BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD

THURSDAY, 28 MARCH 2024 AT 10:00 HOURS
IN COMMITTEE ROOMS 3 & 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1 **NOTICE OF RECORDING/WEBCAST**

The Chair to advise/meeting to note that this meeting will be webcast for live or subsequent broadcast via the Council's Public-I microsite (please click this link) and that members of the press/public may record and take photographs except where there are confidential or exempt items.

2 **DECLARATIONS OF INTERESTS**

Members are reminded they must declare all relevant pecuniary and other registerable interests arising from any business to be discussed at this meeting.

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

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

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

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

3 **APOLOGIES**

To receive any apologies.

4 **DATES OF MEETINGS**

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

Thursday 9 May 2024

5 - 10

5 **MINUTES AND MATTERS ARISING**

To confirm and sign the Minutes of the meeting held on 28 November 2023.

11 - 12

5A **COMMISSIONERS REVIEW AND COMMENTS ON THE AGENDA**

There were no comments submitted by the Commissioners in relation to any of the agenda items.

13 - 14

6 **ACTION LOG**

To review the actions arising from previous meetings.

7 **CHAIR'S UPDATE**

(1005 - 1015) to receive an oral update

8 **PUBLIC QUESTIONS**

(1015-10120) - Members of the Board to consider questions submitted by members of the public.
The deadline for receipt of public questions is 1500 hours on 21 March, 2024.
Questions should be sent to: HWBoard@Birmingham.gov.uk.
(No person may (submit more than one question)
Questions will be addressed in correlation to the agenda items and within the timescales allocated. This will be included in the broadcast via the Council's Public-I microsite (please click this link)
NB: The questions and answers will not be reproduced in the minutes.

15 - 156

9 **DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2023-2024**

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

157 - 168

10 **BIRMINGHAM AND SOLIHULL ICB JOINT FORWARD PLAN UPDATE**

(1035- 1050) Rob Checketts (Chief Officer for Policy, Birmingham and Solihull ICB) will present this item.

169 - 322 11 **CREATING AN ACTIVE BIRMINGHAM STRATEGY - CONSULTATION FINDINGS AND FINAL STRATEGY**

Humera Sultan (Consultant in Public Health, Birmingham City Council) will present this item.

323 - 378 12 **BIRMINGHAM AND LEWISHAM AFRICAN CARIBBEAN HEALTH INEQUALITIES REVIEW (BLACHIR) PROGRESS UPDATE**

(1110-1135) Helen Harrison (Assistant Director of Public Health, Birmingham City Council will present this item.

379 - 406 13 **PHARMACEUTICAL NEEDS ASSESSMENT (PNA)UPDATE - SUPPLEMENTARY STATEMENT**

(1135-1145) Rebecca Howell-Jones (Assistant Director, Public Health, Birmingham City Council) will present this item.

407 - 442 14 **HEALTH AND WELLBEING BOARD - EXECUTIVE BOARD PAPERS (DECEMBER 2023)**

(1145-1150) Dr Clara Day (Vice-Chair, Chief Medical Officer, NHS Birmingham and Solihull will present this item.

INFORMATION ITEMS

443 - 478 15 **BIRMINGHAM AND SOLIHULL CHILD DEATH OVERVIEW PANEL (CDOP) ANNUAL REPORT 2022-23**

479 - 480 16 **CREATING A BOLDER HEALTHIER CITY (2022-2030) - INDICATOR UPDATES**

481 - 488 17 **HEALTH AND WELL BEING BOARD FORWARD PLAN**

18 **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.

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD MEETING TUESDAY, 28 NOVEMBER, 2023

MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON TUESDAY, 28 NOVEMBER, 2023 AT 1000 HOURS IN COMMITTEE ROOMS 3 AND 4, COUNCIL HOUSE, BIRMINGHAM, B1 1BB

PRESENT: -

Councillor Mariam-Khan (Chair) Cabinet Member for Health and Social Care and Chair for the Birmingham Health and Wellbeing Board in the Chai (Present for part of the meeting)

Dr Clara Day (Vice-Chair) Chief Medical Officer, NHS Birmingham & Solihull ICB
Councillor Karen McCarthy
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Jo Tonkin, Assistant Director (KEG), BCC (in place of Justin Varney)
Helen Price, Director of Education and Skills
Andy Cave, Chief Executive Officer, Healthwatch Birmingham
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Natalie Allen Chief Executive SIFA FIRESIDE
Jonathan Brotherton C Exec. University Hospitals NHS Foundation Trust
Andy Couldrick, Chief Exec. Birmingham Children's Trust

ALSO PRESENT:-

Louisa Nisbett – Committee Services
Aidan Hall – Service Lead, Governance
Ceri Saunders – Cabinet Support Officer
Sarah Pullen, Service Lead (Food System), Public Health
……. Helen Harrison, Assistant Director Healthy Behaviours and Communities
Becky Pollard (Assistant Director, Public Health, Birmingham City Council)

A number of people attended the meeting online.

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NOTICE OF RECORDING/WEBCAST

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

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

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

DECLARATIONS OF INTERESTS

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

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

There were no declarations made.

APOLOGIES

748 Apologies for absence were submitted on behalf of :-

Dr Justin Varney, Director of Public Health
Professor Catherine Needham, Professor of Public Policy, University of Birmingham
Richard North, Chief Superintendent, WMP
Joanna Statham, DWP
David Melbourne, NHS Birmingham and Solihull CCG
Dr Anne Coulopoulos, University College Birmingham
Karen Creavin, TAWS

MINUTES AND MATTERS ARISING

749 The Minutes of the meeting held on 26 September, 2023, having been previously circulated, were confirmed and signed by the Chair.

COMMISSIONERS REVIEW AND COMMENTS ON THE AGENDA

The Commissioner's comments on the agenda items were noted.

DATES OF MEETINGS

750 The Board noted the dates of future meetings of the Committee for the remainder of the municipal year commencing at 1000 hours

30 January, 2024

26 March, 2024

ACTION LOG

751 No outstanding actions were raised for the Action Log.

CHAIR'S UPDATE

752 The Chair informed that Councillor Rob Pocock had been appointed to cover her role on the Board during her absence.

Dr Clara Day, Deputy Chair had agreed to Chair the Health and Well Being Board meeting in the absence of the Chair and the Chair thanked her for chairing the last meeting.

The Chair advised that the QCQ rating for Adult and Social Care had been good.

BCC was in a difficult financial situation. Every Directorate had to play its part in making savings and would be consulted on the decisions that need to be made. Members could speak to the Chair about any queries they had.

Great examples of joint working had taken place at Saltley Health Centre and Heartlands. They had focussed on meeting the demands of long patient stays. She had been taken aback by the amount of people who had attended and the information would be used to shape and design a way forward.

Finally on Friday 1 December, 2023 it was World's Aids Day.
There was a Back to Back exhibition and an event at Hawthorne House

The Chair would be leaving the meeting early and this was her last meeting until after her maternity leave.

(Dr Clara Day in the Chair)

PUBLIC QUESTIONS

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

There were no questions.

BIRMINGHAM AND SOLIHULL WINTER PRESSURES UPDATE

The following report was submitted:-

(See document attached)

Mandy Nagra (Executive Chief Delivery Officer, Birmingham and Solihull ICS) and Alan Butler (Associate Director of Delivery, Improvement and Urgent and Emergency Care) presented this report setting out the approach to managing winter pressures in BSoL and gave a summary of the report.

The operating model data was in the pack. Some of the changes had been mirrored nationally and there was a lot more work to be done in the key areas.

754 **RESOLVED**:-

That the HWB note the approach being taken to managing winter in BSol in Appendix 1.

MIDLANDS MET HOSPITAL UPDATE

The following report was submitted:-

(See document attached)

Tammy Davies (Deputy Chief Delivery Officer, Sandwell and West Birmingham NHS Trust) presented this item providing the Committee with an update on the progress to date of Midland Metropolitan University Hospital (MMUH).

A recap of the state of art building was set out in page 34 of the report. An overview of the services was on page 31. They were on track to open next year. The hospital had been designed with local people in mind.

In response to question the number of beds had been increased overall in terms of pathways and provision. They will work with local businesses to make food available for visitors and staff. It was noted that there were still opportunities for employees such as training, despite the challenges.

They work with Council's with regards to transport to ensure the services were accessible and people were aware of all the services available.

755 **RESOLVED**:-

That the HWB note and support the progress towards completion of the MMUH and that a further update be provided nearer the opening date.

CREATING AN ACTIVE CITY STRATEGY CONSULTATION

The following report was submitted:-

(See document attached)

The update was provided on behalf of Dr Justin Varney (Director of Public Health, Birmingham City informing Health and Wellbeing Board members about the consultation plan with the public on the Draft Creating an Active Birmingham Strategy. A number of officers attended the meeting and responded to questions. It was noted that there were a number of schemes taking place also that schools were keen to participate.

756 **RESOLVED**:-

That Board members note the comments and discussion on the Creating an Active City Strategy.

CREATING A HEALTHY FOOD CITY FORUM ANNUAL UPDATE

The following report was submitted:-

(See document attached)

Sarah Pullen (Food System Service Lead, Public Health presented this item providing an update on delivery to date, and current and planned activity on selected workstreams within the context of the Creating a Healthy Food City Forum and wider food portfolio of work. Sarah Pullen gave a summary of the work carried out. During the discussion reference was made to the financial challenges faced by the City Council. Board Members agreed there should be a role for joint working and they were keen to provide support.

757 **RESOLVED**:-

That the Board note the past and ongoing work by the Creating a Healthy Food City Forum

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INFORMATION ITEMS

WRITTEN UPDATES

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

BIRMINGHAM CHILDREN AND YOUNG PEOPLE'S PARTNERSHIP

(See documents attached)

758 **RESOLVED**:-

That the written updates be noted.

CREATING A BOLDER HEALTHIER CITY (2022-2030) - INDICATOR UPDATES

(See documents attached)

759 **RESOLVED**:-

That the written updates be noted.

FORWARD PLAN

760 The Forward Plan was noted.

(See document attached)

OTHER URGENT BUSINESS

761 No other urgent Business was raised.

The meeting ended at 1149 hours.

…….
CHAIR

Birmingham City Council
Birmingham Health and Wellbeing Board
28 March 2024

Commissioner Review

There were no comments submitted by Commissioners in relation to any of the agenda items.

Action Log 2023/24

Rag rating:

Overdue
In progress
Complete

Index no.	Date of Entry	Agenda Item	Action or Event	Named Owner	Target Date	Date Complete	Outcome/Output	Rag
1	18/07/2023	11. Children and Young People's Plan	Agree a future HWB meeting date for Children and Young People's Plan update.	Aidan Hall	26/09/2023	26/09/2023	Added to the HWB Forward Plan.	
2	18/07/2023	12. Birmingham and Solihull Joint ICB Forward Plan	Agree a future HWB meeting date for 'Joint Forward Plan' for the ICS 10-year strategy.	Aidan Hall	26/09/2023	26/09/2023	Added to the HWB Forward Plan.	
3	18/07/2023	10. Health and Wellbeing Board Development 2023-24	Defer the HWB Development item to the next meeting.	Aidan Hall	26/09/2023	26/09/2023	Item refined and brought back to the following meeting.	
4	18/07/2023	20. Exclusion of the Public	'Private' Minutes will be deferred to the next meeting and HWB will be given access	Louisa Nisbett	26/09/2023	26/09/2023	Private minutes circulated to members via email	
5	26/09/2023	9. Health and Wellbeing Board Development	Review Executive Board after 6 months.	Aidan Hall	26/03/2023			
6	26/09/2023	10. Joint Strategic Needs Assessment (JSNA) Update	Agree a future HWB meeting date for the Deep Dive Programme and JSNA update.	Aidan Hall	28/11/2023	28/11/2023	Added to the HWB Forward Plan (24/25).	

7	26/09/2023	11. Draft Birmingham and Solihull Enabling Primary Care Strategy	Agree a future HWB meeting date for the Enabling Primary Care Strategy	Aidan Hall	28/11/2023	28/11/2023	Added to the HWB Forward Plan (24/25).	

	Agenda Item: 9
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**28th March 2024**
TITLE:	**Director of Public Health Annual Report 2023-24**
Organisation	**Birmingham City Council**
Presenting Officer	**Dr Justin Varney**

Report Type:	**Information / Discussion**

1. Purpose:

1.1. To present the Director of Public Health Annual Report for 2023-24 to Health and Wellbeing Board members for endorsement.

2. Implications (tick all that apply):

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

3. Recommendation

3.1. To note the findings of the Director of Public Health Annual Report 2023-24.

3.2. To endorse the Director of Public Health Annual Report 2023-24 for wider dissemination.

4. Report Body

4.1. The Director of Public Health (DPH) has a statutory duty to write an independent, evidence-based annual report detailing the health and wellbeing of our local population. The DPH report is an opportunity to provide advice and recommendations on population health to both professionals and the public. The report includes a selected, specific issue that the DPH wishes to discuss within the report.

4.2. The content and structure of the report are decided locally based on current evidence-based health priorities. Previous year's reports in Birmingham have focused on various topics, including the impact of the coronavirus (COVID-19) pandemic (2020-21), the built environment's relationship with health (2021-22), and the role that digital technology can play in improving health and wellbeing (2022-23)

4.3. This year's Annual Report (2023-24) has been focused around demographic change and how it can affect the health and wellbeing needs of Birmingham's population. This focus has been explored through six topics that encapsulate where have been the greatest changes since the last census:

- Age
- Ethnicity
- Sexual Orientation & Gender Identity
- International Immigration
- Housing
- Employment

4.4. For each chapter, there is an exploration of the census data through visualisations and analysis. These highlight where there have been the greatest demographic changes since the last census and some of the wider trends impacting Birmingham's population.

4.5. There is also a discussion on the health and wellbeing implications of these changes. Finally, there is a consideration of what these changes and trends might mean for the future of the population.

4.6. To supplement our analysis, we have also included case studies from a qualitative research exercise into the perspectives of Birmingham's residents around these changes. One case study has been included per chapter and a summary of all the case studies can be found in the appendices.

4.7. Each chapter also has a set of system reflections from key senior leaders across the city. These reflections provide their response to the census data as well as insight towards how organisations in the city might respond.

5. Compliance Issues
5.1. HWBB Forum Responsibility and Board Update
N/a
5.2. Management Responsibility
Rebecca Howell-Jones, Assistant Director (Knowledge, Evidence and Governance) Alex Quarrie-Jones, Senior Programme Officer (Governance)
5.3. Finance Implications
N/a
5.4. Legal Implications
N/a
5.5. Equalities Implications (Public Sector Equality Duty)
N/a

6. Risk Analysis

Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Partners do not endorse the report and do not disseminate widely.	Low	Low	Partners will be asked at Health and Wellbeing Board to endorse the report and, if possible, share it more widely through their networks so it can be used to generate discussion on the demographic changes in Birmingham.

Appendices
Appendix 1 – Director of Public Health Annual Report 2023-24 (*From numbers to narratives*: An exploration of population trends, health, and wellbeing using the 2021 Census) Appendix 2 – Case Study Summary Report Appendix 3 – Population Projection Methodology

Appendix 4 – Additional visualisations for Director of Public Health Annual Report 2023-24

Background Papers
N/a

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

Alex Quarrie-Jones, Senior Programme Officer (Governance), Public Health
Abayomi Ajewole, Programme Officer (Governance), Public Health

Director of Public Health Annual Report 2023-2024

'*From numbers to narratives*: An exploration of population trends, health, and wellbeing using the 2021 Census'

Public Health Division, Birmingham City Council

Contents

Foreword

Director of Public Health

I am pleased to present this year's Director of Public Health's Annual Report, which explores some key demographic changes in our city.

Birmingham's population is changing and will continue to change. Changes in demography bring opportunities to understand, learn from and engage with our diverse communities and citizens. A population with a different make-up has different needs, and by exploring how we are changing, the potential drivers and possible implications, we can collectively shape a healthier future for Birmingham.

Some of the changes we are experiencing reflect national trends, but some relate to our local history and shifts. Birmingham has changed significantly in previous decades and, in 2021, became a super-diverse city, meaning citizens from ethnic minorities make up more than half the population. Birmingham remains a young city, but it is still ageing with the rest of the country and will become older relative to the working-age population.

The report explores key areas through various sources, including census data. Once every ten years, the census allows us to build a detailed and comprehensive picture of Birmingham. The census was conducted in March 2021, during the extraordinary circumstances of the COVID-19 pandemic in our third national lockdown.

The census is not just another survey; it is much more than that because the information collected shapes the support available in our communities. As well as underpinning population estimates and projections that influence funding allocations, the census details population characteristics that help us tailor services to reflect Birmingham's needs.

However, demographic change is more than statistical phenomena and the census. It is about people and communities, their stories, experiences and perspectives, and why we have included the voices of Birmingham's citizens throughout this report. Many people have contributed to this report, and I am grateful for their insights and reflections.

We reflect on the past and look ahead to the future, but it is not all-seeing and all-knowing. Many things will change over time, so any glimpse into the future should be considered a 'do nothing' and 'if nothing changes' future.

This report is for everyone to use. I hope it inspires action across the city to understand our population further and enable our citizens to make choices that allow them to live long and healthy lives.

Dr Justin Varney

Director of Public Health

Birmingham City Council

Acting Cabinet Member for Health and Social Care

I am pleased to receive this year's annual report from the Director of Public Health, which focuses on the changing demography of Birmingham and how it might affect the health and wellbeing of Birmingham's citizens and communities.

There is no better time to look at our demography than now. Birmingham's population has changed significantly in recent years. This means we need to adapt our services and the ways they work to ensure they best align with the ever-wider range of expectations, needs and cultures of our city's changing population and engage with the diverse communities that live, work and learn in Birmingham. That's a pre-requisite for ensuring a thriving environment for all of Birmingham's citizens and communities.

As noted in the report, one of the most significant and unique changes for Birmingham is its super-diversity. This must become our distinctive asset, giving us an opportunity to celebrate and showcase our uniqueness, diversity and cultural heritage to the wider world. We can all be proud to be part of this wonderful city.

I was particularly interested in the report exploring how the different parts of our identities interact. It helps us understand that people may be disproportionately affected by a changing population because they face one or more inequalities relating to their identity. It also reinforced the challenges that we face as a council and a partner within the health and care system if we are to further reduce health inequalities with the city.

Trends and projections were explored, making it possible to predict the likelihood of the impacts of the demographic changes on health and wellbeing. It is time for us to come together, realising our strength, and taking advantage of the demographic changes while doing all we can to ensure that no one is negatively impacted, as we move forward in our collective aim of building a better Birmingham for the future.

Cllr Rob Pocock

Acting Cabinet Member for Health and Social Care

Birmingham City Council

Introduction

Purpose

All Directors of Public Health in England have a statutory duty to produce an annual report, usually on the health and wellbeing of their local community. In recent years, Birmingham has chosen to focus on a specific topic and to present the annual report as a 'discussion starter' on that topic. The focus of this year's annual report is on Birmingham's changing demography, as captured by the 2021 Census, and how these changes will affect the health and wellbeing of its residents in the future. This topic has been chosen because Birmingham's population has rapidly changed since the last census. In some respects, it has mirrored national trends, such as a gradually ageing population and shifts to homeworking. In others, it is more unique, such as through its ethnic superdiversity or migration profile. Moreover, the 2021 Census data gives us a rich and comprehensive understanding of the population by allowing us to combine all variables and see a more complete and more holistic picture.

The report predominantly uses data from the 2021 Census, along with supplementary data from other sources, and seeks to answer three questions for each chapter:

1. What does the data tell us?
2. What are the health and wellbeing implications?
3. What might this look like in the future?

The report is split into six chapters each focusing on a topic within the census that illustrates the changes in Birmingham's population and their implications for health and wellbeing. Within each chapter, there are several data headlines which summarise the greatest changes and trends and the headline health and wellbeing implications. There are also case studies from Birmingham residents on their perspectives of demographic change in the city and their outlook for the future. Finally, there are reflection statements on the data and discussion in each chapter from key leaders across the council, its partners and the community and voluntary sector in Birmingham.

Context

The census is a national survey completed by the whole population every ten years. It is undertaken by the Office for National Statistics (ONS) who then compile and release the data publicly.[1] The census provides vital insights into the population at the exact time it was conducted. The 2021 Census was conducted on the 21st of March 2021 and was the first census to ever be completed digitally alongside paper booklets.[1]

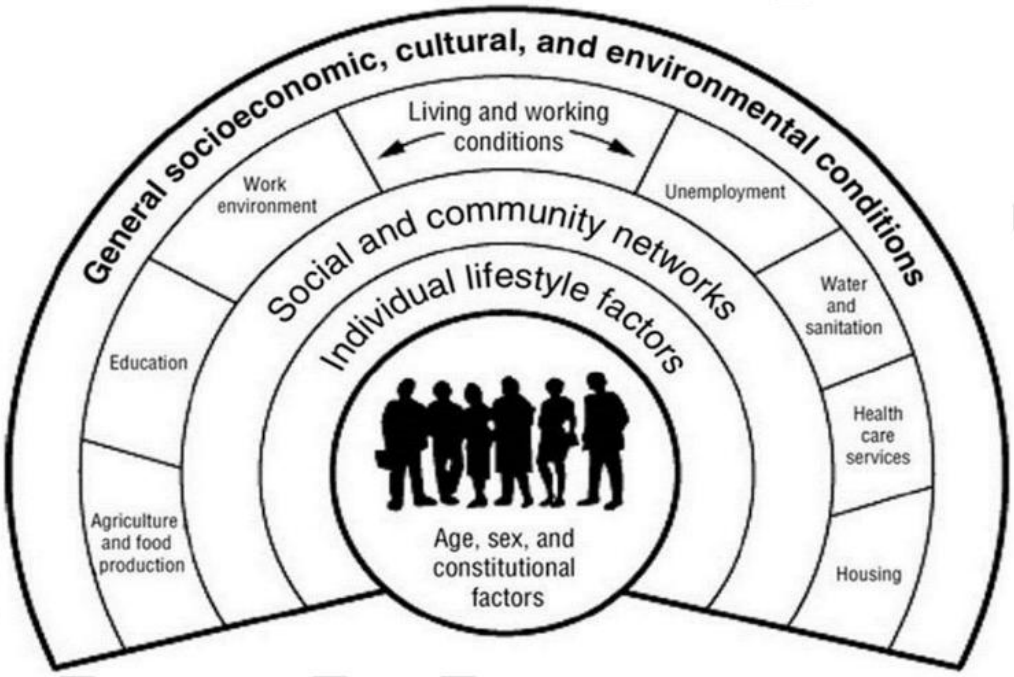
The 2021 Census was also unique because it was conducted during the COVID-19 pandemic. At the time, Birmingham, alongside the rest of the United Kingdom, was still in a form of 'lockdown' and many regular activities were restricted to prevent the spread of the virus.[1] As a result, some of the data collected was not representative of the usual circumstances that the population live, work, and socialise in. This means that it is harder to compare the data collected in 2021 to previous censuses and establish trends about the population. This issue will be explored later in the report.

The rationale for the chapter topics is that each of them encapsulate an aspect of the Birmingham's population that has experienced major changes since the last census and can be part of a broader demographic trend. These chapter topics are:

1. Age
2. Ethnicity
3. Sexual Orientation & Gender Identity
4. International Immigration
5. Housing
6. Employment.

While these topics broadly align with those in the 2021 Census, they also have a clear relevancy to the health and wellbeing of the population. This can be shown through the Dahlgren and Whitehead Model of Health Determinants (Figure 1).

Figure 1: Dahlgren and Whitehead's Model of Health Determinants[2]



The model shows the influence that these determinants can have on health and wellbeing with the centre focused around physical or genetic factors and the next layers focusing on lifestyle, social networks, living conditions and environment. The topics chosen for the report coincide with several of the determinants identified in the model. Equally, the model emphasises that these determinants are interconnected and should be treated as such. While this report is split into chapters, we have explored how these determinants relate to each other. This will also present an intersectional understanding of the population's health needs.

Our approach

This report has been developed through several stages, using a variety of primary and secondary sources to inform the insights and analysis. Initially, a research question was created to frame the direction of the report and the areas of the census to explore. Three

sub-questions were then developed for each chapter to further explore the data and understand the potential implications for health and wellbeing.

Chapter topics were scoped by using the topics of the 2021 Census that highlighted the greatest changes for Birmingham. Under these topics, the relevant data was collated, and particular variables were chosen to best present the data through. Equally, for the topics where it was possible, population projections were produced to consider what the population might look like by the time of the next national census in 2031. These projections were developed using the current population figure and then factoring in the birth rate, death rate and migration trend for each subsequent year. To reduce the uncertainty with these rates, total fertility rate and age-dependent mortality rate were calculated as probabilistic. This allowed for a plausible range of future population numbers, as seen in Figure 3 (Full methodology can be found in Appendix 2).

Once the topics were agreed, an evidence review was conducted for each chapter to establish an understanding that could complement the census data through possible health and wellbeing implications. Further to this, a brief qualitative project was commissioned to gather the perspectives of Birmingham's residents on these changes. A selection of these perspectives has been presented as case studies and quotations in each chapter. Finally, a series of stakeholders have been engaged on each chapter topic to provide a 'system reflection' that includes both their response to the data and their local insight on how they may affect Birmingham in the future.

'Birmingham in 2021': A snapshot

Census Data
(Infographics)

Age	Ethnicity	Sexual Orientation and Gender Identity
✓ The average (median) age of Birmingham increased by two years, from 32 to 34 years of age. ✓ Birmingham had the lowest average (median) age in the West Midlands and a lower average (median) age than England (40 years). ✓ The number of people aged 50 to 64 years rose by just over 30,900 (an increase of 20.0%). ✓ The number of people aged 4 years and under fell by around 6,900 (8.4% decrease).	✓ Birmingham is now a super-diverse city. The city's minority ethnic groups now represent more than half (51.4%) of the population. ✓ 31.0% of Birmingham residents identified their ethnic group as "Asian, Asian British",11.0% identified as "Black, Black British, Black Welsh, Caribbean or African", 4.8% identified as "Mixed/Multiple ethnic groups", 4.2% identified as "Other ethnic group", and 48.6% identified as "White". ✓ The greatest increases were for 'Pakistani' (an increase of 3.6% on the proportion) and 'African' (an increase of 3.0% on the proportion).	✓ 87.6% of Birmingham residents identified as straight or heterosexual, 3.0% identified with an LGB+ orientation, and 9.4% did not answer the question on sexual orientation. ✓ 90.8% answered that their gender identity was the same as their sex registered at birth, 0.9% answered that their gender identity was different from their sex registered at birth, and 8.4% did not answer the question on gender identity. ✓ Of those who identify with an LGB+ orientation, 44.7% are Gay or Lesbian, 42% are Bisexual, 7.6% are 'An other sexual orientation', 2.7% are Pansexual, 1.7% are Asexual and 1.2% are Queer.
International Immigration	**Housing**	**Employment**
✓ Around 824,000 Birmingham residents said they were born in England (72.0%). ✓ Pakistan was the next most represented, with around 67,400 Birmingham residents reporting this country of birth (5.9%). This figure was up from around 55,900 in 2011, which at the time represented 5.2% of the population of Birmingham. ✓ People who were born outside of the UK but now live in Birmingham generally arrive in the UK at a young age. The age group with the highest number is 20-24 years (Male and Female).	✓ 27.2% of homes in Birmingham were owned outright in 2021. ✓ Most households in Birmingham have one person per household, meaning most people live on their own. ✓ Over half of people aged 85 years and above live alone in Birmingham. ✓ 22.6% of households in Birmingham were rented privately, up from 17.9% in 2011. ✓ Just under one in four households (23.5%) lived in socially rented housing, compared with 24.2% in 2011.	✓ 52.1% of the population were 'economically active', while 44.4% were 'economically inactive'. 3.5% were economically active while full-time students. ✓ Economic inactivity increased between 2011 and 2021. The biggest reasons for this were 'retirement' (15.6%) and '16+ education' (10.0%). ✓ Of those in employment, 25.8% reported that they 'work mainly at or from home'. ✓ The most common method of travelling to work remains a car or van (45.9%)

Figure 2: Population pyramid for Birmingham (2011 and 2021)[1]

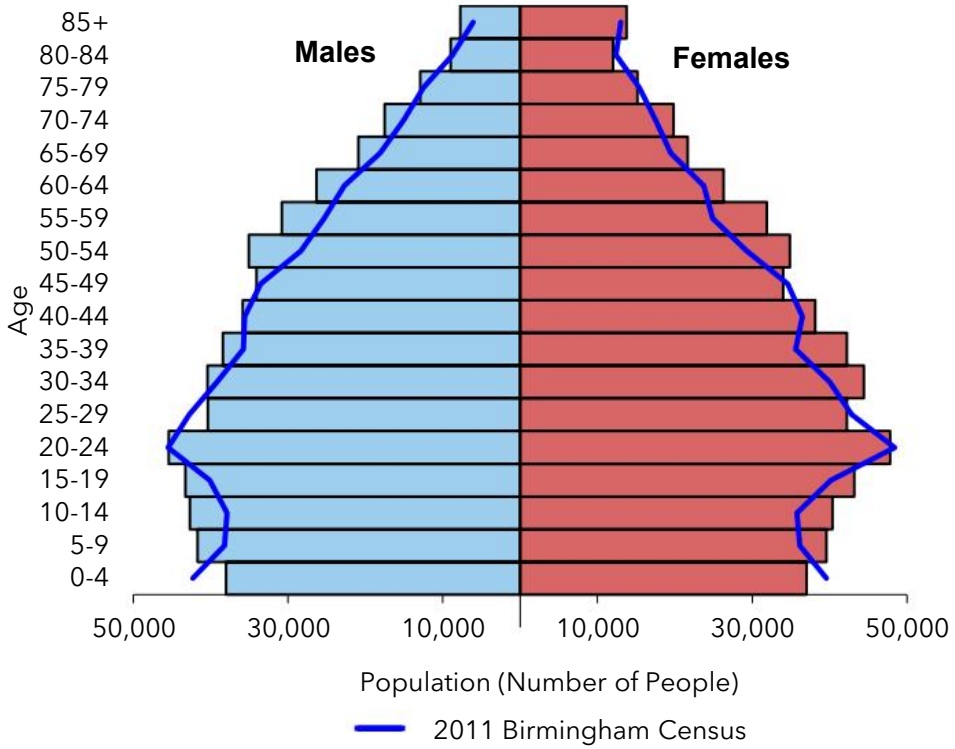


Figure 3: Population projection by all ages to 2031 in Birmingham.

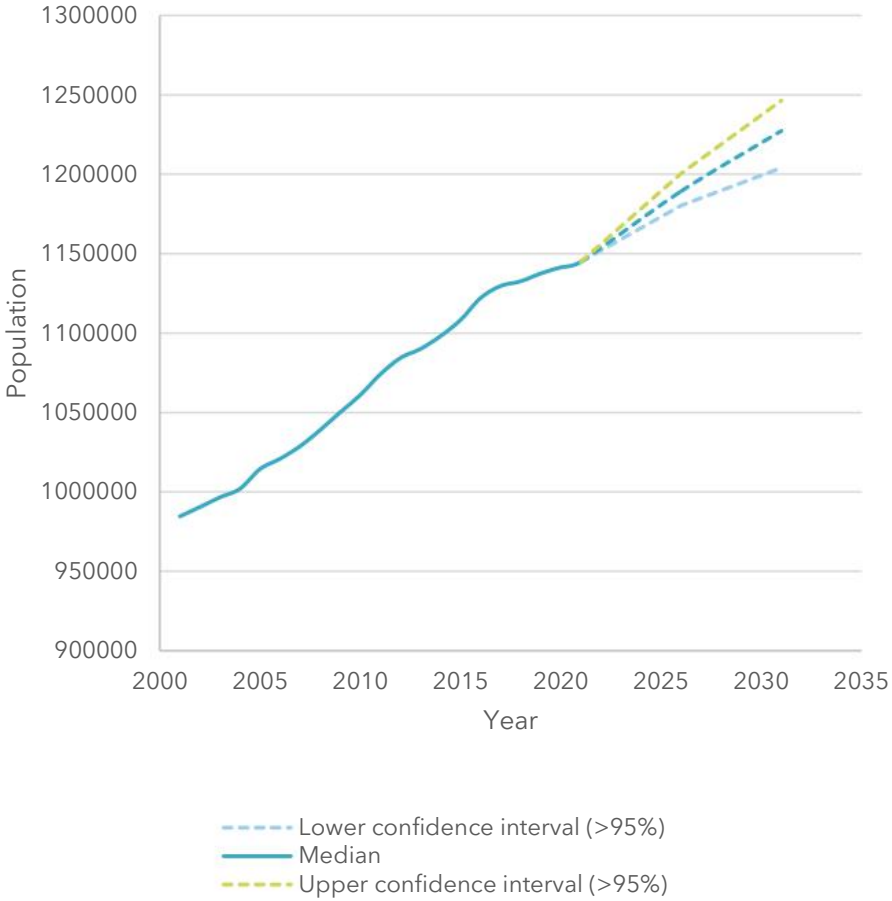


Figure 4: Life expectancy at birth for Birmingham and England (Females) (2001-2022)

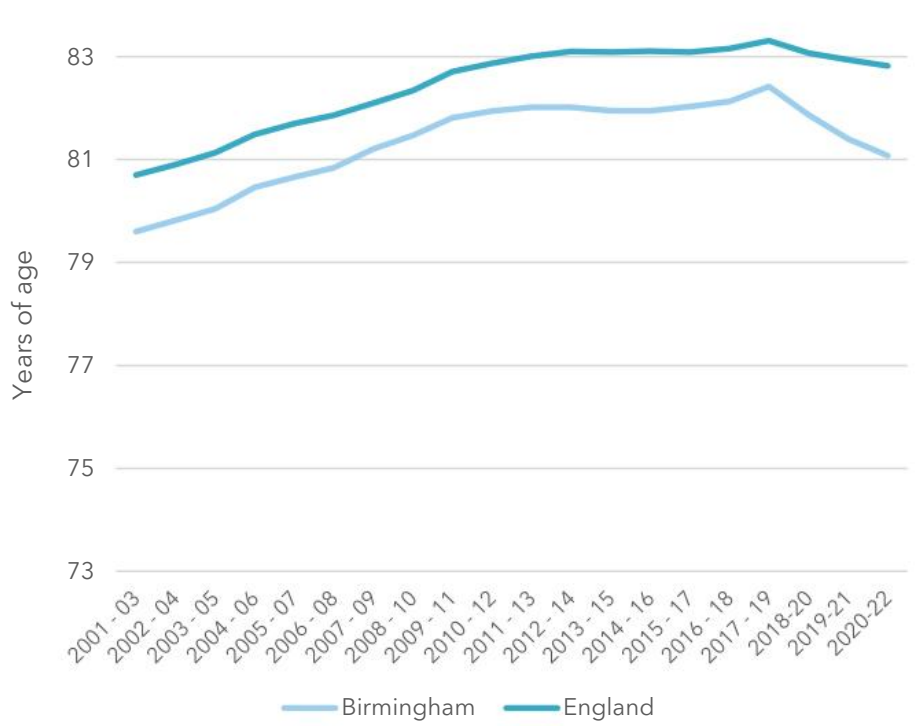


Figure 5: Life expectancy at birth for Birmingham and England (Males) (2001-2022)

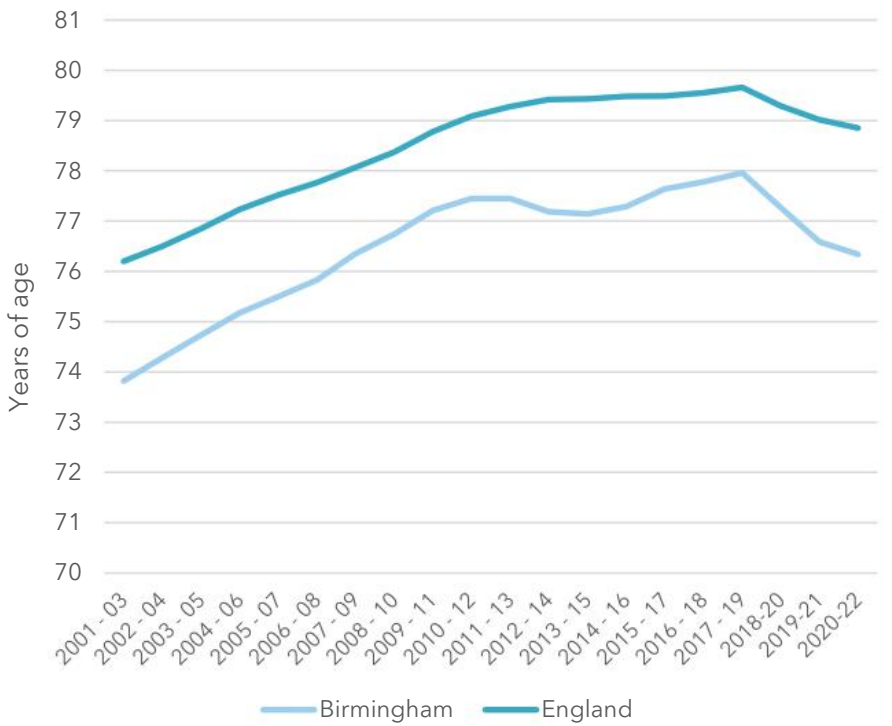
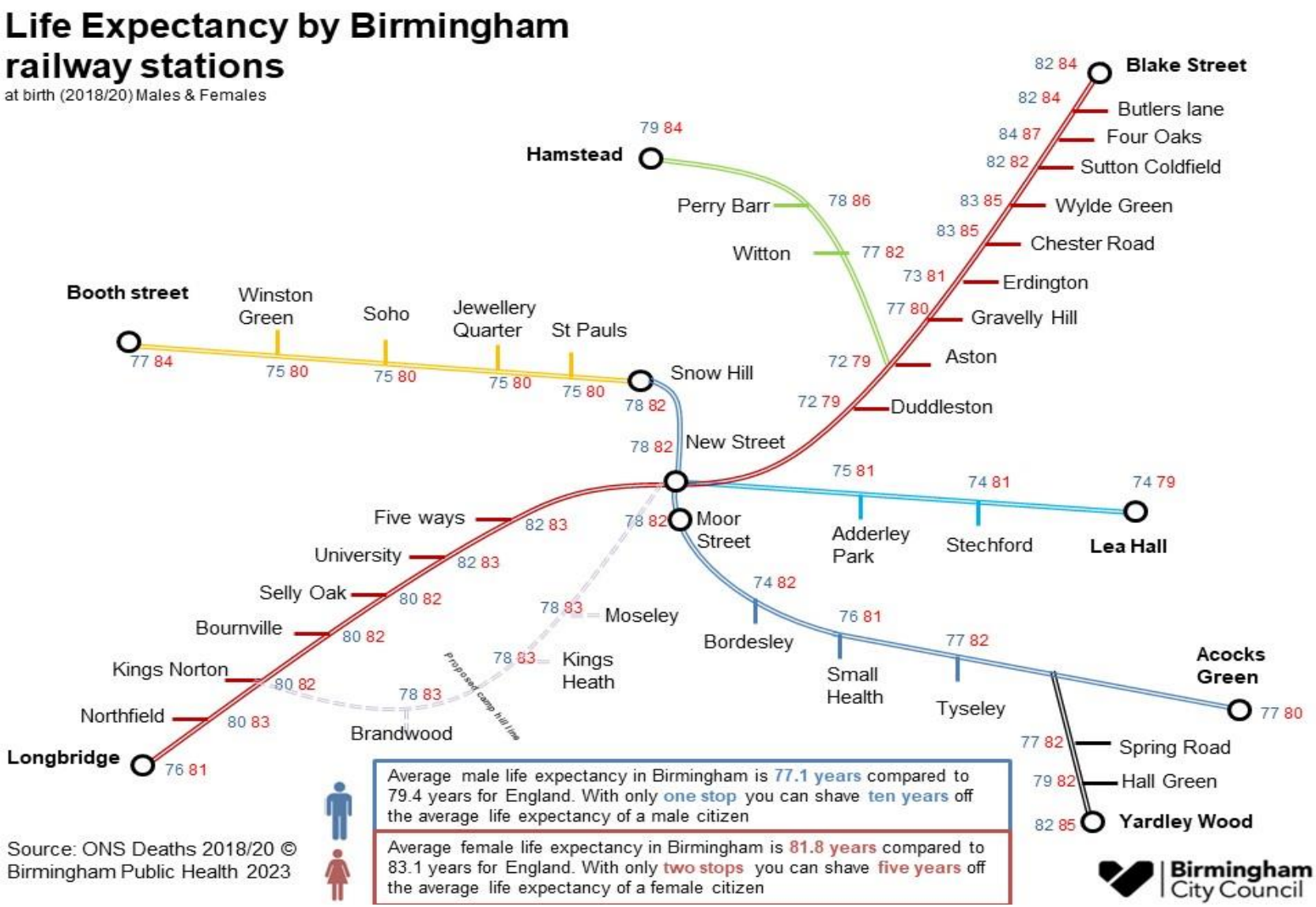


Figure 6: Life expectancy at birth by Birmingham railway stations (2018/20)



Implications of demographic change for Health and Wellbeing

Age	Ethnicity	Sexual Orientation and Gender Identity
➢ Changes in birth rates and decreases in number of children mean there is increased uncertainty for planning to meet the needs for education and children-related services in the future, as well as uncertainty on planning for the complexity of the need. ➢ As a greater number of Birmingham's population enters older age, there will be an associated rise in health and social care need. ➢ Health and care needs associated with ageing will be geographically spread across the city, with higher proportion of older people in the north and southern areas of the city, and inequality bringing poor health to those in deprived areas at a younger age. ➢ Whilst ageing is inevitable, aging in poor health is not. There is much that can be done to delay or prevent the decline in physical, mental, and emotional well-being and to enable older people to maintain independent lives.	➢ Ethnic minority groups tend to experience higher rates of conditions such as diabetes, obesity, asthma, heart disease, and cancer, and may also experience earlier onset. ➢ Ethnicity impacts on health through different mechanisms: racism and discrimination, social determinants including income, education, employment and housing, cultural and lifestyle factors, health services and clinical factors and genetics such as sickle-cell disease. ➢ The age-ethnicity profile in the city varies greatly, with the older age-group having a different ethnicity profile to the younger age-groups: there is a need for services to recognise this and respond to need appropriately and adapt over time. ➢ With continued increase in ethnic minorities populations, specific diseases will see increases such as sickle cell disease which has an increased prevalence in African and Caribbean populations, and Type 2 diabetes which is higher in South Asian groups. ➢ Ethnicity intersects with other characteristics, leading to worse health outcomes for example for older adults and people with learning disabilities from minority ethnic groups.	➢ The LGBTQ+ population is more likely to be affected by inequalities around mental health and wellbeing, substance misuse, and smoking rates. ➢ They are also more likely to experience direct and indirect discrimination both when accessing health-related services and in wider society. ➢ Those who identify as 'trans+' and seek to medically transition face additional barriers as there are no Gender Dysphoria Clinics in the West Midlands and long-waiting lists for referrals and treatment. ➢ Future trends are difficult to determine as this was the first time LGB+ data have been collected in the Census, many possible reasons for non-reporting and uncertainty on whether greater identification of LBG+ in the younger population will continue as this population ages.
International Immigration	**Employment**	**Housing**
➢ Migrants often experience barriers in accessing health and social services, especially if they are undocumented. ➢ Migrants may experience discrimination and are therefore vulnerable to physical and mental illness. ➢ Those who migrated for employment, family and study reasons have better health than the UK-born, while those who migrated to seek asylum have worse health outcomes. ➢ Those who migrate are more likely to be younger and are also less reliant on the health system. ➢ Migrants who choose to migrate have better health than their host population, but there is a deterioration of health status the longer they reside in the host country.	➢ With increasing age, the proportion of economically inactive residents reporting long-term sickness or disability as the cause of their inactivity increases up to pre-retirement ages (50-64 years). ➢ People who are economically inactive primarily because of their health tend to have increasingly complex health needs, the majority with more than one health barrier to them returning to the labour market. ➢ Pre-pandemic there was a trend of increasing prevalence of poor health, and of poor health as a reason for economic inactivity. Further to the pandemic, economic inactivity for health reasons is likely to be exacerbated by conditions like long COVID and longer waiting lists for treatment, and the impact on the mental wellbeing. ➢ Evidence shows that working carers can experience a range of difficulties including lack of time, excessive stress and resulting health problems, and financial pressures. Active travel, especially for short, routine journeys, can create a positive health effect for both individuals (more physical activity) and the wider population (improved air quality from less vehicle-based pollution).	➢ Housing is one of the key determinants of health and homelessness hugely impacts health and wellbeing. ➢ Overcrowding can have negative effects on both physical and mental health and wellbeing and is associated with increased risk of infectious diseases such as COVID-19. ➢ Living alone can be associated with unfavourable health outcomes such as anxiety, depression, and physical health conditions. ➢ Owning a house can improve mental health, as this can provide a sense of emotional security: mental distress is more common in renters than homeowners.

Age

Data Headlines

- Birmingham's birth rate has declined by 3.4% over the past decade and the number of 0-4 year olds has decreased by around 6,900 (8.4% decrease)
- The total population grew with the largest population increase seen in the pre-retirement age groups, with those aged between by 55-59 growing by 25% (12,400) since 2011.
- 50% of 65+ year olds in 2021 reported very good or good health compared to 41% in 2011.

Implication for Health and Wellbeing

- Changes in birth rates and decreases in number of children mean there is increased uncertainty for planning to meet the needs for education and children-related services in the future, as well as uncertainty on planning for the complexity of the need. .
- As a greater number of Birmingham's population enters older age, there will be an associated rise in health and social care need.
- Health and care needs associated with ageing will be geographically spread across the city, with higher proportion of older people in the north and southern areas of the city, and inequality bringing poor health to those in deprived areas at a younger age.
- Whilst ageing is inevitable, aging in poor health is not. There is much that can be done to delay or prevent the decline in physical, mental, and emotional well-being and to enable older people to maintain independent lives.

What does the data tell us about age in Birmingham?

Birmingham has a young demographic profile compared to the rest of the country.[3] Overall, the population of Birmingham has seen an increase of 6.7%, growing from around 1,073,000 in 2011 to 1,144,900 in 2021: approximately 255,300 (23.4%) of the population are aged under 16 years old, 686,500 (57.7%) are aged between 16 and 59 years old, and 203,100 (18.9%) are aged 60 years and above.[3] This is compared to England where the population is 18.6%, 57.3% and 24.2% in the same respective age groups.[1]

Whilst Birmingham remains a young city, the number of adults and older people has increased. Between the last two censuses, Birmingham's average (median) age increased by two years, from 32 to 34 years of age. This remains the lowest in the West Midlands and lower than the England average (40 years).[1]

The reasons behind these demographic changes in Birmingham's size and age structure include natural change, which refers to the difference between the number of births and deaths[4] and international migration[5]. The city has been attracting individuals from around the world, contributing to its diverse and dynamic population[6] while Birmingham-born have also residents moved to other areas[7].

Birmingham's changing age profile also influences the health and care needs of the population. Whilst ageing is inevitable, ageing in better or worse health is more variable. With the greatest need and vulnerability in the youngest and oldest ages, a preventative approach to poor health can help the entire future population.

> *"I've seen a lot more young people around Birmingham, in town, and I think just in schools as well, because I was doing some work experience at my school and they normally have six form classes in secondary school, and they've had to add another one just because so many young people are coming in…*
>
> Kabir, 19, Male, Handsworth Wood

The birth rate across Birmingham has decreased since 2011 as has the number of under 5 year olds

Since 2011, Birmingham has experienced significant shifts in its birth rate.[3] The Total Fertility Rate (TFR), which represents the average number of children a woman would have, assuming that current age-specific birth rates remain constant throughout her childbearing years, decreased from 2.09 in 2011 to 1.74 in 2020.[8]

Figure 7: Live Births and Total Fertility Rate in Birmingham (2021)[8]

Date	Live Births	Total Fertility Rate (TFR)	Percentage Change in births
2019	15,483	1.78	
2020	14,991	1.74	-3.2%
2021	14,477	1.68	-3.4%
2022	14,482	1.66	0.0%

The ONS outlined potential factors contributing to the decline in total fertility rates[9]:

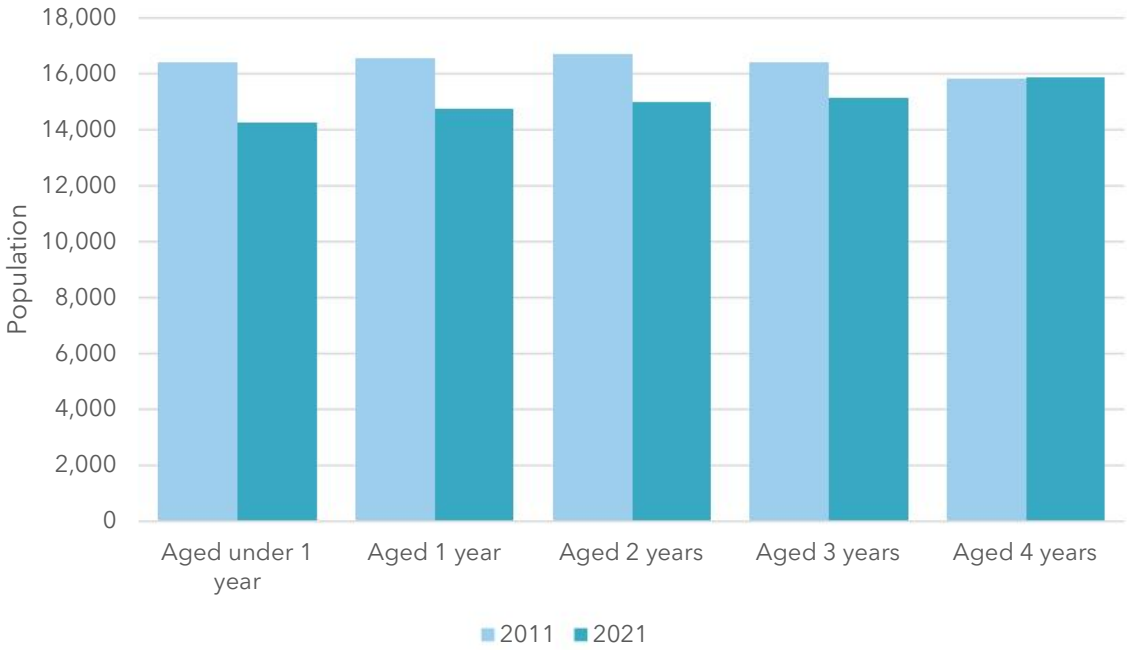
1. Increased accessibility to contraception.
2. Higher participation in higher education.
3. Postponing the formation of partnerships/marriages.
4. Prioritising longer careers before starting a family.
5. Uncertainties in the labour market.

Furthermore, between 2011 and 2021, the decline in the number of births in Birmingham was much steeper for UK-born mothers, with a decrease of 21%, compared to a modest 2.2% decrease for non-UK born mothers.[8]

"Pregnancy isn't all what people might make it out to be. It is like a very lonely time, and the people who are most closest to you are actually the people that you push away."

Nicola, 20, Female, Kingstanding

Figure 8: Population change for those under 4 years old in Birmingham between 2011 and 2021 (2021)[1]



A significant reduction (9.2%) in the number of children aged 4 years and under was observed in 2021 compared to 2011 (Figure 8). This trend varied across the city as some wards experienced a percentage increase in this age group. The most significant percentage increase within this age group between 2011 and 2021 was observed in Kingstanding (+15%) and the largest decrease was noted in Bordesley Green (-25%), although the actual number of children aged 4 years and under decreased in both wards (from 1,710 to 1,469 in Kingstanding and 1,415 to 1,069 in Bordesley Green). The wards with the greatest proportion of the population aged 4 and under are in Central and East Birmingham (Figure 10).

Figure 9: Ward map of Birmingham showing the largest percentage change in those aged 0-4 between 2011 and 2021[1]

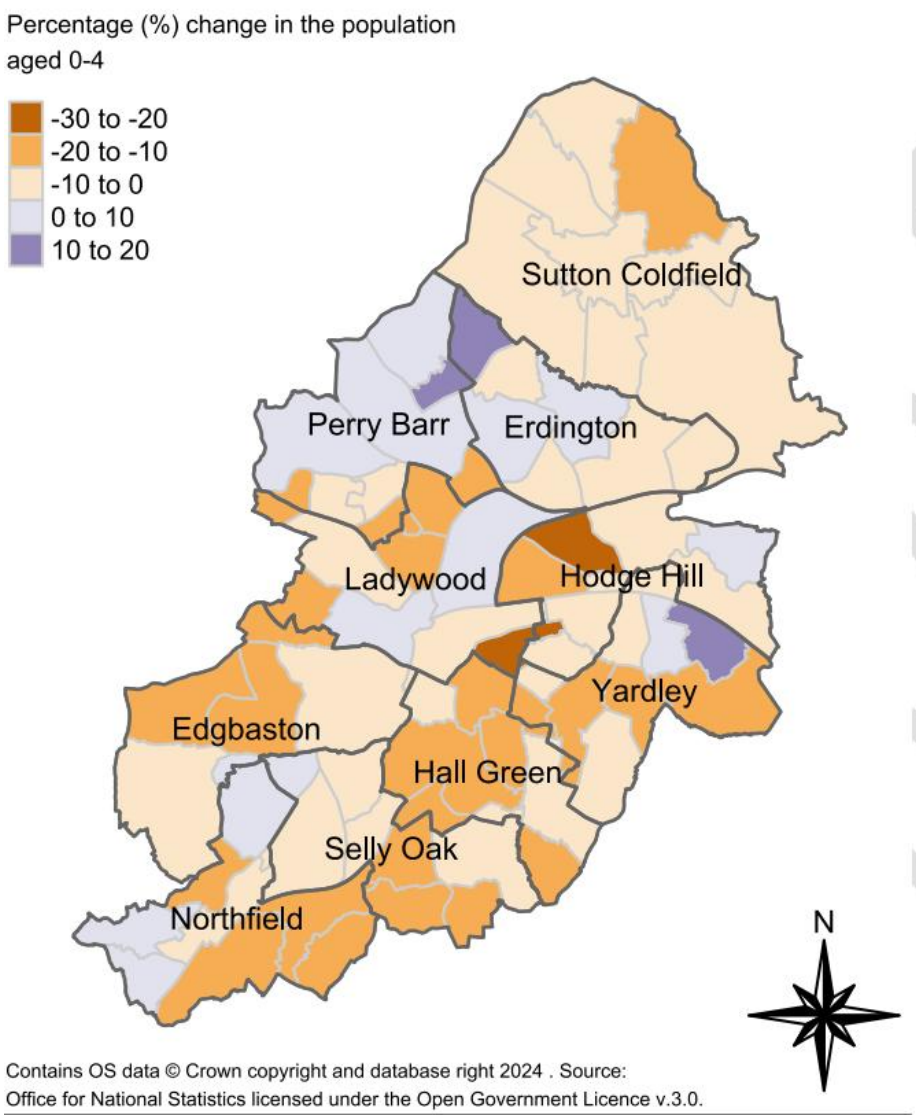
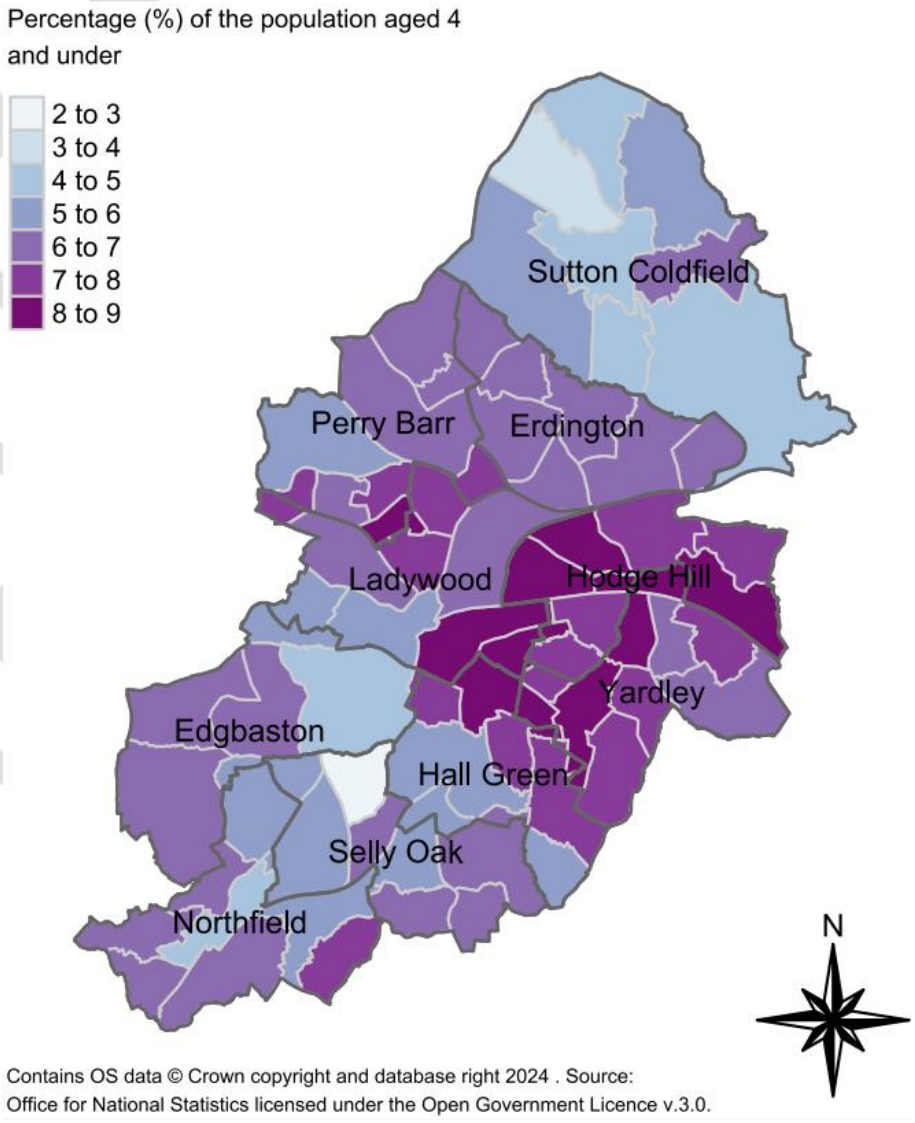


Figure *10: Ward map of Birmingham showing the percentage (%) of the ward aged 0-4 (2021)*[1]



One of the main implications for a declining birth rate is the impact upon services for children, including education.[4] Many schools are state-funded on the basis of pupil numbers and uncertainty around future enrolment may impact on future funding allocations, potentially leading to increased competition among schools for children, especially urban and lower-rated ones.[10] As noted earlier, this trend varies across wards, so the pressure on schools and other services for children will be different in different wards.

Equally though, both internal and international migration have been shown to play an important role in maintaining the number of pupils in schools.[11] In January 2018, approximately 7% of children in state-funded primary schools and 10% in state-funded secondary schools in England were born outside the UK.[13] Similarly, migration data from the 2021 Census shows that the 'inflow' of children (aged 1 to 15) into Birmingham slightly exceeded the 'outflow' leaving the city.[12] While migration to some extent offsets the effects of a declining birth rates, there will still likely be a considerable impact on the number of children in the city in the long term.[13] Therefore, it is imperative for policymakers and education leaders to consider these trends and develop comprehensive strategies.

Largest increase in pre-retirement and retirement age groups by 20%

Figure 11: Population change (%) between 2011 and 2021 by age group[1]

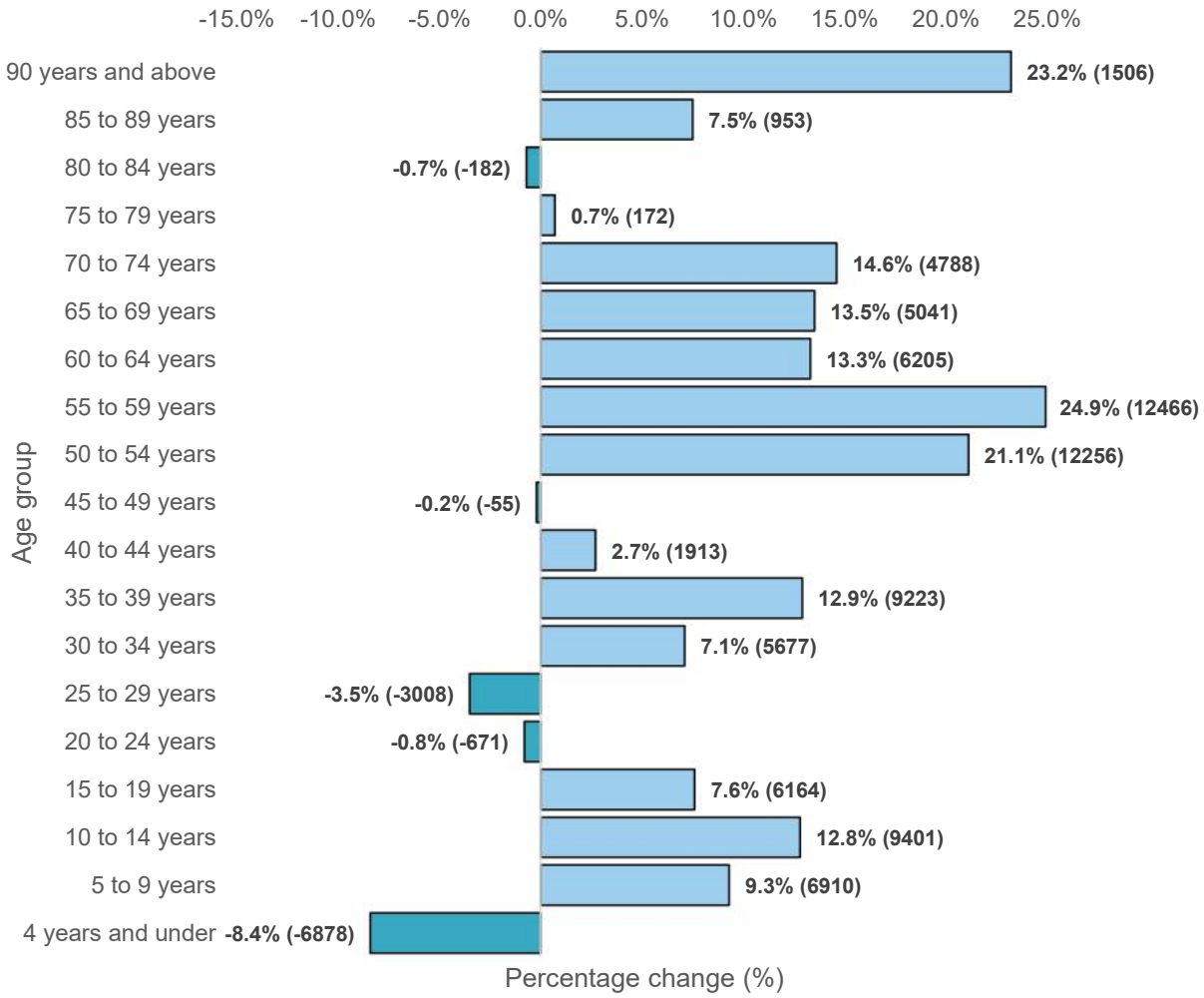


Figure 11 shows the population change by percentage and number within roughly 5 year age bands. The largest increases can be seen in the majority of age groups above and including 50 years. This is also where there has been the greatest increase in the actual number of people within the age group. Figures 11 and 12 (below) show the geographic distribution of those in the pre-retirement and retirement populations across the city. The majority of these populations live in the far north and far south of Birmingham, although it is clear that the 55-59 age group is more geographically spread. Figures 13 and 14 show where there has been the greatest percentage increase in these age groups on a ward level.

The pre-retirement age group in Birmingham, typically those aged 50 to 64, has seen a significant average increase of 19.8%, the highest among all age groups.[2] This is likely to be as a result of a cohort effect where there are a greater number of people within this age group, just as the 40 to 54 age group would have appeared in the 2011 Census. Locally, Newtown recorded the most significant percentage increase within the 55-59 years and 60+ age group.[1].

National forecasts predict an overall rise in the pensioner population.[3] As of 2020, there were 280 pensioners for every 1000 working-age individuals in England.[15] This ratio is expected to increase rapidly from the 2030s, reaching an unprecedented 393 pensioners per 1000 working-age people by 2070.[14] Birmingham's population of people aged 65 and over is expected to grow by 29% to 194,100 by 2040, up from 150,600 in 2020.[8]

"As you say, the age has increased by two years. It looks to me a lot more than that… but maybe that's just the people I engage… obviously, I'm nearly 65, but everyone in the pub seems to be getting older as well…

Terry, 65, Male, Sutton Walmley & Minworth

Figure 12: Ward map of Birmingham showing the largest percentage change in those aged 55-59 between 2011 and 20211

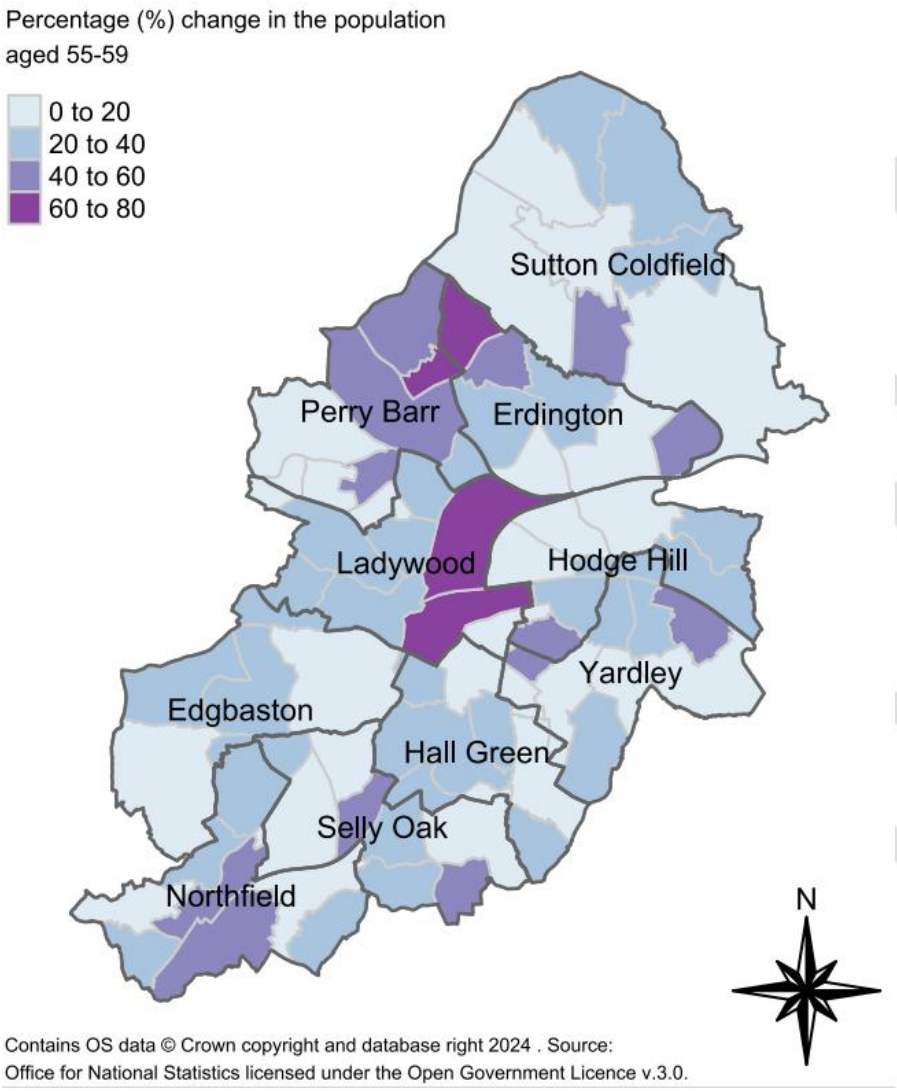


Figure 13: Ward map of Birmingham showing the largest percentage change in those aged 60 and older between 2011 and 2021[1]

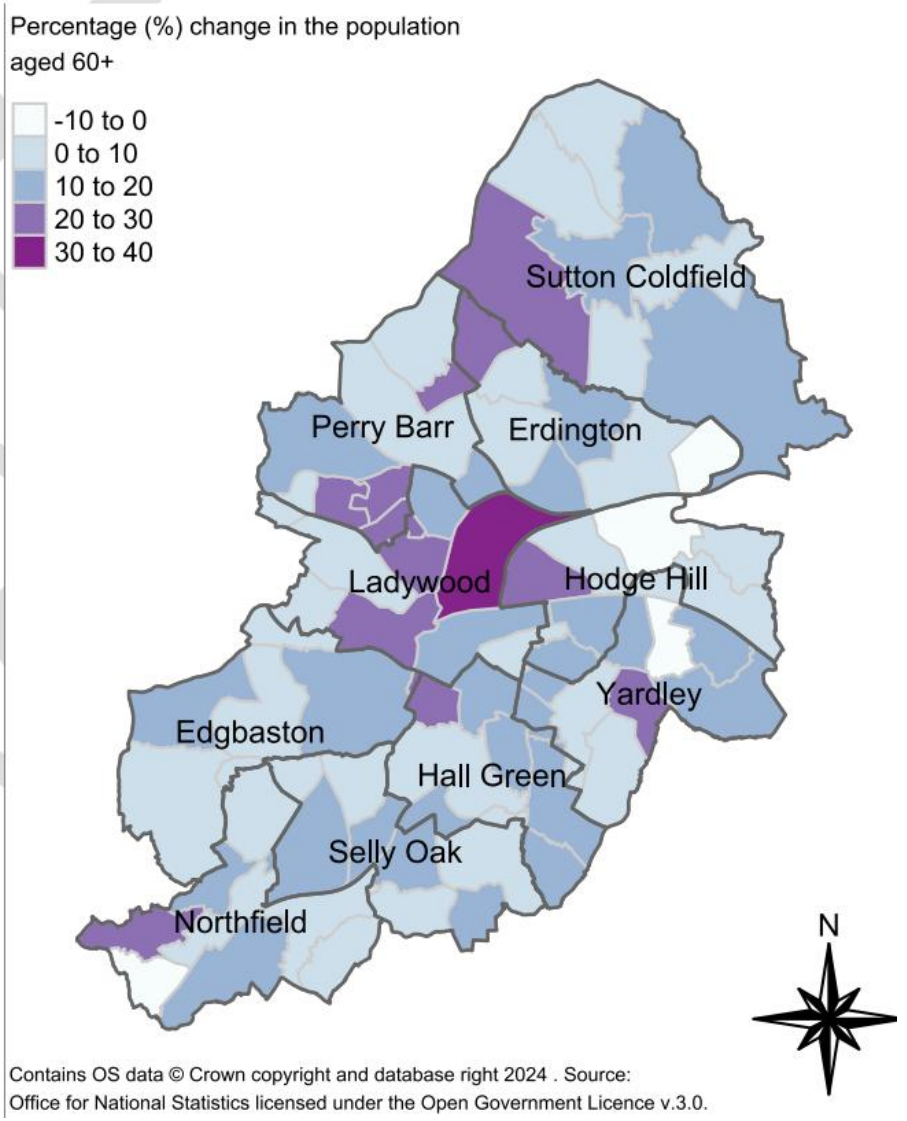


Figure 14: *Ward map of Birmingham showing the percentage (%) of the ward aged 55-59 (2021)*[1]

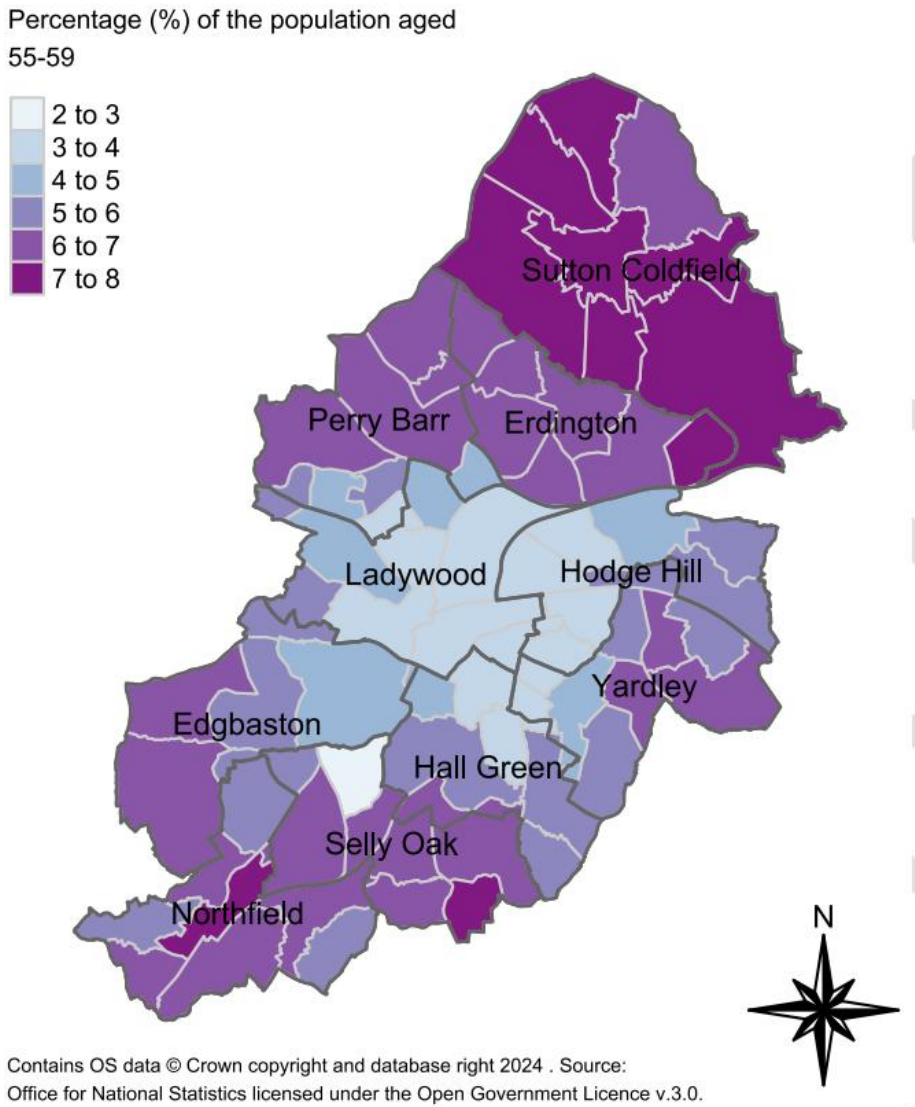
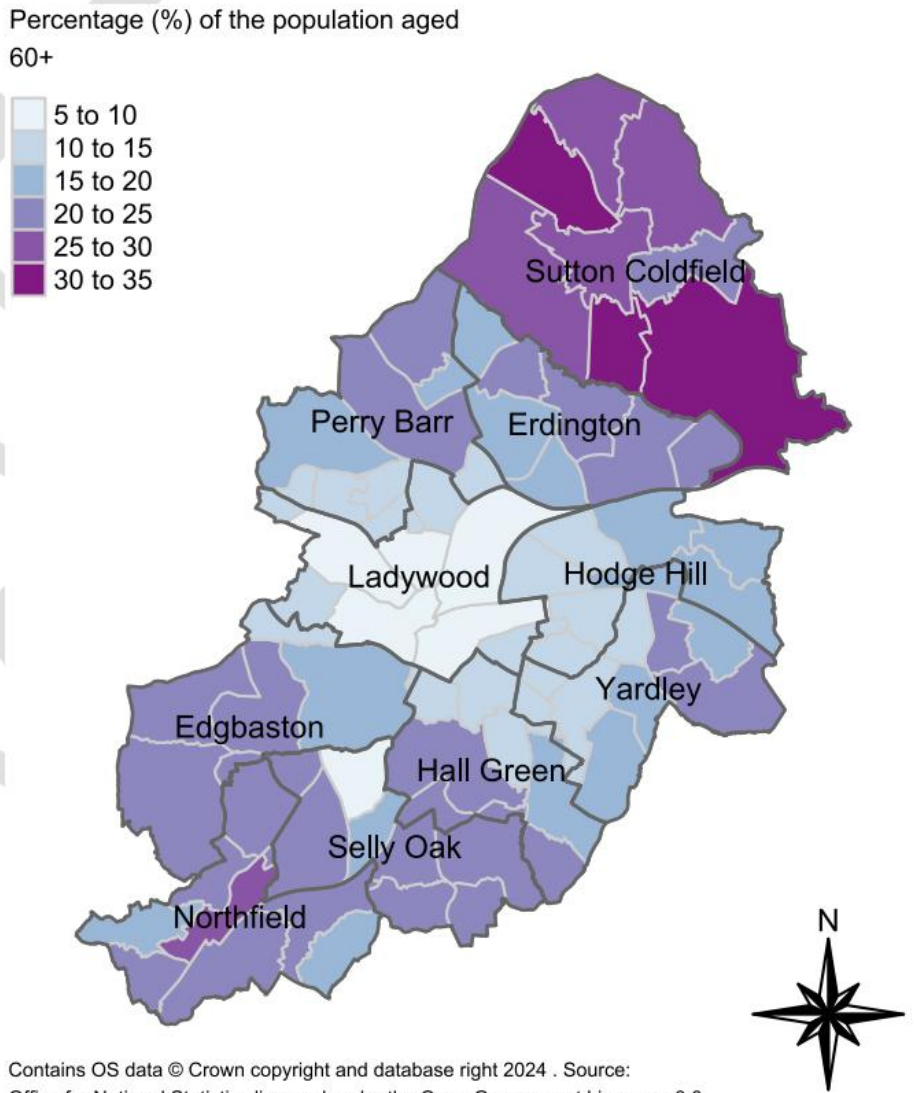


Figure 15: *Ward map of Birmingham showing the percentage (%) of the ward aged 60 and older (2021)*[1]



Case Study: Michelle

Ward:	King's Norton North	**Sexual Orientation:**	Heterosexual
Age:	58	**Gender & Gender Identity:**	Female
Ethnicity:	Black British	**Occupation:**	Hotel housekeeper
Faith:	Christian	**Living Arrangements:**	Homeowner with a mortgage or loan

Michelle has noticed the population increase, explaining that there are more cars around and longer wait times for NHS appointments. She recognises that there is an ageing population and thinks this is due to a mixture of people living longer and fewer children being born due to the cost of raising a child. Michelle believes the cost of living has significantly increased in recent years and questions the reasons why it has risen so drastically.

"[Fewer people under 4 years old] "It doesn't surprise me at all really. I think financially, people probably are having less children because they're so expensive. When I was growing up and all my friends of my age group have families with five or more in the family. Now you probably get two or three at the most in a family, because it's just the cost thing and people tend to have less children"

Michelle has always been fairly healthy and active. She goes to the gym regularly and her job requires her to walk a lot. She thinks that people are now more focused on their health and wellbeing, and are much more pro-active in looking after themselves.

She described an app offered at work that supports employees with their mental health. Although she doesn't use it herself, she feels that having support systems in place, such as apps and helplines, is important for those who may not have a strong support network like she does. Michelle has a strong friendship group who she sees regularly, which helps her mental health.

"I've always been pretty healthy, going to the gym and I'm working at a hotel and we do a lot of walking around the building."

"I think people focus more on their health and wellbeing now. Whereas you sort of just did it before, you didn't think, 'I've got to do this for my health or for my wellbeing.' It's now at the forefront."

Michelle is not overly concerned about her own future, as she appreciates her own financial security, however, she is worried about other family members, particularly her nieces and nephews, who she thinks will struggle to be able to ever afford their own property.

"I don't worry too much about my future. It's more my family's future and their health and wellbeing. I'm quite resilient and I'll just get on with it and I don't feel too worried about anything."

Michelle would like to see greater financial support to families with a single parent or those in low-income households. She suggested creating more job opportunities, encouraging people to work rather than relying on benefits. She believes these opportunities could involve the community, such as cleaning the streets or gardening.

"I think it's looking at ways of helping the single parents or people on low income, providing more jobs for people, getting them out, doing things, you know."

"There's so many people suffering at home claiming benefits, so I think could be out there working and doing more to help Birmingham. So then we can put more money for the people that are working, but on low income."

65+ year olds in 2021 report better health than those in 2011

Figure 16: Self-reported health status for 65-year-olds and above (2011 & 2021)[1]

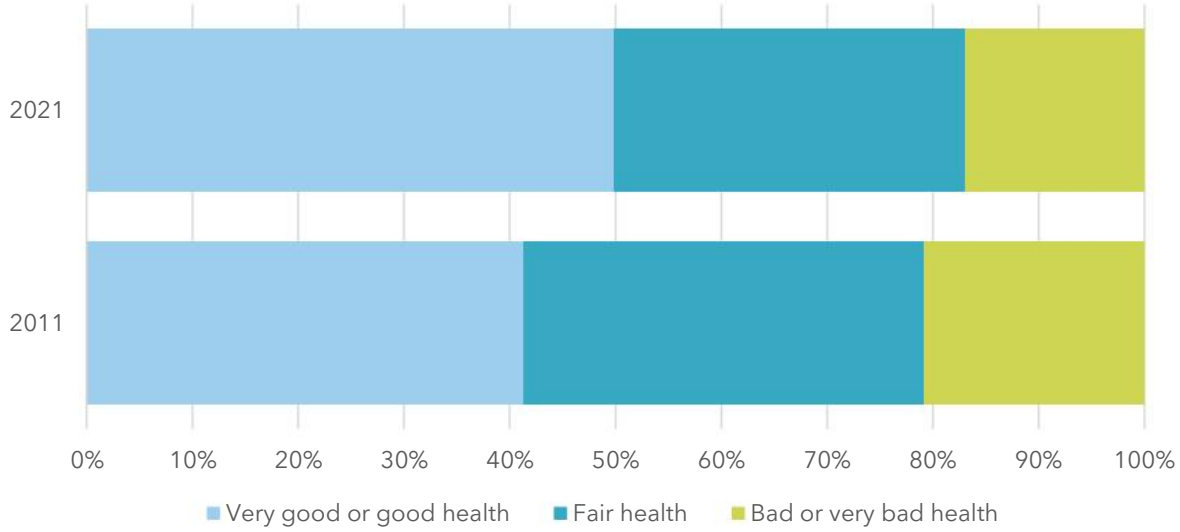
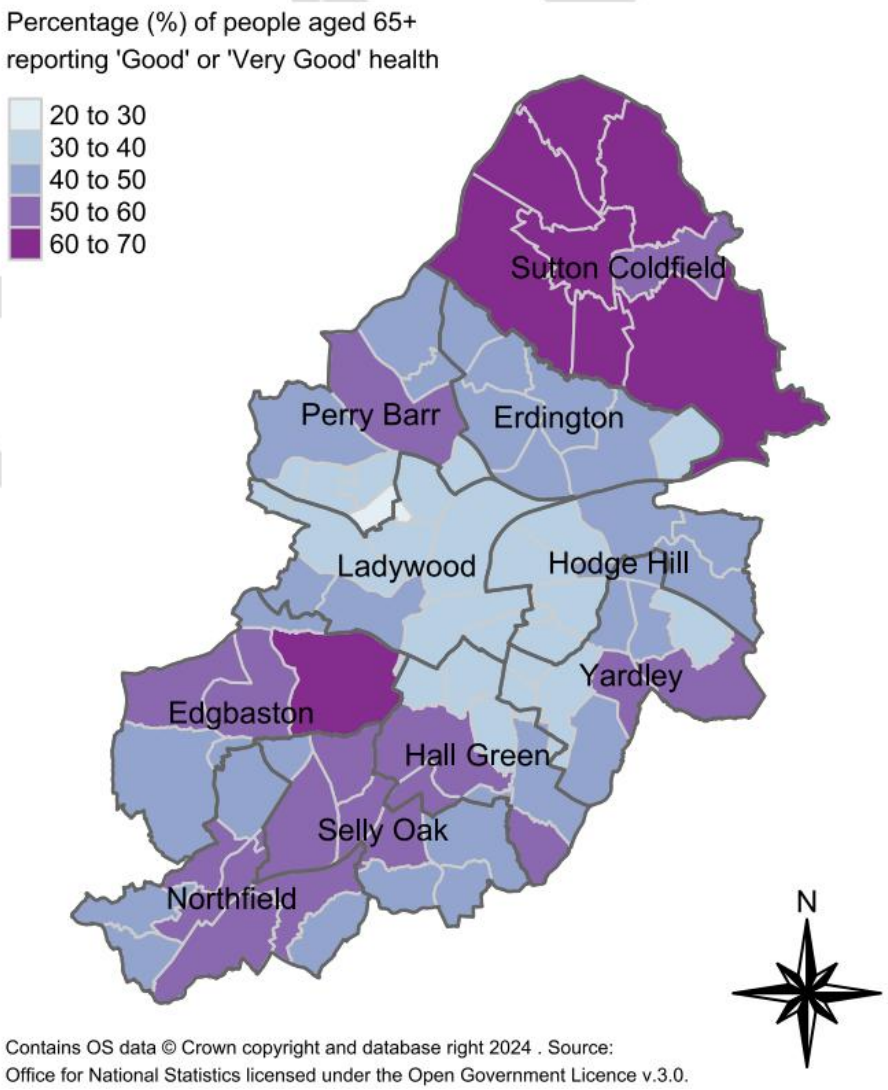
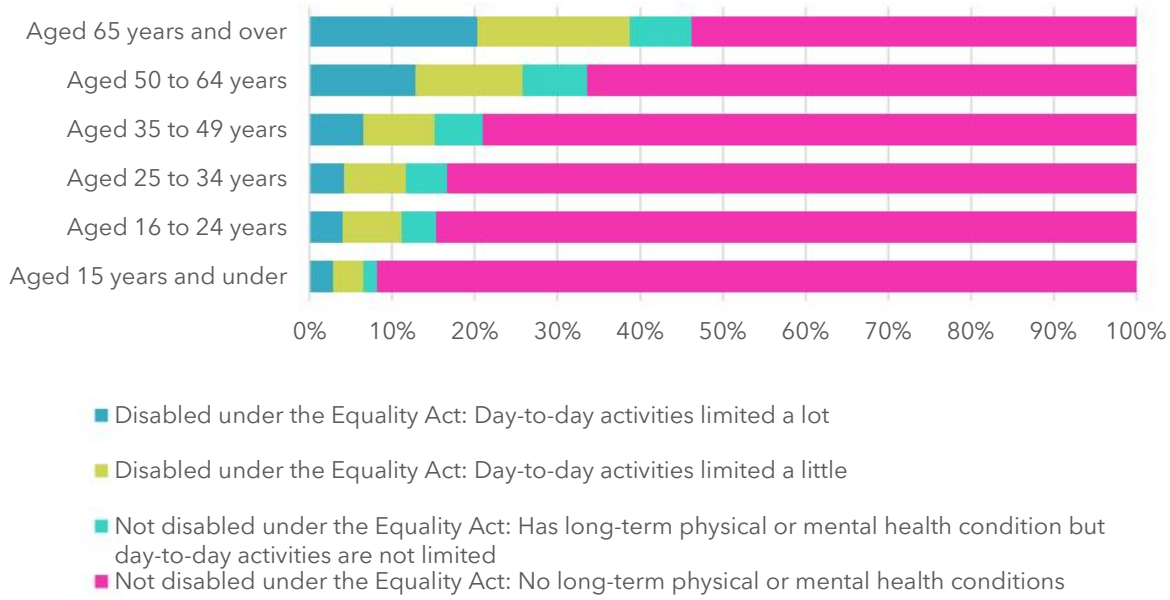


Figure 17: Geographic distribution of 65 years and above who report 'Very good or good health' (2021)[1]



Self-reported health of individuals aged 65 and over in Birmingham has seen a significant improvement over the past decade (Figure 16).[2] In 2021, 49.1% of individuals aged 65 and older described their health as either good or very good, compared to 41.2% in 2011.[2] There is a large disparity in self-reported health across the city, with those aged 65 years and over who report 'Very good or good health' concentrated in wards with lower levels of deprivation (Figure 17). Moreover, individuals in the more affluent parts of Birmingham can anticipate a life expectancy that is approximately five years longer after age 65 than their counterparts in the most deprived areas.[1]

Figure 18: Disability status by age group (2021)[1]



While the data suggests an overall improvement in self-reported and a marginally smaller number of people reporting a disability, the prevalence of long-term conditions and disabilities impacting day-to-day activities will continue to increase with age (Figure 18).[15] In a more elderly population, you would expect more disability and poorer health, with higher levels of unpaid care and an increased demand for health and social care services. With advancing age, the likelihood of developing two or more chronic health conditions such as cardiovascular disease (CVD), cancer, respiratory ailments, diabetes and pain, significantly increases[15]. Additionally, dementia, frailty, recurring back issues and risk of falls becomes more prevalent, while poor mental health, isolation, and loneliness can affect those with diminishing social circle and limited opportunities for social interaction.[15]

"I think you can see that the number of people aged between 50 and 64 has rapidly increased, basically. I think you can see that's in the amount of, like, nursing homes, retirement homes, like at assisted living and everything, like where I live, they're just popping up constantly."

Jack, 26, Male, Sutton Wylde Green

Whilst ageing itself is inevitable, ageing in ill-health is not. There is much that can be done to delay or prevent the decline in physical, mental, and emotional well-being and to enable older people to maintain independent lives. Stopping smoking, maintaining healthy weight, reducing alcohol, increasing physical activity, healthy diet and nutrition all improve health in older age.[16] Supporting our older population (and future older population) to maintain a healthy lifestyle requires a supportive environment, such as access to green spaces and safe streets, as well as services and behavioural interventions. Early identification of disease and decline e.g. through screening programmes, recognition of sight or hearing loss, also extend the period that people can live in better health. For example, there is good evidence that addressing hearing loss in older people can help people remain socially active, reduce the risk of depression, and may reduce risk of dementia.[16,17]

What might this look like in 2031?

The population of Birmingham is projected to continue growing increasing from 1,141,400 in 2018 to 1,186,000 (3.9%) in 2028 and 1,230,000 (7.8%) by 2038. Factors such as natural change (the difference between births and deaths) and international and national migration are likely to continue influencing Birmingham's population growth.

The age-structured projections for Birmingham's population indicate a shift in demographic trends over the next decade (Figures 18 -22). Key changes are:

- By 2031, Birmingham will have a projected 227,000 individuals under the age of 14 – a decrease from 239,350 in 2021. The number of children in each 5-year age-group (0-4, 5-9 and 10-14 years) is expected to decrease, although there is greatest uncertainty around the predictions for 0–4-year-olds (Figures 20 to 22).
- By 2031, Birmingham will have a projected 203,000 over 65-year-olds – an increase of approximately 30% increase on 2021 numbers.

These trends are largely attributed to the assumption that the Total Fertility Rate will remain at a lower level in the future, and migration patterns similar. It is these shifts in particular which will define Birmingham's population, and the city itself, in the future. If the fertility rate continues to fall then there will be less need for nursery provision but primary and secondary schools will be needed at current levels of provision. Whilst, an ageing population will see associated rises in health and care needs. For example, In 2023, the number of individuals aged 65 and older with dementia in Birmingham was 6,764 out of 168,779 within that age group[18]. With a projected population of 203,000 people aged 65 and older in Birmingham by 2031, the estimated dementia prevalence will rise by 1,350 to 8,070 in 2031[16].

Looking ahead, key challenges for Birmingham include ensuring the built environment and services are able to support the increasing population total and its changing demographic, for example with accommodation that enables the increasingly sizable population of older people to continue living independent and active lives, facilities and services for children that are in the right parts of the city, health services which can cope with the increasing multimorbidity of older adults. A further challenge is the levels of deprivation seen in the city: 50% of the population live in areas that are amongst the 20% most deprived areas in the country. This means many of our residents face worse health outcomes than their counterparts in less deprived areas of the city and country throughout their life-course. Reducing these inequalities across our city is essential.

