coils and removed 1,921 as well as fitting 2,323 SDI's and removing 2,828.

Umbrella Pharmacies

Pharmacies have also played a key role in delivering elements of the Umbrella Service since March 2020 in terms of providing free condoms, emergency hormonal contraception (EHC - morning after pill), chlamydia treatment, contraceptive pill, contraceptive injections, continuation of hepatitis B vaccine injections started at an Umbrella clinic and acting as a collection point for STI self-sampling kits ordered online.

For the period April 2020 to March 2021, Umbrella pharmacies dispensed: EHC – 14,102, Condoms – 8,070, Progestogen-only contraceptive pill – 3,099, Combined oral contraceptive pill (oestrogen and progesterone) – 3,067 and Chlamydia treatment – 603.

STI Home Testing Kits

The ability for all Birmingham and Solihull residents to request STI Home testing kits via telephone or the Umbrella website has been an Umbrella service offer since contract commencement in August 2015. Throughout COVID-19 this service has still been available, however, there was a national shortage of STI kit components for the period Sept-Dec 2020 as they were being diverted to COVID-19 testing kits. As a result, Umbrella removed the online ordering option from their website and advised that if someone was symptomatic to call Umbrella where there would be triaged and if necessary sent an STI kit from their back up stock. The ability to order an STI kit free of charge and online without the need to visit a clinic in person can sometimes lead to the "worried well" ordering kits and then not returning them (the current returns rate is approx. 60%), therefore, by offering telephone triage Umbrella were able to ascertain if an STI kit was required or not.

This issue was resolved by January 2021 and since then STI kits have been available to order online via the Umbrella website. For the period April 2020 to May 2021 a total of 46,784 STI kits have been dispensed by Umbrella, with numbers since January 2021 returning to pre-COVID-19 levels.

Pre-exposure Prophylaxis (PrEP)

Following a successful national trial there is now provision within the Umbrella contract to provide HIV pre-exposure prophylaxis (PrEP) for the prevention of HIV transmission consistent with national guidance. Additional funding has been received from PHE via the Public Health Grant and the service commenced on 06.10.2020. To date demand has been positive and for the period 06.10.2020 to 31.03.2020, quarterly targets for new attendees were met; an average of 178 per quarter against a target of 137.

Umbrella Service Recovery Planning

Public Health and Commissioners worked closely with Umbrella in terms of their Recovery Planning and restarting practices that have were reduced due to COVID such as:

- Increasing face to face attendances and appointments clinics
- Re-instating walk-in appointments
- Extending clinic opening hours
- Working with Delivery Partners face to face
- Re-introducing face to face staff training sessions
- Training teams being able to attend partner training

Amplifying New Practices

Public Health and Commissioners have also been working with Umbrella in terms of amplifying new practices that have worked well during COVID-19 such as:

- Maintaining a measure of reduction in walk-in patients through other access mechanisms to the service.
- Increasing Video consultations
- Telephone consultation process for streamlining patients
- Increasing engagement with key partners
- Increasing Postal medication and prescriptions
- Increasing condom distribution by post
- Increasing STI kit distribution
- Increasing support for victims of domestic violence
- Integrate Independent Sexual Violence Advisors (ISVAs) presence within Umbrella clinics

Umbrella Service Summary

To summarise, throughout COVID-19 whilst the way in which the Umbrella Service has been delivered changed with fewer face to face appointments, Birmingham and Solihull residents have still been able to:

- Receive telephone triage and if required telephone and video consultations
- Have face to face appointments when required
- Have long acting reversible contraception fitted
- Order STI testing kits online to be delivered to their home address
- Order medication over the telephone and have it delivered to their home address
- Access Pharmacies for services which includes; free condoms, emergency hormonal contraception (morning after pill), contraceptive pill and contraceptive injections

In terms of re-opening complex sexual health clinics within Birmingham, offering video triage/consultations and dispensing medications by post, the Umbrella service led the way nationally in terms of best practice which was recognised by the Faculty of Sexual and Reproductive Healthcare (FSRH).

It should also be noted that throughout COVID BCC and SMBC continued to pay Umbrella as normal with no reductions to their funding despite the drop in activity.

1.4 Future Developments

Proposed Contract Extension

It is the intention of Public Health and Commissioners to further extend the Umbrella contract by a period of approx. 7.5 months for the period 10th August 2022 to 31st March 2023; these intentions were shared with the HWB Board on Friday 11th June 2021.

The purpose of the proposed contract extension is to mitigate against the unforeseen and unavoidable delays and impacts due to COVID-19 on re-procurement timelines and constituent tasks. The Public Health Division's support to the Birmingham Emergency COVID response in terms of leading the Health Protection Cell and supporting the Wellbeing & Communications, Corporate COVID and Health and Welfare Cells directly impacted the initiation of the Sexual Health Needs Assessment and subsequent activities necessary to procure a new Sexual Health contract by 10th August 2022. The cost of the proposed 7.5-month contract extension is £8,774,116.88 to be met by the Public Health Grant.

Sexual Health Needs Assessment

Birmingham City Council and Solihull Metropolitan Borough Council have commissioned S Squared Analytics for the provision of a Sexual Health Needs Assessment (SHNA) for Birmingham and Solihull which will include engagement from service users and stakeholders. The SHNA will play a critical role in the design of the Sexual Health treatment and prevention service specification for Birmingham and Solihull for 2023+. The completed SHNA report will provide both Local Authorities with the necessary information and evidence to inform critical decision making for recommissioning. Good progress is being made by S Squared Analytics and the completed SHNA is due to be completed by early August 2021.

Fast Track Cities Plus

Birmingham City Council is one of the pilot cities chosen by the HIV Commission to work towards ending new transmissions of HIV by 2030. The ambition for Birmingham has been wider than this and with the support of the HIV commission and local partners, Birmingham want to apply this ethos to Hepatitis B, Hepatitis C and TB; hence the programme in Birmingham is branded as Fast Track Cities+. The launch of the programme was in March 2020 where Birmingham was the Flagship city and the event was attended and supported by BCC Elected Members.

The Birmingham Public Health Division commissioned qualitative and quantitative research with Enigma Consultancy who are working with a number of representative third-sector organisations and established groups within the Birmingham community to produce a final report in which findings and recommendations will be fed back to BCC. The final report will also contain a

needs assessment which will provide a statistical analysis of the Birmingham Position regarding BBV's. This information will provide Birmingham City Council with the key information required to ensure effective, targeted, and necessary public health interventions are in place for BBV's and TB.

Funding will need to be agreed by NHSE&I and other funders to invest in initiatives around increasing testing across the city and other such initiatives, such as communications, education and removal of stigma, thus ensuring as many individuals as possible are tested and referred into treatment in order to reduce/remove the risks of wide transmission of these viruses. The aim is to work with existing providers and provide outreach to those areas where engagement is more difficult to ensure everybody who needs testing is tested and look at more robust pathways for individuals into service.

2. Substance Use

2.1 Introduction

The provision of adult drug and alcohol treatment services is defined as one of the grant conditions as part of the Public Health Grant. Spending the grant, a local authority has to "have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services".

Substance misuse treatment has been evaluated by researchers on a wide range of measures, including: drug use; abstinence from drug use; drug injecting; overdose rates; health and mortality; crime; social functioning, including employment; housing; family relations and the perceptions of service users about their recovery status. The breadth of these measures reflects the broad range of benefits anticipated from providing effective substance misuse treatment.

The demand on the substance misuse service continues to increase with regards to the prevalence of misuse of illicit drugs that include heroin, cocaine and novel psychoactive substances (NPS) and from alcohol. The complexity of service user presentations also continues to increase citywide.

2.2 Local Provision

The current drug and alcohol treatment and recovery provision in Birmingham is delivered by the third sector organisation 'Change Grow Live' (CGL). They were awarded a 5-year contract for the period 1st March 2015 – 28th February 2020 and BCC exercised the option to extend the contract for a further two years from March 2020 to February 2022 with a yearly contract value of £14,190,609.00

A 'recovery' approach has been taken regarding the treatment for Birmingham citizens experiencing the harms associated with drug and alcohol misuse. This currently involves the treatment and care of approximately 5,500 service users.

To support the recovery focused delivery model CGL provide service users with the necessary advice and support which is delivered via a 5-tier model which responds to differing levels of case complexity. The tiers are:

Tier 1: Advice & Information; including signposting to other services which include advocacy and mutual aid.

Tier 2: Non-dependent drug and alcohol use – Group / 1:1 work up to 12 weeks

Tier 3: Dependent alcohol use, opiate use, heavy crack cocaine/synthetic cannabinoids etc. – Group/1:1 work, longer term, structured support

Tier 4: In-patient specialist unit (Park House in Hockley) which delivers detoxification and stabilisation

Tier 5: Aftercare provision – Group/1:1 work

2.3 Service Delivery from March 2020 to May 2021

Since the start of the COVID-19 pandemic in March 2020, Public Health and Commissioners have been in continuous contact with Public Health Service Leads and Service Providers in order to receive Business Continuity Plans and subsequent updates, Operational Updates/Positions and details of any newly identified risks. In conjunction with this, CGL's Operational Team comprising of Senior management meet daily and any risks/issues are communicated to Commissioners. The Public Health Contracts Board initially met weekly, then bi-weekly and now monthly in order to be briefed on the operational status of all Public Health Contracts and a monthly public health contracts operational update detailing these statuses is produced and circulated to Cllr Hamilton and key partners.

The Birmingham CGL Adult Substance Misuse service continued to operate throughout all stages COVID-19 pandemic and Birmingham citizens have been able to access the service since 24th March 2020 to present, albeit in a different way and without major disruption.

The CGL website https://www.changegrowlive.org/drug-and-alcohol-service-birmingham is continually updated and details how and where services can be accessed as well as offering Coronavirus information for service users.

CGL Locality Hubs

The four CGL locality hubs (North, South, East & Central and West) provide accessible and welcoming spaces for service users designed to develop the tackling substance misuse/prevention agenda within local communities. There are multi-disciplinary teams based at each of the four hubs, with a wide range of expertise that includes; Doctors, Nurses, Recovery Co-ordinators and Outreach Workers. From March 2020 to present all 4 CGL Locality Hubs have remained open 9am – 5pm, Monday to Friday.

Initially this was with a critical staffing level of 1 Team Leader and 4 Frontline staff working at each Hub as well as a Consultant on call. Only the most vulnerable service users (both new starts and restarts) were being seen at a Locality Hub; this was service users required to provide a urine test in order to receive Opioid Medication Assisted Treatment – specifically Physeptone (Methadone) and Espranor.

Presently all 4 locality hubs are open for new starts, service user reviews, Hepatitis C testing and all medical appointments with nursing staff. CGL are following government guidance on social distancing before re-introducing groups and have advised that many service users prefer the newer ways of communicating with their Recovery Co-ordinator as opposed to physically visiting a hub.

Contact with Service Users and Utilising Technology

Throughout COVID-19 CGL were in regular contact with all service users via telephone, face to face in locality hubs where necessary and by utilising technology wherever possible to meet virtually. CGL segmented their entire caseload and identified the levels of risk for each service user and Recovery Co-ordinators contacted higher risk service users twice weekly by telephone and lower risk service users fortnightly by telephone.

CGL hold Service User Welcome meetings via Skype, CGL Partners (DATUS, KIKIT & Intuitive Recovery) are delivering SMART Recovery Groups for Phase 2 (Non-dependent drug and alcohol) services users utilising Skype & Zoom. CGL run virtual groups for Phase 3 service users (Dependent opiate use, heavy crack cocaine/synthetic cannabinoids use and Alcohol dependant) and a day programme for Phase 5 service users (Aftercare Provision).

New Referrals to Service

From 23rd March 2020 to present the CGL service has been open and accessible to all Birmingham citizens, cumulatively from 23rd March 2020 to 18th June 2021 there have been 3,663 new treatment starts; 2,080 opiate and 1,583 alcohol.

Medication Assisted Treatment (MAT)

During the initial lockdown phase of COVID-19 all service users on supervised consumption were moved to unsupervised consumption and provided with 2 week take home supply of MAT. This was to reduce the pressure on Pharmacies following discussions with the Local Pharmaceutical Committee (LPC) and to ensure that 2,750 service users were still able to receive Opioid Medication Assisted Treatment required to manage their medical condition. To support this approach CGL hand delivered prescriptions (to avoid postal delays) to all Pharmacies, delivered opiate substitute medication to all service users self-isolating, if a service user was self-isolating and had no appointed person to collect their MAT CGL delivered the medication to the service user directly and ensured that where needed all service users received a safe storage box for their medication as well as Naloxone.

CGL continue to case manage the prescribing arrangements of the MAT cohort of 2,750 approx. service users on a daily basis based on levels of risks (1-4 High Risk, 5-8 Medium Risk and 8+ Low Risk) with all service users categorised 1-9. CGL monitor those who present the highest risk which predominantly is the homeless cohort.

Inpatient Detox at Park House (Hockley)

The CGL inpatient detox facility was closed due to COVID in mid-March 2020. Park House re-opened on 17.08.2020 to provide a 2-week in-patient detox for drugs and alcohol, the initial intake on 17.08.2020 was 6 service users (usually 18) and the reduced capacity was to enable patients to adhere to social distancing guidance. Capacity is currently 14 beds and will be increased to the full capacity of 18 beds at the earliest opportunity based on government guidance.

Home Detox for Alcohol

During lockdown CGL have successfully completed 223 alcohol home detox's which have only been offered to service users when it is completely safe to do so. CGL's are looking to develop a similar approach for home detox for opiates.

Hepatitis C Postal Testing & BBV Pathway

CGL launched their new BBV Pathway on 6th August 2020 which included a new self-test postal option which involved Change Grow Live staff sending out a DBST (Hep C & HIV) to the home of the individual who has agreed to complete the self-test. A range of supporting documents have been developed to support the new process including a 'How To' video, written guidance for staff and service users and step by step implementation guides.

CGL Staying Free Telephone App
CGL have developed an App that is available to download via Google Play and the Apple App Store. This App provides mindfulness, urge surfing, getting active, activity diary and staying aware advice and is available for anyone to access. Someone currently not engaged with CGL can use the App initially and then if they feel they would like to engage with CGL can then find the service local to them and contact CGL. Details of the App have been shared extensively across the city with key partners and stakeholders through various channels.

Mutual Aid Groups
Government Guidance on Mutual Aid Groups meetings has been shared with all 3 mutual aid groups (Narcotics, Cocaine and Alcoholics Anonymous). They all deliver a mix of online virtual groups and "live" meetings which are well attended.

PHE Rough Sleeping Drug and Alcohol Treatment Grant
Birmingham successfully secured £1,273,615 of grant funding from Public Health England in order to address the substance use of the Rough Sleeping/Homeless population. CGL have recruited to 18 new posts in order to deliver their service model and the new service is fully operational.

PHE Universal Grant Funding

In addition to the abovementioned grant, Birmingham has been awarded a further £1,209,000 by PHE to fund additional drug treatment crime and harm reduction activity in 2021/22 – primarily prison releases. CGL have developed a service model and pathway and are currently recruiting to the posts within the model. This includes working in partnership with KIKIT in terms of funding 2

Diversion and Outreach workers and Emerging Futures in terms of funding 4 Prison Link workers. In addition, part of the new service offer will be the prescribing of Buvidal which is a Buprenorphine prolonged-release monthly subcutaneous injection. This is a positive step as it removes the need for daily Opioid Substitution Treatment (OST).

Service Recovery Planning

Public Health and Commissioners have also been working with CGL on their Service Recovery Planning in terms of:

- Increasing face to face attendances at locality hubs
- Re-instating face to face Recovery Groups
- Re-opening Locality Hubs
- Re-instating face to face mutual aid groups at Locality Hubs
- Increasing the digital offer
- Working with Delivery Partners face to face
- Re-introducing face to face staff training sessions

CGL Service Summary

To summarise, throughout COVID-19 whilst the way in which the CGL Service is delivered has changed with fewer face to face appointments, Birmingham residents have still been able to be referred into CGL in order to commence treatment as well as:

- Visit Locality Hubs in order to receive Opioid Medication Assisted Treatment
- Attend welcome meetings and recovery groups via Skype
- Be in regular contact with their Recovery Co-ordinator
- Have face to face appointments when required
- Access the CGL phone App
- Receive inpatient detox
- Access Opioid Medication Assisted Treatment
- Access Treatment for BBV's
- Undertake home detox

2.4 Future Developments

Draft Triple Zero City Strategy

The Triple Zero City Strategy is our plan on how we think we should tackle drug and alcohol addiction across Birmingham. The ambition is to aim for:

- Zero deaths due to drug or alcohol addiction
- Zero overdoses due to drug or alcohol addiction
- Zero people living with any addiction without the support needed to manage it.

The strategy has been developed using data and information gathered from the areas of need in the City and in partnership with Birmingham City Council, the West Midlands Police and Crime Commissioner and other statutory partners and service providers.

In order to take on board the voices and experiences of citizens and stakeholders, the draft strategy is out to public consultation and went live on Birmingham Be Heard on 10th May 2021 and will run until 2nd August 2021. Commissioners and Public Health briefed the online People for Public Services Forum on 25th May which was well received and the PH Health Protection Team have developed a comprehensive communications plan in order to ensure a good number of responses from citizens and stakeholders alike. The link to the Public Consultation is: https://www.birminghambeheard.org.uk/people-1/triple-zero-city-strategy/

Contract Re-procurement

The current CGL contract extended has been extended by 13 months to 31st March 2023 to mitigate against the delay in commencing the Public Consultation (approved by BCC Cabinet in March 2020) on the draft Triple Zero City Strategy. This delay was due to the Public Health Division supporting the Birmingham Emergency COVID response in terms of leading the Health Protection Cell and supporting the Wellbeing & Communications, Corporate COVID and Health and Welfare Cells.