Figure 19: Population projection for ages 50-64 years by 2031 in Birmingham

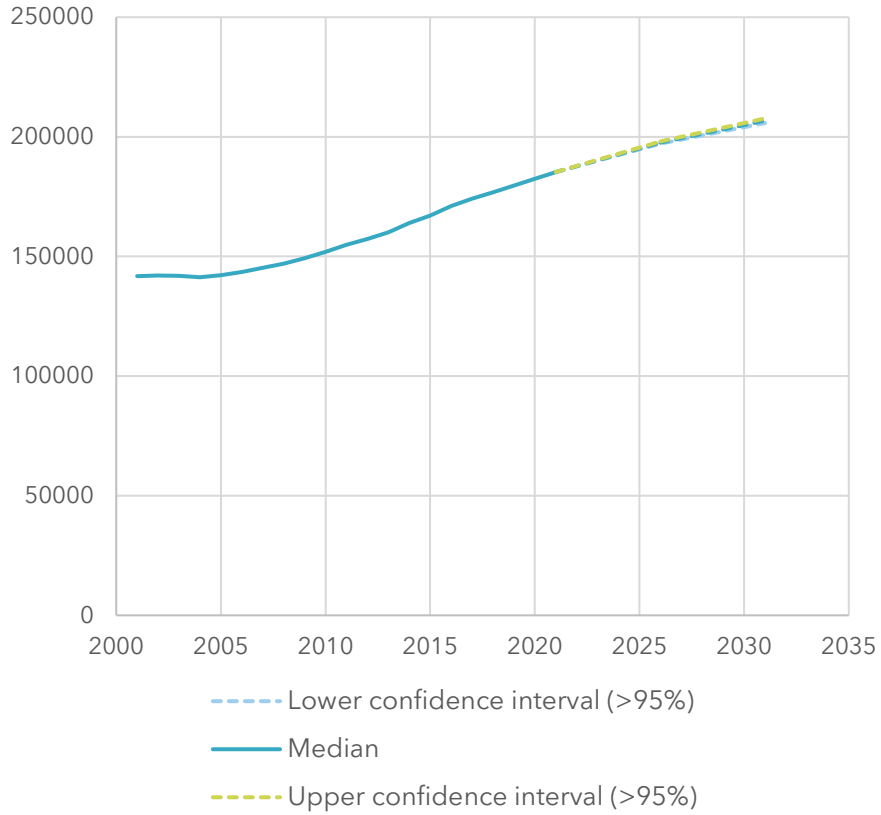


Figure 20: Population projection for 65+ years by 2031 in Birmingham

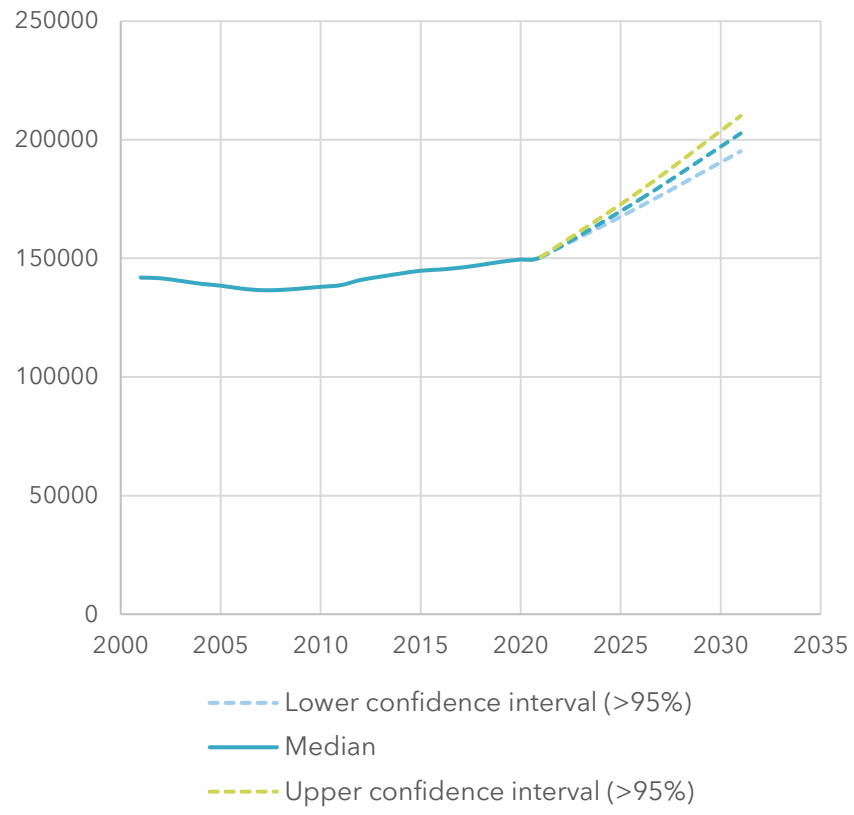


Figure 21: Population projection for age group 0-4 years by 2031 in Birmingham.

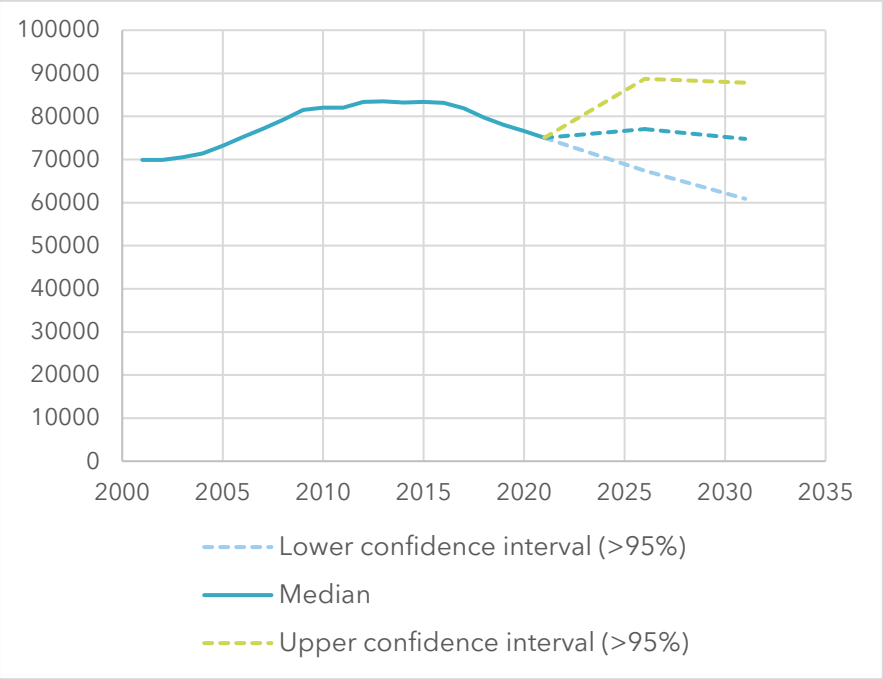


Figure 22: Population projection for age group 5-9 years by 2031 in Birmingham

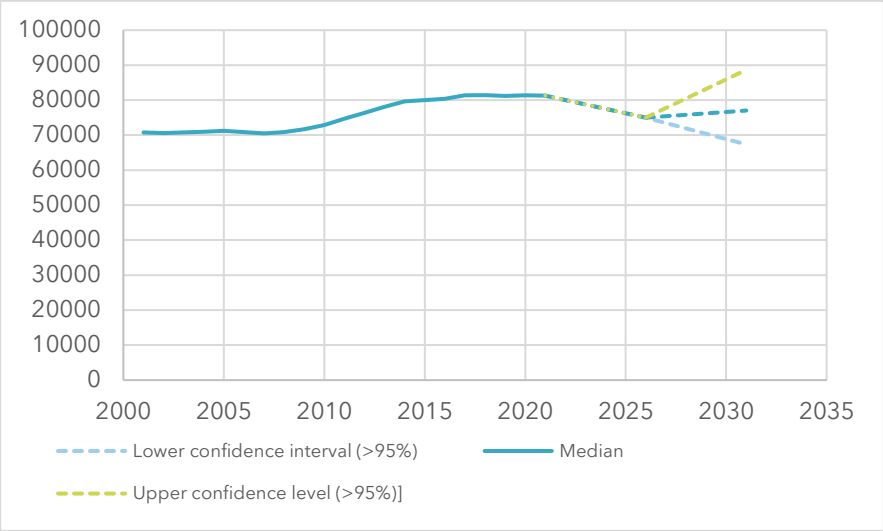
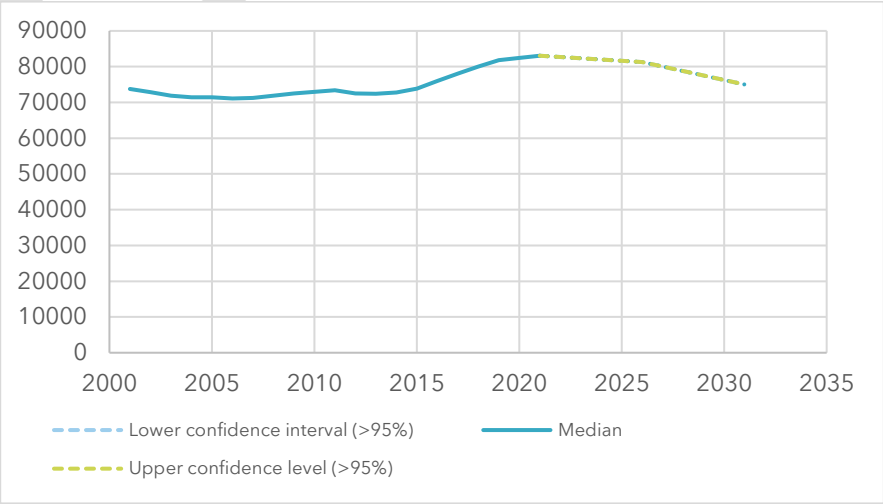


Figure 23: Population projection for age group 10-14 years by 2031 in Birmingham



System Reflections

Professor Graeme Betts (Strategic Director of Adult Social Care, Birmingham City Council)

The report highlights the key areas of Birmingham's demographic changes. Adult social care can positively transform people's lives. It can support people to stay more independent, improve their wellbeing and continue to enjoy living in their communities Our goals are to support adults and older people so that they can be resilient, living independently whenever possible and exercising choice and control over their lives, and so enjoy good health and wellbeing.

It is a great achievement for society that more people are living for longer, especially those with complex needs. While Birmingham is one of the youngest cities in Europe, the older population is growing rapidly. An estimated 10,000 adults suffer dementia. Further, there are significant numbers of young adults who have disabilities or suffer from mental illness. Over the coming decades we will also see demographic change as the ethnic profile of the population continues to evolve. We need to ensure that our services keep pace with this, and offer culturally sensitive support. How we deliver and enable social care has an effect on people's health and wellbeing, including their mental health, and is of course intrinsically linked to the pressures on our partners in the NHS. The public rightly have higher expectations of the public sector, and standards are constantly rising thanks to the hard work and innovation by staff across the health and social care sector, and it is increasingly recognised that people want support to enable them to exercise independence, choice and control. In Birmingham we are focussing on early intervention and prevention, to ensure that wherever possible, people receive the support and guidance they need to stay healthy and independent.

Although adult social care can transform people's lives for the better, the quality and sustainability of the sector is at risk. As more people with increasingly complex needs rely on care and support, the cost of providing care is rising. Together with the government and our partners, we must work together to meet the challenges we face in recruiting and retaining good quality, dedicated care staff. In this city we are all part of a partnership, working together across social care, NHS, Public Health, Housing, the Voluntary Sector and others. We want this partnership to continue to grow, to continue our progress of making better use of our collective resources, and to improve the health, quality of life and independence for everyone living in Birmingham.

Ian Soars (Chief Exec of Spurgeons)

The demographic changes highlighted in this report are, at first glance, quite challenging. The trend of reduction in new births will lead to changes in the priorities of engaging with families as we track the "baby" bulge current working its way through the system. In this respect, Birmingham is in many ways ahead of the curve as we shift our focus from working only with the 0-5 age group through our children's centres and towards addressing the needs of the whole family from 0-19 (25 for SEND) as part of Birmingham's Family Hub strategy.

Seen in this light the change in the demographic profile of Birmingham's children presents an exciting opportunity. The Birmingham Forward Steps Partnership (of which Spurgeon's is

a part) can carefully curate the resources invested in children to ensure a holistic approach (and a warm welcome) to all families that walk through our doors, regardless of the nature of the presenting issues, the ages of the children or indeed their ability to travel to one of our centres. It also means that we have more freedom to target health inequalities that have been deepened in the cost of living crisis.

This also means Spurgeon's and our partners can be more accessible, more holistic, more able to collaborate with faith groups and communities. Indeed, it invites the opportunity for real innovation in how we in Birmingham care for our families; to ensure that every family in need receives the care and expert support they deserve; to consider how we can shift our thinking away from the delivery of services and towards a measurable outcome of transforming children's lives.

Of course, just because the demographics point to this future we mustn't forget that the first 3 years of a child's life are arguably the most influential in determining outcomes for that child…and so Spurgeon's will continue to ensure laser focus on delivering care to the early years even as we look to expand how care across the age ranges.

Ethnicity

Data Headlines

- Birmingham is the only core city in England and Wales to have more than half of the population (51.4% in 2021) from an ethnic minority background.
- Birmingham's superdiversity is higher in younger people, with 67% of those aged 0-15 being identified as from ethnic minority backgrounds.
- The largest ethnic group is still 'White', which comprised 48.6% of the total population. The number of people in this group decreased by 10.4%, from 621,636 in 2011 to 556,608 in 2021.
- The greatest increase in proportion was for the 'Pakistani' population, which made up 13.5% (144,627) of the population in 2011 and 17.0% (195,102) of the population in 2021 (3.5 percentage points*).
- The second largest increase in proportion was for the 'African' population, which made up 2.8% (29,991) of the population in 2011 and 5.8% (66,822) of the population in 2021 (3.0 percentage points*).

Implications for health and wellbeing

- Ethnic minority groups tend to experience higher rates of conditions such as diabetes, obesity, asthma, heart disease, and cancer and may also experience earlier onset.
- Ethnicity impacts health through different mechanisms: racism and discrimination, social determinants including income, education, employment and housing, cultural and lifestyle factors, health services and clinical factors and genetics such as sickle-cell disease.
- The age-ethnicity profile in the city varies greatly, with the older age-group having a different ethnicity profile than the younger age groups. There is a need for services to recognise this and respond to need appropriately and adapt over time.
- With a continued increase in ethnic minority populations, specific diseases will see increases, such as sickle cell disease, which has an increased prevalence in African and Caribbean populations, and Type 2 diabetes, which is higher in South Asian groups.
- Ethnicity intersects with other characteristics, leading to worse health outcomes, for example, for older adults and people with learning disabilities from minority ethnic groups.

* Percentage points describe the difference between percentages.[19] Percentage point change is used in this chapter to show the difference between the 2011 and 2021 percentages.

What does the data tell us about ethnicity in Birmingham?

Collecting data on a person's ethnicity can be complex. Ethnicity is self-defined, subjectively meaningful and can change over time.[20] It is characterised by features such as a shared history, origins, language, and cultural traditions. As such, collecting data on a person's ethnicity can be complex. The first time an ethnicity question appeared in the British Census was in 1991 with 7 set answers and two enabling free text answers. It asked respondents to select one from the following categories: White, Black-Caribbean, Black-African, Black-Other (with description), Indian, Pakistani, Bangladeshi, Chinese, and Any other ethnic group (with description). Before 1991, censuses and surveys in the 1960s, 70s and 80s used proxy questions or estimates to understand ethnicity in the city and across the country. This included questions on nationality and the different 'Commonwealth' groups.[21] Following 1991, the question was refined in future Censuses to cover broad and specific ethnic groups.

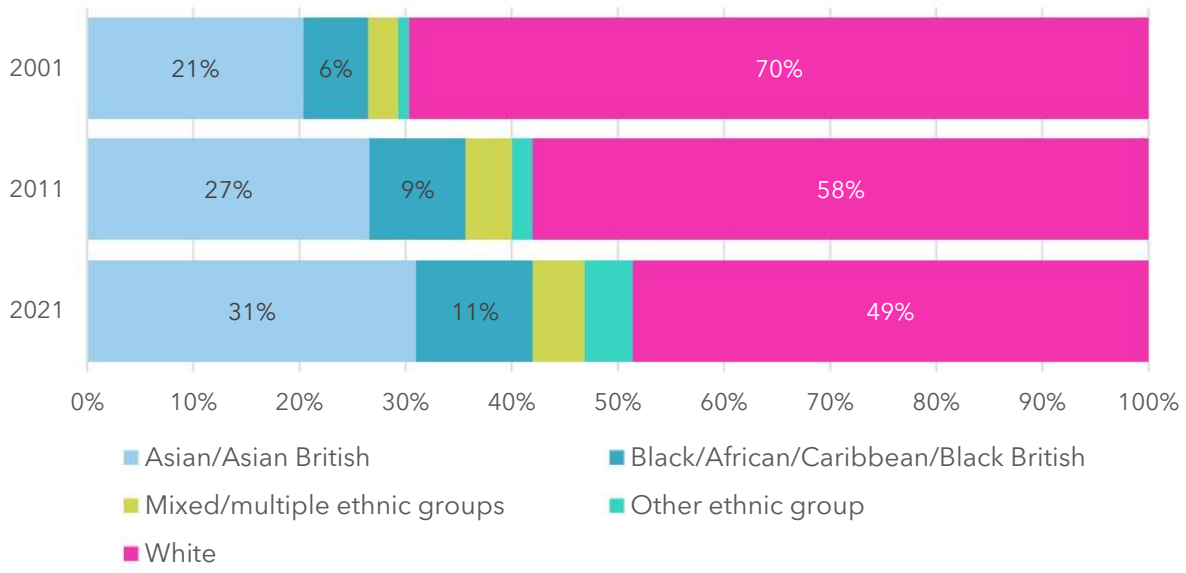
The 2021 Census question on ethnicity had two stages. Firstly, a person identified through one of the following five high-level ethnic groups: "Asian, Asian British", "Black, Black British, Caribbean or African", "Mixed or Multiple", "White"; or "Other ethnic group". In this report, these categories are termed "broad ethnic groups". Following this, a person identified through one of the 19 available response options (in this report termed "specific ethnic groups"). These included categories with write-in response options. In Birmingham, this captured 287 different ethnic identities (Figure 24).

Figure 24: A word cloud showing the 287 different ethnic identities in Birmingham (excluding White British)[1]

Birmingham is a 'superdiverse' city

In 2021, Birmingham officially became a super-diverse city. More than half of our population (51.4%) identify as belonging to an ethnic minority. This is higher than all other core cities in the UK and local authorities in the West Midlands. The changes in ethnicity in Birmingham can be seen to be a part of a longer term trend. This can be observed by looking at the changes in the proportion of broad ethnic groups (Figure 25) in current and preceding censuses. In 2021, the White ethnic group remains the largest single group despite decreasing relative to other groups (-9.3 percentage points) and decreasing overall numbers (-65,028). All of the other broad ethnic groups have increased in proportion and numbers.

Figure 25: Change in ethnic group proportion (%) between 2001, 2011 and 2021[1]



"You can quite clearly see since I've lived here that the diversity in the areas has increased. Especially in my area, which has always been a predominantly Asian area and I think now you're starting to see not just Asians, but black and other ethnic minorities coming over or like just a bit more present… The changes have been very apparent and I think the data kind of does reflect what I've been seeing over the years."

Ash, 26, Male, Sparkhill

Many factors contribute to the changing ethnic composition of Birmingham, such as topics explored in this report, including ageing, fertility, mortality, and migration. A key factor driving super-diversity is Birmingham's history of welcoming people and its commitment to being a 'City of Sanctuary'. This history is reflected in previous censuses and the age profile of the current population in Birmingham (explored later in this chapter). Many Irish people came to Birmingham looking for work, and the Windrush era saw people from the

Caribbean help rebuild the country after the Second World War. Both communities have the highest proportion of adults aged 50 and older (69% of the White Irish community and 45% of the Caribbean community are aged 50+). More recently, Birmingham has experienced change through the expansion of the European Union, as well as various conflicts and crises. Most recently, people seeking safety arrived from Afghanistan, Syria and Ukraine. The migration (international) chapter focuses on some significant changes from the previous Census (2011) and longer-term trends.

"There's some people in my ethnic group, especially from Nigeria, from Africa, who have needed healthcare assistance, to reach the GP, and they are calling, calling, calling and the majority of them give up. I always try to let them know that you need to keep pushing and call again. They call twice, three times and no response and when the need is arrived next time, they don't want to call again which will affect their health."

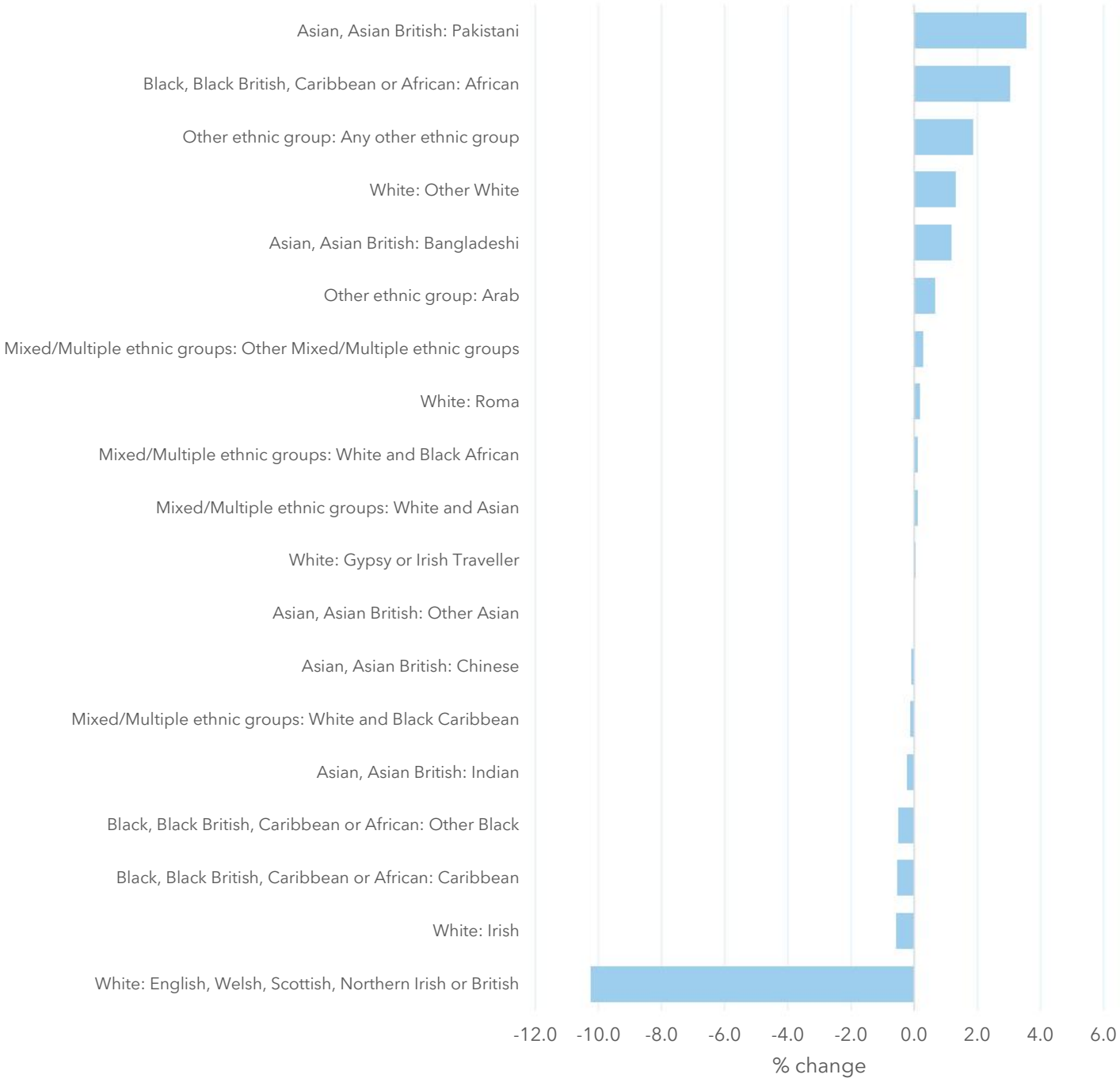
Samuel, 35, Male, Yardley West and Stechford

The largest increases were seen in the Pakistani and African ethnic groups

Further to the broad ethnic group patterns, it is important to explore and explicitly consider differences between specific ethnic groups to enable greater understanding of the Birmingham population and inequalities. The largest population increases between the 2011 and 2021 censuses in specific ethnic groups were seen in the Pakistani and African ethnic groups, whilst the largest decrease was in the White British group. Other specific ethnic groups, such as Bangladeshi, Other White and Any other ethnic group, also experienced notable increases. These changes are based on the proportion of the total population and are therefore shown as percentage point changes (Figure 26).

In 2011, the White (English, Welsh, Scottish, Northern Irish or British) population comprised 53.1% of the Birmingham population. In 2021, it was 42.9%, a decrease of 10.2 percentage points. The Pakistani population increased from 13.5% in 2011 to 17.1% in 2021, an increase of 3.6 percentage points. Some groups, such as the Indian population, increased in total population, but the proportion compared with other ethnic groups decreased slightly. Although there was an overall increase in those who identified within the "Black, Black British, Caribbean or African" group (11% of the total population compared with 9.0% the previous decade), there were notable differences within the group itself. The African group more than doubled in population numbers and increased by three percentage points. In contrast, the Caribbean population decreased by 0.5 percentage points.

Figure 26: Percentage point change in specific ethnic groups between 2011 and 2021[1]



These changes can also be observed geographically (Figure 27 and Figure 28). In comparison with 2011, the wards with the highest proportion of those identifying as African and those identifying as Pakistani remained similar. For example, Newtown remains the ward with the highest proportion of those identifying as African. However, this proportion has increased significantly from 16.2% of the ward identifying as African in 2011 to 32.6% in 2021. An increase is seen for those identifying as Pakistani in wards located towards the East of the city. Sparkhill is now the ward with the highest proportion of people identifying as Pakistani at 63.4%, which has increased from 56.9% in 2011.

Figure 27: Map of African population by Birmingham ward (2021)[1]

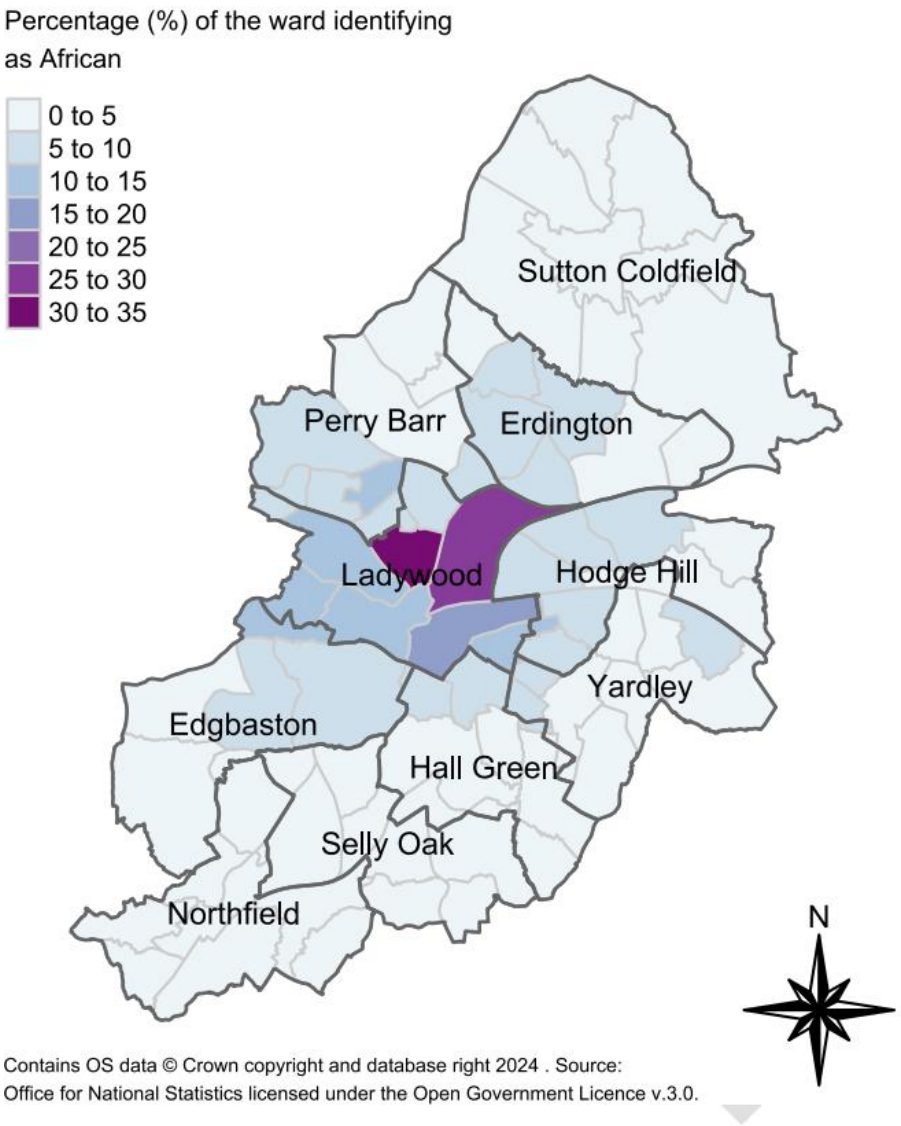
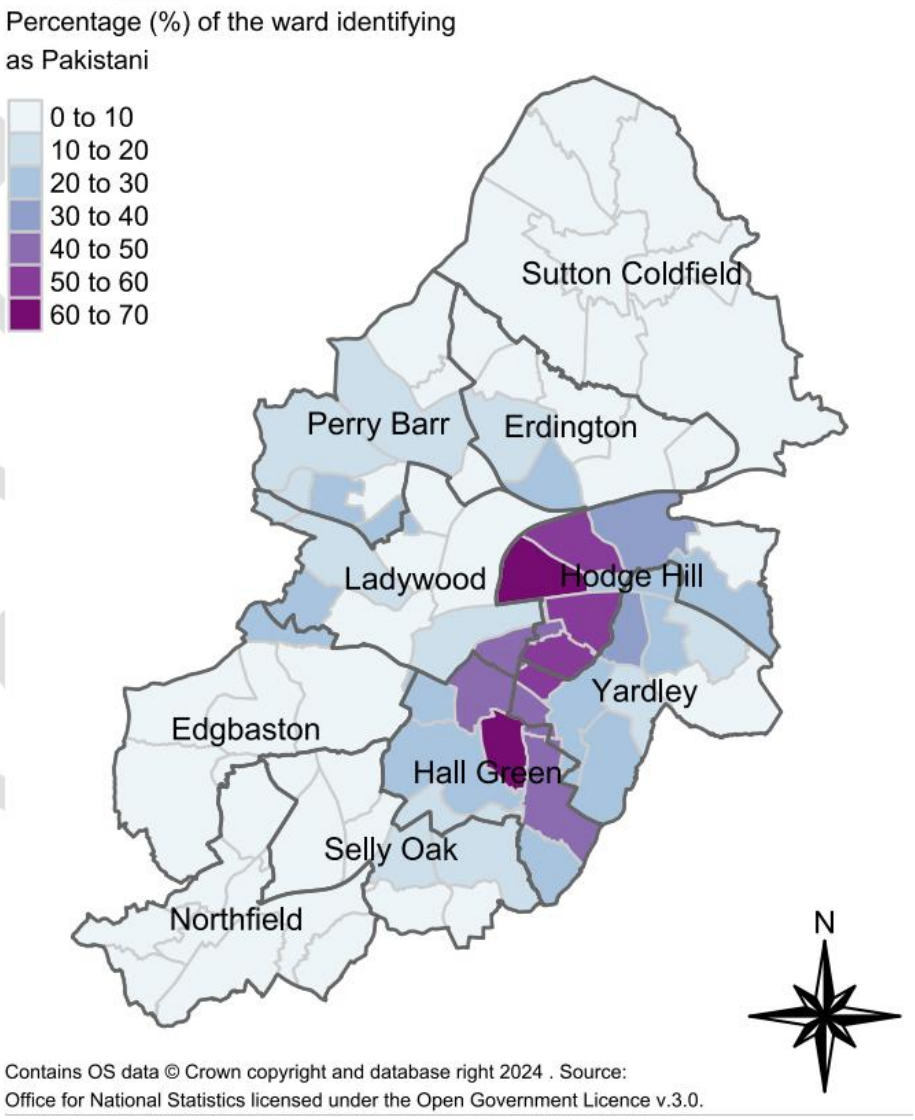


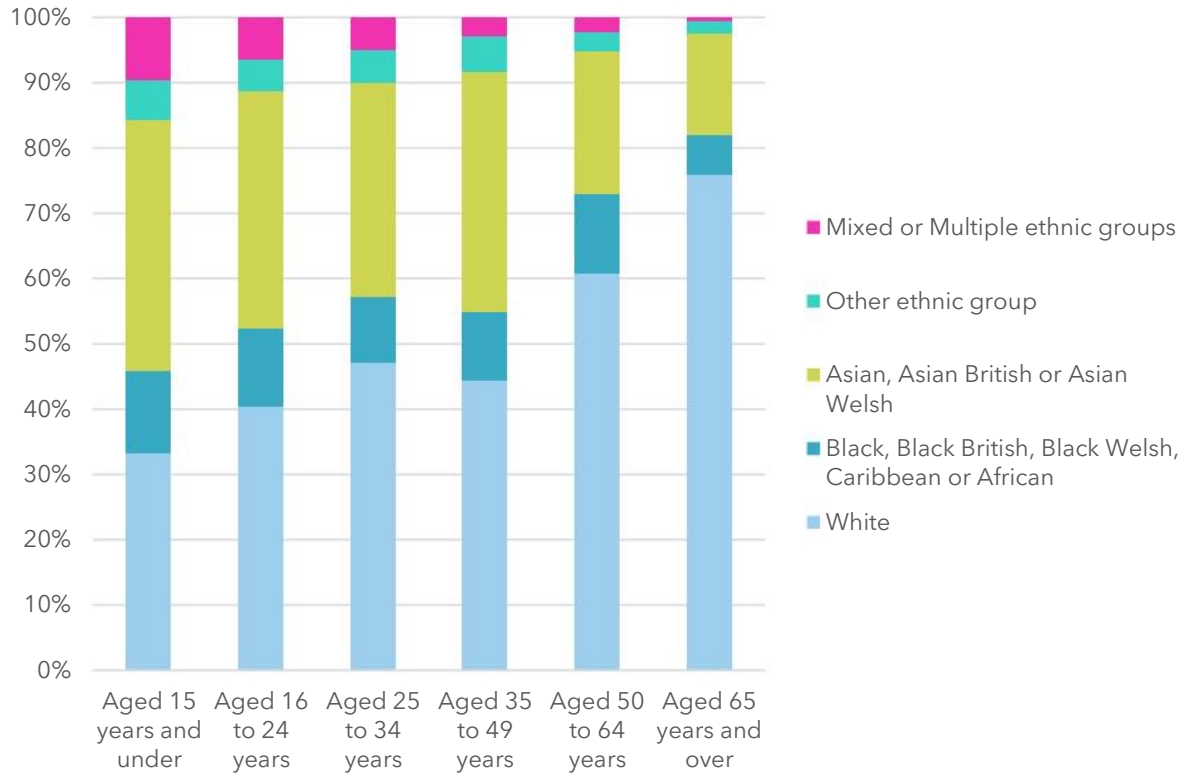
Figure 28: Map of Pakistani population by Birmingham ward (2021)1



There is greater ethnic diversity in younger age groups

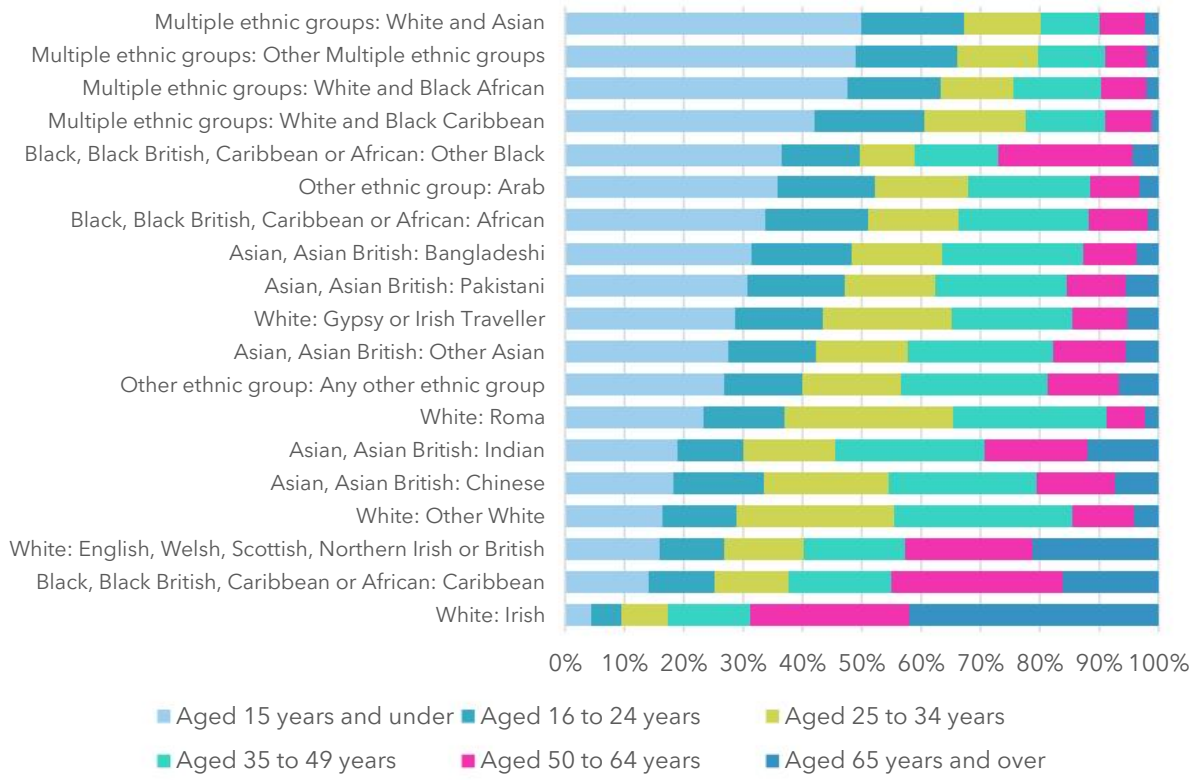
Birmingham's super-diversity is particularly evident in the younger population, with 67% of those aged 0-15 being identified as from an ethnic minority. Around a third of people (aged 0-15) were in the White group (33.1%), less than the Asian or Asian British group (38.3%). For age groups 50 and above, the White group makes up over 50% of the population (67% of those aged 50 and above).

Figure 29: Usual residents in Birmingham by age group and ethnicity (broad group)[1]



However, there are differences within the specific groups which are not apparent in the broad ethnic groups' classifications (Figure 29). Whilst, the broad Black, Black British, Caribbean or African group is a young population, this is mainly due to the young African population with 55% of those who identified as Caribbean aged 50 and older. People with mixed ethnicities make up a small proportion of the total population but have the highest proportion of younger people within those groups. Two ethnic groups have an older age profile than White British: Caribbean and Irish. Almost 70% of those who identified as White Irish were 50 and older. These age profiles and patterns reflect a city of historic and ongoing migration.

Figure 30: Usual residents in Birmingham by ethnicity (specific group) and age group[1]



There are differences in birth rates across different ethnic groups, but this report also shows that most people who migrate to the country are young. Studying is one of the main reasons people migrate to the UK, and the number of international students was 12,600 in 2021, the second highest of all local authorities in England.[22]

"A lot of people are coming to Birmingham, it attracts a lot of people, particularly with the university… people want to go to where they know people. People today want to migrate to these places so that they can seek help from their people, while black people also wanted to come to Birmingham, they know that the cost of living here is not the way it is in London."

Samuel, 35, Male, Yardley and West Stechford

Health and ethnicity

Birmingham's super-diversity poses both challenges and opportunities for health and wellbeing. People from ethnic minority groups tend to experience higher rates of poor health and disease for a range of preventable and treatable conditions, such as diabetes, hypertension, obesity, asthma, heart disease and cancer.[23,24] The inequalities in health experienced by people from ethnic minority communities came to the forefront during the COVID-19 pandemic: people from ethnic minorities in Birmingham experienced higher rates of COVID-19 exposure, infection and mortality, caused largely by social determinants of health and existing health conditions.[25]

National evidence comprehensively shows health inequalities between ethnic minority and white groups and between different ethnic minority groups. The ONS used census data and death registrations to understand ethnic inequalities and differences in mortality from physical health conditions, such as cardiovascular disease or cancer. They show that some ethnic minority groups, such as the African community, have lower mortality from some conditions than the White British group. It also shows the differences between ethnic minority groups, including the South-Asian sub-groups. The Pakistani and Bangladeshi groups had the highest mortality rates for many individual conditions, including Covid-19 mortality. This was not seen in the Indian group (including Covid-19).[26,27]

Similar findings have been published by the Health Foundation but focused on morbidity (illness) rather than mortality (death). The Health Foundation linked primary care and hospital records to describe a more detailed picture of variations in diagnosed illnesses by ethnicity. They show that people from Pakistani and Bangladeshi ethnic backgrounds in England have more diagnosed chronic pain, diabetes, dementia and cardiovascular disease. The White British population have more diagnosed anxiety or depression, alcohol problems, atrial fibrillation and cancer.[28]

The causes of health disparities and inequalities for ethnic groups are complex but largely driven by the social determinants of health, such as income, education and housing. Health-related behaviours also play a role, as do other factors such as the 'healthy migrant effect'.[29] Racism and discrimination play a crucial role, through wider determinants of health[30] as well as influencing how people access health information, services and treatment.[23] People who experience racism and discrimination have poorer mental and physical health than those who do not.[31]

Diabetes is an example of a disease which is more common in people from ethnic backgrounds due to a complex interplay between biological, lifestyle, social, clinical and health system factors. [32] The risk of developing type 2 diabetes is higher in South Asian groups than in white groups, and South Asian groups have higher mortality from the condition. The prevalence is also higher in Black groups than in the white population.[33]

There are also differences in health outcomes that do not necessarily relate to discrimination but to genetic conditions, such as sickle cell disease. As one of the most common genetic conditions in England, Sickle Cell Disease affects around 1 in every 2000 live births. It occurs predominantly in people of African and African-Caribbean origin, but also in countries with a history of malaria, or migration from a malarial area. Sickle cell trait or disease can protect people from malaria in endemic regions, and this has led to positive selection for the mutation of the sickle cell gene. [34]

Evidence has demonstrated worse health outcomes in minority ethnic groups for older adults[35] and people with learning disabilities compared to white counterparts.[36] Potential associations and suggested reasons for worse outcomes include increased prevalence of long-term conditions, poorer access to and experience of support, lower confidence in supporting their own health and higher levels of deprivation. [23,35,36]

Whilst there is considerable evidence that people from the African community and Pakistani community often experience higher rates of poor health and disease,[37] this was not consistently seen in self-reported health and disability. In the 2021 census, respondents from the African community had one of the highest proportions of people reporting 'good or very good health' (Figure 31) across different age groups. Three quarters (75%) of people who identified as African aged 50 and older reported 'good or very good health', the highest of any group. The Pakistani group had one of the lowest percentages of all communities in the 'Asian, Asian British' group across all ages. Similarly, the Pakistani and African groups had a greater percentage of people without a long-term physical or mental health condition than the White British group. These differences don't appear to be a result of the different age profiles of ethnic groups (Figure 30), as similar results are observed across different age groups (Figure 32). There may be other factors that impact, such as the 'healthy migrant effect', explored later in this report.[38] These measures are based on self-reporting and so might reflect differences between cultures. Self-reported measures of morbidity in Census data have been shown to positively correlate with routinely collected health records. However, there was an under-representation of ethnic minority groups in the linked healthcare data, which may reflect the likelihood of engaging with health services.[39]

Increasing ethnic diversity in younger people has important implications for health and wellbeing now and in the future. Birmingham's diversity and young population are strengths but may also pose challenges and increase the risk of health inequalities.[40] Inequalities based on ethnicity, as well as other factors explored in this report, have profound effects on young people and can persist into adulthood.[40] Issues that may affect young and diverse populations include areas such as sexual and reproductive health, substance misuse, mental health, obesity and nutrition. Similarly to those of all ages, racism is a key factor and determinant of a young person's health and can have a direct link to health outcomes.[41] The trend towards increasing diversity amongst Birmingham's young people is likely to continue.

Figure 31. Percentage of usual residents in Birmingham reporting as having 'good or very good health' by age[1]

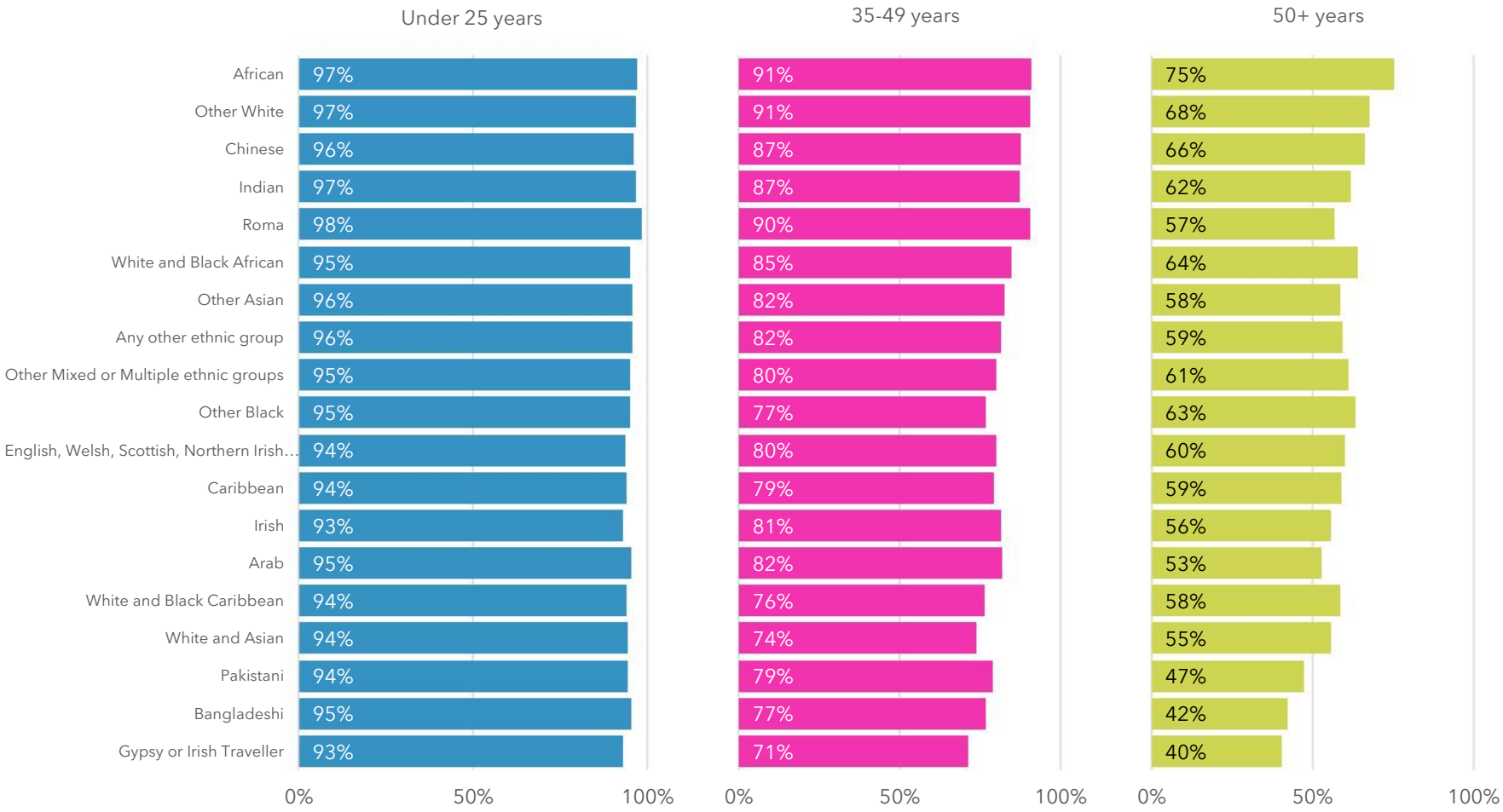
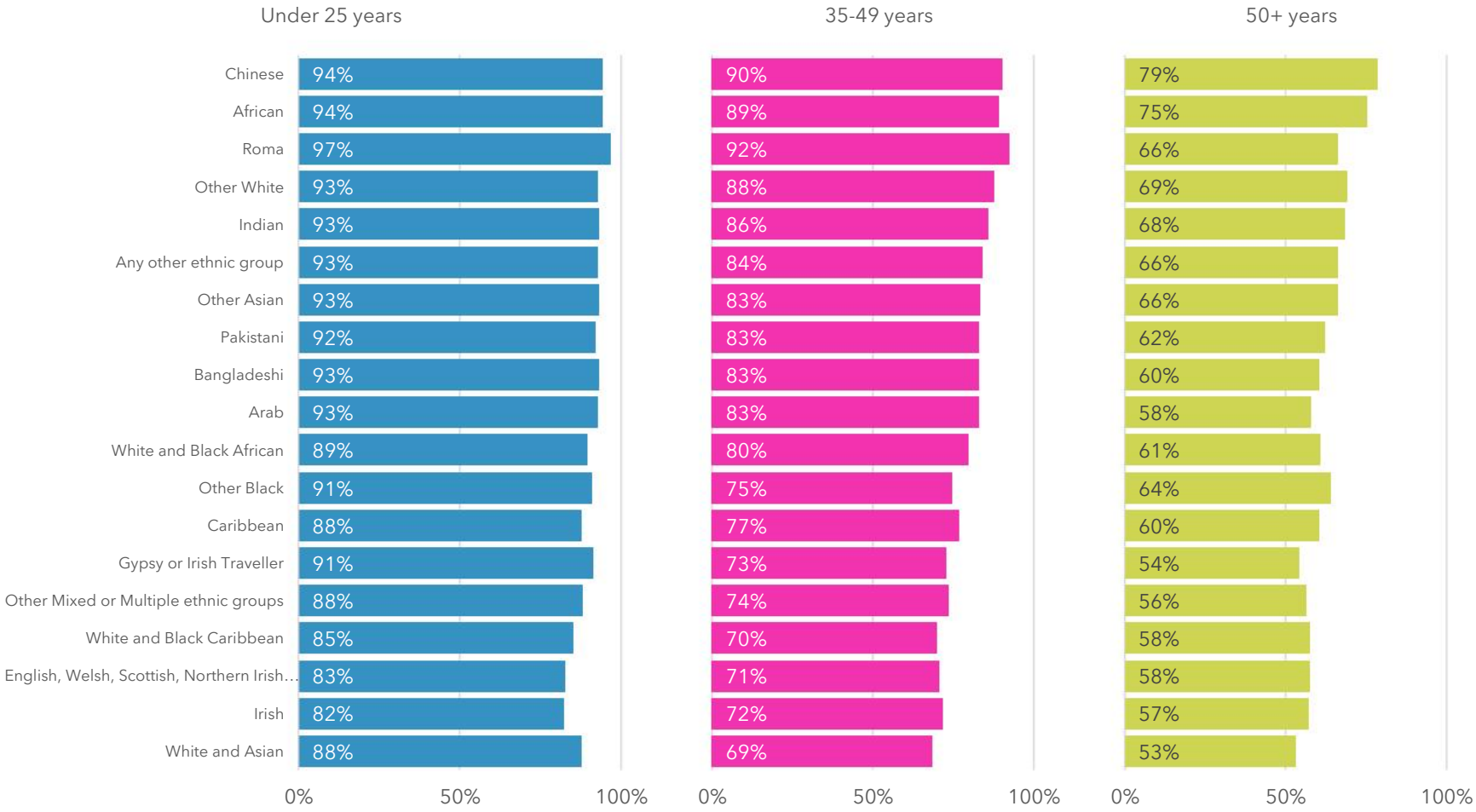


Figure 32. Percentage of each ethnic group in Birmingham reporting as having a no disability and no long term condition by age[1]



Case Study: Hamza

Ward:	Handsworth Wood	**Sexual Orientation:**	Heterosexual
Age:	57	**Gender & Gender Identity:**	Male
Ethnicity:	Asian British	**Occupation:**	Shop worker
Faith:	Hindu	**Living Arrangements:**	Owns with a mortgage or a loan

Hamza was born in Birmingham and has lived in the city most of his life. He has Pakistani heritage and lives in Birmingham with his wife and children. He thinks there has been an increase in the number of people from ethnic minorities living in Birmingham, particularly those from African, Indian and Pakistani backgrounds. He explained that at his temple, they have seen an increase in people from overseas attending, especially people from India. He is aware of quite a few Indian and Pakistani people who have moved to the UK on either student or skilled visas, which he sees as a positive thing for the economy. However, he feels that an increasing population will put pressure on resources and facilities. He is aware of overcrowding in houses – which he believes is due to high rental prices and the cost-of-living crisis.

"You can definitely notice that there's more ethnic minorities. I go to the Hindu temple... I've spoken to some of the people and those who run it, and they say there's definitely a lot more people coming from abroad… we used to only get like 50 or 60 or 70 people coming for the prayers but now we get about 300-400 people on a Sunday and a Tuesday."

Hamza described how the cost-of-living crisis has impacted his physical and mental health. He worries about his bills, and he is having to reduce his heating and how much he travels. He has noticed that many more people are having to rely on food banks and sharing free items through Facebook groups. Hamza explains that, like others, he has struggled to get a doctor's appointment. He believes this causes stress to many people throughout Birmingham.

"A lot more people are going to food banks, there's some food banks near us and you can see the people queuing up for them. And then I'm on a lot of the neighbourhood groups on Facebook and a lot of people are speaking and discussing their issues as well. And the problem they're having is, lots of people are asking if people have got free items available because they can't afford to buy them."

Hamza feels neutral about the future. He thinks there needs to be a balance in attracting more people to the city to boost the economy, without overwhelming resources. He believes it's particularly positive if skilled or healthcare workers move to the city. However, he feels that migration might create shortages in terms of housing and employment for those already living in Birmingham. He also thinks it could put additional pressures on the NHS, schools and local services.

"I think to boost the economy, we need more people in the area and also because if they are working and supporting the local economy. At the moment, Birmingham City Council's going through a crisis as well, so they need to have some more income coming into the economy."

Hamza recommended introducing more public areas, such as libraries and leisure centres, to improve people's mental health. He is particularly interested in seeing more youth support in the city. Hamza values the support a local gurdwara provides to the community. He appreciates this support and would like to see it continue, as well as more facilities like this open in other communities around Birmingham.

[Discussing a local gurdwara] "They've got their own health centre as well and wellbeing centre. They tend to be a lot of the older, older community… It's helping the community quite a bit, and they've got a centre as well where they have different courses, and they used to have a gym as well."

What might this look like in 2031?

The city's identity has changed over the decades and will continue to change. By 2031, if current trends continue in a linear way (Figure 33), Birmingham will continue to become more diverse over the next decade: the broad Asian/Asian British group would have a proportion similar to the White group (around 38%). Other ethnic groups, including those with mixed ethnicity, will also rise.

However, these trends are unlikely to occur linearly as there are many other factors at play, not least the heterogeneity in these broad groups and the difference in birth rates, mortality rates, overall age profiles, and migration patterns. When estimates of birth and mortality rates of age groups are added, more modest changes are predicted in the next ten years (Figure 34). In summary, whilst there is some uncertainty, we know Birmingham will remain a super diverse city and continue to change in the decades to come.

As we explore future change and the potential impact on health and wellbeing, it is important to remember the limitations on our discussion. Future trends are generally based on past data and as such cannot take account of policy shifts or world events which influence migration, nor can they easily predict the future of health of an ethnic group, given that generations within a group can have very different life experiences e.g. parents who were first-generation migrants, and their children and grand-children who have grown up in Birmingham. None-the-less, thinking about these potential futures is important because many of the inequalities discussed in this chapter could widen or increase without action.

Looking ahead to 2031 can help us understand the potential needs of communities in Birmingham. Some of this need may arise from differences in prevalence of inherited conditions. For example, sickle cell disease, which, as discussed, occurs predominantly in people of African and African-Caribbean origin. If current trends continue linearly (Figure 33), 14% of Birmingham's population will identify as Black, African, Caribbean or Black British. In numbers, 14% of the projected population for 2031 (1,227,323) is approximately 171,825 people. This would be an increase of almost 50,000 people from 125,760 in 2021. Given that approximately 8% of Black people carry the sickle cell gene[34], over 3,000 more people will be estimated to have the gene if population trends continue. According to the National Institute for Health and Care Excellence (NICE), the prevalence of the sickle cell gene is increasing in mixed race families[34]. This has implications for Birmingham, given that a high proportion of those with mixed or multiple ethnicities are younger (Figure 30), and this is likely to increase in the next decade.

Most differences in health outcomes however arise due to a complex interaction of differences in social determinants of health, such as income, education and housing; differences in individual health-related behaviours; differences in experience of and access to services; all impacted by racism and discrimination. In these circumstances, predicting the future rise of health outcomes is particularly challenging. However, there are some health outcomes that will undoubtedly have a future impact, and more so in Birmingham. For example, Type 2 diabetes, which has different risk in different ethnic groups, is expected to double globally over the next 30 years.[42] Modelled estimates for Birmingham, which takes into consideration the ethnicity, age, gender and deprivation of the city suggest that diabetes prevalence will rise to 11% of over 16 year olds by 2035 (110,000 people).[43] Intervention is strongly needed to prevent this rise – much of which is preventable - with its associated impact on people's lives as well as health and care costs.

Figure 33: Ethnic Group in Birmingham (Linear Forecast)

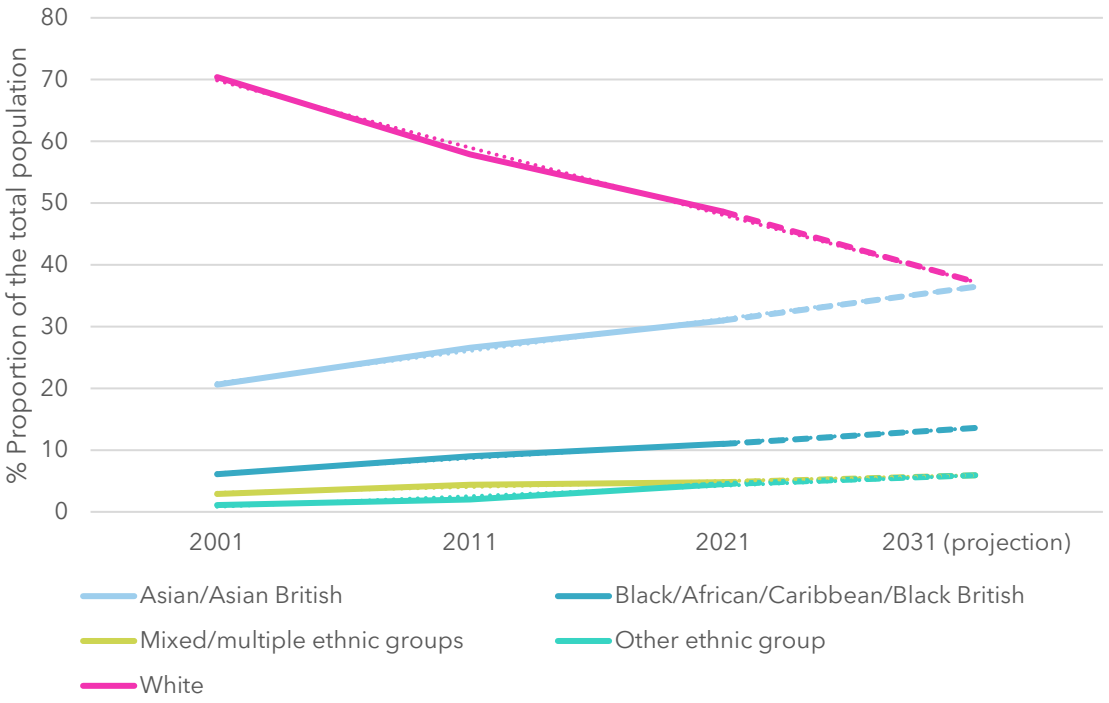
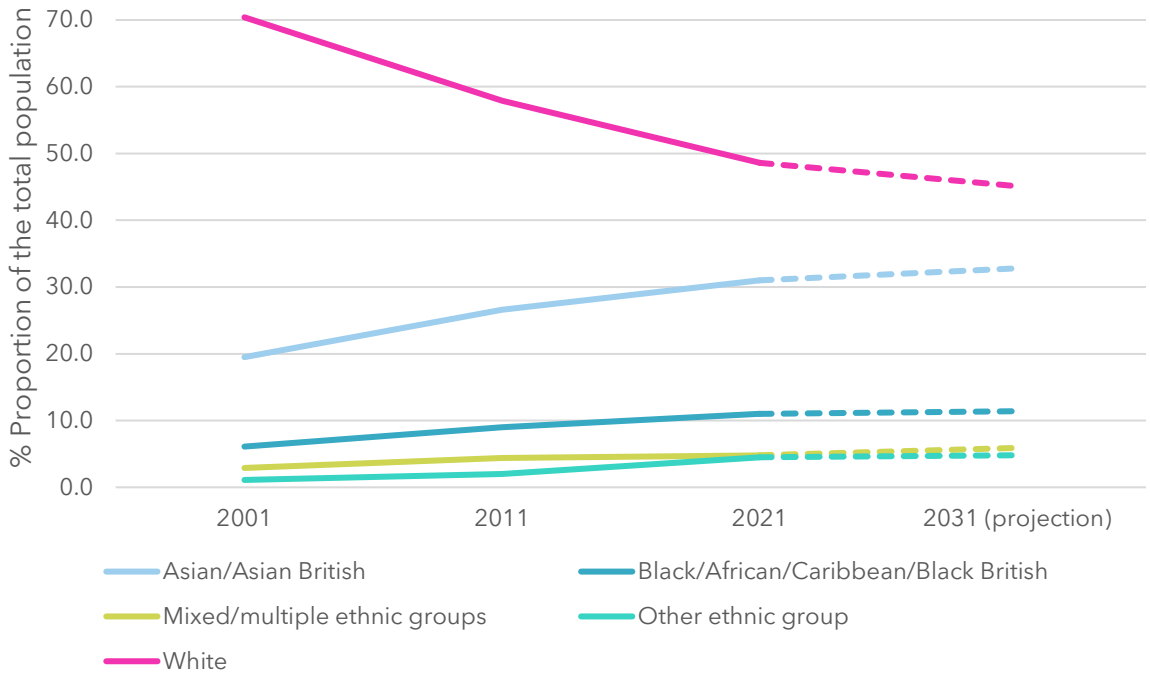


Figure 34: Ethnic Group in Birmingham (Bayesian Population Projections)



Despite the challenges of health inequalities facing different communities, it is important to recognise that increasing diversity can positively impact public health. Birmingham's super-diversity can foster social cohesion and cultural development. We must ensure that policies, services, and interventions are tailored and responsive to the needs and assets of different ethnic groups and involve them in the design, delivery, and evaluation. Moreover, the

health and care system, as well as the wider workforce should reflect the diversity of the population it serves and develop the skills and knowledge to address the health issues of different ethnic communities.

The Census provides a rich data source for organisations and communities to understand our city better, and by accessing better data on ethnicity, more culturally informed care and support can be provided to people from different backgrounds. As a system, we need to move beyond the broad ethnic groups and explore how people identify in more detail, and by doing this, we can see some of the key changes in the previous decade. Locally, we are building on this national evidence through reviews going beyond the 19 ethnic groups in the Census. The Community Health Profiles explore the health needs and inequalities within specific communities discussed here, such as the Pakistani community as well as communities within Census categories, for example, recognising the significant heterogeneity in the African group, there are reviews on the Kenyan, Nigerian and Somalian communities in Birmingham. Additionally, these profiles and BLACHIR have identified gaps in data collection that are being addressed through local action. This includes the Birmingham Measurement Toolbox, which has built on the census question on ethnicity to collect better data to evaluate interventions trying to improve health and wellbeing in Birmingham.

"I have my own way of thinking and my contribution from Nigeria. Someone from Pakistan will have their own way of thinking and their own contribution. Someone from India and someone from Australia the same. When we come together, we see things from different perspectives, and it helps."

Abioye, 48, Female, Aston

System Reflections

Sal Naseem (Assistant Director; Strategy, Equality and Partnerships, Birmingham City Council)

Reading the report shows how proud we are of the incredible diversity of our communities. Birmingham's super-diversity has been confirmed through UK Census 2021, with over 50% identifying with an ethnic minority heritage. Although this statistic does not truly capture the full diversity of our population, it does show that our city is significantly more ethnically diverse than it was ten years ago.

Ethnicity refers to a common group identity based on language, culture, religion or other social characteristics. People define their own ethnicity, and everyone (and not just those in minorities) has an ethnicity, and someone's ethnic identity may change over time. Health patterns differ significantly between ethnic minority groups, the white population, and different minority groups. We know that ethnicity and race have been shown to systematically influence health outcomes, socio-economic status and employment opportunities. Racial inequity continues to damage the lives and health of people, and COVID-19 disproportionately harmed some of our communities. If you are from an ethnic minority, you may already have had struggles to learn from, and maybe that lived experience has shaped you as a person and a leader. We must acknowledge that everyone has unique

experiences of systematic inequality and consider everything and anything that can marginalise people. A person is not Pakistani on a Monday, a woman on a Tuesday and disabled on a Wednesday. They experience all of these things at once, and this is intersectionality. Our work in equality, diversity, and inclusion is about understanding people's experiences, becoming more self-aware and removing barriers. We will only tackle inequalities by understanding and acting to make real change.

Nike Arowobusoye and Sola Afuape, BLACHIR Co-Chairs

In 2021, Birmingham was identified as one of the first 'super-diverse' cities in England and Wales and is the only core city, with over half of its total population from the global majority (often referred to as Black, Asian Minority Ethnic) communities, a 7% increase from the last Census. The DPH report also predicted population change over the next decade and noted further increases in populations from global majority communities, predicted partially using ethnicity breakdowns by age; 67% of residents in the city aged under 15 were from a global majority community compared with 33% of residents aged 50 and above. Positive and negative lived experiences and other intersectional factors of identity such as traditions, culture, country of birth, language, religion etc. can be impacted and shaped by an individual's ethnic background. In addition, descriptions of ethnic group and one's perspective on ethnicity, can be personal, complex and mainly subjective. 1 in 10 people in Birmingham (11%), described themselves as Black, Black British, Black Caribbean or African.

Birmingham's 1.1 million plus population is made up of 287 different ethnic identities. Therefore, it is essential to understand on a granular level, the heterogeneity of community groups under umbrella terms such as 'African' or 'Caribbean' in order to build a healthcare system which can appropriately and effectively reduce the experiences of health inequalities. The BLACHIR (Birmingham and Lewisham African and Caribbean Health Inequalities Review) report mirrors much of the data included in the DPH annual report. Both reports highlight that many aspects of health inequalities are often driven by both the social determinants of health and the influences of structural racism and discrimination. BLACHIR highlights that we must utilise this learning to address the root causes, as well as poor access, experiences of services and care, and outcomes. All of which result in poor health.

The BLACHIR report takes a whole system approach and provides seven key priority areas for action and 39 'opportunities' which are actionable next steps proposed for the Health and Wellbeing Board, BCC and the NHS Integrated Care Systems to act upon. This BLACHIR approach is underpinned by anti-racist terminology and focuses on understanding the evidence from the communities, racism, and the impact of the different ethnic backgrounds and cultures on health and wellbeing. The solution focussed approach has inherent within it community involvement and empowerment and partnership working with the wider health and social care system. In doing so, it aims to ensure that disparity in experience and health inequalities among Birmingham's super-diverse communities are reduced with improvements in overall health and wellbeing, lived experiences and receiving and accessing health care services. Achieving this in a culturally alert fashion is foundational to this body of work and is the unique added value for the residents of Birmingham. It remains vital to reflect on both the strengths and challenges associated with the rich diversity in Birmingham.

Sexual Orientation & Gender Identity

Data Headlines

- For the first time in the 2021 Census, voluntary questions were asked on sexual orientation and gender identity for respondents aged 16 years and over.
- 87.6% of Birmingham residents identified as straight or heterosexual, 3.0% identified with an LGB+ orientation, and 9.4% did not answer the question on sexual orientation.
- 90.8% answered that their gender identity was the same as their sex registered at birth, 0.9% answered that their gender identity was different from their sex registered at birth, and 8.4% did not answer the question on gender identity.

Implications for Health and Wellbeing

- The LGBTQ+ population is more likely to be affected by inequalities around mental health and wellbeing, substance misuse, and smoking rates.
- They are also more likely to experience direct and indirect discrimination both when accessing health-related services and in wider society.
- Those who identify as 'trans+' and seek to medically transition face additional barriers as there are no Gender Dysphoria Clinics in the West Midlands and long-waiting lists for referrals and treatment.
- Future trends are difficult to determine as this was the first time LGB+ data have been collected in the Census, many possible reasons for non-reporting and uncertainty on whether greater identification of LGB+ in the younger population will continue as this population ages.

What does the data tell us about sexual orientation and gender identity in Birmingham?

For the 2021 Census, the ONS defined sexual orientation as "*an umbrella term covering sexual identity, attraction, and behaviour*".[44] The ONS' definition of gender identity was "*a person's sense of their gender, whether male, female, or another category such as non-binary*".[45] The ONS use the term' trans(gender)' to describe all those whose gender identity was not the same as their sex registered at birth, including binary, non-binary, and non-gendered identities, although 'trans+' will be used for this chapter.[46]

According to the 2021 Census, 3% of Birmingham's population (aged 16 and above) identify with an LGB+ sexual orientation and 0.9% of the population (aged 16 years and above) identify with a gender identity that is different from their sex registered at birth. Related to this, 9.4% chose not to answer the question on sexual orientation while 8.4% chose not to answer for gender identity. Assuming that those who chose not to answer still reflect the population as a whole, there are approximately 13,100 people who identify as 'Gay or Lesbian', 12,300 who identify as 'Bisexual' and 4,000 who identify with an 'Other sexual orientation' in Birmingham. Similarly, there are 4,500 people who identify with a different gender identity from their sex registered at birth, but gave no specific identity,

1,500 who identify as a 'Trans Man', 1,350 who identify as a 'Trans Woman', and 900 who identify as 'Non-Binary' or another gender identity. When compared to the overall percentage proportions for England and Wales, Birmingham has a slightly smaller LGB+ population percentage and a slightly larger percentage of people with a different gender identity from their sex registered at birth.[1]

There is likely to be under-reporting of the total LGBTQ+ population as those under 16 years old are excluded and the Census was completed by one person on behalf of the household.[46] There may also have been those who identify as part of the LGBTQ+ population but did not wish to share this information on the Census.[46] Overall though, the Census is still the most comprehensive data source on sexual orientation and gender identity in Birmingham as previous estimates, such as one from ONS in 2015, showed a much smaller LGB+ population.[47]

1 in 3 LGB+ oriented individuals are aged between 16 and 24 years old

Figure 35: Sexual Orientation by Age Group in Birmingham (excluding 'Straight/Heterosexual' or 'Not Answered') (2021)[1]

The Census shows differences in reported sexual orientation by age-group, with a greater percentage identifying as LGB+ in younger age groups and with younger LGB+ people more commonly identifying as bisexual, where older age-groups more commonly identified as gay or lesbian. Indeed, 1 in 3 (32.2%) LGB+ orientated individuals in Birmingham are aged between 16 and 24 years old (Figure 36). These differences by age are likely to reflect societal changes with individuals in younger age groups more comfortable identifying with LGB+ orientations,[45] whilst, those in older age-groups more likely to have experienced social, policy and legal discrimination in their lifetimes that may dissuade them openly identifying with an LGB+ sexual orientation.[48]

Figure 36: Percentage of LGB+ orientated individuals by age group (2021)[1]

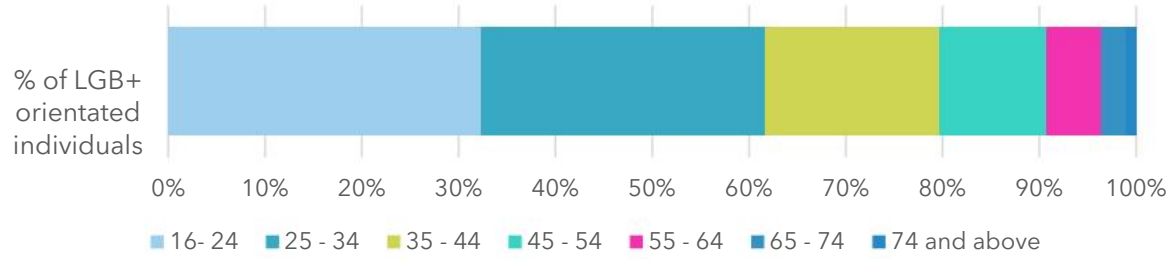
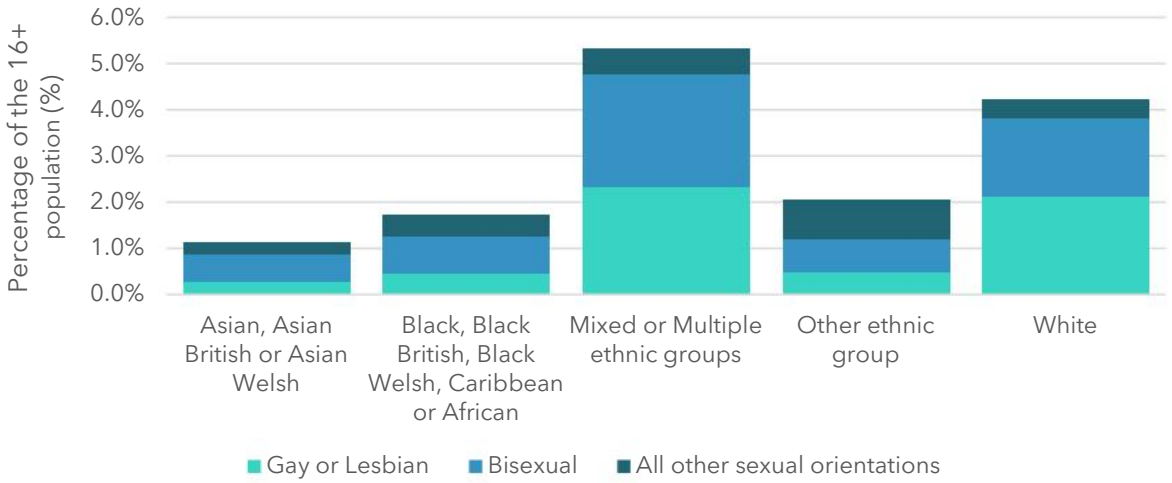


Figure 37: Sexual orientation by ethnic group (excluding 'Straight or Heterosexual' and 'Not answered') (2021)[1]



There are differences in the population identifying as LGB+ by ethnicity, some of which is likely to reflect the different age-structures of the ethnic groups (Figure 37) shows a similar breakdown of those who identify with an LGB+ orientation by ethnic group. For example, the higher proportion in the 'Mixed or Multiple' ethnic group corresponds to the age profile of this group with it being very young in comparison to other ethnic groups. It is also interesting to note that with the exception of the 'White' ethnic group (which has an older age-profile overall), the most common LGB+ orientation identified with is 'Bisexual'.

There are well-reported inequalities between those who identify as straight/heterosexual and those that identify with an LGB+ orientation. These include differences in risk behaviours such as higher smoking rates, alcohol consumption and substance misuse.[49,50,51] Furthermore, societal acts, including hate crime, sexual violence and causes of homelessness including parental rejection, disproportionately impact the LGB+ population.[52] There are also specific inequalities within the LGB+ population. For example, gay men and men who have sex with men (MSM) are more likely to engage in higher levels of drug use and have a higher risk of contracting certain sexually transmitted infections (STI).[53]

There are clear inequalities in mental health, with higher prevalence of mental health conditions seen amongst the LGB+ population. For example, Stonewall (UK-based LGBTQ+ charity) reported that in 2018 "*half of LGBT people have experienced depression and three in five have suffered from anxiety, far exceeding estimates for the general population*".[50] Prevalence is also greater among younger age groups, with a higher

likelihood of engaging in health risk behaviours, such as self-harm and suicidal ideation.[50,54] For the LGB+ population in Birmingham, health needs relating to mental health and wellbeing are likely to be the most pressing as the age profile of this population is far younger than older.

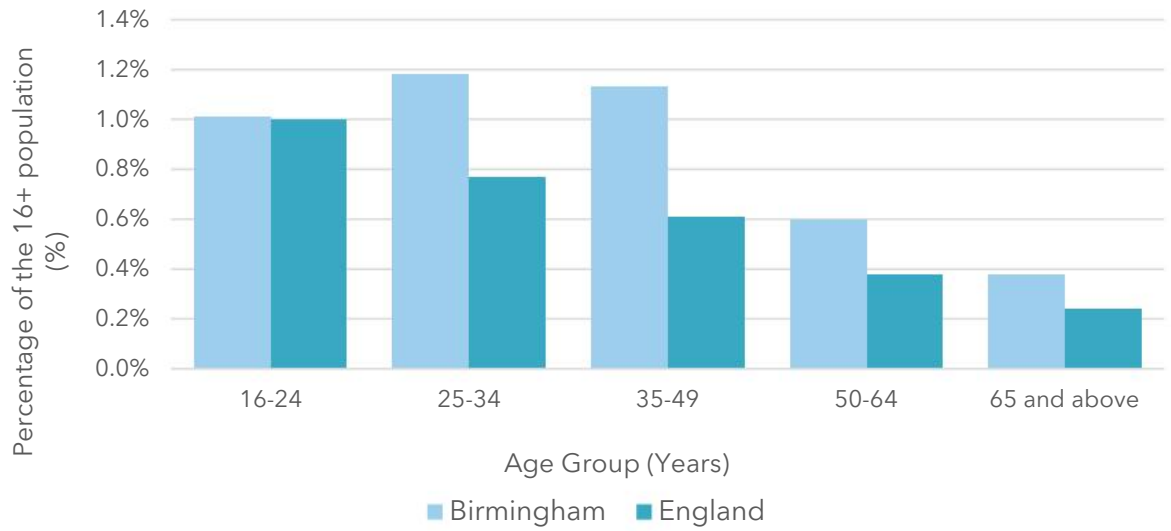
To meet the needs of the LGB+ population, Birmingham will require health and care services to be inclusive. In their 2018 report, Stonewall stated that 1 in 4 LGBT people had experienced a misunderstanding by healthcare staff of their specific health needs.[50] Research suggests that a lack of understanding is not always due to direct discrimination but health and care professionals feeling poorly equipped to respond to the needs of the LGB+ population.[50] Furthermore, "*there is often an unhelpful conflation of LGBT communities in health and social care services*".[50] The net result is that LGB+ oriented people may become more likely to avoid treatment or engagement with health and care services because they either expect or believe that they will face discrimination.[49,54] It will be crucial for the health and care system in Birmingham to acknowledge these barriers and develop inclusive approaches for the LGB+ population.

"I don't see much harm coming from inclusion and supporting people… I feel like that would have had a direct positive impact on the health and wellbeing of someone like me".

Mischa, 24, Female, Perry Barr

Compared to England, Birmingham has a higher proportion of residents who identify with gender identities different to their sex registered at birth

Figure 38: Gender Identity by Age Group (excluding 'same gender identity as registered at birth' and 'Not Answered') (2021)[1]



Birmingham has a greater proportion of people identifying as 'trans+' than seen in England and the differences are greater in those aged over 25 years (Figure 38). These figures may underestimate the true number s as there may be a proportion of people who identify as

'trans+' but did not disclose this in the Census. This may be indicative of the evidence that some are reluctant to share their identity for data collection purposes.[55]

People who identify as 'trans+' face inequalities in health and wellbeing outcomes. In particular, there is a higher prevalence for mental health conditions and self-harming behaviours, including attempted suicide.[50,56] There is also evidence that they are more likely to have a less healthy lifestyle and a higher rate of self-reported disability.[55] These inequalities are compounded by multiple barriers to accessing health services. In their 2018 report, Stonewall reported that around 40% of those who identified as transgender in their LGBT survey had "*difficulty accessing healthcare due to their gender identity*".[50] The most common issues were recorded as; expected or actual discrimination, lack of understanding, and lack of knowledge around specific treatment pathways.[56] As a result, similar to parts of the LGB+ population, individuals will avoid services, particularly primary care, in the expectation that they will not receive equal treatment.[50]

An additional issue for this population is accessing services related to medical transitioning. Whilst not all of those who identify as 'trans+' will seek to transition, of those that do, there are several barriers. To begin to medically transition, a person needs a gender dysphoria diagnosis which can only be obtained from clinicians at a Gender Dysphoria Clinic (GDC's).[56] There are no GDC's in the West Midlands.[56] Furthermore, there are long-waiting lists for any referral or treatment relating to gender-focused health services.[54] The current and future risk for the 'trans+' population in Birmingham is that these inequalities of access exacerbate inequalities related to health outcomes.

Case Study: Ajani

Ward:	Kingstanding	**Sexual Orientation:**	Heterosexual
Age:	28	**Gender & Gender Identity:**	Trans Male
Ethnicity:	Black/African/ Caribbean/Black British	**Occupation:**	Carer
Faith:	No religion	**Living Arrangements:**	Rents from a Local Authority

Ajani grew up in Birmingham, lived in London for a few years, before moving back to Birmingham where they have lived ever since. They live by themselves but are close to their family.

Ajani thinks that the percentage of people who do not identify as straight is actually greater than the figure taken from the census. They feel that some people lack the confidence to express their true identity, and that societal pressures to 'come out' can be overwhelming. They feel some might prefer to keep their identity hidden to avoid criticism and judgment.

They agree that a higher percentage of younger people identify as LGBT+, and that younger people are more likely to identify as bisexual, while those older might identify as gay or lesbian – they think this might be because this age group are still exploring their identity and experimenting with their sexuality.

"I would say a lot of people lack the confidence because there's this thing, and I've never understood it personally, about like having to come out and stuff like that… and that in itself puts pressure on the situation of having to come out or of having to just be yourself authentically."

Ajani has always struggled with their mental health. They had experienced a breakdown, which was caused by a bad housing experience when living in a rental property in London. Their health spiralled and they returned to Birmingham to live with their mum. Their experiences made them worried about getting another rental property, and they only felt comfortable moving out once they were able to get a council property.

They feel they had a unique transgender experience, having never felt comfortable in their own body – they did not have a journey of trying to feel comfortable, before then transitioning. Ajani describes the impact testosterone had on them, highlighting that it deepened their voice, making conversations easier as people no longer mistook them for female.

[Discussing testosterone] "It's just been a lot easier to hold a conversation with anybody, just for the simple fact that my testosterone has kicked in. Before, my voice was high and so obviously no matter how I dressed or how I looked, the moment someone will hear my voice instantly they'll call me female."

Ajani is concerned about being financially stable in the future. They feel that despite working full time, it is difficult to save, especially given increasing prices and the cost-of-living crisis. Equally though, they wanted to see more local community initiatives similar to the ones in their area, to help maintain public spaces and to support individuals within the community.

"To be fair where I live, we kind of have a little community of our own… because obviously we pay service charge for the Council to cut the grass, but it doesn't happen all the time. So, like every two weeks or so, we'll go out there and cut. We'll make sure everyone's OK."

The non-response rate was highest in the youngest and oldest age groups

Unlike most questions in the Census, the questions on sexual orientation and gender identity were voluntary. This meant that not answering the question (by leaving it blank) was captured as an answer and considered important data in itself. In Birmingham, the total non-response rate for the question on sexual orientation was 9.4%, and for gender identity was 8.4% (6% chose to not answer both).[1] Both of these rates are higher than the total figures for the country; 7.5% and 6.0% respectively.[57]

Figure 39: Non-response rate for 'Sexual Orientation' question by age group (2021)[1]

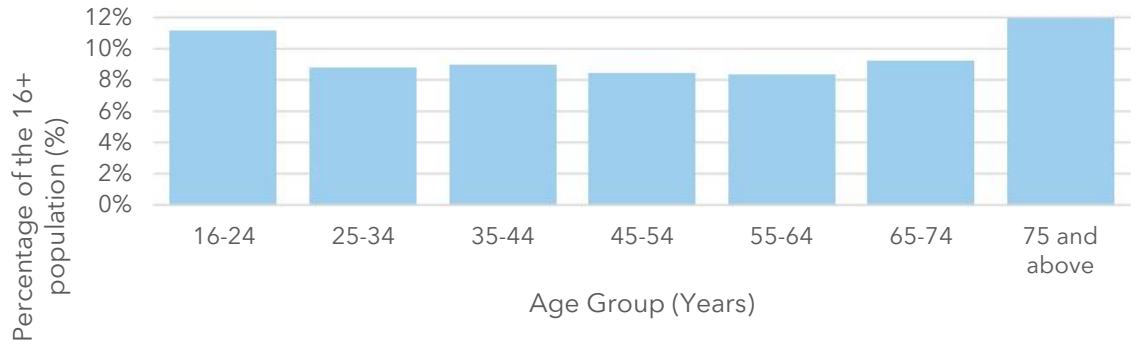


Figure 40: Non-response rate for 'Gender Identity' question by age group (2021)[1]

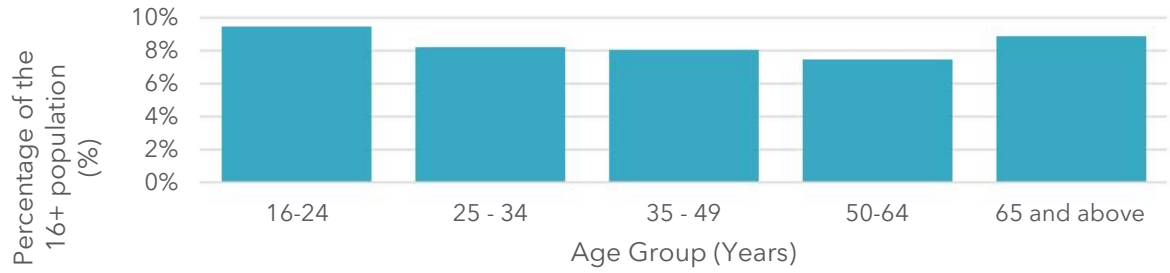
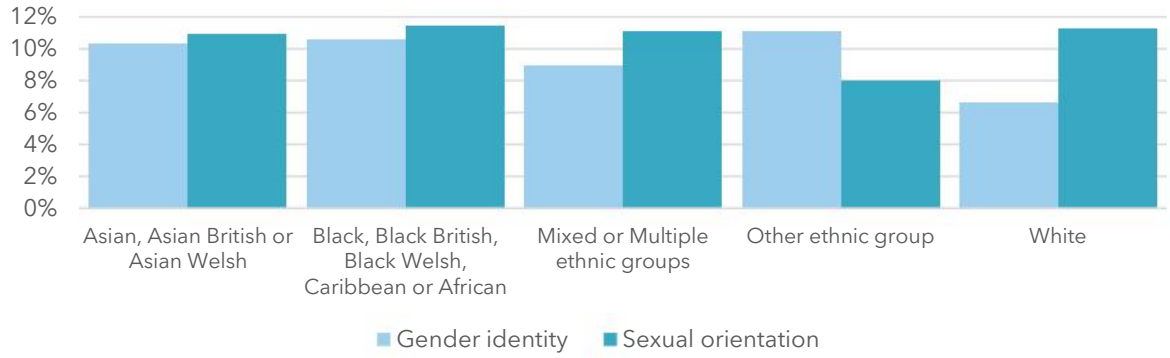


Figure 41: Non-response rates for questions on sexual orientation and gender identity by ethnic group (2021)[1]



Non-response rate was highest in the youngest and oldest age groups for both sexual orientation and gender identity (Figure 39,Figure 40). For the responses on sexual orientation in particular, over 10% of those in the '16-24' age group and '75 and above' age group provided no response. The reasons for non-response rates, and why these are highest in these age-groups, are not known and difficult to explain. No clear pattern was

seen for non-response by ethnicity (Figure 41). There are many reasons as to why an individual may choose not to disclose this information. For example, even though the Census is a fully anonymous survey, some people may have been uncomfortable with sharing information that is very personal to them. [58] The implication for Birmingham is that the Census may have under-reported those who identify with an LGB+ sexual orientation or a 'trans' gender identity.

What might this look like in 2031?

As this is the first time this data has been captured comprehensively through a census, it is difficult to create a projection of how any trends might continue to 2031. For sexual orientation, it is likely that there will be an age-cohort effect where younger age groups continue to identify with LGB+ orientations at a higher level than preceding cohorts. The current 5% in the 16-24 age group is unlikely to decrease significantly as this cohort ages, although variation is possible as sexual fluidity is also more common in this group.[59] Taking this into account, the expectation would be an overall flattening of the percentage across each age group. Therefore, there would be higher levels of LGB+ identification within the total population and a more even distribution across the age groups. This effect will also have implications for services that are more commonly associated with middle-age and older adults as those who identify with LGB+ orientations become more visible and present their own health needs.

A secondary trend which is difficult to predict is whether there will be further increases in the next cohort of 16-24 years olds in future years. In a 2022 survey from Stonewall on attraction and identity in Great Britain, 28% of respondents aged between 16-26 years old identified with an LGB+ sexual orientation.[60] While there is still a large difference between the census data for Birmingham and the estimates from Stonewall, which may be due to self-reporting methods, both suggest that levels of LGB+ identification are likely to increase in the population and across age groups. If the health and other needs of the LGB+ population, and the inequalities they face, are not recognised and addressed then the LGB+ population will continue to experience worse health outcomes and there will continue to be those that feel they have to hide their sexual orientation.

It is more difficult to suggest how levels of identification with different gender identities will change in the future as it does not fully mirror the same pattern as LGB+ identification in Birmingham. Generally, younger age groups have slightly higher proportions of those who identify as 'trans+'. However, the lower proportion in the 16-24 age group, coupled with the higher non-response rate, indicates that there is no defined trend at this point. It is likely though that the 'trans+' population will increase in Birmingham over the next 10 years and health services and professionals will need to be aware of the stark inequalities experienced currently by this population. These services will need to adapt to accommodate greater diversity around gender identity and encourage better access for the 'trans+' population, particularly around gender-focused health services.

System Reflections

Bradley Yakoob (Chair of LGBTQ+ & Allies Network, Birmingham City Council)

Inclusion! It may seem like an over exaggeration to use the word inclusion or to use an exclamation mark but there is a triumphant here. The census is rarely a major part of everyone's wish list and is something we can often overlook in its importance, however for the first time since 1801, the LGBT+ population has been seen and included. Visibility is one of the foundations bricks behind the Pride movement, as for many decades the LGBT+ community fell victim to erasure and people were told to be ashamed or hide their most authentic self. In 2021, the UK Census allowed the LGBT+ community to seen and to be accounted for in one of the most powerful data sets in our land that informs decision making and service provision for the next 10 years.

To read a quick insight into the 3% LGB+ and 0.9% Non-Cisgender Birmingham people and begin to see a glimpse of the LGBT+ community in our city. The growing LGBT+ community of the future with more young people (16-24) and younger adults (24-34) identifying as LGBT+ is testament to a changing and more inclusive future.

Conversely, it is important to recognise and reiterate that this is the first time these two questions relating to LGBT+ identity have been asked, and we have much to learn. This report identified that the non-response rate was highest in our youngest and oldest age groups – is this down to trust? Or maybe the fact that multiple generations are living in one household for longer than before? Or historic and current discrimination and societal aggression experienced? There are so many questions the census has unearthed but questions and challenges the LGBT+ community has highlighted many times before. Maybe the data and evidence that this census provides will enable leaders to hear and address these challenges.

The non-disclosure rate of both sexual orientation and gender identity in Birmingham was higher than the England average, our rates were higher in our youngest and oldest age groups, and our trends of disclosure in our non-white ethnic communities were low. These are all indicators of the change and action needed in our city. We need to ensure that every person in Birmingham feels safe and supported to be their most authentic self and be proud to be themselves. We need to do more as a city to ensure Birmingham citizens have the knowledge and resource to understand their experiences and feel safe to be open.

The service provision and consideration for the needs of the LGBT+ people in Birmingham is poor – with no dedicated gender confirming provision in the entire West Midlands even though we have a higher than England average for people who identify as Non-Cisgender, an under-funded LGBT+ Centre that supports Birmingham and the wider region, rising LGBT+ hate crime rates, and a lack of visibility of our city's ally-led pride in our LGBTQ+ community outside of the Birmingham Pride weekend. If our city does not act now, we will see a rising number of people experience mental health challenges, substance misuse, victims of hate, and more health and social inequalities experience by LGBTQ+ people. Birmingham has the opportunity to be a vanguard of intersectional LGBTQ+ service provision and pride, with a population bursting with unique experiences, identities, and passion – it is time that our city, region, health and social care, and educational leaders do more to create a thriving LGBTQ+ city fit for the future. To slightly amend the opening of reflection: Inclusion, and now Action!

Mike Morgan (Co-Founder, Alliance Network and Hays Pride Network)

There are some extremely interesting points in this data and as someone who works closely with internal and external networks in Birmingham, I was surprised that the largest identifying characteristic in all ethnic groups was Bisexuality. I feel this group of people lack support in Birmingham not only around healthcare but in around support networks where there are safe spaces to share experiences and seek support and advice. Given the data presented earlier in the report I am not surprised that Birmingham has a larger community of people identifying as LGB+ than the England standard as we have a much larger demographic of 16 – 24-year-olds than other areas in the UK. Whilst we know that these numbers are relatively accurate and probably underinflated, I would concur with the report that more work is needed now and certainly in the future to support these people given the number of young people identifying as LGB+ is likely to rise and also support for our trans community in the form of a specific West Midlands GDC.

International Immigration

Data Headlines

- 73.3% of people (around 824,000) living in Birmingham were born in the UK, compared to 77.8% in 2011. Nearly two thirds of those who were born outside the UK have lived here for 10 years or more.
- Younger people contribute most to immigration: two-thirds (66.7%) of people who arrived in the UK in the previous decade, and were living in Birmingham in 2021, were under 30 when they arrived in the UK.
- GP registrations of migrated individuals increased in 2021.

Implications for Health and Wellbeing

- Migrants often experience barriers in accessing health and social services, especially if they are seeking asylum.
- Migrants may experience discrimination and are therefore vulnerable to physical and mental illness.
- Those who migrated for employment, family and study reasons have better health than the UK-born, while those who migrated to seek asylum have worse health outcomes.
- Those who migrate are more likely to be younger and are also less reliant on the health system.
- Migrants who choose to migrate have better health than their host population, but there is a deterioration of health status the longer they reside in the host country.

What does the data tell us about international immigration in Birmingham?