When the public consultation on Triple Zero ends on 2nd August 2021, Public Health and Commissioners will commence the constituent reprocurement tasks which will include producing a Consultation Summary Report, developing the procurement and commissioning strategy, obtaining BCC Cabinet approval and commence a competitive tendering process with a new contract being in place on 1st April 2023.

3. Health Checks

3.1 Introduction

Cardiovascular disease (CVD) affects the lives of around 7 million people in United Kingdom (UK) and is a significant cause of disability and death, affecting individuals, families and communities, with 26% of all deaths being related to CVD. It is one of the leading causes of premature death in Birmingham and accounts for approximately 24.4% of mortalities for Birmingham residents (ref: 2016 VS3 tables) and 21.2% of deaths under the age of 75 years (this compares to 27.75% nationally). The burden of CVD falls disproportionately on people living in deprived circumstances and on particular ethnic groups, such as South Asians.

Consequently, CVD accounts for the largest part of the health inequalities in our society. Therefore, prevention, early identification and management of CVD remains a key strategic priority for Birmingham City Council Public Health.

During the response to COVID, the government identified that individuals with certain underlying conditions are at high risk of suffering adverse effects of COVID if they are infected especially those who are of older age. The Health Check Programme acts as a preventative initiative to ensure the key conditions identified by the government such as CHD, Diabetes, Obesity, High Blood Pressure are reduced and caught early, promoting individual to make lifestyle choices to be able to lead a healthy life.

3.2 Local Provision and Delivery During COVID

The provision of Health Checks is currently delivered via a Primary Care GP model and is delivered by every GP Practice within the Birmingham Boundary. This is a 5-year programme and the national benchmark over the 5 years is to invite 20% of the 5 years eligible cohort every year for health checks and to screen at least 50% of those invited.

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The current 5-year Health Check programme started on 1st April 2018 and the performance to date is as follows:

The current 5-year Health Check programme started on 1st April 2018 and the performance to date is as follows:	**2018/19**	**2019/20**	**2020/21**	**Total Programme to Date**
Invite Target	54,631	53,715	53,745	162,091
Invite Actual	81,970	68,619	20,091	170,680
Over/(Under) Acheivement	**27,339**	**14,904**	**(33,654)**	**8,589**
Completed Target	27,315	26,858	20,091	74,264
Completed Actual	33,408	28,286	10,262	71,956
Over/(Under) Acheivement	**6,093**	**1,428**	**(9,829)**	**(2,308)**

The data shows the underperformance for 2020/21 delivery of Health Checks, which is as a result of the COVID Pandemic. The underperformance to date has not been impacted as much as was expected and this is likely to be recovered over the final two years of the 5-year programme. Although many Local Authorities decided to stop delivery, in Birmingham the approach taken was to leave the decision to GP Practices and for them to use innovative methods for delivery, which is an approach that has proved successful and regionally we have been recognised as good practice with our approach.

3.3 Delivery and Payments

During 2020/21 the GP Practices were paid over the 4 quarters, whether they delivered or not. For the first two quarters it was a directive of the PPN notice from Cabinet Officer and the payments for quarter 3 and 4 was a local decision. 75% of the payment was provided as a Payment in Advance and GP Practices are aware that they will start to have deductions from their quarter 1 2021/22 Payment onwards to clawback the payments in advance and we are working

with the practices to increase activity so as that the clawback does not have much of an impact on the quarterly payments we make them and will also support towards meeting the 5 Year target.

3.4 Post COVID Delivery

It is also hoped that post COVID, that activity could be ramped up at scales via GP Practices to make up for underperformance so that overall performance for the 5 year programme is met or over achieved, along with the 50% of the cohort having a Health Check to decrease inequalities, resulting in individuals leading more healthier lives, through better food nutrition, active lifestyles, better mental health, etc. The NHS have also provided GP Practices Guidance on restarting delivery of prevention services which will support BCC's push to promote increased activity with GPs.

3.5 Contract Re-procurement

The current Health Check Contracts run out on 31st May 2023. It is anticipated that re-procurement activity will start in mid-2022 and once more clarity is known around the Integrated Care System work streams. It is likely that a Single Contract Negotiation will be pursued as previously, given GP practices are the most equitably placed to provide a citywide offer with full geographic coverage and such a clinical programme.

4. Smoking Cessation

4.1 Background

Smoking remains the single greatest cause of preventable illness and premature death in the UK. One in two smokers dies prematurely from smoking-related diseases, on average losing 10 years of life. Every year over 4,500 people in Birmingham die from a smoking related disease. Smoking is directly linked with Birmingham's three biggest killers and is attributable to:

- 1 in 4 of all cancers
- 1 in 5 of all deaths from CVD
- 1 in 3 of all deaths from respiratory disease

There are approximately 120,310 adults over 16 years old who smoke in Birmingham 13.7% of the adult population. National survey data shows that the smoking rates in Birmingham are similar to the England average at 14.9%, although rates are much higher in some areas. Tobacco use is one of the most significant causes of health inequalities and there is a strong link between cigarette smoking and socio-economic groups. Smoking has been identified as the single biggest cause of inequality in death rates between rich and poor in the UK. Smoking accounts for over half of the difference in risk of premature death between social classes.

Stopping smoking is considered one of the single most effective methods for improving health and preventing illness. National surveys report that around 67% of smokers want to quit. Evidence-based NHS Stop Smoking Services are well established and considered both cost and clinically effective.

NHS Stop Smoking Services offer support to help people quit smoking. This can include intensive support through group therapy or individual one-to-one support. Such services are expected to be widely accessible within the local community and provided by trained advisors.

The National average quit rate at 4-weeks for clients accessing Stop Smoking Services is 45%, although certain population groups (e.g. under 30-year olds; routine and manual workers and pregnant smokers) have lower rates of abstinence.

The core elements of the service are the provision of behavioural support and pharmacotherapy. The service aims to maximize the number of smokers accessing the service and quitting long-term, therefore contributing to the reduction of smoking prevalence in Birmingham. To work most effectively, it will be necessary for the service to focus on specific segments of the population, increasing access from priority groups where smoking prevalence is highest (i.e., routine and manual (R/M) occupational groups, deprived communities, young people and pregnant smokers).

The objectives of the stop smoking service will be to:

- Provide equitable access to all smokers
- Offer the most effective, evidence-based treatments available
- Support people to successfully quit smoking
- Achieve high levels of client satisfaction

4.2 Local Provision and Delivery During COVID

The local Smoking Cessation Service is primarily provided to individual's via a primary care model via GPs and Pharmacies. There is also one Vape Shop who delivers the service who are IBVTA registered as per PHE guidance. The programme is either based on a 4 week or 12-week basis which consists of fortnightly behavioural support and the provision of Nicotine Replacement Therapy along with the offer of e-Cigarettes. The offer is available to individuals over the age of 12 and anyone who lives, works and studies in Birmingham. The service was delivered by approximately 180 providers equitably throughout Birmingham Via GP Practices and Pharmacies.

The service is not one that is mandated by government but is a priority for NHS and Local Authority. The vision to reduce smoking prevalence national is a key message which comes out of the NHS 10-year plan and given this vision the number of providers offering smoking cessation has increased by at least 50% over the last 1.5 years.

Due to more people wanting to quit due to health messages being marketed the number of quits have been consistently going up in the pharmacy setting and below is a summary of performance comparisons from one year to another:

	2018/19	2019/20	2020/21
4 wk Quit (GP)	1067	989	634
12 wk Quit (GP)	547	543	369
4 wk Quit (Pharmacy)	1094	1269	1020
12 wk Quit (Pharmacy)	475	485	613
4 wk Quit (AI App)	0	0	833
12 wk Quit (AI App)	0	0	115

The GP Performance during 2020/21 was low as they had closed their doors for Face-to-Face sessions for smoking services, however some practices maintained the service via video call or phone call and electronically sending prescriptions to the patients chosen pharmacy. The Pharmacy offer also decreased slightly due to the pandemic but overall maintained their numbers quitting over the 4 week and 12 week quits. The key player in achieving overall higher quits even though there was a pandemic was the introduction of an Artificial Intelligence app “Quit with Bella”, which was launched quite quickly due to the lockdown and the push from government as part of the Quit for Covid campaign.

4.3 Delivery and Payments

As described in the section for Health Checks and the supplier relief note PPN 02/20, it was agreed to pay Pharmacies the average quarter quit payments as a good will for continuing to deliver the service at pace during the pandemic outbreak and the basis of payment was they would either get paid the average quarters activity or actual activity, whichever is higher. It was decided not to pay anything around relief payments to GPs for smoking as they were already getting paid for Health Checks. As a result of the PPN 04/20 relief note, it was agreed through a general consensus by the Local Pharmacy Committee that pharmacies did not require any payment for Quarter 2 onwards.