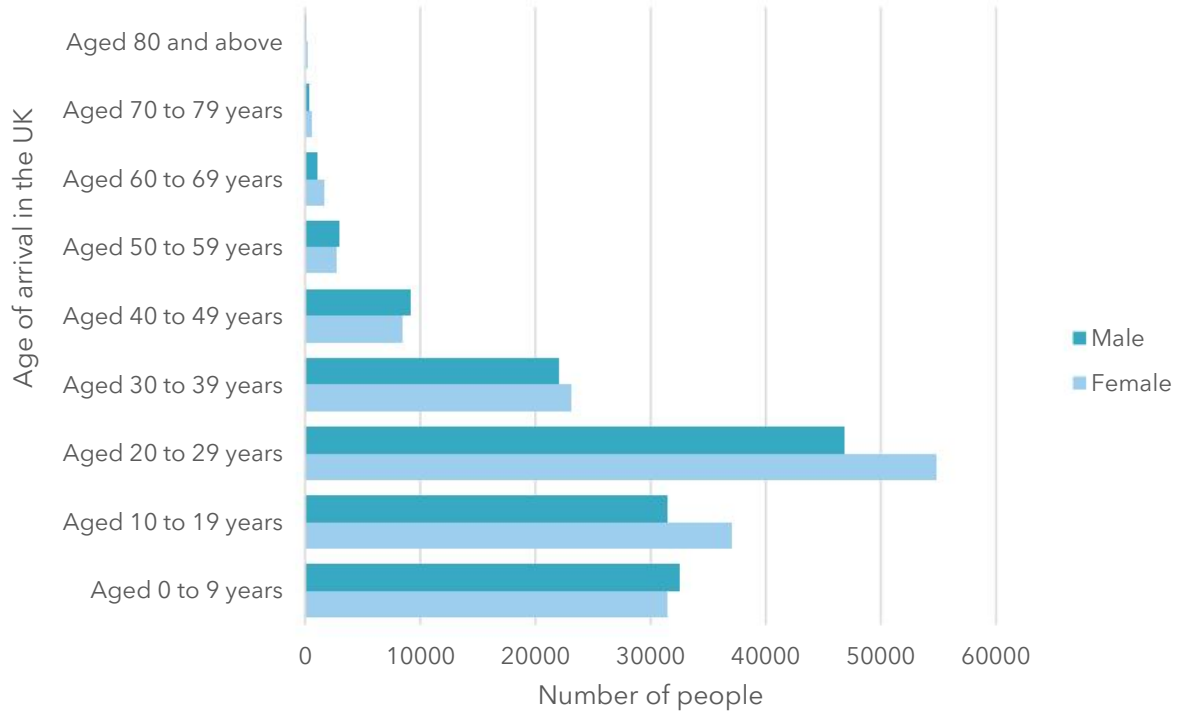
Migration is broadly defined as a change in a person's usual residence, it is an important contributory factor to population and social change. Migration can be divided into movement across national boundaries (international) and within a country (internal). Migrants in this report are defined as those born outside the UK, regardless of UK citizenship. Within the report international migration is discussed to understand health outcomes and is of the main drivers of population change in Birmingham.

Birmingham has a history of immigration during the 19th century, becoming an important destination for migrants seeking to settle and find work. Significant events include the following. Major immigration into the city from Ireland, following the Great Irish Famine (1845–1849).[61] Also, Jewish people fled religious discrimination in the 18th and 19th Centuries. In the decades following World War II, the ethnic make-up of Birmingham changed significantly, as immigration from the Commonwealth of Nations and beyond increased as employment opportunities increased during the 1950s-1960s.[61] The outcome of conflict around the world has led to many nationalities seeking asylum in Birmingham. Including residents from the Balkans, Somalia and East Africa, and later Iraq and Afghanistan during the 1990s. Following the Migration from the 'Accession Eight' or 'A8'

East European Countries that joined the European Union (EU) in May 2004 (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia).[61]

Two-thirds (66.7%) of people who arrived in the UK in the previous decade were under 30 when they arrived

Figure 42: Age of arrival in the UK by age group by sex (Arrived from 2011 to 2021)[1]

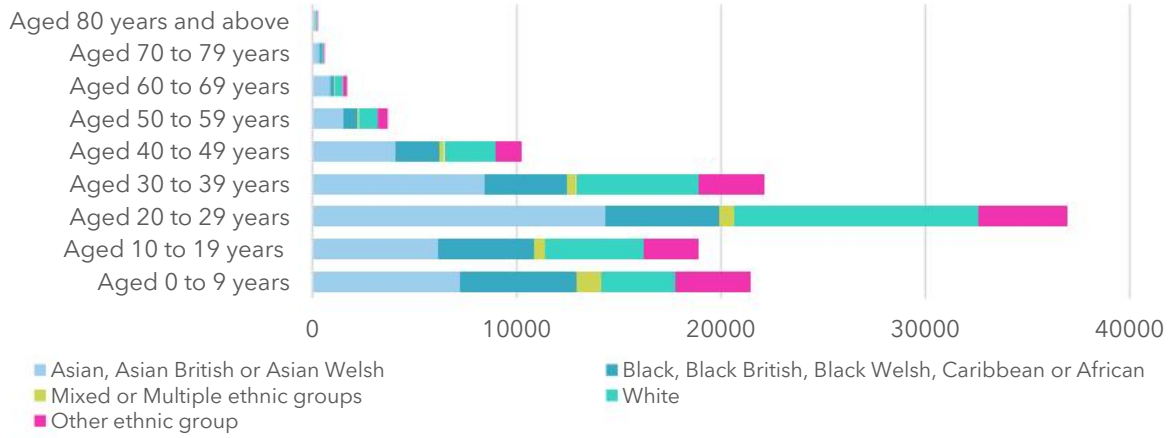


In Birmingham, in 2021, there were 298,730 people born outside of the UK (26.7% of the population). The data shows migrants who arrived in Birmingham are more likely to be female (52%) and aged 29 years old and younger.

International migration occurs when people leave their country of birth and stay in the host country for some length of time. The reason an individual chooses to leave their country of birth also can influence health outcomes. Health outcomes for migrants differ according to their reason for migration, country of birth, duration of stay in the UK and the type of work they undertake in the UK. Those who migrated for employment, family and study reasons have better health than the UK-born, while those who migrated to seek asylum have worse health outcomes.[63] Interestingly, after 15 years in the UK, non-born and UK-born populations report similar health outcomes across all age groups.[63]

The Census 2021 shows migrants who have arrived in Birmingham are more likely to be younger (Figure 42). Migrants tend to be young when they arrive, typically as young adults coming for work or study or as children accompanying their parents.

Figure 43: Age of arrival in the UK by ethnic group (Arrived between 2011 and 2021)[1]



The increasing population of migrant women in the United Kingdom has implications for the provision of healthcare and healthcare experiences. Research has shown that ethnic minority and migrant women are disproportionately affected by existing barriers to access to healthcare and have poorer maternal health outcomes. Migrant women are at increased risk for complications related to pregnancy and childbirth, possibly due to inadequate access to and utilisation of healthcare. The impact on Birmingham's health may need to consider migrant women as a vulnerable group who may experience challenges in adapting to a new country.

"I'm still not very confident using NHS… I'm going through the process for the ADHD medication and I'm not feeling like I'm very taken care of… I never actually speak to anyone in person… and they don't explain it"

Agne, 27, Female, Ladywood

62% of Birmingham residents who were born outside the UK have lived in the UK for 10 years or more

Figure 44: Age of arrival in the UK by length of residency (2021)[1]

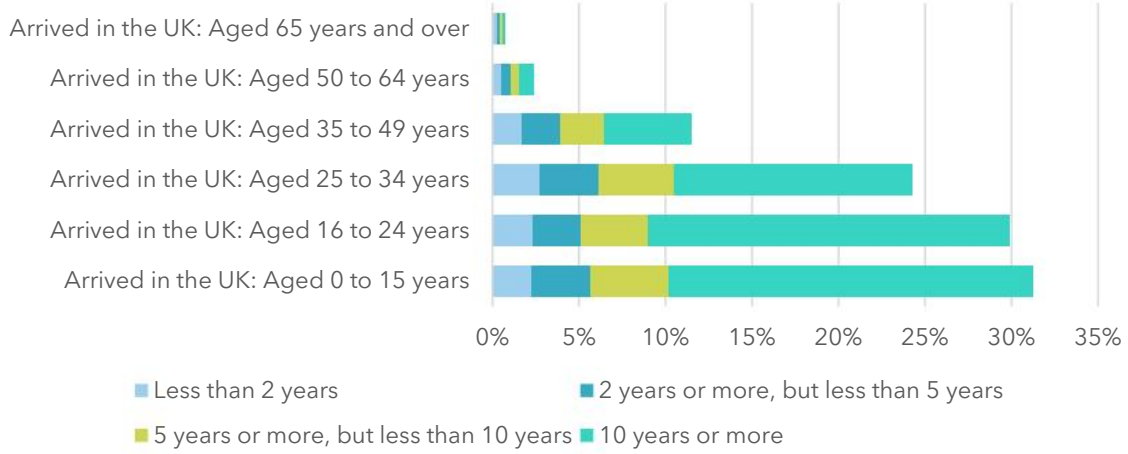


Figure 44 shows the age of a person who has arrived and the length they have stayed. The length of residence in the UK is the date that a person most recently arrived to live in the UK. The data shows those who are arriving are younger (aged 0-15 years) and are also staying in the UK for a significant length of time (10 years or more).

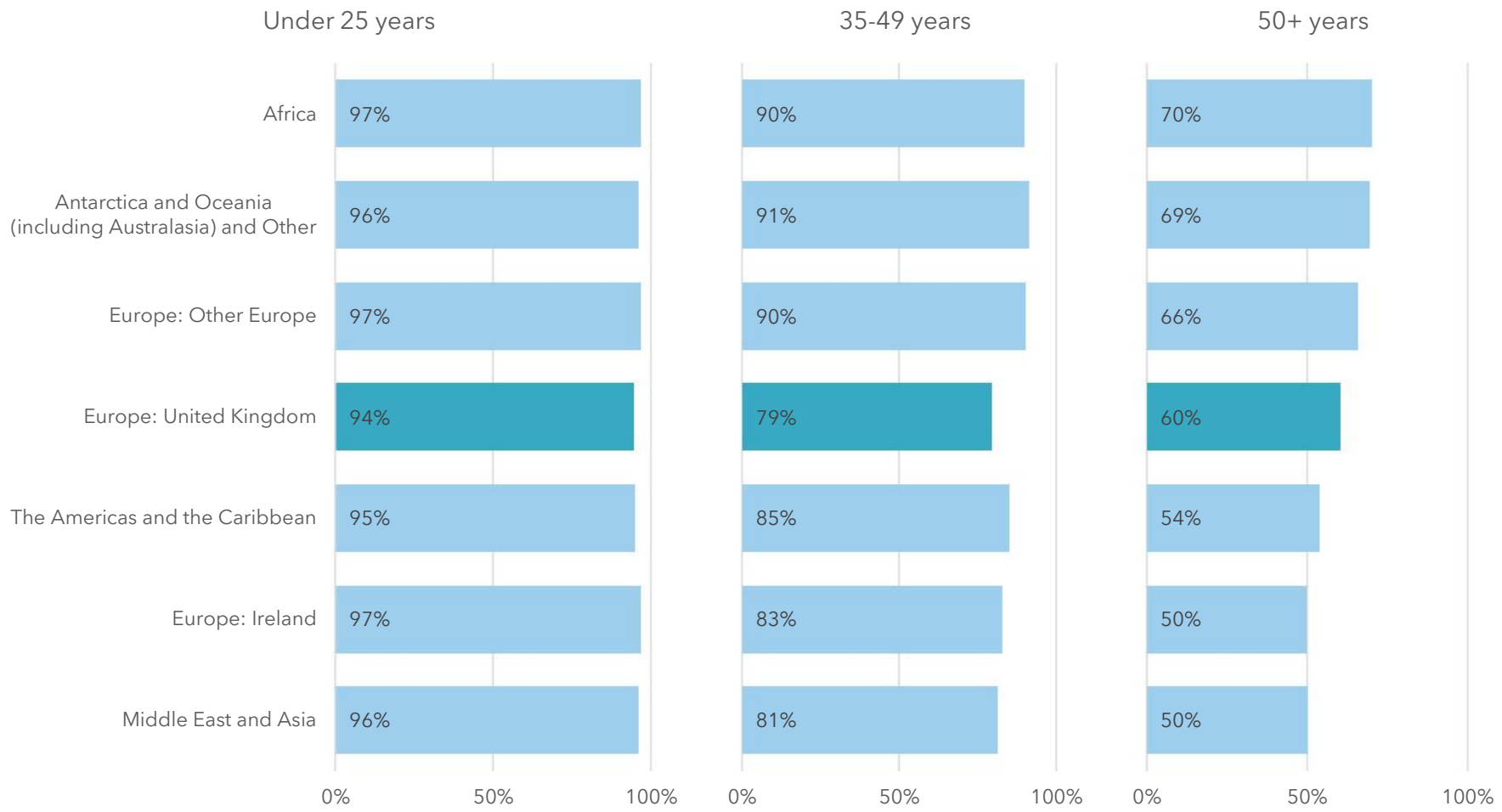
The 'healthy migrant effect' refers to observations that migrants have been found to have a better health status at migration than the other population in their country of birth and to some extent also better health status than the population in the host country.[62] This difference is in part explained by the fact that non-UK born are on average younger.[62] But even within the same age groups, the non-UK-born are healthier than the UK-born, at least among the population below age 50.[63]

People who were born in the UK reported lower levels of 'good or very good health' than several other groups who were not born in the UK (Figure 45). In adults aged 35-49, 79% of people born in the UK reported 'good or very good health'. For the same age group, 90% of people born in Africa, and 81% of people born in the Middle East and Asia reported 'good or very good health'. Greater disparity is seen in older adults which may have implications for the next decade as this population increases.

The health implications for Birmingham may see migrants who arrive in the UK, are more likely to be younger. Therefore, younger age groups are less likely to be diagnosed with age-related diseases and are less likely to be dependent on the healthcare systems.[64]

Migrants have been reported to make a positive contribution to the UK health service.[65] Migrants contribute through tax, tend to use fewer health services compared to others and provide vital services through working in the NHS.[65] However, work in manual or lower-skilled jobs and may therefore be more exposed to work-related risks and more vulnerable to work-related diseases.[66] Moreover, a few studies show that migrants' health advantage diminishes over time and their health status becomes equal to or worse than the host population's within 10-15 years after migration.[62] Length of stay in the UK increases with migrants who arrive younger (seen in figure 39).

Figure 45. Percentage of usual residents in Birmingham reporting as having 'good or very good health' by age and country of birth[1]



Case study - Kamran

Ward:	Harborne	Sexual Orientation:	Heterosexual
Age:	54	Gender & Gender Identity:	Male
Ethnicity:	Iranian	Occupation:	Film writer and director
Faith:	Christian	Living Arrangements:	Temporary Council accommodation

Kamran migrated from Iran to the UK with refugee status 4 years ago, and two months after arriving to the country, he moved to Birmingham. After spending 8 months in a hotel, he now lives in temporary accommodation provided by the Council. As he does not speak English well, his son often acts as a translator for him.

Kamran believes Birmingham is a hugely diverse city, but he feels there is a lack of social cohesion and that there are tensions between different ethnicities. He thinks racism is on the rise, and that often these tensions are fuelled by the government – whether it's through the language they use or via their policies. He thinks that some ethnicities are treated differently. For example, he feels Ukrainian refugees were able to find accommodation and employment much quicker than Afghan or Iranian refugees.

Kamran and his family were given temporary accommodation in a hotel when he first moved to Birmingham. The room was dirty and there were bed bugs and cockroaches. He later moved into a council property, which he described as being in poor condition. However, he did not complain as he had been warned by others in a similar situation that this would be the case. Instead, he sought help from his church, who were able to make his home a nice place to live. During his stay in a hotel, he met many families who had experienced homelessness due to rising living costs or difficult landlords. Kamran has a heart condition, which prevents him from working full time. However, he knows that his church has supported other Iranian refugees to find employment. Nevertheless, he explained that the employer had treated these Iranian employees differently compared to British ones.

"*I think it's very diverse and that's something I enjoy about the UK… it's very deeply ingrained, and I feel like it makes my position as an immigrant easier to fit in. People are used to hearing people speak with accents. There is a bit of like, oh, where are you from? And like a bit of, you know, trying to put people in boxes, but generally I think it's not as big of an issue, people accept that you can be, I don't know, Asian and British or, you know from any country. I feel like I don't have to constantly prove my right to exist in this country as much as I did in Denmark. And to me, I think that comes [from] the fact that there's so many different people from so many different places*."

"*I get quite a lot of my healthcare done back home. So I go, you know, see a dentist, do my glasses there because it's cheaper, but also because I have more trust and I go to the same dentist, like, I went to as a child, and I don't like it's very difficult for me to know which dentist to trust even if I were able to pay for it here. I go back. I interact with those doctors differently. I can demand what, you know – how [a] GP sometimes would go in and you have to tell them what you want and you have to demand it. And you have to be like, no, I want this service, and I'm way more assertive and confident in doing that in my own country than I would be here*."

2021 saw the greatest number of migrant GP registrations in Birmingham

Figure 46: GP registrations of migrants in Birmingham by year and sex[67]

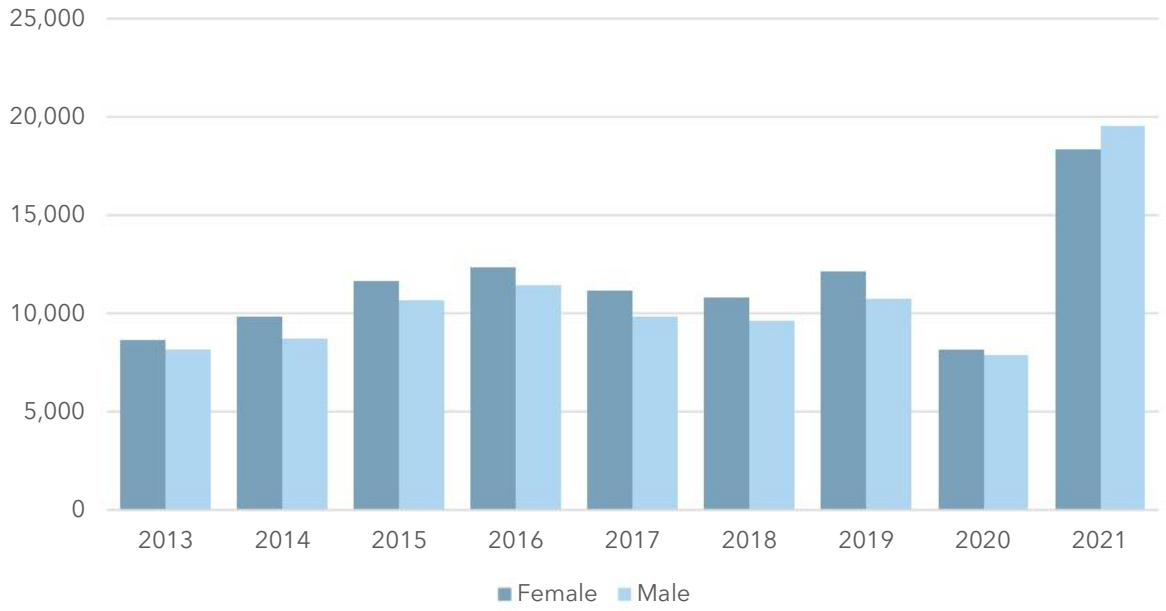


Figure 46 shows the data that GP registrations for migrants are increasing and vary year to year between genders. The greatest number of migrant GP registrations was seen in 2021 (female: 18,317 and male: 19,534). We can assume the low figures in 2020 could be a result of a lack of movement between countries in 2020 due to the COVID-19 pandemic. The increase in registration in 2021 may have been associated with the recovery from the pandemic and the NHS vaccination rollout programme as GP registration is one of the most effective ways of enabling access to the COVID-19 vaccine.

Vulnerable migrants are susceptible to multiple barriers to access to healthcare with impacts on short and long-term health outcomes.[68] The evidence defined main barriers to 'vulnerable migrants' receiving good quality primary care are language and administration barriers.[68] Themes included access to primary care, mental health, use of interpreters, post-migration stressors and cultural competency.[68]

""I'm on regular medication, so I was so lucky recently because I have my annual asthma check, and it's a hard chance to get an appointment with my GP. It's like a fortress."

Lena, 44, Female, Aston

Vulnerable migrants perceived high levels of discrimination and reported the value of a respectful attitude from health professionals.[68] Those without documents were perceived as burdensome, and/or moral judgements were made about their deservedness for resources.[69] Lower proficiency in English makes it difficult for people to access suitable healthcare, which may have a longer-term impact on health.[70] There was also a more rapid decline in good health by age among people who were less proficient in English.[70]

Due focus on 'the language problem' has meant little attention is paid to diversity within and between migrant populations.[71] It has been highlighted through the evidence migrants are less likely to use the National Health Service (NHS) than the general UK population.[64] This is partly because people who move to the UK tend to be young and healthy. General practice has played a key role in efforts to tackle health inequities among migrant populations but they are still a marginalised group who experience barriers to access services.[72] Migrants including refugees, asylum seekers, and undocumented migrants may experience health inequities due to social exclusion, discrimination, language barriers, and, for some, restricted entitlement to health care due to their immigration status.[72]

What might this look like in 2031?

It is difficult to predict migration demographic trends as the likelihood of migrants coming to, and staying in, the UK varies over time in response to national and international policy and events, for example post-Brexit restrictions on EU migration and the Ukraine war. That said, from the Census 2021, if Birmingham demographic trends continue, we would expect the migrant population to continue to be a substantial proportion of the population, with a relatively young age profile.

"I can see great people living in Birmingham, they're very helpful. I moved to Birmingham, I met a lot of people who were from different charities and they're always helpful, they're trying to help. They understand your situation, that you are a migrant. You have some difficulties. So, they're trying their best to help you."

Lena, 44, Female, Aston

System Reflections

Arten Llazari (Chief Executive of the Refugee and Migrant Centre)

In 2021, 27% of the Birmingham population were born in a foreign country, 0.15% of the Birmingham population are asylum seekers.[73,74] Migrants are less likely to use the NHS, and to be less of a financial burden on the NHS, than the UK born population (though interestingly, they are more likely than the overall UK population to work in the NHS [64]).

By far the most needed support which impacts on the health and wellbeing of the 14,000 new arrivals attending RMC's services each year, is immigration advice. Once this is addressed, holistic support around all the other wider determinants of health becomes a priority, including improving, stabilising and protecting physical and mental health and wellbeing.

Health literacy: 'the ability, skill and capacity to communicate, process and understand basic health information and make appropriate healthcare decisions'[75] is closely linked to happiness and therefore wellbeing.[76]

New arrivals continually express their need for such education, information and awareness raising around NHS provision. They don't know what is 'normal' in the UK. This training needs to be combined with support for those lacking confidence and those for whom language is a barrier. Equally, new arrivals request that health professionals are trained in: diversity and

equity, active listening skills and cultural humility, and that primary care access is improved. There is good evidence[77] that if all of these measures are in place, the current high need for mental health support will be reduced and physical health will improve.

Housing

Data Headlines

- Overcrowding is higher amongst ethnic minority groups, in central and eastern wards and for young people.
- 31.5% of households in Birmingham are 1 person per households. Over half of people aged 85 years and above live alone.
- The biggest increase since 2011 has been in private rented tenure (from 17.9 to 22.6%) and is now similar to the proportion living in socially rented housing (23.5%).

Implications for Health and Wellbeing

- Housing is one of the key determinants of health. In the extreme, homelessness severely impacts health and wellbeing.
- Overcrowding can have negative effects on both physical and mental health and wellbeing, and is associated with increased risk of infectious diseases such as COVID-19.
- Living alone can be associated with unfavourable health outcomes such as anxiety, depression, and physical health conditions.
- Owning a house can improve mental health, as this can provide a sense of emotional security: mental distress is more common in renters than homeowners.

What does the data tell us about housing in Birmingham?

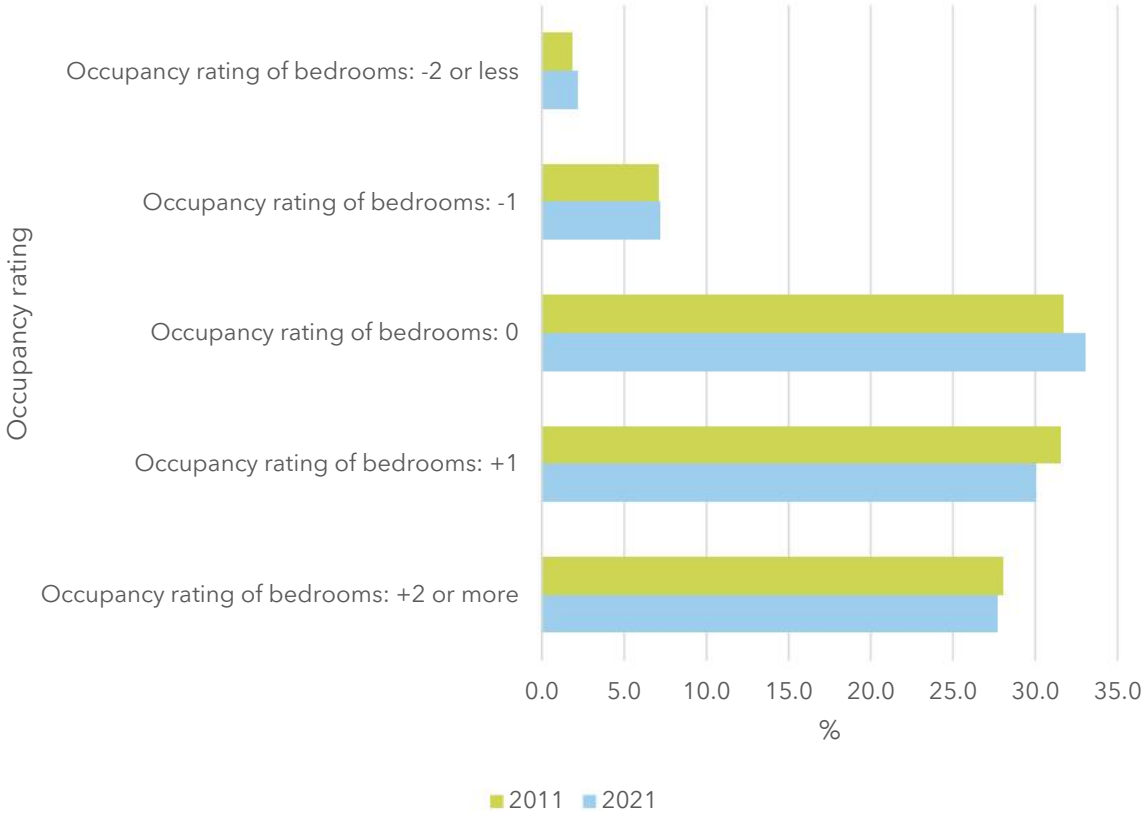
Housing is a key determinant of health across the life course. Good quality housing can save more lives, improve quality of life, reduce disease burden and reduce poverty whilst also assisting in combating climate change[78]. Poor quality housing or a lack of housing can produce negative short and long-term effects on both the physical and mental health and wellbeing of its inhabitants[79]. As a determinant of health, housing has the potential to improve or sustain health inequalities.

There are 423,456 households in Birmingham, nearly one-third of which are one-person households, and over half of people aged 85 years and above live alone. The percentage of Birmingham households who own their homes outright or with a loan or mortgage decreased from 55.2% in 2011 to 52.7% in 2021 and there was a 4.7 percentage point increase in private renting in this time (from 17.9% to 22.6%). Whilst most households (over 90%) in Birmingham have sufficient bedrooms for their size, overcrowding is common in central and east areas of the city and is higher amongst Asian, Asian British or Asian Welsh ethnic group.

* Percentage points describe the difference between percentages.[19] Percentage point change is used in this chapter to show the difference between the 2011 and 2021 percentages.

Overcrowding is disproportionately affecting households in the central and east areas, and those from Asian/Asian British, Black/Black British and Other ethnic groups

Figure 47: Occupancy rating for bedrooms in Birmingham in 2011 and 2021 (2021) [1]



There are two measures of occupancy ratings in the Census: the occupancy rating for rooms and the occupancy rating for bedrooms. Each measure considers whether the number of bedrooms is adequate in respect of the household structure (e.g. one bedroom would be considered appropriate for a married/co-habiting couple but not for a single parent with a child) and the rooms rating also requires a minimum of two common rooms, in addition to the bedroom requirement. For both ratings, the value is then used to describe the occupancy level for the household: -1 or less implies there are fewer rooms than required (overcrowded); +1 or more implies there are more rooms than required (under-occupied); and 0 suggests there is an ideal number of rooms. Due to the differences between census methods, comparison between 2011 and 2021 can only be made for the occupancy rating for bedrooms.

Comparing the census year 2011 with 2021, there has been a small increase in proportion of households with over-occupancy (0.5%) and ideal occupancy (1.3%) in Birmingham overall. However, as shown in Figure 48, there are large differences across the city, from 43.8% of households considered overcrowded in Alum Rock compared to 2.5% in Sutton Wylde Green. There are also difference by ethnicity and age-group. Under-occupancy and ideal occupancy by bedroom rating are more prevalent among the White ethnic group, while over-occupancy is more prevalent among the Asian, Asian British or Asian Welsh ethnic group, Other ethnic group, Black, Black British, Black Welsh, and Caribbean or African (Figure 49).

Over-occupancy also much more commonly affects children and young people, with over a quarter of under 25-year-olds living in a household with over-occupancy by the bedroom rating. Whilst, under-occupancy of bedrooms was commonly seen among the older age groups, especially aged 65 years and above (Figure 50).

Figure 48: Ward map of Birmingham displaying wards with the most over-occupied households (2021) [1]

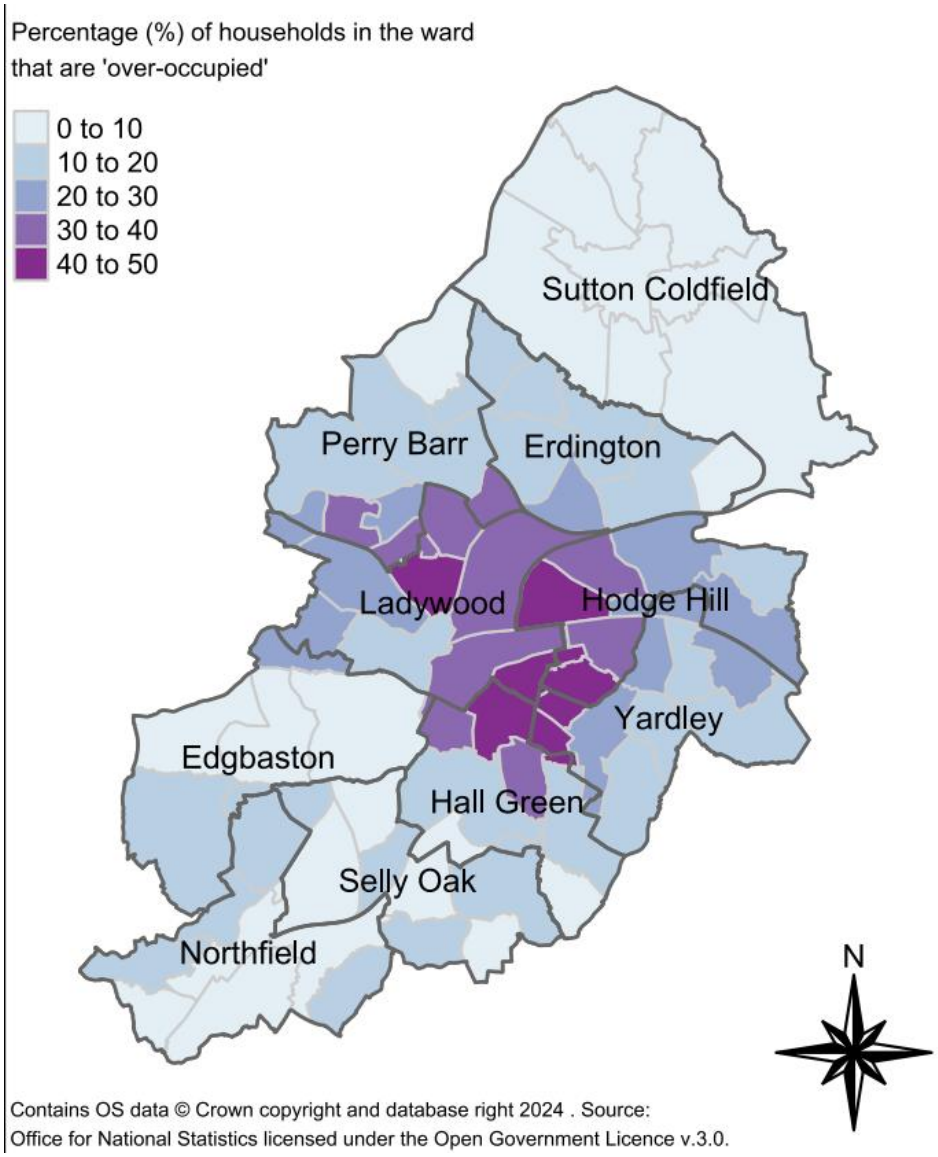


Figure 49: Occupancy rating of bedrooms by ethnic group in Birmingham (2021)[1]

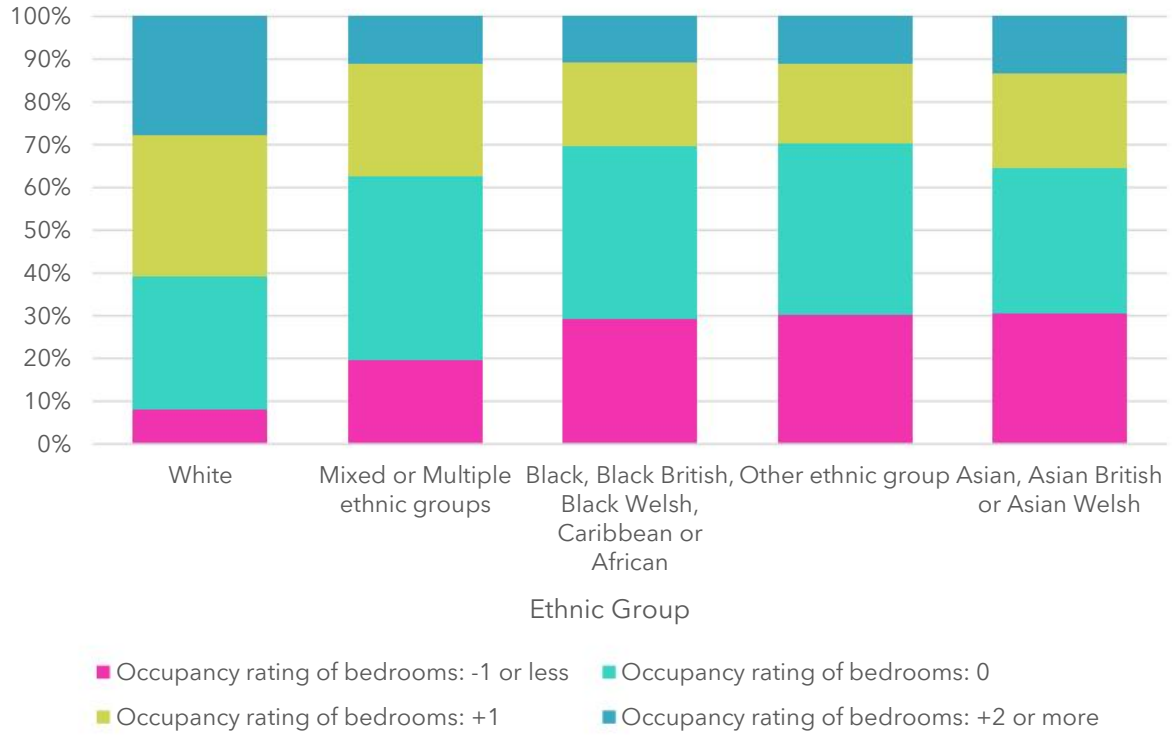
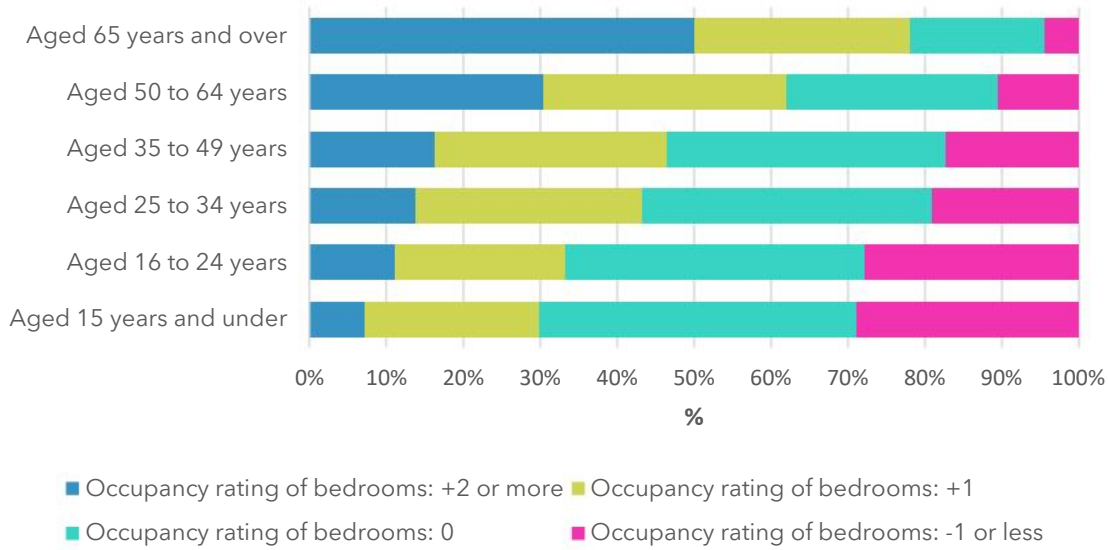


Figure 50: Occupancy rating of bedrooms by age group in Birmingham (2021))[1]



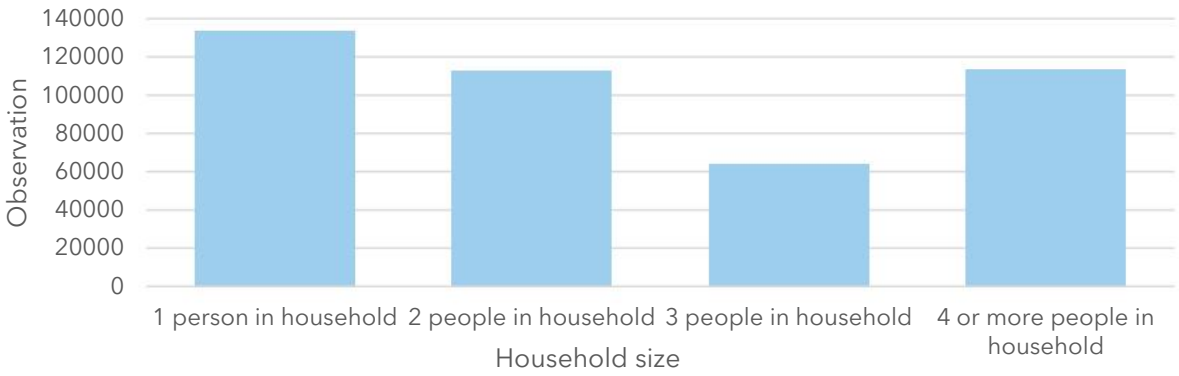
Overcrowded accommodation can have negative impacts on both physical and mental health and wellbeing. Chronic respiratory conditions, poor psychological conditions, and easy spread of bacterial and viral infections are some of the negative health effects associated with overcrowded accommodations. Living in a crowded accommodation has been shown to be associated with psychological stress among women between the ages of 25–45 in London, while living in temporary accommodation has been demonstrated to cause behavioural problems among children[80]. Overcrowding has been described as a risk factor for hospital admission with acute respiratory infection[81], and there is increasing evidence on the association between COVID-19 and overcrowding[82].

"There's loads of people living in sort of like one house and things like that, and a lot of overcrowding. Obviously, that could affect people's health because disease and illnesses and things will travel a lot quicker. I just think we'll see more sort of overcrowding. I think Birmingham is becoming quite overcrowded now."

Jack, 26, Male, Sutton Wylde Green.

1 in 3 households in Birmingham are one-person households

Figure 51: Household size in Birmingham (2021)[1]



Household size refers to the number of people usually resident in the household. The total number of households in Birmingham in 2021, was 423,456 an increase of 12,719 from 2011. Most people in Birmingham live in a household with other people, but approximately 1 in 3 people (31.5%) live in a one-person household (the number of single-person households has increased since 2011, however, there is reduction in percentage point by 0.4 due to increase in population) (Figure 51). However, this pattern changes during the life-course, with very few under 25 year olds living alone, then approximately 10% of each age-group from 25 years up to 45 years living alone, followed by a steady rise in the proportion from about 12% in 45-49 year olds to over 50% of those 85 years and over (100,662 over 85 year olds living alone) (Figure 52).

Figure 52: Household size by age group (2021)[1]

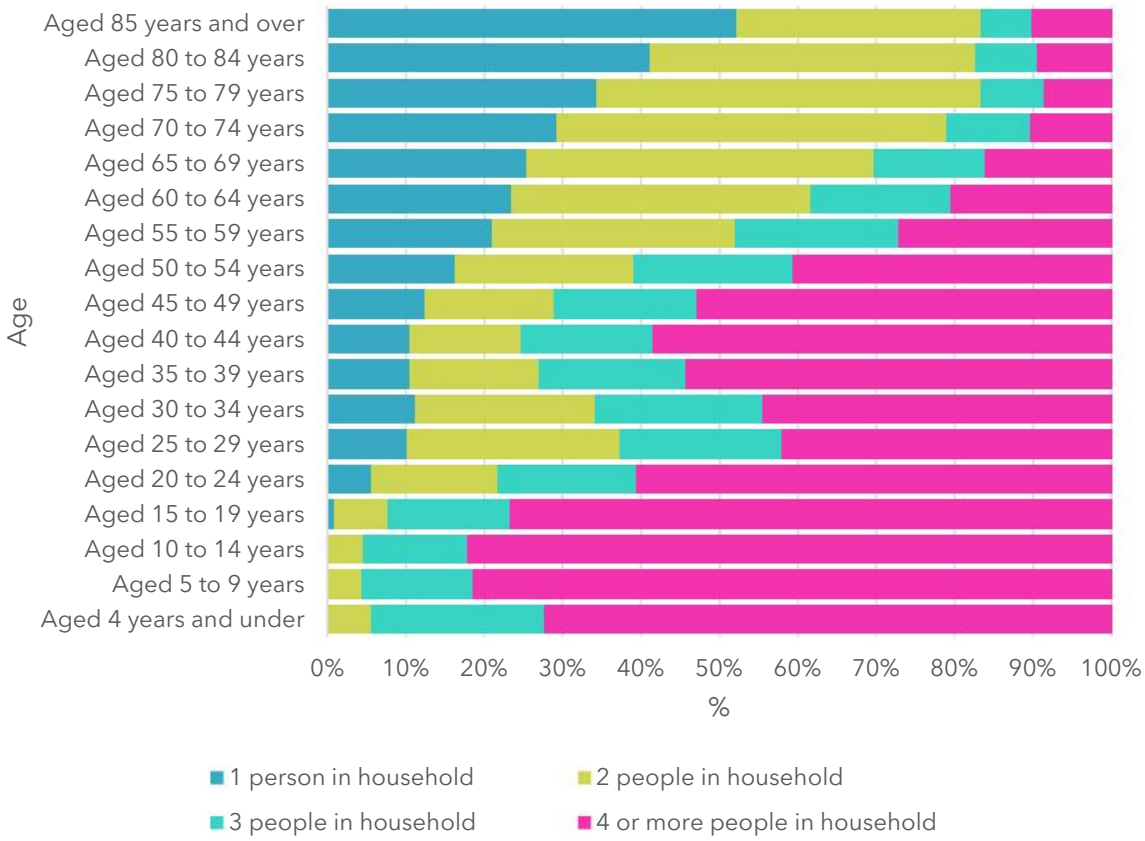
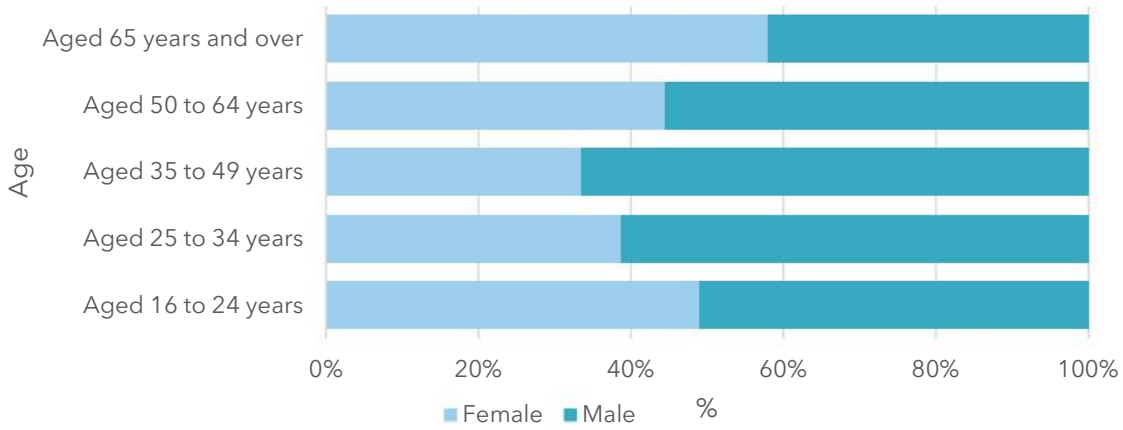


Figure 53: Percentage of single person households by age group and sex (2021)[1]

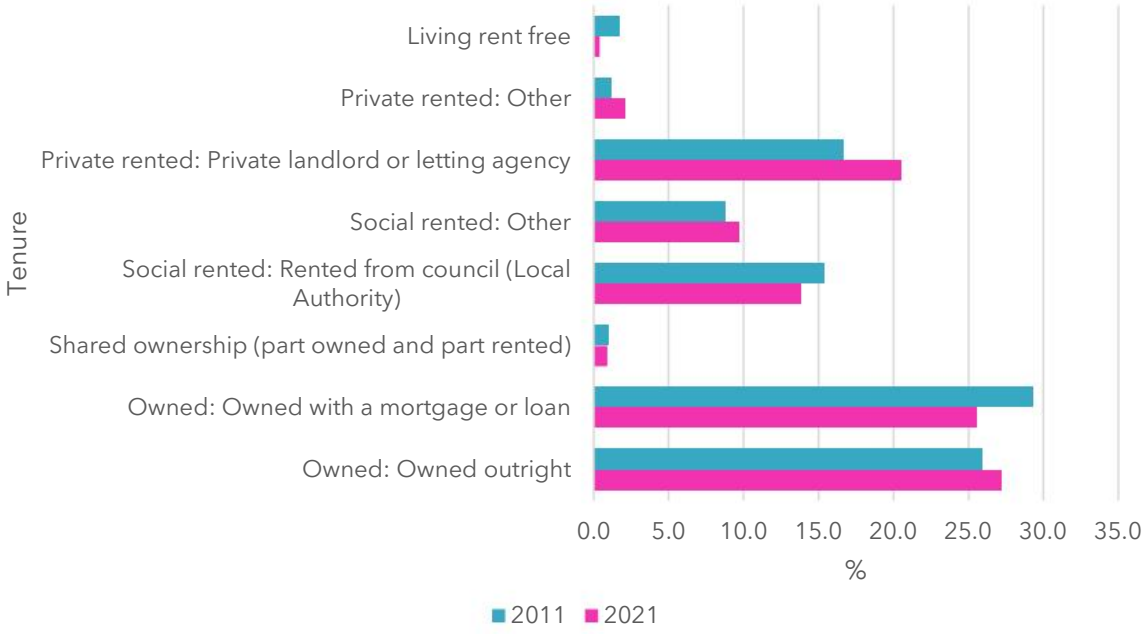


Loneliness can impact older adults and their health and wellbeing, and living alone has been associated with 32% increased likelihood for early mortality.[83] Living alone can lead to social isolation, which can be associated with unfavourable health outcomes such as anxiety, depression, and other mental health outcomes. The absence of social support in households can make coping with emotional stressors challenging for an individual that lives alone. In addition, in an emergency that involves older people who live alone, having access to immediate health support may be challenging. Older people who live alone have increased risk of hospital admissions from fall and respiratory disease.[84] This population

group are susceptible to slips, trips, and falls, and adverse health outcomes, and living alone could reduce their quality of life.

Over half the homes in Birmingham are owned outright or with a mortgage but private renting has seen the greatest increase since 2011.

Figure 54: Tenure of households in 2011 and 2021 (2021)[1]

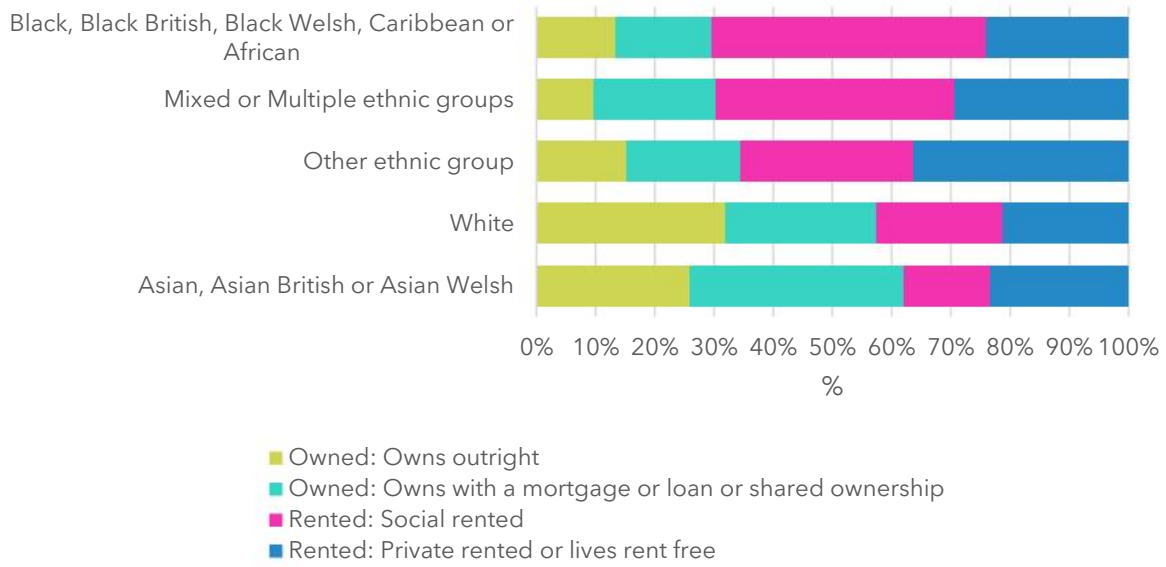


Tenure describes whether a household owns or rents the accommodation that it occupies. Accommodation options involve ownership, whether through full ownership, a mortgage or loan arrangement, or partial ownership through a shared ownership scheme and renting, either through a private rental arrangement, or through social rental scheme provided by a local council or housing association.

There was an increase of 1.2 percentage point for households that were owned outright in Birmingham between 2011 and 2021 census, however, there was a decrease of 3.7 percentage points for households own with mortgage or loan (Figure 54). Homes that were owned outright were commonly seen among White ethnic group (which also has an older age-profile), while homes that were owned with a mortgage or loan or shared ownership were common among the Asian, Asian British or Asian Welsh population. Social rented accommodation was prevalent among the Black, Black British, Black Welsh, Caribbean or African community, while private rented or lives rent free accommodation were more common among other ethnic group (

Figure 55).

Figure 55: Tenure of households by ethnic group (2021)[1]



Research in the UK has shown that type of housing tenure (owns outright, or owns with a mortgage or loan, or through social or private renting) is associated with morbidity and mortality[85]. In a study where renters were compared to homeowners using twelve indicators (from sleep loss to impeded social life), it was found that renters exhibit more mental distress on all the indicators than homeowners[86]. For example, the percentage of homeowners who reported they had been losing sleep was 2% compared to 6% of renters who reported that they had been losing sleep.[86] According to a UK study by the National Child Development, children at age 7 and 23 living in homes that were owned outright had better health than those living in social rented accommodation, based on the following health metrics: height, `malaise', self-reported health, hospital admissions and psychiatric morbidity[85]. The conditions of the homes and the tenure both have effect on mental health because homeownership can essentially provide a sense of emotional security for homeowners, and this is beneficial for mental health[87].

Although, homelessness cannot be measured through the Census, inability to secure or continue to afford housing as result of financial constraints can ultimately lead to

homelessness which has deleterious effects on health and wellbeing. Even without such significant event, higher mortgage and rental costs relative to income may result in economic stress, which may impede the ability of households to afford healthy living conditions and healthy lifestyles, as well as putting the household under stress[88].

"I would say that there's more people renting now than has bought a house or can afford to buy a house".

Yvonne, Female, 32, Handsworth.

Case Study: Liam

Ward:	Moseley	**Sexual Orientation:**	Gay
Age:	36	**Gender & Gender Identity:**	Male
Ethnicity:	White British	**Occupation:**	Primary school teacher
Faith:	Other religion	**Living Arrangements:**	Rents from private landlord

Liam has lived in Birmingham for 11 years and is currently trying to save up to buy his own house in the city. Liam explains that many of his friends and colleagues in Birmingham rent instead of buying homes due to high housing prices. He finds it frustrating to be continually saving while the cost of housing keeps increasing, and also while competing against property investors.

"I think within Birmingham in particular, I think there's a lot of people selling properties that are selling them to investors. It's not so helpful for people that are not on the property ladder because you're competing against people that are buying a chain of properties purely for profit reasons…"

He has noticed the population fluctuating in size within his school, which has seen an increase in refugees from Ukraine and Hong Kong. He thinks Birmingham is diverse in terms of ethnicity, which he sees as hugely positive, believing it enriches the city. Liam thinks there has been an increase in the number of residents identifying as LGBTQ+, particularly among younger people. He doesn't believe this is specific to Birmingham, but instead reflects an overall increased awareness in the UK and the Western world more widely. However, he also knows people in the LGBTQ+ community who choose not to report their sexual and gender identity in the public census, as they are pessimistic about the future and fear discrimination based on how they identify.

Liam feels like he has good physical and mental health. However, he acknowledged that many people are struggling – and were particularly during Covid-19, when there were limited opportunities to exercise and socialise. He explained that the cost-of-living crisis is having an impact on people's mental health across the city. He feels that increasing rents and mortgage rates can negatively impact their wellbeing.

"Obviously rent is increasing and obviously the cost of lots of other things are increasing as well. So, it's just the strain potentially of balancing those demands and kind of budgeting around it. But it's something I'm managing with at the moment."

He thinks that for some people being economically inactive would also negatively impact their mental health as it might affect their self-worth. However, he also noted that flexibility around work has positively impacted some people's lives, as they are able to create a better work-life balance, are able to exercise and see more of their friends and family. Liam is concerned about elderly people who live by themselves, as he thinks that isolation can negatively impact mental health.

[Discussing elderly people living on their own] "I think it can be quite lonely. My grandma is still alive, but she used to live alone and she found it a really lonely experience. And in terms of her mental health, I think she really struggled."

Liam feels pessimistic about housing and thinks that the current situation is disheartening – he believes that for many people, no matter how much they save, housing prices continue to rise and remain out of reach. He is concerned about whether public services will be able to keep up with the increasing population, especially the NHS and schools.

"The main thing is private renting, you're putting money aside each month, but you're not actually gaining anything from it. I think the longer you're in that situation, the more frustrating it's going to be, particularly if you're saving for a house, a housing deposit and the interest rates and things like that continue to rise, you're almost chasing a never-ending goal."

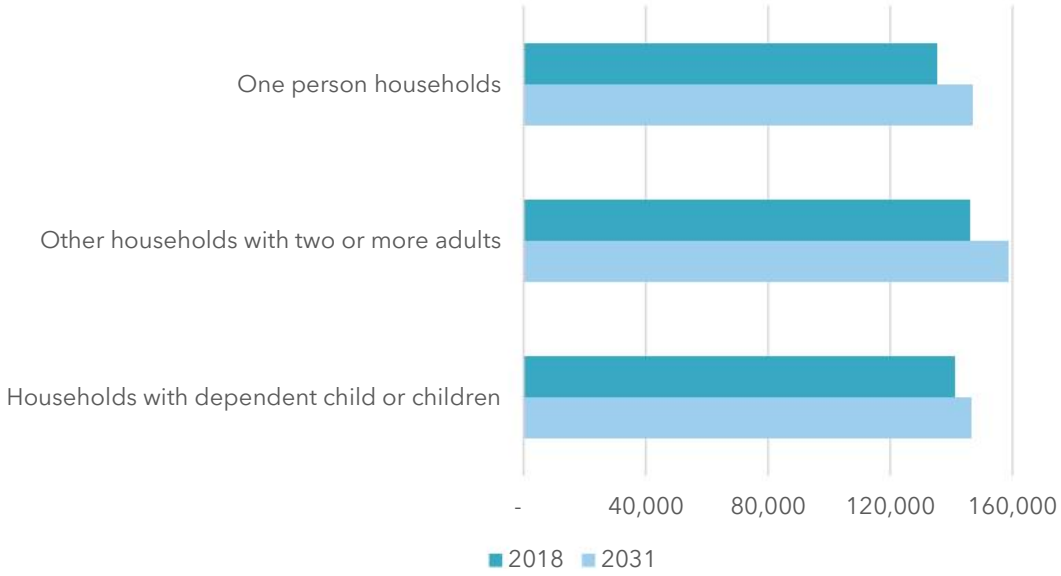
What might this look like in 2031?

The total population and number of households in Birmingham have grown in the previous 10 years and are predicted to continue to grow, whilst the cost of somewhere to live (rent, mortgage and property costs) have all increased. The pressure on families and households in terms of accommodation costs are therefore considerable, and national and international economic conditions do not suggest that costs will be significantly eased in the short term.

Health and wellbeing can be impacted by tenure (which is linked to security of housing, costs and standard of accommodation), overcrowding and single-person households (linked to loneliness). Whilst there are many factors at play, each of these could reasonably be expected to increase in impact over the next 10 years for the most affected in Birmingham.

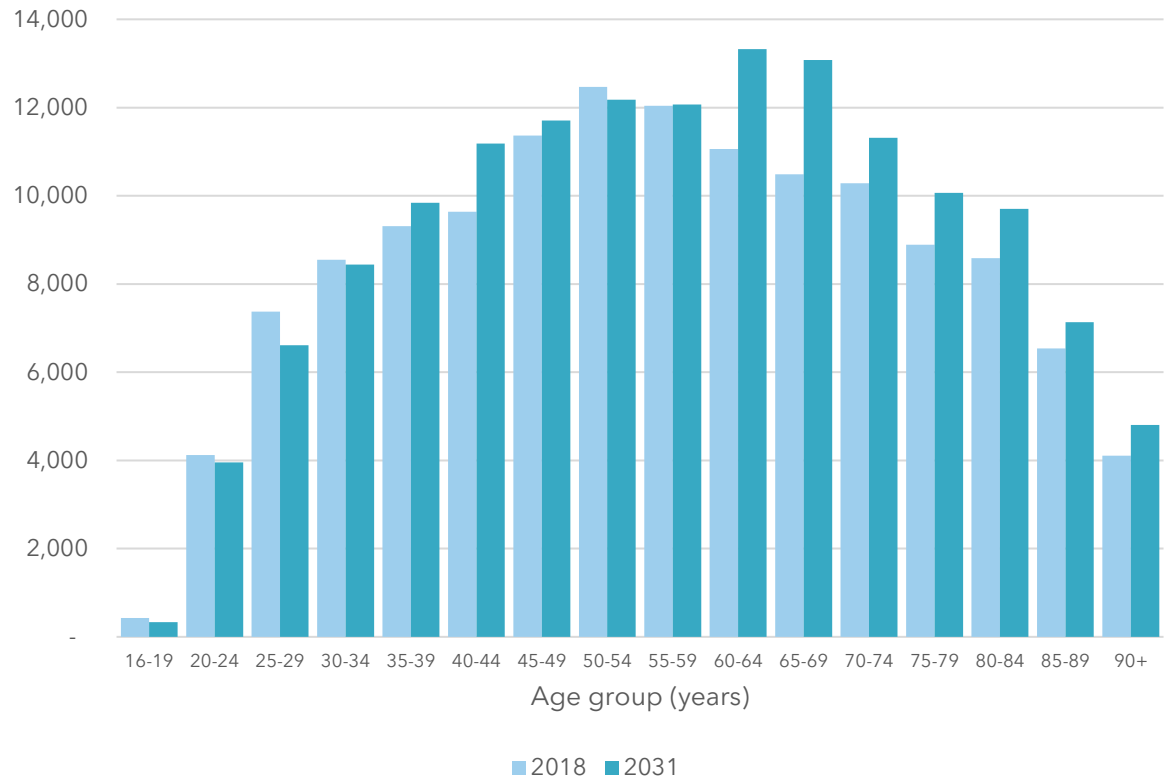
Demographic change is driving trends in the make-up of households. According to ONS, most of the projected household growth will come from one-person and multiple adult households without dependent children (referred to as "other households with two or more adults") (Figure 56). Between 2018 and 2031, the number of households with dependent children is projected to increase by approximately 5,500 (3.8%). One-person households are projected to increase by approximately 12,500 (8.7%). Similarly, the number of other households with two or more adults (without dependent children) is expected to increase by 11,500 (8.6%).

Figure 56. Projected change in the number of households by household type in Birmingham between 2018 and 2031



The predicted growth in the number of one-person households and other households with two or more adults is driven by increases at older ages (Figure 57). The largest projected growth for one-person households in the 13 years to 2031 (from 2018) is where the household reference person (HRP)* is aged between 65-69, which increased by 20% (from approximately 10,500 households to 13,000 households).

Figure 57: Projected change in the number of one-person households and age of household reference person (HRP) between 2018 and 2031



Homelessness has a terrible impact on health and wellbeing, with homeless people dying 30 years earlier than general population[89]. Although, homelessness and housing insecurity were not captured in the Census, these are important areas we cannot ignore when talking about housing. Some of the factors that could lead to homelessness include poverty, high accommodation costs, low income, housing shortage, poor health or disability, unemployment, and domestic abuse. According to homeless link, the two main reasons people cited as the cause of their homelessness were family and friends were unable to accommodate them, and the end of a private rented Assured Shorthold Tenancy[90]. Thus, over-crowding and increasing private rentals are a risk to homelessness in Birmingham.

Based on the recent census data (2021) and contrasting it with data from the 2011 census, it is evident that there has been an increase in the proportion in privately rented accommodation. If the trends persist in Birmingham, it is likely that people may shift from owning houses to renting houses. This may put people at risk of becoming homeless. Also, if the changes continue in similar directions in Birmingham, it may widen the health inequality gap as a result of the unfavourable health outcomes associated with overcrowding and solitary living (social isolation).

System Reflections

Paul Langford (Strategic Director of City Housing, Birmingham City Council)

This report highlights that 9.4% or 39,804 of the 423,456 households in Birmingham are overcrowded whilst 57.7% of households under occupy accommodation. White households are much less likely to live in overcrowded conditions. Approximately 30% of Black, Asian and other ethnic groups are overcrowded, this is true for less than 10% of white households. Another issue identified through this report is the high prevalence of black and mixed ethnic minority groups who are dependent on social housing. In the households we see becoming homeless, some communities are significantly over-represented. Through our new homeless prevention strategy and other city wide strategies such as Everyone's Battle Everyone's Business we have demonstrated a commitment to working with partners to reduce racial and housing inequality to improve life chances and outcomes for all Birmingham residents.

The reason as to why greater numbers of white ethnic groups under occupy accommodation might be explained by the fact that trends in ethnic make-up in Birmingham differ hugely by age group. More than 80% of households aged 70+ in Birmingham consist of two or less people and more than 50% of those aged 85 and over live alone which indicates a good proportion may be socially isolated and at greater risk of serious harm due to slips and falls. Older people are also more likely to own their property outright as a result of paying off their mortgages meaning that a significant proportion of family sized accommodation is unavailable for use by larger households. This suggests a need for more attractive and affordable retirement and older peoples supported accommodation as a means of freeing up larger properties for those that truly need the space.

Overcrowding and under occupancy places significant strain on statutory homelessness services and social housing. 14,810 households are currently on the Council's Housing Register as a result of being overcrowded and in the last financial year 1,253 households were accepted as homeless by Birmingham City Council because friends and family were unwilling to accommodate them. The majority of those made homeless were single female parents who would also be owed a temporary accommodation duty. Owing to current socio-economic conditions, a lack of suitable affordable housing, and the cost of living crisis, such households are likely to struggle to find an affordable accommodation solution in Birmingham and therefore are likely to become long term statutorily homeless dependent upon temporary accommodation at which point the wider emotional and practical support needs (including mental and physical health) of all household members are likely to increase.

Our Housing Strategy 2023-2028 aims to increase the supply of affordable housing in Birmingham and some significant achievements have been made, particularly in relation to encouraging third party development across the city but the fruits of this labour are unlikely to have an immediate impact on overall numbers. Therefore it is important that we seek widen the geographical scope of suitable and affordable accommodation offers in discharge of homelessness duties for those households who might wish to resettle out of area with support.

Jean Templeton (Chief Executive, St Basil's)

There are significant pressures on housing supply, affordability, quality and accessibility as a result of a number of factors cumulative over many years. Lack of investment in social housing, freezing of local housing allowance by national government, significant reduction in funding for supported housing, and rising poverty have led to increased levels of homelessness for families and single people with many more living in temporary, insecure accommodation. This disproportionately affects some people and communities more than others.

Rent levels in the private rented sector have increased significantly, whilst assistance with housing costs have not. Zoopla data for September 2022 shows that those requiring assistance through local Housing Allowance are only able to access some 5% of private rented accommodation in the city. Some private landlords, unable to let at Local Housing Allowance, have left the sector, some moving into the exempt sector or other types of short-term lets. Sustainable, affordable homes are therefore increasingly difficult to access for many people.

The 2023 Destitution in the UK study by Joseph Rowntree Foundation reveals approximately 3.8million people experienced destitution in 2022 including around 1 million children. This is almost two and a half times the number of people in 2017, and nearly triple the number of children.[91]

The health consequences of housing insecurity are significant and require a cross government, long term Housing and Inclusion Strategy and implementation plan. In the meantime, health services need to consider the health needs of those in precarious housing, those who are homeless or at risk and ensure that their services are bespoke, accessible, inclusive and psychologically informed.

Homelessness is the ultimate exclusion and is therefore everybody's business. Good health, a secure, safe and affordable home, sufficient income to live, and people who care about you, are the fundamentals which enable any of us to thrive. Achieving those, requires all of us to play our part.

Employment

Data Headlines

- 42,000 of the working age population are economically inactive due to long term sickness or disability
- Almost 50,000 people are economically active and providing unpaid care, with carers more likely to be older and female.
- Most common method (60%) of travel for journeys less than 5km was by car or van.

Implications for Health and Wellbeing

- With increasing age, the proportion of economically inactive residents reporting long-term sickness or disability as the cause of their inactivity increases up to pre-retirement ages (50-64 years).
- People who are economically inactive primarily because of their health tend to have increasingly complex health needs, the majority with more than one health barrier to them returning to the labour market.
- Pre-pandemic there was a trend of increasing prevalence of poor health, and of poor health as a reason for economic inactivity. Further to the pandemic, economic inactivity for health reasons is likely to be exacerbated by conditions like long COVID and longer waiting lists for treatment, and the impact on the mental wellbeing.
- Evidence shows that working carers can experience a range of difficulties including lack of time, excessive stress and resulting health problems, and financial pressures. Active travel, especially for short, routine journeys, can create a positive health effect for both individuals (more physical activity) and the wider population (improved air quality from less vehicle-based pollution).

What does the data tell us about employment in Birmingham?

Income and employment are key determinants of health and drivers of health inequalities.[92] The greater one's income, the less likelihood of disease and premature death[93] and being in "good work" improves health and wellbeing across the life-course, and protects against social exclusion[93], whilst unemployment is associated with increased risk of ill-health and dying. The Census is a useful tool for understanding employment in Birmingham and associated self-reported health of those working and not working.

The Census asked those aged 16 years and above a series of questions on their employment, including their economic activity status. The ONS defines a person as economically active if they are working (employed) or looking to start work within two weeks (unemployed) and economically inactive if they were not looking for work or couldn't work (e.g. retired, looking after family, student not looking for work).[95] Unemployment is therefore not the same as economic inactivity. The Census also asked about the method that people use to get to work and the distance these journeys take. While impacted by the COVID-19 pandemic, the changes to methods of travelling to work (particularly the increase

in home-working) illustrate the future of work and how health and wellbeing can be better emphasised in good working practices.

The ONS recognise that the Census 2021 data and employment information in particular may have been affected by the unique situation of the COVID-19 pandemic and the measures in place to control the pandemic, including advice against use of public transport and the 'furlough' scheme , which is not easily captured as a work status on the Census.[95] The effects of some changes brought on, or accelerated by, the pandemic have clearly remained, including for example, increased levels of working from home however, others have returned to pre-pandemic levels (e.g. levels of cycling have broadly returned to pre-pandemic levels as conventional traffic has increased on the roads).[94]

42,000 of the working age population are economically inactive due to long term sickness or disability

Figure 58: Economic activity status by age group (2021)[1]

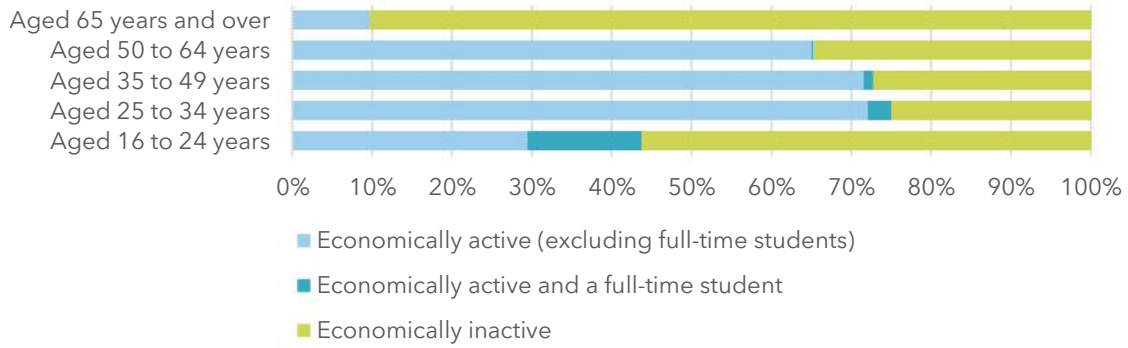


Figure 59: Economic activity status by sex (2021)[1]

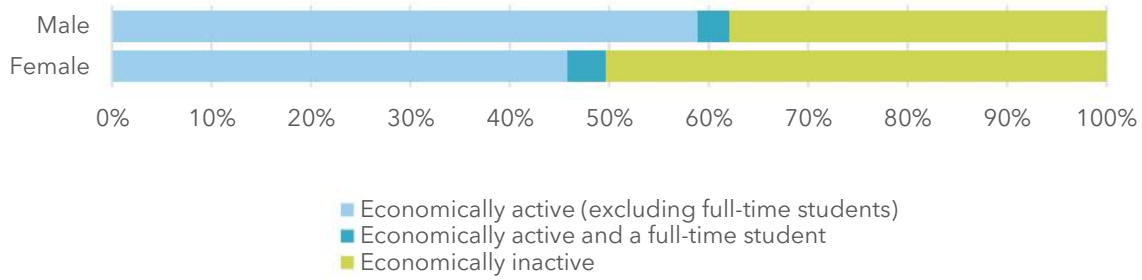
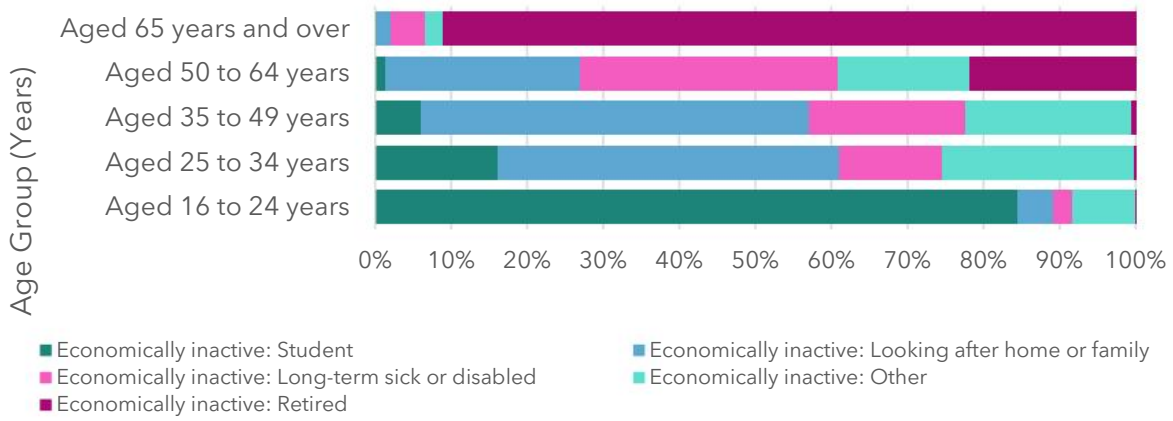


Figure 60: Reasons for economic inactivity by age groups in Birmingham (2021)[1]



Just over half (52.1%; 463,304) of Birmingham residents were economically active (excluding full time students), 44.4% (394,873) were economically inactive and 3.5% (31,316) were economically active full-time students. Figures 57 and 58 show how the economic activity status of the 16+ population breaks down by sex and age group. The division of activity to inactivity follows generally established trends in age group, and overall, a greater proportion of females are economically inactive than males.

The reason for changes to economic inactivity over the life-course are as expected, with the most common reasons being studying for 16–24-year-olds, looking after home or family for 25–50-year-olds, long-term sick/disabled for 50–64-year-olds and retirement for those 65 years and older (Figure 60). The ONS have noted that there may have been more people responding 'Other' than expected due to the working restrictions caused by the COVID-19 pandemic. [95] Overall, 4.7% (42,143) of the working age population (16–64-year-olds) report they are economically inactive due to long term sickness or disability.

Figure 61: Rates of economic inactivity ('Long-term sick or disabled') by age group (2001 to 2021)[1]

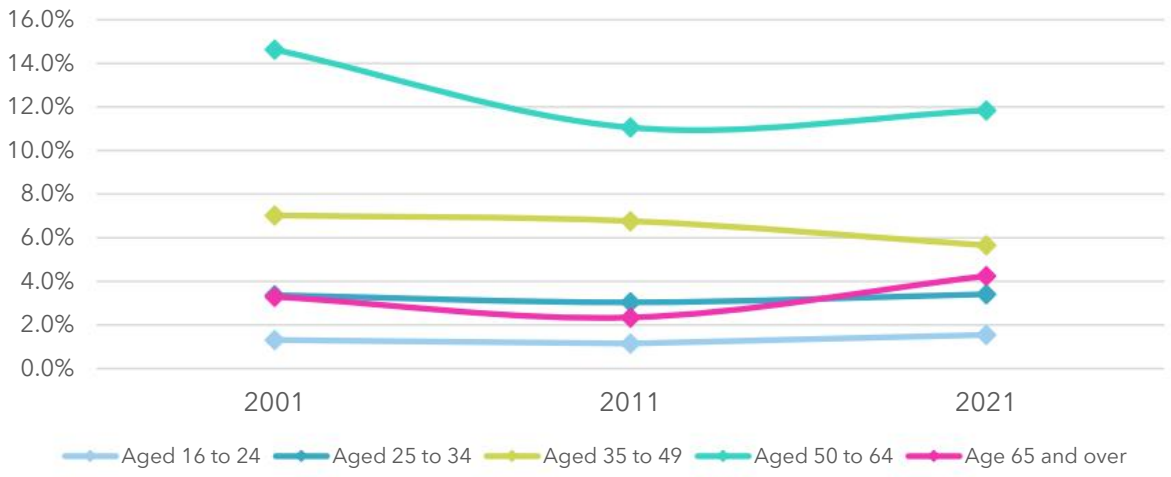
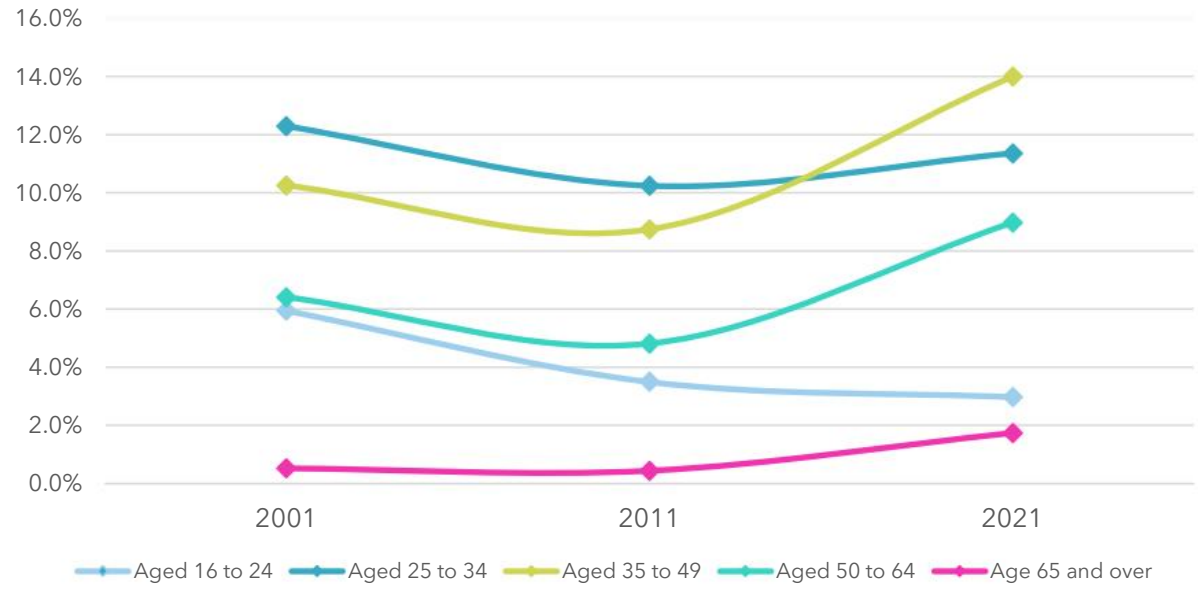


Figure 62: Rates of economic inactivity ('Looking after family or home') by age group (2001 to 2021)[1]



Trends over time for economic inactivity due to sickness or disability and due to looking after family or home, by age group are given in Figures 60 and 61. For the most part, the percentage reporting that they are not working due to sickness or disability remained fairly constant for each age-band between 2011 and 2021, but this was a change from the downward trend seen for 50-64 year olds between 2001 and 2011. Similarly, the downward trend seen across age-groups of economic inactivity due to looking after family or home between 2001 and 2011 was reversed in 2021, with rates increasing particularly in the 35-49- and 50-64-year age-groups.

Figure 63: Rates of economic inactivity ('Long-term sick or disabled') by ethnic group (2001 to 2021)[1]

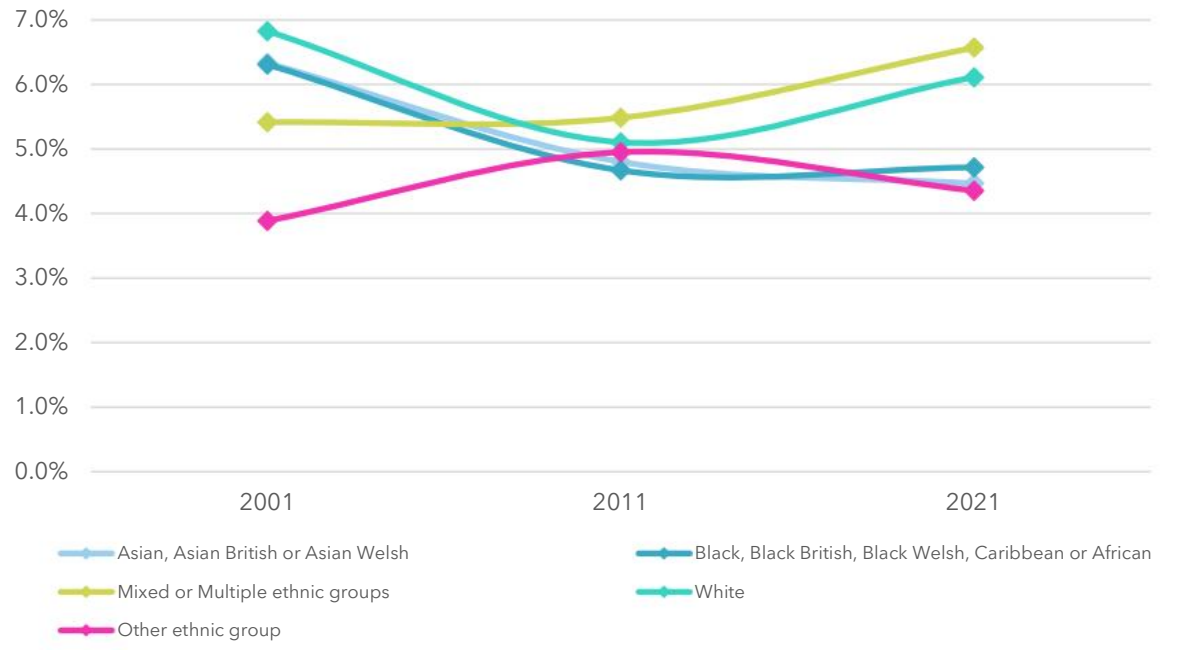
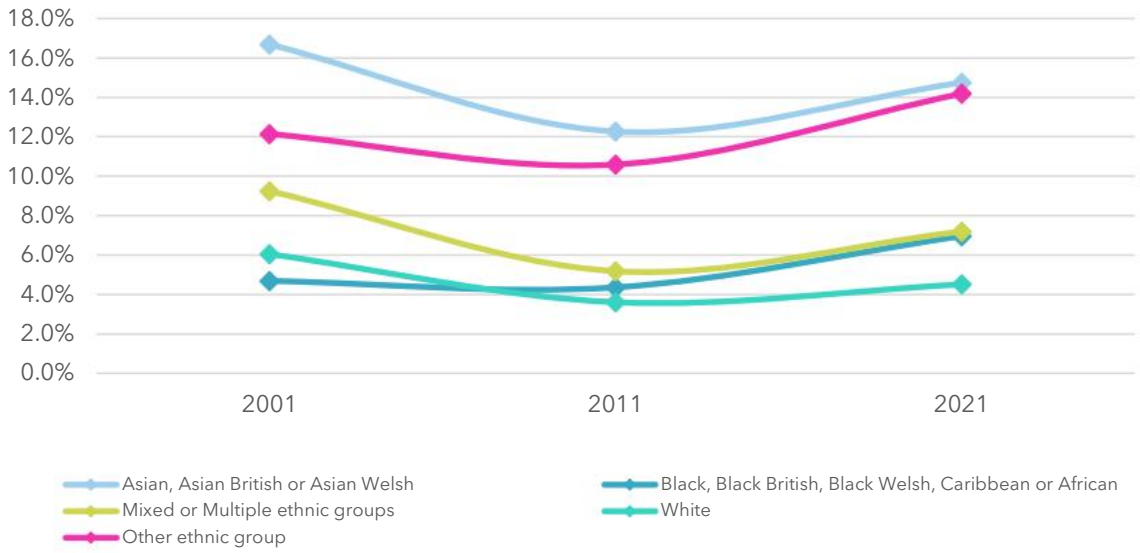


Figure 64: Rates of economic inactivity ('Looking after home or family') by ethnic group (2001 to 2021) [1]



Figures 62 and 63 show a more nuanced picture on economic inactivity, through the lens of ethnic group. Long-term sickness or disability has increased within the 'White' and Mixed or Multiple' ethnic groups while decreasing slightly or remaining roughly the same within the 'Asian/Asian British', 'Black/Black British' and 'Other' ethnic groups. 'Looking after the home or family' has increased in all ethnic groups since 2011 but the increase has been greatest in the 'Asian/Asian British' and 'Other' ethnic groups.

The relationship between health and economic activity works both ways: economic activity can lead to better health and better health leads to economic activity. Lack of good health is a determinant of economic inactivity across different age groups, albeit of greater prevalence in older, pre-retirement age-groups.[96] The likelihood of returning to work is lower at older ages and particularly for those also with poor health.[101] Equally, there are well-documented inequalities in access to work across ethnicity, sexual orientation, gender identity, and sex.[97,98] These in turn can impact upon health and wellbeing as they present a barrier to becoming economically active.

People who are economically inactive primarily because of their health tend to have increasingly complex health needs, the majority with more than one health barrier to them returning to the labour market.[99,100] The Office for National Statistics reported between 2019 and 2023, the number of people inactive because of long-term sickness who reported depression, bad nerves or anxiety rose by 386,000 (40%).[99] Most of this increase was from people reporting it as a secondary health condition (increased 50% over the same period), whereas it only increased by 14% as a main health condition.[99] Moreover, people can have multiple concurrent reasons (sickness, retirement and/or looking after the family or home) for not engaging in the labour market,[101] and they may have a preference to report one or identify more strongly with one as the primary reason for example, preferring to report themselves to be economically inactive due to retirement rather than long terms sickness over the age of 65.[101]

Factors that may have driven the recent rise in people reporting economic inactivity due to poor health include long COVID and long waiting lists for treatment.[99] However, these

contributing factors have been exacerbated by a pre-pandemic trend of increasing prevalence of poor health, and of poor health as a reason for economic inactivity.[102]

> *"I'm 58 now, but for the last 18 years I've been disabled, and I needed a hip replacement over 10 years ago… if they'd repaired that hip 10 years ago, I'd still be a working person today"*
>
> Sally, 58, Female, Edgbaston

Case Study: Caroline

Ward:	Longbridge & West Heath	**Sexual Orientation:**	Straight/Heterosexual
Age:	53	**Gender & Gender Identity:**	Female
Ethnicity:	White British	**Occupation:**	Homemaker
Faith:	No religion	**Living Arrangements:**	Homeowner with a mortgage or loan

Caroline is a 53-year-old mother of several children, who recently lost her husband during the pandemic. She used to work in a school but has been at home for the last few years. She has noticed changes in employment, particularly Covid-related changes and believes that more people are working from home or are enrolled in colleges. She has also noticed that more people are only working 15 hours per week. She felt this was so they do not lose their benefits, as the costs of childcare are so expensive that it negates earnings over that amount. This was the experience of some of the other parents she used to work with.

"When I worked a few years ago, people only work the 15 hours because they didn't want their benefits affected, and for child care… it's just so expensive to get children into childcare, it's not really worth them working full time"

Caroline feels crime has increased in the city, making her concerned for the safety of her children – and making her more wary of letting them leave the house. This is exacerbated by her belief that the number of police on the streets has decreased – she used to find police presence reassuring. Not working also had a negative impact on her mental health and social wellbeing, as it had been a considerable source of human connection for her, particularly amongst people of her own age.

She feels that since she has stopped working her life has become more monotonous, and she is less able to see her friends, who all work full time. She still feels able to go out for exercise and feels positive about the parks and council-run gyms in Kings Heath. Previously, she had been able to attend a local gym for free, though she was not sure if this was still being offered.

"I'll try and walk a lot. I've got dogs and walk a lot, which helps me. I've got loads of nice places in Birmingham that you can go, lots of parks."

Caroline is generally concerned for the future due to the increased cost of living and the impact she expects this to have on crime and homelessness.

"I think suicide's going to go really high. I think the mental state's going to just go high. I think crime is very ridiculous because people can't afford to live."

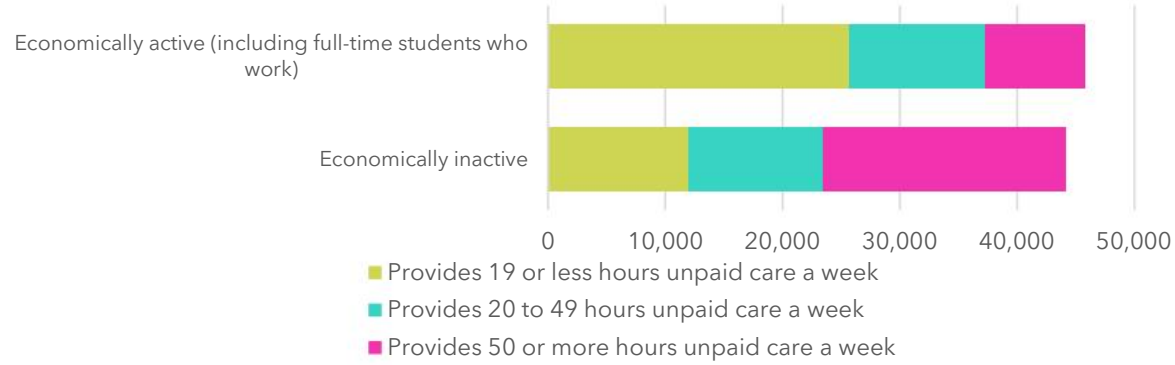
Caroline feels that education on health and wellbeing, in schools and in workplaces, could be improved, as some people are not aware of what resources are available to them. She was also positive about her community and felt they were good at checking in and looking out for each other. She also feels that free activities for children after school would help parents who can't afford after-school clubs for their children

"Just put things in place to educate people more about it. Because a lot of people don't know or don't know that this thing's out there, that they can access… it doesn't have to be school. It could go to the workplace. Just to promote all these things in half an hour, just something like that. Just to tell them what's out there."

"Our community where we are, we're quite good. We spend a lot of time looking out for each other."

Almost 50,000 people are economically active and providing unpaid care

Figure 65: Economic activity status by provision of unpaid care (excluding those who provide no unpaid care) (2021)[1]



Almost 90,000 Birmingham residents provide unpaid care, with approximately 29,000 residents providing more than 50 hours a week. Figure 58 shows the economic activity status of those who provide some form of unpaid care at the time of the Census. It shows that just under 10% of all economically active individuals are providing at least 1 hour of unpaid care a week. Within this, the majority provide between 1 and 19 hours of care a week, although approximately 2% (8,488) of the economically active population in Birmingham are also providing 50 or more hours of care a week.

Figure 66: Provision of unpaid care by sex (excluding those who provide no unpaid care) (2021) [1]

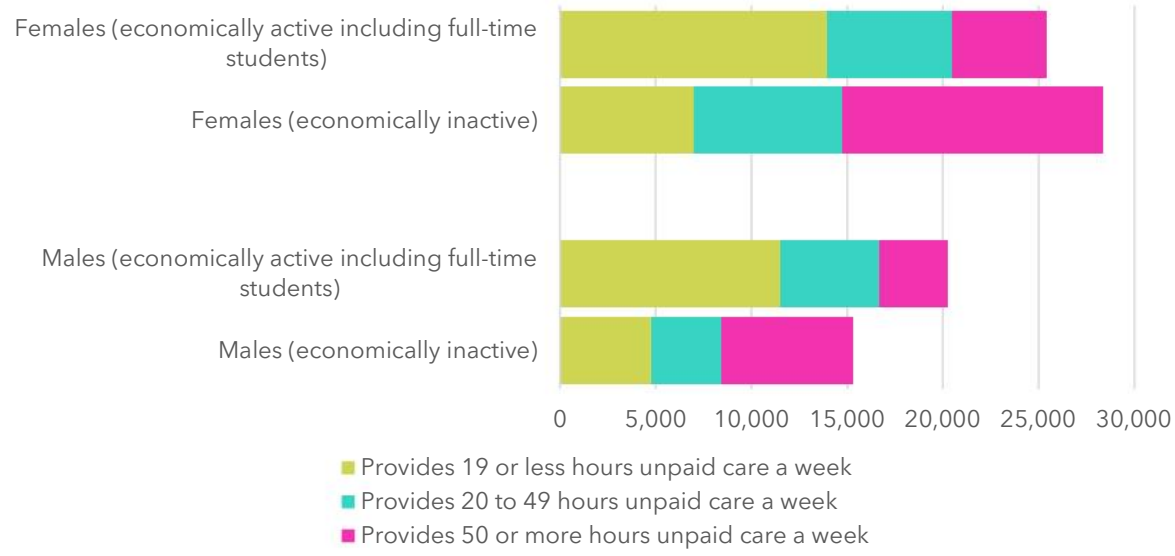
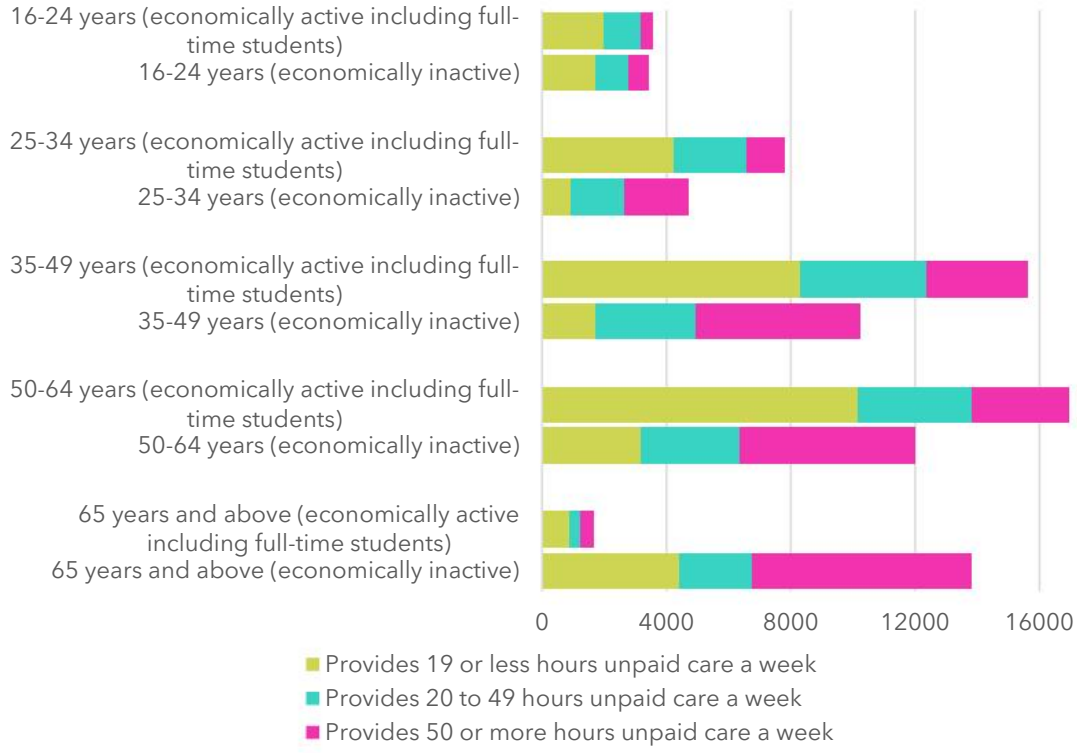


Figure 67: Provision of unpaid care by age group (excluding those who provide no unpaid care) (2021) [1]



Unpaid care was already known to have both a gender and an age gap, and the 2021 census confirms that economically active individuals who provide unpaid care broadly follow this pattern.[103] Figure 65 shows that both economically active and inactive females provide more unpaid care than their male counterparts. Those aged 35 to 49 and 50 to 64 contributed the most unpaid care of those who were economically active and providing care (Figure 66).

A person is a provider of unpaid care if they look after or give help or support to family members, friends, neighbours or others (excluding children aged under 18 years) because of long-term physical or mental ill-health or disability, or problems related to old age.[104] The number of people who combine work and unpaid care is slowly increasing as more people need care, public and private care systems are progressively under pressure and more people are required to work for longer.[105] Without adequate support, these working carers may experience detrimental effects on their well-being.[105] Evidence shows that working carers can experience a range of difficulties including lack of time, excessive stress and resulting health problems, and financial pressures. Health problems might have already existed before they started caring or developed because of chronic physical and emotional exhaustion.[106]

Positive effects of caring include improvements in psychological well-being, personal fulfilment and physical health.[104] However, in general, research shows that providing unpaid care is associated with negative impacts on carers' education, employment, household finances, health and wellbeing, and personal and social relationships.[104] Carers' health, physical and mental, has been shown to have a big impact on their ability to work and care.[106] Unpaid work is an important aspect of economic activity and the well-being of individuals.[104]

Most common method (60%) of travel for journeys less than 5km was by car or van

Figure 68: Method used to travel to work (all distances) (2021)[1]

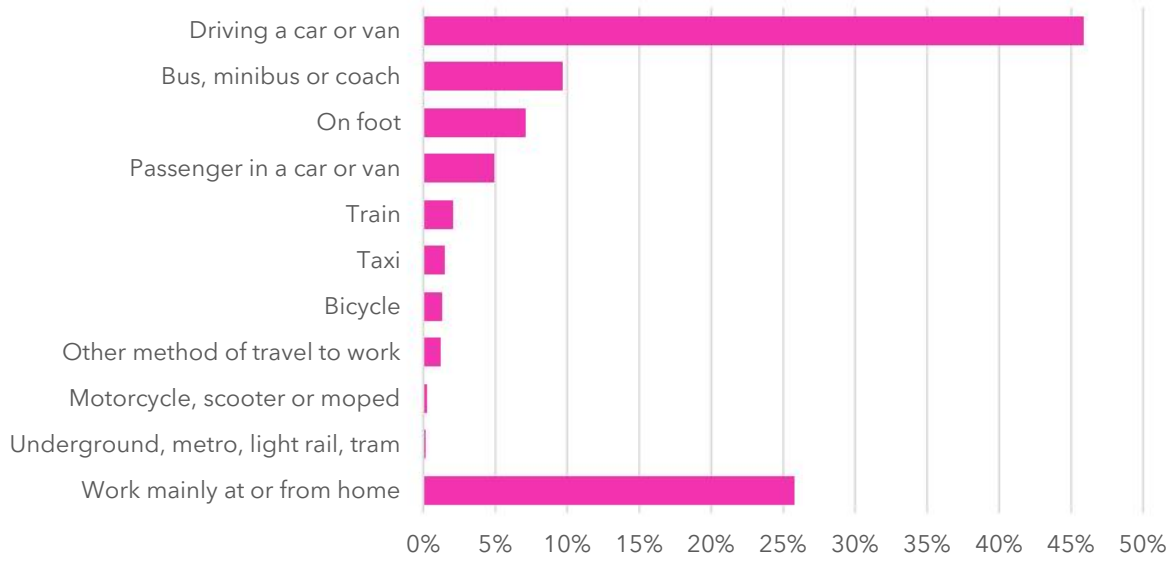
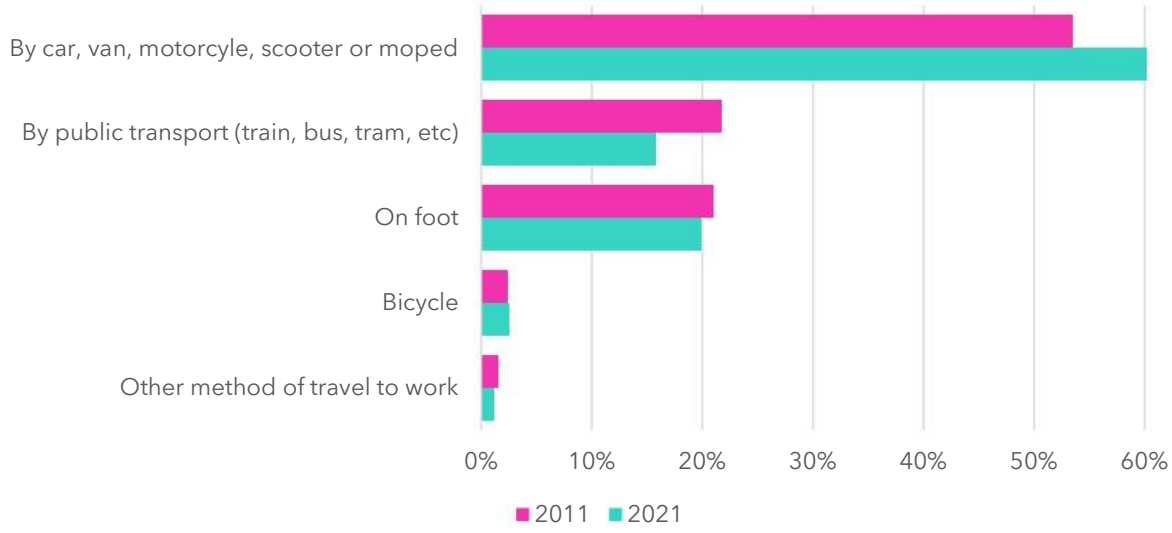


Figure 69: Method used to travel to work by those who travel less than 5km (2011 & 2021) [1]



The COVID-19 pandemic resulted in a large shift in the place of work, with considerable increases in working from home which have continued post-pandemic restrictions.[107] [1]In 2021, 25.8% of people reported working 'mainly at or from home'. The ONS acknowledge this and note that the shift to working from home may not fully reflect past-pandemic behaviours.[108] UK government guidance at the time discouraged unnecessary the use of public transport.[108]

As in previous years, Figure 68 shows that the most common method of travel to work was 'driving a car or van'.[1] Furthermore, short journeys were also most commonly undertaken by car or van (Figure 69 shows the methods of travel to work for journeys less than 5km, as reported in 2011 and 2021). For 2021, journeys 'less than 5km' comprised 44.3% of all

journeys to work.[1] There is an opportunity to target these journeys to encourage active travel to workplaces.

Active travel means making journeys in physically active ways, particularly walking and cycling.[109] There is strong evidence that physical activity benefits many aspects of physical and mental health and well-being.[110] Physical activity is associated with many improvements in health and wellbeing, including lower premature death rates, and lower risk of heart problems and depression. It benefits people of all ages, ranging from helping children maintain a healthy weight to reducing conditions such as hip fractures in frail older people.[111] Active travel can contribute positively towards mental health in comparison to commuting by car.[111] Cycling to work reduces the relative risk of mortality by almost 40% by reducing the risk of cardiovascular disease, obesity and general health improvement, and results in lower absenteeism.[112,113]

During lockdown many people turned to active travel, especially walking and cycling for local exercise and shopping.[114] However now the rise of private motorised transport and at the same time a reduction in walking and cycling has reduced everyday opportunities for physically active lifestyles through travel.**Error! Bookmark not defined.** Many people now spend long periods inactive at work, and only a large minority choose a significant amount of active recreation. This means physical activity has fallen for many of us in day-to-day life.**Error! Bookmark not defined.** Equally, while 'passive commuting' (by train, bus, metro, car passenger) is less impactful on local air quality and congestion, there are still issues with longer commute times being associated with increased stress, higher blood pressure and BMI.[115]

Therefore, the implication is that if cars and vans continue to be used as the primary method of traveling to work, the negative health impacts associated with them will continue. However, there is an opportunity with the change to conventional working patterns to boost active travel, particularly for short and necessary journeys to the workplace.

What might this look like in 2031?

A key concern for the future of employment in Birmingham will be if economic inactivity continues to increase, particularly from the impact of long-term sickness and disability . Interestingly, further analysis of labour force data for the West Midlands, found an increase in the number of people in the West Midlands citing long-term sickness between 2021 and 2022. This analysis also showed difference by employment type, with professionals aged 60-65 years much less likely to leave the labour market due to ill-health than those working in elementary or as operatives.[116] There are also differences in economic inactivity levels by ethnicity and gender. It is likely therefore that economic inactivity will continue to rise in the city. With an increasing number of older people in the city and increasing rates of long-term conditions such as diabetes[117], the proportion of economically active people who also provide unpaid care may also be expected to increase as their family members, become less independent.

The challenge of encouraging active travel for shorter distance journeys, such as to work, is likely to continue over the next 10 years. Active travel requires effective infrastructure as well as behaviour change. Whilst the pandemic supported some aspects of this, with fewer cars on the road and in many places social distancing measures which supported active

travel e.g., temporarily wider pavements, the long-term infrastructure changes take time and remain limited so far.

System Reflections

Paul Kitson (Strategic Director of Places, Prosperity and Sustainability, Birmingham City Council)

Birmingham has undergone and is continuing to undergo a huge physical and economic transformation. The city's economy, workforce and business base have all grown strongly in recent years as the city recovers from the pandemic. However, the city still suffers from persistently high levels of deprivation and too many of our residents have low or no qualifications and are not in work or in poorly paid employment. This results in more families living in low-income households, in poorer housing, with poorer health outcomes. These issues are concentrated in certain parts of the city and disproportionately impact some communities.

Resident employment rates in the city (66.9%) are well below the UK level (75.7%) and the second lowest out of the Core Cities. Increasing resident employment rates is key to improving living standards for our residents and tackling poverty and inequality. The changing demography of the city over the next decade will, however, make increasing resident employment rates and reducing economic inactivity and unemployment rates even more challenging.

Birmingham's population is set to grow strongly with an ageing population and faster population growth within more deprived communities. More residents will need to move into work to simply maintain the city's employment rate as the population grows. To really move the dial on the low employment rates in the city and to drive up household income and help tackle high levels of poverty and deprivation we must ensure that our future growth is more inclusive, and more residents, especially those from the most deprived areas and communities' benefit from the significant development and investment planned in the city over the coming decade.

The city has a number of key strategic documents that aim to shape the spatial and economic development of the city in the coming decades to ensure that levelling up and inclusive growth are at the heart of the city's ongoing transformation: Our Future City Plan, The Birmingham Plan, East Birmingham Inclusive Growth Strategy, and Birmingham Transport Plan 2031.

Raj Kandola (Director of External Affairs, Birmingham Chamber of Commerce)

The economic circumstances of the last few years have been uniquely challenging and precipitated long-term changes in the way that many of us live and work in the city-region. However, what hasn't changed is the clear relationship between access to meaningful employment and personal wellbeing.

The significant number of people out of employment due to long-term illness is something that we have picked up on at the GBCC and have lobbied the Government to introduce tax breaks to encourage firms to offer Occupational Health support that can help keep people in work. Occupational health services should be made a non-taxable benefit in kind.

In last year's Birmingham Economic Review, our annual publication written by the University of Birmingham City-REDI in partnership with the GBCC, we found that whilst the analysis of health conditions linked to economic inactivity are still unclear, there are two consistent

causes: musculoskeletal health and mental health causes. Musculoskeletal health remains the most common health condition reported by those no longer working- in over 70% of cases it is listed as a cause.

With all of this in mind, the Chambers are proud to work with partners across the city region, including Birmingham City Council, as well as national government, to try and ensure that local residents who want to access local employment opportunities are supported and enabled to do so.

Discussion and Implications

This report has explored how demographic change in Birmingham may impact population health and wellbeing now and in the future. It serves as an evidence base for understanding our population and how it is changing. Several key changes in the city's population have occurred in the past ten years, including its size, structure, and characteristics. Evidence suggests that demographic changes impact health and wellbeing in a number of ways. Various sources, including census data and the perspective of Birmingham citizens have been used to inform the report. This section outlines the key findings and implications.

Supporting people in getting the best start in life and ageing well

Whilst Birmingham remains a young city, the number of adults and older people has increased. The average age has increased, and the number of people approaching retirement has grown more than any other age group in the city. Older adults reported better health in 2021 than in 2011, but this is not seen across the city, and there are levels of inequality in people's health based on where they live and the levels of deprivation they experience. Fewer babies are being born, and the number of children in their early years (aged 0-4) has decreased. Despite Birmingham's birth rate declining, the population grew overall.

We know that health is closely correlated with age, emphasising the importance of understanding this demographic trend. With changes in birth rates and the number of young people, there is increased uncertainty about planning for the levels of needs for education and children-related services in the future. This impact will also differ across the city, so targeted approaches may be required. The population's health and care needs will also increase with increased numbers of older adults. The prevalence of long-term conditions and disabilities increase with age, as does demand for care.

From pre-conception to older people, there are critical moments and life stages where action can make a big difference to health and wellbeing. Whilst ageing itself is inevitable, ageing in ill health is not. Prevention and early intervention are essential to ensure people in Birmingham can live long, happy and healthy lives. For older people, a life course approach includes primary interventions such as being in work, living in good housing, and living in a built environment that meets their needs. It also includes delaying or preventing the onset of dementia, preventing falls, loneliness, and isolation. Acting in a more preventative way will also result in less demand for health and care services in the future.

Embracing Birmingham's super-diversity whilst tackling health inequalities

Birmingham's ethnic super-diversity was made official in Census 2021, which has important implications for the health and wellbeing of our city. Greater knowledge of the ethnic identity of Birmingham's population will support our understanding of different needs and collaborative action to address avoidable health inequalities faced by different communities. There is strong evidence that, generally, ethnic minority groups tend to experience higher rates of conditions such as diabetes, obesity, asthma, heart disease, and cancer. The COVID-19 pandemic also had a disproportionate impact. Many factors can lead to inequalities, discussed in this report, such as housing, employment, and genetic factors. Genetic conditions like sickle cell disease have an increased prevalence in African and Caribbean populations. The risk of developing type 2 diabetes is higher in South Asian groups.

Local and national evidence shows there are differences within broad ethnic groups. By grouping 'ethnic minority communities' and even by the broad classification (e.g. Asian/Asian British), we may not address health inequalities, and in some cases, we may exacerbate them. Therefore, there is a need for nuanced policy approaches and interventions that consider differences beyond the broad-groups, down to more specific groups. This report provides further evidence for the importance of working with communities in Birmingham through approaches such as the Community Health Profiles, Cultural Intelligence Framework, Cultural Humility & Safety Framework and the demographic component of the Birmingham Measurement Toolbox which aims to collect ethnicity data in a way that reflects the views and culture of the city.

Fostering acceptance and supporting inclusion: LGBTQ+ communities and health

For the first time in the 2021 Census, voluntary questions were asked on sexual orientation and gender identity for respondents aged 16 years and over. It was an opportunity to develop a rich understanding of sexual orientation and gender identity. A high proportion of those who identified with an LGB+ orientation were aged between 16-24 years old. Birmingham has a higher proportion of people who identify with a different identity to their sex registered at birth than the national average. Because this was a voluntary question, we can also observe the non-response rate, which differed by age group and ethnicity. This detail on our city's identity and how it intersects with other characteristics, such as age, ethnicity and disability, help us further understand the population's needs.

The LGBTQ+ population is more likely to be affected by inequalities relating to mental health and wellbeing, substance misuse, and smoking rates. They are also more likely to experience direct and indirect discrimination when accessing health-related services and in wider society. Those who identify as 'trans+' and seek to medically transition can face additional barriers as there are no Gender Dysphoria Clinics in the West Midlands and long waiting lists for referrals and treatment.

Therefore, local health and care services should be inclusive and address the specific needs of LGBTQ+ communities. We must also build on our understanding to improve data collection locally to measure and monitor our impact. Despite the progress, there is still further work to do to increase understanding and awareness about how different LGBTQ+ identities and experiences can contribute to health inequalities. Opportunities to learn and share good practice, such as the LGBTQ+ Pride History Month Conference, remain important.

Understanding international immigration and its impact on population health

Migration is broadly defined as a change in a person's usual residence, and it is an important contributory factor to population and social change. This report focused on international immigration and people who live in Birmingham but were not born in the UK. Birmingham has a history of immigration, and has been an important destination for migrants seeking to settle and find work. Migrants who now live in Birmingham but were not born in the UK often moved to this country at a young age (the majority were under 30). Migrants are often younger and healthier compared to people in their host country. Evidence has also shown that after a period of time in the UK (15 years), non-UK-born and UK-born populations report similar health outcomes across all age groups.

This has important implications for the needs of this group, which differ significantly depending on their experiences and journeys to Birmingham. Those who migrated for employment, family, and study reasons have better health than UK-born people. This is often referred to as the healthy migrant effect. Those who migrate are more likely to be younger and less reliant on services such as the NHS. This contrasts with those seeking asylum, who tend to have worse health outcomes. Migrants often experience barriers in accessing health and social services, especially if they are undocumented. Migrants may also experience discrimination and are therefore vulnerable to physical and mental illness.

The diverse needs of migrants mean local services must adapt and consider factors such as age, country of origin, and reason for migration. Migrants can face language barriers, which should be understood and removed. People arriving in the city often desire education and information about provisions and norms in the UK. There are opportunities to implement a health literacy approach to support different communities settling in Birmingham. Similarly to supporting communities of identity, professionals working across the system must be equipped to serve communities of experience, such as migrant populations. Any work to support cultural competency should include the diversity of migrant needs.

Understanding household trends and intersectionality

Housing is a key determinant of health across the life course. The census provides an opportunity to explore different characteristics of households in Birmingham. By combining census data, we have also explored the intersection of communities of identity and household characteristics. The trends in housing composition, occupancy and tenure are important for us to understand the needs of Birmingham's population.

Whilst most people live in a household with others, one third of households in Birmingham consist of one person, and this is more common amongst older adults. This has important implications for understanding the risk of loneliness and social isolation. Living alone can be associated with unfavourable health outcomes such as anxiety, depression, and physical health conditions. Given that this trend is likely to continue, tailored interventions should be considered for older adults to reduce the risk of isolation and support independence.

Some households are also experiencing over-occupation or overcrowding. This is more common among ethnic communities, including those who identify as Asian or Asian British, Black or Black British, and from an Other ethnic group. It is also concentrated in specific areas of Birmingham and experienced by young people. Overcrowding can have negative effects on both physical and mental health and wellbeing. It is associated with the risk of infectious diseases, for example, during the COVID-19 pandemic.

There have been significant changes in housing tenure and a significant increase in private rented accommodation since 2011. Given that this is likely to continue, this has important implications as it has been shown to lead to greater insecurity and poorer levels of mental health. Owning a house can improve health, providing a sense of emotional security.

Facilitating good employment and economic activity

Income and employment are key determinants of health and drivers of health inequalities. The greater one's income, the less likelihood of disease and premature death and being in "good work" improves health and wellbeing across the life course and protects against social exclusion. The census is useful for understanding employment and economic activity in Birmingham and the associated self-reported health of those working and not working.

There has been an increase in economic inactivity, particularly among older working age, and older age groups, although this might reflect the timing of the Census 2021 with

respect to COVID-19 pandemic. Forty-two thousand people who are classed as working age are economically inactive due to long-term sickness or disability. This is most prevalent in pre-retirement ages. In the past decade, Birmingham saw England's joint largest percentage point rise in the proportion of people who were economically inactive because they were looking after their family or home. However, 50,000 people are economically active and providing unpaid care. The COVID-19 pandemic changed our work patterns, causing a rise in remote work. Where people were travelling to work, most were still driving in 2021. Active travel for short journeys can have positive health effects, at individual and population level, and should be encouraged.

Employers in the city should encourage a work-life balance that supports individuals balancing work, their role as unpaid carers and active travel. Some individuals may benefit from resources and support to manage a long-term health condition, for example through flexible working arrangements.

Glossary

Asexual - A person who does not experience sexual attraction. Some asexual people experience romantic attraction, while others do not.

Behavioural Interventions – Coordinated set of activities designed to change specified behaviour patterns.

Bisexual - This term is used when an individual is physically, romantically and/or emotionally attracted to more than one gender. This can mean being attracted to two genders (e.g., men and women) but bisexual attraction is not limited to two genders.

BLACHIR – Birmingham & Lewisham African & Caribbean Health Inequalities Review.

Built Environment – The parts of the places in which we live that have been built by people, for example buildings and streets, rather than the parts that exist in nature.

CVD – Cardiovascular disease.

Cohort effect - A cohort is a group of people who share a common set of demographic characteristics or experiences, including but not limited to age.

Demography - The study of statistics such as births, deaths, income, or the incidence of disease, which illustrate the changing structure of human populations.

Deprivation - The damaging lack of material benefits considered to be basic necessities in a society.

Economically Active – A person who is in employment or who is unemployed and were looking for a job and could start in two weeks.

Economically Inactive – A person who does not have a job and had not looked for work for at least a month before the census or could not start work within two weeks.

Ethnic - A group of people who share a similar culture (beliefs, values, and behaviours), language, religion, ancestry, or other characteristic that is often handed down from one generation to the next. They may come from the same country or live together in the same area.

Gay - This term is used to describe people whose physical, romantic and/or emotional attractions are to people of the same gender (e.g. a gay man is attracted to men / a gay woman is attracted to women).

Gender Dysphoria – A sense of unease that a person may have because of a mismatch between their biological sex and gender identity.

Gender Identity - A person's innate sense of their own gender, whether male, female or something else, which may or may not correspond to the sex assigned at birth.

Health Literacy – The degree to which individuals have the ability to find, understand and use the information and services to inform health-related decisions and actions for themselves.

Heterogeneity – the state of being diverse in character or content.

Heterosexual - Refers to a man who has a romantic and/or sexual orientation towards women or to a woman who has a romantic and/or sexual orientation towards men.

Internal Migration - The movement of people within their own country.

International Migration – The movement of people from one country to another.

Intersectionality - The idea that identities are influenced and shaped by race, class, ethnicity, sexuality/sexual orientation, gender/gender identity, physical disability, national origin, etc., as well as by the interconnection of all of those characteristics.

LGBTQ+ - Lesbian, Gay, Bisexual, Transgender, Queer, and all other non-heterosexual sexual orientations and non-cisgender gender identities.

Lesbian - This term is used to describe a woman whose physical, romantic and/or emotional attraction is to other women. Some lesbians also refer to themselves as gay.

MSM - Men who have sex with men.

Morbidity - Another term for illness or disease.

Mortality – Another term for death.

Multimorbidity – Two or more long-term health conditions

Multiplicative effect – Increasing an effect by multiplying.

NHS – National Health Service.

NICE – National Institute for Health & Care Excellence.

Non-Binary - An umbrella term for people whose gender identity doesn't sit comfortably with 'man' or 'woman'. Non-binary identities are varied and can include people who identify with some aspects of binary identities, while others reject them entirely.

ONS – Office for National Statistics.

Pansexual - . A sexual orientation that describes a person who is emotionally and

sexually attracted to people of all gender identities.

Queer - An umbrella term used by some to describe people who think of their sexual orientation or gender identity as outside of societal norms.

RMC – Refugee & Migrant Centre.

Sexual Orientation - How a person characterizes their emotional and sexual attraction to others.

STI – Sexual Transmitted Infection.

Social Cohesion - The extent to which people in society are bound together and integrated and share.

Socio-economic factors - Social and economic experiences that help shape personality, attitudes and lifestyle.

Suicidal ideation – Or suicidal thoughts, is the thought process of having ideas, or ruminations about the possibility of committing suicide.

Superdiversity - A population where no single ethnic group makes up a majority (50% or more).

Trans Man - This term is used to describe someone who is assigned female at birth but identifies and lives as a man. This may be shortened to trans man, or FTM, an abbreviation for female-to-male.

Trans Woman - This term is used to describe someone who is assigned male at birth but identifies and lives as a woman. This may be shortened to trans woman, or MTF, an abbreviation for male-to-female.

TRF – Totally Fertility Rate.

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Birmingham City Council: Public Health Case Studies summary report

November 2023

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Contents

Introduction

Changes to the demography of Birmingham were the source of both hope and concern for many of the citizens we spoke to over the course of this study. Birmingham's population increase was plain to see, with residents saying shops and streets feel busier. Participants had strong feelings on this growth – believing it was the root cause of many areas of their lives becoming difficult in recent years, negatively impacting their quality of life. While it was not within the scope of this research project to ascribe causality or investigate the truth of these claims, it was clear that Birmingham citizens had strong concerns around some of the changes identified in the 2021 Census data – which they directly linked to negative impacts on their health and wellbeing.

Across the board, we heard concerns about the ability for public services, including schools, doctors, hospitals and dentists, to keep up. The NHS in particular was singled out as being under strain in the city. Residents also had concerns around the availability of suitable, affordable housing. There was a widespread perception that private rental and social housing could be undersized and in poor condition.

Immigration to Birmingham – both from other parts of the country and from elsewhere in the world – has long been part of the fabric of life in the city, and residents expected that this would continue to be reflected in changes to the population. However, participants talked about tensions between some nationalities and ethnic groups, particularly in the context of access to healthcare and housing. There was seldom any hard evidence for these perceptions, and challenging incorrect assumptions may be important for Birmingham City Council going forward. Despite these underlying social and economic issues, we heard widespread agreement that Birmingham is a tolerant and socially accepting place.

Looking forward, residents were often anxious about what the future would be like for themselves and their families, given their current, difficult circumstances. Visible investment, including that from the 2022 Commonwealth Games and the ongoing regeneration of the city centre, provided hope that the region would see more, better jobs in the future. Economic prosperity was seen as the basis for an increase in residents' health and wellbeing.

Background and Methodology

This research was commissioned by Birmingham City Council to reflect on demographic changes captured in the 2021 Census, and to explore the impact these changes may have on the health and wellbeing of Birmingham's citizens and communities. This summary report provides headline findings across six topics as a means of understanding how major changes in demographics have impacted on Birmingham citizen, and what their current and future implications are on health and wellbeing. The topics are based on key changes identified between 2011 and 2021:

- Age
- Ethnicity
- Sexual Orientation and Gender Identity
- Migration
- Housing
- Employment

Further information is provided in an accompanying series of citizen case studies, which emphasise how these changes and trends are impacting the everyday lives of Birmingham's residents.

We conducted a series of in-depth, semi-structured interviews with participants from target populations (see appendix for a full breakdown). These participants were all Birmingham residents, and their lived experience related to one or more of the topics explored in this report.

1. Age

Experience of Demographic Change

Many participants felt that the increase in Birmingham's population was clearly visible when going about their day-to-day lives, witnessing busier shops and public transport, larger class sizes, and greater demand for public services. There was a strong perception that this increase was due to migration, particularly of citizens coming from overseas – leading to some strong views on immigrants, their communities and the impact on the quality of Birmingham's services. These are discussed in terms of health and wellbeing in the following subsection.

Many participants commented on the visible increase in older residents, reflecting data which shows a sharp rise in people aged over 50. We heard how care and retirement homes had been opened in citizens' neighbourhoods, which gave the impression of high local demand. In several cases, participants had direct experience with finding suitable care for older family members, which was often difficult for them. There was also a perception that there are many elderly people living alone, which was seen as problematic in terms of these residents' quality of life – but also in limiting the stock of family homes available to those who really need them.

Census data that shows an 8.4% decrease in the number of children under 4 was also well recognised by our sample, and many described how their friends and family were choosing to have children later in life, or otherwise having fewer children than they had planned. This was directly linked to increases in the cost of living. Older participants told us that this represented a clear generational shift, comparing their adult children's situation with their own – where they often had already had a number of children by their late 20s. Again, this was linked to differences in the ability to buy a home and secure a mortgage, and in job security. We spoke to one person in their early 20s who had recently started a family. There was a suggestion from across the sample that this move towards starting a family later in life was not always shared across the different ethnicities, cultures and communities present in the city.

Effect on Health and Wellbeing

While some of this demographic change was of relatively little consequence to participants, such as the city centre seeming to be busier over the weekend, they also described the negative effect from a greater number of people accessing public services. Residents often made a connection between population growth and the increasing difficulty in getting medical appointments, as well as long periods spent on waiting lists. This view was widespread and present across geographies, ages and communities.

Migrants, asylum seekers, refugees and immigrant communities were often perceived to be responsible for the greater demand placed on the NHS. This sometimes included second and third generation families. Others also linked increases in the older population to strained services. We recognise that these views may not be accurate and the picture here is likely to be much more complicated – suggesting that there may be work to be done around communication here.

Future Outlook and Potential Actions

Our conversations found that residents thought that the trend for fewer births would continue. When asked about the future, we heard how many of those in their 20s and 30s had few plans to start a family, feeling it was not realistic in the current climate. Some specifically stated that they did not want to have children.

Older residents were anxious about their own children, especially where they had more than one child. Participants in their 50s and above were also concerned about their quality of life over the rest of their lifetime. The cost-of-living crisis and perceived poor state of public services – especially the NHS – were often at the root of these apprehensions around having children. Participants were concerned about how the city would be able to function with an ever-increasing population, and recent news of the Council's financial difficulties was often raised in this context.

"I worry more for my kids and the grandchildren than for us, because we manage on what we've got. We always have done, but it's worrying thinking 'where will the little ones live when they grow up?' and 'what kind of world are they growing up in?'"

Individual who identifies as Bisexual, aged 33, Oscott

The scale of the problems raised were such that participants struggled to see workable solutions. However, many did desire more community outreach work to be conducted with elderly residents, either from BCC or charities.

2. Ethnicity

Experience of Demographic Change

Perhaps due to a lack of personal interaction, it was hard for many participants to separate their experience of demographic change regarding ethnicity from that related to migration. There was general acknowledgement that Birmingham had long been an ethnically diverse city, which will only increase in future. Many participants described how they had seen the mix of ethnicities present change, in their workplaces, neighbourhoods and across the city as a whole. While few found the Census data surprising, participants seldom shared any experiences or anecdotes relating to first hand interactions with people from other ethnicities, relating instead their broader perceptions and general understanding.

Participants were sometimes quick to describe an underlying sense of a lack of cohesion between different communities and neighbourhoods. We heard from multiple people, across different demographics and ethnic groups, that some areas of Birmingham were strongly associated with particular ethnicities, and that there was little interaction between these residents and those of other areas and wards. The Pakistani community in Alum Rock were often raised by citizens here.

Effect on Health and Wellbeing

It should be stated that we heard little to no evidence for concrete impact on citizens' health and wellbeing that could be reliably connected to demographic changes in the ethnic make-up of Birmingham. However, there was a perception that there is inequality in the system, which some participants believed leads to different ethnicities and areas receiving different treatment and attention. While we did not collect any evidence to suggest that these perceptions are borne out in fact, participants did express strong opinions on the subject – we have provided examples that may be valuable to BCC in directing research and communications in future:

- Two black participants felt they had received inferior NHS treatment, from their GP and in longer waiting/diagnosis times compared to white friends of theirs.
- One Iranian participant and their family had experienced racism, with their child being anxious about the colour of their skin.
- One participant who was a refugee felt that some politicians and the war in Gaza had fuelled community tensions.
- A lack of street cleaning in areas perceived as majority Pakistani and South Asian, and a belief that these communities were routinely 'treated differently' when it came to the provision of public services.
- A belief that some ethnic groups are able to 'jump the queue' when it came to social housing and NHS treatment.
- A perceived hesitance from the police to act in relation to disorder from young Asian men.

However, we did also hear positive sentiment towards representatives from mosques, temples and gurdwaras, who participants thought were offering vital community support by providing food, educational classes, charity work and community outreach.

"To an alarming extent, racism and religious prejudices are on the rise. Of course, some of the racist stances and anti-civil behaviour of the people and crimes are the direct result of the tensions created by the Government's policies in the society."

Individual who lives in privately rented accommodation, in receipt of Universal Credit, aged 32, Handsworth

Future Outlook and Potential Actions

Participants assumed that Birmingham would continue to be diverse in terms of the ethnic groups represented by its residents. Despite the sometimes negative views reported here, participants were hopeful that the future would see increased equality of outcomes for all ethnicities in the city. Older residents believed that Birmingham has become more friendly to those from non-white backgrounds, describing racism and violence in previous decades, and thought that this trend would continue in the future. Parents and grandparents told us that under-18s often held much more open views than themselves, and generally appeared less interested in the ethnicity of their peers.

Many participants associated a reduction in inequality with increased integration between communities. Some felt more free English language tuition was the solution here, while others thought that more attention from the Council in key areas was critical. This meant more outreach, better provision of basic services and maintenance of the public realm. Some participants also suggested using creative means, such as artwork and film, to bring different ethnicities and cultures together.

3. Sexual Orientation and Gender Identity

Experience of Demographic Change

Many of the citizens we spoke to, young and old, noticed a real shift towards society becoming much more accepting around sexual orientation and gender identity, feeling it was increasingly easy for younger people especially to express their true identity. They didn't think this was something unique to Birmingham, perhaps being reflective of broader generational attitudes. Those working with young people or in schools had seen a clear change in recent years, both in acceptance of different sexual orientations and gender identities and in the number of individuals identifying as transgender and non-binary.

A number of participants mentioned having LGBTQ+ friends and family, which contributed to what they considered a more accepting atmosphere. The Gay Village and yearly Pride were a familiar part of the fabric of Birmingham life for many of those interviewed. However, some felt for such a large city, Birmingham had a relatively small LGBTQ+ scene, especially when compared to cities like Manchester or London.

"I feel like for the second largest British city, Birmingham doesn't tap into the queer culture – we don't have such a scene. Like, if you go to Manchester and you can feel it way more. I feel like there is way more of a vibrant queer community there, where in Birmingham I had to, like, get out and go and meet up and try to find places. And it seems way more scattered."

Individual living within a HMO (House in Multiple Occupation), aged 36, Moseley

Those from the LGBTQ+ community, or with many friends who were, tended to think that the Census data underreported the true number of people from these groups. Some suggested that this could explain the 9.4% who did not answer the Census question on sexual orientation.

"I find that statistic of '87.6% of Birmingham residents that identify as straight or heterosexual' quite shocking. There's probably more people that identify in a different sort of way. However, they might be scared to identify that way. I know a lot of gay people and non-binary people."

Individual not currently in employment, aged 40, Sheldon

Effect on Health and Wellbeing

While a more accepting environment was taken as fact by many of our participants, the lived experience of members of the LGBTQ+ community suggested that this may not always be the case in reality. We heard about serious assaults and other crime in the Gay Village. One person described receiving unpleasant comments from members of a range of different communities in Highgate, telling us how, for them, there was still a lot of intolerance in Birmingham. They believed cultural or religious differences were at the root of this intolerance. These issues made some participants feel unsafe or unwelcome in the city centre and beyond. While not directly related, we heard similar concerns from women around personal safety and sexual assault.

Overall, Birmingham was felt to be a good place to live by the LGBTQ+ community, though was considered perhaps a little behind the curve compared to Manchester or London.

Future Outlook and Potential Actions

Members of the LGBTQ+ community described how young people are under increasing pressure to come out, or to define their sexual identity. There were few suggested potential actions regarding sexual orientation and gender identity. However, participants did see it as important for the BCC to work with both the LGBTQ+ community and others to ensure safety and tolerance from all residents, and to provide the correct support for young people in times of need.

4. Migration

Experience of Demographic Change

We spoke to both those who had lived in Birmingham all their lives and those who had migrated from elsewhere. Many participants said they had noticed an increase in the number of people they understood to have come to Birmingham from other nations. This migration was through a number of routes, and different sentiments were attached to each.

- Asylum seekers and refugees: We heard empathy and respect for displaced people living in Birmingham, alongside concerns that they were not being properly looked after, but also that groups of people hanging around (as they were unable to work) with little to do could be intimidating. The number of Ukrainian families present in the city was a particular source of pride.
- Students: The number of students, and student accommodation, had noticeably increased from previous years. Participants said they were from Pakistan, India and African nations, whereas previously they were mainly from China.

- Residents born in Eastern Europe: While a relatively small proportion of the city's population, participants felt these groups were increasingly noticeable on the high street.
- Residents born in South Asia: Many failed to differentiate between these residents and those from South Asian backgrounds with long-term links to Birmingham.

Very few non-migrant participants had had any direct contact with these communities, unless they were represented in their workplace, were working in schools and healthcare, or if they shared a place of worship. The presence of these migrant groups was often felt more through the sight of new shops and restaurants appearing in the local area. For example, we heard how Polish and Romanian convenience stores had become commonplace. However, these were seldom, if ever, used by the general population.

Effect on Health and Wellbeing

NHS services were the primary concern for both long-term residents and those who had come to Birmingham more recently, in terms of migration. A Polish participant who had moved for economic reasons told us how it had initially been tough for them to navigate the healthcare system, requiring them to find others in the community to help guide them through the process. They felt that they were taken less seriously or received a poorer standard of care from most healthcare professionals compared to UK nationals. They told us that this had been most obvious when dealing with NHS nurses from Eastern European nationalities, who were more caring and attentive. Others were shocked by the length of waiting times for routine GP appointments.

Housing was also mentioned by many participants as having a negative impact on their health and wellbeing. Those from the asylum system particularly described being placed into poor-quality accommodation, including hotels and housing association properties, which were small, damp and mouldy. It was extremely difficult and long-winded to get a more suitable place to live for them and their families.

"After I moved, they just did the same what they do… they put fresh wallpaper, just paint over, but they never treated the damp and the mould will still be there. I think it's not fair. Something must be done, there must be some more control on those kind of houses."

Individual who has migrated with refugee status (arrived between 2011 to 2021), aged 56, Harborne

We spoke to one Iranian refugee who felt that some ethnicities and nationalities received preferential treatment. For example, he felt Ukrainian refugees had been able to find accommodation and employment much quicker than Afghan or Iranian refugees. He explained that he worries about his family experiencing racism and difficulties finding employment. However, he also discussed factors that have had a positive impact on his mental health, such as connecting with Persian and Arabic communities as he can communicate with more people, and the support he has received from his church in terms of English lessons and improving his home.

Of those who were not migrants themselves, there was a concern that migrants were taking up a disproportionate amount of limited NHS resources. Part of this was about 'fairness' and additional budget and effort required, for example, around the necessity for translators.

A number of residents told us they wanted to leave Birmingham, in search of a better quality of life.

Future Outlook and Potential Actions

Migration was seen as a part of Birmingham's past, present and future. Participant suggestions here were largely focused on the BCC facilitating better integration between communities wherever possible.

5. Housing

Experience of Demographic Change

Our sample included representation from renters, homeowners and those living in social housing. The recent increase in the prevalence of private rented accommodation in Birmingham was familiar to most participants. We spoke to several landlords, who reported that they had received unprecedented interest in their properties. This often involved a larger number of people than they expected. We heard an anecdote elsewhere about two couples sharing a one-bedroom flat.

Participants across a range of demographics said over-occupation and overcrowding were familiar to them. It was not an uncommon experience for full-time employed adults in their 30s and 40s to move back in with their parents. For residents looking to buy a place of their own, there were a range of difficulties relating to mortgages that meant that they were continuing to rent for longer than they had expected.

"I've still got three living at home with the dad because they can't afford to get their own place. They're 26, 30 and 38. The dad sleeps on the sofa while the other three boys have a bedroom because they're all grown men, they can't share, but they can't go anywhere else either. Don't get me wrong, they all work, but they still can't afford to branch out on their own."

Individual who identifies as Lesbian, aged 24, Perry Barr

Elderly people living alone were commonly mentioned, with some frustration evident among participants that they were living in homes that were sorely needed by young families. Over-occupation of homes by those from the 'Asian, Asian British or Asian Welsh' ethnic group also tallied with the assumptions and experiences of our sample.

Effect on Health and Wellbeing

Citizens in social housing described real difficulties in being placed, mentioning wait times of several years in some cases. This put them in a difficult situation, with the decision to either:

- Come off the waiting list and go into (often expensive) private rental accommodation – which meant they would never be able to get back into social housing given wait times.
- Stay on the list, but remain living in substandard conditions. Some had become homeless, relying on friends and family. Other adults had moved back in with their parents, sometimes into ex-council properties which they had managed to buy.

The constant worry that they had made the wrong decision, or that they could become homeless, caused stress and anxiety for these participants. This was compounded by the often poor state of their current accommodation. We heard that properties were too small to comfortably house families, leading to multiple children of different ages and sexes being forced to share bedrooms.

"Part of mental health is obviously to do with housing as well… I'm stuck in a two-bedroom house because obviously I can't get out of private housing. With one son that's ten and a daughter that's four, so technically they shouldn't be sharing the room anyway, but they are… which is obviously a stress to me in regards to my mental health. Because I'm basically stuck in this house when they need more space."

Asian/Asian British Individual (Pakistani), aged 57, Handsworth Wood

Damp and mould were said to be rife across social and privately rented housing. In the case of the latter, landlords were not always forthcoming with solutions, causing mental and physical health problems. High rents were a perennial problem. On a number of occasions we heard the complaint that landlords were charging 'London prices on a Birmingham wage'.

"In my old property, so I moved about a year ago. It definitely impacted my health then, because I was like ringing them constantly trying to get things fixed and whatever and then they never would. There was mould and I got a bad chest from it, ended up getting [a] quite bad chest infection and things like that. And there were other people in my building that had had the same sort of experience as well. I felt angry as I didn't have a voice really with them at all. I just felt like I was paying money and then just being stuck there."

Asian/Asian British Individual (Pakistani), aged 26, Sparkhill

Some young professionals in our sample told us they preferred to live alone, as a shared house would negatively affect their mental health. Some of these participants did have positive experiences with renting, for example, around not having to worry about fixing or replacing white goods, which improved their wellbeing.

Future Outlook and Potential Actions

Housing was a key area where Birmingham citizens thought there was little chance for improvement in the future. They felt that there was a lack of housing in the city, not enough new developments, and costs were too high. A number of people told us they knew of newbuild houses that remained unoccupied due to their price. Parents often worried about their children and grandchildren.

As with several other areas identified throughout this report, some participants felt that different ethnic groups were receiving preferential treatment. There was a perception that large South Asian families were being prioritised for social housing. This led to some frank conversations around what participants thought was fair and who should have priority – they sometimes linked this to the amount of time families had lived in Birmingham and the UK. Addressing these concerns may be a valuable action for BCC, e.g. through communications with residents.

6. Employment

Experience of Demographic Change

The rise in economic inactivity observed in the Census was familiar to participants. Several told us anecdotes about how they knew people who had decided to retire early, choosing to be 'poor and happy' rather than continue to work. Others were taking agency in their working lives by becoming self-employed – fitting their work around their family or home commitments – where this had previously been the other way around. Younger participants told us about the popularity of apprenticeships and NHS careers with built-in degrees.

The Census data shows that more people worked 15 hours or less per week in 2021 (11.2%) than they did in 2011 (10.0%). We spoke to several interviewees in this position, who told us that this was because they wanted to safeguard their current income from government benefits. If they took on a job that was contracted at more than 15 hours, they would lose access to financial support. Only a 40-hour-per-week contract would be likely to match their current income levels. However, this would require significant lifestyle changes, including spending much less time with their children.

Some participants were forthright in their views that claiming benefits had become an acceptable lifestyle choice for long-term Birmingham residents. They often contrasted this with migrants, who they felt were more likely to make

an effort to find work. However, there was a perception that some companies were paying new migrants lower wages than would be standard for that position. Residents told us about friends and family working jobs they were highly overqualified for.

Additionally, we heard that Birmingham's growing population and what felt like a general uptick in prospects since the 2022 Commonwealth Games, meant that there were more employment opportunities available for those who wanted them. However, there was also felt to be more competition due to an increased population.

Effect on Health and Wellbeing

Economic inactivity had an impact on participants' mental health. We spoke to a resident who had worked as a school lunchtime supervisor. She had lost her husband and her job in quick succession, and not worked since. This negatively impacted her mental health, leaving her feeling isolated and missing the company of people her own age.

It was not just older people who told us that unemployment was depressing. Some young people, in their late teens and early 20s, were struggling to find work, and described finding themselves in a spiral of poor health, a lack of income and diminishing prospects. We had honest conversations with these participants about feeling a lack of self-worth and considering themselves a burden on the NHS. Several participants in their 40s and 50s described similar situations, reporting widespread issues with alcohol and substance abuse among many of their peers, used as a coping mechanism.

"If I could get 40 hours a week or a full-time contract, I would work. The uncertainty of not knowing how many hours I will have each week isn't worth it. It feels very limited and you can feel quite worthless at times, and I have no money and am having to use food banks at the moment."

Individual who has migrated for education/work between 2011 to 2021 (Poland), aged 27, Ladywood

While economic inactivity related to the Covid-19 pandemic looks to have subsided, the move to working from home had been embraced by many in the sample. This came with many positives, particularly around being able to spend more time with their family and achieve a better work-life balance.

Conversely, residents described the negative mental and physical health impacts of jobs where home working wasn't possible. Working long hours with few breaks and commutes that meant they sometimes didn't see daylight, and struggled to fit in any exercise, led to health issues.

Future Outlook and Potential Actions

Participants were hopeful that Birmingham's population growth and increasing diversity would come with increased levels of opportunity for residents, with more and better jobs. There was a hope that salaries would increase to match ever-rising rents. They also wanted to see more programmes and apprenticeships to help people get into jobs, including migrants and the homeless.

7. Conclusion and Summary of Potential Actions

We asked participants what actions the Council, Government, communities and other organisations could take in the future to improve the health and wellbeing of Birmingham residents. Citizens were well aware of not only the wider context of a cost-of-living crisis, but also the circumstances of BCC's section 114 notice. As a result, they were pragmatic about the level of change they could expect to see, for example, around the NHS.

We heard an immense amount of civic pride, and our interviews suggest that being more vocal on what makes Birmingham a great place to live, now and in the future, would be well received. Several times we heard participants say that they seldom heard any good news about the city. They mentioned that the 2022 Commonwealth games provided a significant boost – not just of investment, but also of positivity in the region. There was a real appetite for building on this. In part, this was a communications issue, with low awareness of the Council's role and existing campaigns.

However, there are serious issues which need to be addressed for this to be seen as authentic. There was significant anxiety about crime and personal safety, which in many cases was preventing residents spending time outside. Older residents especially were worried about break-ins, and a number told us they had installed security cameras on their property.

We have broken down potential actions into four areas which touch all the key topics addressed across this report:

Communication

- Shouting louder about the positives.
- Increasing visibility of the Council, building knowledge of who BCC are and what they can do. Having a presence in schools and colleges.
- Making systems/services easy to navigate, including face-to-face options.

Engagement, Outreach and Partnerships

- More funding and community facilities for all ages, e.g. youth clubs, community centres.
- Working with charities and small businesses to tackle community issues.
- Enhancing English Language learning opportunities.
- Increasing space for the arts at a community level.

Crime and the Public Realm

- Making areas feel safe to support people in exercising outside.
- Increasing green space.
- Taking tough action on hate crime, knife crime and sexual harassment.
- Increasing visible policing and improving follow-up on thefts and burglaries.
- Ensuring cleaner streets, action on fly-tipping and more attention given to areas including Alum Rock.

Infrastructure

- Drawing private investment to the area.
- Ensuring that redevelopment is well planned and amenities are within easy access.
- Prioritising affordable homes.
- Improving both the quality of and access to social housing.

"I've seen a lot of redevelopments in Birmingham at the moment, which is obviously very good. The Commonwealth Games helped as well. That brought a lot of money into the city. I've seen that we're building loads of new properties, and also more student accommodation. When they're redeveloping all these places, they're building supermarkets and kids' parks. Having all that in an area where you live will really impact your health and wellbeing, just in terms of you being able to get out of the house more easily and having more choice for everything."

Individual who lives in privately rented accommodation (in employment and not in receipt of Universal Credit), aged 30, Sutton Wylde Green

Appendix

Demographic profiles of participants

Topic		Target populations
Age	**1**	1 x Individual aged between 16–24-years old (without children)
	2	1 x Individual aged between 16-24 years old (with a child aged between 0-4 years old)
	3	1x Individual aged between 25– 39-years old (in full-time employment)
	4	1x Individual aged between 50-60 years old (in full-time employment)
	5	1 x Individual aged between 40-49-years old (not currently in employment)
	6	1 x Individual aged between 60-65 years old (who has retired in the last 3 years)
	7	1 x Individual aged between 70-75 years old (who has only lived in Birmingham)
Ethnicity	**8**	1 x Asian/Asian British Individual (Pakistani, aged 18 to 34 years old)
	9	1 x Asian/Asian British Individual (Pakistani, aged 50-64 years old)
	10	*1 x Black/Black British Individual (Somalian, aged 18-49)**
	11	1 x Black/Black British Individual (Nigerian, aged 18-49)**
	12	1 x Black/Black British Individual (Caribbean, aged 50-64 years old)
	13	*1 x White Individual (Polish, 25-34 years old)*
	14	*1 x White Individual (Romanian, 25-34 years old)**
Sexual orientation and gender identity	**15**	1 x Individual who identifies as Gay or Lesbian (aged 16-54 years old)
	16	1 x Individual who identifies as Bisexual (aged 16-34 years old)
	17	1 x Individual who identifies as Transgender, Pansexual, Asexual or Queer (aged 16-34 years old)
Migration	**18**	1 x Individual aged between 20 to 44 years old, who arrived in the UK from 2011 to 2021
	19	1 x Individual who has migrated for education or work between 2011 to 2021 (aged between 20 to 44)
	20	1x Individual who has migrated for resettlement or with refugee status (arrived between 2011 to 2021)
	21	*1 x Individual who is seeking asylum (who arrived in the UK between 2011 and 2021)**
Housing	**22**	1 x Individual living within either a HMO (House in Multiple Occupation) or an overcrowded household, aged 18-50 years old
	23	1 x Individual who owns their accommodation outright
	24	1 x Individual who lives in socially rented accommodation (provided either by the local authority or by a housing association)
	25	1 x Individual who lives in privately rented accommodation (in receipt of Universal Credit)
	26	1 x Individual who lives in privately rented accommodation (in employment and not in receipt of Universal Credit)
Employment	**27**	1 x Individual who is economically inactive: as they look after their home or family
	28	1 x Individual who is not in employment and has never worked
	29	1 x individual employed on a 'zero hours' contract
	30	1 x Individual who is economically inactive: Long-term sick or disabled (Asian/Asian British, Black/Black British or White)

* These profiles do not have a dedicated case study, due to challenges with recruiting suitable individuals.

**We spoke to two participants from this profile.

Demographics breakdown of participant sample*

Participant numbers under 4 have been suppressed.

Age	Number of participants
0-18	0
19-30	9
31-40	5
41-50	<4
51-60	7
61-70	<4
71-80	<4
81+	0

Gender	Number of participants
Male	12
Female	14
Non-binary	<4
Prefer not to say	<4

Sexuality	Number of participants
Bisexual	<4
Gay	<4
Lesbian	<4
Heterosexual / straight	22
Other	<4
Prefer not to say	0

Ethnicity	Number of participants
English / Welsh / Scottish / Northern Irish	11
Any other white background	<4
Mixed / multiple ethnic groups	<4

Asian / Asian British	4
Black / African / Caribbean / Black British	7
Any other ethnic group	<4
Prefer not to say	0

Housing	Number of participants
Owns their home outright	4
Owns with a mortgage or loan	4
Shared ownership	<4
Rents from a local authority	6
Rents from a housing association	<4
Rents from a private landlord	8
Rents from other source	<4
Lives rent free	<4

Religion	Number of participants
Christian	11
Buddhist	<4
Hindu	<4
Muslim	<4
Jewish	<4
Sikh	<4
No religion	10
Any other religion	<4
Prefer not to say	<4

Region of Birmingham	Number of participants
North	7
South	5
East	<4
West	9
Central	4

NE-SEC Classification	Number of participants
Higher managerial, administrative and professional	<4
Lower managerial, administrative and professional	9
Intermediate	<4
Small employers and own account workers	<4
Lower supervisory and technical	<4
Semi-routine	<4
Routine	<4
Never worked/long-term unemployed	7
Full-time student	<4

Bayesian Probabilistic Projection in Birmingham

April 25, 2023

1 Introduction

The Office for National Statistics (ONS) produces population projections every two years, which are broken down by gender and age structure. The projection is essential for various levels of planning purposes and has been widely used by government sectors, local authorities, and researchers. Population projection also helps to inform decision making on resource prioritisation and targeted interventions for future needs in health care services.

The ONS currently employs the cohort component method to produce nation population estimate (ONS, 2014). The equation is written as follows:

$$Population_{t+1} = Population_t + Births_t - Deaths_t + Immigrants_t - Emigrants_t \tag{1}$$

The simplified age-structured version of the method is written as follows:

$$Population_{a+1,t+1} = Population_{a,t} * SurvivalRate_{a,t} + NetMigration_{a,t} \tag{2}$$

$$Population_{0,t+1} = \sum_a women_{a,t} * FertilityRate_{a,t} \tag{3}$$

The population aged 0 which is the infants in the next time point is the sum of overall ages a of the number of women currently aged a times the Fertility rate of the corresponding age in the current period. The key point from this equation is that it is deterministic and requires assumptions about future fertility, mortality, and migration rates. The ONS currently obtains these future rates from expert panel. The assumptions for the vital rates for population projection are made based on a combination of analyzing trends and making extrapolations, as well as seeking advice from experts in the field.

The cohort component of population produces a single value of the population projection. This does not assess uncertainty in which a single value is not helpful enough for decision making when one wants to be confident about the accuracy of the results. The ONS assesses uncertainty by producing additional variants based on alternative assumptions on the vital rates. For example, the ONS assumes a high and low fertility rate as the upper and lower bound range of value that the projection can vary. Expert opinions no wonder can provide valuable insights when data is limited or difficult to obtain. However, experts are not very good at producing forecasts from scratch. The need of a probabilistic projection can provide a better assessment of uncertainty which allows for a more accurate representation of the potential projection. This enables decision-makers to avoid risks when making decisions.

2 Method

Bayesian Probabilistic Projection is a complex model, please read "Bayesian Population Projections for the United Nations" written by Raflery.A, Alkema.L and Gerland.P in 2014. This method makes the total fertility rate (TFR) and life expectancy probabilistic, migration rate is kept deterministic as the packages do not support for migration rate to be probabilistic.

2.1 TFR

The TFR is modeled in 3 phases, the first phase is the beginning of the TFR transition in which the TFR is high and increasing. Phase 2 TFR is where the rate starts to decline from high levels and below the 2.1 replacement level (United Nation's assumption). Phase 3 is the post-fertility transition period.

Phase 1 of the TFR transition is not considered to be in part of the simulation process. Starting from Phase 2, a double logistic function with added stochasticity. The package then models the TFR for different countries from a "world distribution", the wpp2022 dataset(the United Nation's dataset has the latest TFR for United Kingdom) includes 237 countries or areas. The importance of a "word distribution" is that when modelling the TFR for a chosen country, it can borrow strength from data for other countries to make the model hierarchical. In addition, estimating country specific's double logistic curve is unstable and the data for a single country is often sparse. By using a hierarchical model, the estimation process can be more robust and reliable.

Phase 3 is where the prediction of the future TFR begins. However, the model creators have placed the UN's assumption that the TFR will tend to increase back towards replacement level of TFR=2.1 after phase 2 in the long run. They model this by using a single first-order autoregressive model (AR1), namely

$$TFR_{c,t+1} = \mu + \rho(TFR_{c,t}) + b_{c,t} \tag{4}$$

The equation implies that the TFR in the next time point depends on the TFR in the present plus a constant/mean and white noise. The mean is equal to the approximate replacement level of 2.1 as being predetermined by the model creators. It means that the predicted TFR will tend to increase to 2.1 and fluctuate around this level in the long-run.

However, this long term assumption is not applicable for us to model regional level of population with two reasons. Firstly, we are only projecting our population 10 years forward in time, while the model creators project the population up to 2100, a long term replacement level is not suitable for a short-term projection. Secondly, UN's assumption on the replacement level at 2.1 might not be applicable to the UK as well as Birmingham. Having looked at the ONS website, the experts assume the future will be 1.53 in short-run and 1.59 in long run. As the model uses long run TFR, we have to fine tune the values in the AR1 model such that the predicted TFR values fluctuate at around 1.6 in the short term prediction. The reason of choosing 1.6 instead of 1.5 is that Birmingham has slightly higher historical TFR than the England average.

2.2 Life expectancy

Life expectancy is modelled in the same way as TFR. A double logistic function is fitted to project expected gains in life expectancy. The model creators generate male life expectancy in condition on the projections of female life expectancy. We have to be careful about the joint projections of female and male because female always tend to have higher life expectancy. It is regulated by smoothing the gap between female and male. The gap is widen for female at around age 75, and then narrows thereafter.

These projections are then converted into age- and sex-specific mortality rates used in a cohort component method.

2.3 Bayesian Population Projection

In order to generate probabilistic forecasts, a total of 100 simulations were conducted for the total fertility rate (TFR) for every five-year interval between 2021 and 2031, as well as for the joint trajectories of male and female life expectancy, based on their posterior predictive distribution. These were transformed into age- and gender-specific mortality rates. The migration schedules were constructed from the total migration counts of the United Kingdom derived from the wpp2022. We have supplied the Birmingham sex-specific migration shares for the process. These simulations were then used to create a joint probabilistic projection using the cohort component method.

3 Results

The population projections up to 2031 are given as line plot and table for convenience. The projection is calculated as a five year average and therefore no annual projection can be provided from this R package.

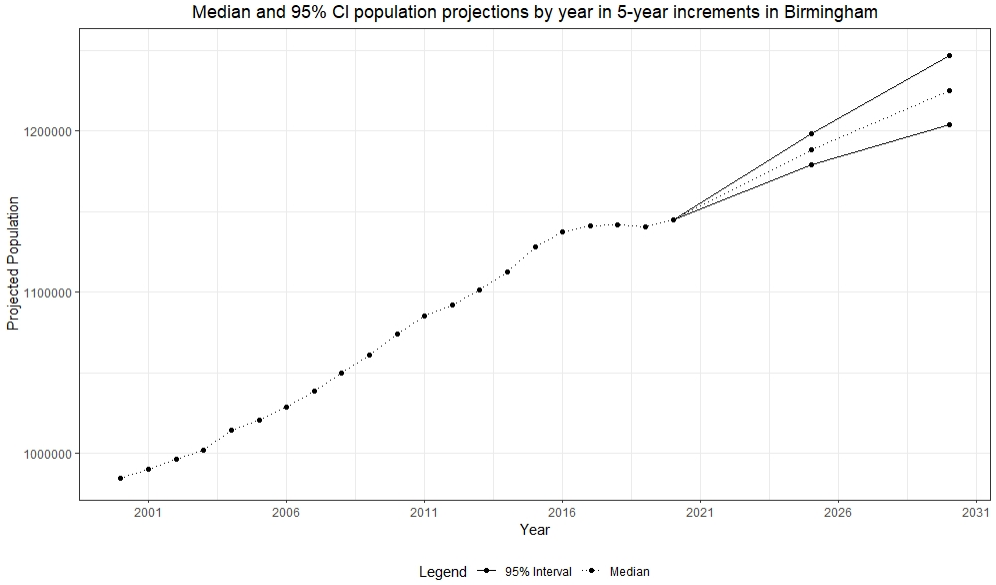


Figure 1: Probabilistic population projection by all age to 2031 in Birmingham

Table 1: Median and 95% Confidence Interval of the projected population in Birmingham

Year	Median	Upper 95% CI	Lower 95% CI
2021	1144923	NA	NA
2026	1188181	1198460	1179242
2031	1224868	1246317	1203901

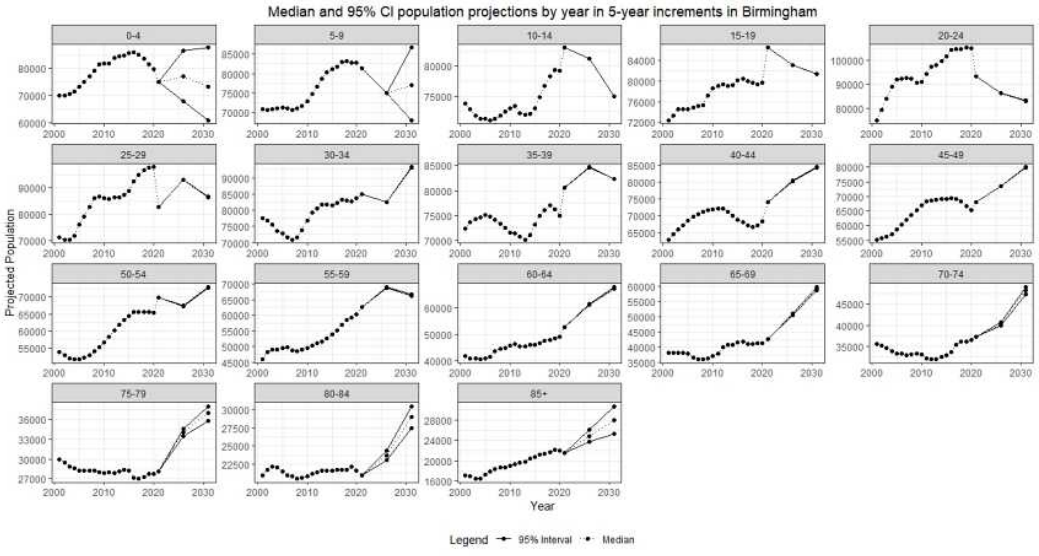


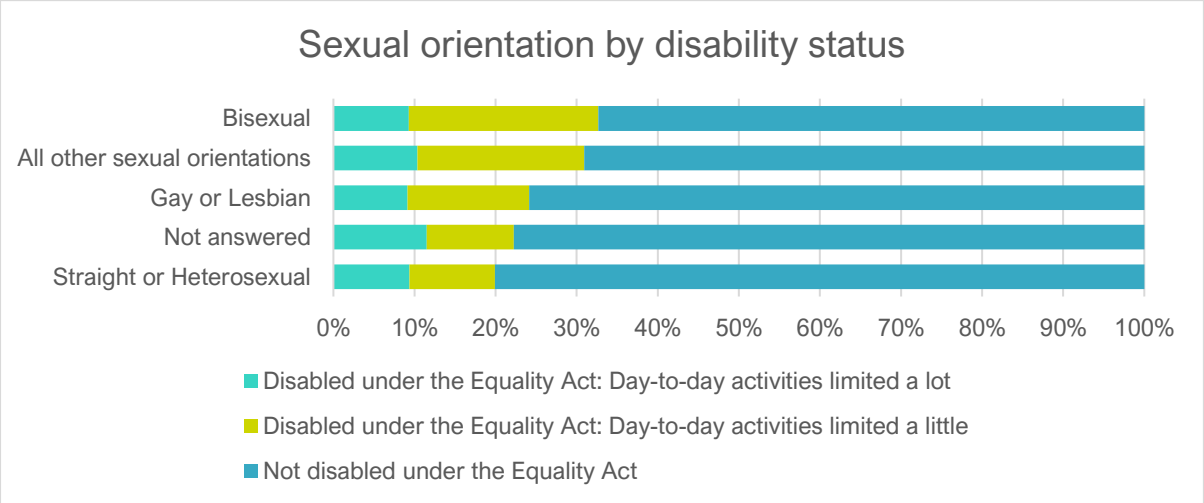
Figure 2: Probabilistic population projection by age structure to 2031 in Birmingham

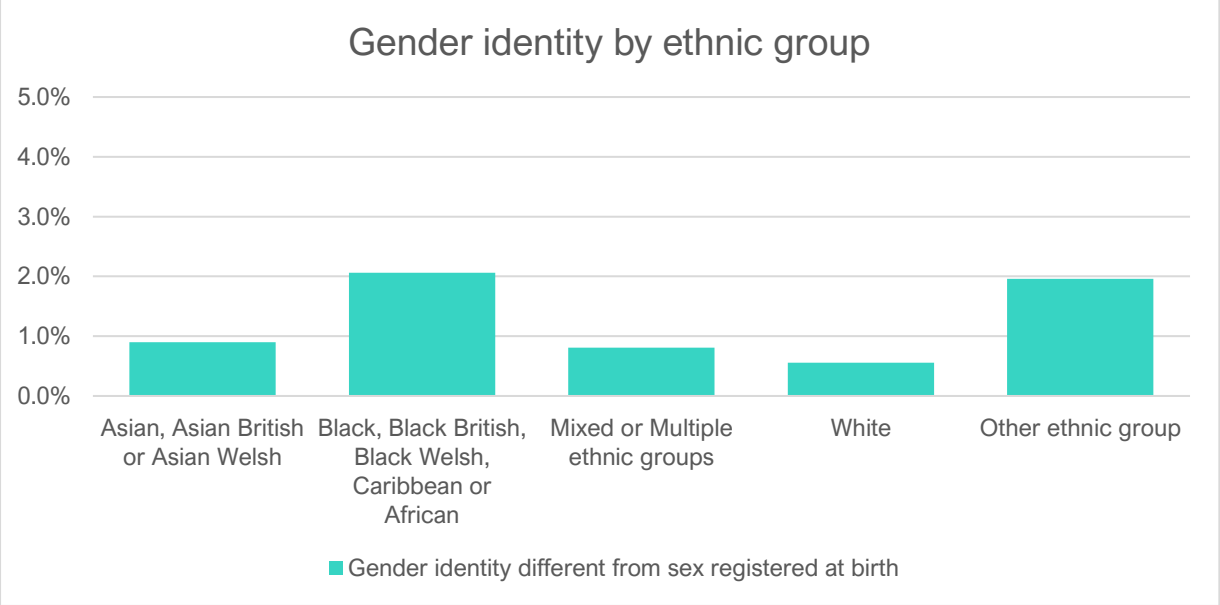
The projection of the Birmingham population in 2031 will be at 1.22 million and the value of the true population lies between 1.2 million and 1.24 million at the 95% CI (see table 1). The projection is further broken down into age-structured projection (see figure 2), the population in the younger cohort tends to decrease and the older population tends to increase in the next 10 years. It is because the future TFR is assumed to fluctuate at a lower level.

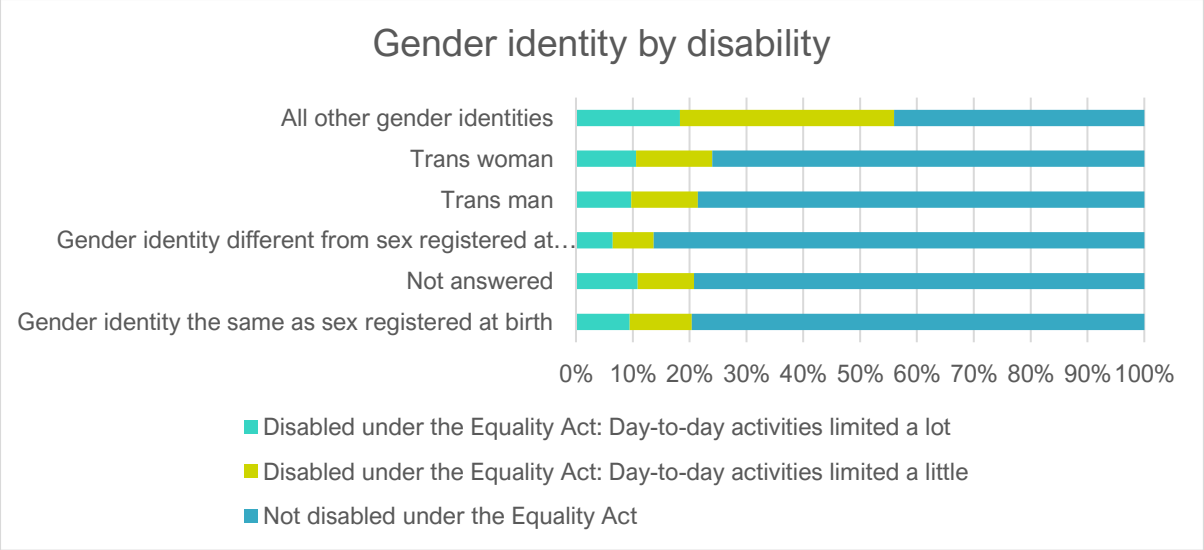
4 Conclusion

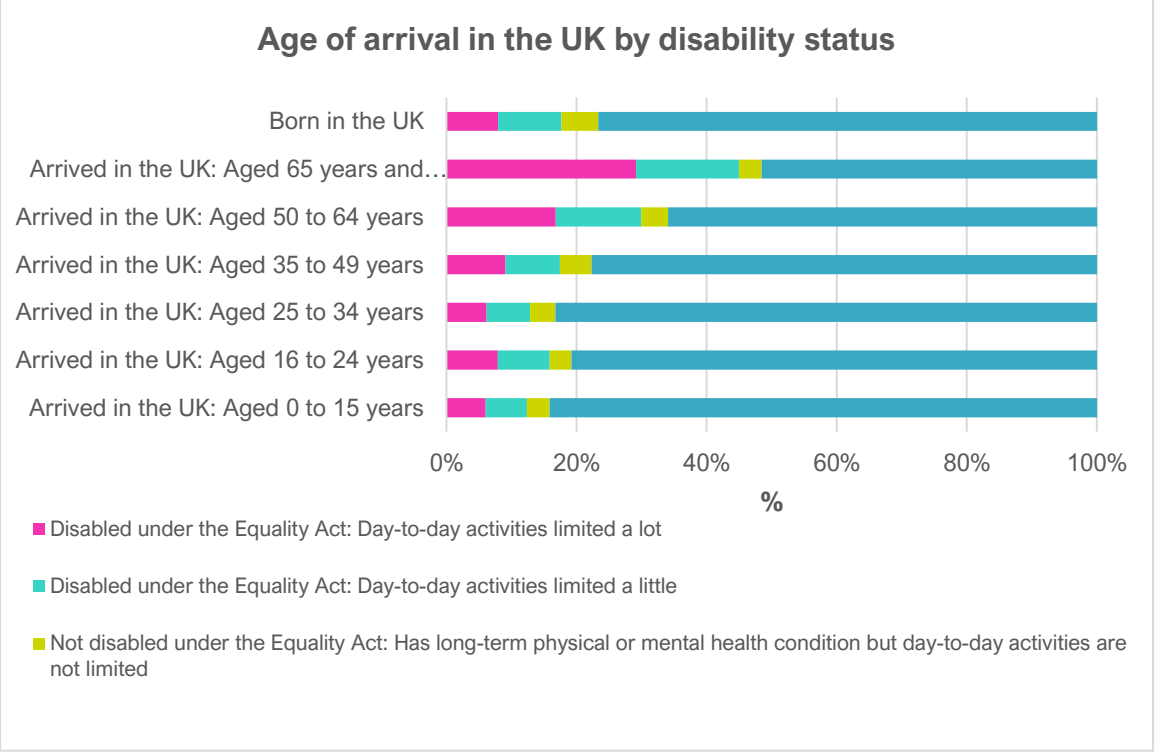
Using this method is a lot better than the method we showed the governance team before which was just a linear extrapolation. The linear extrapolation we did has no consideration to TFR, life expectancy, mortality rate and migration, yielding a value that are not useful for informing the higher management level. With this method, we have included all the vital rates under consideration and making the TFR and life expectancy probabilistic. Assessing the uncertainty of the future population projection is helpful for decision making such that the risks of health care planning purposes are considered.

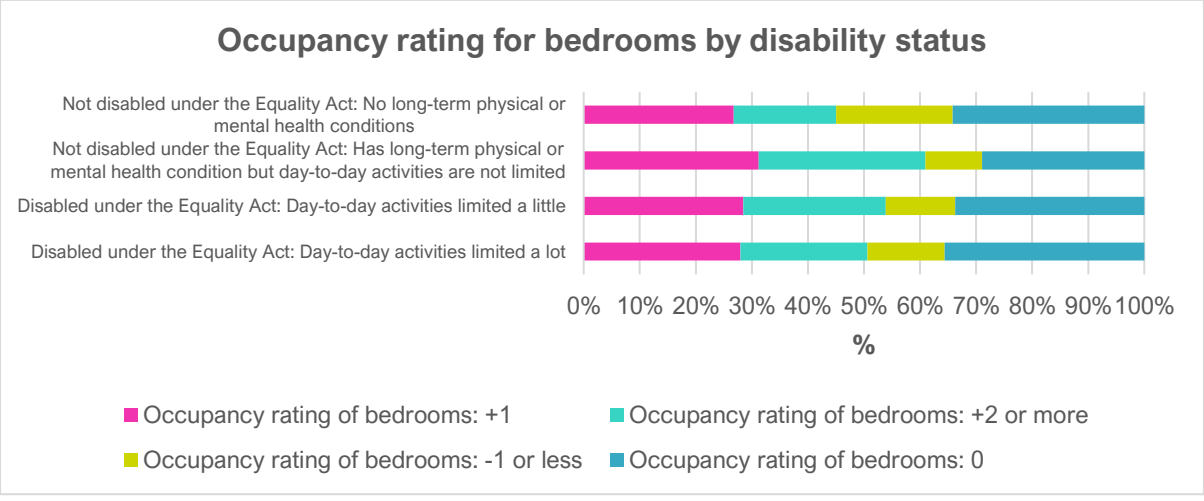
Additional visualisations for Director of Public Health Annual Report 2023-24

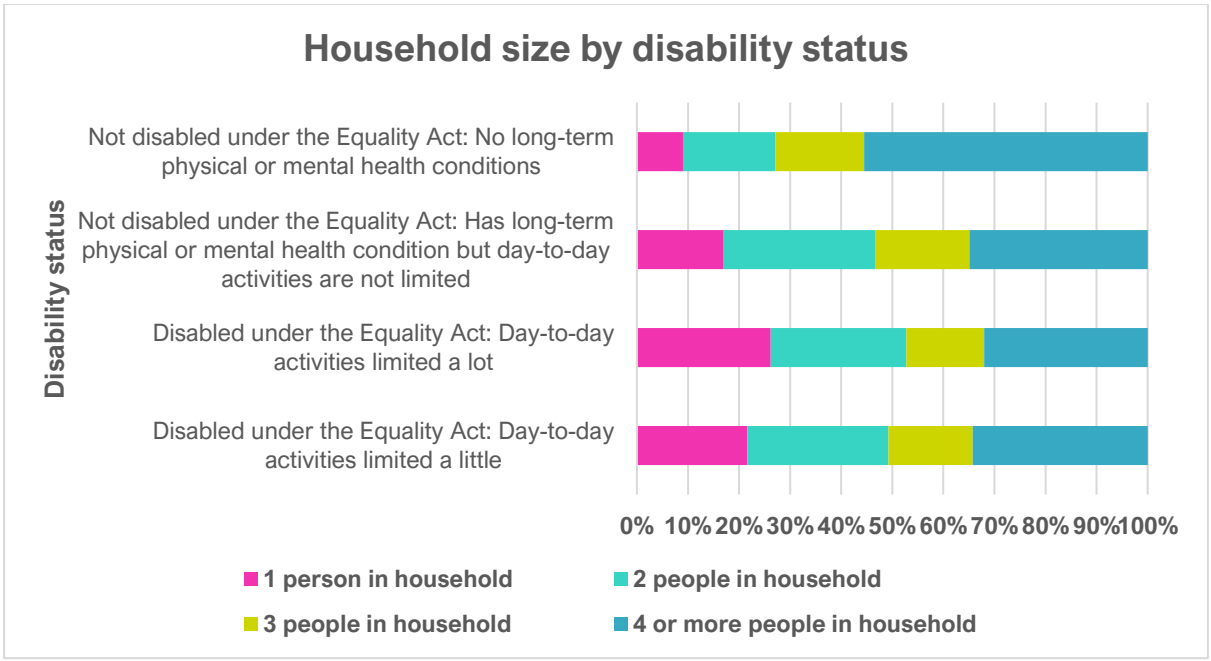


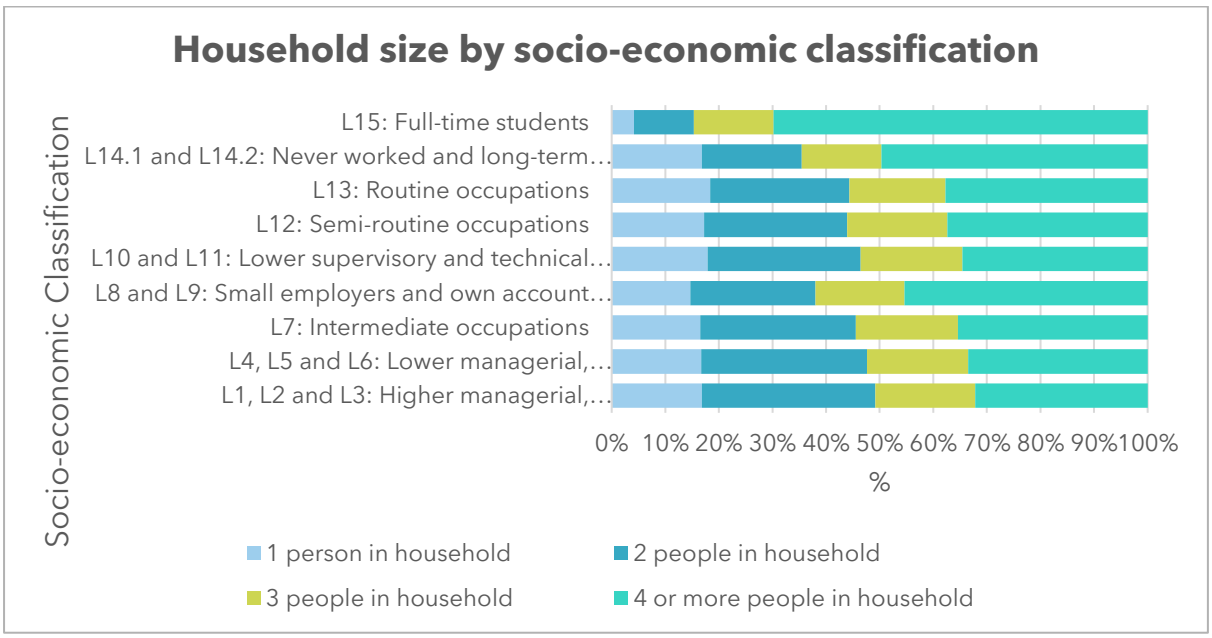


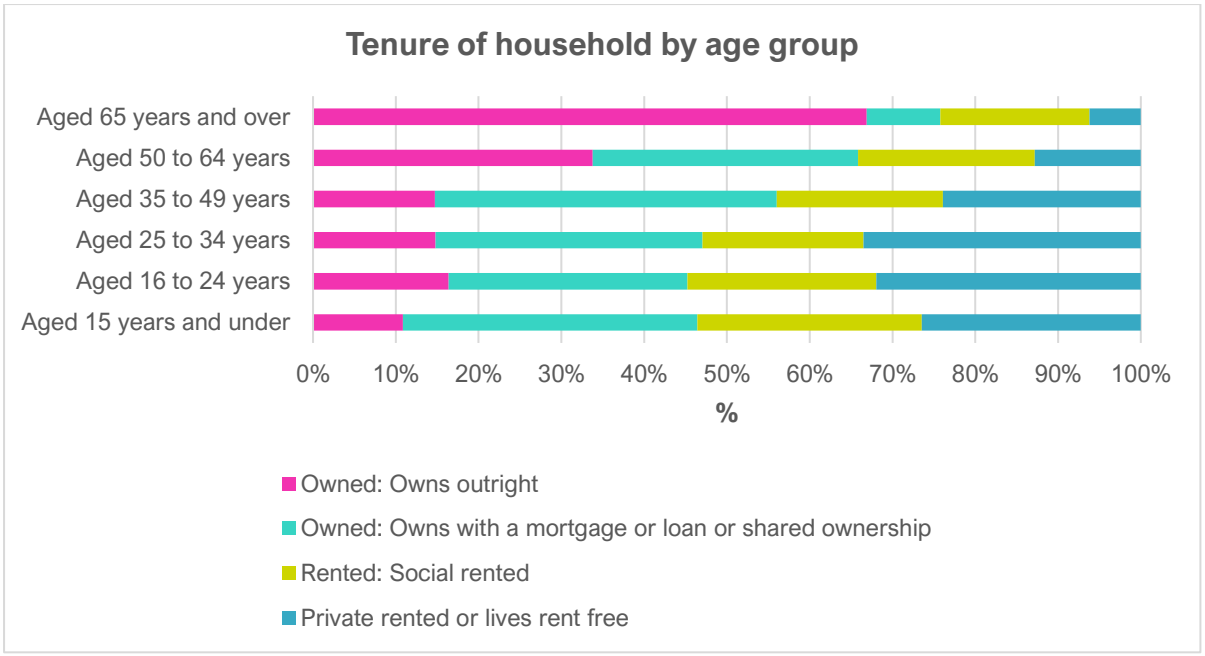

Gender identity by disability
All other gender identities
Trans woman
Trans man
Gender identity different from sex registered at…
Not answered
Gender identity the same as sex registered at birth
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Disabled under the Equality Act: Day-to-day activities limited a lot
Disabled under the Equality Act: Day-to-day activities limited a little
Not disabled under the Equality Act

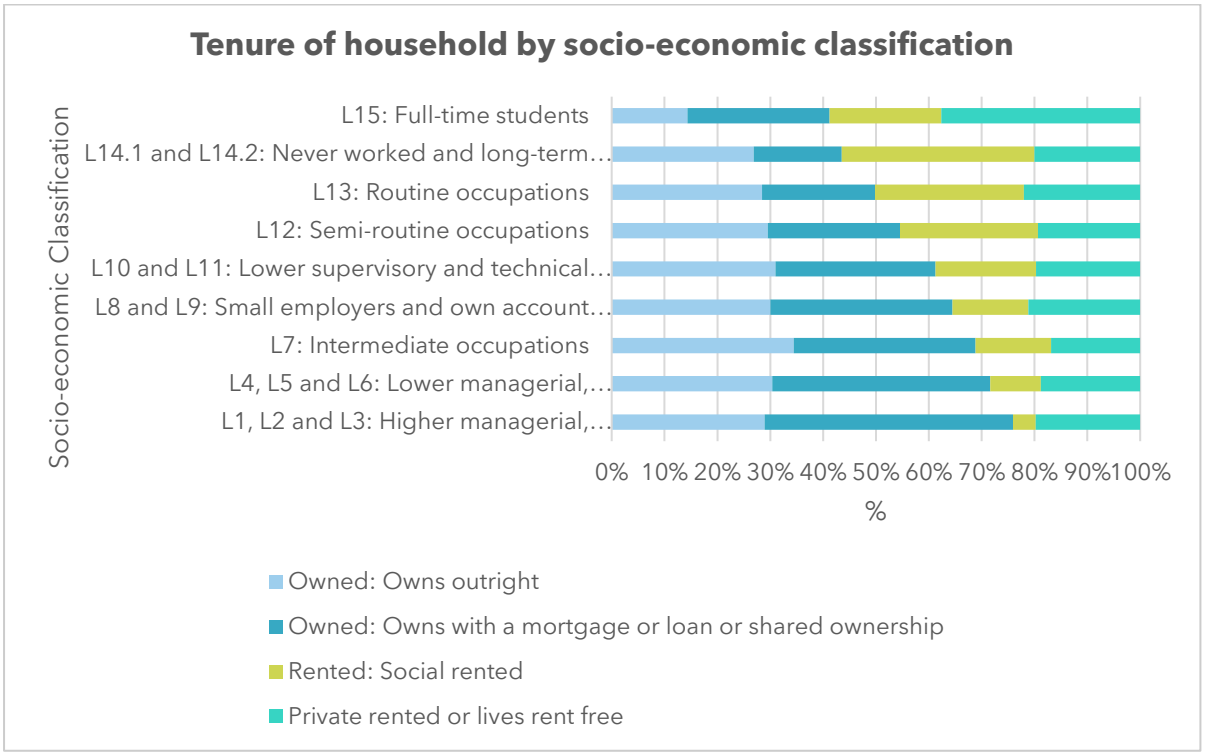

Age of arrival in the UK by disability status
Born in the UK
Arrived in the UK: Aged 65 years and…
Arrived in the UK: Aged 50 to 64 years
Arrived in the UK: Aged 35 to 49 years
Arrived in the UK: Aged 25 to 34 years
Arrived in the UK: Aged 16 to 24 years
Arrived in the UK: Aged 0 to 15 years
0% 20% 40% 60% 80% 100%
%
Disabled under the Equality Act: Day-to-day activities limited a lot
Disabled under the Equality Act: Day-to-day activities limited a little
Not disabled under the Equality Act: Has long-term physical or mental health condition but day-to-day activities are not limited

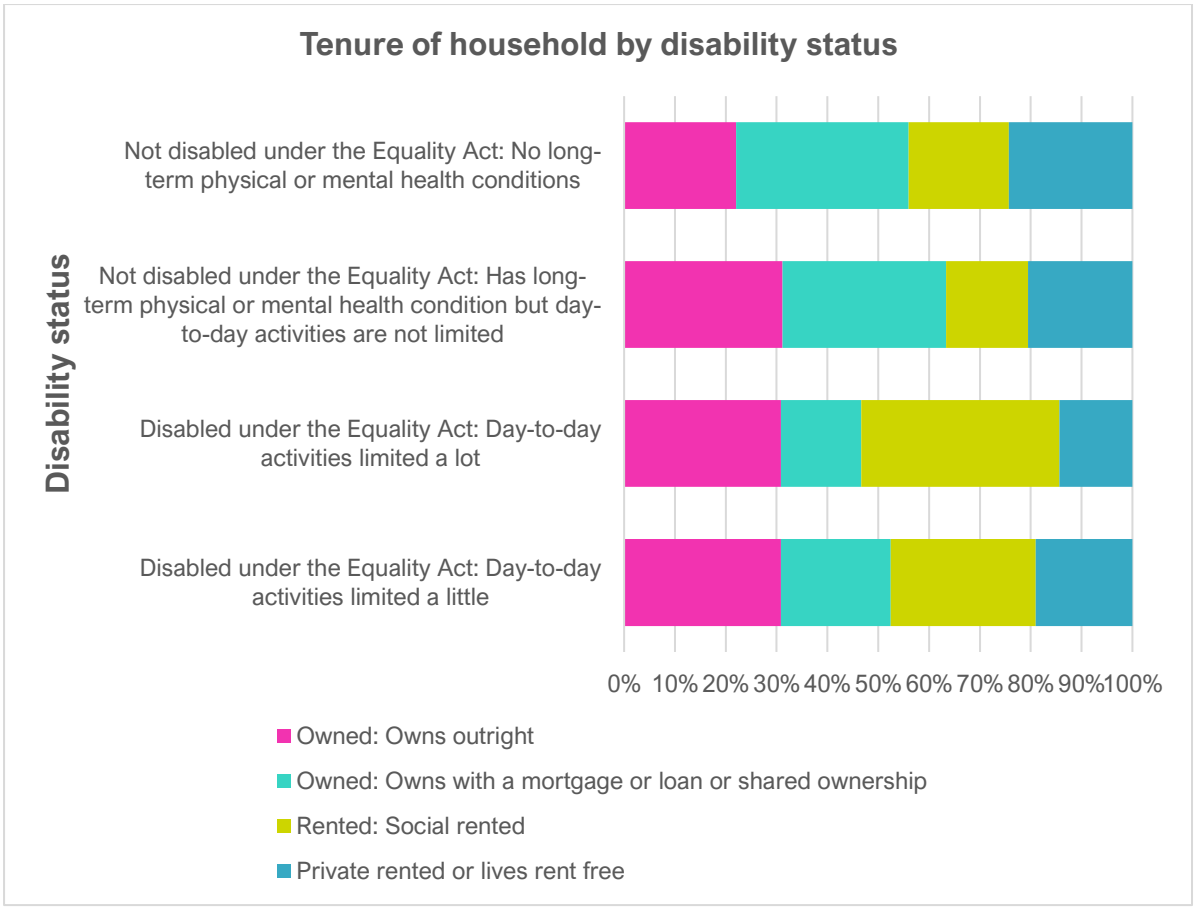

Occupancy rating for bedrooms by disability status
Not disabled under the Equality Act: No long-term physical or mental health conditions
Not disabled under the Equality Act: Has long-term physical or mental health condition but day-to-day activities are not limited
Disabled under the Equality Act: Day-to-day activities limited a little
Disabled under the Equality Act: Day-to-day activities limited a lot
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
%
Occupancy rating of bedrooms: +1
Occupancy rating of bedrooms: +2 or more
Occupancy rating of bedrooms: -1 or less
Occupancy rating of bedrooms: 0

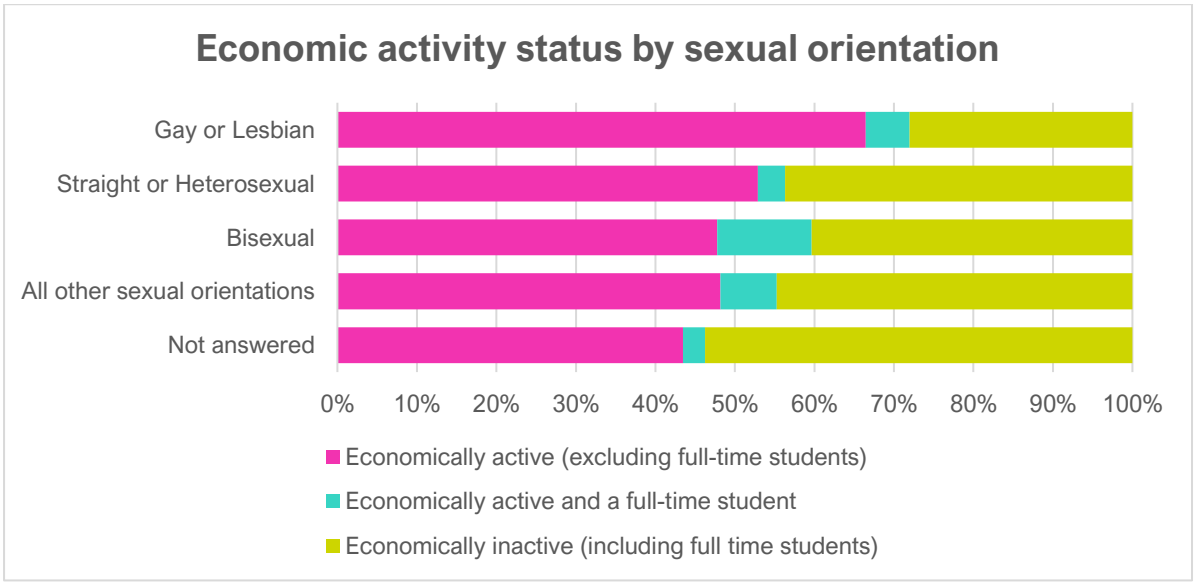

Household size by disability status
Disability status
Not disabled under the Equality Act: No long-term physical or mental health conditions
Not disabled under the Equality Act: Has long-term physical or mental health condition but day-to-day activities are not limited
Disabled under the Equality Act: Day-to-day activities limited a lot
Disabled under the Equality Act: Day-to-day activities limited a little
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
1 person in household
2 people in household
3 people in household
4 or more people in household

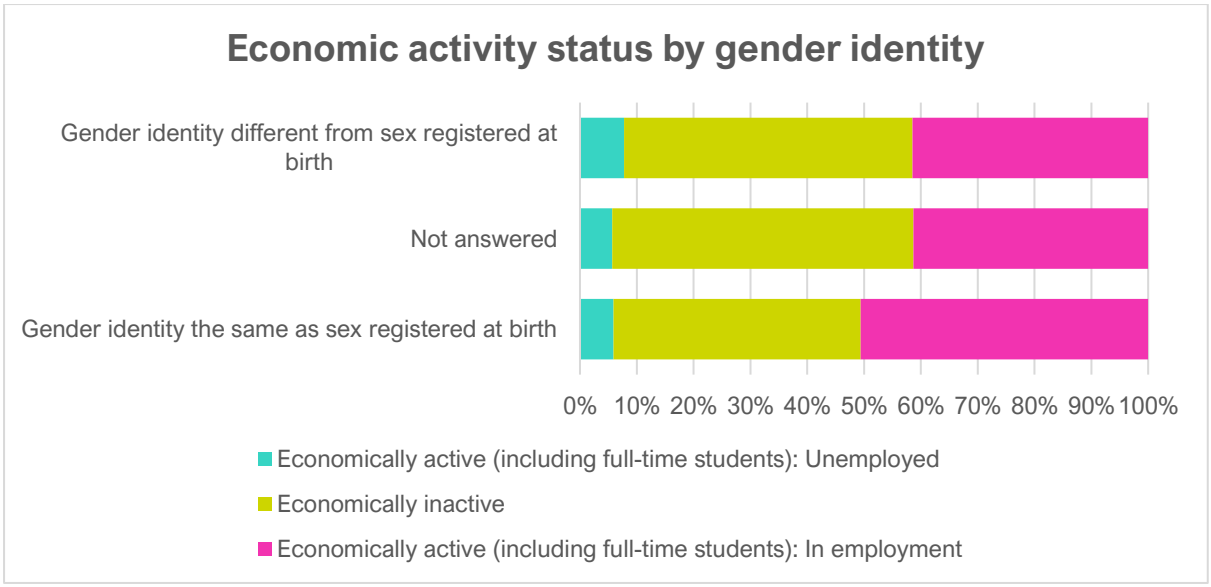

Household size by socio-economic classification
Socio-economic Classification
L15: Full-time students
L14.1 and L14.2: Never worked and long-term…
L13: Routine occupations
L12: Semi-routine occupations
L10 and L11: Lower supervisory and technical…
L8 and L9: Small employers and own account…
L7: Intermediate occupations
L4, L5 and L6: Lower managerial,…
L1, L2 and L3: Higher managerial,…
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
%
1 person in household
2 people in household
3 people in household
4 or more people in household

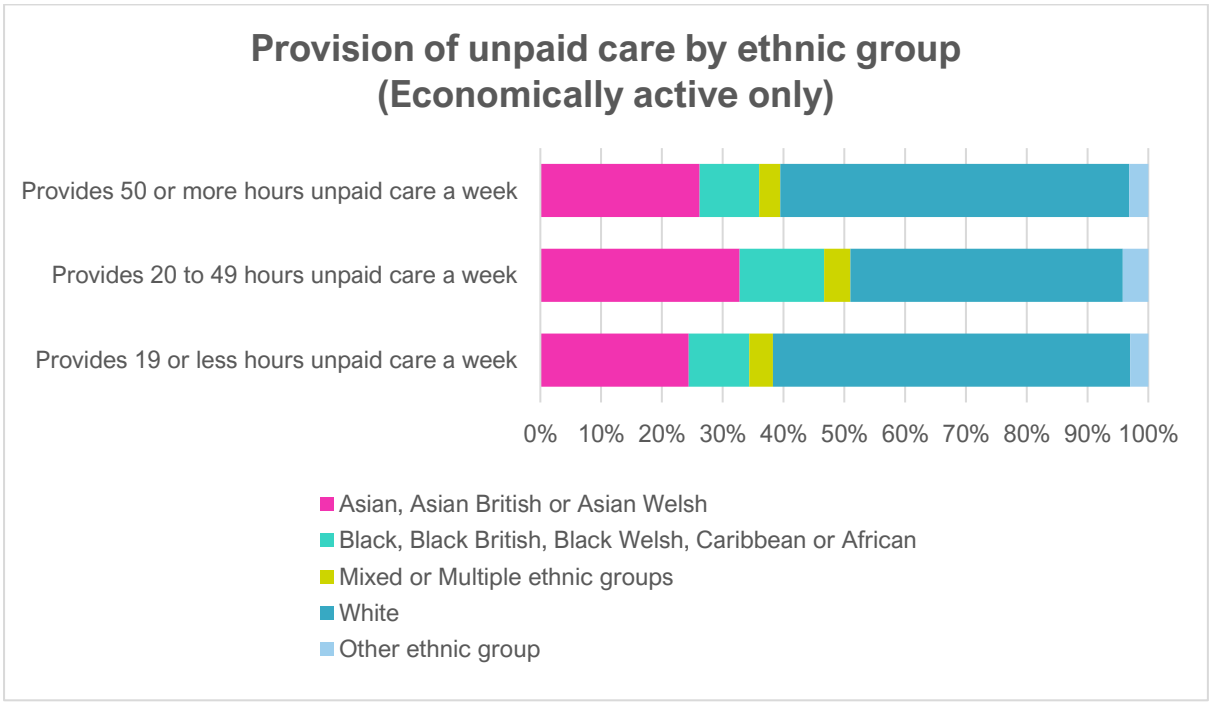

Tenure of household by age group
Aged 65 years and over
Aged 50 to 64 years
Aged 35 to 49 years
Aged 25 to 34 years
Aged 16 to 24 years
Aged 15 years and under
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
%
Owned: Owns outright
Owned: Owns with a mortgage or loan or shared ownership
Rented: Social rented
Private rented or lives rent free


Tenure of household by socio-economic classification
Socio-economic Classification
L15: Full-time students
L14.1 and L14.2: Never worked and long-term…
L13: Routine occupations
L12: Semi-routine occupations
L10 and L11: Lower supervisory and technical…
L8 and L9: Small employers and own account…
L7: Intermediate occupations
L4, L5 and L6: Lower managerial,…
L1, L2 and L3: Higher managerial,…
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
%
Owned: Owns outright
Owned: Owns with a mortgage or loan or shared ownership
Rented: Social rented
Private rented or lives rent free

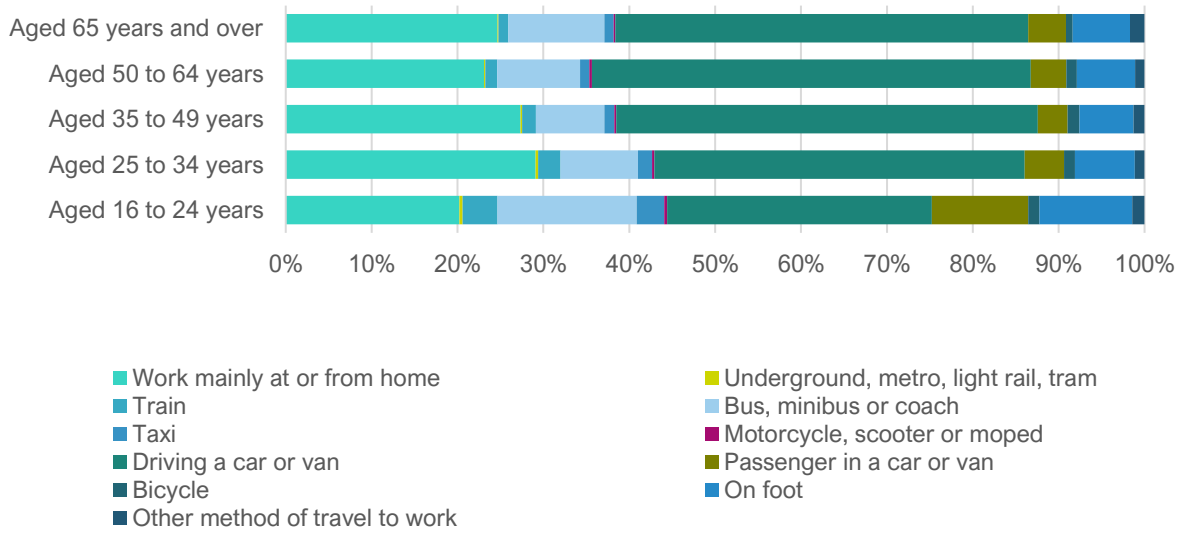

Tenure of household by disability status
Disability status
Not disabled under the Equality Act: No long-term physical or mental health conditions
Not disabled under the Equality Act: Has long-term physical or mental health condition but day-to-day activities are not limited
Disabled under the Equality Act: Day-to-day activities limited a lot
Disabled under the Equality Act: Day-to-day activities limited a little
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Owned: Owns outright
Owned: Owns with a mortgage or loan or shared ownership
Rented: Social rented
Private rented or lives rent free


Economic activity status by sexual orientation
Gay or Lesbian
Straight or Heterosexual
Bisexual
All other sexual orientations
Not answered
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Economically active (excluding full-time students)
Economically active and a full-time student
Economically inactive (including full time students)

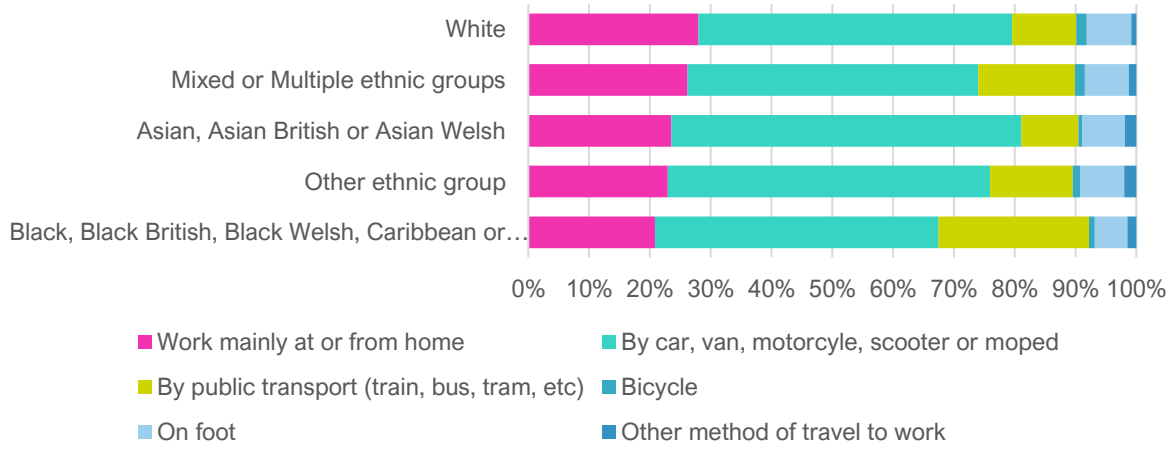

Economic activity status by gender identity
Gender identity different from sex registered at birth
Not answered
Gender identity the same as sex registered at birth
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Economically active (including full-time students): Unemployed
Economically inactive
Economically active (including full-time students): In employment


Provision of unpaid care by ethnic group
(Economically active only)
Provides 50 or more hours unpaid care a week
Provides 20 to 49 hours unpaid care a week
Provides 19 or less hours unpaid care a week
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Asian, Asian British or Asian Welsh
Black, Black British, Black Welsh, Caribbean or African
Mixed or Multiple ethnic groups
White
Other ethnic group

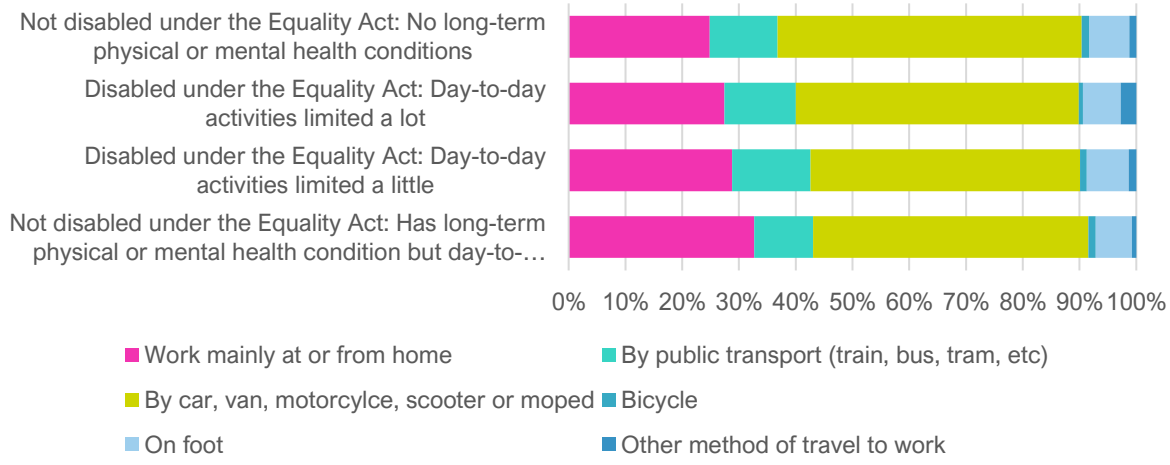
Method of travel to work by age group



Method used to travel to work by ethnic group



Method used to travel to work by disability



	Agenda Item: 10
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**28th March 2024**
TITLE:	**Updating the Joint Forward Plan 2024/25**
Organisation	**BSol Integrated Care Board**
Presenting Officer	**Rob Checketts, Chief Officer for Policy**

Report Type:	**Information / Discussion**

1. Purpose:

1.1. To update the committee on the process and plan for updating the Joint Forward Plan (JFP).

2. Implications (tick all that apply):

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

3. Recommendation

3.1. For the committee to note the process and plan to update the JFP for 2024/25.

4. Report Body

4.1. **The report notes the following key points and includes a timeline for delivery:**

- Not planning on making substantial changes to JFP itself: this is a five year strategy (although we will be updating a small number of details to accommodate regulatory or legal changes)
- However, we will be publishing a JFP Delivery Plan this year to help to drive the commitments we've made in the JFP
- In the process of agreeing a series of Strategic Intentions with the three main integrators
- Will also include high-level planning commitments made for 2024/5 to provide a single plan for delivery

1. Compliance Issues

1.1. HWBB Forum Responsibility and Board Update

The Board is asked to support the approach being taken to developing the updated JFP and delivery plan.