4.4 Post COVID Delivery

It is anticipated that activity will continue to rise now that GPs will start to increase their services and that Pharmacies have now got more capacity to continue to deliver services. Birmingham Public Health are also working with a wider range of partners to embed smoking cessation as part of their standard offer which will also enhance the number of individuals quitting within Birmingham.

The Quit with Bella app will be further pushed and it is hoped that this will become the first point of access for anybody through regular communications around the use of the app and promoting citizens who use to download it if they have a smart phone. It is anticipated that all NRT provision will become electronic voucher based so there is no handling of vouchers and individuals can more easily access their pharmacotherapy in the future.

4.5 Contract Re-procurement

The current Smoking Cessation Contracts run out on 31st May 2023. It is anticipated that re-procurement activity will start in mid-2022 and once more clarity is known around the Integrated Care System work streams. It is likely that a Single Contract Negotiation will be pursued as previously, given GP practices and Pharmacies are the most equitably placed to provide a citywide offer with full geographic coverage and such a clinical programme.

Birmingham Health and Wellbeing Board

	Agenda Item: 16
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**27th July 2021**
TITLE:	**CREATING A HEALTHIER CITY STRATEGY**
Organisation	**Birmingham City Council**
Presenting Officer	**Dr Justin Varney**

Report Type:	**Discussion**

1. Purpose:

1.1 To communicate the outcomes from engagement sessions with the Health and Wellbeing Board sub forums to support the development of the Creating a Healthier City Framework.

1.2 To highlight the continued progress in the development of the Creating a Healthier City Framework and steps required to consolidate and agree a draft document for public consultation.

2. Implications:

BHWB Strategy Priorities	Childhood Obesity	x
	Health Inequalities	x
Joint Strategic Needs Assessment		
Creating a Healthy Food City		x
Creating a Mentally Healthy City		x
Creating an Active City		x
Creating a City without Inequality		x
Health Protection		x

3. Recommendation

It is recommended that the Board:

3.1 Note the outcomes from the Health and Wellbeing Board sub forum consultations.

3.2 Continue to support the direction of travel suggested to finalise the draft Creating a Healthier City Framework document.

4. Report Body

4.1 Context

4.1.1 As outlined at the May 2021 Health and Wellbeing Board meeting, the Health and Wellbeing Board Strategy, Creating a Healthier City Framework has undertaken a period of partner and forum consultation throughout May and June 2021.

4.1.2 The framework has been presented and discussed at the Councils Corporate Leadership Team, the Creating a Healthy Food City Forum, the Creating a City Without Inequalities Forum, the Creating a Physically Active City Forum and the Creating a Mentally Healthy City Forum. Meetings took place throughout May and June 2021.

4.1.3 Discussions have centred around the requirement for a Health and Wellbeing Board Strategy, positioning of and proposed detail including the five themes and the cross-cutting approaches. Discussions aimed to create a platform for engagement and shaping of the proposed indicator journey and ambitions.

4.1.4 The presentation and discussion have focused on the appropriate themes within the framework as dictated by the forum/meeting focus.

4.1.5 Summary of the key points from the forum discussions are below.

4.2 Creating a Healthy Food City Forum

4.2.1 The discussion at the Creating a Healthy Food City Forum centred around the Healthy and affordable food theme within the draft Creating a Healthier City Strategy.

4.2.2 The forum members discussed relevant inequalities, leadership for action for the theme and the proposed ambitions and indicator journey.

4.2.3 Forum members identified a gap in data and metrics available to support progress in the Healthy and affordable food theme. Access to child tooth decay data was identified and has since been shared by forum members.

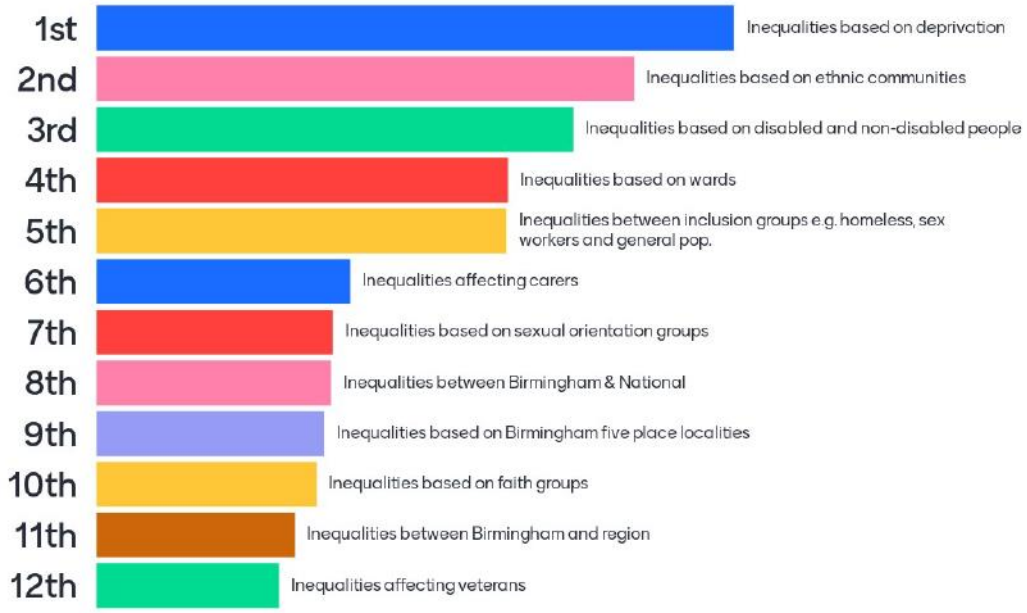
4.2.4 Forum members were largely supportive of the developed of the Creating a Healthier City Framework and their role in supporting the Healthy and affordable food theme.

4.3 Creating a City Without Inequalities Forum

4.3.1 The discussion at the Creating a City Without Inequalities Forum centred around the Closing the Gap component of the draft Creating a Healthier City Strategy.

4.3.2 The forum considered the many inequalities affecting citizens in Birmingham. Forum members ranked inequalities for focus in the framework.

4.3.3 Mentimeter was used for the ranking exercise with twelve possible inequality priorities considered. Forty-four individuals took place in the ranking exercise. The ranking was as follows:



4.4 Creating a Physically Active City Forum

4.4.1 The discussion at the Creating a Physically Active City Forum centred around the Active at Every Age and Ability theme within the draft Creating a Healthier City Strategy.

4.4.2 The Forum members considered the proposed indictor journey for the theme and the proposed ambitions.

4.4.3 The Forum also considered additional indictors; suggestions included.

- Economic savings to the population through active travel
- Connection between community cohesion and physical activity levels
- Relationship between physical activity and mental health
- Starting position and journey of change

4.4.4 Mentimeter was used for the ranking exercise with seven suggested ambitions considered. Eleven individuals took place in the ranking exercise. The ranking of

the proposed ambitions was as follows:

4.4.5 The forum suggested further topics for ambitions including the percentage of journeys of less than one mile made on foot or bicycle, system change and integration, increasing habitual activity time and safety. They were however unable to suggest measures from current metrics for the proposals. Work is underway to determine possible measures and targets.

4.5 Creating a Mentally Healthy City Forum

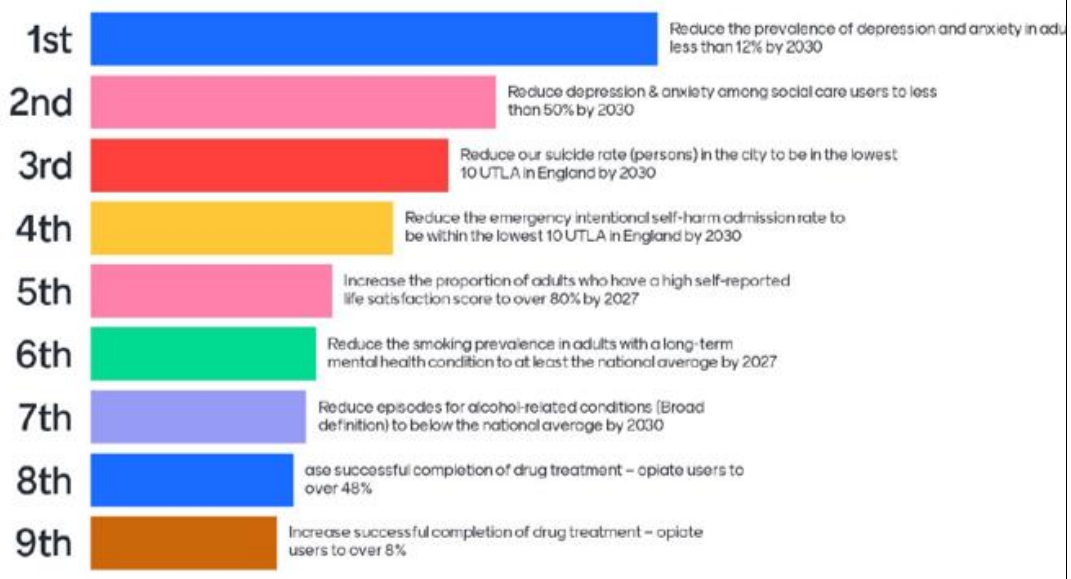
4.5.1 The discussion at the Creating a Mentally Healthy City Forum centred around the Mental Wellness and Balance theme within the Creating a Healthier City Strategy.