1.2. Management Responsibility

All management across the system will be asked to operationalise the delivery plan in the area that they are responsible for.

1.3. Finance Implications

To consider the delivery plan in the context of the financial restraints that we are facing in health and social care across the system.

1.4. Legal Implications

To support the delivery of the plan to ensure the system work towards and meets any statutory requirements.

1.5. Equalities Implications (Public Sector Equality Duty)

To ensure the public sector equality duty is considered and applied where applicable.

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
A continued delay to the planning guidance being published	Possible	Delay to planned timeline and completion of the JFP	Continue to develop the plan using assumptions and known targets

Appendices
Appendix one - Updating the Joint Forward Plan 2024/25

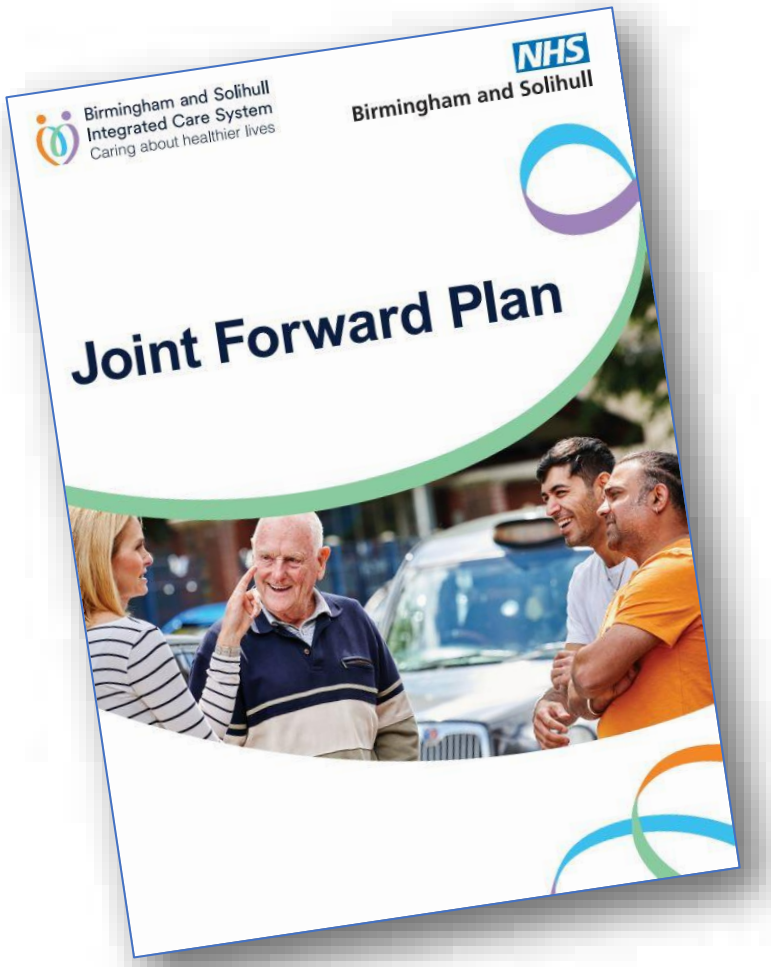
Background Papers
Current JFP - NHS Birmingham and Solihull – 5-year Joint Forward Plan

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

Birmingham and Solihull
Integrated Care System
Caring about healthier lives

Updating the Joint Forward Plan 2024/25

UPDATING THE JFP



- Not planning on making substantial changes to JFP itself: this is a five year strategy (although we will be updating a small number of details to accommodate regulatory or legal changes)
- However, we will be publishing a **JFP Delivery Plan** this year to help to drive the commitments we've made in the JFP
- In the process of agreeing a series of Strategic Intentions with the three main integrators
- Will also include high-level planning commitments made for 2024/5 to provide a single plan for delivery

PLANNING ROUND 24/5: ENGAGING THE WHOLE LEADERSHIP COMMUNITY TO DEVELOP OUR APPROACH

AT THE JANUARY QUARTERLY LEADERSHIP SESSION WE FOCUSSED ON PLANNING AND HOW WE COULD IMPROVE ON OUR APPROACH LAST YEAR

What lessons can we learn from previous planning exercises that can help us to improve our approach?

- Understand high level plans and ambitions
- Planning is for all year not just for xmas
- Collective board support early
- Collaborative and SRO (provider) ownership of trajectories

Reflecting back on the compassion charter what behaviours will be critical for us to demonstrate in this process?

- Balancing top down pressures and how people are currently experiencing the system and willingness to take risk
- How do we have honest conversations in psychologically safe spaces
- Importance of listening with curiosity
- Even with all the planning we will get flash points so how do we deal with those in year
- Reflect on skills we need to help everyone engage
- What do we need for leadership skills and how do we use those to support our people

How can we ensure that staff, patient and citizen voice is built into our approach?

- Build on the open conversation and staff surveys and actively engaging staff in the business planning processes – what do our services think we should improve
- Use current asset base we have for citizens and work with partners such as health watch
- Think about voice through locality lens
- Need to focus on storytelling – authentic stories of staff and citizens lived experience

How does the progress on our provider collaboratives influence our planning approach?

- Should make it more accessible and easier, tackle variation and duplication and enablers that will get us to the end
- Will empower people to own the issues we are solving and work with practitioners to resolve issues for our communities
- Create greater flexibility by pooling knowledge skills and expertise and across resources
- Commonality of voice agreeing on the right priorities
- Will mean we need to identify gaps where things don't fit – should these then be ICB or collaborative take on for system
- Need to do alignment and collaboration between collaboratives
- What are the mechanisms that we need to put in place to act on it

PLANNING ROUND 24/5: WHAT DO WE NEED TO ACHIEVE?

OBJECTIVES

1. **STRATEGIC IMPROVEMENT –** HARD-WIRING THE REFORMS INTO DELIVERY
2. **PERFORMANCE DELIVERY –** CLEAR TRAJECTORIES AGREED WITH THE SYSTEM
3. **FINANCIAL BALANCE –** DELIVERY WITHIN OUR MEANS
4. **A SOLID WORKFORCE PLAN –** TO UNDERPIN OUR APPROACH

OUTPUTS DELIVERED WITH AND THROUGH SYSTEM LEADERS

AGREE STRATEGIC COMMISSIONING GOALS – DEVELOPED WITH NOMINATED SROs FOR COLLABORATIVES AND TRUSTS: TO ACHIEVE CLEAR TARGETS TO ACCELERATE DELIVERY OF THE NEW MODEL OF CARE

NEW ACTIVITY METRICS AGREED WITH SOG – CONVERSATIONS TO BEGIN BEFORE PLNNING GUIDANCE IS PUBLISHED ASSUMING FLAT CASH FOR 24/5

DATA, FINCANCE AND WORKFORCE TO UNDERPIN EVERY AMBITION SET OUT IN THE NEW STRATEGIC COMMISSIONING GOALS AND REVISED ACTIVITY METRICS

REVSIED ROADMAPS AND REVISED JOINT FORWARD PLAN – TO BE PUBLISHED AT THE END OF THE PROCESS

BUILDING ON THE SYSTEM ENAGEMENT WE DELIVERED THROUGH THE PLANNING PROCESS LAST YEAR, OUR AMBITION IS TO ENSURE THAT ALL NOMINATED SROs ARE GIVEN THE AMPLE OPPORTUNITY TO BE FULLY ENGAGED IN AGREEING TRAJORTORIES AND DELIVERABLES FOR 24/5

PLANNING ROUND 24/5: FOUR OBJECTIVES, ONE TEAM APPROACH

ONE TEAM APPROACH – ICB PLANNING GROUP WILL INCLUDE SENIOR LEADERSHIP FROM ACROSS THE ICB TO ENSURE OUR APPROALCH IS AS ROBUST AS POSSIBLE

AIM IS TO ENSURE THAT TRUSTS AND COLLABORATIVES ARE GETTING CONSISTENT ADVICE, SUPPORT AND EXPECTATIONS THROUGHOUT THE PLANNING PROCESS

PLANNING ROUND 24/5: FOCUS ON WORKFORCE

Where we were

- High nursing vacancies
- Little or no growth in workforce over the medium term
- Turnover/ Sickness absence one of highest in Midlands
- Significant growth in agency spending

Where we are

Achieving workforce growth through:

- Reducing turnover in line with plans
- International Recruitment (1000 recruits over 2yrs)
- Reduction in sickness absence
- Reduction in Agency Utilisation
- No off framework agency
- Reduction in price cap breaches
- Significant reduction in admin/ estates agency

- Work to reset workforce baseline and assumptions into 24/25
- 3 new HEIs providing Nursing education, significant growth in placements

Transformation activity

- Established 4R's Workforce Delivery Framework- funding sought for delivery from April 24 onwards
- Support offer being developed for Collaboratives, INTs and Place

Building on existing successes e.g.:

- I Can- work as Anchor organisation (500 jobs offered)
- Education Collaborative- Widening access to Health and Care Careers Faculty (incl Work Experience/ Apprenticeships) and Social Care Faculty Development
- System Retention Programme
- E,D & I Strategy
- Talent Strategy Development
- Cultural Framework and System Values and Behaviours

PLANNING ROUND 24/5: SUBMISSION TIMELINES

- Templates issued 30th Jan
- Finance flash submission 29 Feb (finance and activity)
- Finance activity first cut submission 21st March
- JFP Delivery Plan drafted 30th March
- Final submissions 2nd May

Some dates may shift depending on when planning guidance comes through

	Agenda Item: 11
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**28th March 2024**
TITLE:	**Creating an Active Birmingham Strategy – Consultation Findings**
Organisation	**Birmingham City Council**
Presenting Officer	**Humera Sultan / Ibrahim Subdurally-Plon**

Report Type:	**Discussion and Approval**

1. Purpose:

1.1. To present the findings of the Creating an Active Birmingham Strategy (CABS) consultation and the Final strategy

1.2. To advise Health and Wellbeing Board members about the intention to seek Cabinet's ratification

2. Implications (tick all that apply):

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

3. Recommendation

3.1. Board members to note the CABS Consultation Findings

3.2. Board members to support the Final Strategy and Implementation Plan

4. Report Body

4.1. Co-produced with city partners, the Public Health (PH) Physical Activity (PA) team has developed the Creating an Active Birmingham Strategy (CABS) which focuses on developing opportunities for people to build PA into everyday life, through active living, active recreation, and active travel. It complements other strategies and plans in place across the city, such as the Sports Strategy and Birmingham transport Plan. Collectively these come together to ensure a whole system approach will be taken to increasing PA. A Physical Activity Needs Assessment has also been conducted to ensure the strategy has a strong evidence base.

4.2. CABS can be found in Appendix 1; Implementation Plan can be found in Appendix 2; PANA can be found in Appendices 3.

4.3. The strategy identifies opportunities, barriers and challenges and bring all partners together to develop a coordinated set of delivery plans to support the implementation of the strategy, focusing on key geographies and communities where targeted action is needed. These plans will drive the change needed and show how we will go further and faster to reach our ambitious targets for the city.

4.4. CABS will be implemented and delivered across the entire Birmingham system and will be managed by the Active City Forum (previously Creating an Active City Forum). It aims to achieve the following:

4.5. Reduce the percentage (%) of adults who are physically inactive (25%) to 20% by 2030

4.6. Increase the percentage (%) of adults walking (17.7%) for travel at least three days a week to 25% by 2030

4.7. Increase the percentage (%) of adults cycling (2%) for travel at least three days a week to 4% by 2030

4.8. Increase the percentage (%) of physically active children and young people (41.6%) to the national average (47.2%) by 2030

4.9. Reduce the inactivity gap (20%) between those living with disabilities and long-term health conditions and those without to 10% by 2030

4.10. Reduce the inactivity gap between minority ethnic communities (Asian not including Chinese – 38%, Black – 35%) and white ethnicity (29%) by 50% by 2030.

4.11. The PH PA Team obtained permission from cabinet in November to consult with the public from 20th of November 2023 until the 15th of January 2024.

4.12. To maximise responses, the Consultation primarily tapped into three platforms – BeHeard online questionnaire, Face-to-face Consultation sessions and Assisted Consultation through the Seldom Heard Voices (SHV) project where those who are most disadvantaged when it comes to physical activity were supported to give their views on the draft strategy. These include carers, older

adults, women and girls, South Asians, those with physical disability and those with learning difficulties.

4.13. 321 responses (inclusive of Assisted Consultation responses) have been received from the BeHeard platform, the team has engaged with 879 citizens face-to-face at 19 libraries, 10 leisure centres, 11 community centres and 1 faith-based organisation. Four SHV providers supported 93 of the most disadvantaged demographics to complete the BeHeard questionnaire.

4.14. During the Consultation process, respondents were asked to indicate interest if they would like to be part of a citizens Panel that will provide advice and contribution on best approaches to implement the CABS. 127 respondents volunteered to be part of the Citizens Panel. We have informed them that we are devising a plan for continued engagement through the year to maximise their input without necessarily taking too much of their time.

4.15. The full Consultation Report can be found in Appendix 4.

4.16. The most recurring theme from the Consultation findings was in relation to inclusivity and accessibility of Physical Activity opportunities for people of all ages and all abilities. Residents also emphasised for partnerships with grassroot and community-led organisations to bridge the gap in inactivity levels across diverse groups.

4.17. Accessibility and inclusivity were important to respondents. They emphasised the importance of considering diverse needs in the Creating an Active Birmingham Strategy. The strategy should address the needs of all ages and abilities, ensuring access to resources for physical activity. Residents also highlighted the need for equitable provision for the most disadvantaged groups facing health inequalities.

4.18. Concerns were raised about practical access, such as inconvenient timing or inaccessible locations for activities. Working-age individuals may face disadvantages due to conflicting work hours, and poor public transport limits access.

4.19. Affordability is a significant theme, extending beyond access to activities. Residents worry about potential decreases in affordability due to the Council's financial challenges. Many raised they enjoy BeActive classes, and that more investment should be made into accessible classes at appropriate times.

4.20. Respondents felt safe and adequate infrastructure is crucial to making physical activity an easy choice. This encompasses safer roads, cycle paths, green spaces, and secure indoor facilities.

4.21. Residents felt it is key to have a holistic, whole-system approach to ensure Birmingham becomes an active city. Collaboration with partners is crucial, but residents emphasised involving and empowering grassroot and community-led organisations, leveraging existing relationships to bridge the inactivity gap.

4.22. Appendix 5 outlines the key asks from residents in the Consultation and how we have addressed the strategy and implementation plan to reflect these.

4.23. Equality Impact Assessment complete on the 7th of February 2024. Approval pending.

5. Compliance Issues

5.1. HWBB Forum Responsibility and Board Update

The Active City forum (ACF) is a sub-forum of the Health and Wellbeing Board, a statutory body created under the Health and Care Act 2012. The ACF will manage delivery of the CABS.

5.2. Management Responsibility

Dr Justin Varney, Director of Public Health, BCC
Humera Sultan, Consultant in Public Health, BCC
Dr Mary Orhewere, Assistant Director, Public Health, BCC
Ibrahim Subdurally-Plon, Service Lead, Physical Activity, Public Health, BCC

5.3. Finance Implications

There are no financial implications on the Council's general fund resources arising from this report. Where relevant and appropriate the Public Health Grant may be used for programmes of focused work highlighted in the Creating an Active Birmingham Strategy (CABS) and Physical Activity Needs Assessment (PANA). However, most of the work of the team will involve co-production work with partners in the city to promote individual behaviour change.

5.4. Legal Implications

None identified.

5.5. Equalities Implications (Public Sector Equality Duty)

Equality Impact Assessment complete on the 7th of February 2024. Approval pending.

6. Risk Analysis

6.1. There are no perceived risks associated with the Creating an Active Birmingham Strategy. We will embed continuous monitoring to identify, mitigate, and manage any risks should they arise in the future.

6.2. The key focus on the strategy is on enabling system collaboration to promote behaviour individual change. As such, financial risk is minimal too.

6. Appendices

Appendix 1 – Creating an Active Birmingham Strategy

Appendix 2 – Implementation Plan

Appendix 3 – Physical Activity Needs Assessment

Appendix 4 – Creating an Active Birmingham Strategy Consultation Report

Appendix 5 – 'You said, we did' summary

Appendix 6 – Summary Slides

The following people have been involved in the preparation of this board paper:
Ibrahim Subdurally-Plon, Service Lead, Physical Activity, Public Health, Birmingham City Council

CREATING AN ACTIVE BIRMINGHAM STRATEGY

Birmingham Physical Activity Strategy 2024-2034

Document Information

Document status	Final
Author	Public Health
Document Version	6.0
Document Date	January 2024

Contents

Foreword

Being active and enjoying physical activity has many benefits for our physical and mental health. Physically active people are less likely to suffer from health conditions such as cancer, heart disease and diabetes. In addition, being physically active has a positive impact on our mental wellbeing. It is important that we build activity into our daily lives from early years through to older age.

However, in Birmingham not everyone is meeting the daily recommendations for physical activity. Across the city there are also health inequalities that exist, with some communities and wards not being as active as others and therefore not experiencing the benefits that come from being active. For this reason, we are working in partnership with stakeholders from across the city through the Active City Forum. This will support all people living in Birmingham to become more active and to create places that ensure being active is an easy choice.

This strategy sets out our vision for Birmingham to be an active city and how we will enable everyone to move more, creating a bolder, healthier city. The strategy provides a framework for collective action, working across a wide range of partners and communities, putting them at the heart of action. As a partnership we will work together over the next ten years to break down the barriers faced within our communities and create opportunities for large scale, lasting change. The legacy from the Commonwealth Games, the new regional transport plans, and work to create beautiful green spaces in the city all make a huge contribution to supporting local people to build physical activity into their everyday lives. However, we can and should be doing more. Together we can drive the bold changes needed to prioritise physical activity to enable everyone in our city to be active at every age and ability.

Cllr Mariam Khan

Introduction

Birmingham is a wonderfully diverse city, with a vibrant and growing population. It has a well-established and varied physical activity landscape including a wealth of community groups, clubs and facilities, physical activity providers, community organisations and venues. In addition, Birmingham has a rich sporting heritage ranging from top international athletics, world championship snooker, international badminton, and most recently, Birmingham hosted the 2022 Commonwealth Games. There is lots to celebrate and build upon in the city.

Birmingham has ambitious plans which play an instrumental role in developing a more active city; the innovative Low Traffic Neighbourhoods scheme has created spaces and places that are more accessible and safer enabling people to be more active in different ways. This has provided an increased focus on active travel, supporting people to walk and cycle in their local communities. Through the Future Parks Accelerator programme, the City of Nature Alliance has been established to implement the work that the accelerator identified. It is anticipated that over the next 25 years, this Alliance will help deliver Birmingham's vision to become a 'City of Nature'.

In contrast, Birmingham is the 7th most deprived local authority in the country, and the most deprived authority in the West Midlands. Across Birmingham there are stark inequalities that exist between neighbourhoods relating to health outcomes, living conditions and life chances. Through the creation of equitable, accessible and affordable opportunities and an environment that supports people to build activity into everyday life we can make real differences in addressing these inequalities. By prioritising physical activity, as residents of Birmingham agreed, we will improve the health and wellbeing of our city, contribute to our climate change ambitions and support our city economy to thrive.

Background

Why do we need a physical activity strategy?

"Giving people the opportunity to engage with physical activities local to them will help combat health related issues . Physical and mental. I think there should be long term sustainable plans to continue access of physical activities to the locals."

Female; 40s; South Asian; Bordesley Green

Being active and enjoying physical activity has many benefits for our physical and mental health. Physically active people are less likely to suffer from health conditions such as cancer, heart disease and diabetes. In addition, being physically active has a positive impact on our mental wellbeing. In Birmingham we want to create an environment where everyone can build physical activity into their lives right across the life course from early years through to older age.

However, not everyone within the city is meeting the daily recommendations for physical activity. There are also several inequalities that exist across the city, with some communities and wards being less active than others and therefore not experiencing the many benefits that come from being active. We can and should be doing more; together we can drive the bold changes needed to prioritise physical activity and sport so everyone in our city can be active and enjoy the benefits this brings.

This citywide, co-produced strategy captures how we will work together to create a movement across the city to enable people of every age and ability to be active, by building physical activity into everyday life and making it an easier choice.

What will the strategy do?

We want to create Birmingham as an active city, where physical activity is an easy choice. The strategy focuses on developing equitable, accessible and affordable opportunities for people to build physical activity into everyday life, through active living, active recreation, and active travel. It complements other strategies and plans in place across the city which collectively come together to ensure a whole system approach is taken to increasing physical activity.

Working across Public Health, Sport, and Active Travel within Birmingham City Council (BCC) and a range of partners, we are undertaking exciting work to develop a whole system approach to physical activity in Birmingham. By working together, across a wide range of partners and communities, we aim to change our culture to one that values physical activity, sport, and movement. As a partnership we want to work together to break down the barriers faced within our communities and create opportunities for large scale, sustainable change.

The strategy has a key focus on behaviour change and is underpinned by evidence-based models such as COM-B model. The ability to be physically active is influenced by what residents know and can do (C= Capability), the people, the opportunities and the environment around them (O = opportunity) and their beliefs on how they see themselves being active, their emotions and habits (M=Motivation).

Through the identification of the opportunities, barriers and challenges, all partners can come together to develop a coordinated set of delivery plans to support the implementation of the strategy, with a focus on key geographies and communities where targeted action is needed. These plans will drive the change needed and show how we will go further and faster reach our ambitious targets for the city.

How has the strategy been developed?

The strategy has been co-produced with a wide range of stakeholders who have an interest in and are involved in physical activity across the city. A series of stakeholder meetings, surveys and workshops have been organised to bring people together and to involve them in the development of the strategy and delivery plans. These include:

A large stakeholder engagement event held in April 2023 that brought partners together to inform and shape the work that Public Health, Sport, and Active Travel are undertaking to develop a vision to create a whole system approach to physical activity in Birmingham. A summary of this event can be found in Appendix 1. The outputs from this event have been used to inform the vision and priorities for the strategy.

Two follow up online events were held at the beginning of September 2023 with the aim of sharing with stakeholders a summary of findings from the Physical Activity Needs Assessment, the emerging themes for the Creating an Active City Strategy and starting a conversation about system leadership of priorities and development of implementation plans. Outputs from the second set of events have been used to review the work of the Creating an Active City Forum which reports to the Health and Wellbeing Board. The Forum will be the place where progress against the Strategy is discussed and monitored.

In November 2023 until January 2024, for 8 weeks, a series of consultations, online and offline, with the public took place that informed the Implementation Plan for this ten-year strategy.

Why is Physical Activity important?

It saves lives and protects our health, both mental and physical

It benefits communities

It saves the NHS and wider system money

The UK Chief Medical Officers' (CMOs) physical activity guidelines launched in September 2019, reiterated a clear message about physical activity:

"If physical activity were a drug, we would refer to it as a miracle cure, due to the great many illnesses it can prevent and help treat".

Regular physical activity provides a range of physical and mental health, and social benefits, many of which are increasing issues for individuals, communities and society. These include:

- reducing the risk of many long-term conditions
- helping manage existing conditions
- ensuring good musculoskeletal health
- developing and maintaining physical and mental function and independence
- supporting social inclusion
- helping maintain a healthy weight
- reducing inequalities for people with long-term conditions

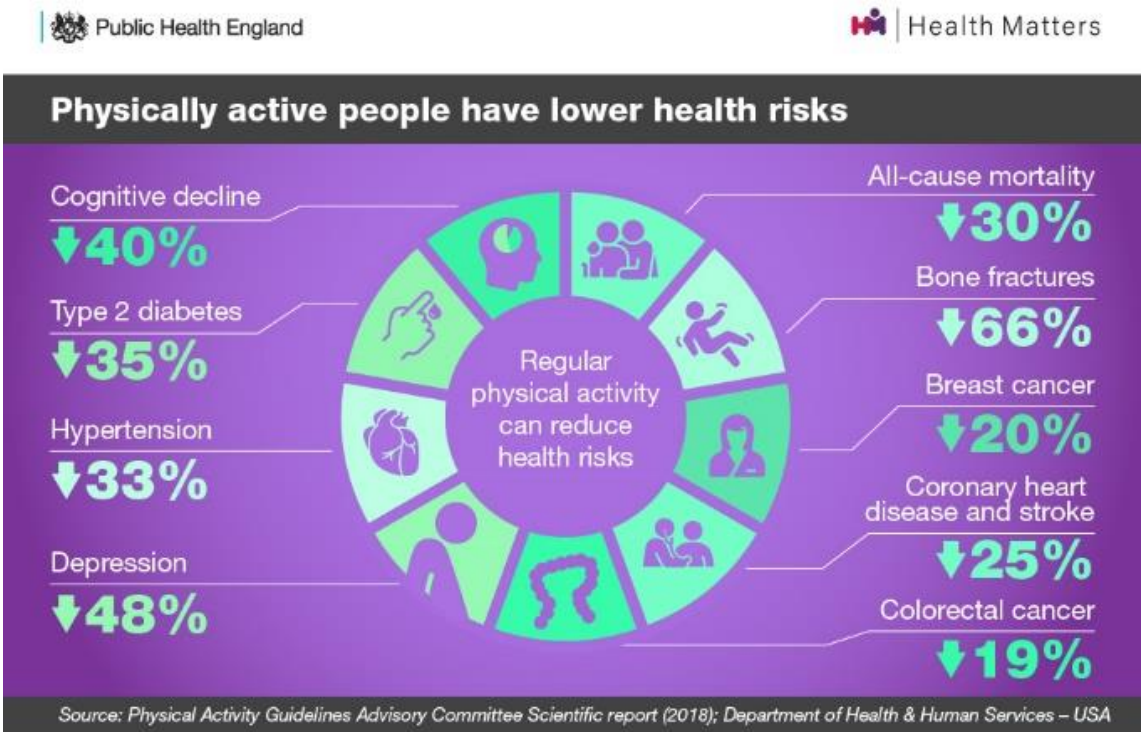


Figure 1: The reduction in health risks from regular physical activity[1]

The Picture in Birmingham

To help us understand the picture in Birmingham, a rapid Physical Activity Needs Assessment (PANA) was carried out. The PANA aimed to develop a systematic approach to understand the physical activity needs of the Birmingham population. It gathered local information about physical activity across the city to identify and prioritise the most effective support for those in the greatest need. The information generated through the PANA helps us to understand where we need to prioritise action to have the biggest impact.

Overall Physical Activity Levels

Nationally, 63.1% of the population are active, and 25.8% are inactive. Overall, activity levels have recovered following a period of falls during the pandemic and proportion of active adults is back in line with pre-pandemic levels. The proportion of inactive adults remains slightly up on pre-pandemic levels, with fewer adults being 'fairly active'[2,17]

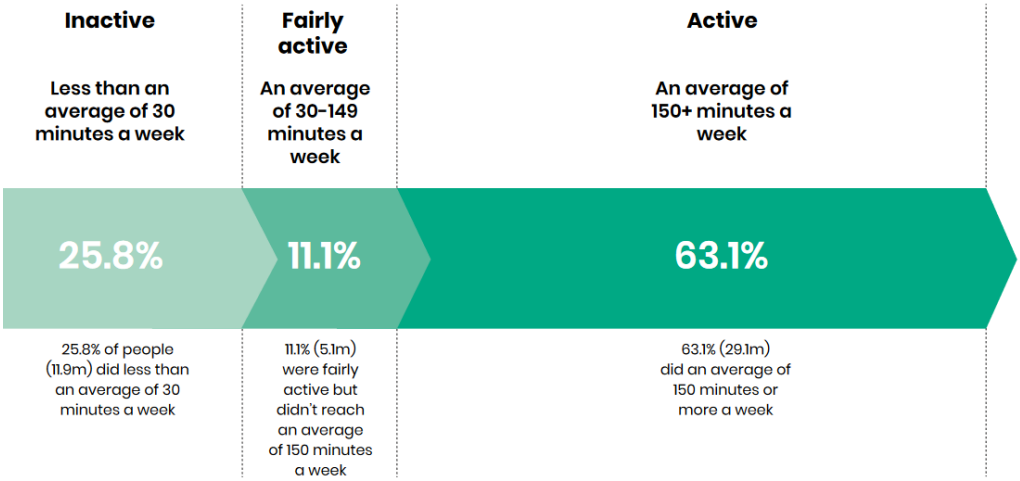


Figure 2: Levels of physical activity nationally according to CMO guidelines[1].

In Birmingham, over half of the adult population (55%) are meeting CMO guidelines, however this is less than both the West Midlands and national average. This means that nearly half of adults in the city are not doing enough activity. When we break this down a little further to look at different life stages, we can see that:

- 2 in 5 (42%) children & young people living in Birmingham are active (an average of 60+ minutes per day). However, when compared nationally and regionally, levels of activity in children living in Birmingham are among the lowest in the region (only Walsall and Wolverhampton have lower levels, 34% and 35% respectively) and second lowest (to Newcastle), when comparing with the core cities[i].
- Nearly 1 in 3 (30%) people aged between 16-54 living in Birmingham are inactive and 2 in 5 (39%) of older adults (aged 55 and above) are inactive. Only 30% of older adults (aged 55+) are meeting the CMO guidelines of 2+ sessions per week of muscle strengthening activity[1].

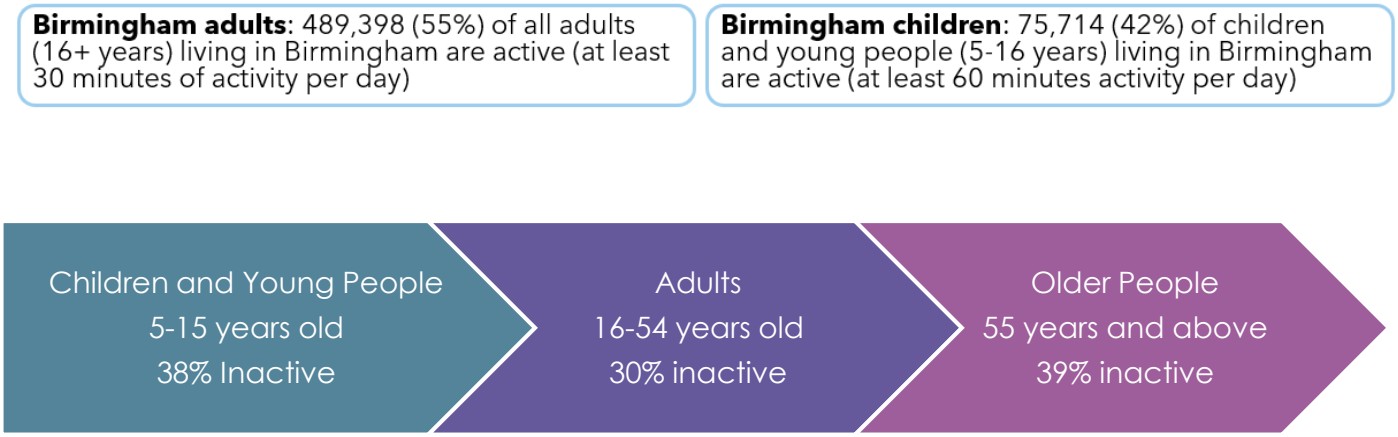


Figure 3: Levels of physical activity and inactivity in Birmingham across the life course.

[i] Birmingham, Bristol, Leeds, Liverpool, Manchester, Newcastle, Nottingham, Sheffield

What are the inequalities within Birmingham?

The PANA identified several significant inequalities in relation to physical activity in the city. It identified areas of greatest inactivity where we need to focus to have the maximum impact. The diagram below outlines the unmet needs across the city.

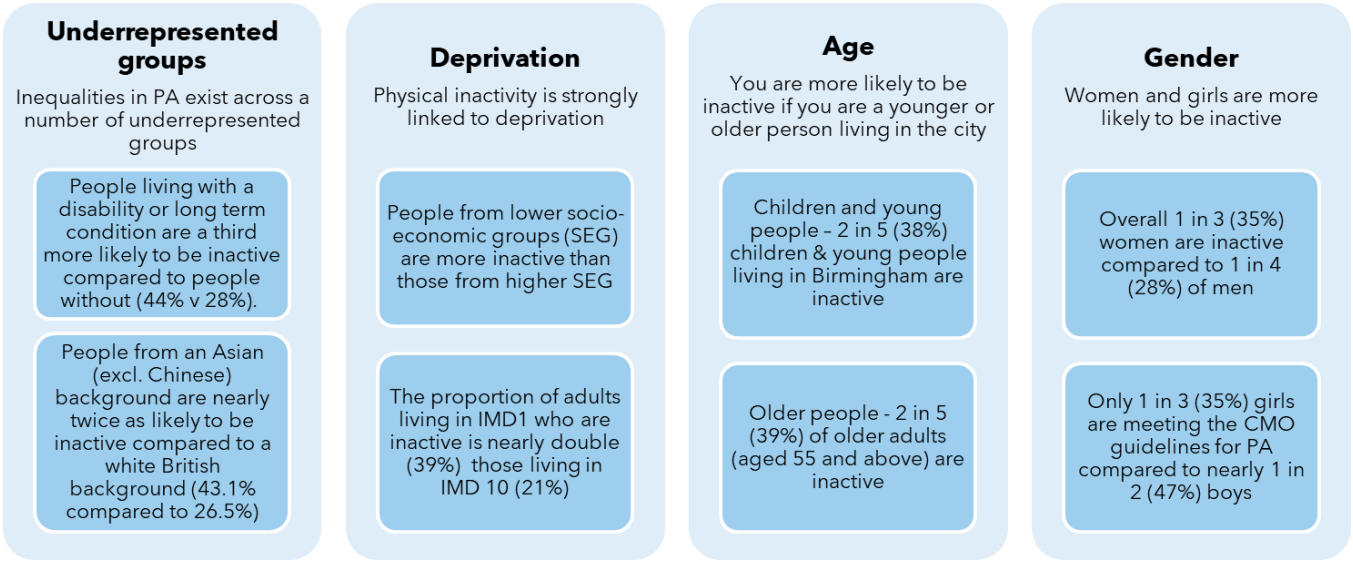


Figure 4: Physical activity Inequalities in Birmingham

The impact of COVID

"Since covid, some people's mental health was seriously impacted, and it will be useful to think how these people? will be motivated."

Male; 50s; White British; Bordesley Green

COVID exacerbated inequalities in physical activity, significantly impacting on physical and mental health and quality life for certain population groups. The COVID-19 National Impact Survey illustrated that the highest level of inactivity was in age groups 40-49 and 50-59 [3].

In Birmingham physical activity levels across all age groups were significantly impacted by the pandemic. Although levels of physical activity are returning to pre-pandemic levels, the ongoing impact may still be seen and felt. An ongoing focus will therefore be required on helping to remove the barriers to activity through understanding behaviour change and providing opportunities to people and communities that are experiencing these inequalities.

Insight from local communities

As part of the PANA, insight was developed into the barriers and enablers for local communities, especially those who are seldom heard, to support them to increase their physical activity. The PANA and the subsequent consultation with the public recommended that the following be considered when designing services or creating opportunities to increase physical activity in these groups:

- Develop knowledge and understanding of the local community to ensure needs are understood.
- Undertake appropriate engagement before developing provision and co-produce activities with communities and community-led grassroot organisations to ensure they are tailored to meet their needs.
- Use trusted organisations and relationships to provide information and activities to increase engagement and maintain commitment.

- Provide a diverse choice, which takes a flexible, person-centred approach.
- Where appropriate, target equitable, accessible and affordable activities for specific communities so they can be tailored to meet their needs and maximise engagement.
- Making use of technology to provide easily accessible and clear information to inform and engage people in activity.

Physical Activity – global, national and local picture

Creating an Active Birmingham Strategy has been informed by a range of global and national policies. These will be used as a framework to ensure our local strategy is evidence-based and in line with global and national guidance. In addition, the strategy will align to a range of local strategies, maximising opportunities and developing a whole system approach to increasing physical activity and ensure existing work is complemented and to avoid duplication.

What is happening internationally?

The *Global Action Plan on Physical Activity 2018-2030 (GAPPA) More active people for a Healthier World,* developed by the World Health Organisation, sets out four strategic objectives achievable through 20 policy actions that are universally applicable to all countries [4]. The plan recognises that each country is at a different starting point in their efforts to reduce levels of physical inactivity and sedentary behaviours [4]. It responds to the requests by countries for updated guidance, and a framework of effective and feasible policy actions to increase physical activity at all levels. It also responds to requests for global leadership and stronger regional and national coordination, and the need for a whole-of-society response to achieve a paradigm shift in both supporting and valuing all people being regularly active, according to ability and across the life course [4]. The action plan was developed through a worldwide consultation process involving governments and key stakeholders across multiple sectors including health, sports, transport, urban design, civil society, academia and the private sector [4].

The four strategic objectives provide a universally applicable framework for the 20 multi-dimensional policy actions, each identified as an important and effective component of a population-based response to increasing physical activity and reducing sedentary behaviour [4]. In combination, they capture the whole-of-system approach needed to create a society that intrinsically values and prioritises policy investments in physical activity as a regular part of everyday life.

1. Active societies - Create a paradigm shift in all of society by enhancing knowledge and understanding of, and appreciation for, the multiple benefits of regular physical activity, according to ability and at all ages.
2. Active environments - Create and maintain environments that promote and safeguard the rights of all people, of all ages, to have equitable access to safe places and spaces, in their cities and communities, in which to engage in regular physical activity, according to ability.
3. Active people - Create and promote access to opportunities and programmes, across multiple settings, to help people of all ages and abilities to engage in regular physical activity as individuals, families and communities.
4. Active systems - Create and strengthen leadership, governance, multisectoral partnerships, workforce capabilities, advocacy and information systems across sectors to achieve excellence in resource mobilisation and implementation of coordinated international, national and subnational action to increase physical activity and reduce sedentary behaviour.

The *Physical Activity Strategy for the WHO European Region 2016-2025* focuses on increasing the level of physical activity amongst European citizens [5]. The physical activity strategy aims to inspire governments and stakeholders to work towards increasing the level of physical activity among all citizens of the European Region by:

- promoting physical activity and reducing sedentary behaviours
- ensuring an enabling environment that supports physical activity through engaging and safe built environments, accessible public spaces and infrastructure
- providing equal opportunities for physical activity regardless of gender, age, income, education, ethnicity or disability
- removing barriers to and facilitating physical activity

The strategy focuses on five priority areas:

Priority area 1: Providing leadership and coordination for the promotion of physical activity
Priority area 2: Supporting the development of children and adolescents
Priority area 3: Promoting physical activity for all adults as part of daily life, including during transport, leisure time, at the workplace and through the healthcare system
Priority area 4: Promoting physical activity among older people
Priority area 5: Supporting action through monitoring, surveillance, the provision of tools, enabling platforms, evaluation, and research

What is happening nationally?

A Framework for Physical Activity- Everybody Active, Every Day (EAED) is a national evidence-based approach to physical activity developed by Public Health England. The framework aims to support all sectors to embed physical activity into the fabric of daily life and make it an easy, cost-effective, and 'normal' choice in every community in England [6] . It aims to improve physical and mental health and reduce health inequalities by increasing physical activity levels across the population[6] . Published in October 2014, the EAED framework calls for action across four specific domains and aims to improve physical and mental health and reduce health inequalities by increasing physical activity levels across the population. Published in October 2014, the EAED framework calls for action across four specific domains of:

- Active society - creating a social movement
- Moving professionals - activating networks of expertise
- Active environments - creating the right spaces
- Moving at scale - interventions that make us active

The Chief Medical Officers in the UK have developed Physical Activity Guidelines on the frequency, intensity and type of physical activity people should be doing to improve their health [1]. The document aims to help health professionals, policymakers and others working to promote physical activity, sport and exercise for health benefits [1] The guidelines are split into age groups from infants (less than 1 year) through to older adults (aged 65 and above). See appendix 1 for a summary of the guidelines.

Uniting the Movement is Sport England's 10-year vision to transform lives and communities through sport and physical activity [7]. Sport England have three key objectives:

- Advocating for movement, sport and physical activity
- Joining forces on five big issues
- Creating the catalysts for change

The strategy focuses on five big issues:

- Recover and reinvent
- Connecting Communities
- Positive experiences for children and young people
- Connecting with health and wellbeing
- Active environments

The *National Institute for Health and Care Excellence* have published evidence-based documents relating to physical activity which have been developed by independent committees, including professionals and lay members, and consulted on by stakeholders and provide recommendations to guide decisions at a local level across a wide range of stakeholders [8].

Behaviour change: general approaches – this guideline covers a set of principles that can be used to help people change their behaviour. The aim is for practitioners to use these principles to encourage people to adopt a healthier lifestyle by, for example, stopping smoking, adopting a healthy diet and being more physically active [9].

Promoting physical activity in the workplace– this guideline covers how to encourage employees to be physically active. The aim is to increase the working population's physical activity levels [10].

Promoting physical activity for children and young people) – this guideline covers promoting physical activity for children and young people aged under 18 at home, preschool, school and in the community. It includes raising awareness of the benefits of physical activity, listening to what children and young want, planning and providing spaces and facilities, and helping families build physical activity into their daily lives[11] (

Walking and Cycling: local measures to promote walking and cycling as forms of travel or recreation– this guideline covers how to encourage people to increase the amount they walk or cycle for travel or recreation purposes [12]

Physical activity: brief advice for adults in primary care– this guideline covers providing brief advice on physical activity to adults in primary care. It aims to improve health and wellbeing by raising awareness of the importance of physical activity and encouraging people to increase or maintain their activity level [13]

Exercise referral schemes to promote physical activity) – this guideline covers exercise referral schemes for people aged 19 and older, particularly those who are inactive or sedentary [14]

Quality Standard; Physical Activity: encouraging activity in all people in contact with the NHS.

Physical activity and the environment– this guideline covers how to improve the physical environment to encourage and support physical activity [8] It includes:

- Active Travel
- Public Open Spaces
- Buildings
- Schools

Physical activity: encouraging activity in the community– this quality standard covers how local strategy, policy and planning and improvements to the built and natural physical environment such as public open spaces, workplaces and schools can encourage and support people of all ages and all abilities to be physically active and move more [15].

Behaviour change: digital and mobile health interventions – this guideline covers interventions that use a digital or mobile platform to help people eat more healthily, become more active, stop smoking, reduce their alcohol intake or practise safer sex. The interventions include those delivered by text message, apps, wearable devices or the internet. The guideline only includes those that are delivered by the technology itself and not by healthcare professionals using technology to deliver interventions [16] .

What is happening locally?

This strategy aligns to and complements a range of local strategies, plans and reports. These strategies cover a range of interrelated areas and together will ensure a whole system approach is developed to addressing physical inactivity within the city.

Creating a Bolder Healthier Birmingham 2022-2030 – physical activity is one of five core themes to support the achievement of the vision to create a city where every citizen, whoever they are, wherever they live and at every stage of life, can make choices that empower them to be happy and healthy.

Birmingham Sports Strategy – a new strategy is currently in development and aims to create a shared vision for sport across the city with the ambition of getting more people physically active and participating in sport, providing opportunities from grassroots sports through to elite performance.

Birmingham Transport Strategy – The Birmingham Transport Plan 2031 describes what the city needs to do differently to meet the demands of the future. A key component of the plan is around prioritising active travel in local neighbourhoods and ensuring walking, cycling and active travel become the first choice for short journeys.

A Bolder, Healthier Future for the People of Birmingham and Solihull Strategy for Health and Care 2023 – 2033 – Birmingham and Solihull's Integrated Care Strategy outlines five clinical areas to focus on:

- Circulatory disease
- Infant mortality
- Respiratory disease
- Cancer
- Mental health

Birmingham 2022 Commonwealth Games Legacy Plan – Birmingham 2022 Commonwealth Games organisers and its partners developed a national Legacy Plan, which outlined a series of ambitions to leave a lasting, positive impact on jobs, skills, education, culture, physical activity and investment across the West Midlands and the UK. The plan boosted investment across Birmingham and the West Midlands, to engage people who face multiple barriers and look to approach these challenges in new ways. This included projects like the 'Active Communities Local Delivery Pilot' in partnership with The Active Wellbeing Society. This project supports physical activity in deprived communities to help close the inequality gap, focusing on deprivation, age, and ethnicity. It will be part of this wider strategy that will work on culturally competent approaches to promote physical activity.

Promoting Health and Wellbeing – a Commonwealth Games Legacy Overview and Scrutiny Report – the inquiry conducted by the Commonwealth Games, Culture and Physical Activity Overview and Scrutiny Committee set out a number of recommendations to ensure the legacy from the Commonwealth Games improves access to physical activity opportunities (both participating and spectating) for disabled citizens and communities in Birmingham.

Future City Plan – sets out a blueprint for central Birmingham to create a vibrant city with a mix of activities including retail, offices, leisure, education, tourism, civic and community functions. With equal opportunities for all including access to jobs and high-quality homes.

Working together to create a whole system approach to physical activity

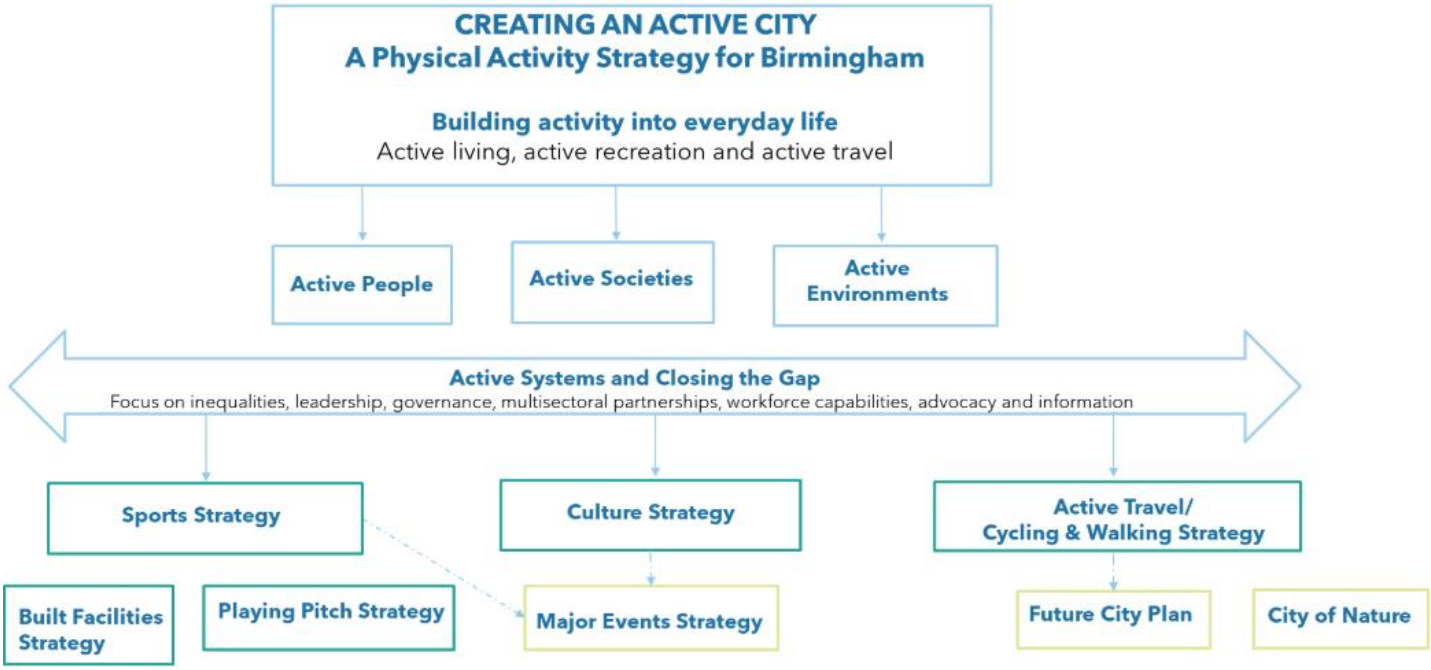


Figure 5: The relationship between the local strategies relating to physical activity across Birmingham.

Services, Initiatives and Opportunities

Birmingham has a wealth of initiatives and opportunities already in place which this strategy will build upon. This will enable us to realise our ambition to create a far-reaching movement into communities that makes physical activity the easy choice.

As part of the Physical Activity Needs Assessment (PANA), many services, initiatives and place-based physical activity opportunities were identified as part of the service and place-based mapping that was completed.

The PANA themed these activities using the following framework with examples.

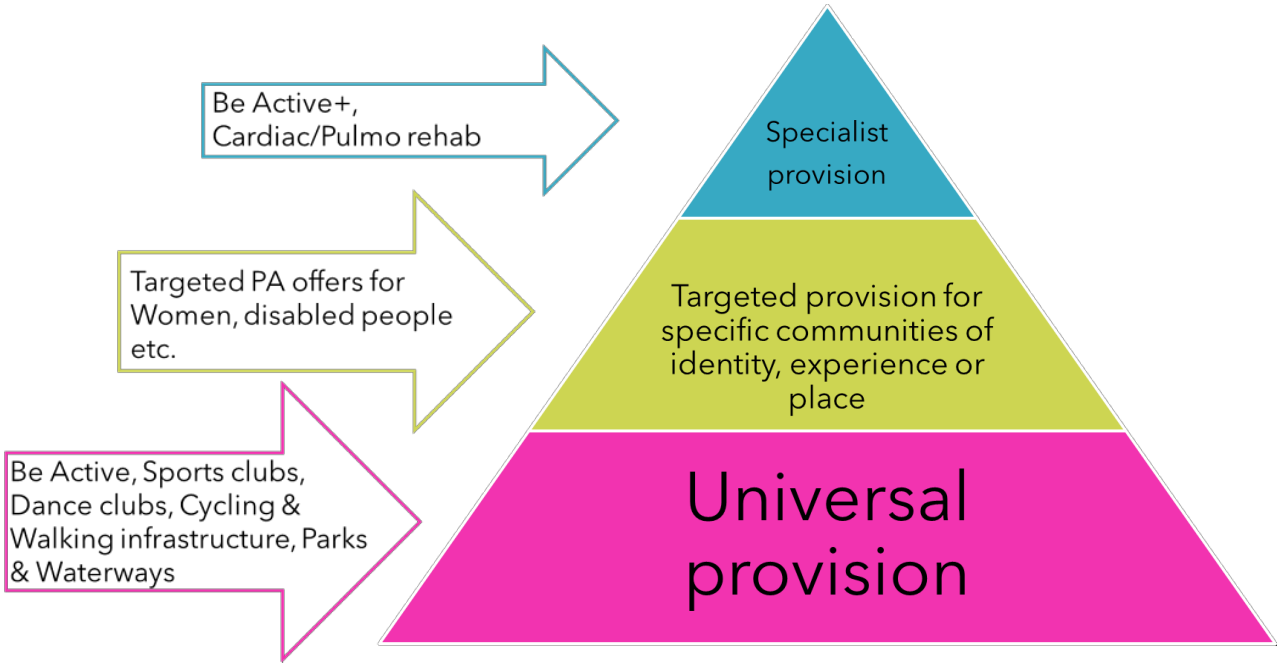


Figure 4: Service mapping themes for physical activity provision.

These existing opportunities provide the foundation for the city to build upon to reach further into communities by ensuring they are equitable, accessible and affordable through a whole-system approach. This will create lasting change for people living in the city.

What works? The current evidence base

A review of the current evidence has helped us to understand what the most up to date research is suggesting are the most effective interventions for increasing levels of physical activity. In July 2022, the UK Health Security Agency (UKHSA) worked with us to complete a search across three databases for the following questions:

- Which interventions show highest levels of physical activity increases?
- Which interventions work best for certain demographic groups?

A review of the results identified three major intervention types. These were exercise referral schemes (ERS), digital interventions, and place-based interventions. With these themes identified, further searches were completed to identify recent papers and relevant guidelines on these three topics. The findings from the review are summarised below.

Place-based interventions

What are they?

Place-based initiatives can be described as “any intervention, policy, programme or action that aims to improve health and reduce health inequalities and is delivered at a local or regional level, excluding interventions at a national level”.

Place-based approaches enable resources to be targeted towards the most disadvantaged areas and communities, supporting people to make healthier choices and have better health outcomes. In addition, approaches are strengthened when underpinned by behavioural science to support changes in behaviour to enable people to sustain increases in physical activity.

Whilst place-based interventions have the potential to increase levels of physical activity in the population, evidence of effectiveness is limited, and systematic reviews present mixed results with mostly positive, albeit small increases in physical activity.

Place-based interventions fall into three overlapping categories

- Improving the physical built environment
- Improving the social environment
- Improving the economic environment

Key findings include[7-10]:

- Environmental factors act as both enablers and barriers to physical activity in all age groups.
- Modifying the built environment can contribute to increased levels of physical activity for all ages.
- Interventions to promote walking and cycling as active transport deliver positive results on physical activity outcomes.
- Closer proximity to the intervention is associated with better outcomes.
- Transport links impact levels of activity – providing opportunities for active travel helps people incorporate physical activity into everyday life.

- Park-based interventions increase park use and subsequent physical activity behaviours and are most effective when promotion and marketing is implemented alongside physical change.
- Engaging with communities to tailor interventions increases positive effects.
- Green space interventions can integrate with social prescribing and ERS.
- Environmental approaches generate a wide range of co-benefits, improving many aspects of environment and health.
- Multiple systems need to be addressed together to improve levels of physical activity.

Exercise Referral Schemes (ERS)

What are ERS?

ERS are well-established and popular health interventions which aim to encourage sedentary individuals to increase their physical activity by providing supervised exercise over a set period, typically 10-12 weeks alongside behaviour change techniques. Participants receive specialist advice and support alongside personalised, supervised exercise. Referral route is via GPs or other health professionals following brief advice in primary care. .

Key findings include

- ERS can be effective in the short term, but data on long-term effects is limited.
- ERS can positively influence a range of physical health outcomes as well as mental wellbeing and perceptions of health.
- Interventions should be person-centred and offer a choice of activities – participants are more likely to commit to an individually tailored programme.
- Adherence is often poor – social support, group activities, and involvement of physical activity specialists may aid adherence.
- Multicomponent interventions, early consideration of barriers to physical activity, and lower expectations of change are also associated with increased adherence.
- NICE guidelines recommend exercise referral for sedentary or inactive people who have a health condition or other health risk factors.
- Public Health Scotland recently published guidance to enhance service quality and build the evidence base. To be used in support of NICE guidelines, the six standards inform design, delivery, and commissioning of physical activity referral services:
    - Partnership working
    - Local delivery models
    - Learning and workforce development
    - Data systems
    - Monitoring and evaluation
    - Sharing learning and good practice

Digital interventions

What are they?

Digital interventions (also referred to as technology-enhanced interventions; e-health; mHealth) are increasingly used as behaviour change interventions to promote physical activity. Technologies include

websites, wearables and mobile applications. Digital approaches can deliver bespoke interventions, underpinned by behavioural science, using nudge techniques and have the capacity to engage otherwise hard to reach populations. Evidence suggests they are strongest as part of a wider intervention rather than stand-alone intervention.

Key findings include[6]:

- Multiple reviews suggest digital interventions can be effective to reduce sedentary behaviour and increase physical activity.
- Digital interventions are as effective as conventional methods for physical activity promotion and can be used in all age groups.
- NICE recommend they could be considered as optional adjunct to existing services although their effectiveness can be variable. Effectiveness is enhanced when combined with other delivery methods, such as face-to-face contact.
- Interventions may not be equivalently effective for people of high and low socio-economic status, with no evidence of efficacy in low socio-economic groups – further research is required to meet the needs of these populations.
- High attrition is common in studies, and likely to be even higher in real life settings, strategies are required to sustain usage.
- For evaluation, the objective measures utilised by digital interventions can capture effects more accurately than self-reporting.

Which interventions work best?

There is a general lack of evidence with regards to targeted interventions for the purpose of reducing health inequalities. In a study to understand inequalities across and within protected characteristic groups, Office for Health Improvement and Disparities (OHID) – previously Public Health England – identified three major themes to consider[11]

1. Enablers, barriers and identifying opportunity
2. Community consultation, engagement, and partnership
3. Holistic approach for protected characteristics and intersectionality

OHID recommends the following be considered when designing services or creating opportunities to increase physical activity in protected characteristic groups:

- Appropriate engagement
- Knowledge of the local community
- Meaningful consultation
- Community role models
- Flexible client-centred approach
- Providing a diverse choice
- A holistic approach
- Measuring impact
- Partnership working

Our Vision

We will create a bold, healthy, and active city where people have access to a wide range of opportunities and a supportive environment to enable them to become more active. Birmingham will be a city where physical activity improves people's lives and the places in which they live. By working collaboratively with partners from across Birmingham, we will inspire, motivate, and make it easier for everyone to be active at every age and ability.

"I like the idea that the vision statement has taken into account its people, environment and physical activities and also acknowledged that some people will need more support than others."

Female; 50s; Soho

This Vision is closely aligned to the Birmingham Health and Wellbeing Strategy which aspires to create a Birmingham where every citizen, whoever they are, wherever they live and at every stage of life, can make choices that empower them to be happy and healthy. The strategy sets out a number of ambitions that as a city we are working together to achieve:

- Reduce the percentage (%) of adults who are physically inactive (25%) to 20% by 2030
- Increase the percentage (%) of adults walking (17.7%) for travel at least three days a week to 25% by 2030
- Increase the percentage (%) of adults cycling (2%) for travel at least three days a week to 4% by 2030
- Increase the percentage (%) of physically active children and young people (41.6%) to the national average (47.2%) by 2030
- Reduce the inactivity gap (20%) between those living with disabilities and long-term health conditions and those without to 10% by 2030
- Reduce the inactivity gap between minority ethnic communities (Asian not including Chinese – 38%, Black – 35%) and white ethnicity (29%) by 50% by 2030.

Strategy Priorities

Our priorities have been developed using the pillars within GAPPA and EAED. This is based on the need for a targeted approach that focuses on the geographies and communities in the city where there are unmet needs.

Priority 1 - Active People

"Ensuring people from all backgrounds have access to Physical Activity opportunities, lots of free opportunities to help reduce barriers to being physically active."

Female; 20s; White British; Springfield

We will create and promote access to opportunities by taking a life course approach across multiple settings to help people to be physically active . We will achieve this through the:

Starting Well

- Building the right foundations for habits that last a lifetime by making sure physical activity is prioritised in early years and school settings.
- Continue to develop our understanding of the barriers to play and sport, especially among girls and those living in deprived areas.

Living Well

- Embedding physical activity into treatment pathways to improve the prevention and management of long-term health conditions through the roll out of the Moving Medicine resources.
- Promote, and where appropriate, use technology in interventions that are designed to increase physical activity.
- Supporting employers to make physical activity available to their workforce throughout their working day.
- Placing physical activity at the heart of the preventative agenda to prepare and support adults to increase activity levels, improve health and wellbeing and prepare for the transition into later life.

Ageing Well

- Support people to maintain health and wellbeing in their older age through tailored programmes and opportunities in settings such as community venues, health, social and long-term care settings.
- Make more activities for strength, balance and coordination available to help prevent falls, frailty and dementia.

Priority 2 - Active environments

"Encouraging walking by creating a more pleasant built environment. Encouraging walking by having a better public transport network so the car stays at home. Protecting and enhancing green space for use for sports and leisure."

We will create and protect spaces where people of all ages and abilities can be physically active. We will achieve this through the:

- Development of inclusive and attractive physical activity opportunities that are safe, affordable, local and accessible to all. . This was one of the key aspects that, through the public consultation, citizens said were important to them.
- Build on existing efforts to improve active travel in local neighbourhoods, which will increase physical activity levels and help address health inequalities in line with the Birmingham Transport Plan.
- Continued roll out of the Future Parks Accelerator Project to test new approaches to caring for the city's green spaces.
- Development of physical activity opportunities, such as the daily mile, and walking, which are always available and can be undertaken and enjoyed by a broad spectrum of people.
- Supporting employers across the city to develop targeted interventions aimed at increasing physical activity in the workplace.
- Partnering with initiatives such as Healthy Living Zones to reduce inequalities in physical activity by ensuring that active spaces are designed to be inclusive.

Priority 3 - Active Societies

"An easy way to find all Information and upcoming events in 1 single place."

Female; 30s; White British; Springfield

We will change the narrative around physical activity across the city by building insight and evidence into policy, commissioning, planning decisions and communication messages, and marketing campaigns. We will achieve this through the:

- Development of our understanding and address the barriers to physical activity and promote enablers where insight currently is not available e.g., active play or for groups with unmet needs.
- Development of insight-led communication messages and marketing campaigns informed by behavioural science to support a shift in attitudes and motivation that can help to break down barriers experienced by communities.
- Consideration and embedding of physical activity into all relevant policies, strategies, commissioning, and planning decisions. Active steps will be taken to effectively implement those policies and strategies after the embedding process.
- Supporting regular mass participation initiatives in accessible and safe public spaces which will help to provide free access to a broad range of equitable physical activity opportunities.
- Utilisation of technology to enable people to:
    - connect with and take part in opportunities to be physically active, especially the most inactive within the city. Capitalise on the opportunities provided by initiatives such as Active Birmingham Activity Finder which supports people in finding physical activity opportunities closest to them. This fulfils the need for accessibility; an important aspect to citizens identified during the public consultation.
    - Monitor and encourage changes to their behaviour, tracking movement and physical activity participation over time to embed behaviour change.

Priority 4 - Active systems

"Work collaboratively with other partners. e.g., how can we continue to cap bus prices to promote active travel. Public health can't control all of this or commission our way out of this; we need to work with partners across the city and influence them."

Male; 60s; Hall Green

We will create a more integrated and interconnected system by strengthening our local leadership, governance, partnerships and workforce capabilities. We will achieve this through the:

- Continued development and growth of partnership and governance arrangements through the Active City Forum, Sport Birmingham and the Physical Activity Alliance. This will strengthen collaborative working, local leadership and assurance across a wide range of sectors including grassroot and community-led organisations.
- Identify training needs that promote physical activity and develop proper training opportunities to build capacity and capability. This will ensure the effective delivery of programmes and services to address the needs of communities in relation to physical activity.
- Implement learning from the Moving Healthcare Professionals programme and build on the success of physical activity champions work already implemented within the city.
- Enhance the use of physical activity-oriented evidence-based approach to guide and inform practice and governance e.g., embedding the findings from the PANA across a wide range of stakeholders to build understanding and to enable a data-driven and targeted approach
- Identification and harnessing of opportunities to strengthen relationships with our universities to embed physical activity training, research, and evaluation opportunities.

Priority 5 - Closing the gap

"All communities have inequalities. Girls especially. Also, people with disabilities. A better approach than the postcode lottery is needed. It will be necessary to invest in youth and community workers and social spaces in all communities."

Female; 70s; White British; Springfield

We will continue to develop a better understanding of local barriers and enablers to increase activity across the city and ensure we focus on the least active groups as identified in the PANA. This will be achieved through the:

- Creation of a more diverse physical activity and sport offer based on the lived experience of underrepresented groups within the city.
- Co-production of tailored and practical solutions with communities where significant inequalities exist, to enable them to increase their participation in physical activity tailored to meet their needs.
- Strengthening the implementation of programmes and services that increases access to equitable physical activity opportunities, for those who are least likely to be active in the city.
- Using technology, including apps and gamification, to increase inclusive physical activity participation for Birmingham's diverse range of communities especially under-represented groups.
- Connecting underrepresented groups with local green spaces and opportunities to be active.
- Use physical activity as way to improve community cohesion through targeted community events to build on previous successful projects.

Strategy Principles

To enable us to deliver our priorities these principles will be adopted:

- Implement a whole system approach to physical activity in Birmingham.
- Provide senior level commitment to embed physical activity in policy to ensure multiple outcomes are met around health, climate change, air quality through strong strategic collaboration.
- Take a life course approach and focus on the unmet needs using data, intelligence and insight to focus on geographies and communities where inequalities exist.
- Adopt a community centred approach and empower local people to lead, embedding the voice and influence of local people across the system.
- Create the right environment to help people to be active in their day-to-day life.
- Focus on early help and prevention and ensure interventions are tailored and person-centred.
- Develop local, accessible activity opportunities, built on local community assets.
- Support a more sustainable, strategic, and joined up approach to funding opportunities.

How will we know we are making a difference?

The long-term outcomes and targets have been set within the Joint Health and Wellbeing Strategy 2022-2030:

Long Term Outcome	Current Level (Sport England, 2023; OHID 2023)	Target by 2030
Reduce the percentage (%) of adults who are physically inactive	25%	20%
Increase the percentage (%) of adults walking for travel at least three days a week	17.7%	25%
Increase the percentage (%) of adults cycling for travel at least three days a week	2%	4%
Increase the percentage (%) of physically active children and young people	41.6%	47.2%
Reduce the inactivity gap between those living with disabilities and long-term health conditions and those without	20%	10%

Reduce the inactivity gap between minority ethnic communities and white communities[ii]	Asian – 38% (excluding Chinese) Black – 35% White British – 29%	by 50%

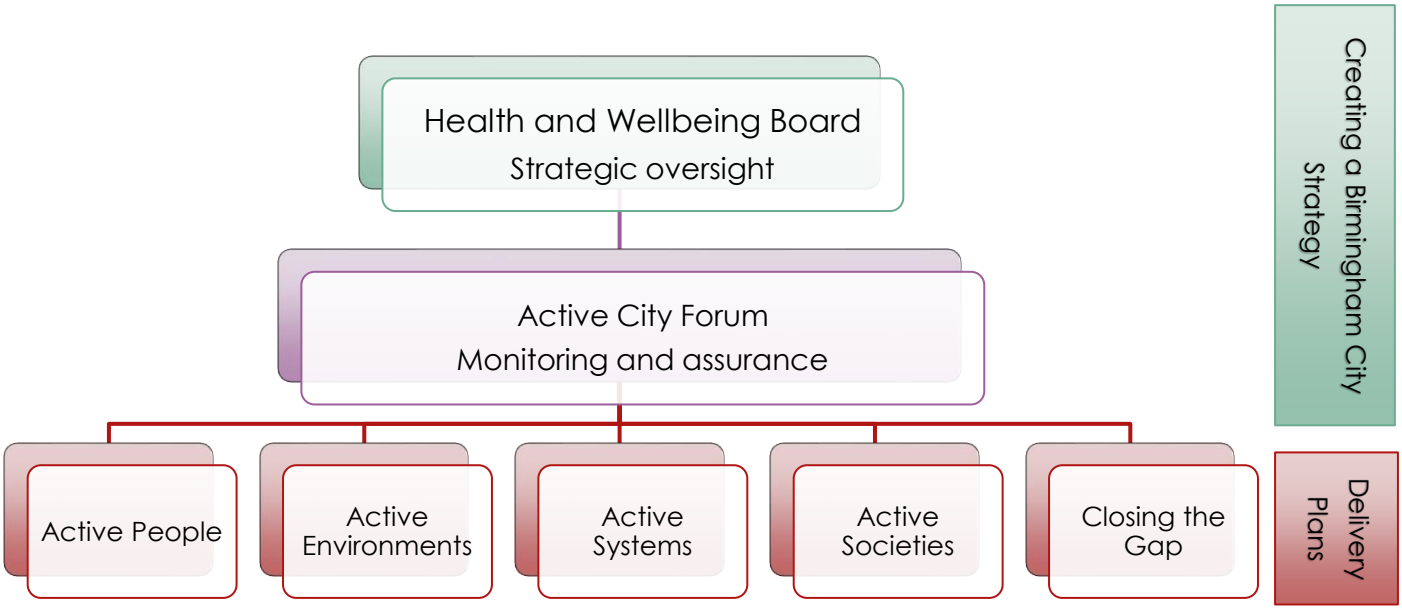
The following Key Performance Indictors have been identified to enable us to monitor progress on an annual basis and ensure that the strategy and action plan are on track to meeting the longer-term outcomes within the strategy. The baseline has been taken from the current Public Health Outcomes Framework data available through OHID Fingertips.

Indicator	Source	Year	Current Position/%	Ambition
Overall Physical Activity				
Physically active adults	OHID/Active Lifestyle Survey	2021/22-2022/23	58.1	A year-on-year increase
Physically inactive adults	OHID/Active Lifestyle Survey	2021/22-2022/23	29.4	A reduction
Physically active children and young people	OHID/Active Lifestyle Survey	2021/22-2022/23	41.6	A year-on-year increase
Travel and Transport				
Adults walking for travel at least 3 days per week	Department for Transport (based on Active Lives Adult Survey, Sport England)	2022	17.7	A year-on-year increase
Adults cycling for travel at least once per week[iii]	Department for Transport (based on Active Lives Adult Survey, Sport England)	2022	4.8	A year-on-year increase
Method of travel to work - bike	Census	2021	1.3	A year-on-year increase
Method of travel to work - walk	Census	2021	7.1	A year-on-year increase
Green Space				
Access to Woodland - % of population living near accessible woodland	OHID/Woodland Trust	2020	14.70	An increase over the life of the strategy

[ii] Sample sizes for missing ethnic groups did not meet the threshold for analysis.
[iii] Cycling frequencies for at least three times per week have been discontinued due to low frequencies recorded in sample.

Governance

The Physical Activity Strategy will be overseen by the Health and Wellbeing Board, as a statutory committee of Cabinet. The delivery plans will be driven and monitored by the Active City Forum and delivered in conjunction with partners and key stakeholders from across Birmingham. The Active City Forum reports to the Health and Wellbeing Board, under the leadership of the Cabinet Member for Transport. The forum brings together relevant local statutory, voluntary and community sector organisations with a role or interest in the implementation of the strategy and delivery plans.



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16) National Institute for Health and Care Excellence; 2020; Behaviour change: digital and mobile health interventions; Overview | Behaviour change: digital and mobile health interventions | Guidance | NICE

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Special thanks go to the Active City Forum for their guidance and contributions to this strategy. We are grateful to all those colleagues and partners that have attended workshops, shared insight and supported the development of the strategy.

Appendices

Appendix 1 – CMO Guidelines

Summary of Guidelines by age group

Under-5s

Infants (less than 1 year):

Infants should be physically active several times every day in a variety of ways, including interactive floor-based activity, e.g., crawling.

For infants not yet mobile, this includes at least 30 minutes of tummy time spread throughout the day while awake (and other movements such as reaching and grasping, pushing and pulling themselves independently, or rolling over); more is better.

NB: Tummy time may be unfamiliar to babies at first, but can be increased gradually, starting from a minute or two at a time, as the baby becomes used to it. Babies should not sleep on their tummies.

Toddlers (1-2 years):

Toddlers should spend at least 180 minutes (3 hours) per day in a variety of physical activities at any intensity, including active and outdoor play, spread throughout the day; more is better.

Pre-schoolers (3-4 years):

Pre-schoolers should spend at least 180 minutes (3 hours) per day in a variety of physical activities spread throughout the day, including active and outdoor play. More is better; the 180 minutes should include at least 60 minutes of moderate-to-vigorous intensity physical activity.

Children and Young People (5 to 18 years)

Children and young people should engage in moderate-to-vigorous intensity physical activity for an average of at least 60 minutes per day across the week. This can include all forms of activity such as physical education, active travel, after-school activities, play and sports.

Children and young people should engage in a variety of types and intensities of physical activity across the week to develop movement skills, muscular fitness, and bone strength.

Children and young people should aim to minimise the amount of time spent being sedentary, and when physically possible should break up extended periods of not moving with at least light physical activity.

Adults (19 to 64 years)

For good physical and mental health, adults should aim to be physically active every day. Any activity is better than none, and more is better still.

Adults should do activities to develop or maintain strength in the major muscle groups. These could include heavy gardening, carrying heavy shopping, or resistance exercise. Muscle strengthening activities should be done on at least two days a week, but any strengthening activity is better than none.

Each week, adults should accumulate at least 150 minutes (2 1/2 hours) of moderate intensity activity (such as brisk walking or cycling); or 75 minutes of vigorous intensity activity (such as running); or even shorter durations of very vigorous intensity activity (such as sprinting or stair climbing); or a combination of moderate, vigorous and very vigorous intensity activity.

Adults should aim to minimise the amount of time spent being sedentary, and when physically possible should break up prolonged periods of inactivity with at least light physical activity.

Older Adults (65 years and over)

Older adults should take part in daily physical activity to gain health benefits, including maintenance of good physical and mental health, wellbeing, and social functioning. Some physical activity is better than none: even light activity brings some health benefits compared to being sedentary, while more daily physical activity provides greater health and social benefits.

Older adults should maintain or improve their physical function by undertaking activities aimed at improving or maintaining muscle strength, balance and flexibility on at least two days a week. These could be combined with sessions involving moderate aerobic activity or could be additional sessions aimed specifically at these components of fitness.

Each week older adults should aim to accumulate 150 minutes (two and a half hours) of moderate intensity aerobic activity, building up gradually from current levels. Those who are already regularly active can achieve these benefits through 75 minutes of vigorous intensity activity, or a combination of moderate and vigorous activity, to achieve greater benefits. Weight-bearing activities which create an impact through the body help to maintain bone health.

Older adults should break up prolonged periods of being sedentary with light activity when physically possible, or at least with standing, as this has distinct health benefits for older people.

Creating an Active Birmingham Strategy Implementation Plan

The Creating an Active Birmingham Strategy aims to set out a vision for Birmingham to be more active, across all ages and abilities. It proposes a framework for collective action working with a wide range of partners and communities to help local people to build physical activity into their everyday lives and break down the barriers which prevent individuals and communities being active every day.

The Strategy has been informed by a Physical Activity Needs Assessment (PANA) which has gathered information about the activity of people in Birmingham, taking a life course approach. Conversations with Stakeholders, review of national and international Physical Activity policy, conversations with Seldon Heard Groups, and consultation with the public have informed the five themes for the Strategy: Active People; Active Society; Active Environments; Active System; and Closing the Gap.

Table 1. Deliverables against key priorities

Strategy Theme	**High Level Action**	**Key Deliverables**	**Organisation/Team to lead the action**
Active System We will create a more integrated and interconnected system by strengthening our local leadership, governance, partnerships, and workforce capabilities	**Leadership**	Identify system leaders to own and drive all five priority themes.	Public Health and Theme Leads
	Governance	Review the Terms of Reference for CPAC Forum and align them to the aims for the Creating an Active Birmingham and Sports Strategy. Take a Forum Report to the Health and Wellbeing Board at the end of each financial year with update on progress of	Public Health and Active City Forum Members

Strategy Theme	High Level Action	Key Deliverables	Organisation/Team to lead the action
		delivering the Creating an Active Birmingham Strategy. Create a governance process that supports delivery of the Strategy e.g., subgroups for a range of implementation requirements such as data or funding. Create a Physical Activity Citizens Forum and ensure there is a representation on the Active City Forum to bring co-production into strategic decision making.	
	Partnerships	Develop wider partner relationships to bring in sectors not represented at the CPAC Forum currently. These community-led and grassroot organisations with immediate impact on and access to the community. Create greater connections with overlapping strategies like: City of Nature; Birmingham Local Plan; Walking and Cycling Strategy; and Culture Strategy. Overlapping aims and goals should be reported on at the Active City Forum.	Active City Forum Members

Strategy Theme	High Level Action	Key Deliverables	Organisation/Team to lead the action
	Workforce Capabilities	Set up a workstream to support Physical activity workforce development. Workforce developments consider how to best spread inclusive good practice in physical activity training activities that are developed. Scale up the Moving Medicine programme in Birmingham and evaluate the impact Homepage - Moving Medicine	Active City Forum Members
	Monitoring and Evaluation	Create a Dashboard for the Forum to monitor and demonstrate impact of the Creating Active Birmingham Strategy in ensuring it is being delivered across all its five priorities. Use data to inform interventions, understand impact, and target resources to the places. Establish a data group that reports to the Creating an Active City Forum.	Public Health and Active City Forum members.
Active People We will create and promote access to opportunities taking a	**Children and Young People**	Set up a workstream that focuses on physical activity for children	Children and Families Team Educational Settings

Strategy Theme	High Level Action	Key Deliverables	Organisation/Team to lead the action
life course approach across multiple settings to enable people to engage in regular physical activity.		and young people, segmented by age: Under 5 years; Primary School age; Secondary School age; and 18 – 25-year-olds Create a plan of engagement with educational settings, and indirectly with parents, to support physical activity in children. Extend Bikeability Scheme.	Education and Infrastructure Team Health Visiting Team Educational Settings
	Working Age Adults	Set up a physical activity workstream that focuses on working age adults. Engage with workplaces to increase support for employees to be physically active.	Public Health Workplaces
	Older Adults	Set up a physical activity workstream that focuses on older adults, with a focus on falls prevention. Create communications and processes which support over 65s to be active twenty minutes a day to help reverse frailty and build resilience in over 65-year-olds *Public Health Older People Plan*	Public health, Adult Social care

Strategy Theme	High Level Action	Key Deliverables	Organisation/Team to lead the action
Active Society We will change the narrative around physical activity across Birmingham, building insight and evidence into policy, commissioning, planning decisions and communication messages and marketing campaigns.	**Policy**	Bring external income to the city to support Physical Activity in Birmingham Physical activity in housing policy to be developed.	Public Health Other Birmingham City Council representatives Active City Forum Members
	Commissioning	Identify commissioning opportunities in line with gaps highlighted in PANA. Where possible and relevant, contracting should include specifications that support physical activity.	Public Health Active City Forum members
	Planning Decisions	Engagement with Planning, especially through the Local Plan Review, to agree a process in ensuring planning decisions consider Physical Activity needs	Public Health Planning team
	Communication Messages	Use of digital platforms that are affordable to promote access to information about physical activity in Birmingham to be escalated e.g. Birmingham Activity Finder Find local activities | Active	Public Heath Active City Forum members

Strategy Theme	High Level Action	Key Deliverables	Organisation/Team to lead the action
		Birmingham (activityfinder.net) and 69 wards walking and cycling routes in Birmingham 69wards by bike or foot - ecobirmingham Create accessible and inclusive messaging and training which promote better understanding of Chief Medical Officer physical activity guidelines across the life course, using the CMO Communications framework UK Chief Medical Officers' physical activity guidelines communications framework - GOV.UK (www.gov.uk) Ensure physical activity messaging is part of healthy behaviours promotions such as healthy eating, mental health and stop smoking.	
	Marketing Campaigns	Create an accessible and culturally competent health literacy-informed annual plan for physical activity campaigns in the city working with Creating an Active City Partners to get breadth of topics and scale.	Public Heath Active Birmingham Forum members

Strategy Theme	High Level Action	Key Deliverables	Organisation/Team to lead the action
Active Environments We will create and protect the places and spaces that promote and engage people of all ages to be active across the life course.	**Green Spaces**	Utilise green spaces to offer physical activity opportunities to citizens.	Public Heath City of Nature
	Blue Spaces	Collaborate with partners in increasing swimming skills across all ages and, where relevant and possible, abilities.	Public Heath Active Birmingham Forum members
	Geographical Localities	Using Public Health Profiles, map the physical activity needs for each locality in Birmingham.	Public Heath Data sub-group of Active City Forum members
	Infrastructure	Planning for infrastructure maintenance needs to be considered as part of BCC finance review. Embed Physical activity needs in infrastructure development. Embed Physical Activity needs in housing policies. Utilise the road and byways assets to increase physical activity e.g., walking and cycling strategy. Development of robust Travel Plans across the City	Public Heath Other BCC departments Public Health, Transport Planning and Active City Forum organisations

Strategy Theme	High Level Action	Key Deliverables	Organisation/Team to lead the action
	Workplaces	Develop the potential of workplaces to reduce inactivity by setting up a workstream. Increase the physical activity of health professionals. Promote Thrive at Work Scheme Promote Cycle2Work schemes.	Public Health Thrive at Work Team Relevant BCC departments Workplaces
	Art, Culture and Heritage	Culture Strategy to be informed by physical activity to help people get active by default using interesting means to engage individuals.	Public Health Culture Team
Closing the Gap Continue to develop a better understanding of local barriers and enablers to increase activity across the city and ensure we focus on the least active groups as identified in the Physical Activity Needs Assessment	**Focus on most inactive groups**	Increase the opportunities for people living with learning disabilities to be physically active and/or participate in sport in the community. *Learning Disability Deep Dive*	Children's trust Public Health Adult Social care Active City Forum members
		Set up a physical activity workstream that reviews and focuses on disability/impairment.	Public Health

Strategy Theme	High Level Action	Key Deliverables	Organisation/Team to lead the action
	Focus on Locations in the city that are most Inactive		
		Set up a physical activity workstream that focuses on mental ill health, including elements about how to support those will Severe Mental Illness (SMI) or dual diagnosis to be active.	Public Health
		Ensure all physical activity workstreams consider how they can close the gap between the most active and the least active.	Active City Forum members
		Use data about deprivation to identify where resource allocation is best applied.	Active City Forum members
		Regularly carry out and review insights in groups with the highest levels of inactivity and apply the learning.	Public Health Active City Forum members
	Co-production Plan	Create a co-production plan that has a strong representation from groups with the highest levels of inactivity.	Active City Forum members
	Innovation	Interventions and workstreams should be innovative to maximise reach and impact in order to have better return on investment.	Active City Forum members

Physical Activity Needs Assessment

Birmingham Public Health

January 2024

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Contents

Foreword

Being active every day should be easy, fun, efficient and just the normal way of being in Birmingham. Yet too often the environment around us, social and physical, makes it easier to be sedentary and inactive and this is a major factor behind the shorter life expectancy of our citizens caused by diseases that can be prevented or reduced through physical activity. The reality is that moderate physical activity every day can reduce the risk of over 40 different clinical conditions including dementia, type two diabetes, heart disease and many forms of cancer and it also improves mental wellbeing. If you are living with a long-term health condition, being physically active can improve symptoms like fatigue and pain, can reduce complications and can help manage the stress and anxiety associated with ill health. At every age and every ability getting active every day can make a difference, even at the end of live. But being active isn't just good for health, there is a wide range of evidence showing positive impacts including improving educational attainment, reducing loneliness, boosting economic and environmental sustainability for local communities.

There are many different ways to get active, the majority of us will achieve a healthy level of moderate physical activity through everyday utility-based activity, the short walk to the shops, commuting to work on public transport or cycling with the kids to school, and top up with fun recreational activities like sport, dance and play. This is why is it so important that this strategy is an umbrella for the broad range of activities through which we can all get active every day, the type of activity will be different for different individuals and may change as we age, and our commitments and social networks change. Becoming an active city is one of the key steps to giving every citizen the opportunity to live a healthier, happier life, and making the changes to bring this strategy to life will require all of us to play our part to create a more active future.

Director of Public Health
Dr Justin Varney

Executive Summary

This Physical Activity Needs Assessment (PANA) forms part of a rapid review to understand the needs of all citizens living in Birmingham in relation to physical activity. It has been developed to provide an evidence base to inform the development of a coordinated and integrated strategy and delivery plans to address the physical activity needs within Birmingham.

The needs assessment takes a life course approach and seeks to understand the levels of physical activity and inactivity in children, young people, adults, and older people living in Birmingham. The needs assessment draws on multiple sources of evidence and data including national and local policies and strategies, research literature, national and local data sources and qualitative evidence gathered from stakeholders and residents.

In Birmingham inequalities in physical activity are linked to:

- Age – you are more likely to be inactive if you are a younger (under 16) or older person (over 55) living in the city
- Deprivation – physical inactivity is strongly linked to deprivation across the life course in Birmingham
- Gender – women and girls are more likely to be inactive than men and boys.
- Ethnicity – Some ethnic minorities in Birmingham have lower rates of physical activity participation
- COVID – the pandemic had a significant impact on participation in physical activity across the life course both locally and nationally.

Children and Young People

- 2 in 5 children and young people (38%) aged 5-16 years in Birmingham are less active (completing less than 30 minutes of activity a day), compared to the national rate of 30%. Within the less active group, one fifth are taking part in no physical activity at all.
- More children living in the most deprived decile are classified as being less active (37%) than those from the least deprived decile (28%).
- The pandemic had a significant impact on levels of inactivity in children and young people living in the city. This is especially apparent in boys.
- More girls are classified as less active (33%) than boys (42%). Only 1 in 3 girls are meeting the recommended levels of activity each day.

Adults

- 1 in 2 (55%) people living in Birmingham are meeting the recommended levels of physical activity (an average of 150+ minutes a week), compared to 63% nationally. However, 33% of the Birmingham population are classified as inactive (completing less than 30 minutes of physical activity per week), and 1 in 4 (25%) are totally inactive (completing no physical activity at all).
- Analysis of levels of activity by IMD shows a clear correlation between deprivation and inactivity. The proportion of adults living in the most deprived decile who are inactive is double (38%) those living in the least deprived (19%).

Introduction

Physical activity plays an important role in our lives and society. However, not enough of us are meeting the recommended levels of physical activity each day. Physical inactivity is one of the top ten causes of disability and disease in England and is attributed to 6% of deaths globally. In the UK, inactivity causes 1 in 6 deaths and costs an estimated £7.4 billion a year.

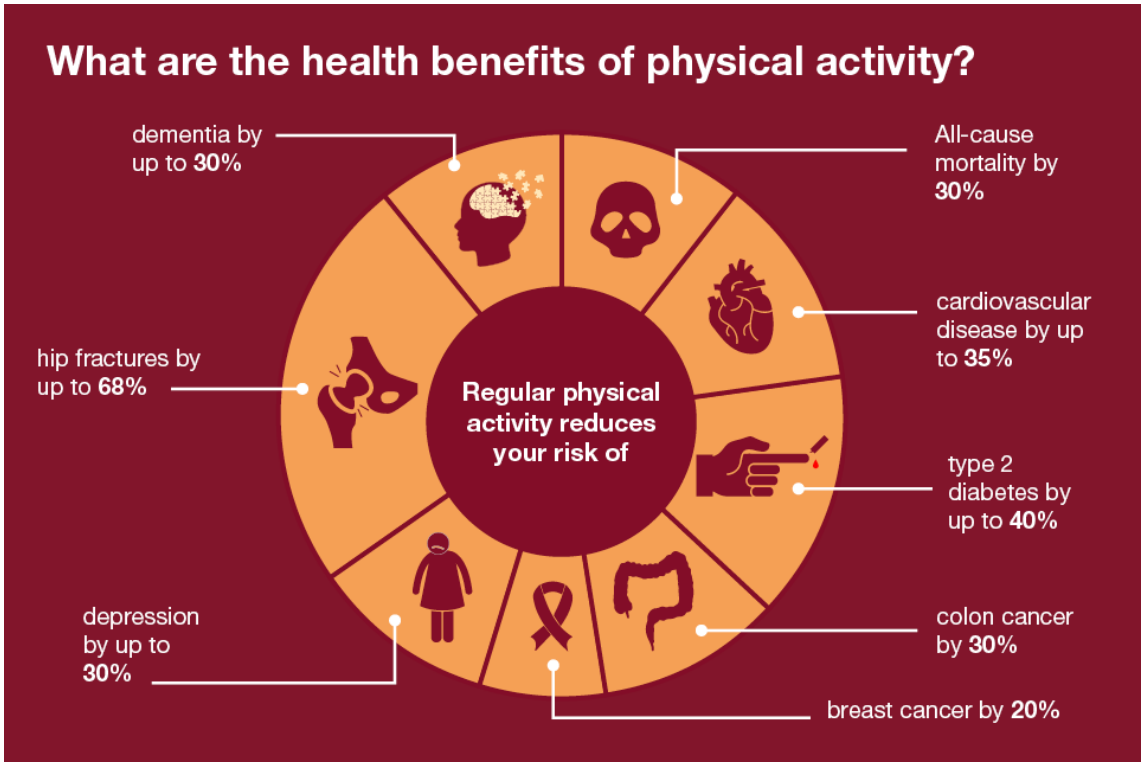
This Physical Activity Needs Assessment (PANA) forms part of a rapid review, providing a snapshot of physical activity levels in Birmingham to understand the needs of all citizens living in the city. It has been developed to provide an evidence base to inform the development of a coordinated and integrated strategy and delivery plans to address the physical activity needs within Birmingham.

The needs assessment takes a life course approach and seeks to understand the levels of physical activity and inactivity in children, young people, adults, and older people living in Birmingham. The needs assessment draws on multiple sources of evidence and data including national and local policies and strategies, scientific literature, national and local data sources and qualitative evidence gathered from stakeholders and residents.

Background

Physical inactivity is one of the leading risk factors for the development of diseases such as cancer, heart disease, stroke and diabetes. It is thought to increase the risk of these conditions by 20–30%. The World Health Organisation estimates that four to five million deaths per year could be averted if the global population was more active.

Figure 1: Diagram show the health benefits of physical activity



The UK analysis of the Global Burden of Disease, Injuries and Risk Factors Study found physical inactivity and low physical activity to be the fourth most important risk factor in the UK for premature death from any cause. In the UK, it causes one in ten premature deaths from coronary heart disease and one in six deaths overall.[1]

Nationally it is estimated that 1 in 3 adults, 1 in 2 children and young people are not doing enough physical activity. There are several inequalities that exist with women and girls, older adults and people living with disabilities less likely to be active leading to them missing out on the wide-ranging benefits that physical activity brings and having a negative impact on their health.

In addition, physical inactivity brings wider issues for society. It has a significant financial burden on the NHS and leads to loss of productivity for the country. There is an estimated UK annual cost of £7.4 billion attributed to physical inactivity, with an estimated direct cost to the NHS of between £0.9 and £1.2 billion [1]

Definitions

Physical Activity refers to all movement. Popular ways to be active include walking, cycling, wheeling, sports, active recreation, dancing, and play, and can be done at any level of skill and for enjoyment by everybody.

Moderate and Vigorous Activity can be differentiated by the 'talk test': being able to talk but not sing indicates moderate intensity activity, while having difficulty talking without pausing is a sign of vigorous activity.

Muscle and Bone Strength and Balance underpin physical function, particularly in later life. It is important to work all major muscle groups during muscle strengthening activities. Bone strengthening involves moderate and high impact activities to stimulate bone growth and repair. Balance training involves a combination of movements that challenge balance and reduce the likelihood of falling.

Sedentary Behaviour refers to individual behaviours in which energy expenditure is very low with sitting and lying being the dominant mode of posture.

Purpose

The purpose of the PANA is to:

- Determine the scale of physical activity and inactivity in Birmingham
- Gather local intelligence relating to physical activity needs and to the current provision for physical activity
- Identify inequalities and improve outcomes by supporting a targeted approach
- Identify and prioritise the most effective support for those in the greatest need to inform planning and delivery
- Inform the development of the physical activity strategy and delivery plans.

Approach

The figure 2 below sets out the process that has been undertaken to bring together the PANA. This process ensures:

- there is an evidence base provided for the development of local strategies and plans
- the evidence base has been informed by the most up to date data, intelligence, evidence and insight in relation to physical activity [1,2].

Figure 2: Process steps taken to carry out the Physical Activity Needs Assessment

Review of existing evidence, policies and guidance

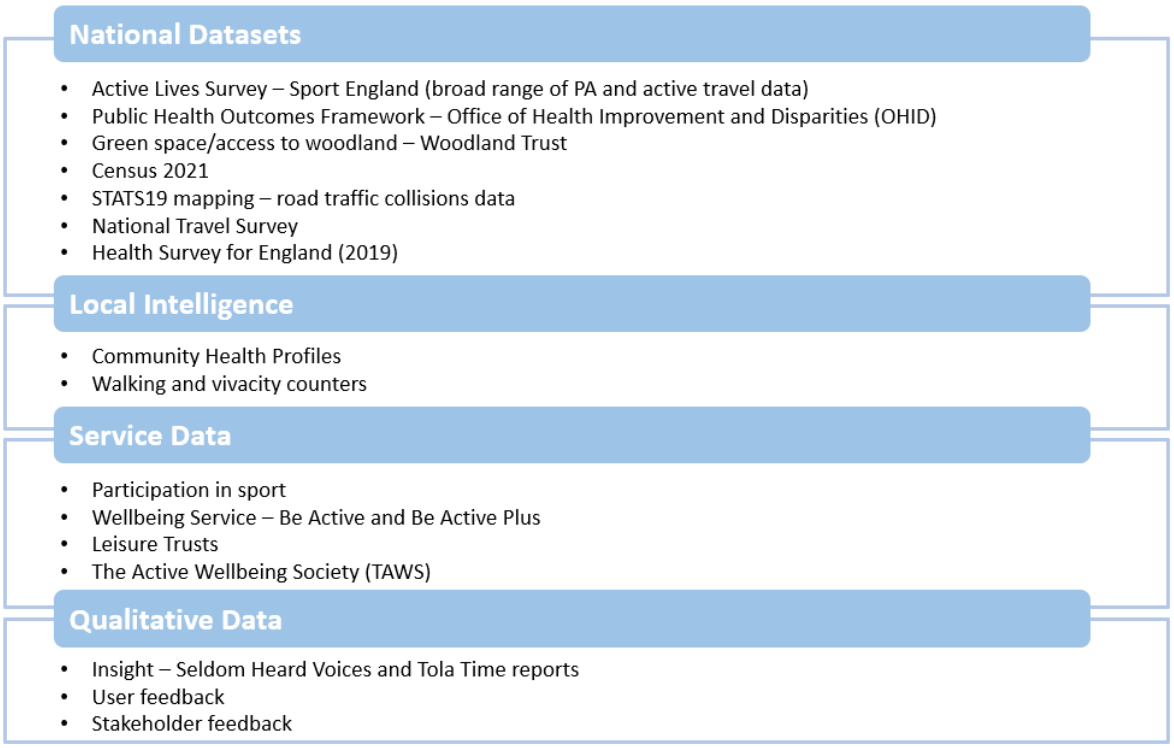
The following evidence, national and local strategies, policies, and guidance have been reviewed to provide an understanding in relation to the current evidence base and best practice.

- Physical activity evidence review
- Global and national policies
    - Global Action Plan on Physical Activity 2018-2030 More active people for a Healthier World
    - Everybody Active, Every Day - An evidence-based approach to physical activity (Public Health England)
- Regional and local strategies and assessments
    - Creating a Bolder Healthier Birmingham 2022-2030
    - Joint Strategic Needs Assessment
    - Birmingham Sports Strategy and Transport Strategy
    - Commonwealth Games Legacy Plan
- Guidance
    - UK Chief Medical Officers' Physical Activity Guidelines
    - NICE Guidance e.g., NG90 Physical Activity and the Environment, PH84 Quality Standard: Physical activity; encouraging activity in all people in contact with the NHS

Analysis of existing datasets

As part of the data analysis a range of data and evidence has been considered. Figure 2 outlines the data and evidence sources that have been drawn upon.

Figure 3: Data sources reviewed for the Physical Activity Needs Assessment



The data has been analysed to provide the physical activity profile by:

- *Life course*: Children and young people; Working Age Adults; Older People
- *Geography and overall demographics*
- *Key health needs related to physical activity*

Where appropriate comparisons have been made with England, West Midland region and Nearest Neighbours to provide benchmarking information

Evidence Base

Physical activity evidence review[i]

In July 2022, the UK Health Security Agency (UKHSA) worked with the Public Health Team to complete a search across three databases for the following questions:

- Which interventions show highest levels of physical activity increases?
- Which interventions work best for certain demographic groups?

A review of the results identified three major intervention types. These were exercise referral schemes (ERS), digital interventions, and place-based interventions. With these themes identified, further searches were completed to identify recent papers and relevant guidelines on these three topics. The findings from the review are summarised below.

Place-based interventions

Place-based initiatives can be described as "any intervention, policy, programme or action that aims to improve health and reduce health inequalities and is delivered at a local or regional level, excluding interventions at a national level".

Place-based approaches enable resources to be targeted towards the most disadvantaged areas and communities, supporting people to make healthier choices and have better health outcomes. Whilst place-based interventions have the potential to increase levels of PA in the population, evidence of effectiveness is limited, and systematic reviews present mixed results with mostly positive, albeit small increases in PA.

Place-based interventions fall into three overlapping categories:

- Improving the physical built environment
- Improving the social environment
- Improving the economic environment

Key findings include:

- Environmental factors act as both enablers and barriers to PA in all age groups.
- Modifying the built environment can contribute to increased levels of PA for all ages.
- Interventions to promote walking and cycling as active transport deliver positive results on PA outcomes.
- Closer proximity to the intervention is associated with better outcomes.
- Transport links impact levels of activity – providing opportunities for active travel helps people incorporate PA into everyday life.
- Park-based interventions increase park use and subsequent PA behaviours and are most effective when promotion and marketing is implemented alongside physical change.
- Engaging with communities to tailor interventions increases positive effects.
- Green space interventions can integrate with social prescribing and ERS.
- Environmental approaches generate a wide range of co-benefits, improving many aspects of environment and health.
- Multiple systems need to be addressed together to improve levels of PA.

[i] See Appendix 1

Exercise Referral Schemes (ERS)

ERS are well-established and popular health interventions which aim to encourage sedentary individuals to increase their PA by providing supervised exercise over a set period, typically 10-12 weeks alongside behaviour change techniques. Participants receive specialist advice and support alongside personalised, supervised exercise. Referral route is via GPs or other health professionals following brief advice in primary care.

Key findings include:

- ERS can be effective in the short term, but data on long-term effects is limited.
- ERS can positively influence a range of physical health outcomes as well as mental wellbeing and perceptions of health.
- Interventions should be person-centred and offer a choice of activities – participants are more likely to commit to an individually tailored programme.
- Adherence is often poor - social support, group activities, and involvement of PA specialists may aid adherence.
- Multicomponent interventions, early consideration of barriers to PA, and lower expectations of change are also associated with increased adherence.
- NICE guidelines recommend exercise referral for sedentary or inactive people who have a health condition or other health risk factors.
- Public Health Scotland recently published guidance to enhance service quality and build the evidence base. To be used in support of NICE guidelines, the six standards inform design, delivery, and commissioning of PA referral services:
    - Partnership working
    - Local delivery models
    - Learning and workforce development
    - Data systems
    - Monitoring and evaluation
    - Sharing learning and good practice

Digital interventions

Digital interventions (also referred to as technology-enhanced interventions; e-health; mHealth) are increasingly used as behaviour change interventions to promote PA. Technologies include websites, wearables and mobile applications. Digital approaches can deliver bespoke interventions using nudge techniques and have the capacity to engage otherwise hard to reach populations. However, evidence suggests they are strongest as part of a wider intervention rather than standalone intervention.

Key findings include:

- Multiple reviews suggest digital interventions can be effective to reduce sedentary behaviour and increase physical activity.
- Digital interventions are as effective as conventional methods for PA promotion and can be used in all age groups.
- NICE recommend they could be considered as optional adjunct to existing services although their effectiveness can be variable. Effectiveness is enhanced when combined with other delivery methods, such as face-to-face contact.
- Interventions may not be equivalently effective for people of high and low socioeconomic status, with no evidence of efficacy in low socioeconomic groups – further research is required to meet the needs of these populations.

- High attrition is common in studies, and likely to be even higher in real life settings, strategies are required sustain usage.
- For evaluation, the objective measures utilised by digital interventions can capture effects more accurately than self-reporting.

Which interventions work best for demographic groups?

There is a general lack of evidence with regards to targeted interventions, for the purpose of reducing health inequalities. Further review is required, particularly post-Covid as for some of these groups, access to physical activity clubs and organisations was severely impacted by the pandemic and has not recovered to pre-pandemic levels. In a study to understand inequalities across and within protected characteristic groups, Public Health England identified three major themes to consider [3]. The themes are as follows:

1. Enablers, barriers and identifying opportunity
2. Community consultation, engagement, and partnership
3. Holistic approach for protected characteristics and intersectionality

PHE recommended the following be considered when designing services or creating opportunities to increase physical activity in protected characteristic groups:

- Appropriate engagement
- Knowledge of the local community
- Meaningful consultation
- Community role models
- Flexible client-centred approach
- Providing a diverse choice
- A holistic approach
- Measuring impact
- Partnership working

Global and National Policy, Strategy and Guidance

Global Action Plan on Physical Activity 2018-2030 More active people for a Healthier World -

The World Health Organisation Global Action Plan on Physical Activity contains 4 strategic objectives and 20 policy actions that are universally applicable across countries to improve physical activity uptake [4].

The plan recognises that each country is at a different starting point in their efforts to reduce levels of physical inactivity and sedentary behaviour and responds to the requests by countries for updated guidance, and a framework of effective and feasible policy actions to increase physical activity at all levels [4]. It also responds to requests for global leadership and stronger regional and national coordination, and the need for a whole-of society response to achieve a paradigm shift in both supporting and valuing all people being regularly active, according to ability and across the life course [4]. The action plan was developed through a worldwide consultation process involving governments and key stakeholders across multiple sectors including health, sports, transport, urban design, civil society, academia and the private sector [45].

The four strategic objectives provide a universally applicable framework for the 20 multidimensional policy actions, each identified as an important and effective component of a population-based response to increasing physical activity and reducing sedentary behaviour. In combination, they capture the whole-of-system approach required to create a society that intrinsically values and prioritises policy investments in physical activity as a regular part of everyday life.

1. Active societies - Create a paradigm shift in all of society by enhancing knowledge and understanding of, and appreciation for, the multiple benefits of regular physical activity, according to ability and at all ages.
2. Active environments - Create and maintain environments that promote and safeguard the rights of all people, of all ages, to have equitable access to safe places and spaces, in their cities and communities, in which to engage in regular physical activity, according to ability.
3. Active people - Create and promote access to opportunities and programmes, across multiple settings, to help people of all ages and abilities to engage in regular physical activity as individuals, families and communities.
4. Active systems - Create and strengthen leadership, governance, multisectoral partnerships, workforce capabilities, advocacy and information systems across sectors to achieve excellence in resource mobilisation and implementation of coordinated international, national and subnational action to increase physical activity and reduce sedentary behaviour.

Everybody Active, Every Day: A Framework for Physical Activity

Everybody Active, Every Day (EAED) is a national evidence-based approach to physical activity developed by Public Health England. The framework aims to support all sectors to embed physical activity into the fabric of daily life and make it an easy, cost-effective, and 'normal' choice in every community in England [5]. It aims to improve physical and mental health as well as reduce health inequalities by increasing physical activity levels across the population [5]. Published in October 2014, the EAED framework called for action across four specific domains of:

1. Active society - creating a social movement.
2. Moving professionals - activating networks of expertise.
3. Active environments - creating the right spaces.
4. Moving at scale - interventions that make us active.

A two-year update was released in 2017, *Everybody active everyday: two years on*[1], which highlights the progress made against each of the four domains.

Guidelines for Physical Activity

Physical activity guidelines: UK Chief Medical Officers' report

The Chief Medical Officers in the UK have developed guidelines on the frequency, intensity and type of physical activity people should be doing to improve their health [6]. The document aims to help health professionals, policymakers and others working to promote physical activity, sport, and exercise for health benefits [6]. The guidelines are split into age groups from infants (less than 1 year) through to older adults (aged 65 and above).

Figure 4: Chief Medical Officer Physical Activity Guidelines for Children

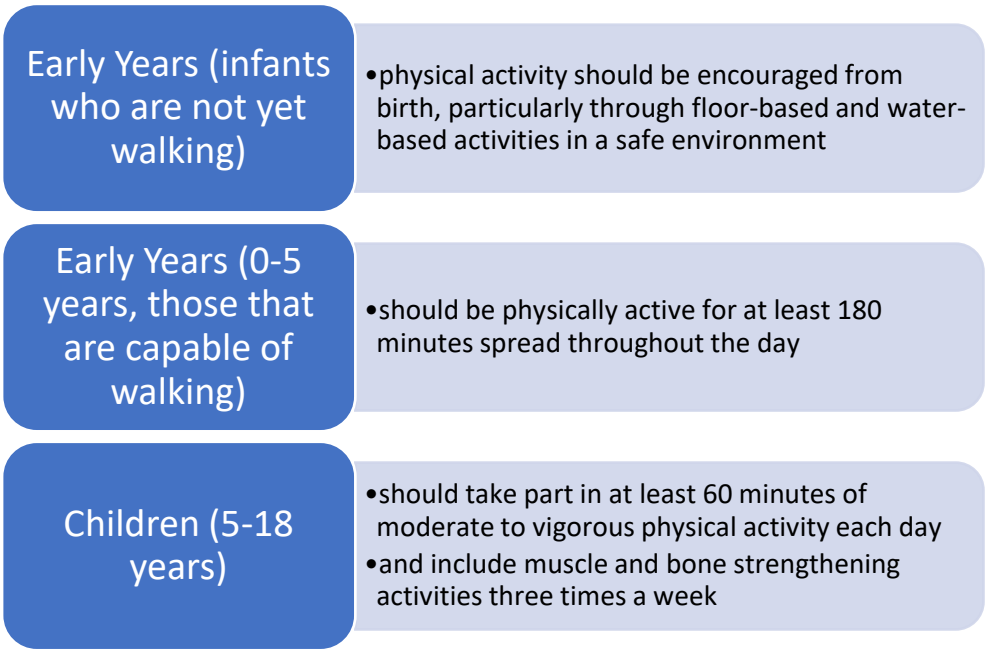
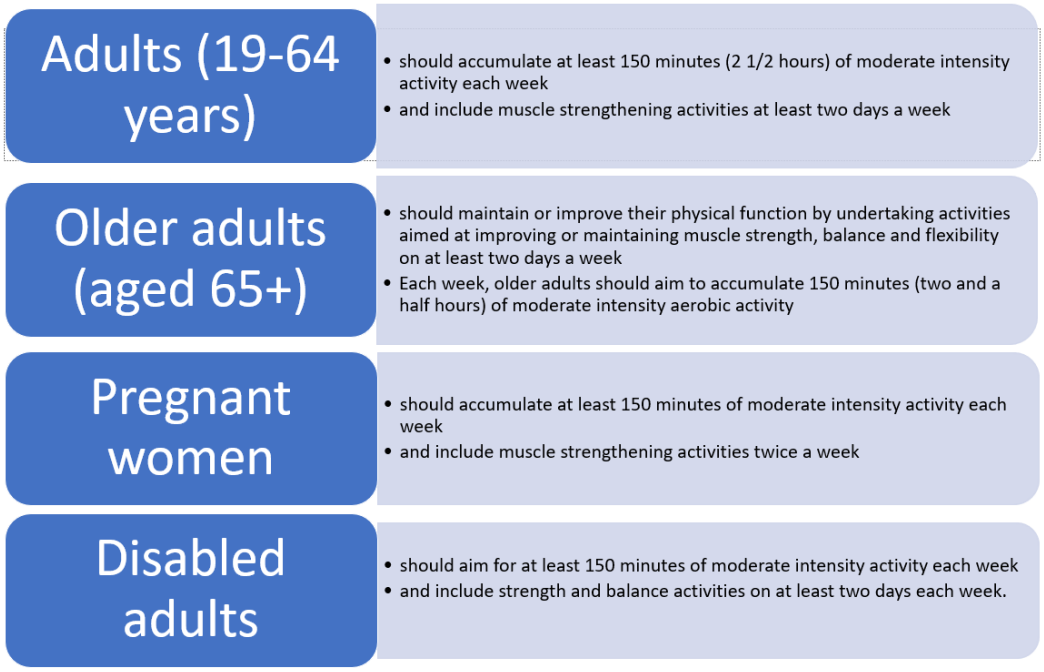


Figure 5: Chief Medical Officer Physical Activity Guidelines for Adults



In addition to the above guidelines the CMO guidelines recommend minimising sedentary behaviour.

NICE Guidelines

NICE have published several evidence-based documents relating to physical activity which have been developed by independent committees, including professionals and lay members, and consulted on by stakeholders and provide recommendations to guide decisions at a local level across a wide range of stakeholders.

Figure 6: Physical Activity NICE Guidelines

Nice Guideline Title	Nice Guideline Description
Promoting physical activity in the workplace (see footnote on page 17 for more details)	covers how to encourage employees to be physically active. The aim is to increase the working population's physical activity levels
Promoting physical activity for children and young people (see footnote on page 17 for more details)	covers promoting physical activity for children and young people aged under 18 at home, preschool, school and in the community. It includes raising awareness of the benefits of physical activity, listening to what children and young people want, planning and providing spaces and facilities, and helping families build physical activity into their daily lives.
Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation (see footnote at page 19) [ii]	covers how to encourage people to increase the amount they walk or cycle for travel or recreation purposes.
Physical activity: brief advice for adults in primary care (see more details on footnote on page 19)	covers providing brief advice on physical activity to adults in primary care. It aims to improve health and wellbeing by raising

[ii] *Promoting physical activity in the workplace* [iii] *Promoting physical activity for children and young people*

	awareness of the importance of physical activity and encouraging people to increase or maintain their activity level.
Exercise referral schemes to promote physical activity (see more details on footnote on page 19)	covers exercise referral schemes for people aged 19 and older, particular, in those who are inactive or sedentary. Quality Standard; Physical Activity: encouraging activity in all people in contact with the NHS PH84 (2015)
Physical activity and the environment (see more details on footnote on page 20)	covers how to improve the physical environment to encourage and support physical activity. It includes: Active Travel; Public Open Spaces; Buildings; Schools
Physical activity: encouraging activity in the community (see more details on footnote on page 20)	this quality standard covers how local strategy, policy and planning and improvements to the built and natural physical environment such as public open spaces, workplaces and schools can encourage and support people of all ages and all abilities to be physically active and move more.

Local Strategies and Plans

Creating a Bolder Healthier Birmingham 2022-2030 – physical activity is one of five core themes to support the achievement of the vision to create a city where every citizen, whoever they are, wherever they live and at every stage of life, can make choices that empower them to be happy and healthy.

Birmingham Sports Strategy – a new strategy is currently in development and aims to create a shared vision for sport across the city with the ambition of getting more people physically active and participating in sport, providing opportunities from grassroots sports through to elite performance.

Birmingham Transport Strategy - The Birmingham Transport Plan 2031 describes what the city needs to do differently to meet the demands of the future. A key component of the plan is around prioritising active travel in local neighbourhoods and ensuring walking, cycling and active travel become the first choice for short journeys.

A Bolder, Healthier Future for the People of Birmingham and Solihull Strategy for Health and Care 2023 - 2033 - Birmingham and Solihull's Integrated Care Strategy outlines five clinical areas to focus on: Circulatory Disease; Cancer; Infant mortality; Mental health and Respiratory disease.

Birmingham 2022 Commonwealth Games Legacy Plan - Birmingham 2022 Commonwealth Games organisers and its partners developed a national Legacy Plan, which outlined a series of ambitions to

[iiiiv]leave a lasting, positive impact on jobs, skills, education, culture, physical activity and investment across the West Midlands and the UK. The plan boosted investment across Birmingham and the West Midlands, to engage people who face multiple barriers and look to approach these challenges in new ways.

[iii] *Physical activity: brief advice for adults in primary care*
[iv] *Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation*

The picture in Birmingham

The population of Birmingham has grown over the last 10 years; the 2021 Census showed that there were 1,144,922 people living in the city compared to 1,073,045 in 2011 Census [7]. This is a growth of approximately 6% over the last 10 years.

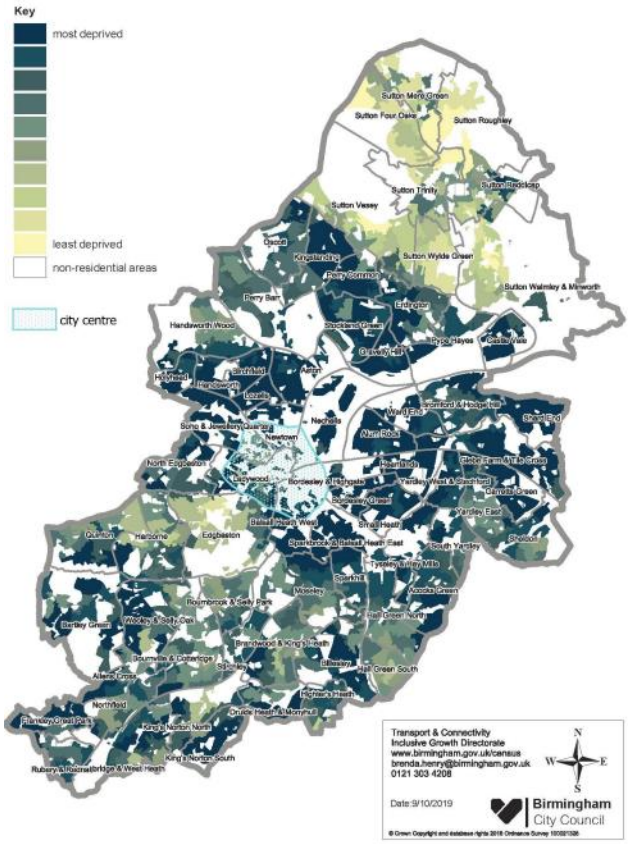
There are slightly more females living in the city (49% male compared to 51% female). Birmingham is a younger city with the largest age group for both genders being 20-24 years. The population under the age of 24 is 419038, representing 37% of the population, compared to the over 65 population which represents 13% of the total population (147,488).

Birmingham is one of the UK's most diverse cities; figures from the 2021 census show that the city's ethnic minorities represent 51.4% of the population. Birmingham is one of the first 'super diverse' cities in the UK where citizens from ethnic minorities make up more than half the population.

Birmingham has high levels of deprivation and is the 7th most deprived Local Authority nationally. 43% of the population live in Lower Super Output Areas (LOSAs) in the 10% most deprived in England, with just over half of children (51%) under the age of 16 years living in the 10% most deprived areas.

The map below shows deprivation by LSOA in Birmingham. Two of Birmingham's LSOAs are in the 100 most deprived LSOAs in the country. There are 7 LSOAs in the city that are extremely deprived and ranked amongst the top 1% of deprived areas nationally.

Figure 7: 2019 English Index of Multiple Deprivation – Birmingham LSO As[2]



Birmingham adults are less active than the England average (58.1% active compared to 67.3%) and less active than other core cities. Bristol (74.2%), Nottingham (67%) and Manchester (63%) all have higher numbers of active adults than Birmingham.

Figure 8: Percentage of physically active adults (16+yrs) in Birmingham compared to nearest neighbours

Source Fingertips Office for Health Improvement and Disparities 2021-2022

Percentage of physically active adults 2021/22

Proportion - %

Area	Value	95% Lower CI	95% Upper CI
England	67.3	67.1	67.5
Neighbours average	-	-	-
Bristol	74.2	72.2	76.1
Sheffield	71.7	69.7	73.7
Leeds	69.1	67.0	71.1
Newcastle upon Tyne	67.1	65.0	69.2
Nottingham	67.0	65.0	69.1
Liverpool	64.9	62.8	67.1
Manchester	63.6	61.5	65.7
Salford	63.1	60.1	66.1
Bolton	59.6	56.6	62.6
Bradford	58.9	54.5	63.4
Coventry	58.4	55.2	61.5
Birmingham	58.1	56.3	60.0
Walsall	57.2	53.5	61.0
Wolverhampton	57.2	53.4	61.1
Leicester	57.0	52.6	61.4
Sandwell	56.3	52.8	59.7

Birmingham children and young people are less active than the England average (41.6% active compared to 47.2%) and less active than several core cities. Salford (57.1%), Bristol (54.8%), and Nottingham (48.6%) all have higher numbers of active children and young people than Birmingham.

Figure 9: Percentage of physically active children and young people in Birmingham compared to nearest neighbours

Source Fingertips Office for Health Improvement and Disparities 2021-2022

Percentage of physically active children and young people 2021/22

Proportion - %

Area	Value	95% Lower CI	95% Upper CI
England	47.2	46.6	47.9
Neighbours average	-	-	-
Salford	57.1	50.2	63.6
Liverpool	55.2	48.3	62.0
Bristol	54.8	47.3	62.1
Bolton	51.2	39.1	63.1
Leeds	49.3	44.6	53.9
Nottingham	48.6	41.1	56.1
Leicester	48.5	40.3	56.8
Sandwell	45.5	41.4	49.7
Sheffield	41.8	36.9	46.8
Birmingham	41.6	36.8	46.5
Bradford	40.4	32.7	48.7
Newcastle upon Tyne	38.8	31.2	47.1
Wolverhampton	35.0	30.2	40.1
Walsall	33.7	28.0	40.0
Coventry	*	-	-
Manchester	*	-	-

Birmingham adults are more inactive than the England average (29.4 inactive compared to 22.3%) and more inactive than several core cities. Bristol (17%), Nottingham (23.3%) and Manchester (26.3) all have lower numbers of inactive adults than Birmingham.

Figure 10: Percentage of physically inactive adults (16+yrs) in Birmingham compared to nearest neighbours

Source Fingertips Office for Health Improvement and Disparities 2021-2022

Percentage of physically inactive adults 2021/22

Proportion - %

Area	Value	95% Lower CI	95% Upper CI
England	22.3	22.1	22.5
Neighbours average	-	-	-
Leicester	32.5	28.4	36.7
Bradford	31.2	26.9	35.3
Sandwell	31.0	27.7	34.2
Walsall	30.9	27.5	34.3
Wolverhampton	30.5	27.0	34.0
Birmingham	29.4	27.7	31.1
Coventry	28.1	25.3	30.9
Bolton	27.5	24.7	30.4
Salford	26.7	23.9	29.5
Manchester	26.3	24.4	28.3
Liverpool	24.8	22.9	26.7
Nottingham	23.3	21.3	25.1
Newcastle upon Tyne	22.4	20.6	24.3
Leeds	21.5	19.6	23.3
Sheffield	19.0	17.2	20.8
Bristol	17.0	15.4	18.7

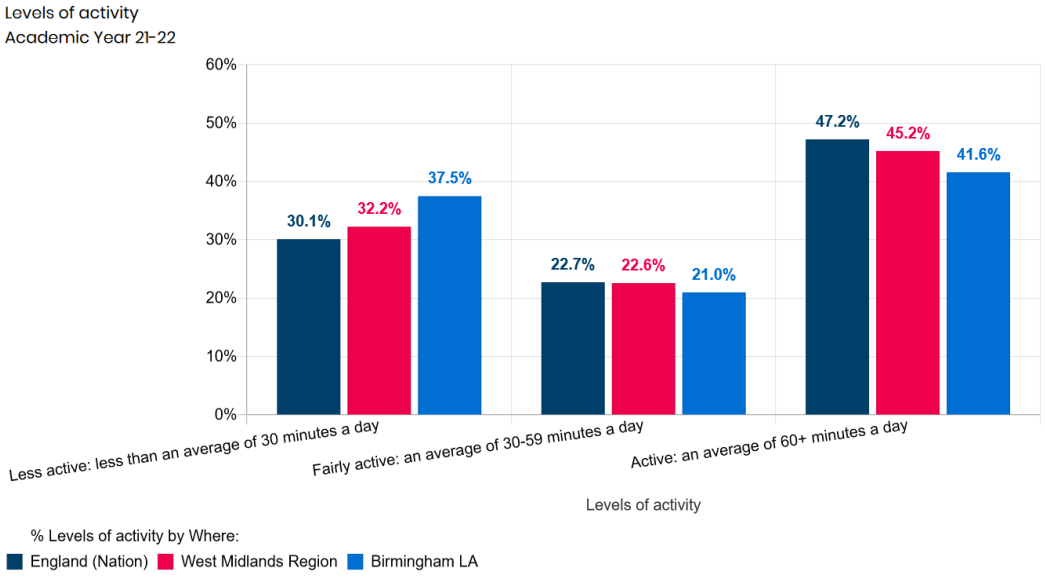
Physical Activity Across the Life Course

Physical Activity Levels in Children

Data from the Active Lives Survey 2023 shows 42% of children (ages 5-16) in Birmingham are physically active and meeting the recommended guidelines of 60+ minutes per day [8]. This is lower than both the West Midlands (45%) and England (47%) as a whole.

Almost 2 in 5 children (38%) are classified as less active, higher than the proportions across the West Midlands (32%) and nationally (30%) [8].

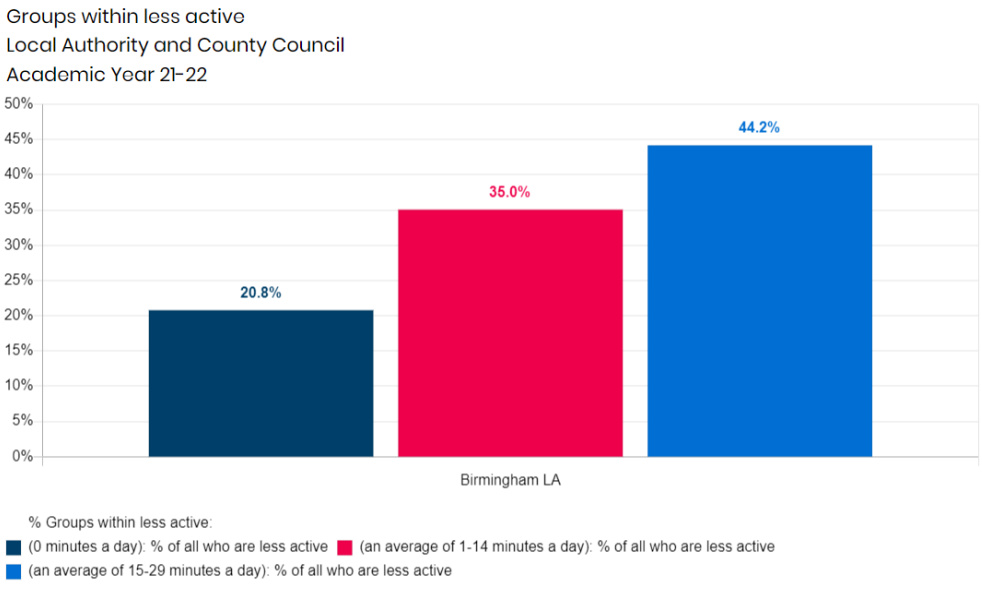
Figure 11: Levels of Physical Activity in Birmingham Children compared to England Average and West Midlands Average 2021-2022



Source Active Lives Data

Further analysis of the less active group of children in Birmingham shows a fifth of this group (21%) were totally inactive, completing no physical activity at all.

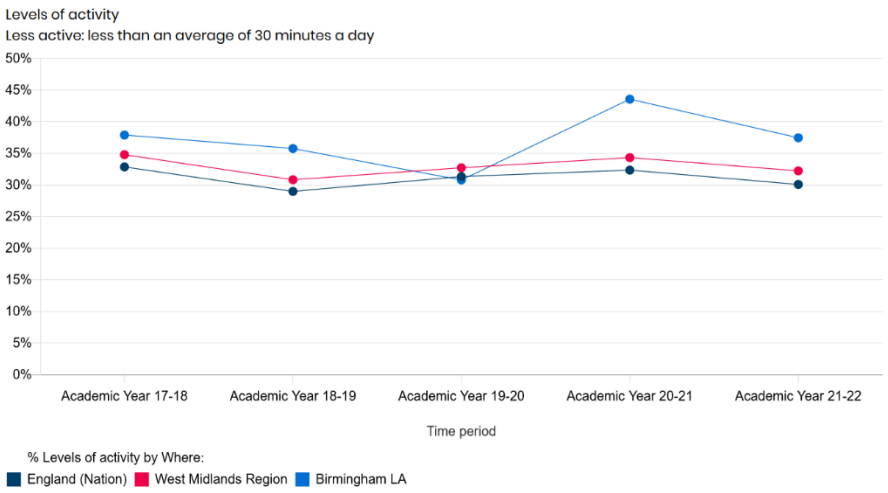
Figure 12:



Analysis of trends over time shows in the 7-year period 2015-2022, the level of physical inactivity in Birmingham children was falling, however, this trend did not continue. Instead, the proportion of children classified as less active increased significantly during the pandemic, from 31% to 44%. This jump in less active children was much greater in Birmingham compared to the slight increases observed across the West Midlands or England.

The proportion of children in Birmingham classified as less active has now reduced and has returned to the same level as it was in 2017 (38%). There is still a gap between Birmingham and the rest of the region and nationally, with Birmingham's levels of less active children post-pandemic being higher than the West Midlands (32%) and England (30%).

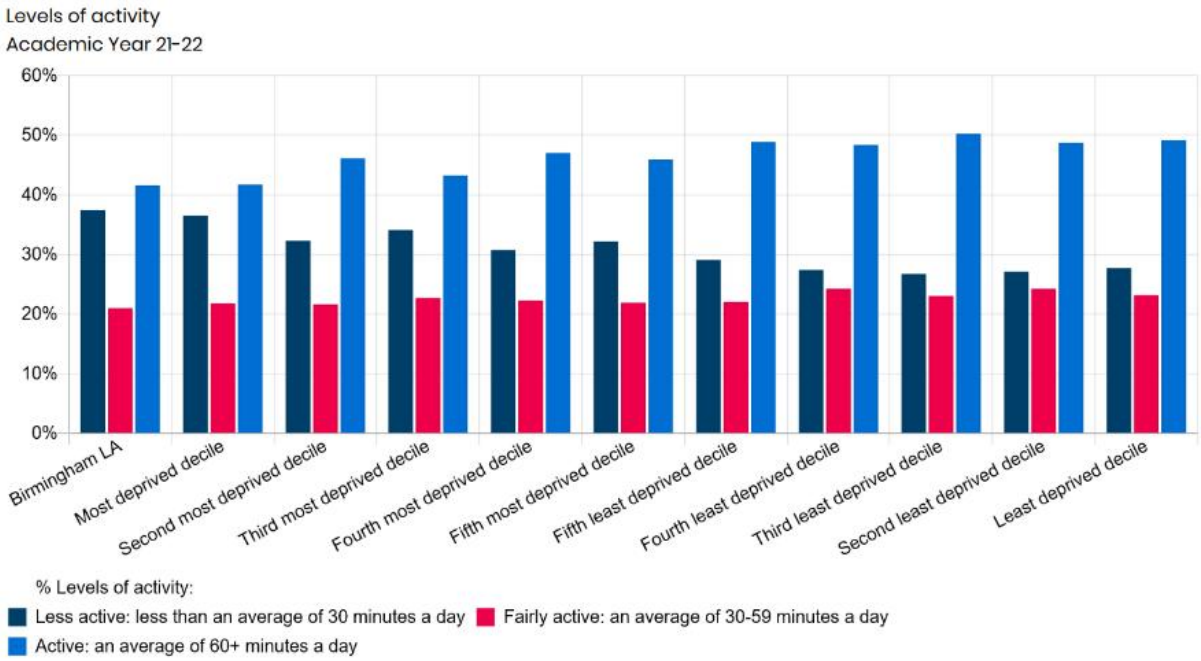
Figure 13:



Income Deprivation

Results from the Active Lives Survey using the Income Deprivation affecting Children Index shows a correlation between deprivation and inactivity. The chart below shows children living in the most deprived decile are more inactive (37%) than those from the least deprived decile (28%). This mirrors national evidence which indicates that children from lower socio-economic groups have lower rates of physical activity participation.

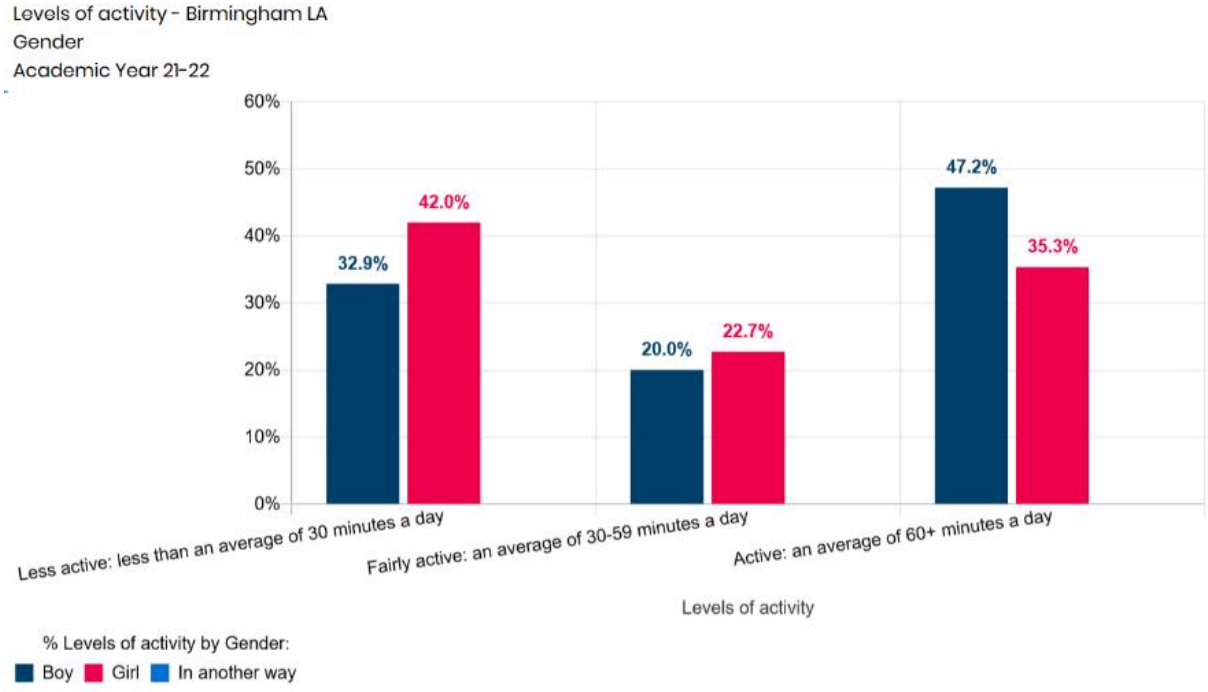
Figure 14:



Gender

Results from the Active Lives Survey shows that in children only 1 in 3 (35%) of girls met the recommended amount of physical activity each day. This picture improved for boys with nearly half (47%) of all boys aged 5-16 years taking part in at least 60 minutes of physical activity each day. On the other hand, Birmingham girls are more likely to be less active (42%) compared to boys (33%).

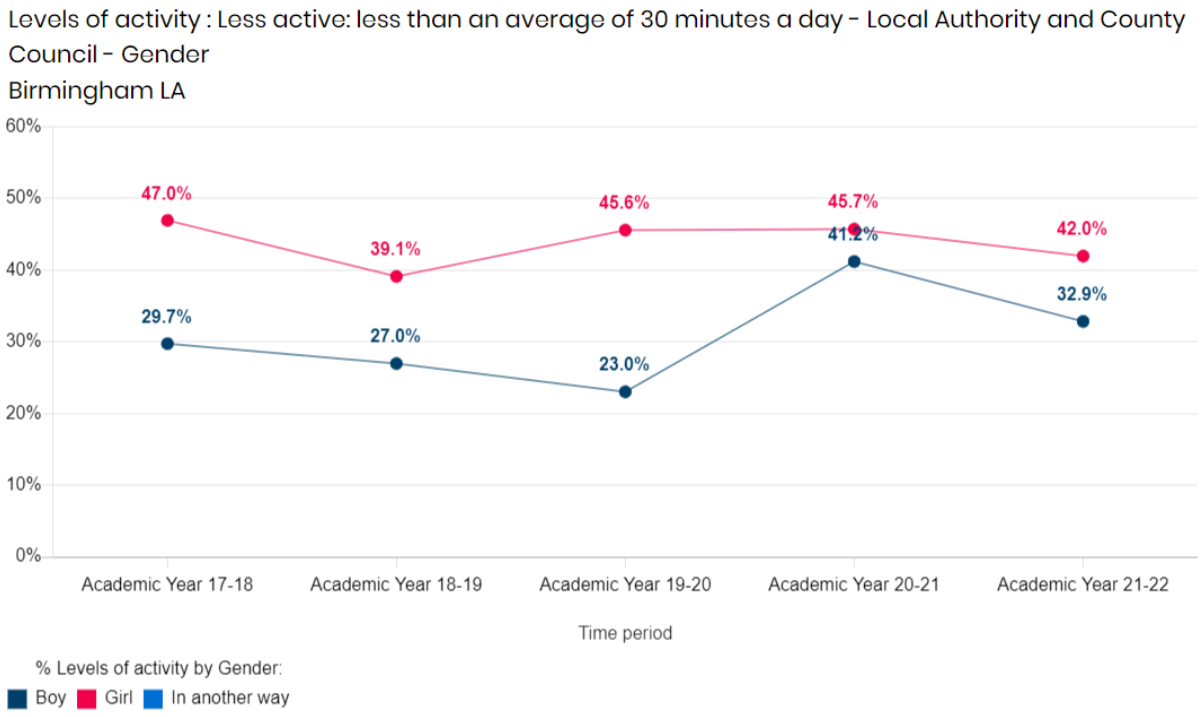
Figure 15:



When looking at the trends over time by gender we can see that in the academic year 19-20, the proportion of less active girls (46%) was double that of boys (23%). This gap has now narrowed largely due to the impact the pandemic had on the activity levels in boys living within the city. The prevalence of less active boys had been decreasing year on year up until the pandemic, when it rose sharply from 23% to 41%. In 2021-22 levels of less active children have fallen but have not recovered to pre-pandemic levels.

In comparison, the proportion of less active girls remained static over the pandemic period and were similar to the levels observed in 2019-20. Levels have fallen again in the academic year 2021-22, however there is still a 10% gap between the genders.

Figure 16:



PE lessons at school are only once a week and some of the girls don't even get changed into sports clothes, they just hang around and watch people play football.

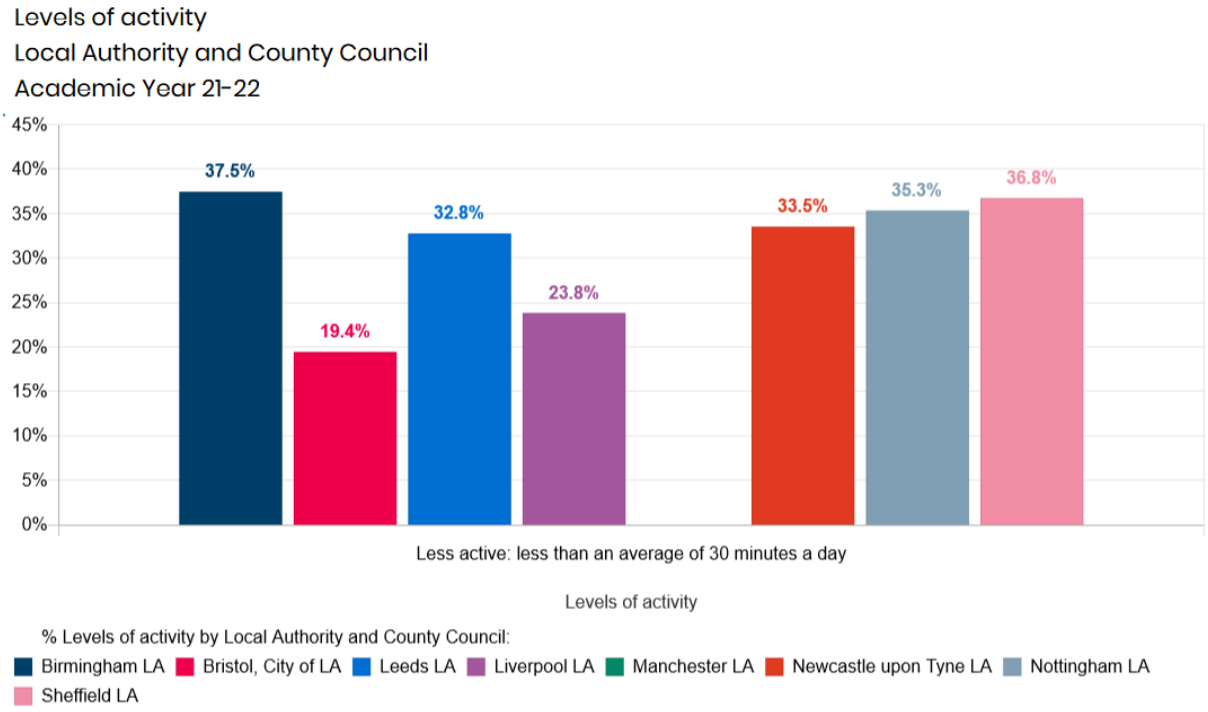
15-year-old boy

Comparison to similar Local Authority areas

Benchmarked against the Core Cities, data from the 2021-22 academic year shows that Birmingham has the highest level of less active children.

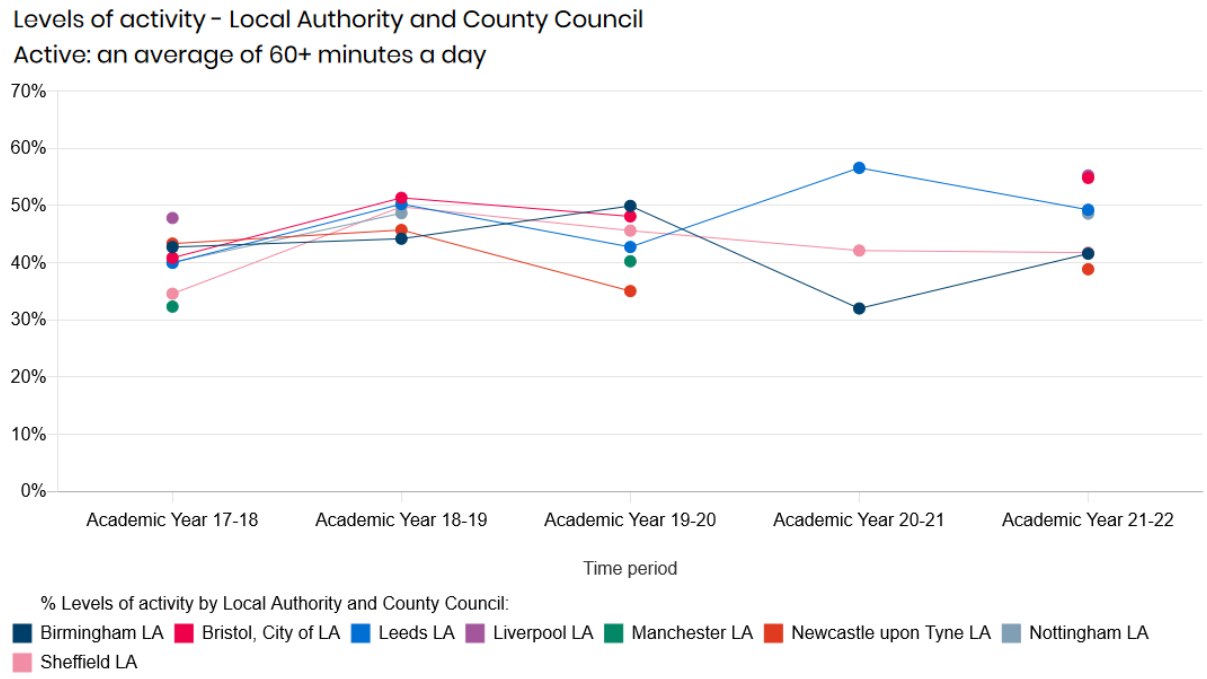
Children taking part in less than 30 minutes of physical activity a week – comparison with Core Cities

Figure 17:



Analysis of trends over time also show that the pandemic had the largest impact on Birmingham's physical activity levels when compared to the Core Cities. Between 2017-2020, the proportion of active children was steadily increasing, however the impact of the pandemic was most striking in Birmingham with levels falling to the worst performing Core City. The most recent data shows signs of post-pandemic recovery.

Figure 18:

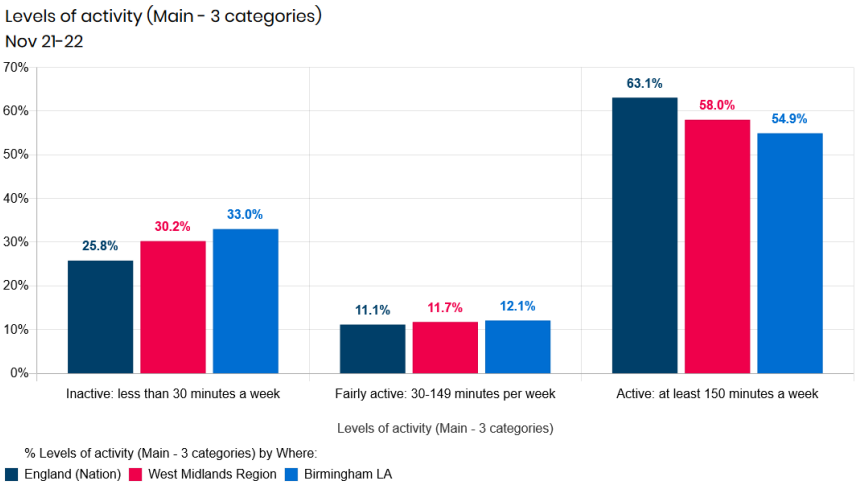


Physical Activity Levels in Adults

55% of the adult (aged 16+) population in Birmingham were physically active compared to 58% of adults in the West Midlands and 63% in England as a whole [8,9].

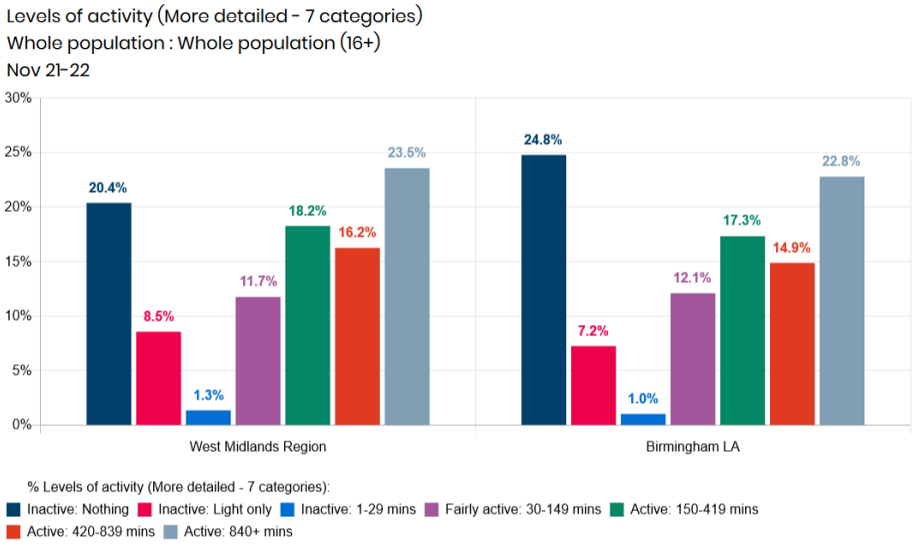
A third of adults were classified as inactive, higher than the proportions across the West Midlands (30%) and nationally (26%).

Figure 19:



More detailed analysis of activity in 7 categories shows almost a 1 in 4 (25%) of the Birmingham population are totally inactive, completing no physical activity at all. This is compared to around 1 in 5 (20%) of the West Midlands population.

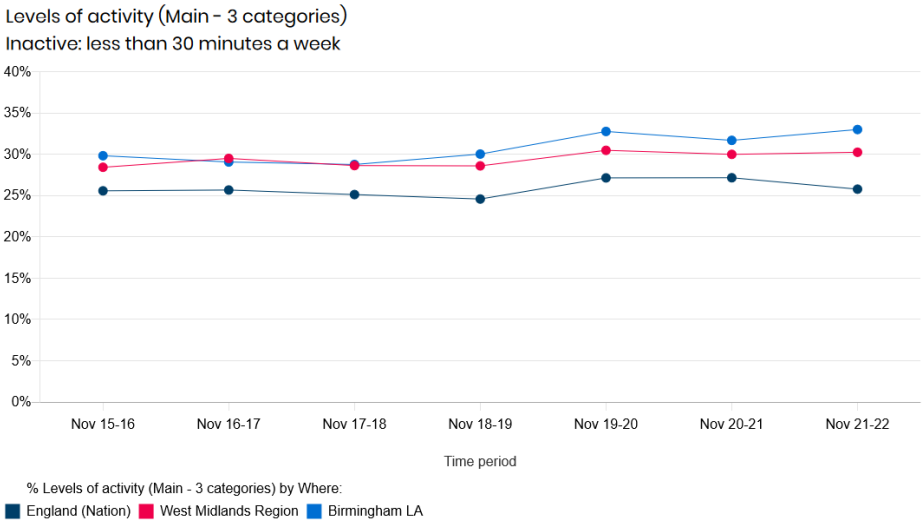
Figure 20:



Analysis of trends over time shows in the 7-year period 2015-2022, the level of physical inactivity in Birmingham increased over this time from 30% to 33%. The gap between Birmingham's inactivity levels and regional and national figures narrowed during the pandemic, however this has widened

again and is most prominent between Birmingham and the rest of the country where there is a 7% difference.

Figure 21:

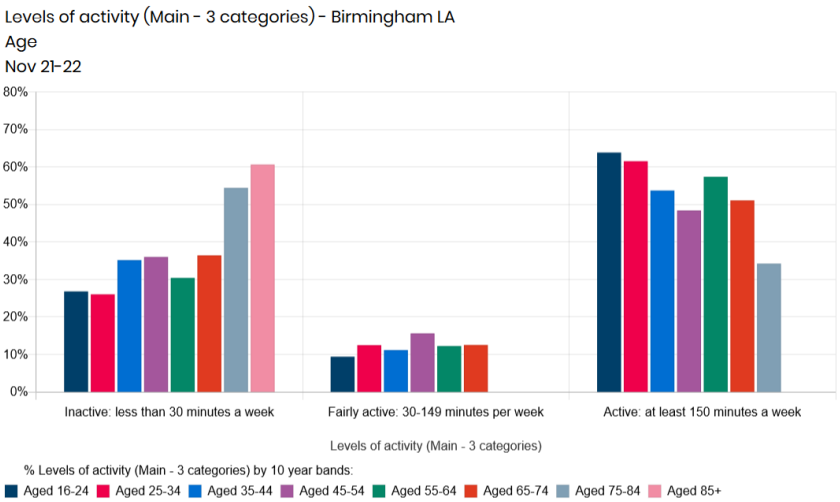


	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
England	25.6%	25.7%	25.1%	24.6%	27.1%	27.2%	25.8%
West Midlands	28.4%	29.5%	28.6%	28.6%	30.5%	30.0%	30.2%
Birmingham LA	29.8%	29.1%	28.8%	30.0%	32.8%	31.7%	33.0%

Age

Inactivity increases with age; around 1 in 4 people aged 16-34 are inactive, rising to 1 in 2 aged 75-84 and nearly 2 in 3 aged 85+. In a variation from the general pattern, inactivity also appears to increase between the age of 35-54 age groups before falling again in the 55-74 age groups. People in midlife having multiple roles therefore this reduction in activity could be due to a range of factors including working arrangements and caring responsibilities for both children and/or older relatives.

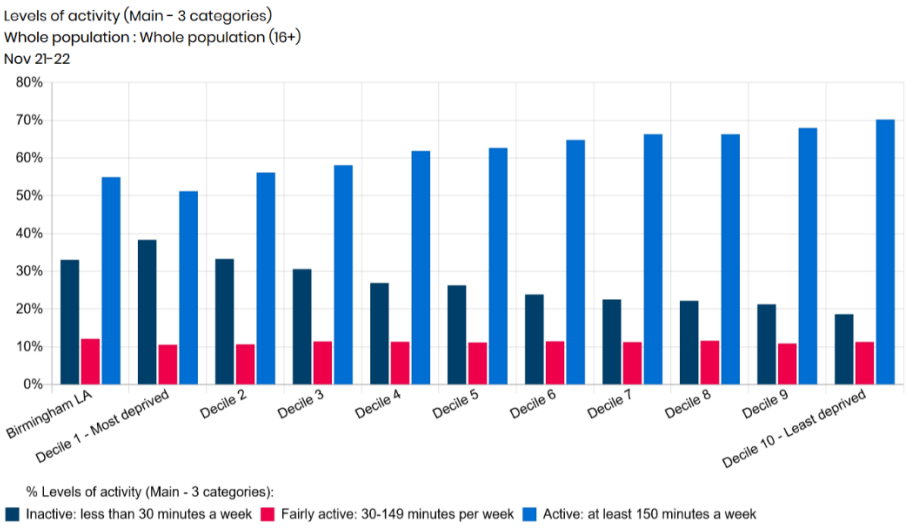
Figure 22:



Deprivation

Analysis of levels of activity by IMD shows a clear correlation between deprivation and inactivity. Adults living in the most deprived deciles are the most inactive within the city, compared to those living in the least deprived IMD deciles who are more physically active. The proportion of adults living in IMD 1 who are inactive is double (38%) those living in IMD 10 (19%). Fairly active remains constant across all IMD deciles.

Figure 23:

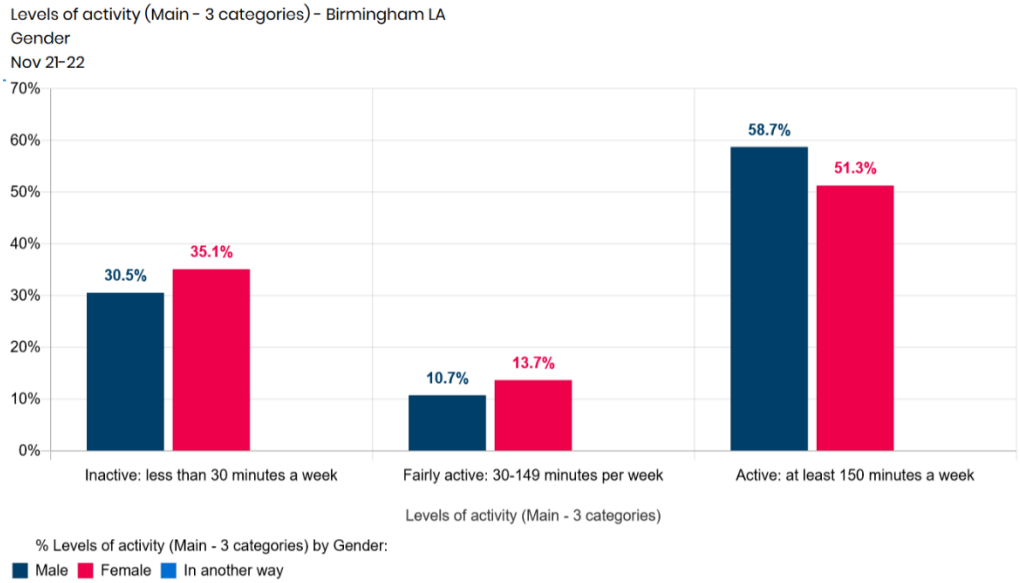


Gender

The Active Lives Survey shows that 51% of women and 59% of men meet the recommendations for levels of physical activity each week.

Females are less physically active than men with more than one third (35%) inactive, compared to around 31% of male respondents.

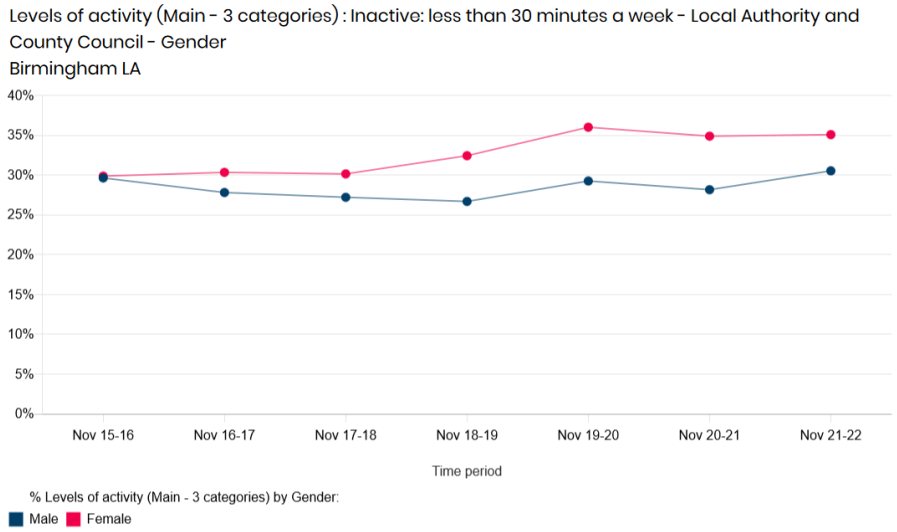
Figure 24:



Inactivity has increased in both genders over the past 7 years. However, it is worth noting that at the beginning of this period the percentage of inactive males started to decrease until around the time of the pandemic, at which point it began to increase. For females, there has been a steady increase over the 7-year period.

At the start of the 7-year period, the prevalence of males and females who were inactive was the same (30%) however over the last 7 years, the gender gap has widened, with currently 4% more females inactive compared to males.

Figure 25:

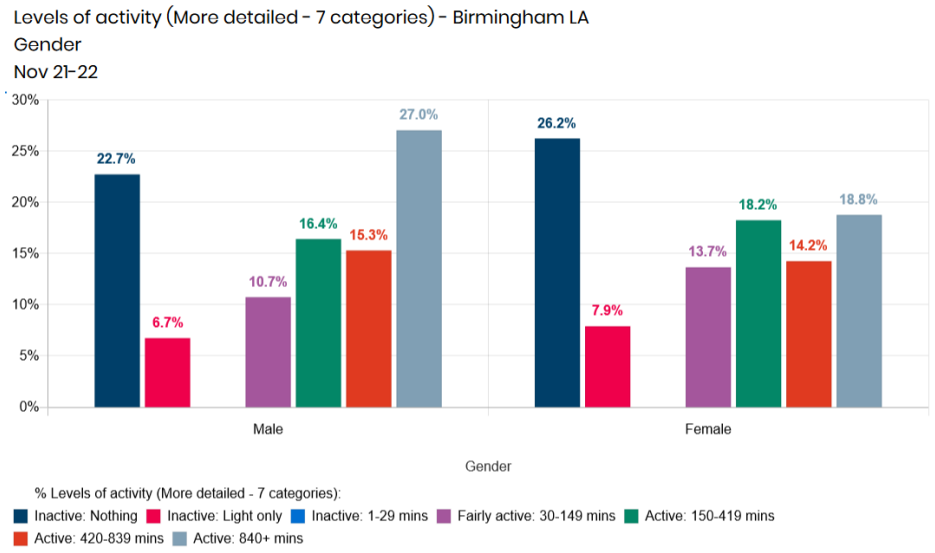


	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Male	29.6%	27.8%	27.2%	26.7%	29.3%	28.2%	30.5%
Female	29.9%	30.3%	30.1%	32.4%	36.0%	34.9%	35.1%

ore detailed analysis of 7 activity categories shows this gender difference is more marked, with more than a quarter of females being completely inactive. The highest levels of activity (active more than 840 minutes per week) are reported in males (27%), with just 19% of females achieving this level of activity[v].

[v] Sample sizes for missing category (inactive 1-29 minutes) did not meet the threshold for analysis.

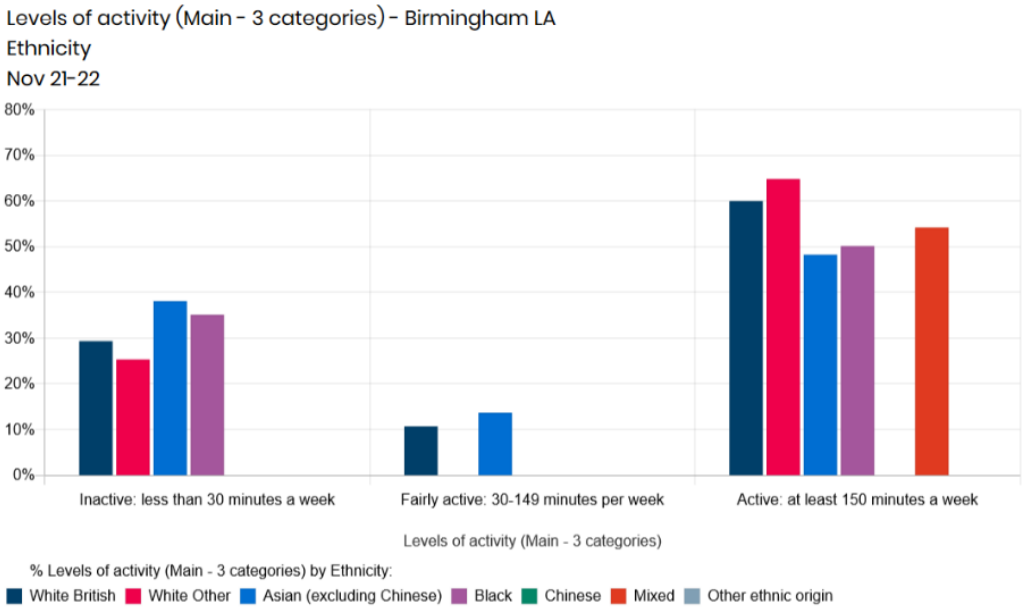
Figure 26:



Ethnicity

The data available for levels of activity in ethnic groups is limited, but UK evidence consistently shows that South Asian and Black ethnicities are least likely to be active. The data available from the Active Lives Survey for Birmingham shows higher levels of inactivity reported in Asian (38%) and Black ethnic groups (35%)[vi].

Figure 27:

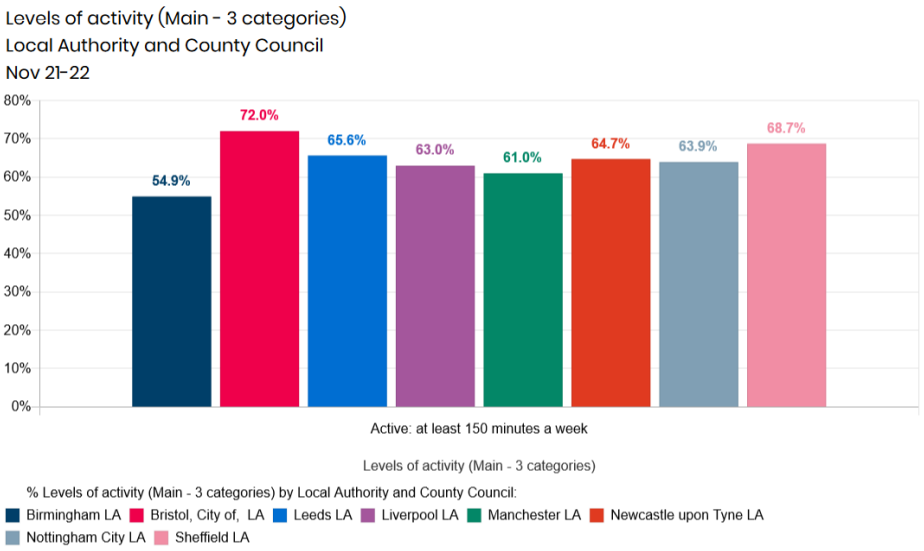


[vi] Sample sizes for missing ethnic groups did not meet the threshold for analysis.

Comparison to Core Cities

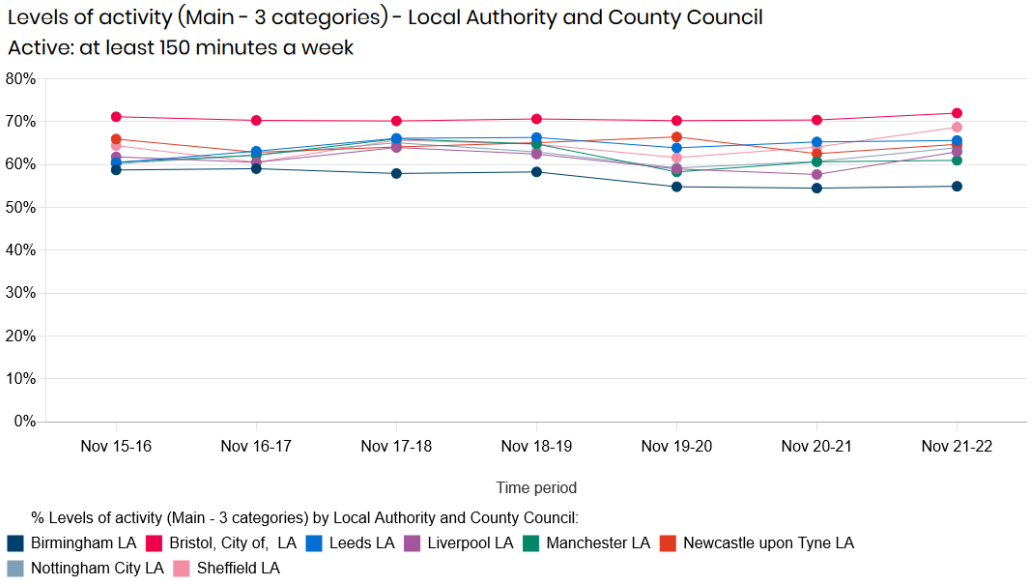
Birmingham has the lowest levels of adults meeting CMO guidelines compared to all Core Cities.

Figure 28:



Trends over time show that Birmingham consistently performs worst of all Core Cities. Since 2015/16, the proportion of active adults has been steadily falling and Birmingham is the only Core City showing a decrease during this period.

Figure 29:



	Nov 15-16	Nov 16-17	Nov 17-18	Nov 18-19	Nov 19-20	Nov 20-21	Nov 21-22
Birmingham LA	58.7%	59.0%	57.9%	58.3%	54.8%	54.5%	54.9%
Bristol, City of, LA	71.2%	70.3%	70.2%	70.6%	70.3%	70.4%	72.0%
Leeds LA	60.4%	63.1%	66.1%	66.3%	63.9%	65.3%	65.6%

Liverpool LA	61.8%	60.5%	64.0%	62.5%	59.0%	57.7%	63.0%
Manchester LA	60.6%	62.2%	66.0%	64.8%	58.3%	60.6%	61.0%
Newcastle upon Tyne LA	66.0%	62.9%	64.1%	65.1%	66.5%	62.5%	64.7%
Nottingham City LA	60.2%	62.2%	65.1%	62.9%	59.2%	60.7%	63.9%
Sheffield LA	64.4%	60.5%	65.7%	64.8%	61.6%	64.1%	68.7%

Birmingham has the highest proportion of inactive adults compared to all other Core Cities, and trends over time show this has been consistent since 2015-16.

Figure 30:

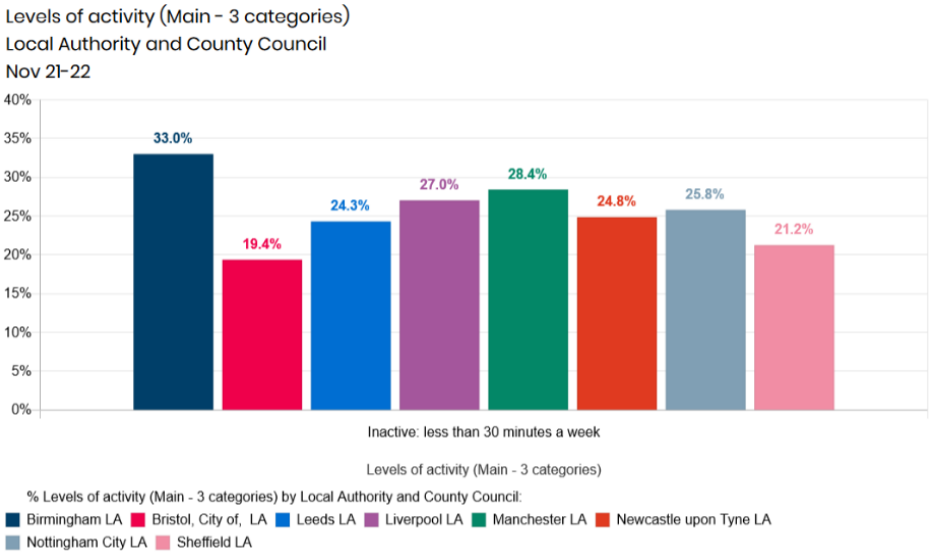
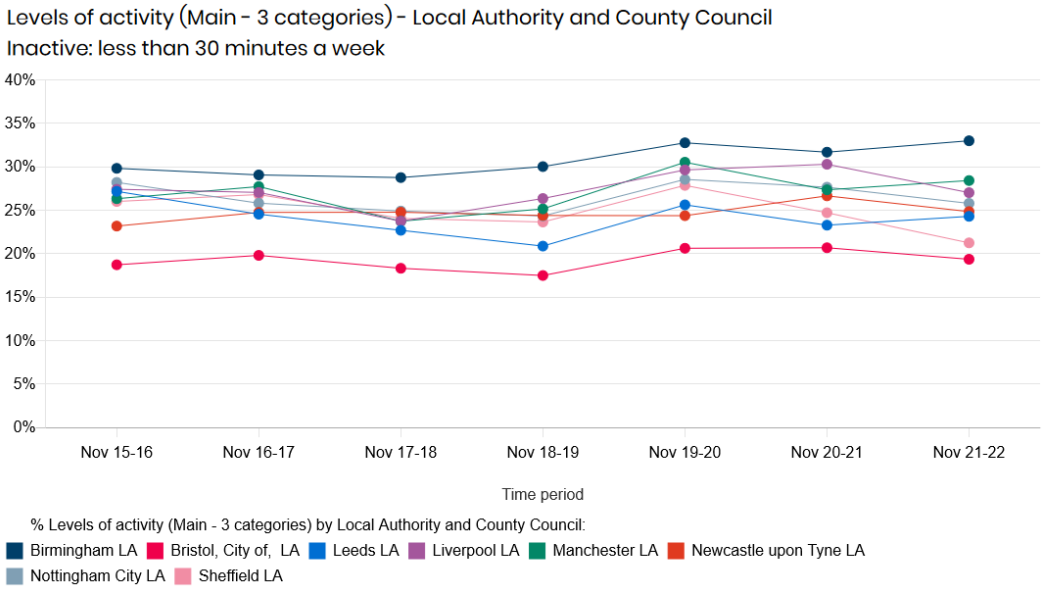


Figure 31:



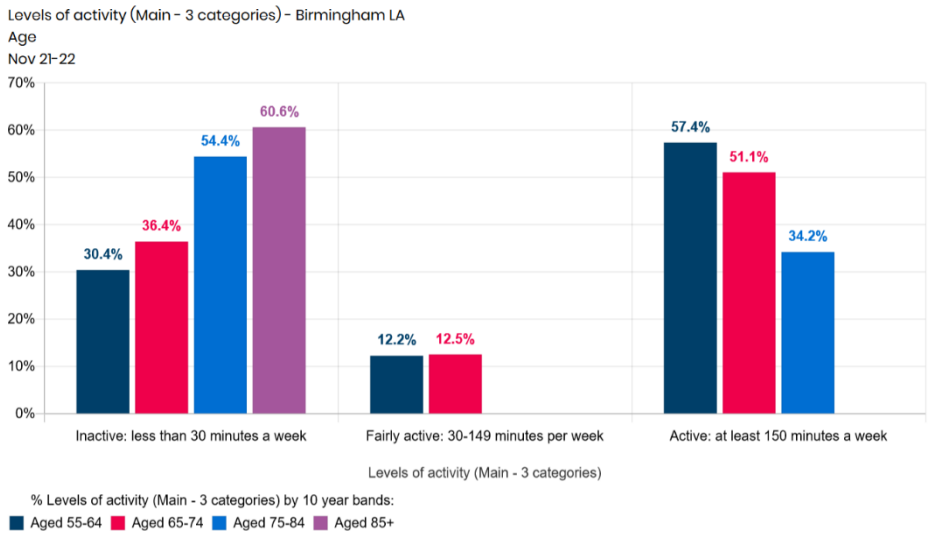
	Nov 15-16	Nov 16-17	Nov 17-18	Nov 18-19	Nov 19-20	Nov 20-21	Nov 21-22
Birmingham LA	29.8%	29.1%	28.8%	30.0%	32.8%	31.7%	33.0%
Bristol, City of, LA	18.7%	19.8%	18.3%	17.5%	20.6%	20.7%	19.4%

Leeds LA	27.2%	24.5%	22.7%	20.9%	25.6%	23.3%	24.3%
Liverpool LA	27.4%	27.1%	23.7%	26.4%	29.6%	30.3%	27.0%
Manchester LA	26.3%	27.7%	23.7%	25.2%	30.5%	27.4%	28.4%
Newcastle upon Tyne LA	23.2%	24.8%	24.8%	24.4%	24.4%	26.7%	24.8%
Nottingham City LA	28.2%	25.8%	24.9%	24.3%	28.6%	27.7%	25.8%
Sheffield LA	26.0%	26.8%	24.1%	23.6%	27.9%	24.7%	21.2%

Older People

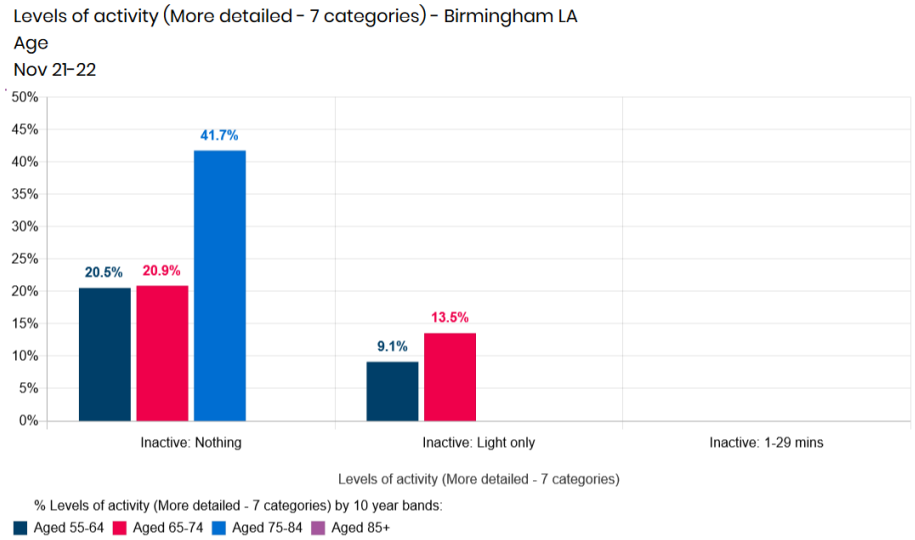
Levels of activity decrease with age, 57.4% of 55–64-year-olds are active at least 150 mins a week this drops to 51.4% in the 65- to 74-year-old age group and 34.2 % in the 75-84 age group.

Figure 32:



Inactivity increases the older people get and 60.6% of over 85years are active less than 30 mins a week.

Figure 33:



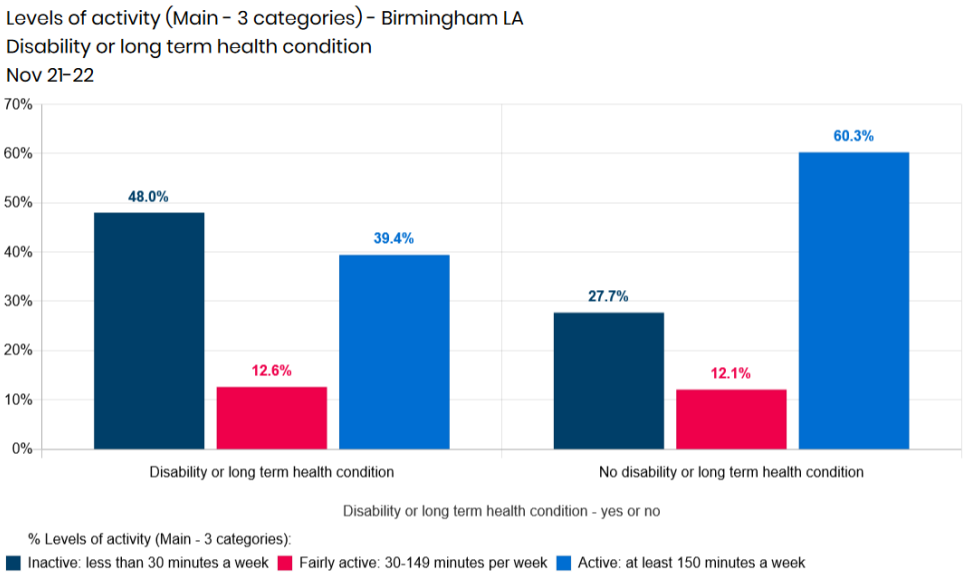
More detailed analysis of the inactive group shows a significant proportion of people in older age groups do no physical activity at all – around 1 in 5 in (21%) the 55-74 age groups, doubling to 2 in 5 (42%) in the 75-84 age group.

A recent study, informed by a systematic review and meta-analysis of all published frailty interventions in primary care, showed that a simple, low-cost, home-based intervention can reverse frailty and significantly improve muscle strength, bone mass, activity levels, and slowness in three months. The intervention included twenty minutes of daily activity at home, alongside consumption of sufficient protein (1.2g/kg bodyweight) in a normal daily diet. The authors believe this approach could yield substantial benefits if rolled out across the community [10].

Disability

Almost half (48%) of people with a disability or long-term health condition report as inactive, compared to 28% of people without. Only 1 in 5 (39%) people with a disability meet recommended levels of physical activity.

Figure 34:



Levels of inactivity in people with a disability or long-term health condition increases with age, with more than 1 in 5 (44%) of 16–64-year-olds reporting inactivity, increasing to 3 in 5 (60%) of those aged 65+. The inverse is true for people with a disability or long-term health condition meeting recommended levels, with 45% of ages 16-64 completing at least 150 minutes of physical activity a week, falling to just 27% of over 65s.

Figure 35:

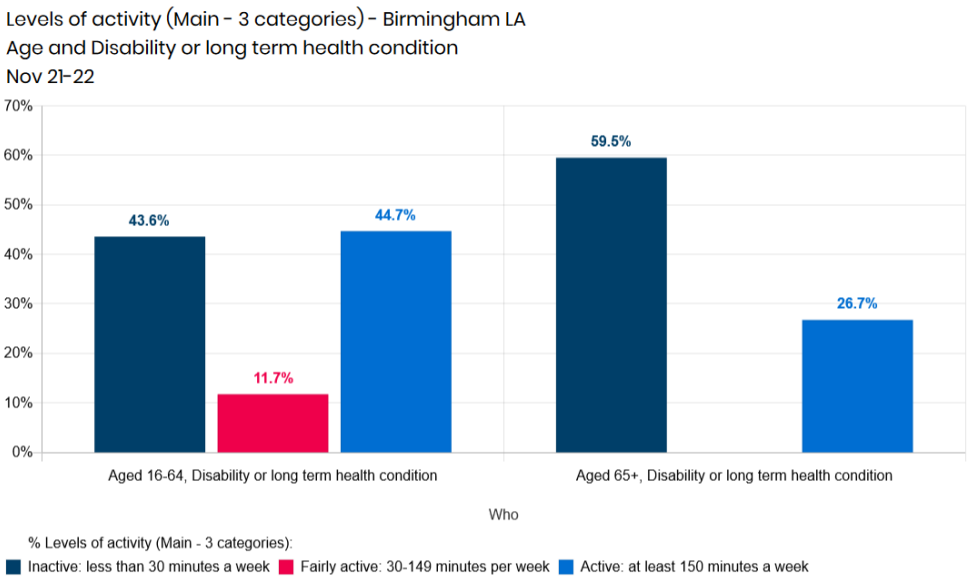

Levels of activity (Main - 3 categories) - Birmingham LA
Age and Disability or long term health condition
Nov 21-22
70%
60%
50%
40%
30%
20%
10%
0%
43.6%
11.7%
44.7%
59.5%
26.7%
Aged 16-64, Disability or long term health condition
Aged 65+, Disability or long term health condition
Who
% Levels of activity (Main - 3 categories):
Inactive: less than 30 minutes a week
Fairly active: 30-149 minutes per week
Active: at least 150 minutes a week

Figure 36:

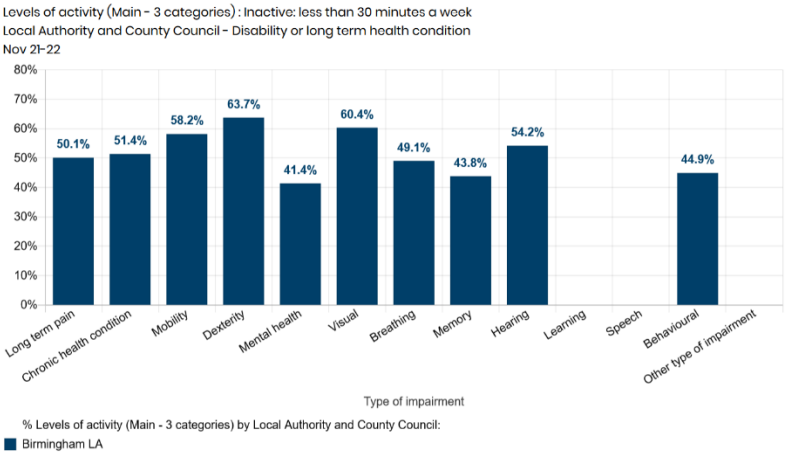
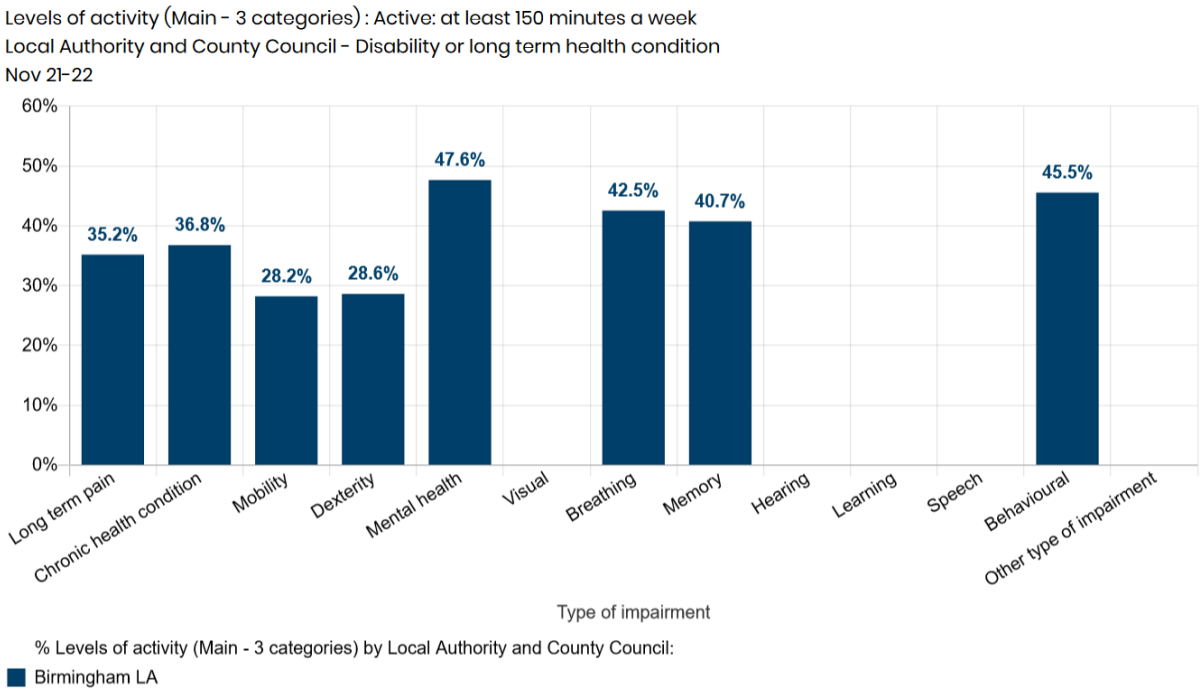

Levels of activity (Main - 3 categories) : Inactive: less than 30 minutes a week
Local Authority and County Council - Disability or long term health condition
Nov 21-22
80%
70%
60%
50%
40%
30%
20%
10%
0%
50.1%
51.4%
58.2%
63.7%
41.4%
60.4%
49.1%
43.8%
54.2%
44.9%
Long term pain
Chronic health condition
Mobility
Dexterity
Mental health
Visual
Breathing
Memory
Hearing
Learning
Speech
Behavioural
Other type of impairment
Type of impairment
% Levels of activity (Main - 3 categories) by Local Authority and County Council:
Birmingham LA

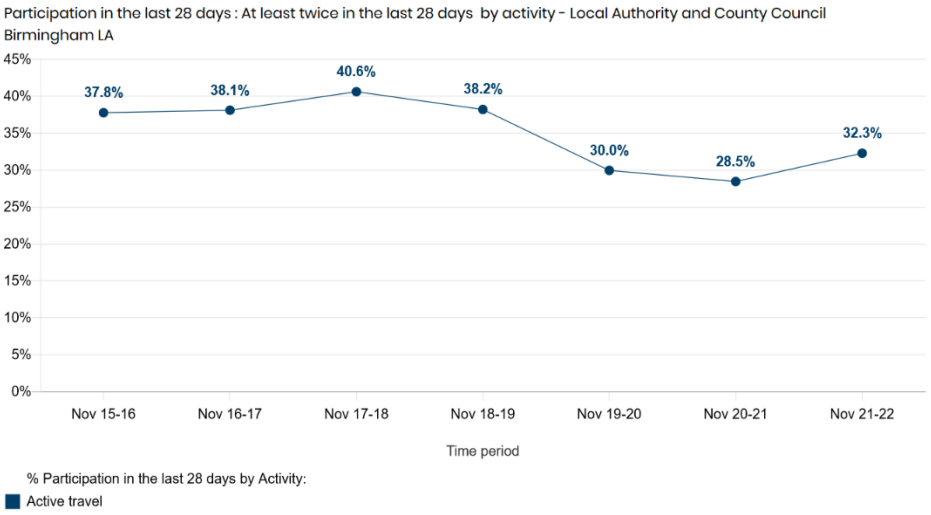
Figure 37:



Active Travel

Participation in active travel has decreased over the period 2015-2022 but is showing some signs of recovery since the pandemic.