4.5.2 The forum considered the proposed indicator journey and the proposed ambitions for the Mental Wellness and Balance theme.

4.5.3 The forum members were largely supportive of the proposed indicator journeys ranking the increase in the proportion of adults who have a high self-reported life satisfaction score to over 80% by 2030 first. The proposed indictor to reduce our suicide rate in the city to be the lowest 10 UTLA in England by 2030 was ranked the lowest.

4.5.4 The forum also suggested inequalities for consideration which broadly correlate to the those proposed for the closing the gap and life course components of the strategy. These include deprivation, living conditions, population and age specific inequalities.

4.5.5 Mentimeter was used for the ranking exercise with nine suggested ambitions considered. Twenty-three individuals took place in the ranking exercise. The ranking of the proposed ambitions was as follows:



4.5.6 The forum members suggested subject areas for further ambitions which broadly group into population specific support, access to and coordination of care services, and access to safe spaces and housing and culturally appropriate services. Work is currently underway to identify appropriate measures and targets where data is available.

4.5.7 Forum members were largely supportive of the draft creating of the Creating a Healthier City Strategy. They highlighted that it would provide opportunity for collaboration, to embrace and support diversity and for research and coproduction:

4.6 Creating a Healthier City Strategy next steps

4.6.1 Feedback is currently being consolidated in preparation for the public consultation phase. A final draft will be shared with Board members at the beginning of August. Board member or Board member organisation input is welcomed on an ongoing basis throughout the strategy development process.

4.6.2 The Consultation phase is planned to run from 14th September until 14th December 2021. The consultation link will be shared with Board members for promotion once live.

4.6.3 Consultation findings will be summarised into a report for the January Health and Wellbeing Board meeting.

4.6.4 The final Creating a Healthier City Strategy Framework is due to launch in April 2022.

5. Compliance Issues

5.1 HWBB Forum Responsibility and Board Update

5.1.1 The development of the Joint Health and Wellbeing Board Strategy is managed by the Health and Wellbeing Board.

5.2 Management Responsibility

Dr Justin Varney, Director of Public Health

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Stakeholders/partners lack of engagement	Medium	Medium	Consultation with partners, stakeholders and public included in timeline.
Changes suggested to the elements within the draft strategy	Low	Low	Changes will be prioritised in officer's work programmes.

Appendices

The following people have been involved in the preparation of this board paper:
Dr Justin Varney – Director of Public Health
Stacey Gunther – Service Lead, Governance

Birmingham Health and Wellbeing Board
Draft Forward Work Programme and Board Membership:
July 2021-22

Board Members:

Name	Position	Organisation
Councillor Paulette Hamilton (Board Chair)	Cabinet member for Adult Social Care and Health	Birmingham City Council
William Taylor (Vice Chair)	Chair	NHS Birmingham and Solihull CCG
Councillor Kate Booth	Cabinet Member for Children's Wellbeing	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
Dr Graeme Betts	Director for Adult Social Care and Health Directorate	Birmingham City Council
Kevin Crompton	Director of Education and Skills	Birmingham City Council
Paul Jennings	Chief Executive	NHS Birmingham and Solihull CCG
Paul Maubach	Chair, Sandwell and West Birmingham CCG	Sandwell and West Birmingham CCG
Andy Cave	Chief Executive of Healthwatch	Healthwatch Birmingham
Andy Couldrick	Chief Executive of Birmingham Children's Trust	Children's Trust
Dr Robin Miller	Head of Department, Social Work & Social Care Co-Director, Centre for Health & Social Care Leadership	University of Birmingham Education Sector
Chief Superintendent Stephen Graham	Chief Superintendent	West Midlands Police
Gaynor Smith	Senior and Employer Partnership Leader	Department for Work and Pensions
Peter Richmond	Chief Executive of Birmingham Housing Trust	Birmingham Social Housing Partnership

Doug Simkiss	Medical Director and Deputy Chief Executive of Birmingham Community Healthcare NHS Foundation Trust	Birmingham Community Healthcare NHS Foundation Trust
tbc	tbc	Birmingham and Solihull Integrated Care System
tbc	tbc	Birmingham Chamber of Commerce
Co – optees		
Carly Jones	Chief Executive of SIFA FIRESIDE	SIFA FIRESIDE
Waheed Saleem	Executive Director Strategic Partnership	Birmingham and Solihull Mental Health Trust
Stephen Raybould	Programmes Director (Ageing Better)	Birmingham Voluntary Services Council

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Business Support Manager for Governance & Compliance
Landline:0121 303 4843
Mobile : 07912793832
Email : Tony.G.Lloyd@birmingham.gov.uk

Forward Plan:

	27th July 2021	**21st September 2021**	**30th November 2021**	**18th January 2022**	**15th March 2022**	**April date tbc**
Draft Papers Deadline	7th July 2021	25th August 2021	3rd November 2021	3rd January 2022	23rd February 2022	**Board Dev. Day**
Final Papers Deadline	15th July 2021	9th September 2021	18th November 2021	6th January 2022	10th March 2022	
Standing items	Covid-19 position statement -Dr Justin Varney Vaccination update -Paul Jennings ICS Update - Yve Buckland	Covid-19 position statement - Dr Justin Varney Vaccination update - Will Taylor ICS Update - Yve Buckland CWG Legacy Update	Covid-19 position statement -Dr Justin Varney Vaccination update - Will Taylor ICS Update - Yve Buckland CWG Legacy Update	Covid-19 position statement -Dr Justin Varney Vaccination update - Will Taylor ICS Update - Yve Buckland CWG Legacy Update	Covid-19 position statement -Dr Justin Varney Vaccination update - Will Taylor ICS Update - Yve Buckland CWG Legacy Update	
Theme	**Business Meeting**	**Equity of access to health services/care**	**System Strategies**	**Inequalities**	**Business Meeting**	
Items	Appointment of Health and Wellbeing Board – Functions, Terms of Reference, and Membership of the Board Schedule of HWB Meetings for 2021/22 **JSNA deep drive** -Luke Heslop, Service Lead	**Population Health Management** opportunity -What's the system doing to improve uptake in services. -TBC PH/ICS inequalities board **Screening and Immunisations** -CCG	**HWB Creating a Healthier City Framework** -Dr Justin Varney **Infant Mortality Task Force** update/feedback - Dr Marion Gibbon, Assistant Director of Public Health **Creating a Healthy Food City Forum**	**Creating a City Without Inequalities Forum** -Poverty Truth Commission - BLACHIR - Monika Rozanski, Service Lead **ICS Inequalities Plan** - Richard Kirby, BSol	**JSNA deep dive** - Luke Heslop, PH Service Lead **JSNA** -TBC, PH Service Lead - Dr Marion Gibbon/Dyna Arhin-Tenkorang, Assistant Director of Public Health **Children and Young People Public**	

	PH Commissioned Services -Bhavna Taank/Karl Beese, Service Lead **HWB Creating a Healthier City Framework** -Dr Justin Varney, Director of Public Health **Creating a Mentally Healthy City Forum** -MH bid Natalie Stewart, Service Lead **Ofsted Report** -Kevin Crompton, Director of Children's Services	**Flu/covid vaccination 2021/22 rollout** - CCG **Annual Health check uptake** - Learning Disabilities - Mental Health - CCG/Social Care **Social Prescribing** - CCG	-Birmingham Food Strategy -Seldom Heard Voices report - Maria Rivas, Interim Director of Public Health **Health Protection Forum** **-** Annual report Chris Baggot, PH Service Lead	**Creating a Physically Active City Forum** - Tola Time - GHCP Campaign - CWG legacy Kyle Stott, PH Service Lead **JSNA deep dive** - Luke Heslop, PH Service Lead	**Health Commissioned Services** -tbc **Integrated Care Partnership** - Mike Walsh, Service Lead, Adult Social Care **HWB Creating a Healthier City Framework** Dr Justin Varney, Director of Public Health **BLACHIR Final report** tbc	
Nonthematic items		**ADPH Report** - Dr Justin Varney, Director of Public Health **The City of Nature Vision** - Hamira Sultan, Public Health Consultant	**Better Care Fund** - Mike Walsh, Service Lead, Adult Social Care			
Written updates	BLACHIR Forums LCOEB	Forums BLACHIR LCOEB	BLACHIR Forums LCOEB	Forums BLACHIR LCOEB	Forums LCOEB	

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).

Health Inequality Focus and Childhood Obesity Focus agenda presentations can be several items if appropriate, but all must include decision(s) and / or action(s) for the Board.

Health and Wellbeing Board Fora will provide a written update to each Board meeting; each will have an annual formal presentation to the Board on a rotational basis.

Public Questions

Public questions are to be submitted in advance of the meeting via the Birmingham Health and Wellbeing Board public question portal.

Birmingham Health and Wellbeing Board

	Agenda Item: 19
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**27th July 2021**
TITLE:	**HEALTH AND WELLBEING FORUM UPDATES**
Organisation	**Birmingham City Council**
Presenting Officer	**Stacey Gunther, Service Lead, Public Health**

Report Type:	**Information**

1. Purpose:

1.1 This update report details recent, current and future work related to:

- Creating a Healthy Food City
- Creating a Physically Active City Forum
- Creating a Healthy Food City Forum
- Creating a City Without Inequalities Forum
- Health Protection Forum Update

1.2 Sub forum meetings, excluding the Health Protection Forum, were initially paused as the Public Health Division diverted resource to support Covid-19 response.

1.3 Paused forums have now resumed. All Health and Wellbeing Board sub forums have met during May and June 2021. They are currently meeting online.

2. Implications:

BHWB Strategy Priorities	Childhood Obesity	Y
	Health Inequalities	Y
Joint Strategic Needs Assessment		N
Creating a Healthy Food City		Y
Creating a Mentally Healthy City		Y
Creating an Active City		Y
Creating a City without Inequality		Y
Health Protection		Y

3.	Recommendation
3.1	It is recommended that the board note the contents of the report.

4.	Report Body
	Background
4.1	The Birmingham Health and Wellbeing Board has five thematic forums. The forums oversee the development and delivery of shared action to drive city-wide improvement. The forums are: Creating a Mentally Healthy City, Creating a Healthy Food City, Creating an Active City, Creating a City Without Inequality, and the Health Protection Forum.
4.2	The Creating a Mentally Healthy City is presenting at the July 2021 Board meeting, with the remaining forums providing a written update. Following the July meeting, forums will continue to present on a rota basis, with each theme presenting at least annually.
4.3	This report is formed of 4 written updates. Further detail specific to each Forum can be found in **Appendices 1-4.**

5.	Compliance Issues
5.1	**HWBB Forum Responsibility and Board Update**
5.1.1	Regular updates will be reported to the Health and Wellbeing Board via a joint update report in this format, with each forum providing a presentation item rather than an information item update at least annually.
5.1.2	Action logs of the forums shall be recorded and reviewed at every forum to ensure actions are delivered.

5.2	Management Responsibility
	Stacey Gunther, Service Lead, Public Health Kyle Stott, Service Lead, Public Health Monika Rozanski, Service Lead, Public Health Chris Baggott, Service Lead, Public Health Maria Rivas, Acting Assistant Director, Public Health Dr Justin Varney, Director of Public Health

6. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Partners not delivering on the assigned actions required to enable the forums work.	Medium	Medium	Robust monitoring and regular update reports via the relevant forum

Appendices
Appendix 1 - Creating a City Without Inequalities Forum Appendix 2 – Health Protection Forum Appendix 3 - Creating a Physically Active City Forum Appendix 4 - Creating a Healthy Food City Forum

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

Stacey Gunther, Service Lead, Public Health
Chris Baggot, Service Lead, Public Health
Kyle Stott, Service Lead, Public Health
Monika Rozanski, Service Lead, Public Health
Maria Rivas, Assistant Director, Public Health

Birmingham Health and Wellbeing Board

Appendix XX - Creating a City Without Inequalities Forum Highlight Report

1.1 Context

The Public Health Division refreshed and restarted work on the CCwI Forum and associated workshops in June 2021. The refreshed approach is incorporating the national Marmot review '*Fair Society, Healthy Lives*' policy areas for action. The forum members through collaborative leadership and co-produced actions across systems are seeking to turn these into tangible and measurable outputs. The policy areas for mitigating inequalities are:

1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.

The national context for each of the policy areas for reducing health inequalities will guide dedicated workshops of the same theme and align with the *Creating a Healthier City Strategy*; (the Health and Wellbeing Boards' pending new strategy) and associated key performance indicators. The aim is to facilitate discussion on a Marmot policy area with input from relevant stakeholders to inform the subsequent Forum meeting, providing a sharper focus on the specific area and identify action.
As well as a thematic/policy area focus (with prior workshops), each Forum meeting will also include updates on cross cutting themes or specific work relevant to tackling health inequalities.

1.2 Current work

The Introductory Forum meeting took place on 8th June 2021 and 53 people attended; the invite was extended to both members and partners, Birmingham Youth Service young people (3) representatives also attended and actively contributed to discussions.

A new structure was introduced by Cllr Cotton and a final draft of refreshed *terms of reference* were shared for all to provide comments with the intention of a final sign off at the next forum meeting (August 2021). An interactive presentation update was provided by the Assistant Director of Public Health on the pending *Creating a Healthier City Strategy* that is being co-produced with stakeholders. This involved ranking inequality priorities and an opportunity for other considerations.

The *HealthNow Alliance* provided an overview of a peer research investigation into homelessness; 64 homeless people participated in the research and were supported with training. Working alongside key partners the findings have contributed to an action plan seeking to address issues identified as well as influencing local and national change through campaigns and training.

A brief update was provided on the Birmingham *Poverty Truth Commission -BPTC#2* (a citizen engagement approach to enable local experiences of poverty to be heard by the council & strategic partners). It involves recruitment of community commissioners (people with lived experience of poverty) speaking their truth and civic commissioners (those in positions of power and influence) to work together to influence decision and policy making with the aim to tackle poverty and prevent destitution. The project is currently recruiting citizens as community commissioners and work has started to recruit civic commissioners. The project

have commissioned a robust evaluation, which will be conducted by University of Wolverhampton and Birmingham Voluntary Sector Council, the work to create a framework for the evaluation has been initiated. There is an internal strategic oversight group for this project.
A brief update was also provided on *BLACHIR* (a collaboration between Birmingham and Lewisham councils to look in depth at how to tackle health inequalities in Black African and Black Caribbean communities). The review is made up of an academic and advisory boards who meet and discuss the findings and share insight. The insights and opportunities for action identified from the reviews completed so far (3 out of 9) will be further discussed through public engagement to verify, refine and prioritise them.

Regular updates will be provided to the forum on both *BPTC* and *BLACHIR* work.

1.3 Next Steps

- Creating fair employment and good work for all is the theme for the first CCWIF workshop scheduled for 2 September 2021. All forum members and relevant partners have been invited to attend with the latter being those that are able to provide expert contribution to this policy area. The outputs will shape the forum's agenda on 15 September 2021 and actions going forward.

Birmingham Health and Wellbeing Board

Appendix X – Health Protection Forum Highlight Report (July 2021)

1.1 Context

The Health Protection Forum (HPF) is currently meeting monthly to facilitate the transition from a majority focus on Covid-19 to the other 'business as usual' health protection areas of work. Covid is still being covered at the Forum, but more time will be allocated to screening, immunisation, emergency planning, communicable and non-communicable diseases.

1.2 Current Circumstance

The terms of reference (ToR) have been reviewed and the membership has been refreshed due to changes in organisations and roles. By updating the membership we are ensuring that we have the right representatives from partner teams/ organisations to focus the work of the Forum going forwards.

The standing agenda items remain the same as in the last update report and cover the following issues:

1. The HPF coronavirus discussions include:

    a. Current situation regarding case rates, test positivity rates, testing activity, cluster and outbreak summaries, ongoing plans and changes to covid response processes, vaccination activity
    b. Review of activity related to different setting types (education, residential, clinical, workplaces and others)
    c. Updates to process and structural changes to ensure covid response capacity is appropriate

2. Non-coronavirus discussions include:

    a. Challenging health protection cases (including TB, blood-borne viruses, and other communicable diseases or environmental hazards situations)
    b. Vaccination and screening programme uptake activity, delivery and plans (including flu, MMR and other childhood vaccinations)
    c. The last meeting discussed immunisation uptake and plans to increase the rates – some mapping work focussing on MMR uptake is ongoing to identify which communities have lowest uptake so that plans may be developed
    d. Additional projects on school-age immunisation uptake and immunisation assurance are being scoped and developed - updates will be provided in future reports
    e. HPF members all being part of the assurance function that the HPF delivers and having an active role in HPF meetings – this is ongoing work

1.3 Next Steps and Delivery

- Planning for the seasonal flu 2021/22 programme is ongoing and will be shared with the HPF over the coming meetings – current expectation is

that it will be closely aligned to an autumn/winter covid booster vaccination programme

- Delivery of the SARS-CoV2 (known as covid) vaccination programme is ongoing and will report into the HPF. This is being led by the NHS.
- The Forum will also be seeking assurance on plans for catch-up child vaccination programmes and national screening programmes that have been impacted by the pandemic.
    - Over the next month the PH team will be exploring a project plan for school-age immunisation uptake improvement and community engagement
    - Mapping of current MMR uptake/gaps will be delivered and used to inform further plans
- Case studies of recent incidents will be presented to the refreshed HPF membership to ensure that lessons learned are identified and inform future service delivery
    - A table-top scenario-based session will be delivered to further develop and improve the engagement of HPF members
- Current situation reports for the different areas of health protection will be produced and these will inform the development of the work programme of the HPF for the next 12 months
    - A work programme will be developed with actions assigned to HPF attendees and partners

Birmingham Health and Wellbeing Board

Appendix 3 – Creating A Physically Active City (CPAC) Forum Highlight Report

1.1 Context

The CPAC met on Wednesday 16th June. The forum continues to focus on the development of an action plan, and the production of a bid for Commonwealth Games Commonwealth Active Communities funding to tackle inequalities in physical activity. The forum also supported the development of the emerging Healthier City Strategy.