Figure 38:



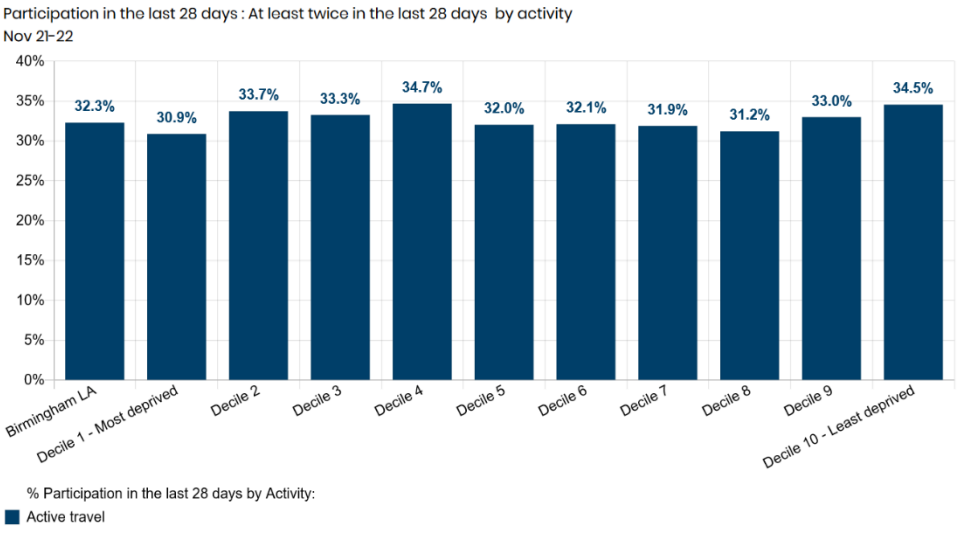
Data from the Census 2021 shows 7% of the Birmingham population travel to work on foot, and 1% by bike. Active travel to work has increased since the 2011 Census, when around 6% were travelling on foot, and close to 1% by bike.

Figure 39:

Method of travel to workplace	2021	
Total: All usual residents aged 16 years and over in employment the week before the census	442,418	
Work mainly at or from home	114,058	25.8%
Underground, metro, light rail, tram	977	0.2%
Train	9,220	2.1%
Bus, minibus or coach	43,123	9.7%
Taxi	6,673	1.5%
Motorcycle, scooter or moped	1,118	0.3%
Driving a car or van	202,963	45.9%
Passenger in a car or van	21,557	4.9%
Bicycle	5,741	1.3%
On foot	31,483	7.1%
Other method of travel to work	5,505	1.2%

Participation in active travel is lowest in decile 1, the most deprived area, but there is little variation across all deciles.

Figure 40:



Sustrans Walking and Cycling Data

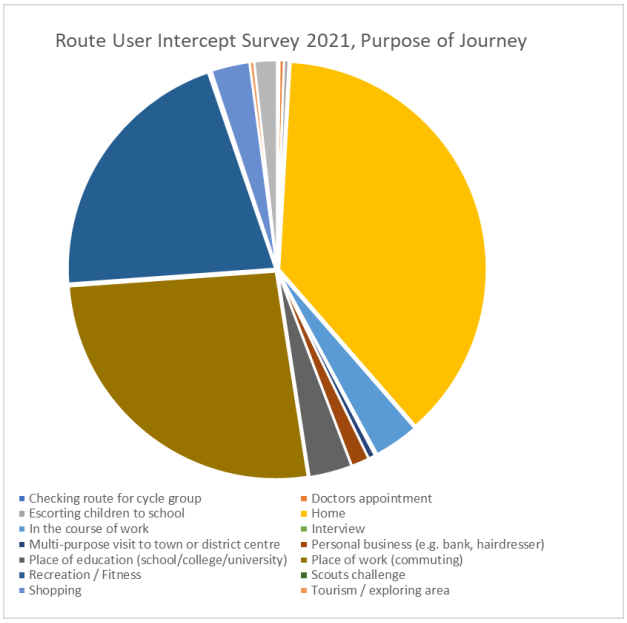
Cycling in Birmingham

The 2021 Route User Intercept Survey questioned 571 cyclists on their travel behaviour at 16 sites across the city. The majority of participants (83%) were white, followed by 9% Asian, 5% black, 3% Mixed and less than 1% other. Most participants were male (72%), with 26% being female and just under 1% identifying as other. Participant age breakdown was 25% aged 45-54, 22% aged 35-44, 18% aged 25-34, 14% aged 55-64, 12% aged 18-24 and 7% aged 65+. 14-15- and 16–17-year-olds accounted for less than 1% of survey participants each. Most survey participants were in full-time employment (64%), with 13% working part-time, 11% full time students, 7% retired and 4% unemployed.

If not cycling, participants reported other modes of transport to complete the journey may have been bus (29%), car or van (24%), rail (15%), walk or run (9%), taxi (2.9%) or e-scooter (1%). 19% stated they would not have made the journey if not by cycle. The presence of a cycle route did not increase use of the route for 65% of participants, with 21% reporting it had in part, and 14% reporting yes, totally.

The purpose of the participants' journeys is shown in the chart below.

Figure 41:



Road Traffic Collisions in Birmingham

Data on road traffic collisions is published annually by the Travel Planning team, and as the impact of the Physical Activity Strategy progresses, these indicators may decrease. The most recent data is in the appendix and can be used as a baseline to measure improvement.

Key health needs related to physical activity

Service and Place Based Provision in Birmingham

Birmingham has a well-established and varied physical activity landscape including a wealth of community groups, clubs and facilities, physical activity providers, community organisations and venues.

This section of the PANA provides a snapshot summary of the current physical activity service and place-based provision that is available in the city. The list is not intended to be a complete picture but to give an overview of the types and variety of activity there is within the city.

To support the development of this section a:

- Survey was shared with partners to identify the range of services, initiatives and place-based physical activity opportunities that are available across the city.
- Framework was developed to help identify the themes in provision across the city. This framework was used to capture the wide range of opportunities and identify any gaps in provision.

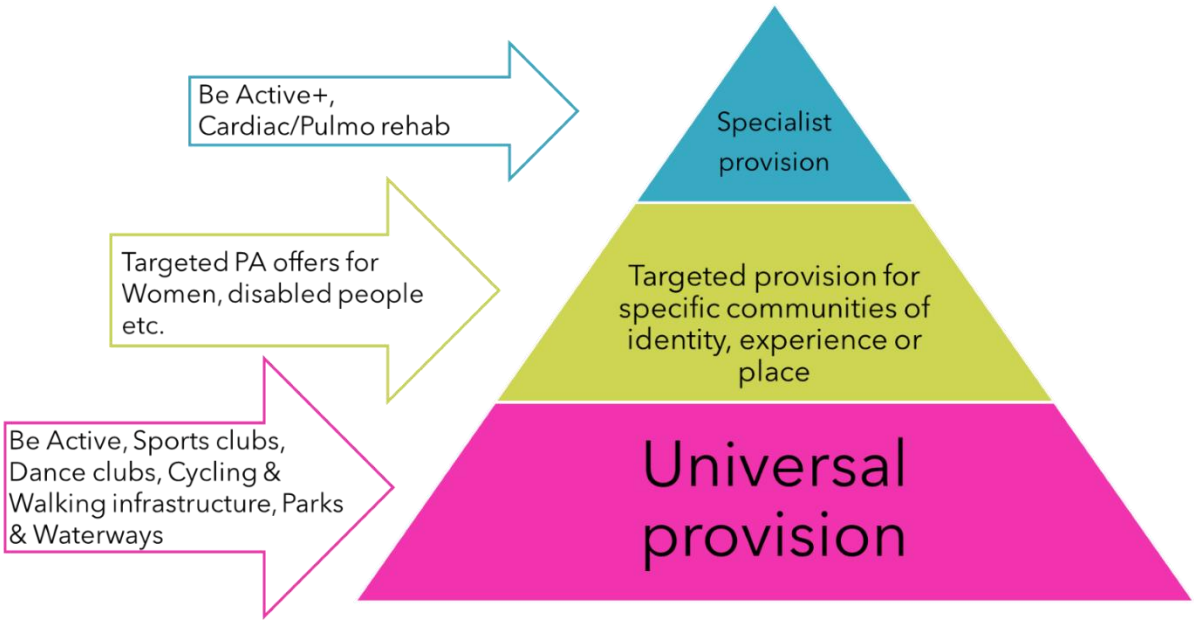


Figure 42: Service mapping themes for physical activity provision

Universal Provision

Green and blue spaces

Green and blue spaces are important for both the physical and mental health benefits that they bring. Spending time in the natural environment encourages physical activity and improves mental health and wellbeing.

Birmingham is one of the greenest cities in Europe with over 600 publicly accessible blue and green spaces across the city. Connecting these spaces are 160 miles (257km) of canals and 400km of urban brook courses.

Green and blue spaces owned by Birmingham City Council are managed through the work of the Parks Service, its partners, and an increasing number of volunteers. The Ranger Service also help engage the wider community through conservation land management, educational sessions and a wide range of events and activities.

It is estimated that over 58 million visits are made to Birmingham's parks and green spaces each year. Nearly six out of ten (59.9%) of Birmingham residents visit green spaces on a weekly basis, with a further 17.5% visiting at least monthly.

Birmingham's parks and green spaces are an incredibly important asset to engage and encourage the citizens of Birmingham to be more active. The most popular reasons for visiting green spaces in Birmingham are:

1. To walk or walk the dog (57.6%)
2. Peace and quiet and to relax (54.1%)
3. To experience nature and wildlife (48.0%)

Future Parks Accelerator

To maximise the potential of parks and green spaces the Future Parks Accelerator, a collaboration between the National Lottery Heritage Fund, the National Trust and the Department for Levelling Up, Housing and Communities (DLUHC) has been working with communities to build a sustainable future for the UK's urban parks and green spaces. One of the projects within the accelerator is Naturally Birmingham, which has been working to create a plan for the sustainable provision, maintenance and use of green and blue spaces in the city.

City of Nature Plan

In February 2022 a 25-year City of Nature Plan was approved by Cabinet which brings together all the work of the Naturally Birmingham Project and aims to change the way Birmingham treats its natural environment and how it thinks about the future of its parks and green spaces. The delivery plan sets out how the Birmingham Fair Parks Standard will be applied to all parks, ensuring all those falling below the thresholds are brought up to standard and ensuring all parks move from red to green by 2047 (see more details on footnote in page 47).

Play Space

Parks provide outdoor play space and facilities for children and young people within the city. Birmingham's parks host a range of opportunities for children and young people to be more physically active through play equipment, bike tracks, Multi-Use Games Area (MUGA) and skate parks. In 2018, the Parks Service held 256 public play facilities across the city.

The Outdoor Play Facilities Policy 2020 outlines several objectives to ensure new and existing play areas are inclusive, safe, meet community needs and provide for different ages. Where possible

[vii]the policy states that a new play area provided by the City Council should aim to be a maximum walking distance of 800 meters from all households, aiming to improve the accessibility for children, young people and their families (see more details on the footnote on page 47).

Playing Pitches

There are a wide range of playing pitches across Birmingham available which provide access to high-quality facilities so everyone can play sport and be physically active. These include football, cricket, rugby, hockey, and lacrosse as well as other 3G and grass sports pitches.

A Playing Pitch Strategy is in place to protect and enhance the existing supply of sports playing pitches, as well as provide extra new sites wherever possible to promote sport at all levels. The strategy also outlines an aim to maximise community use of education facilities, improving quality and securing developer contributions for projects (see more details on the footnote on page 47).

Allotments

Birmingham has 113 allotment sites and nearly 7,000 plots, more than any other local authority in the UK. Over 90% of the sites are managed by independent Allotment Associations, the rest are managed by the Birmingham District Allotment Confederation. There are multiple benefits to having an allotment which extend beyond the physical activity involved in gardening and growing. People who have allotments are also more likely to eat fruit and vegetables and feel connected with nature.

In addition to formal allotments, there are a wealth of community-based initiatives such as Fruit and Nut Village, on the Rea Valley and in Druids Heath, which engage the local community in growing and promoting knowledge of growing and green open space.

Active Design

New guidance on how the design of our environments can help people to lead more physically active and healthy lives has been published by Sport England in partnership with Active Travel England (ATE) and the Office for Health Improvement and Disparities (OHID).

The third iteration of our Active Design guidance has been produced to help create 'active environments'. The guidance seeks to help planners, designers and everyone involved in delivering and managing our places to create and maintain environments that encourage people to move more [8].

A wide range of opportunities and initiatives have been or are being developed in Birmingham to ensure the design of the city enables communities to build more physical activity into their everyday lives including:

15-minute neighbourhoods

The aim of the 15-minute neighbourhoods project is to enable all residents with access to a good quality green environment and are able to access all the good services they need to live full, healthy, and happy lives, all within a short walk or public transport journey of their home. At the moment, this is a pilot scheme but if it is successful, it may be rolled out across the whole city. 15-minute neighbourhoods are mentioned as an aspiration in the Our Future City Plan and the developing local development plan review.

Walking and cycling infrastructure

The Birmingham Transport Plan 2031 describes what the city needs to do differently to meet the demands of the future. A key component of the plan is around prioritising active travel in local

[vii] City of Nature Plan Outdoor Play Facilities Policy 2020 Active Design guidance Playing Pitch Strategy

neighbourhoods and ensuring walking, cycling and active travel become the first choice for short journeys. The Walking & Cycling Strategy and Road Safety Strategy both contribute towards the delivery of this and provide further detail around what is required in these areas of work.

West Midlands Walking and Cycling Index 2021

The Walking and Cycling Index (formerly Bike Life) is the biggest assessment of walking and cycling in urban areas in the UK and Ireland. It is delivered by Sustrans in collaboration with 18 cities and urban areas. Each city reports on the progress made towards making both walking and cycling more attractive, everyday ways to travel. The Walking and Cycling Index reports every two years, and a second report has been published for the West Midlands produced in partnership with Transport for West Midlands.

BCC Commissioned services and activities

Birmingham City Council support physical activity provision and opportunities across the relevant functions including public health, sport, planning, transport, social care, and economic development.

The Council commissions several universal services including local sports and fitness provision and the provision of free physical activity programmes provided at leisure Centres across the city through opportunities such as Be Active. The Be Active scheme offers all Birmingham residents access to free swimming, group exercise classes and gym sessions.

Be Active Plus is a 12-week programme of support offered to any individual with a long-term condition and can be a follow-on intervention post NHS funded rehabilitation provision.

Public Health commissions some provision from The Active Wellbeing Service. Details about the work of this service are set out in the section of this report about targeted interventions.

The Council has huge potential to engage with local community groups to activate organisations and maximise opportunities to engage individuals and communities to become more physically active. This could be through building on existing work:

- The Every Step Matters programme has expanded the Daily Mile concept outside of school settings, with one-mile tracks installed in eight Birmingham parks in wards with diverse communities and low levels of physical activity. Alongside community engagement and regular led walks, the one-mile tracks provide a supportive environment to help combat the negative effects of physical inactivity within these communities.

- Ward planning activities which could have a focus on maximising the use of community assets to enable easier access to physical activity opportunities within trusted venues in local communities.

- Training for front line staff – the Public Health Team has been working with clinical champions who are delivering free, peer-to-peer online training sessions to healthcare professionals. An opportunity exists to adopt a similar model and work across the Council to ensure front line staff are knowledgeable, skilled and confident to support physical activity across communities. The Council and its staff are in a unique position to reach into communities to support local residents to engage in more activity and where relevant, signpost to physical activity opportunities within their community.

Voluntary and Community Sector

The Active Wellbeing Society (TAWS)

The Active Wellbeing Society is a community benefit society and cooperative working to build healthy, happy communities living active and connected lives. They deliver a wide range of free activities and services aimed at improving wellbeing at an individual and community level including:

- Big Birmingham Bikes (Community cycling clubs) run in partnership with Cycling UK, Big Birmingham Bikes supports Community Cycle Clubs across the city with activities such as cycle training and led rides.
- Bikeability - cycling training programme for all levels of cycling on and off road for all levels of cyclists.
- Parkride Sessions - inclusive family cycling project that provides the whole family the opportunity to enjoy the great outdoors through cycling together.
- Active Parks - supports participants to engage in a wide range to physical activities to improve health and wellbeing whilst having a lot of fun. This includes walks, Zumba, Tai Chi and tennis.
- Active Streets - supports participants to engage in a wide range to physical activities on their street (after closing the road). This can improve health and wellbeing whilst having a lot of fun.
- Step Back out – a co-designed intervention with local communities to support people to come back out following Covid-19. Activities include one-to-one support in green spaces or joining walking, picnics and running groups.

Sports Clubs

A wide range of sport and physical activity opportunities are provided by sports clubs and community groups across Birmingham each week. Sport Birmingham have developed a database which has captured over 780 clubs and community groups running activities across the city.

Parkrun

Parkrun is a free volunteer led physical activity events held in parks. It is a weekly community event where anyone can participate in a walk, jog or run a 5k course in a range of parks across the city. Birmingham hosts six Park runs around the city. There are also 2 Junior Park runs in Birmingham, a 2k run dedicated to 4–14-year-olds and their families every week.

Birmingham 2022 Commonwealth Games Legacy

Birmingham 2022 Commonwealth Games organisers and its partners developed a national Legacy Plan, which outlined a series of ambitions to leave a lasting, positive impact on jobs, skills, education, culture, physical activity and investment across the West Midlands and the UK. The plan boosted investment across Birmingham and the West Midlands, to engage people who face multiple barriers and look to approach these challenges in new ways. This included projects like the 'Active Communities Local Delivery Pilot' in partnership with The Active Wellbeing Society. This project supports physical activity in deprived communities to help close the inequality gap, focusing on deprivation, age, and ethnicity. It will be part of this wider strategy that will work on culturally competent approaches to promote physical activity. The project includes a number of universal projects including:

- Workforce, Sport Birmingham - Workforce supports the new and existing workforce through training and development of our people and leaders, focusing on the skills needed to do whole systems change. Workforce's objectives are to develop the skills needed to create system change; to support organisational development to help community organisations

become more resilient; to embed key ways of working across workforce, projects, partners & stakeholders; to build core skills/competencies across workforce to enable them to be effective.

- Community Networker Project
    - Colebridge Trust receives funding to operate as a Community Networker with the Active Communities programme. Networkers reach into communities and build strong trusted relationships, bringing people together to deliver a range of activities which grow confidence and skills. Their objectives are to bring local people together to foster connections and co-create services with the community.
    - Witton Lodge Community Association also receives funding and a range of 'network' models have been tested within the programme. They are more actively connecting with Locally Trusted Organisations (LTOs) who have established trust and credibility within their local communities, leveraging their existing relationships and knowledge to achieve its goals.

Targeted Provision

Children and young people

Bring it on Brum! Holiday Activity and Food Programme

Bring it on Brum! is a programme funded by the Department for Education designed for families in Birmingham to help children, young people and their parents to have fulfilling, active, fun-filled and healthy school holidays. Part of the new Holiday Activities and Food programmes, Bring it on Brum! is the biggest scheme of its kind in the country, and has over 130 providers running physical activity provision through the holidays. The programme is aimed at young people aged between 4-16 years old who receive benefits-related free school meals. Benefits-related free school meals (FSM) are available to pupils if their parents are in receipt of one of the qualifying benefits and have a claim verified by their school or local authority.

Racketscubed

University of Birmingham in partnership with Racketscubed are providing squash and badminton sessions for underprivileged primary school children, whilst also providing extra tuition in STEM subjects and food.

Primary League Kicks

Birmingham City FC Community Trust provide sporting activities to 8–18-year-olds alongside routes into education, employment, and training.

Why Teens Podcast, Sutton Coldfield YMCA

The YMCA's podcast 'Why Teens' is produced by and for young carers. The podcast aims: to offer support and respite for young carers by creating a community to reach out to one another; to offer young carers opportunities to take ownership and gain additional skills through learning how to produce and host the podcast.

Podcasting with young people can foster a positive environment that promotes physical activity, providing motivation, guidance, and inspiration for them to lead active lifestyles.

The project is co-created by and with young people. This includes hosting all the podcasts, upskilling, new content creation and even reaching international audiences.

Role Models and Inspirational Stories: Podcasts can feature stories of young individuals who have achieved success or overcome challenges through physical activity. By sharing these inspiring

narratives, young listeners can be motivated to emulate their role models and engage in activities that promote physical fitness.

Educational Content: Podcasts targeting young people can provide educational content on the importance of physical activity, its benefits, and tips for staying active. By offering valuable information and insights, podcasters can motivate listeners to incorporate physical activity in their lives and adopt healthier habits.

Participation/Demonstration Episodes: Some podcasts may incorporate practical episodes where hosts or guests engage in physical activities while recording. This can include activities like going for a walk, exploring nature, visiting local sessions or trying out new activities. By sharing their experiences, podcasters can inspire young listeners to get involved in similar activities.

People living with physical and learning disabilities

Inclusive Cycling

The Active Wellbeing Society (TAWS) provide cycling services to people with disabilities and differing needs.

Fit for All

Fit for All is run by the Children's quarter, a cooperative alliance of community groups, schools, volunteers, and voluntary organisation working to make inclusive school holiday times for children with priority given to disabled and vulnerable children who are eligible for free school meals.

The Inclusive Sports Academy

The Inclusive Sports Academy is funded through the Active Communities Programme and aims to raise awareness and enhance the lives of children, young people, and adults with Special Education Needs and Disabilities (SEND). They deliver physical activity and wellbeing sessions to improve the wellbeing and health of participants, alongside volunteering opportunities to increase their civic activity. Their objectives are to use activity sessions to provide young SEND people with opportunities to prepare them for employment.

Beat it Percussion

This project, funded through the Active Communities Programme, aims to use sound, rhythm and movement to improve mental health and wellbeing and help those with disability become more active. Beat it Percussion's objectives are to work with residents in areas of high indices of multiple deprivation, including older adults with ageing-related conditions.

Drumming involves rhythmic movements that require coordination, strength, and endurance, making it a great form of exercise and introduction to movement, civic engagement and connecting people into wider networks and physical activity.

Delivery takes place in local community settings, inclusive to all, taster opportunities, skills sharing sessions, trust building and social connections that reduces loneliness and opens up opportunities of support and further participation with new friendships.

ATHAC Access to Heritage Art and Culture

ATHAC provides supported access to heritage, arts and culture in creative ways. Their objectives are to increase physical activity levels of participants, by incorporating movement incrementally through weekly sessions. In addition, they aim to work with sports sector organisations to understand the barriers faced by young disabled people, encouraging them to learn how to adapt their approaches; to include practical life skills into sessions to further prepare participants.

The project encourages alternative activity that is incorporated into art work and educational learning outside the traditional school setting. This has included everyday health changes such as water consumption, healthier snacks, table tennis and packed lunches and having a sport coach advise and support design and ideas for a more active environment that suits the needs of the groups, this has included food diaries and reflection on current physical activity to aspirational activity opportunities. On these journeys they have been creative in the use of photography and artwork. This has prompted visits to the art galleries, outdoor spaces and further afield to outdoor centres where the group have learnt about trees, planting and nature. These sessions have encouraged the group from what was a very sedentary lifestyle to a more engaging participatory delivery that enables more connection and increase in physical activity.

Sessions have included martial arts one-to-one sessions to lead the way for these young people to be included in some of the out of reach sessions previously due to costs or accessibility due to individual needs. Bikes has also been an area of development for ATHAC for adapted bikes to be accessible so the whole family can participate in bike sessions in the local park spaces. Partnership working to strengthen this opportunity across the city to enable more inclusive sessions that are reachable for all.

Women and girls

The International Working Group (IWG) on Women & Sport

The International Working Group (IWG) on Women & Sport is the world's largest network dedicated to advancing gender equity and equality in sport, physical education and physical activity. It is fully aligned to the 17 United Nations Sustainable Development Goals.

Established in 1994, the IWG advocates and runs programmes globally year-round. The IWG Secretariat & World Conference 2022 – 2026 quadrennial will be hosted by Birmingham and the West Midlands in the United Kingdom, with the IWG World Conference on Women & Sport to be held in Birmingham in 2026. On August 5, 2022, we opened a circle of leadership where the IWG UK took over Secretariat leadership globally.

A consortium with representation from IWG Women & Sport, Sport England, Sport Birmingham, NEC Birmingham, ICC Birmingham, University of Birmingham, Birmingham City Council and West Midlands Growth Company has been established to lead on the development of a Strategic Plan for IWG in the UK. This will aim to establish how to make the most of the unique opportunity that IWG presents for the region.

Sähëlï Hub

The Sähëlï Hub mainly offer a women-only environment for group fitness both indoor and outdoor. Sähëlï is a Social Enterprise, most of the women who deliver the service are local, trained and mentored by Sähëlï to offer a professional, happy experience for individuals starting out on their active journey. They offer a number of women-only activities including bell boating and kayaking, running groups and a cycling club, working in partnership with Big Birmingham Bikes, Cycling UK and Active Parks to deliver women-only cycling sessions in three parks.

This Girl can

Service designed to get more active and feeling confident doing so. Sessions are currently being run on zoom but may change to in-person. Activities include Zumba, Soca, Active Mums, Yoga, and menopause matters.

Older people

Active Club

The University of Birmingham Sport and Fitness provides sport activities for people over the age of 50. Gentle exercise and low impact sessions, tailored to suit all levels of fitness, Active Club sessions are tailored for older adults looking to get active in a sociable and supportive environment.

Age UK Birmingham

Age UK Birmingham offers services for older people and their carers across the whole of the Birmingham City Council Area. They offer a range of physical activity opportunities tailored to meet the needs of older people in the city. These include Walking Football programme, walking groups and pilates. The activities are designed to improve strength, balance and coordination as well as provide opportunities for social connection to reduce isolation among the older population.

Culturally Diverse Communities

The 'Beaming Brandwood' project

Our Scene aims to connect local neighbourhoods in Brandwood through activities in green spaces. The 'Beaming Brandwood' project's objectives are to promote physical and social activity through themed walks, collaborations with local schools, and seasonal craft projects; raise community spirit and morale; to generate movement and participation by people living outside the immediate neighbourhood; engaging south Asian communities.
Creating a series of new walking and fitness trails with a smiling-making twist, to help people get active, get social, have a laugh and enjoy our wonderful Brandwood green spaces and neighbourhoods together. All trails are being co-designed and tested with local residents and groups.

Specialist Provision

Be Active Plus

A support exercise programme for people with a variety of chronic conditions. The exercise referral scheme is commissioned by Birmingham Public Health. Participants are referred via their GP and receive specialist support to enable them to increase their physical activity and improve the management of their conditions.

Live Well Taking Control

Live Well Taking Control is a not-for-profit programme of the Health Exchange which provides the Diabetes Prevention Programme across Birmingham. It provides specialist support from health coach over 9 months via a smart phone app (Liva's App). The programme is for people living with pre-diabetes to help them to avoid developing Type-2 diabetes through simple diet, exercise and lifestyle changes.

Fitfans

Fit fans is a 12-week lifestyle change programme funded by the EFL Trust and run by the Birmingham City FC Community Trust. The programme is aimed at increasing physical activity, losing weight, and living a more active lifestyle for people aged between 35-65 years and with a BMI above 28.

Better: Healthwise

Healthwise is a physical activity referral scheme dedicated to keeping participants living with a health condition fit and healthy through physical activity support and guidance. They offer:

- Physical activity on referral - Health professionals can refer patients to low-cost programmes to help improve, manage, or prevent conditions like diabetes, hypertension, and depression.
- Cardiac rehab scheme – this scheme is designed for those people who may have had a cardiac event. Referral is made by their GP or from a Phase 3 team at the local hospital.
- Adult weight management course – a 12-week weight management programme designed to explore motivation, nutrition and techniques to change behaviour.
- Family weight management course – a 10-week weight management course for families to attend providing both nutritional and physical activity advice.
- Falls prevention classes – designed to help older people develop strength and balance to reduce the risk of falls and injury.
- COPD health and training – a programme designed for those people living with COPD.
- Cancer rehabilitation programme – for people that have survived cancer to encourage them to be more physically active.

Lived Experience

Birmingham Council commissioned focus groups as part of the Seldom Heard Voices project and Tola time project to generate insight to inform the development of the approach to creating an Active City in Birmingham. A series of targeted focus group conversations took place about physical activity, especially exploring beliefs and attitudes, with communities that are rarely heard.

The following summary reflects the participants' views on these themes and highlights where there are implications for the approach taken and opportunities for action.

Seldom Heard Voices Focus Groups		
Community	**Insight**	**Implications for Approach/Action**
d/Deaf and hard of hearing	Communication is a barrier. Taster classes and encouragement from friends seen as an enabler as was access to a parks or green spaces.	Walking opportunities especially if part of a d/Deaf group. Referral routes through **trusted professionals or organisations** such as Healthcare Professionals or BID.
Older People	Enjoyment is as important as health. Motivation was high to take part in activities outside/accessing green space. Information about location and cost was key. PA was seen as key to managing health conditions and maintaining independence.	Access to **specific sessions aimed at older people** especially activities utilising green space. **Information and advice** provided through **trusted sources** with a focus on where to access and **cost**. Social aspects of physical activity and the benefits to maintaining health and independence should be the focus of messages.
LGBTQ+	Mental health was cited as a key barrier to PA alongside other unique and substantial barriers such as homophobia, transphobia, exclusion, and discrimination.	Use of **trusted sources** of **information and advice** e.g., Birmingham LGBT network. Co-production of meaningful and practical solutions to eliminate discrimination and develop inclusive opportunities.
Long Term Conditions	Cost is a barrier. Medical professionals strongly inform beliefs around physical activity and are a trusted sources of advice about physical activity. Confidence about being physically active is low and additional support is needed.	Referral routes and support should be through **trusted sources** such as healthcare professionals. **Specific groups for people with LTCs** that GPs endorse and opportunities to 'buddy' with someone to offer additional support when starting to become more active. **Access to free**, local activities in their area is important.
Asylum seekers and refugees	Information about what activities are available and where free facilities can be found be found.	**Information and advice** about **free** opportunities. Planning of activities to consider the asylum/refugee journey and the specific needs associated with it and a PA workforce who understand this.
Young Women	Family, media and social media are influences on this group's view of physical activity. Barriers to participation include financial and lifestyle (work or education time	Already familiar with how to access physical activity opportunities. **Information often sought through "new" technologies** (social media, open to using fitness apps), but can be overwhelmed by information, so a focused

	pressures, for example). Other activities can be a priority over considering physical activity opportunities. This group understands the benefits of being active on physical and mental health, however. Safety is a consideration for this group (some opportunities not taken up because they are considered not safe – using parks at night, for example). No continuity between physical activity from school age into adulthood. Body image is a consideration for this group and perceptions about what women should look like.	approach might be beneficial, with more targeted information sharing about what is available. Access to activities that are not necessarily gym or swim orientated – a wider variety of opportunities may make physical activity more appealing.
Adults of Working Age with Mental Health Conditions	Some members of this group understand physical activity can be beneficial to help their mental health needs, however some find their mental health condition affects their levels of motivation to engage with activity. This group is likely to engage mostly in active travel rather than more formal physical activity. Barriers include finance and cost being prohibitive factors to formal activity. This group can feel other people's perception can be a barrier to them engaging in activity, particularly formal activity. There is a feeling that activities are not targeted at this group and therefore "not for them". There appears to be a lack of information accessible to this demographic.	Recommendations may include **sharing of information across community support groups** to connect resources and strengthen knowledge about availability of opportunities targeted to this group. Provision of information about **free activities**. Provision of accessible information about being active and what opportunities might be available. Consideration of providing opportunities that are **targeted specifically at this group** (gym, swim sessions in "relaxed" atmospheres, for example). Sustainable opportunities, such as walking groups, gardening, etc. to provide ongoing active lifestyles. **Publicity around physical activity should focus on the mental health benefits** as well as physical.
Teenagers	This group understands physical activity and what the benefits are. However, are less likely to be familiar with formal guidance and recommendations. This group may participate in formal exercise but are more likely to use active transport (although not seen as exercise).	Actions could include supporting students with maintaining **physical activity to support mental health**. Accessibility to opportunities giving young people the chance to try different activities that they may not normally have access to (other than traditional sports, for example). Information about activities should appropriately targeted to this age group, for example providing information about health benefits (physical and mental) and associated benefits of active travel (such as climate change). Consider **reward-based initiatives** to encourage physical activity - use of apps, for example with benefits such as discounts

		etc. Having more **events in parks and green spaces** was also noted as a driver.
3rd/4th Generation Migrants	This demographic may adapt their physical activity to meet the needs of their families. Information about physical activity is gained through online resources. This group is aware of the benefits of physical activity and where to find information about it.	Time and lifestyle pressures may impact this demographic in accessing opportunities. Opportunities for active travel may be missed due to perceived time constraints, the commute of school run may be carried out by car, for example.
First Generation Migrants	This demographic's choices are influenced by family and friends and sometimes to a greater extent than managing their own health needs. Active travel (walking) is a main mode of transport, but not necessarily seen as exercise. Insights suggest this group has limited interest in cycling but may be interested in swimming. Appears to be some reluctance to accept some health advice/messaging (from healthcare professionals for example).	Members of this group have been informally advised by **family, friends**, etc. therefore, could be influential with key messages about the benefits of physical activity. **Intergenerational and/or involvement of family members.** There is some reluctance to engage with formal advice.
Unemployed	Barriers to participation for this demographic include safety, cost, time constraints and accessibility in terms of location. Some members of this group have other responsibilities (parenting and caring, for example), that may take priority over engaging in physical activity.	Targeting this demographic to increase awareness of physical activity and benefits to health and wellbeing, whilst taking barriers to participation into account. Provide messaging around the **use of the technology** (apps) to encourage physical activity and share.
Chinese, Vietnamese, Korean Migrants	This demographic has a lower-than-average rate of participation in physical activity. There is an understanding physical activity is important for health, but less likely to have engaged with formal messaging/guidelines. Due to tradition, this community may engage more with traditional therapy where others may have engaged with their GP. Barriers include safety, cost of equipment, weather.	Engagement maybe required with **community therapists/groups to promote messaging**. This group may engage/have greater trust with community therapists/groups than council/NHS messaging. Increasing awareness of opportunities and engaging with population in **community languages**.

Tola Time

Community	Insight	Implications for Approach/Action
African Caribbean	Highly engaged in walks focussing on discovering green spaces which had been co-designed with members and walks to learn about the African Caribbean heritage within the city.	**Co-production** approach to ensure ownership and meeting the communities' interests and needs. **Asset-based approach** designed around the assets within the communities.
Indian (Hindu and Sikh)	Uptake of physical activity was good. Participants were willing to engage with a wide range of other opportunities. Supporting elders within the community struck a chord across the community.	**Intergenerational and/or involvement of elders**
Pakistani and Kashmiri	Taking part in physical activity within their kinship groups is important, indicating that the community prefers to do activities with some privacy. This is especially so for women.	Engagement is **amplified if other family members participate**.
Somali	Physical activity sessions participated in, but they do not always feel completely welcome by other minority communities. In addition, opportunities provided by other communities do not always cater for their needs. Cross reference GAPPA and EAED to develop further	A **tailored approach** aimed specifically at the Somali community may help to improve engagement and uptake
Young people	Young people are more likely to engage in physical activity if their friends or colleagues are participating.	The **social element** of physical activity is core to them engaging

Findings and opportunities for action

This section summarises the findings and recommendations of the PANA for Birmingham. It is important to recognise that this has been a rapid needs assessment process using current and readily available data. In addition, the volume of provision and activity across the system means that the mapping of current services and place-based provision is by no means fully comprehensive. Therefore, several of the recommendations highlight areas where further work can be carried out to build on the emerging evidence base that the PANA has developed.

The diagram below summarises the inequalities which exist in Birmingham.

What are the inequalities within Birmingham?

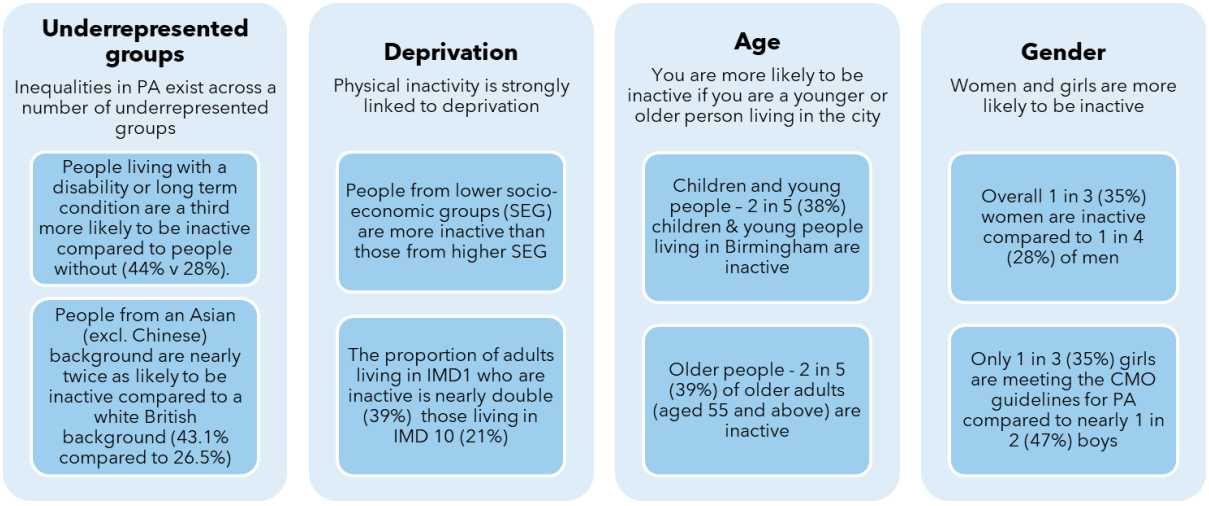


Figure 43: Inequalities in Birmingham

Insight from local communities

Insight gathered from these seldom heard communities suggests that the following should be considered when designing services or creating opportunities to increase physical activity in these groups:

- Develop knowledge and understanding of the local community to ensure needs are understood.
- Undertake appropriate engagement before developing provision and co-produce activities with communities to ensure they are tailored to meet their needs.
- Use trusted organisations and relationships to provide information and activities to increase engagement and maintain commitment.
- Provide a diverse choice, which takes a flexible, person-centred approach.
- Where appropriate targeting activities for specific communities so they can be tailored to meet their needs and maximise engagement.
- Making use of technology to provide easily accessible and clear information to inform and engage people in activity.

Recommendations

Recommendation One: Data

There were limitations to much of the physical activity data collected as part of this Needs Assessment. Availability of local data was hindered by the fact that many of the local services contacted collect data but were unable to extract it in ways that were helpful. National data is updated annually and some of the extracts were measurements from several years ago. Sample sizes for national data, Active Lives Survey for example are small and do not give the local nuance needed to measure locality-based change over time. The capacity to carry out the review was also time constrained and was not as thorough as it could have been.

The recommendation for data going forward requires the following actions:

- Review the data in this needs assessment within two years following local service data collection changes which are due to happen in 2024
- Identify other types of local data not considered due to time
- There is no data available for physical activity levels by ethnicity or disability for children though the Active Lives Survey. Consideration should be given to alternative data sources and ways of capturing this information to ensure a full understanding about activity levels is developed.
- Explore opportunities to increase sample size for national data sets.

Recommendation Two: Applying Physical Activity Policy at a Local Level

The review of policy and local practices relating to physical activity show evidence of silo working, lack of effective collaboration between partners and little to no benchmarking of service provision.

The recommendation for policy application going forward requires the following actions:

- Implement a whole system approach to physical activity by bringing partners together to develop an integrated and coordinated physical activity strategy for the city
- Audit current practice and interventions against policy and guidance e.g., the Sport England Active Design checklist to support the implementation of physical activity strategy delivery plans
- Investment prioritised and targeted to Physical Activity opportunities that meets needs and ensures progress is made to close the inactivity gap
- Physical Activity to be considered and embedded in all relevant policies and strategies.

Recommendation Three: Taking a Life Course Approach

Physical Activity is important at all stages of life and the UK Chief Medical Officer (CMO) guidelines vary for different age groups. The data review showed there are some key actions required for specific age groups.

The recommendation for taking a life course approach going forward requires the following actions:

- There should be a focus on children, young people and their families to ensure positive experiences and the right foundations for physical activity habits are built, and in ways that can last a lifetime

- The current and future health needs of the over 65's should be considered as a priority to ensure there is a focus on strength, balance and coordination as well as improving physical and mental wellbeing to support people to live independently for as long as possible.

Recommendation Four: Under-represented Groups

Some groups are much less active than the general population in Birmingham, showing a gap in activity and higher levels of inactivity. The data and evidence review showed there are some key actions required for specific groups.

The recommendation for under-represented groups going forward requires the following actions:

- There is no data available for physical activity levels by ethnicity or disability for children though the Active Lives Survey. Consideration should be given to alternative data sources and ways of capturing this information to ensure a full understanding about activity levels is developed
- Recommendations for engaging seldom heard communities made through this needs assessment should be shared and implemented to ensure opportunities are tailored to meet their needs
- Communities which require a tailored approach are; Children and Young People; women; South Asian and African communities, those with a disability; those with a serious mental health condition; LGBTQ+ and over 65-year-olds.

Recommendation Five: Communications and marketing

Lack of understanding about Chief Medical Officer guidelines in the population and in professionals is high and the need for a life course approach means that any approach to improving physical activity requires regular modification as people age. Communications and marketing will need to be a key tenant of any plan for change.

The recommendation for communications and marketing going forward requires the following actions:

- Develop our understanding about the barriers and enablers where insight currently is not available e.g., active play or for groups with unmet needs such as people living with disabilities
- Working in partnership, across a wide range of stakeholders and communities, to change our culture to one which values physical activity, sport, and movement
- Develop insight led communication messages and marketing campaigns to support a shift in attitudes and motivation.

Recommendation Six: Capacity Building

Ranging from specialist teams, whose role is focused on physical activity and sport, to mainstream services, there is a requirement for capacity building to get any scale to aspirations to increase physical activity in the city.

The recommendation for capacity building going forward requires the following actions:

- Share findings from the PANA widely to support improved understanding and to enable more targeted approachs
- Identify training needs and develop appropriate training opportunities for front line professionals.

Recommendation Seven: Monitoring and evaluation

Improving levels of physical activity in all populations in Birmingham will require several complicated actions and there is limited funding available to support change. Monitoring and evaluation of what is working will be key to timely success.

The recommendation for monitoring and evaluation going forward requires the following actions:

- Establish robust systems to monitor the reach and impact of the Creating an Active Birmingham strategy as it is implemented. This needs assessment shines a light on inequalities of physical activity between populations in the city. The impact of action on addressing the inequalities that exist across the city in relation to physical activity, requires attention as does universal actions on the whole population. Regular analysis and reporting on relevant public health indicators and routinely collected data, should be built into programmes of work.
- Ensure appropriate evaluation of any commissioned activities related to physical activity this includes monitoring residents use of facilities and uptake of opportunities, activities and programmes across the city.

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Creating an Active Birmingham Strategy

Birmingham Physical Activity Strategy 2024 – 2034

Consultation Findings

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Introduction

The Creating an Active City Forum is a sub-forum of the Health and Wellbeing Board. The Forum in collaboration with other stakeholders has co-produced the Creating an Active Birmingham Strategy with the aim of increasing Physical Activity levels in Birmingham, across all ages and abilities. This is the first Physical Activity-oriented Strategy for Birmingham. The Strategy has been developed by the Physical Activity team in the Public Health Division within Birmingham City Council (BCC), with input from the public and local stakeholders whose vision is aligned with Physical Activity directly or indirectly. It has also been informed by local and national research and evidence that includes conversations with Birmingham Seldom Heard Voices. This is a stream of work whereby various providers working with grassroot communities obtain views and perspectives from the most disadvantaged groups in Birmingham.

The Strategy aims to address low levels of Physical Activity with a focus on developing opportunities for people to build Physical Activity into everyday life, through active living, active recreation, and active travel. The Strategy complements other programmes of work in place across the city, such as the Sports Strategy and Birmingham Travel Plan. Collectively these come together to ensure a holistic approach to increasing Physical Activity. Birmingham will achieve this by focussing on five areas:

- **Active People:** By creating and promoting access to Physical Activity opportunities, taking a life course approach across multiple settings, we will enable more people to engage in regular activity.

- **Active Society:** By creating and protecting the places and spaces that promote and engage people of all ages and abilities in activity, we will enable more people to engage in regular activity.

- **Active Environment:** By changing how we talk about Physical Activity across the city, building insight and evidence into policy, commissioning, planning decisions, communication messages and marketing campaigns, we will enable more people to engage in regular activity.

- **Active System:** By creating a more connected system and strengthening our local leadership, governance, partnerships, and workforce capabilities, we will enable more people to engage in regular activity.

- **Closing the Gap**: By continuing to develop a better understanding of local barriers and enablers to increase activity across the city and ensure we focus on the least active groups as identified in the Physical Activity Needs Assessment, we will enable more people to engage in regular activity.

In November 2023, BCC Cabinet granted us permission to start Physical Activity consultation of the Strategy with the public. This took place from the 20th of November 2023 until 15th of January 2024. Throughout this period, the Council Physical Activity team heard from local citizens, strategic partners, and key agencies. This report outlines the findings from the consultations.

Methods

The consultation method is built on the approved standards and evidence-based best practices for public consultation. We designed a comprehensive and innovative consultation plan, built on other previous successful consultations (e.g., the Food System team). This led us to engage with 1200 Birmingham residents.

One of the key rationales for the Strategy public consultation is to develop a people and community-oriented Strategy co-produced and co-implemented by the people of Birmingham to create a more active city. Hence, it was necessary to obtain the feedback of the diverse public and other stakeholders across Birmingham.

The Consultation was done through three different platforms.

1. **BeHeard** - This is the BCC platform for collating opinions, views, perspectives, and suggestions of residents. We obtained 321 responses, inclusive of responses from Assisted Consultation.
2. **Face to face consultation** – The team leveraged its existing relationship with partners to access various Council owned or commissioned spaces to hold consultation sessions. These include libraries, leisure centres, wellbeing centres and ward meetings. We engaged with 879 residents through this means. We ensured that areas with lower health outcomes were allocated more in-person consultation as a means of promoting inclusion and bridging existing health inequality gap. *Figure 1* shows the distribution of face-to-face consultation sessions across the city.
3. **Assisted consultation** – Due to the disparity of Physical Activity levels in Birmingham among more disadvantaged groups such as those with disabilities or South Asians, the team commissioned existing providers to obtain support these demographics. We obtained 93 BeHeard responses through this means.

Data Analysis

The quantitative data were analysed through data analysis software and presented visually where possible.

The qualitative data were analysed using Content Analysis to complement the quantitative information. The more poignant quotes were also included in the report and, where relevant, the Strategy.

Communication Plan

The weekly communication plan was comprehensive We leveraged existing relationship as well as various communication platforms to promote the consultation. These included emails, healthy Brum, intranet, social media, yammer, phone calls, webinars, and Birmingham City Council website.

Key Findings

Inclusivity and accessibility have come across through all questions posed to respondents. Birmingham residents feel it is paramount that the Creating an Active Birmingham Strategy and the Action plan to implement it take into consideration the diverse needs of the Birmingham population. This, no doubt, comes from an understanding of the city needs from living, working, studying and /or socialising in the city. Respondents felt people of all ages and all abilities should have access to means, resources, services, and environment to be physically active in. Respondents felt the Strategy should cater equitably to the most disadvantaged groups facing widening health inequalities from not engaging with adequate Physical Activity. This includes people living in more disadvantaged areas of the city, older adults, people with learning disabilities, physical disabilities and women, especially South Asian women.

The other aspect of accessibility that came through was the tangible and practical access to Physical Activity. For example, residents felt activities that they could benefit are at times when they work or in areas of the city that they cannot access. They felt this put working-age people at a disadvantage as they are not able to access various Physical Activity offers as they would be working during hours they are offered. Others felt they may make the time to travel but due to poor public transport, they are unable to access activities that suit them.

One of the key themes that came out was affordability. This went beyond accessing activities; people felt activities should be made more affordable to them. They are aware and concerned that the Council is currently going through some financial challenges, and this may translate into even less affordable opportunities in the city to be active. They were concerned, therefore, whether the Council will have the necessary resources to deliver such an ambitious Strategy.

One of the key things that came out from the consultation and is linked to accessibility was adequate infrastructure. This included safer roads and cycle paths, continued investment in green spaces and generally safer city to be able to be active in. This also included safe and adequate leisure centres and other indoor spaces to be active in.

Residents also felt a holistic whole-system approach is needed to ensure Birmingham becomes an active city. They felt that, in order to deliver the Creating an Active Birmingham Strategy, the Council should continue to collaborate with partners. However, collaboration should extend beyond them; the Council should weave links with and empower grassroot and community-led organisations to engage citizens in increasing Physical Activity. Tapping into the existing relationships these organisations have with local communities should be a key priority in bridging the inactivity gap in the city.

Demographics

We engaged face-to-face with a total of 879 people across Birmingham with an average of 25 people at each of the consultation session. The venues for the in-person events included 19 libraries, 11 community centres, 10 leisure centres and 1 faith-based organisation across Birmingham.

The map shows the different areas the team has held consultation sessions. Significant effort has been made to be present in venues in the most deprived wards.

Figure 1a: MAP of Birmingham showing the different wards where consultation sessions took place

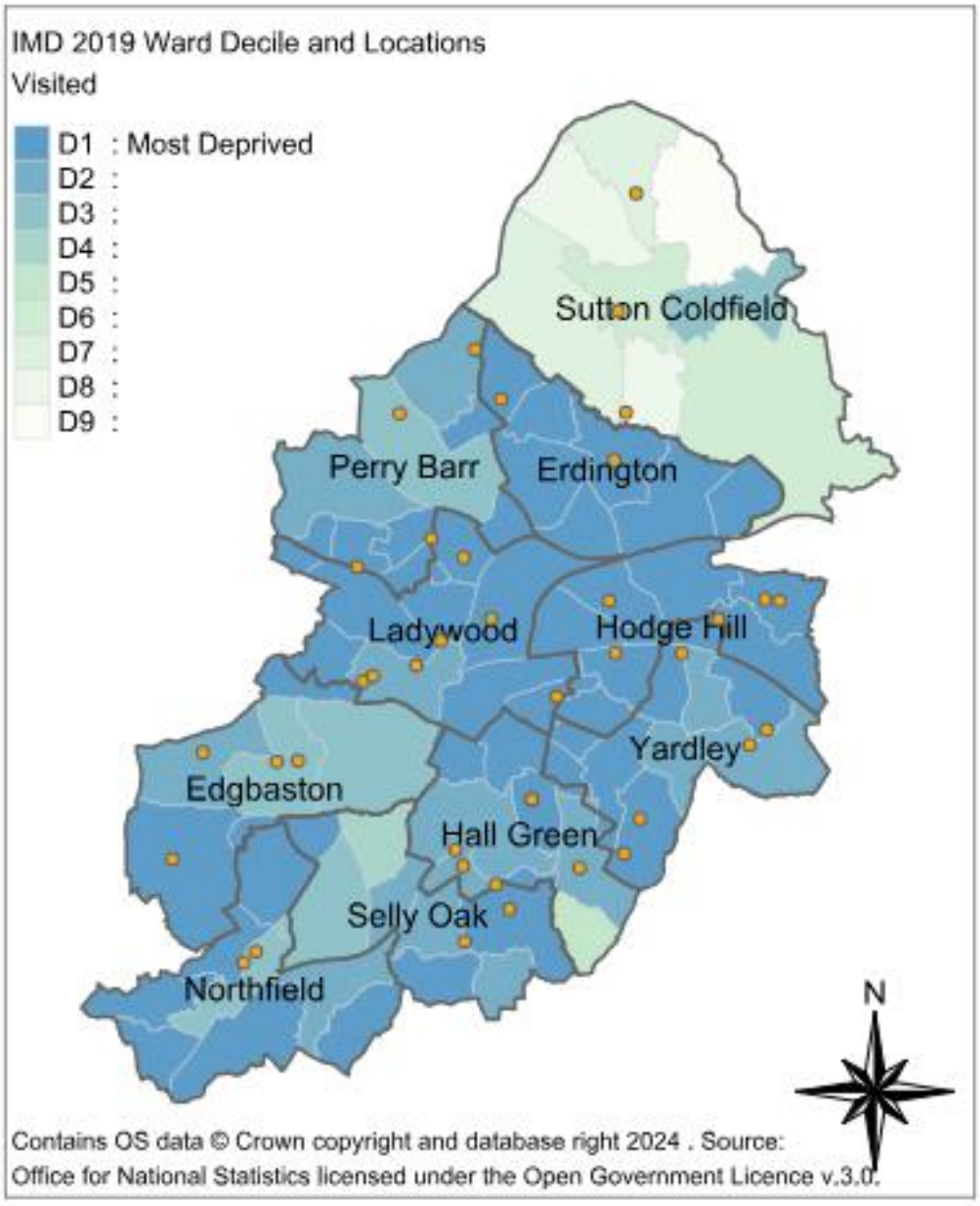
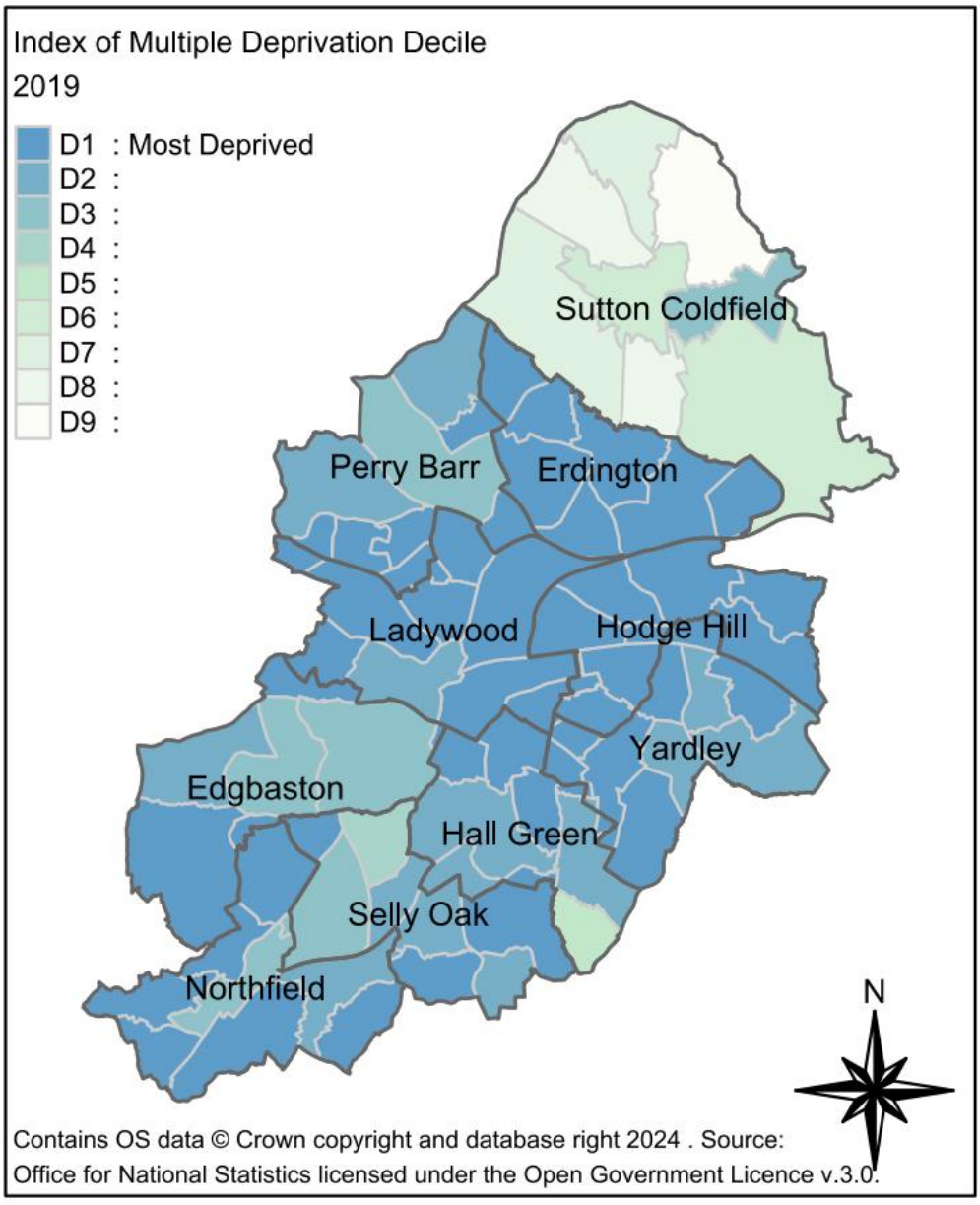
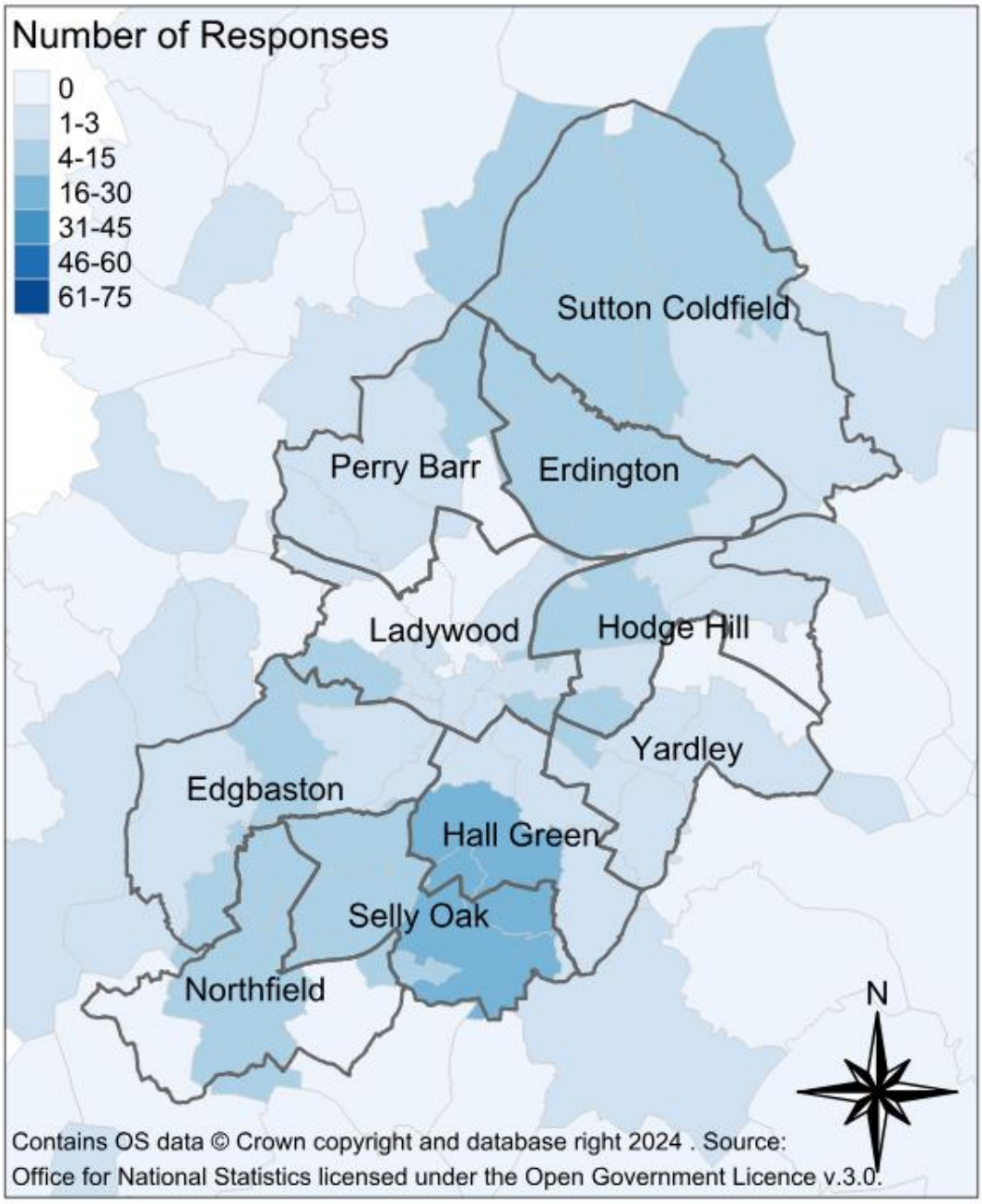


Figure 2a: MAP of Birmingham showing index of multiple deprivation across the city



All of the communications work of the team resulted in 321 members of the Birmingham public completing BeHeard survey. The heat map (Figure 2b) shows the locations of respondents with regards to their postcodes, where provided.

Figure b2: MAP of Birmingham showing the specific locations of respondents



The below graphs show the demographics information of the BeHeard respondents.

Figure 3a: The activity spread of respondents

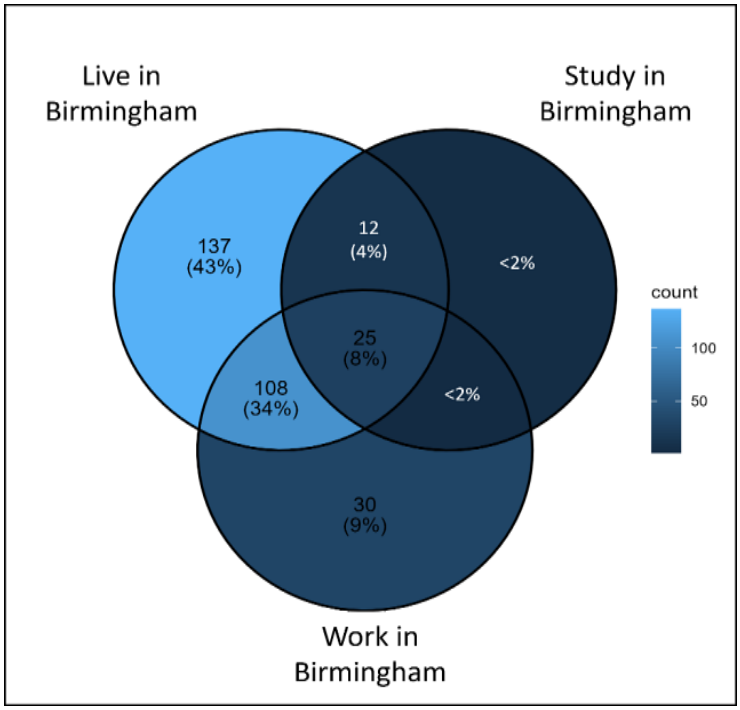


Figure 3b: The activity spread of respondents

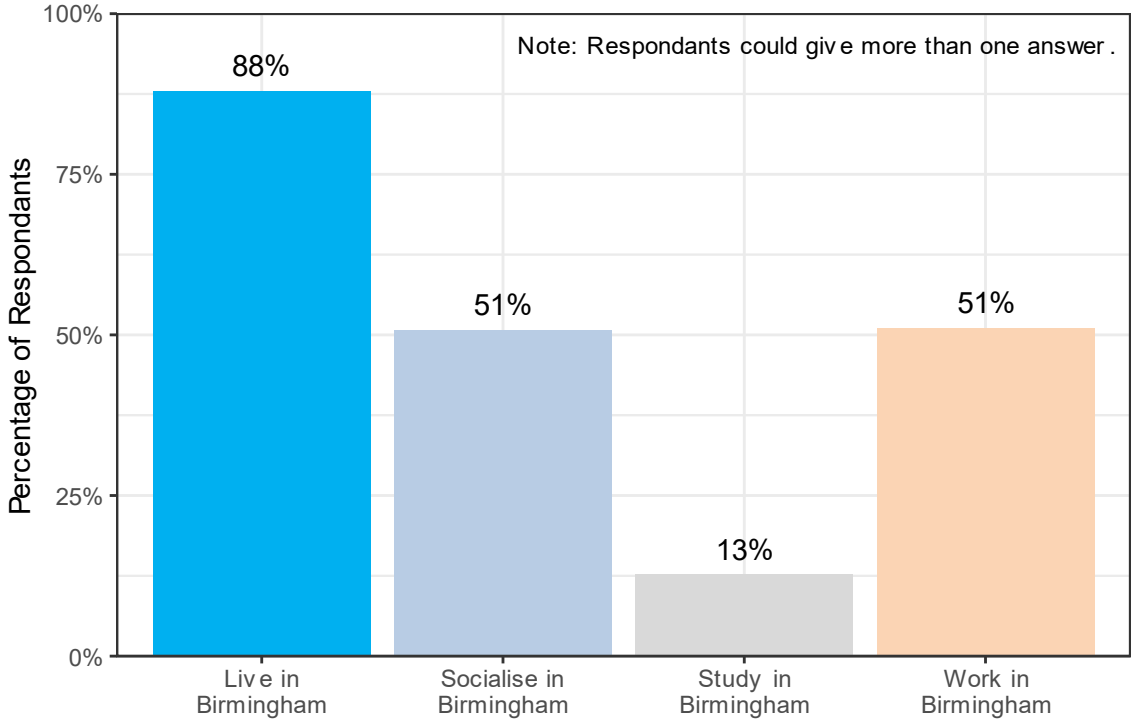


Figure 4: Age of respondents

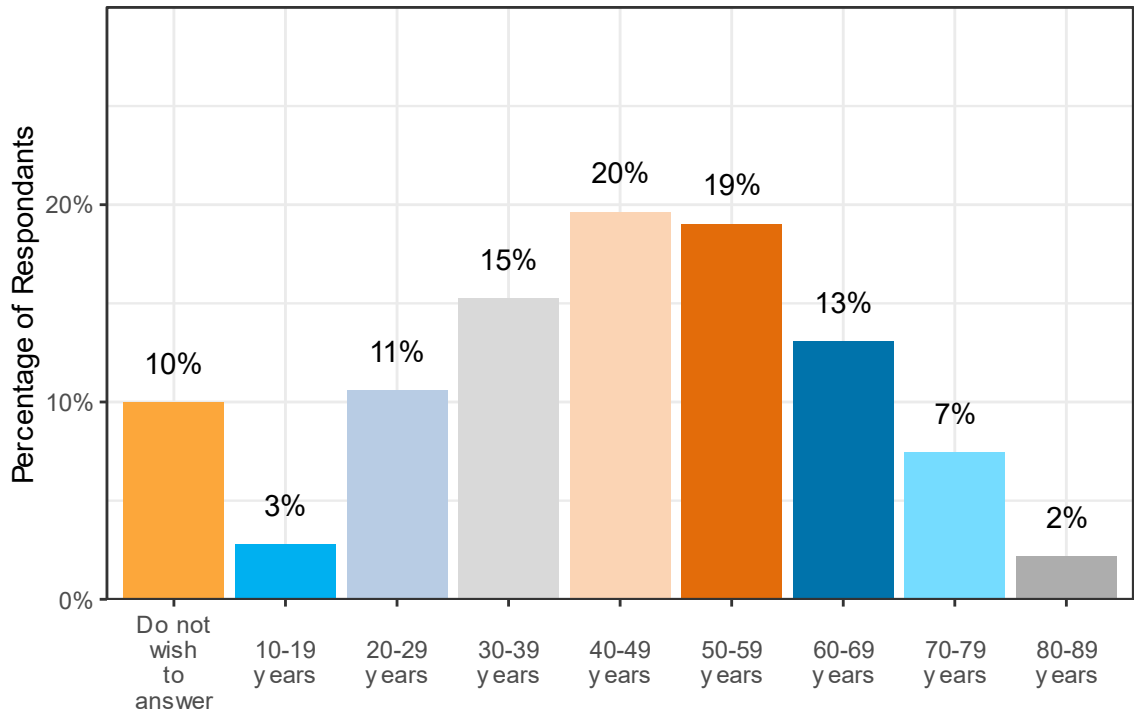


Figure 5: Gender distribution of respondents

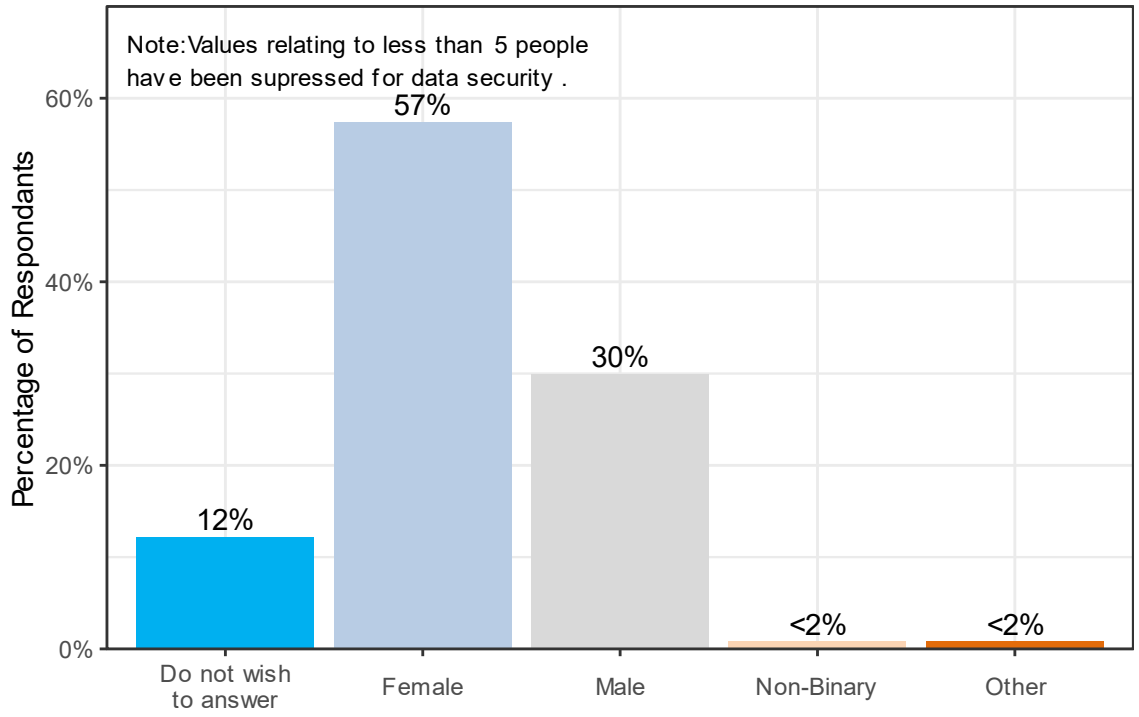


Figure 6: Gender identity of respondents – Respondents who were asked whether their gender identity is the same as the sex registered at birth

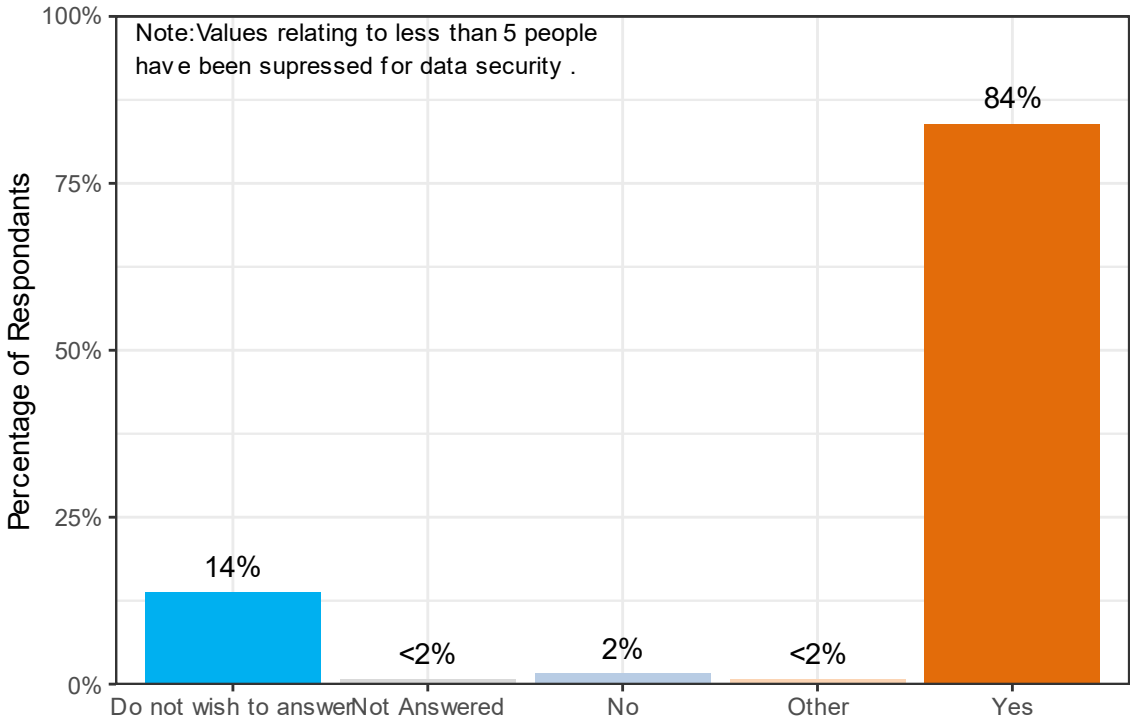


Figure 7: Sexual Orientation of respondents

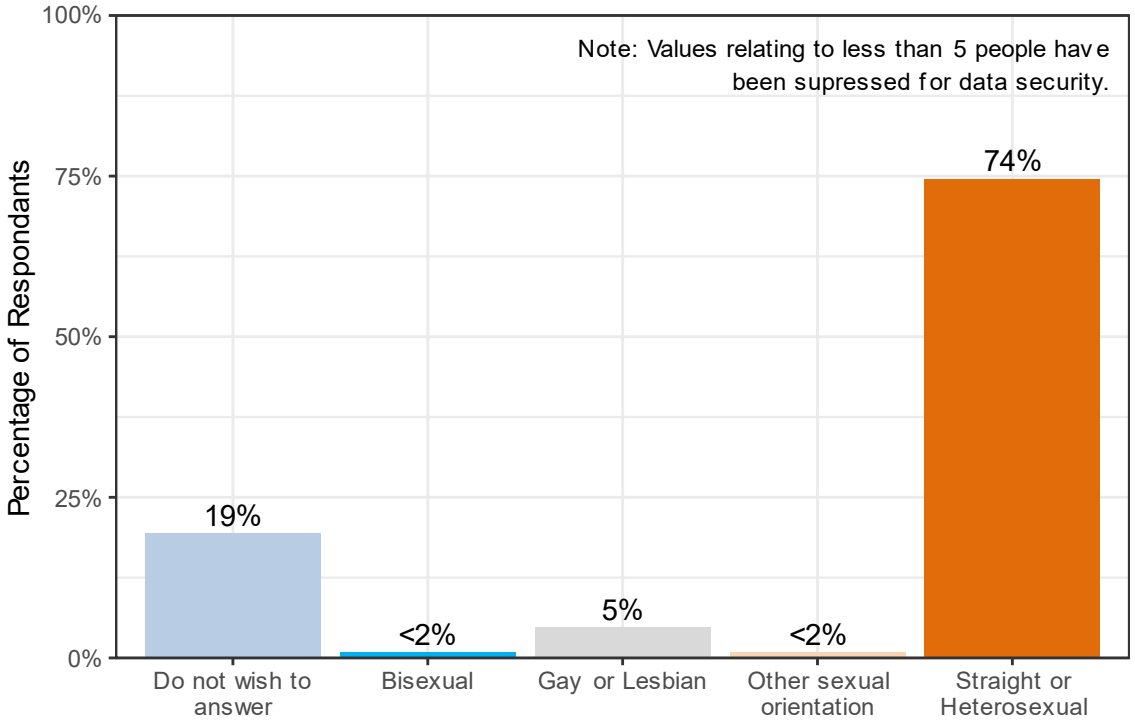


Figure 8: Ethnic spread of respondents

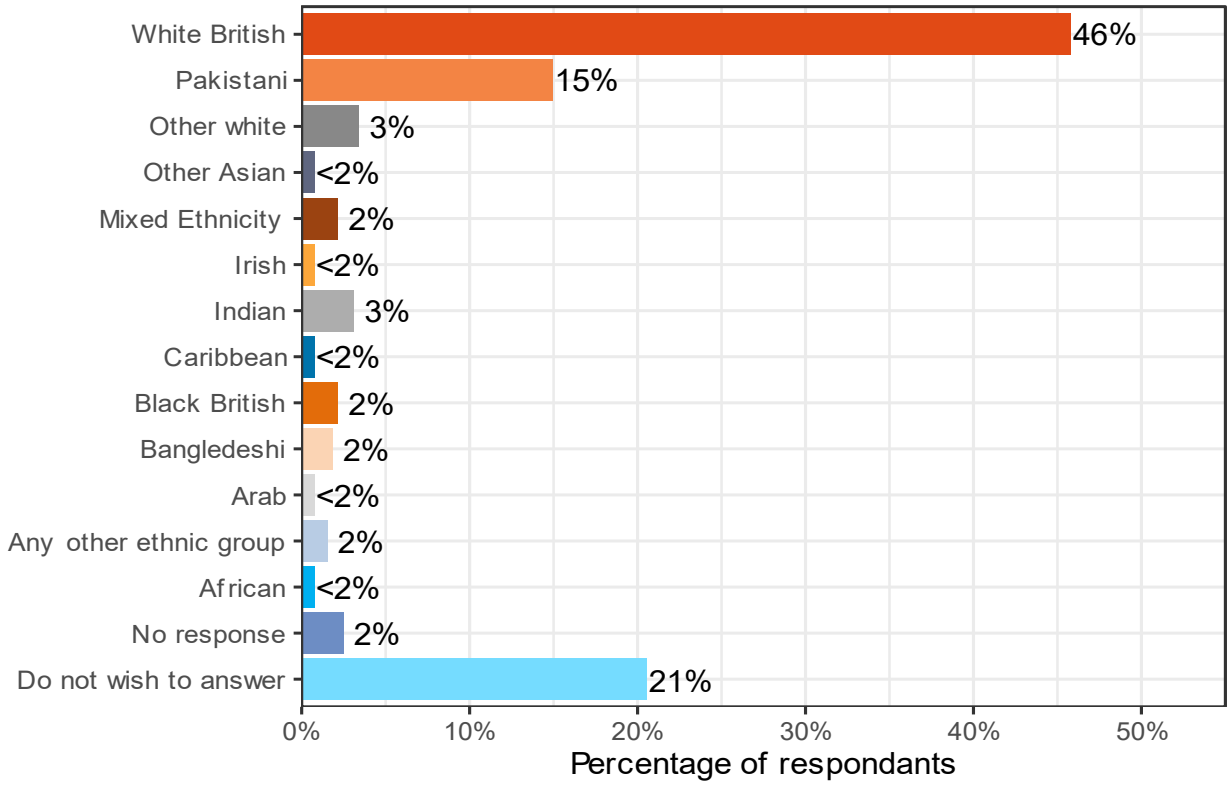


Figure 9: Respondents of mixed ethnicity

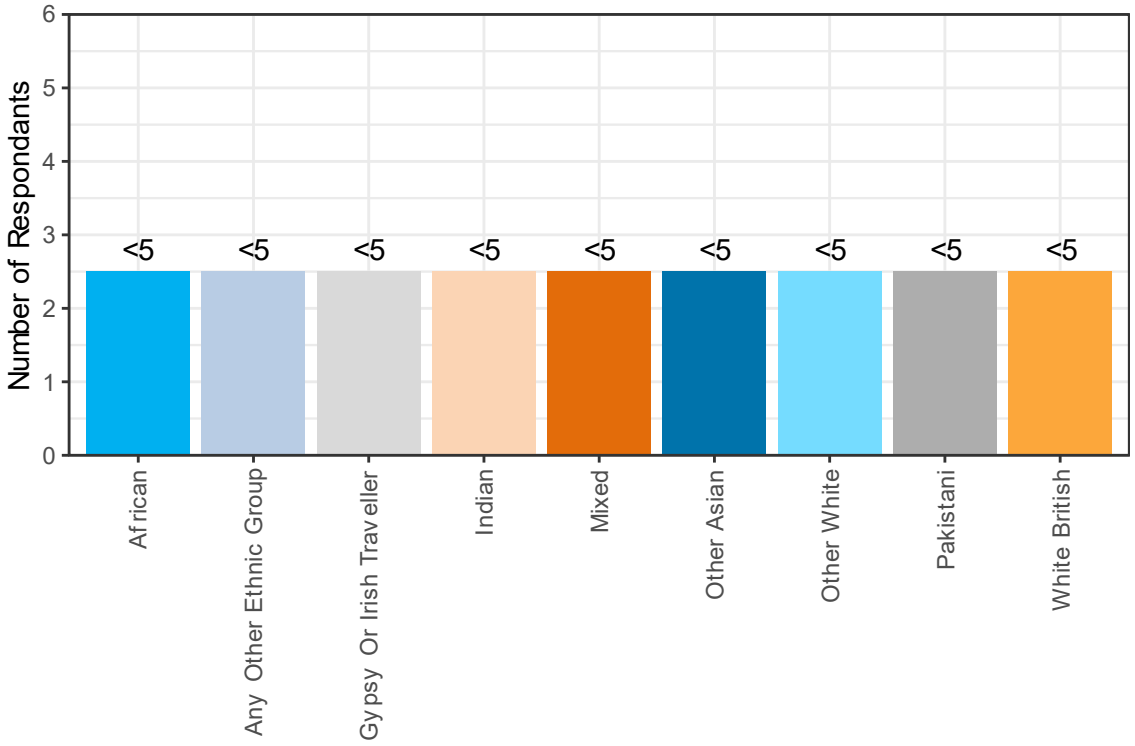


Figure 10: Employment status of respondents

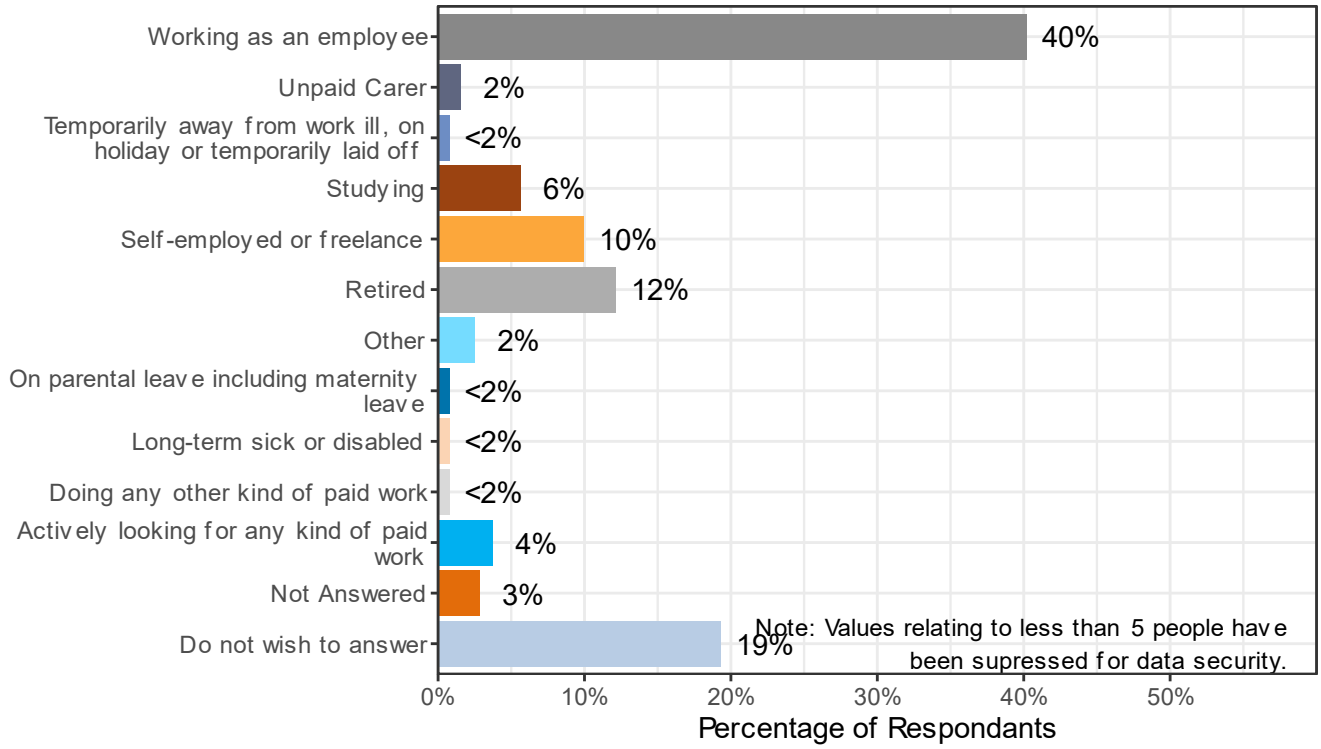


Figure 11: Religion of respondents

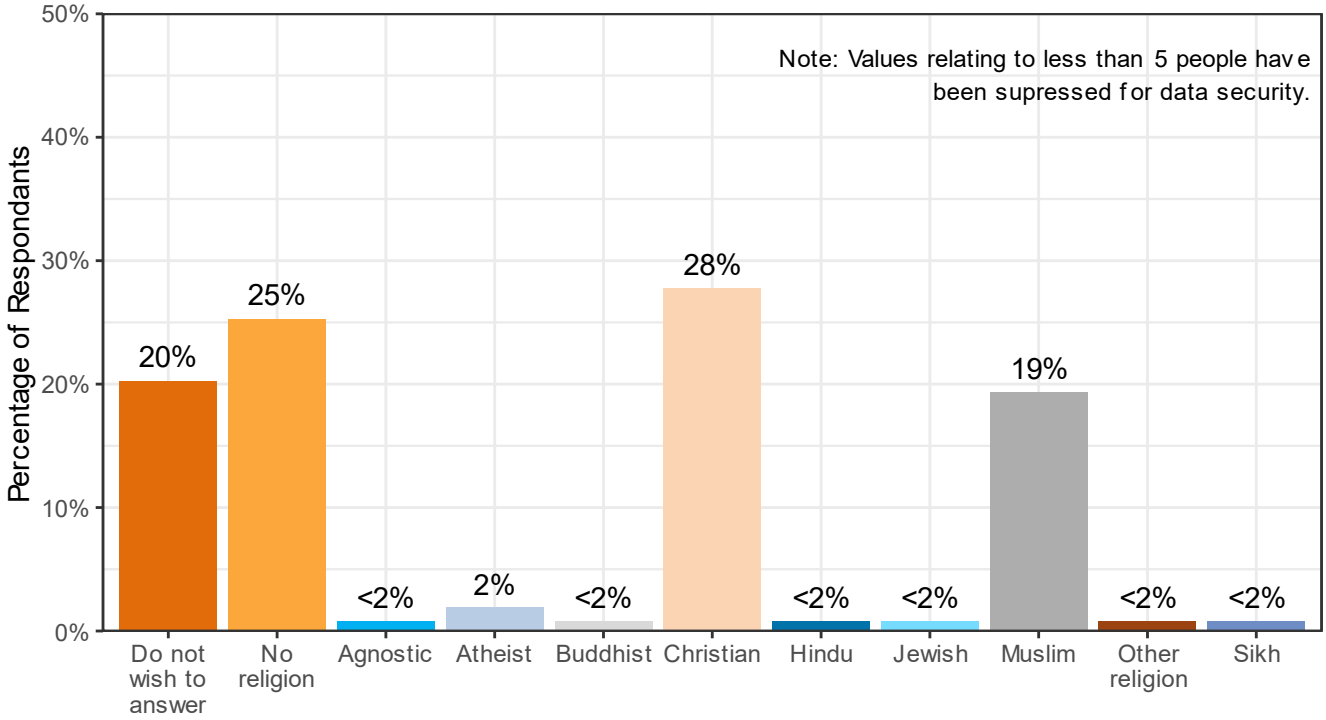


Figure 12: Living situation of respondents.