1.2 Current Circumstance

The forum received updates on:

1. Draft action plan
2. Commonwealth Active Communities funding
3. Partnership for Healthy Cities (Bloomberg Programme)
4. Health and Wellbeing Board draft Strategy

The focus of the agenda was to update on the progress of the action plan development, as well as updating on the progress of the application to Sport England for Commonwealth Active Communities funding. The forum took part in an exercise to inform the development of physical activity indicators and actions that will be embedded into the Health and Wellbeing Board Healthier Cities strategy.

The action plan will be completed in July

1.3 Next Steps and Delivery

- The forum is working towards the adoption of an action plan by the end of July 2021
- The forum has been successful in the EOI stage of the Commonwealth Active Communities Sport England funding, and has been awarded development funding to assist in the development of a final bid for submission for the 30th September.
- Tola Time; the Partnership for Healthy Cities campaign is due to launch towards the end of July. This will target the increase in physical activity in 10 BAME wards.
- The forum is working towards signing up to “Include Me” the campaign to make the West Midlands an exemplar region for engaging disabled people and people with long term health conditions to be physically active

Birmingham Health and Wellbeing Board

Appendix 4 – Creating A Healthy Food City (CHFC) Forum Highlight Report

1.1 Context

The CHFC met on Wednesday 05th May. The forum continues to focus on the development of a food strategy, the implementation and delivery of an emergency food action plan, and playing an integral part in the global food agenda with reference to the Milan Urban Food Policy Pact, Delice, Food Trails and the UN Food Dialogue. The forum also supported the development of the emerging Healthier City Strategy by participating in a menti-meter exercise to feed into draft food indicators and actions.

1.2 Current Circumstance

The forum received updates on:

1. Sustainable Food Places; Bronze award application (Food Foundation)
2. Food Banks and Emergency Food response (Trussell Trust)
3. Food Dialogue: Farm to Fork (LEAF)
4. Health and Wellbeing Board draft Strategy (Public Health)
5. Milan Urban Food Policy Pact (Food Foundation)
6. Food Trails (Food Foundation)
7. Food Webinar Series (Public Health)
8. WHISK, Briefing (Public Health)

The focus of the agenda was a balance of reporting on local work, international work and the development of the food indicators and actions section of the emerging health and wellbeing board *Healthier City* strategy. As part of the work towards the Sustainable Food Places bronze award, it was agreed that Public Health will lead on development of an “at a glance” document that will capture, display and report on partner food success in the city.

The forum has been asked to consider and report any recommended outcomes and measures for the Healthier City strategy to Public Health.

Next Steps and Delivery

- Work continues to take place on the draft food strategy that is due to go out to public consultation at some point in Q3.
- Food Trails/Living Lab launch will take place in June.
- The healthier city planning toolkit consultation is due to end on the 30th June, members are urged to take part.
- Public Health Food Webinars continue until Friday 2nd July.
- Cllr Hamilton has been elected onto the board of the Milan Urban Food Policy Pact.
- The first UN Food Dialogue for Birmingham will take place in June.

Birmingham Health and Wellbeing Board

	Agenda Item: 20
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**27th July 2021**
TITLE:	**BIRMINGHAM AND LEWISHAM AFRICAN AND CARIBBEAN HEALTH INEQUALITIES REVIEW (BLACHIR)**
Organisation	**Birmingham City Council**
Presenting Officer	**Monika Rozanski, Service Lead Inequalities**

Report Type:	**Information**

1.	**Purpose:**
1.1	To report on the progress of Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR).

2.	**Implications:**	
BHWB Strategy Priorities	Childhood Obesity	N
	Health Inequalities	Y
Joint Strategic Needs Assessment		N
Creating a Healthy Food City		N
Creating a Mentally Healthy City		N
Creating an Active City		N
Creating a City without Inequality		Y
Health Protection		N

3.	**Recommendation**
	It is recommended that the Board:
3.1	Acknowledge the progress made by the BLACHIR project.

4. Report Body

4.1 Background and Purpose of BLACHIR

The Birmingham and Lewisham African & Caribbean Health Inequalities Review (BLACHIR) is a partnership between Birmingham City Council and Lewisham Council to share knowledge and resources through a collaborative review process. It follows the work of both Councils as national Childhood Obesity Trailblazers.

BLACHIR focuses on the Black African and Black Caribbean communities. The partnership aims to jointly undertake a series of reviews to explore in-depth the health inequalities being experienced by Black African and Black Caribbean population.

An external advisory board, consisting of individuals with lived experience, and an academic advisory board were recruited to review, critique and discuss the findings. The boards support the review process through examining the evidence with the review team and shaping the recommendations. The main objective of the review is to produce a joint final report that brings together the findings from all of the themed reviews and a series of recommendations being referred to as opportunities for action. The final report will also include data analysis conducted by the review group throughout the 18-month period.

The Review includes 9 topics for discussion, these are:

- Racism & discrimination role in health inequalities
- Early years, Pregnancy & Parenthood
- Children and Young People
- Ageing well
- Behavioural (lifestyle) factors
- Mental health & wellbeing
- Chronic disease
- Acute disease and death
- Wider determinants of health.

4.2 BLACHIR Progress so far

Four of the above nine themes of the review have now been completed. The advisory board for the last Ageing Well completed review met on 30 June 2021.

A public engagement activity has been planned to further review, refine and prioritise the opportunities for action identified from the first three themed reviews (Racism & discrimination role in health inequalities, Early years, Pregnancy & Parenthood and Children and Young People). It will consist of a public survey to be launched w/c 5 July 2021 and will be followed by a stakeholder engagement workshop, which will take place on 20 July 2021.

At present, the outputs from the Ageing Well themed review meetings are being collated.

Work has also commenced on the fifth thematic review (Behavioural factors) led by Lewisham and the sixth one (Mental health and wellbeing), commissioned by Birmingham Public Health from the University of Wolverhampton. University of Wolverhampton along with Birmingham Community Healthcare NHS Foundation Trust have been commissioned to produce an evidence summary.

We are also in the process of commissioning the rapid systematic reviews for the last two themes.

4.3 Next Steps

- Public engagement activity throughout July 2021.
-
- Findings from the rapid research for the Mental Health and Wellbeing theme to be released early August 2021.

The last two systematic reviews to commence in September 2021.

5. Compliance Issues
5.1 HWBB Forum Responsibility and Board Update
5.1.1 A brief update to be provided to the Health and Wellbeing Board on progress to ensure steady progress and address any issues or risks highlighted that may hinder required outputs and outcomes.

5.2 Management Responsibility
Dr Justin Varney, Director of Public Health, Birmingham City Council Dr Maria Rivas – Interim Assistant Director, Birmingham City Council Monika Rozanski – Service Lead - Inequalities

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Risk of delay in progress and outputs due to pressures on the review team in Lewisham and capacity issues and delays in engagement activity across both LA areas due to summer holidays.	High	High	Robust monitoring and reporting mechanisms to ensure collaborative working to promote positive workable solutions. Commissioning of a larger proportion of the thematic systematic reviews and engagement activity by Birmingham Public Health.

Appendices
None

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

Atif Ali, Programme Officer – Inequalities, Birmingham City Council
Monika Rozanski, Service Lead – Inequalities, Birmingham City Council

Birmingham Health and Wellbeing Board

	Agenda Item: 21
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**27TH JULY 2021**
TITLE:	**ICS INEQUALITIES WORK PROGRAMME - UPDATE**
Organisation	**Birmingham & Solihull Integrated Care System**
Presenting Officer	**Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS FT**

Report Type:	**Information**

1. Purpose:	
1.1	The purpose of the report is to provide an update for the Health & Wellbeing Board on the work of the Birmingham & Solihull ICS Inequalities Board

2. Implications:		
BHWB Strategy Priorities	Childhood Obesity	
	Health Inequalities	Yes
Joint Strategic Needs Assessment		Yes
Creating a Healthy Food City		
Creating a Mentally Healthy City		
Creating an Active City		
Creating a City without Inequality		Yes
Health Protection		

3. Recommendation	
The Health & Wellbeing Board is recommended to:	
3.1	NOTE the progress report from the ICS Inequalities Board.

4. Report Body

Introduction

4.1 Tackling inequalities in society and their impact on the health and life chances of the people we serve will be at the heart of the work of the Birmingham & Solihull Integrated Care System (ICS). This report provides a progress report for the Birmingham Health & Wellbeing Board on the work of the ICS Inequalities Board to make this commitment a reality in the way we work.

Background

4.2 Initial priorities for the Birmingham & Solihull ICS Inequalities work programme were shared with the Birmingham Health & Wellbeing Board at its meeting in March 2021. Since then we have continued to work closely with the Health & Wellbeing Board on the development of our work programme.

4.3 The ICS Inequalities work programme last reported progress to the Health & Wellbeing Board at the May meeting of the Board and this report provides a further update.

Our Approach

4.4 We reported in May that we have adopted the two guiding principles for the work of the ICS on inequalities.

- Reducing health inequalities and workforce inequalities is mainstream activity that is core to and not peripheral to the work of the NHS.
- Interventions to address inequalities must be evidence-based with meaningful prospects for measurable success.

4.5 We have set three big priorities to drive our work.

- *Ensuring inequalities are at the heart of our ICS* – ensuring that everything the ICS does contributes to tackling inequalities.
- *Ensuring the NHS plays its full part in tackling inequalities* – addressing variation in access, experience and outcomes for patients and service users.
- *Supporting wider work to tackle the causes of inequality* – working with partners to tackle the factors that drive inequalities including access to employment.

4.6 We are developing our plans in a two stage approach.

- Making progress over the next 9 to 12 months on a small set of short-term priorities for the year ahead. These form the core of the next section of this report.

- Using the period between now and April 2022 to work with stakeholders including the two Health & Wellbeing Boards to develop a 5-10 year inequalities strategy for the ICS.

Establishing the Inequalities Work Programme

4.7 We are still in the establishment / mobilisation phase for the work programme. The ICS Inequalities Board is now meeting monthly including executive leads from each of the ICS partner organisations. The board is concentrating on establishing our workstreams and ensuring that we have a clear shared picture of the nature and scale of inequalities in Birmingham and Solihull and their impact on health. The recruitment process for a system non-executive director to chair our Board has taken place and we hope to be able to announce the outcome shortly.

4.8 We are continuing to work closely with the Black Country & West Birmingham ICS inequalities team to share strategies and ensure that we have a consistent approach to West Birmingham.

4.9 Amongst our next steps we will be looking over the next 2 months to

- set up a group to lead NHS-facing work on digital inclusion working with the ICS Digital Engagement Group;
- working with the Directors of Public Health and the CCG ensure that we re-establish the ICS Prevention Board;
- agree how we build issues of inequality into the ICS Estates programme, for example, ensuring that we make full use as a system of the relatively new, high-quality primary care LIFT estate in some of the most deprived parts of the city.

4.10 We are also working with the ICS on an outcomes framework for health inequalities. In the first instance we are intending to build something that focusses on our short-term priorities for the year ahead. Part of the work on our longer-term strategy will include a more developed outcomes framework so we can track the impact we are making.

Progress

4.11 *COVID19 Vaccinations.* We continue to work closely with the ICS vaccination programme and the Vaccination Inequalities Group chaired by Dr Ruth Tennant. Vaccination coverage (to 5th July) is 63% 1st dose and 45% 2nd dose in Birmingham and 82% and 66% respectively in Solihull. Coverage continues to increase and both BSol and BCWB ICS's are working closely to support West Birmingham where uptake is lowest to date.

4.12 *COVID19 Elective Recovery.* We have undertaken an initial analysis of NHS elective waiting lists by ethnicity and deprivation and expect to have this available routinely from end of July. The current waiting list is broadly representative of the population of the city with c. 40% of patients from the bottom decile of the Index of Multiple Deprivation (IMD) and an ethnicity profile

that reflects the city. This initial analysis has not shown significant variation in average waiting times by deprivation or ethnicity but we are continuing to analyse this. We are seeing significant variation across the city in referral rates with PCNs in more affluent areas more likely to be using Advice & Guidance services. It also appears that patients from more deprived areas are less likely to respond to messages sent electronically raising issues to be addressed in our digital inclusion group.

4.13 *Infant Mortality.* Birmingham has clearly identified infant mortality as a top priority for tackling inequalities and their impact on health. Although the issues are different for Solihull, the first 1000 days of life are also a priority for the borough. We will ensure that the NHS plays its full part in the work being led by the city council taskforce on infant mortality and the work to use infant mortality as a test-bed for our approach to Population Health Management. This will focus on work with BUMP and Birmingham Forward Steps on maternity, neo-natal and early years care pathways.

4.14 *Long-Term Conditions / Prevention.* We are working with the c. 36 PCNs in Birmingham and Solihull to support the PCN Health Inequalities Champions build on the initial PCN population profiles that they have developed. We have committed a small amount of additional resource (£1k per PCN) to add to the capacity that the PCNs have to undertake this work. We are continuing to work with Washwood Heath PCN to build a model for multi-disciplinary working, engaging with the community to improve the health of people living with long term conditions starting with diabetes. The next step for us on prevention is to re-establish the ICS Prevention Board to drive further improvement.

4.15 *Community Engagement and Development.* We recognise that an effective approach to community engagement by local health and social care services is important to tackling inequalities. Good work has already been done in Bimringham through the Neighbourhood Network Scheme and there are lots of lessons to be learnt from the approach to community engagement through the vaccination programme. We plan to consider our approach to this in more detail at our September meeting.

4.16 *Anchor Institutions.* Working jointly with the ICS People Board we aim to develop the role of the NHS partners in the ICS in particular as Anchor Institutions in Birmingham and Solihull. In the first instance this will focus on developing our approach to the recruitment of local people who might not otherwise have access to the opportunities offered by the NHS and on exploring a commitment to be Living Wage employers. We will also follow up the work that the ICS has already undertaken on Social Value in procurement.

Next Steps

4.17 We have made a start but there remains much to do to make an impact on inequalities and their impact on health in Birmingham and Solihull. For the next 2-3 months we will continue to work on: establishing an effective ICS inequalities work programme, progressing our short-term priorities for this year and beginning work on the longer-term ICS inequalities strategy.

5.	Compliance Issues
5.1	**HWBB Forum Responsibility and Board Update**
5.1.1	Regular updates will be reported to the Health and Wellbeing Board via an update report in this format, or as a presentation item to the Board.

5.2 Management Responsibility
5.2.1 Richard Kirby, ICS Inequalities Lead and Chief Executive, Birmingham Community Healthcare NHS FT. 5.2.2 Salma Yaqoob, ICS Inequalities Programme Lead.

6.	Risk Analysis		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
That a lack of engagement undermines impact.	Low	High	Engagement workstream within the programme to address this during the first half of 2021/22.
That a failure to align work with partners reduces impact.	Medium	High	Engagement with Health & Wellbeing Boards and ongoing work with local authorities and Directors of Public Health.
That a failure to commit resources reduces impact.	Medium	High	Commitment from the ICS Board to the work programme and initial support for the programme team.

Appendices
N/A

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

- Richard Kirby, Chief Executive, BCHC
- Salma Yaqoob, ICS Inequalities Programme Lead

Birmingham & Solihull ICS Inequalities Work Programme Priorities 2021/22

Workstream	Priorities 2021/22				
Inequalities as ICS Core Business	Midlands Health Inequalities Toolkit	BSol Inequalities leads Network	HI Priorities for ICS workstreams	HI Priorities for NHS trusts	HI leadership development
Data	NHS activity ethnicity coding	Locality & PCN level data	Mapping access to NHS services	Activity analysis joint with BCWB	Tracking Impact inc ICS OF
Community Engagement	PCN-level prototypes (x2)	Locality stakeholders	BLACHIR – NHS input	Link to Healthwatch Community offer	
COVID Response & Inequalities	Waiting Lists – equality analysis	Vaccination – inequalities grp	Long COVID equity of access	Equality impact of recovery plan	
Prevention	Maternity pathways (BUMP)	Early Years pathways (BFS)	Mental Health pathways	Long Term Condition pathways	
Anchor Institutions	Joint work with the People Board	Recruitment Opportunities	Social Value procurement	Living Wage commitment	
Digital Inclusion	Joint work with the Digital Group	Digital inclusion strategy			
Population Health Management	Led by the PHM programme	Inequalities built into PHM approach			

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