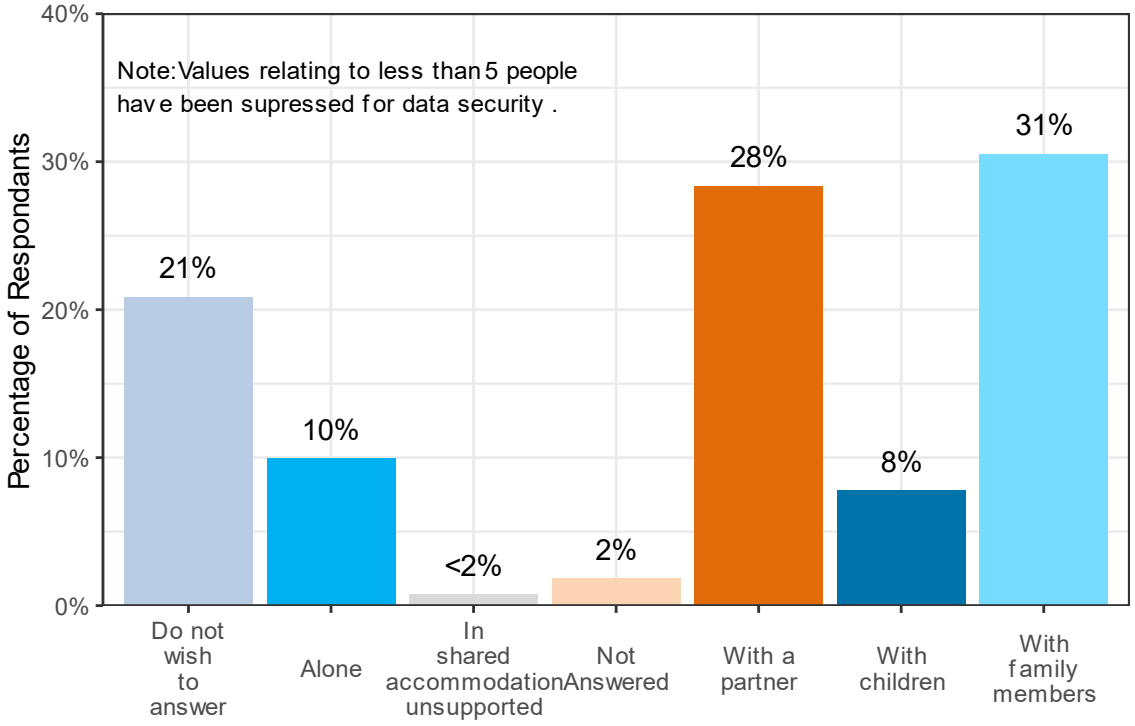


Figure 13: Life experiences of Respondents

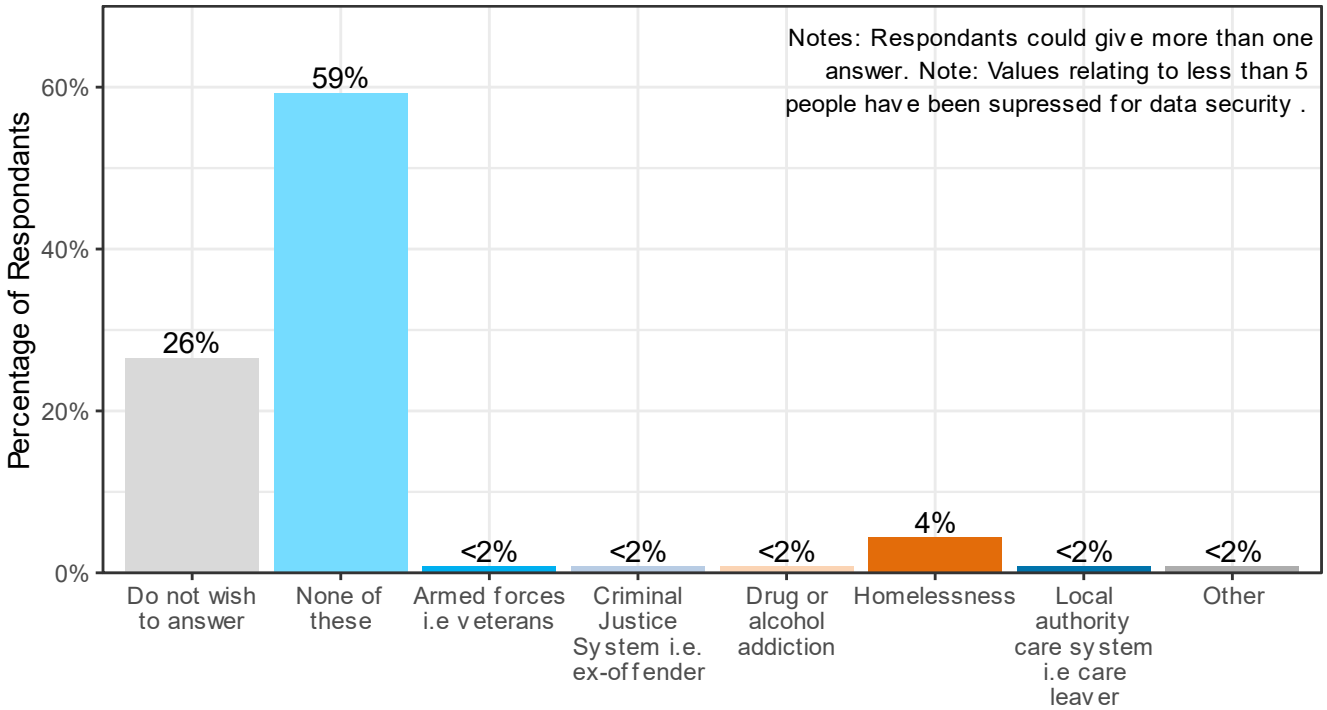


Figure 14: Legal marital or civil partnership status of respondents

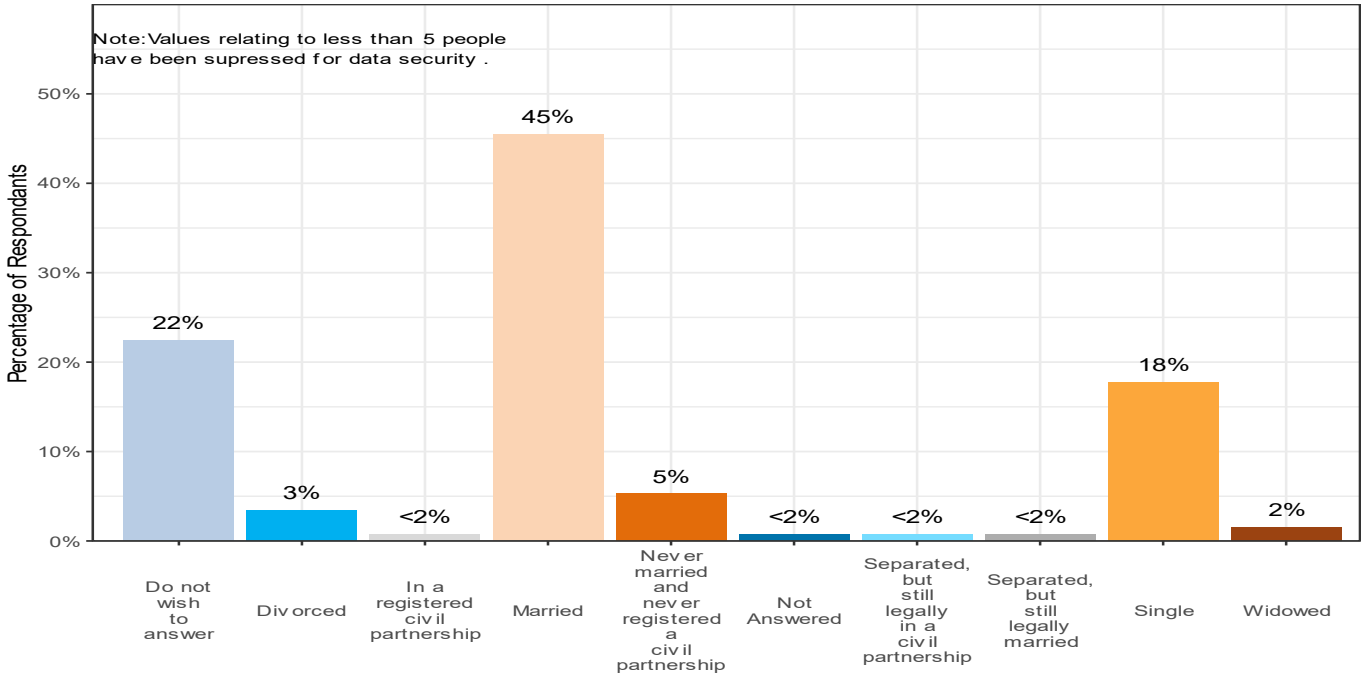


Figure 15: Respondents who have partners

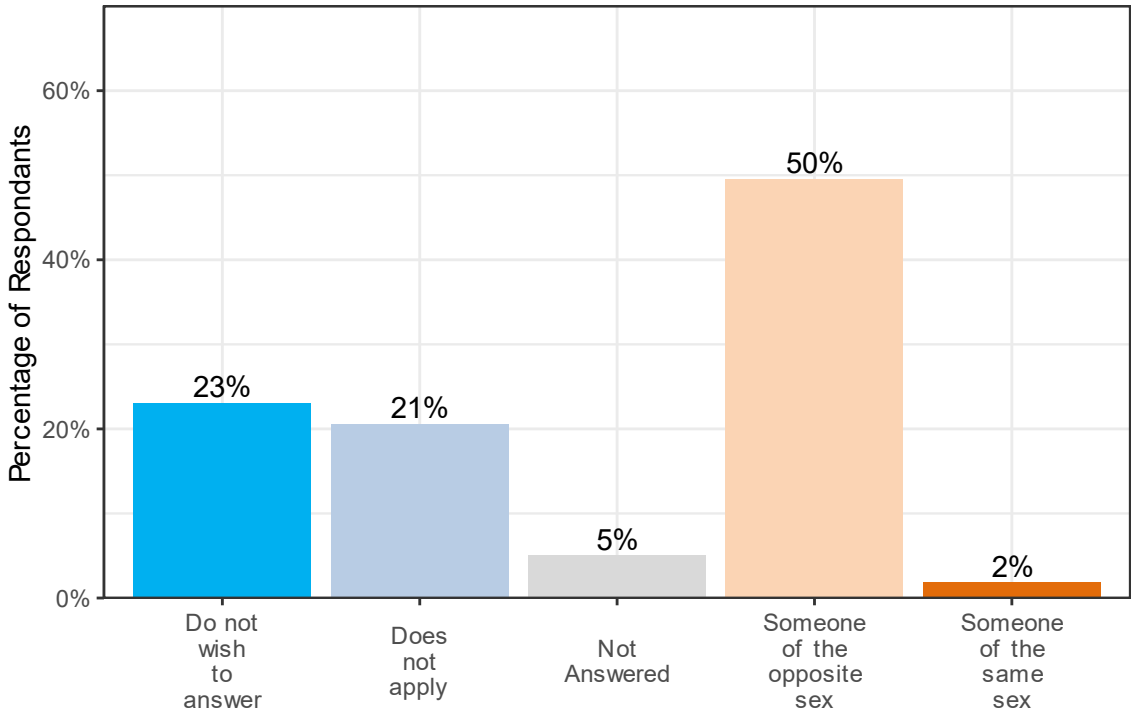


Figure 16: Respondents who are pregnant

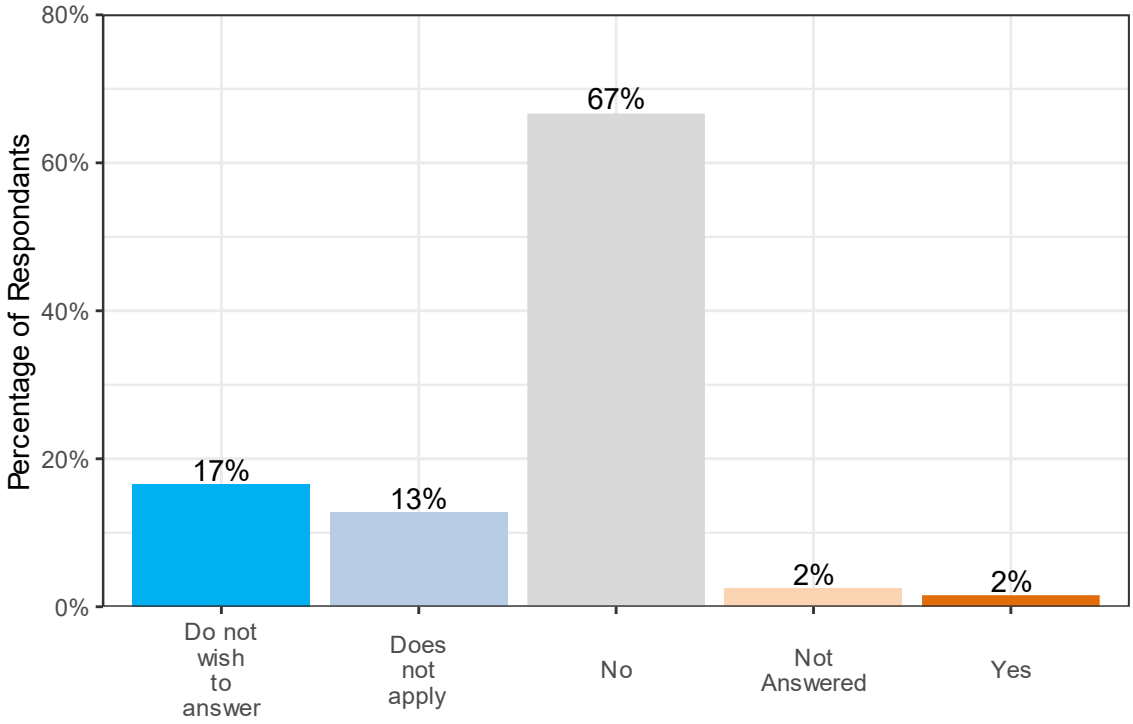


Figure 17: Respondents with childcare responsibilities

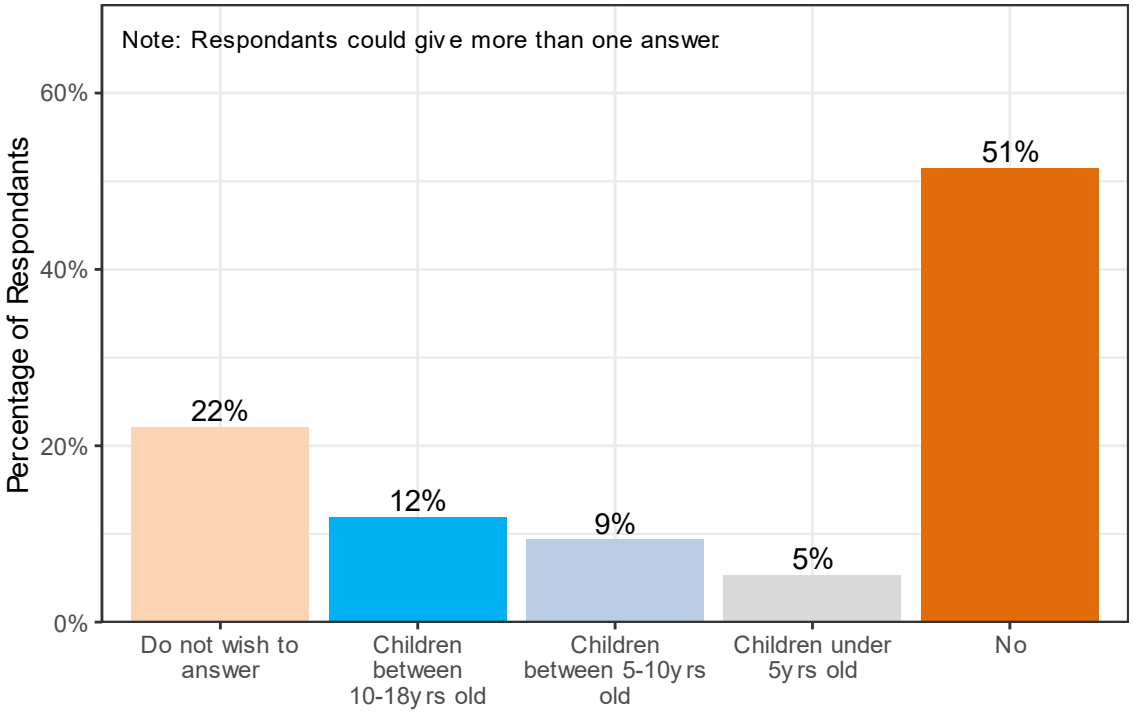


Figure 18: Respondents who are caregivers

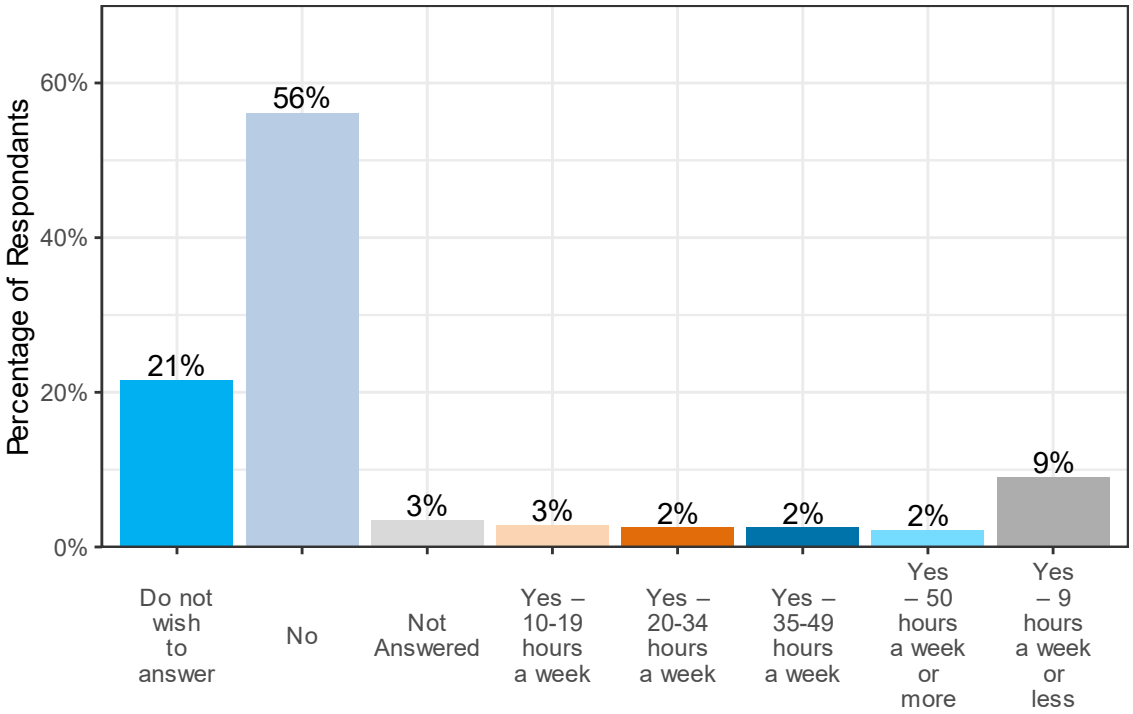


Figure 19: Respondents with health conditions hindering regular activities

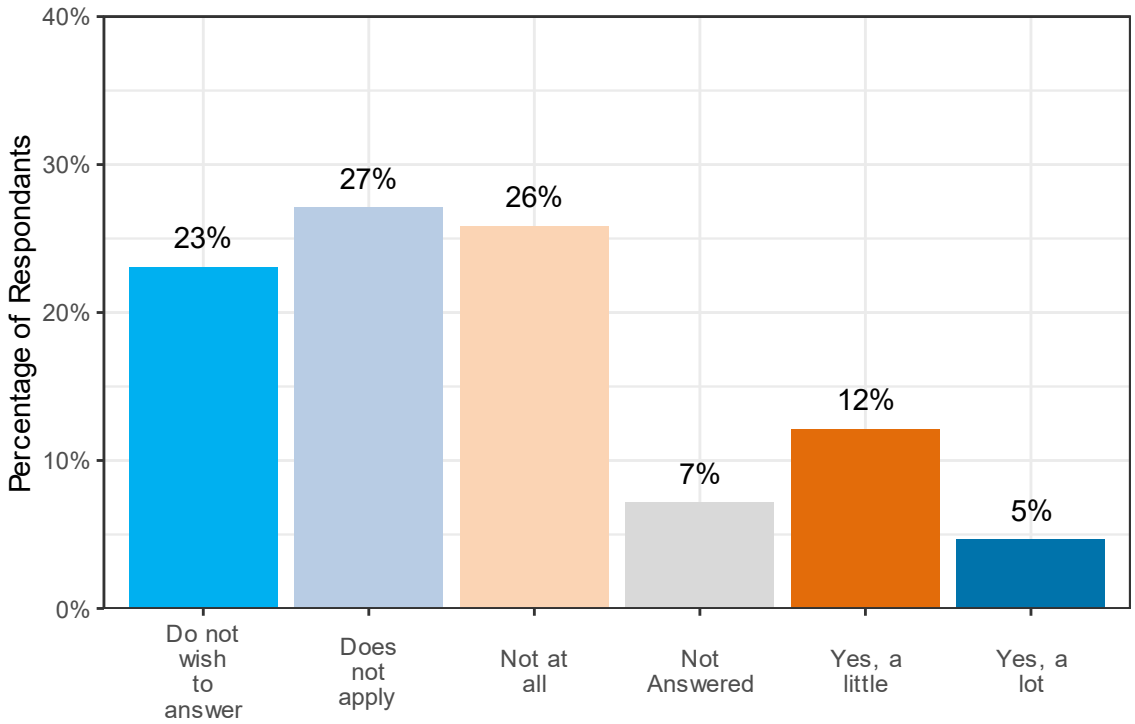


Figure 20: Respondents who have autism, dyslexia or neurodivergence

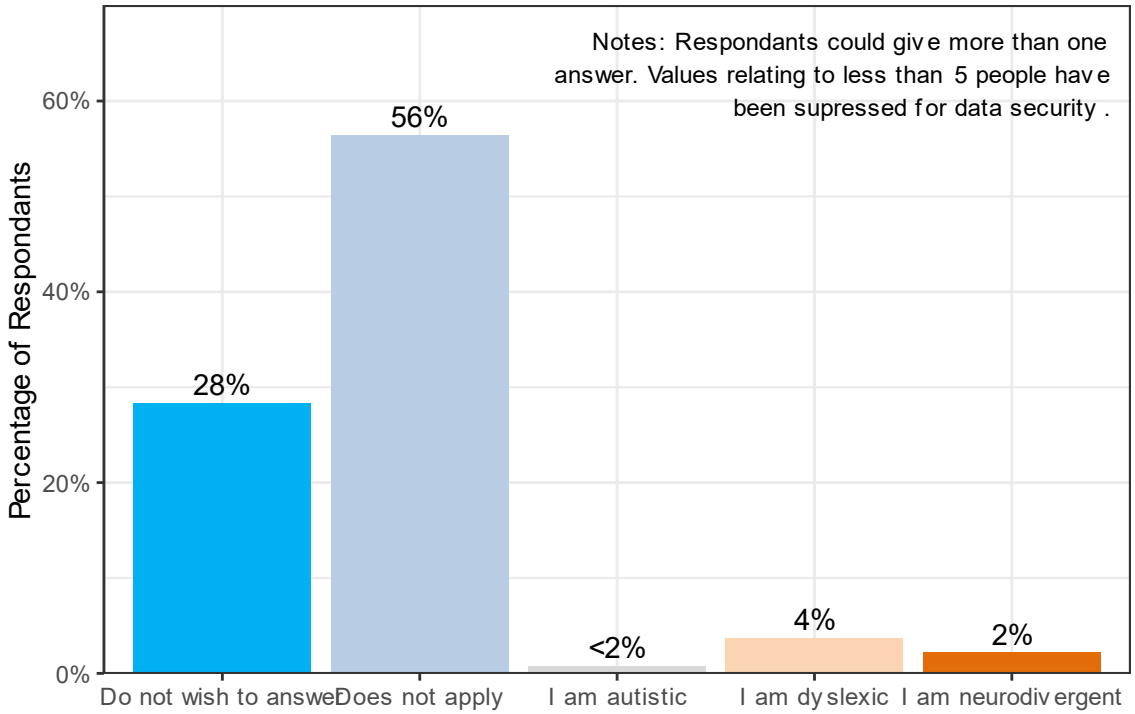


Figure 21: Respondents who experienced daily difficulties

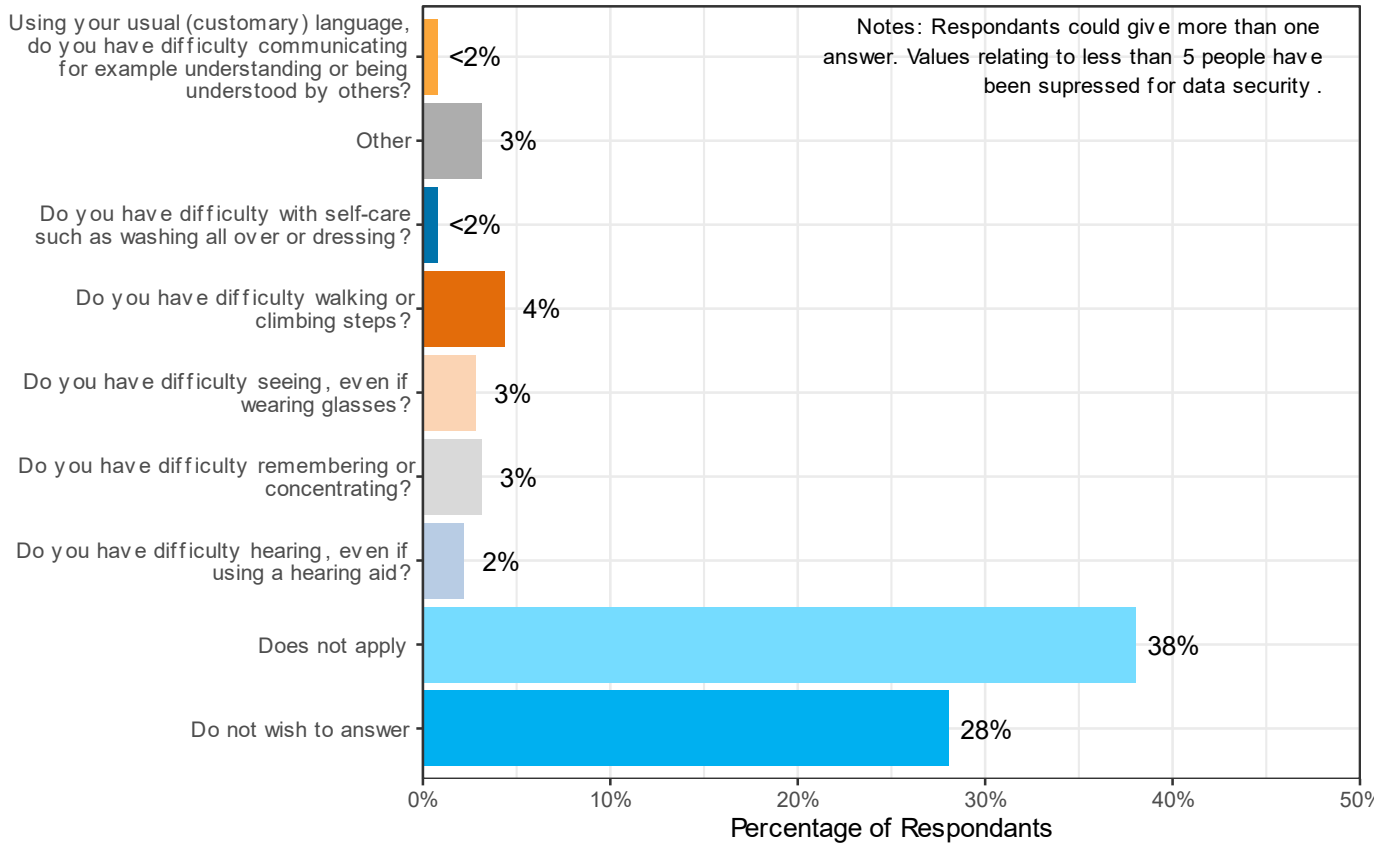
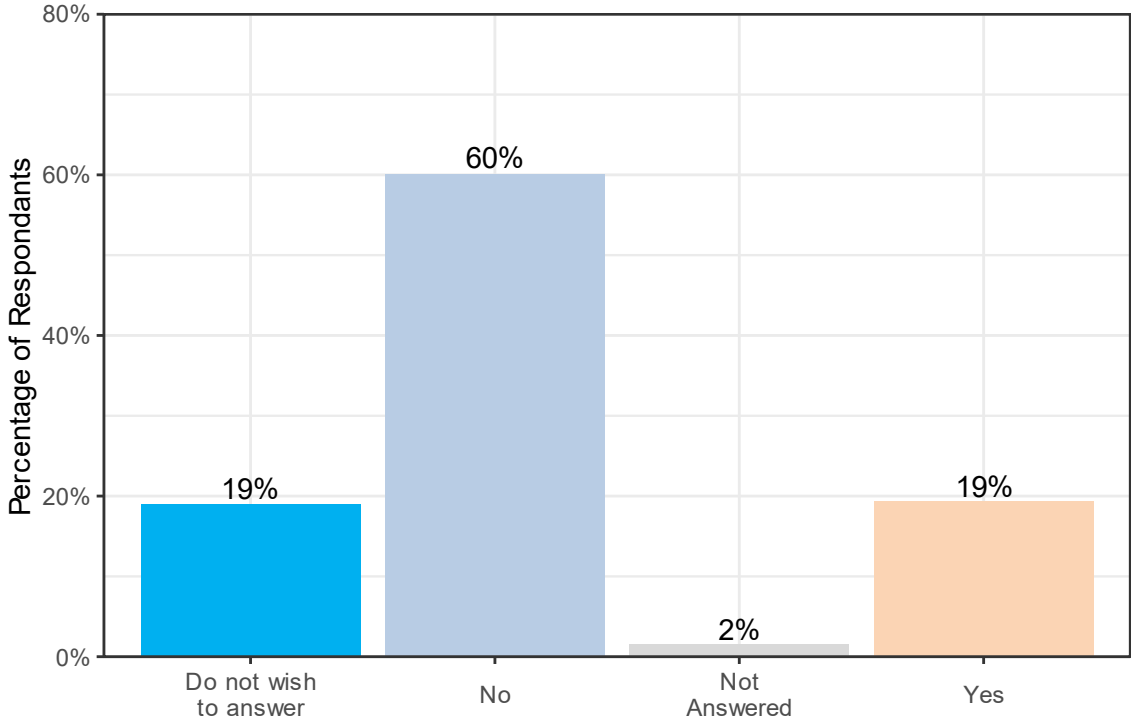


Figure 22: Respondents with disabilities



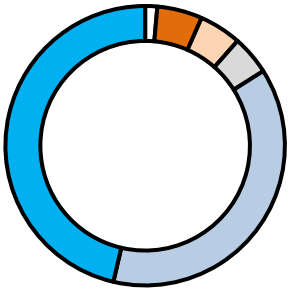
Birmingham City Council

Findings

Vision statement

Our vision is to create a bold, healthy, and active city where people have access to a wide range of opportunities and a supportive environment to enable them to become more active. Birmingham will be a city where Physical Activity improves people's lives and the places in which they live.
By working collaboratively with partners from across Birmingham we will inspire, motivate, and make it easier for everyone to be active at every age and ability. Recognising that some people will require more support than others to be active.

317 respondents answered this question using the scale with 85.66% of total respondents agreeing or strongly agreeing with the vision statement. 154/317 respondents also provided a written response.



Strongly Agree		Agree		Don't know		Disagree		Strongly Disagree		Not Answered	
167	52.02%	108	33.64%	13	4.05%	14	4.36%	15	4.67%	4	1.25%

Top Themes and what they are saying

- **1 in 6 respondents (n=24)** who provided a written answer to their rating of the **Vision (n=154)** highlighted the importance Physical Activity have in **improving mental wellbeing**, be it **physical, psychological, and social.**
- However, there were two main things that respondents felt are key to increasing Physical Activity levels in Birmingham and that they should be included in the Strategy -
    - **Accessibility** - **1 in 5 respondents (n=34)** felt services proposing Physical Activity across the city should be more inclusive catering for those across all ages and all abilities.
    - **Safe and Adequate infrastructure** - This was supported by **1 in 15 respondents (n=12). -**

The following comments are typical of many points raised.

"As an 80-year-old I am no longer able to cycle, walk far, and use public transport. As my wife is disabled, we are unable to access many areas of the city center due to excessive walking distances."

"It makes sense and is inclusive."

"I have recently joined a music/movement/exercise class and I found it extremely beneficial for me aged 78 years."

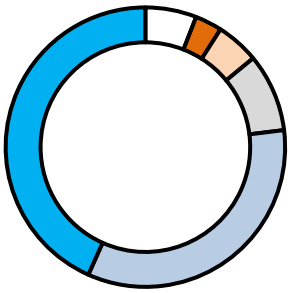
"I like the idea that the vision statement has taken into account its people, environment and physical activities and also acknowledged that some people will need more support than others."

"I want to live in a city with these values."

Principles

Implement a whole system approach to Physical Activity in Birmingham.

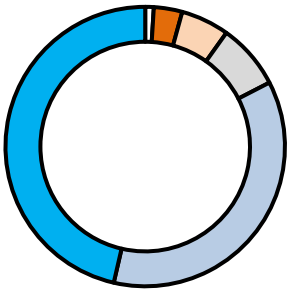
302 respondents answered this question using the scale with 76.94% of total respondents agreeing or strongly agreeing with the vision statement.



Strongly Agree		Agree		Don't know		Disagree		Strongly Disagree		Not Answered	
139	43.30%	108	33.64%	29	9.03%	16	4.98%	10	3.12%	19	5.92%

Provide senior level commitment to embed Physical Activity in policy to ensure multiple outcomes are met around health, climate change, air quality through strong strategic collaboration.

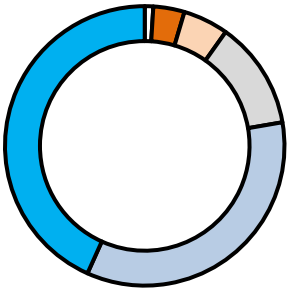
301 respondents answered this question using the scale with 78.20% of total respondents agreeing or strongly agreeing with the vision statement.



Strongly Agree		Agree		Don't know		Disagree		Strongly Disagree		Not Answered	
141	43.93%	110	34.27%	23	7.17%	17	5.30%	10	3.12%	20	6.23%

Take a life course approach and focus on the unmet needs using data, intelligence, and insight to focus on geographies and communities where inequalities exist.

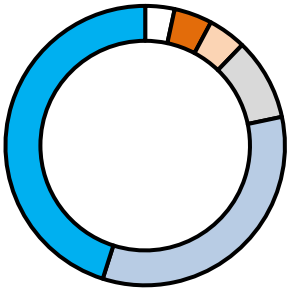
302 respondents answered this question using the scale with 73.83% of total respondents agreeing or strongly agreeing with the vision statement.



Strongly Agree		Agree		Don't know		Disagree		Strongly Disagree		Not Answered	
132	41.12%	105	32.71%	38	11.84%	16	4.98%	11	3.43%	19	5.92%

Adopt a community centred approach and empower local people to lead, embedding the voice and influence of local people across the system.

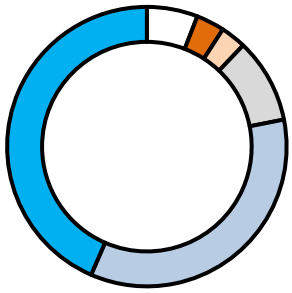
301 respondents answered this question using the scale with 76.55% of total respondents agreeing or strongly agreeing with the vision statement



Strongly Agree		Agree		Don't know		Disagree		Strongly Disagree		Not Answered	
149	46.02%	98	30.53%	28	8.72%	13	4.05%	13	4.05%	20	6.23%

Focus on early help and prevention and ensure interventions are tailored and person-centred.

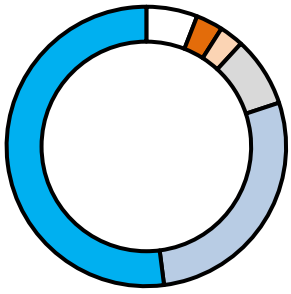
303 respondents answered this question using the scale with 79.13% of total respondents agreeing or strongly agreeing with the vision statement.



Strongly Agree		Agree		Don't know		Disagree		Strongly Disagree		Not Answered	
148	46.11%	106	33.02%	30	9.35%	9	2.80%	10	3.12%	18	5.61%

Develop local, accessible activity opportunities, built on local community assets.

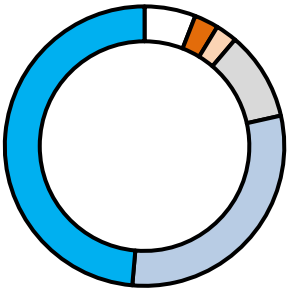
302 respondents answered this question using the scale with 80.06% of total respondents agreeing or strongly agreeing with the vision statement.



Strongly Agree		Agree		Don't know		Disagree		Strongly Disagree		Not Answered	
167	52.02%	90	28.04%	26	8.10%	9	2.80%	10	3.12%	19	5.92%

Support a more sustainable, strategic, and joined up approach to funding opportunities.

302 respondents answered this question using the scale with 78.51% of total respondents agreeing or strongly agreeing with the vision statement.



Strongly Agree		Agree		Don't know		Disagree		Strongly Disagree		Not Answered	
156	48.60%	96	29.91%	33	10.28%	8	2.49%	9	2.80%	19	5.92%

Principles – Key Findings

168
respondents provided a written response to their ratings on Principles.

Top Themes and what they are saying

- **Over 1 in 4 (n=46)** of respondents who provided a written answer to support their rating of the principles (n=168) felt there is a **discrepancy in access for those with limited ability**. This was often accompanied by the need for **increased opportunities to be more active (1 in 12; n=16)** and **better infrastructure (1 in16; n=8)** that were **accessible (1 in 6; n=29)**, especially to those who are from **a lower socio-economic background** living in **more disadvantaged areas** of the city **(1 in 16; n=9)**. This will not only lead towards **better health outcomes** but **increased social inclusion (1 in 20; n=9).**

- There was, however, a **minority of respondents (1 in 34; n=5)** who felt having a Strategy to improve Physical Activity levels in Birmingham was **waste of public resource**.

The following comments are typical of many points raised

"Giving people the opportunity to engage with physical activities local to them will help combat issues health related. Physical and mental. I think there should be long term sustainable plans to continue access of physical activities to the locals."

"Good to implement health and fitness policies across the whole community, regardless of wealth and age very important, compared to other areas to keep everybody healthy, as possible is best for all."

"All communities have inequalities. Girls especially. Also, people with disabilities. A better approach than the postcode lottery is needed. It will be necessary to invest in youth and community workers and social spaces in all communities."

"Long-term funding is needed to enable providers to establish and deliver activities over a longer time period rather than lots of smaller, short-term pots of funding. Activities also need to be delivered across all days/times to enable everyone, including those who work to take part along with activities which families can take part in together."

"This is all very aspirational, but I want to see it in action. I want a website which lists every step forward and every time you tried something that was not successful. I also would like to see something about funding community hubs. We are a social species, and we should make opportunities to play together, no matter the age."

"Clear and concise."

"I agree with these values. I want to live in a healthier and greener city."

"An asset-based approach is important to enable those living in the most deprived areas to have access to the facilities to support them with a healthier lifestyle."

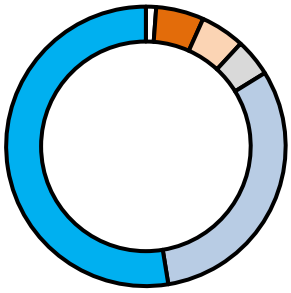
You are becoming a dictatorship and you are not listening to the people

Birmingham City Council

Priorities

Active People: By creating and promoting access to Physical Activity opportunities taking a life course approach across multiple settings, we will enable more people to engage in regular activity.

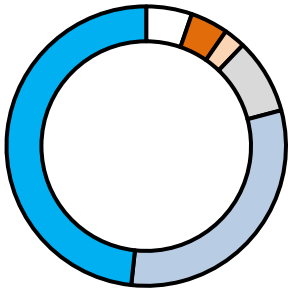
303 respondents answered this question using the scale with 76.26% out of total respondents agreeing or strongly agreeing with the vision statement.



Strongly Agree		Agree		Don't know		Disagree		Strongly Disagree		Not Answered	
138	42.99%	110	33.27%	30	9.35%	15	4.67%	10	3.12%	18	5.61%

Active Environments: By creating and protecting the places and spaces that promote and engage people of all ages and abilities in activity we will enable more people to engage in regular activity.

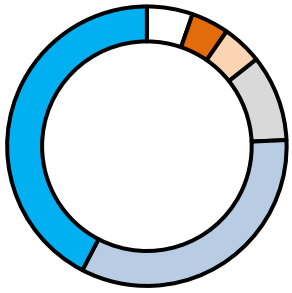
304 of respondents answered this question using the scale with 79.13% out of total respondents agreeing or strongly agreeing with the vision statement.



Strongly Agree		Agree		Don't know		Disagree		Strongly Disagree		Not Answered	
155	48.29%	99	30.84%	28	8.72%	8	2.49%	14	4.36%	17	5.30%

Active Society: By changing how we talk about Physical Activity across the city, building insight and evidence into policy, commissioning, planning decisions and communication messages and marketing campaigns we will enable more people to engage in regular activity.

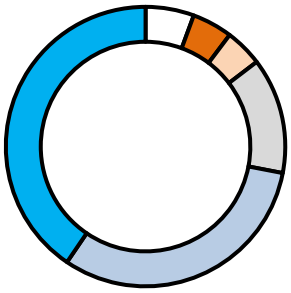
304 of respondents answered this question using the scale with 75.70% out of total respondents agreeing or strongly agreeing with the vision statement.



Strongly Agree		Agree		Don't know		Disagree		Strongly Disagree		Not Answered	
136	42.37%	107	33.33%	32	9.97%	15	4.67%	14	4.36%	17	5.30%

Active Systems: By creating a more connected system and strengthening our local leadership, governance, partnerships, and workforce capabilities we will enable more people to engage in regular activity.

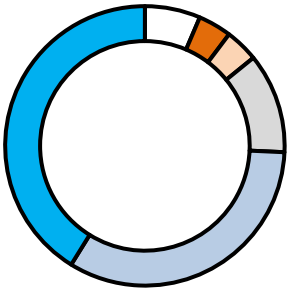
303 of respondents answered this question using the scale with 71.96% out of total respondents agreeing or strongly agreeing with the vision statement.



Strongly Agree		Agree		Don't know		Disagree		Strongly Disagree		Not Answered	
130	40.50%	101	31.46%	43	13.40%	14	4.36%	15	4.67%	18	5.61%

Closing the Gap: By continuing to develop a better understanding of local barriers and enablers to increase activity across the city and ensure we focus on the least active groups as identified in the Physical Activity Needs Assessment, we will enable more people to engage in regular activity.

301 of respondents answered this question using the scale with 75.08% out of total respondents agreeing or strongly agreeing with the vision statement.



Strongly Agree		Agree		Don't know		Disagree		Strongly Disagree		Not Answered	
138	42.99%	103	32.09%	36	11.21%	12	3.74%	12	3.74%	20	6.23%

Priorities – Key Findings

150
respondents provided a written response to their ratings on the Priorities of the Strategy.

Top Themes and what they are saying

- **1 in 5 of respondents (n=31)** who also provided a written response to their rating of the Priorities (n=150) felt the priorities should ensure they take **accessibility and affordability** into account when creating opportunities to be embed Physical Activity in the city. This was often accompanied by the need to use **community-oriented approaches (1 in 15; n=11)** and **improved infrastructure that were safe (1 in 16; n=9)**. Some examples mentioned were **green spaces and cycle lanes**.

- There was, nevertheless, **a minority of respondents (1 in 10; n=14)** who felt that the Strategy might be a **waste of time** as the Council may not have the relevant **resources to deliver the consultation findings**.

The following comments are typical of many points raised.

"The plans put forward do not take into consideration the disabled and the elderly within the community."

"People choose the lifestyle they lead because that is how they want to live their lives. Constant lecturing by BCC won't change this. People need to want to live an active lifestyle for themselves, not because BCC tell them to do so. "

"Stop using Cannon Hill Park as a car park for Edgbaston Cricket ground, put pedestrians first not last, ensure footpaths are well maintained and protected as a priority, not dropped at a moment's notice when there are utility or maintenance works taking place and that bus stop remain accessible."

Birmingham City Council

Plan for Action

The Strategy will create a Plan for Action to implement change themed around the five priorities:

1. **Active People**
2. **Active Society**
3. **Active Environment**
4. **Active System**
5. **Closing the Gap**

There were 267 responses to this part of the question.

Top Themes and what they are saying

- **Accessibility and affordability** were some of the points that stood out in the suggestions for a Plan of Action. Out of the 267 who provided suggestion for a Plan of Action, **nearly 1 in 5 (n=59)** expressed the importance of ensuring the plan includes **activities, services and resources that were accessible and affordable**.
- Accessibility focused on ensuring **equitable provision to disadvantaged groups** such as older adults, people with disabilities, learning difficulties, women (especially South Asian women) and those who usually do sedentary jobs.
- Beyond **accessibility** to disadvantaged groups, respondents felt various activities across the city do not always **suit their schedule** and they would want **more activities during suitable times**. This was in line with the need for **adequate, safe and appropriate environment and infrastructure** for be active in **(1 in 6; n=45)** .
- **Affordability** included **proximity of services** but also **ease of access** such as **improved transport system** across the city.

The following comments are typical of many points raised.

"Affordable and accessible gyms, pools, and better infrastructure for cycling around the city. An easy way to find all Information and upcoming events in 1 single place."

"Workplaces should be included as they have the opportunity to support and influence those, they employ to be active. Also, an active workforce is more likely to be healthy and productive."

"Ensuring people from all backgrounds have access to Physical Activity opportunities, lots of free opportunities to help reduce barriers to being physically active."

"Develop a city-wide system that actively promotes all opportunities to get active."

"Encouraging walking by creating a more pleasantly built environment. Encouraging walking by having a better public transport network so the car stays at home. Protecting and enhancing green space for use for sports and leisure."

"Different places that can hold all ages to bring the community back to how it should be."

"Consideration the diverse needs of the city. Work collaboratively with other partners. e.g., how can we continue to cap bus prices to promote active travel. Public health can't control all of this or commission our way out of this; we need to work with partners across the city and influence them."

"It should be community led and focused, ask the people what they need and will benefit from, and they will both guide you and tell you."

More Comments

184
respondents provided a written response to their ratings on the Priorities of the Strategy.

Top Themes and what they are saying

- 184 respondents chose to provide more comments and **1 in 8 of them (n=22)** had **concerns over whether the Council had adequate resources** to deliver against the consultation findings. Some of the **respondents (1 in 13; n=14)** even expressed their concerns whether the plans were **realistic and practical**.

- An important number **(1 in 3; n=64)** felt, however, that all plans should take into consideration **accessibility** and **inclusivity** such **transportation, harnessing on local assets**, ensuring **equitable services** to those who are **more disadvantaged** and **safer infrastructures**.

The following comments are typical of many points raised.

"Brilliant idea. Building a network of mobility lanes to encourage more people to use active travel is very much needed. Giving people the choice on how to get around will encourage healthier living."

"Funding for families, young people and elderly people."

"Active Travel should be at the core of all policies. This is much better than subsidising gym membership."

Face-to face Consultation feedback

Top Themes and what they are saying

- We engaged with 879 people face to face.

  Most, if not all, of the things that people in the face-to-face consultations said were important to them were similar to what have been reported through the BeHeard platform.
- Inclusivity and accessibility were important to them. While a great deal agreed with the strategy, its vision, principles and priorities, many felt it should cater for the divers Birmingham population - especially those who are disadvantaged.

- Many felt the opportunities available to be physically active should be affordable. For example, there should be more BeActive classes at suitable times.

- They also felt the spaces to be active in should be adequate. They raised the concerns that various spaces they have access to are not maintained and safe. This is about leisure and wellbeing centres, but it goes beyond that to include road, cycle paths and green spaces.

- They also agreed the council need to take a holistic and whole-system approach working more closely with organisations at the heart of the community. One lady in her late fifties who is a GP, said that she could see how community hubs with access to green spaces would be beneficial. This would enable families to engage with nature such as planting their crops.

Recommendations

1. The Creating an Active Birmingham Strategy, Implementation Plan and subsequent programmes of work should take accessibility, inclusivity and affordability into consideration making sure the Physical Activity offer is inclusive, equitable and affordable.

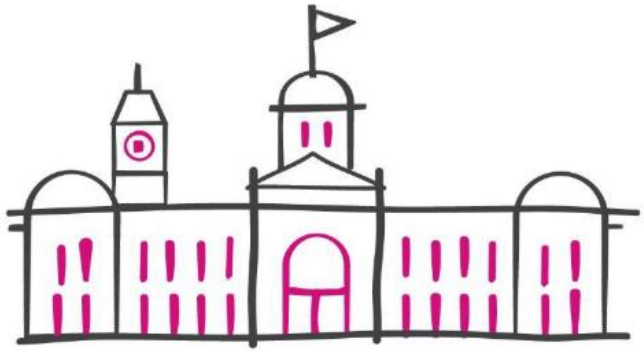
2. The Council should invest into creating and maintaining safe and adequate spaces to be physically active in, be it indoor spaces like leisure centres or outdoor spaces like safer roads, cycling paths and green spaces.

3. The Council should take a holistic whole-system approach and work with not just traditional partners but grassroot community-led organisations to ensure equitable delivery of the Strategy.

You Said…We Did

Summary of Changes to the Creating an Active Birmingham Strategy and Implementation Plan in Response to Consultation Feedback

January 2024



You said…

We did…

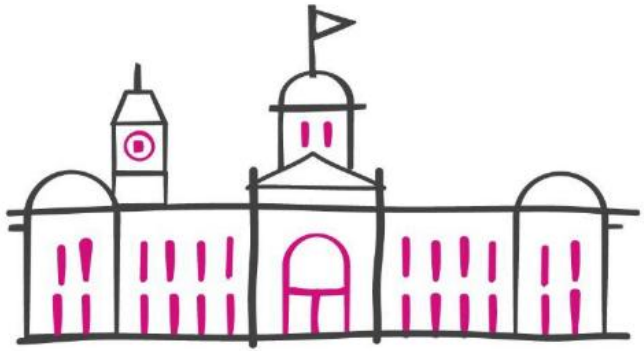
You said…	We did…
The Strategy should be **clearer** with **accessible** and **simple English**.	We have reviewed the strategy and ensured the language used is **accessible**. We have gone beyond and reviewed our use of language across our physical activity work. We have recently changed the name of our physical activity forum from 'Creating an Active City Forum' to just '**Active City Forum**.' This way it is **streamlined and clear**. We intend to use **clear and accessible English** in all aspects of our work. We have **clarified our targets** to make it easier to **measure** the **impact** of the strategy.
Inclusivity and **accessibility** were important to you. You said that strategy should consider the diverse needs of residents of Birmingham, ensuring accessibility for all ages and abilities with a key focus on disadvantaged groups who are the least active in Birmingham. Some of those groups are those living in disadvantaged areas, older adults, individuals with disabilities (learning, sensory and physical) and South Asians, especially women.	This is an important point which also came through when we spoke to organisations who work with the most deprived communities. We, therefore, from the beginning of the strategy, changed the way we talked about opportunities and reinforced that we intend on ensuring **opportunities** are e**quitable and accessible** and takes **cultural needs** into consideration. We changed our language to explicitly mention that we will use **data and evidence** to identify areas of needs where we will focus.
You expressed concerns about practical **access to physical activity**, including timing and location. Working-age individuals feel disadvantaged due to conflicting activity hours, and poor public transport limits accessibility.	As part of our Wellbeing Service in making physical activity **accessible and affordable**, we will continue to improve our BeActive offer based on evidence available.
Being physical active should be **affordable**. You suggested making physical activities more **financially accessible**.	Recognising **affordability** as a barrier to being physically active, we ensured our **Vision** and **Priorities** considered this. Our focus is to make being **physically active an easy choice**. Hence why, we will continue to review and evaluate our programme and services to ensure they are **relevant, equitable, accessible and affordable**.
It is important to have **adequate infrastructure**, including safer roads, cycle paths, green spaces, and **overall city safety**. You emphasised the need for safe and well-maintained leisure centres and indoor spaces.	This has come out really clear in the consultation. Therefore, for '**Active Environments**' priority, we have highlighted our existing action of working to ensure there are **local, safe, affordable and attractive spaces** to be physically active in.
It is key to have a **holistic, whole-system approach** to ensure Birmingham becomes an active city. Collaboration with partners is crucial, but you emphasised involving and **empowering grassroot and community-led organisations**, leveraging existing relationships to bridge the inactivity gap.	We have revised how we will deliver our '**Active Systems**' priority by making it clear that the partners we intend to engage are not just traditional partners we have worked with. We will work with **grassroot and community-led organisations**. We have already started this through the Seldom Heard Voices project, and we are ensuring that the Active City Forum has those **representations**.
You have concerns about the Council's ability to deliver the ambitious strategy due to **financial challenges**. You worry whether the Council will have the necessary resources to support and implement the Creating an Active Birmingham Strategy.	The Creating an Active Birmingham strategy is a **co-produced strategy** and is **owned by the city** rather than just the Council. We will harness existing relationships to ensure the strategy is delivered.
You mentioned you want to be **involved** in designing services for you.	We created a **Citizens Panel** with over **100 members** from the community who we will consult regularly to obtain views and suggestions when designing programmes of work.

Creating an Active Birmingham Strategy 2024-2034

Consultation Findings & Ratification

Physical Activity Team

March 2024



Papers

Cover Notes	• HWB Report
Appendices	1.Stakeholder Engagement in Creating an Active Birmingham Strategy Development 2.Creating an Active Birmingham Strategy 3.Implementation Plan 4.Physical Activity Needs Assessment – Executive Summary 5.Physical Activity Needs Assessment 6.Raw data excluding demographic information to protect identity of respondents. 7.Creating an Active Birmingham Strategy Consultation Report 8.'You said, we did' summary 9.Equality Impact Assessment 10.Legal Sign-off 11.Finance Sign-off 12.Procurement Sign-off 13.HR Sign-off

How active is Birmingham?

Birmingham adults – 481,400 (55%) of all adults (16 years +) living in Birmingham are active (at least 30 mins activity per day)

Birmingham children – 71,800 (42%) of children & young people (5-16 years) living in Birmingham are active (at 60 mins activity per day)

What are the inequalities within Birmingham?

Underrepresented groups

Inequalities in PA exist across several underrepresented groups

People living with a disability or long-term condition are a third more likely to be inactive compared to people without (44% v 28%).

People from an Asian (excl. Chinese) background are nearly twice as likely to be inactive compared to a white British background (43.1% compared to 26.5%)

Deprivation

Physical inactivity is strongly linked to deprivation

People from lower socio-economic groups (SEG) are more inactive than those from higher SEG

The proportion of adults living in IMD1 who are inactive is nearly double (39%) those living in IMD 10 (21%)

Age

You are more likely to be inactive if you are a younger or older person living in the city

Children and young people – 2 in 5 (38%) children & young people living in Birmingham are inactive

Older people - 2 in 5 (39%) of older adults (aged 55 and above) are inactive

Gender

Women and girls are more likely to be inactive

Overall, 1 in 3 (35%) women are inactive compared to 1 in 4 (28%) of men

Only 1 in 3 (35%) girls are meeting the CMO guidelines for PA compared to nearly 1 in 2 (47%) boys

Based on: Academic year 20-21 and data taken from Active Lives children and young people survey and Active Lives Adult Survey Nov 20-21

Priorities

Active People

Recognise the role of play and culture to increase children's and adults' physical activity

Closing the Gap

Tackle Inequalities in activity by focusing on the groups with the highest level of inactivity

Active System

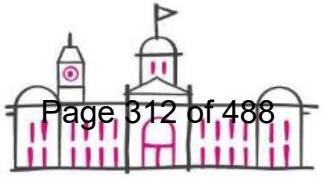
Improve workforce knowledge of the benefits of physical activity and how to have the conversations

Active Society

Ensure Birmingham City Council and NHS funding supports physical activity

Active Environment

Increase the number of people participating in active travel

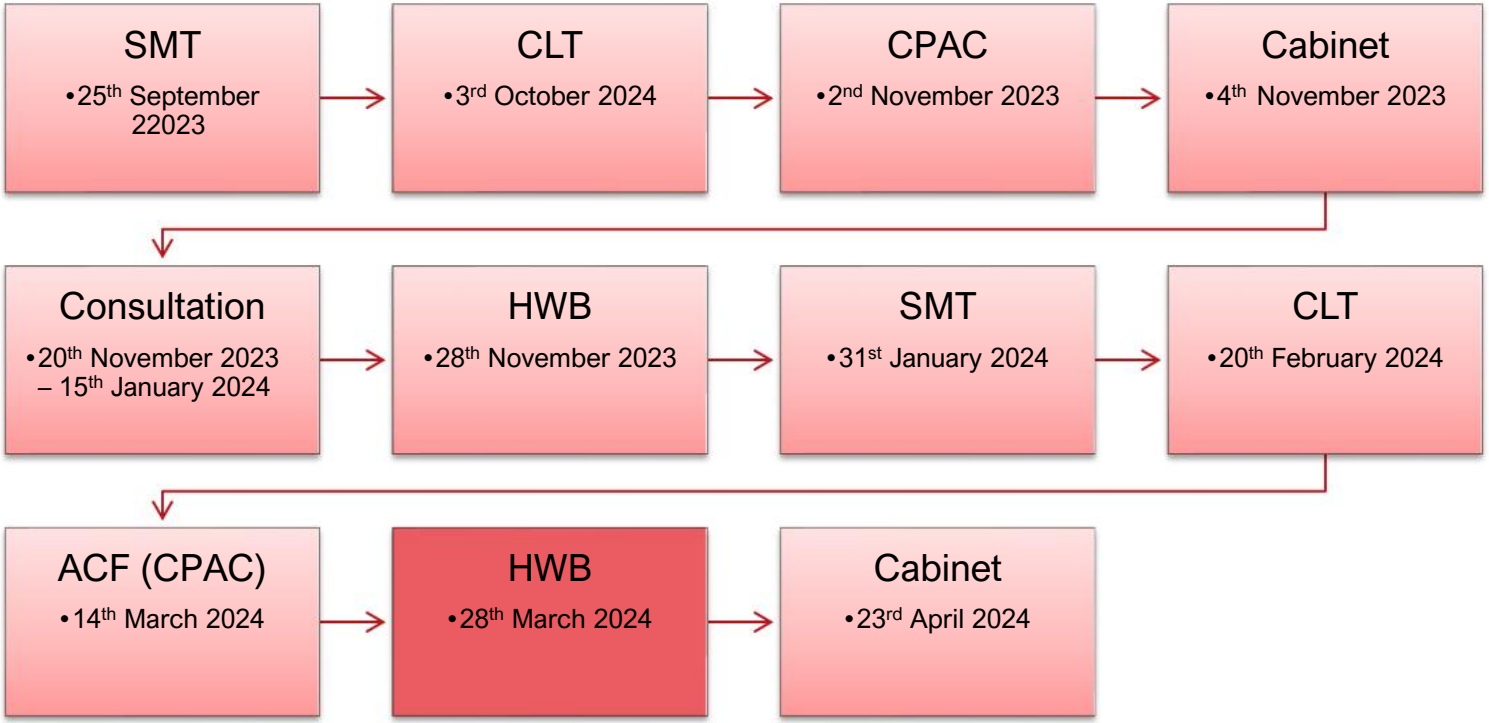


Creating an Active Birmingham Strategy Metrics - 2030

Reduce	Increase	Increase	Increase	Reduce	Reduce
Reduce the percentage (%) of adults who are physically inactive (25%) to 20%	Increase the percentage (%) of adults walking (17.7%) for travel at least three days a week to 25%	Increase the percentage (%) of adults cycling (2%) for travel at least three days a week to 4%	Increase the percentage (%) of physically active children and young people (41.6%) to the national average (47.2%)	Reduce the inactivity gap (20%) between those living with disabilities and long-term health conditions and those without to 10%	Reduce the inactivity gap between minority ethnic communities (Asian not including Chinese – 38%, Black – 35%) and white ethnicity (29%) by 50%

Strategy Development

Governance


SMT
•25th September 22023
CLT
•3rd October 2024
CPAC
•2nd November 2023
Cabinet
•4th November 2023
Consultation
•20th November 2023 – 15th January 2024
HWB
•28th November 2023
SMT
•31st January 2024
CLT
•20th February 2024
ACF (CPAC)
•14th March 2024
HWB
•28th March 2024
Cabinet
•23rd April 2024

Consultation

BeHeard Questionnaire

321 responses

Face to face Consultation Sessions

41 events; 879 conversations

Assisted Consultation

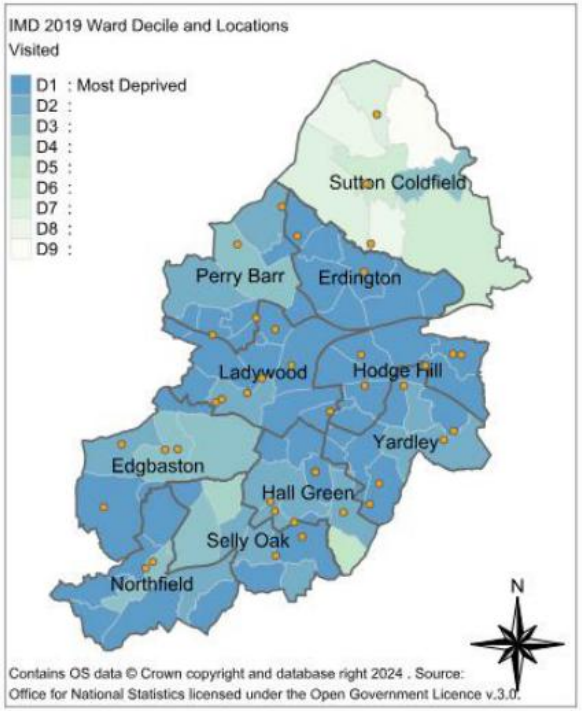
(Seldom Heard Voices)

4 SHV providers; 92 BeHeard responses

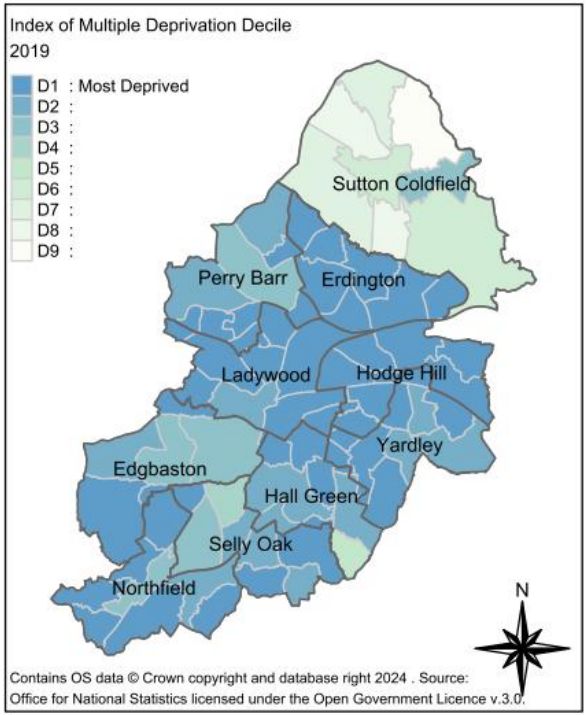
Face to face Consultation

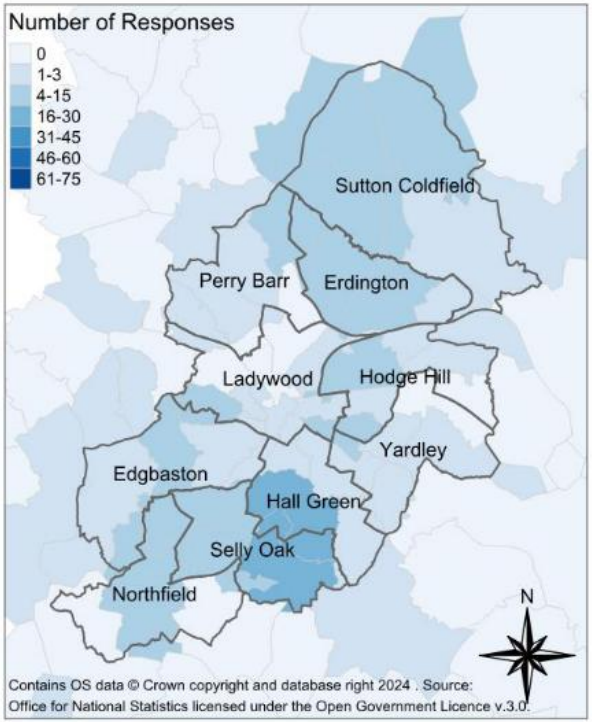
- 41 Consultation Sessions
  - 19 libraries,
  - 10 leisure centres
  - 11 community centres
  - 1 faith-based organisation

- 879 Conversations



BeHeard





- 321 Responses
  - 92 from SHV

Main Findings

Accessibility

Inclusivity

Affordability

Whole-System approach

Concerns on delivery

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Citizens Panel

Throughout the Consultation, respondents were asked if they wish to be part of a citizens panel.

- Provide continuous perspectives on the implementation of the CABS
- 127 Respondents opted to support the team in deliverable the strategy.

Birmingham City Council

Thank you.

RESET RESHAPE RESTART

BIRMINGHAM HEALTH AND WELLBEING BOARD

	Agenda Item: 12
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**28th March 2024**
TITLE:	**BLACHIR UPDATE**
Organisation	**Birmingham City Council**
Presenting Officer	**Helen Harrison, Assistant Director of Public Health – Healthy Behaviour and Communities**

Report Type:	**Information and Support**

1 Purpose:
The purpose of this report is to provide an update to the Board since the previous report in March 2023, regarding the Health and Care system implementation of the recommendations.

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

3 Recommendations
The Board are requested to note the progress being made to implement the BLACHIR opportunities for action and the 7 key priority areas highlighted within the Review and for Board members to continue to support in the system delivery of the key actions.

4 Report Body

1 Introduction and Background

The Birmingham and Lewisham African & Caribbean Health Inequalities Review (BLACHIR) was launched in 2020 as a partnership between Birmingham and Lewisham to explore and better understand the inequalities affecting African and Caribbean communities in these areas and co-produce opportunities for action with communities to break structural inequalities and achieve sustainable change. The review used a new approach of mixed methodology working with an external community advisory board and an academic advisory board to examine findings and shape recommendations. It followed a thematic approach to considering health inequalities drawing on the life-course model and wider determinants of health.

The final report was published in March 2022, and the findings identified 39 specific opportunities for action across 8 themes. From this, 7 overarching key priorities areas have been identified:

1. Fairness, Inclusion, and Respect
2. Trust and Transparency
3. Better Data
4. Early Interventions
5. Health Checks and Campaigns
6. Healthier Behaviours
7. Health Literacy

These actions identified in the review continue to be implemented across the system.

2 Governance

A Governance structure for the implementation of BLACHIR was established in October 2022 to ensure a clear line of accountability for delivery to the Health and Wellbeing Board.

2.1 BLACHIR Team

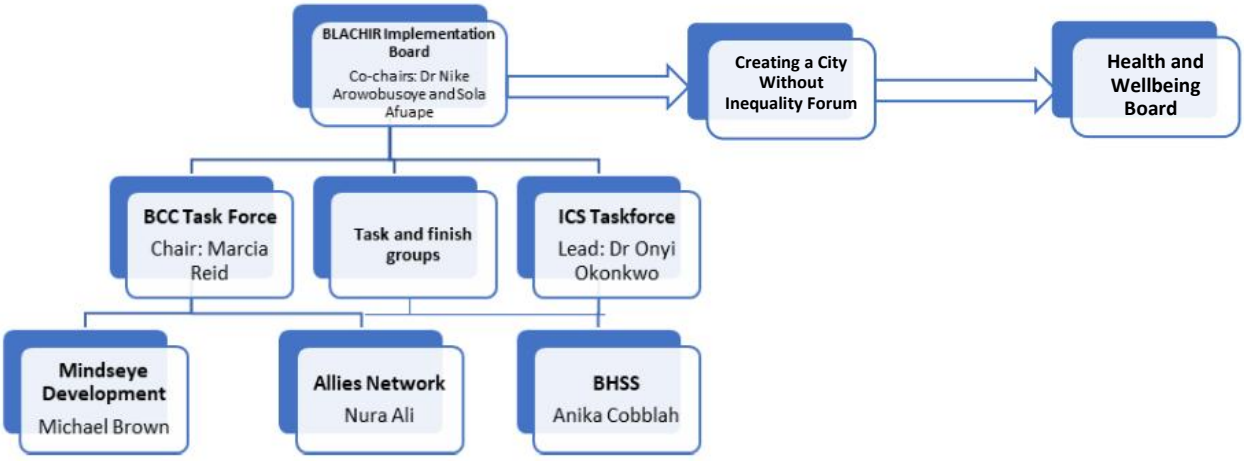
The BCC BLACHIR team is led by the Assistant Director leading Healthy Behaviours and Communities and project support is provided by Public Health Graduate working with a Communities Team Senior Officer and the Communities Team Service Lead. A post is currently being advertised for a Public Health Senior Officer for Ethnic Disparities who will Programme Manager the BLACHIR project and embed learning to address ethnic inequalities. The BLACHIR team provide support to the Implementation Board, manage the Community Engagement Partners, and coordinate co-production and delivery of the key areas for action.

2.2 BLACHIR Implementation Board

The BLACHIR Implementation board (BLACHIRIB) was established to ensure the opportunities for action are embedded across the system and the key areas for action are delivered (see Appendix 1.1 for Terms of Reference). The Board comprises representatives from community organisations, Council, NHS, and Police. The Board formally reports to the Creating a City without Inequality Forum, a sub-group of the statutory Health and Wellbeing board as shown in the governance figure 1 below. Delivery of the opportunities for action is via the Birmingham City Council (BCC) and Integrated Care System (ICS) Task Force groups and the key areas for action are delivered via task

and finish groups. Three Community engagement partners are commissioned to support delivery across all areas.

Figure 1: BLACHIR Governance



Birmingham City Council appointed two independent co-chairs of the Implementation Board in July 2023 Dr Nike Arowobusoye and Sola Afuape. The Co-Chairs ensure robust governance and effective implementation of delivery. Dr Nike Arowobusoye is a Consultant in Public Health medicine and has over 20 years' experience of working for and leading healthcare systems. Currently, Nike works in two London boroughs and leads on promoting health and wellbeing through prevention, addressing health inequalities, and ensuring equitable and responsive healthcare delivery. Sola Afuape is an experienced Non-Executive Director currently sitting on the boards of the Innovation Unit, a social enterprise that develops long term innovations that tackle persistent inequalities; SW London Integrated Care System Health Inequality and Equality, Diversity, and Inclusion (EDI) Board and South West London and St George's Mental Health Trust, where she chairs the People Committee. Sola has over 20 years' operational experience advising, designing, and implementing local, regional, and national health inequality and service improvement programmes.

The Implementation Board had its first meeting with the new Co-Chairs in November 2023. This meeting was used as an opportunity to take stock of delivery to date and to chart the journey for delivery of the remaining actions.

SMART Goals have and continue to be identified across the system for how the 39 opportunities for action will be delivered by all relevant partners which includes goals for both Birmingham and Solihull councils, as agreed in the inception of the BLACHIR report (see Appendix 1.2 for an overview of the SMART Goals).

A monthly report has been created specifically designed for the purpose of tracking progress, assessing needs, mitigating risks, improving quality and effective communication across all streams of the BLACHIR project and to provide updates to the Board. This is to ensure projected goals and

targets are met in a timely fashion. This includes updates from community engagement partners, the ICS and BCC Task Forces, and task and finish groups. (See Appendix 1.3).

2.3 BCC Task Force

Birmingham City Council created a BCC Task Force which was established to capture Council-wide responses to the opportunities for action that were to be responded to by BCC.

The Task Force met on the 27th of July 2023, Chaired by the Assistant Director of Insight, Policy and Strategy. At this meeting, relevant BCC teams and team leads were identified for each opportunity for action.

Due to the changing governance processes and subsequent new staff members, the Task Force has not met since July, however, work against the opportunities for action is progressing and is being overseen by the BLACHIR team and the Implementation Board. The team and the Co-Chairs are exploring how BLACHIR goals can be embedded within the Council's wider Equalities strategy work going forward.

2.4 Integrated Care System (ICS) Task Force

The Birmingham and Solihull Integrated Care System Task Force is facilitated by the Health Inequalities Team and continues to support the healthcare responses to the opportunities for action.

The Task Force continues to mature, involving ICS partners and community engagement partners. The Task Force reports into the People Power Health Inequalities (PPHI) ICB Board and BLACHIR Implementation Board. SMART goals from each provider have been developed and shared with community engagement partners to ensure outcomes are agreed and effectively co-produced.

The new ICS EDI Strategy, 'Belonging at BSol 2023-2026', has been carefully aligned with the 6 high-impact action of the NHS EDI Improvement Plan. This supports the work of BLACHIR and a number of the 17 Birmingham Race Impact Group (BRIG) pledges.

3 Progress against Delivery of BLACHIR Actions

The ICS and BCC has made significant progress on the delivery of the key opportunities for action both via cross-cutting whole systems projects and within specific service areas and NHS Provider services, an overview of the SMART goals are in Appendix 1.

3.1 ICS Projects with Community Engagement Partners

The ICS has been working closely with the 3 community engagement partners for BLACHIR implementation: Mindseye Development, Allies Network and Black Heritage Support Service. Examples of the projects include:

1. West Locality cardiovascular disease (CVD) Awareness and Engagement Project – which aims to increase hypertension awareness and engagement within Black African and Black Caribbean Communities. Completed actions include a co-produced hypertension awareness script

(available in key languages), development of awareness videos with community representatives, identification of community hypertension ambassadors in partnership with Flourish, and co-produced culturally competent training. This project has now commenced with a series of screening events occurring in the community- a total of 96 blood pressure checks have been taken at most recent report.

2. Prostate Cancer in Black Men – a project aiming to reduce inequalities in uptake to prostate cancer screening. Completed actions include collaboration with Prostate Cancer UK and Mindseye Development Men's group, community events including 'Movember' and a health focussed football match with onsite prostate cancer screening as well as CVD and diabetes checks, SMS invites with screening tools and booking information, GP and Nurse champions and community engagement events with Prostate Cancer UK.
3. Facilitated the development of maternity listening exercises and bidirectional conversation with our communities to improve maternal and infant mortality. This aims to ensure pregnant women feel heard, and the ICS is empowering them to looking after themselves, and their communities. Now working with BUMP, LMNS and infant mortality teams to address a joined-up service at locality level across the ICS.

3.2 Birmingham and Solihull (BSol) Primary Care

- A prototype database has been drafted and is ready to be circulated to a larger test group. The database aims to bring data showing the ethnicity breakdown from primary care networks (PCNs) and GPs together. The aim is to support PCN health inequality projects and project scale-up, further monitor ethnicity recording rates, and better inform contracting.
- EDI policies have been gathered from the system and two practice managers are looking at the policies to identify similarities, differences, and applicability to General Practice. This is due to be completed by December 2023.
- Health Inequalities and BLACHIR specific webpages are being developed on the ICB webpages. Initial write up is complete, and planned ICB comms meetings to complete next steps.

3.3 BSol ICB EDI team

- Inclusion & Belonging at BSol - Strategy Development and Accelerator Delivery in place. Work commencing with Leadership, Inclusive Recruitment and Culture workstreams. This work is aligned with the Big Conversation approach, and comms support has been agreed so that the draft strategy can be discussed at the People Committee in October.
- Embed fair and inclusive recruitment processes and talent management including improving diversity of executive and leadership teams, widen recruitment in communities, including career pathways and apprenticeship programmes.

3.4 Royal Orthopaedic Hospital

- Currently undertaking data analysis review of patient ethnicity on the Jointcare Pathway.
- The review of the National 10k Black Intern Programme: Evaluation has been completed and shared at the trust level, with links made to National NHS engagement team to look at opportunities to extend the programme.

3.5 Birmingham Community Healthcare (BCHC)

- BCHC will develop health literacy through letters in order to imbed Public Health messages. They will analyse the style of communication of diabetes service appointment letters to ensure that their written communication to patients and service users is accessible.
- Adult Community Services (ACS) to ensure culturally appropriate data collection and analysis for service planning, monitoring and evaluation that distinguishes by ethnicity and gender for Black African and Black Caribbean populations.
- To develop culturally specific and appropriate weaning support initiatives for Black African and Black Caribbean parents.

3.6 Local Maternity Neonatal Service (LMNS)

- Are aiming to achieve 20% attendance from the Global majority of Birmingham for perinatal pre booking classes within 12 months. This will be achieved using Maternity Link Support Workers via single point of access. Classes will support women to use the Badgernotes app to allow access to personalised care plans.
- Will look to increase the uptake of Folic Acid and Vitamins D amongst the Black African and Caribbean women of Birmingham within 12 months. This will be achieved using Maternity Link Support Workers via single point of access.

3.7 Next Steps: Looking forward, the ICS and system partners will be implementing the following:

- Training of CVD ambassadors to support increased hypertension case finding and support.
- Quarterly reports continue to be gathered from providers against their SMART goals to show progress and development.
- Funding has been secured by the ICB Health Inequality Team through the Challenge Fund, to allow continued chairing, a dedicated project manager and support for community engagement initiatives. This will allow the Task Force to continue to drive change forward, providing clear reporting and oversight.
- Developing approach across HI workstreams: data, system collaboration, community co-production, health literacy promotion. Pilot approaches have demonstrated how co-produced initiatives have the potential to become business as usual across communities and the system.
- Further engagement with community partners and local charities to find alignments and opportunities to support delivery of aims
- Deliver BSol EDI Best Practice Policy for Primary care

4 Delivery of the Key Priority Areas

The BCC BLACHIR Team has focused on delivery of the 7 priority areas, co-producing cross cutting strategic responses with relevant partners and community engagement partners. The 7 key priority areas, represent key enablers to support system-wide change and action on inequalities.

Of the 7 key priority areas, the following work has progressed to date.

4.1 Trust and Transparency

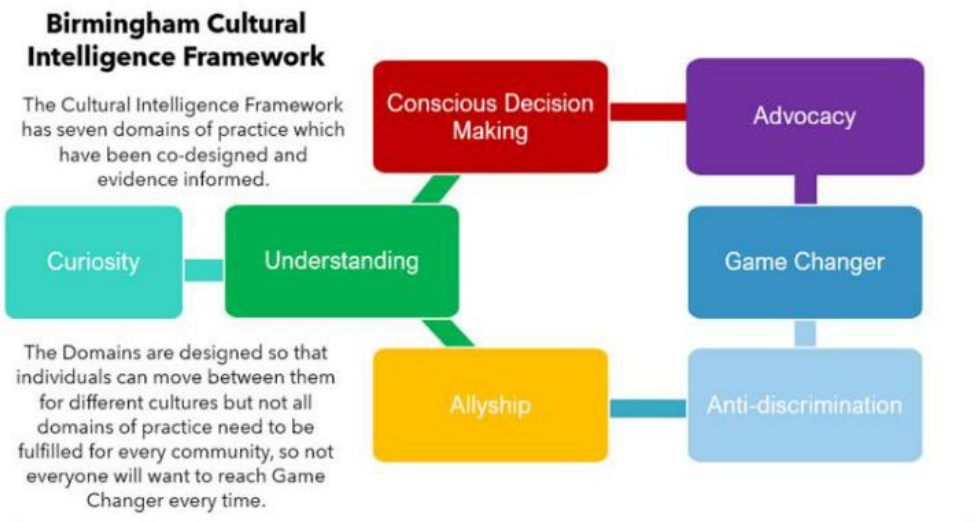
The first of thematic co-production groups for the 'Trust and Transparency' priority in the report focused on cultural competency as an umbrella term for developing culturally intelligent organisations and policies, and culturally humble and safe front-line practices. Two co-production sub-groups were created to progress this work.

- **Cultural Intelligence** aims to develop cultural competency at a strategic, leadership and population level.
- **Cultural Humility and Safety** aims to develop cultural competency at an interpersonal level.

4.1.1 Cultural Intelligence

The Birmingham Cultural Intelligence Framework (BCIF) is a toolkit to help individuals and organisations to develop, strengthen and evidence their deeper understanding and approach to enabling and empowering different communities of identity and experience. The Framework sets out seven domains of competence for cultural intelligence which individuals can work through using competency criteria and reflective practice templates and organisations can audit and evaluate to monitor and demonstrate progress. The draft framework has been produced and is shown in Figure 2, below. This included definitions, example activities to develop the competency, and a case study for each of the seven domains. The content for the domains was developed using findings from multiple evidence reviews and mapping of existing resources.

Figure 2.2: The Birmingham City Council Cultural Intelligence Framework



The BCIF has been tested out with public sector staff though a programme of workshops throughout October and November 2023.

The workstream is also working with student interns to further build the resource bank of tools to further support learning for different communities of identity and experience.

Next steps: Expression of interests have been advertised for organisations to apply to pilot the BCIF. It is aimed to recruit 3-5 partner organisations to pilot, refine and enhance the framework over a period of 12-18 months, starting May 2024. The pilot will focus on 10 specific communities of identity: 5 ethnic communities, 2 faith, 2 disability and 1 LGBTQ+. Staff members within Public Health will be required to complete 2 domains as part of their annual personal development plan. Public Health will also commission an independent evaluator for the BCIF. The evaluator will assess if, within the pilot, the framework is reaching its intended outcomes and is making a meaningful difference in comparison to already available EDI provisions.

4.1.2 Cultural Humility and Safety

The Birmingham Cultural Humility and Safety (CHS) quality improvement framework aims to standardise CHS training across the system, specifically acting to improve the quality and reach of the CHS training offer in Birmingham. The framework is designed for commissioners of CHS Training and providers who deliver the training. It aims to both provide a minimum standard of training, and also provide a framework to enable organisations to evaluate and further develop their training programmes through a process of continuous evaluation.

Initially an evidence review into CHS and CHS training informed the drafted framework. This included mapping out existing training provision and identifying the gaps in current provision. As well as this, the outcomes from the CHS co-production sessions were identified.

The draft framework firstly sets out a minimum standard of training through a skills and knowledge framework. This highlights the evidence-based essential characteristics, skills, knowledge that should be fostered for effective training. This also includes evidence-based tools and approaches that can be used to support and embed learning. Then, a framework is provided to enable organisations to evaluate and further develop their training programmes through a process of continuous evaluation. As the evidence for effective training and skills development in CHS is an emerging area, a continuous improvement approach has been taken to develop the framework.

In January 2024, the CHS draft framework was tested with Equality and Diversity leads across the ICS and with current training providers. The main feedback was to reduce the number of definitions; initially there were 10 separate categories, but attendees felt there was a lot of common themes and overlap between. The number of categories has now been reduced to 6. All feedback has been implemented into the CHS Framework and it is now ready for pilot.

Next steps: Expression of interests have been advertised for organisations to apply to pilot the CHS Framework. It is aimed to recruit 3-5 partner organisations to pilot, refine and enhance the framework over a period of 12-18 months, starting in May 2024. The CHS Framework aims to partner with a wide range of organisations including universities, hospital trusts, primary care, BCC departments, voluntary sector organisations, and others.

Alongside the pilot, all Public Health colleagues and at least one other Council Directorate with public-facing staff members will be offered CHS training. This will be delivered by a provider commissioned by Public Health.

An independent evaluator will also be commissioned for the CHS Framework. The aims for the evaluation are to:

- Determine how well the BCHSF is achieving its objectives and identify any areas for improvement.
- Capture the different ways the BCHSF is being implemented in organisations and identify good practice e.g. in terms of training packages used, managerial and organisational support in place.
- Understand the impact on trainees' knowledge, skills and confidence, and the impact of this on behaviour, and wider cultural competency.
- Understand who is engaging and who is not engaging and the reasons for this.
- Understand the value of CHS training in comparison to normal equality, diversity, and inclusion (EDI) provision

4.2 Better Data

A demographic monitoring questionnaire has been co-produced to strengthen granular culturally sensitive data collection (see Appendix 1.4). A set of standard demographic questions will be integrated into BCC data collection across core public health services including consultations, surveys and delivered, commissioned, or funded services. Questions were developed based on

national standard questions and modifications have been tested with a citizen involvement panel and agreed by the corporate leadership team (Nov 2023). Use of this monitoring questionnaire is also being promoted through the evolving Birmingham Data Charter and adopted through the ICS Fairer Futures Fund model.

The ICS Primary Care team have been working to improve ethnicity recording in primary care data. They have developed a dashboard to allow for greater interrogation of primary care data against ethnicity.

Next steps:

- Continue to develop and evolve these questions as we collaborate with citizens and partners to strengthen our understanding of diversity and inclusion in our city.
- Easy read and translated versions to be developed to increase accessibility and reach.

4.3 Health Checks and campaigns

NHS Health checks: The re-commission of NHS health checks was completed by the Adults Team in August 2023. This was followed by a rapid evidence review in October 2023 to identify best practice in relation to increased uptake from minority ethnic communities, including Black African and Black Caribbean communities. The review offered the following recommendations:

1. Community Outreach, Engagement and Education – Awareness of the programme, particularly its personal relevance has been highlighted as a barrier to NHS Health Checks attendance.
2. Increase accessibility of health checks
3. Administer multimethod invitations
4. Provide culturally and religiously sensitive approaches
5. Conduct ethnic-specific focus groups to better understand the barriers to NHS Health Checks and consider targeted pilot programmes to address the outcomes from the focus groups.

Public Health is commissioning a series of focus groups to better understand minority ethnic communities' perceptions of health checks, including the quality and accessibility of NHS Health Checks and how they are promoted. A provider will be commissioned for the 4 most populous Black African communities (Nigerian, Somali, Eritrean and Ghanaian) and the Black Caribbean community. Each focus group will have a minimum of 10 participants, which will also include elderly cohorts (those aged 65+). Each community provider will deliver 2 focus groups, which will present data on a total of 10 focus groups for Black African and Black Caribbean communities. Findings from focus groups will be embedded into new and existing providers of NHSHC.

Health Campaigns toolkit: the BLACHIR Team are developing a health campaigns toolkit which seeks to provide recommendations for targeted health campaigns for Black African and Black Caribbean communities. The toolkit will be informed by an evidence-base of what works well with Black African and Black Caribbean communities, while also collating examples of good practice of activity occurring around Birmingham.

Jamaican 60th Anniversary Celebration Events - Cardiovascular Disease and Diabetes

In September 2022, this project delivered workshops and cooking sessions which aimed to educate, celebrate, and inform local residents of Birmingham from the Caribbean, and specifically of Jamaican heritage about type 2 diabetes and cardiovascular diseases.

This project included interactive, informative, and engaging workshops that were tailored around Jamaican heritage and culture, for local residents in a culturally appropriate manner. The workshops were hosted and managed by Black female health professionals who were registered nutritionists and registered associate nutritionists. The project connected with Birmingham residents and helped build long-lasting connections in the area and created artistic outputs such as videos and images.

4.4 Healthy Behaviours and Health Literacy:

A faith toolkit has been developed to support the Faith sector in promoting healthier behaviours.

Culturally Diverse Health Eating Guides: The Public Health team commissioned partners to engage with health professionals and diverse communities across Birmingham including working-age individuals, various ethnicities, those with long-term health conditions, pregnant mothers, and expectant fathers to inform the development of diverse eating guidance. Culturally Diverse Healthy Eating Guides will utilise this intelligence to support healthy behaviours and to develop health literacy by providing tailored and easy to follow healthy eating guidance resources that are culturally diverse, adapted for different health conditions, and representing ingredients and diets from around the world.

Creative English Project - in 2022/23, Birmingham City Council funded FaithAction to deliver the Creative English Project which is a community-based programme delivered through local places of worship, faith-based and community organisations and uses practical themes such as shopping, talking to teachers, and going to the doctors to equip people with the skills they need to feel empowered and confident to speak English in their everyday life.

Creative English for Health Birmingham was tailored to promote learning about child and family health matters, accessing support and services, raising awareness, and building confidence for speakers of English as a second language. Key themes in the teaching include making the best use of your GP appointment, using NHS 111, vaccinations, dealing with minor ailments, types of pain, mental health and healthier living. The interim report outlines that 725 learners were engaged and registered onto the programme in 11 hubs. Learners demonstrated improvement in health literacy and a significant number demonstrated positive health behaviour change,
Due to the success, the project has been extended in 2023/24 and is focused on reducing cardio-vascular disease.

Next Steps:

The future proposal is to develop repository of good practice mapped to Healthier Behaviours and Health Literacy. Under this theme, the BLACHIR Team will also look at the importance of health literacy through lived experiences of the communities (Q3 2024- 2025).

4.5 Early Interventions:

Identify board lead and set up task and finish group to scope opportunities that captures the importance of Early Intervention through lived experiences of the communities and explore the option of commissioning a partner to collate good practice. To continue working with the ICS Infant Mortality Lead to improve maternity outcomes for Black women (Q2 2024-2025).

4.6 Fairness, Inclusion and Respect:

This key priority area is closely aligned to Trust and Transparency and aims to expose structural racism and discrimination. This recommendation was largely focused on the system formally recognising the role of racism and discrimination as a drivers of ill health and commit to identify and address it. This commitment has been demonstrated, for example, through the following work:

The Councils Everyone Battle, Everyone's Business programme sets out the Councils commitment to:

- Understand our diverse communities and embed that understanding in how we shape policy and practice across the Council
- Demonstrate inclusive leadership, partnership, and a clear organisational commitment to be a leader in equality, diversity, and inclusion in the city
- Involve and enable our diverse communities to play an active role in civic society and put the citizens' voice at the heart of decisionmaking
- Deliver responsive services and customer care that is accessible, inclusive to individual's needs and respects faith, beliefs, and cultural differences
- Encourage and build a skilled and diverse workforce to build a culture of equity and inclusion in everything we do

The action plan was refreshed for 2023.

Birmingham Racial Inequalities Group – The Integrated Care system signed up to 17 anti-racist pledges in response to BRIG's call to a range of sectors to make their contribution to making Birmingham an anti-racist city. Many of these pledges align to the BLACHIR opportunities for action and place additional emphasis on addressing structural racial inequalities.

5 Update from community engagement partners

Three local community engagement partners were commissioned to ensure implementation plans and solutions are co-produced with the communities affected by the review, and the local voice of lived experience is the key driving force. The engagement partners have continued to be active with the BLACHIR communities, disseminating the report and recruiting co-production partners. The Communities team will be reflecting on the learning from engagement to date and will use this to refine their approach to deep engagement and co-production with communities in 24/25. A market engagement event was held in December 2023 to discuss future engagement plans with voluntary sector organisations to inform the future engagement work. The plan is to commission deep engagement partners after the BLACHIR engagement partners contracts expire (March 2024). More information on this proposal and the partners who will be addressing BLACHIR-related actions is outlined below.

The following outlines each partners delivered activities:

5.1 Allies Network CIC

Allies Network CIC is the community engagement partner for the African Community. They are continuing to work across the system to address the 39 opportunities for action highlighted from the BLACHIR report.
A total of 4 community engagement session have been delivered on a variety of topics including:

1. Maternity, Parenthood, and Early Years
2. Mental Health and Wellbeing
3. Healthier Behaviours - Diabetes and CVD
4. Health Screenings.

These sessions were attended by 145 participants from the following African communities (Nigeria, South Africa, Ghana, Somalia, The Republic of Somaliland, Djibouti, Ethiopia, Kenya, Zimbabwe, Sierra Leone, Gambia, Guinea-Bissau, South Sudan, Morocco, Sudan, Uganda, Senegal, Tanzania, and Eritrea). Allies Network have also delivered a webinar hosted by BSol ICS, discussing addressing health inequalities through a co-produced solution with African communities. This included innovative approaches that bring together voices of Birmingham's African communities and healthcare experts. Allies Network have also participated in the University Hospitals Birmingham NHS Foundation Trust's (UHB) Maternity and Neonatal Event, discussing BLACHIR African Communities issues with maternity and Neonatal services.

Next steps: As outlined in their most recent update report, Allies Network planned to deliver another 5 community engagement workshops to cover the following topics:

1. Maternity, Parenthood and Early years – Maternity and Neonatal Safety Improvement Programme (MNIP) Cultural and Inclusion workstream
2. Aging Well & Emergency care – preventable mortality and long-term physical health conditions
3. Mental Health and Wellbeing
4. Learning Disabilities and Autism
5. Healthier behaviours – CVD awareness in communities.

5.2 Mindseye Development

Mindseye Development are the engagement partner for Young Black Males and Young Black Females. They have been a very active engagement partner and have been attending regular meetings of groups that work to address health inequalities for Black African and Black Caribbean citizens. These meetings include Men's Health and Wellbeing Group, Migration Network Health Meetings, The Turner Foundation and Flourish.

Mindseye development have completed a significant amount of work under each priority area, with examples including:

Early Interventions: Organising and delivering a maternity event with Dr Deepthi Jyothish, Senior Responsible Officer, Infant Mortality Strategy, BSol ICB as main speaker, with delegates drawn

from the community, the LMNS (including the Director), Public Health and the wider health care system. Mindseye Development have also co-produced a pre-conception checklist.

Health Checks and Campaigns: Attending the Targeted Lung Health Check Smoking Cessation meeting – the availability of, but inaccessibility to data was one of the themes discussed at this meeting. Mindseye Development also liaised with the Diabetes Ambassador on thematic review of diabetes letters under the Birmingham Community Health Care action plan.

Healthy Behaviours and Healthy Communities: Supporting organisation of the West Midlands' Chaplaincy health promotion event, including engaging community/voluntary sector exhibitors – Men's Health and Wellbeing Group, Focus Birmingham, OSCAR Birmingham and Healthwatch Birmingham.

Fairness, Inclusion and Respect: Facilitated a break-out discussion on health inequalities at the BRIG Housing Summit.

Next steps: In the most recent update report, the following 3 key themes were identified as the priority areas for November:

1. Maternity – ongoing contributions to maternity workstream
2. Prostate cancer – Mindseye Development are working with Aston Villa Foundation to organise a men's 5-a-side football event which also promotes awareness of prostate cancer.
3. Talent management – explore the value/potential for developing a programme of action to support this agenda.

5.3 Black Heritage Support Service (BHSS)

The Black Heritage Support Service is the community engagement partner for the Caribbean Community. They are working across the system to address the 39 opportunities for action highlighted from the BLACHIR report. Their previous update report has documented the activity they completed in previous months:

- July-Present: BHSS have implemented the trainee counselling service designed to support hidden and burdened individuals who are living in the city without any intervention. The service provides confidence to individuals who are less likely to access talking therapies. Their services cover a range of modalities e.g., relationships, social anxiety, and bereavement. They have identified and acted upon the need to provide trainee counselling opportunities, which provide accessible culturally adapted interventions.
- September: To collaborate with community partners, the team committed to build a relationship with the local group 'Twinsane Fitness.' The aim was to raise awareness, build presence and promote the upcoming conference to encourage attendance.
- October: BHSS promoted the Caribbean Health Exhibition at various Black History Month events. This included engaging with system partners via the ICS Task Force, GP Practices, Pharmacies, and other Community Interest Companies (CIC).

- November: Caribbean Health Exhibition: BHSS designed a Caribbean Health Exhibition to educate the Caribbean community with the tools they need to advocate for themselves effectively in healthcare. In addition, the community will receive a culturally adapted approach towards health in the Caribbean community. This will enable medical professionals and charitable organisations to engage with this community effectively. The exhibition is a response to the opportunity for actions under the theme ageing well, which highlights a need for culturally adapted approach to screening opportunities. The conference was designed to raise awareness as well as to challenge and educate the Caribbean community to improve their attendance of screening.

Next Steps:

- Continue engagement with churches and community organisations across the Birmingham and Sandwell area on the topic of dementia and memory loss.
- Develop opportunities to educate the community on the topic of infant mortality.
- Consult with the Caribbean community on how to adapt culturally appropriate hospice care at home.

5.4 Deep engagement partners – 2024/25

The Communities Team is embedding the Council's Powered by People Plan into their future engagement plans. The Plan outlines Birmingham City Council's commitment to support organisations, communities, and citizens to create change for themselves, improve the areas in which they live, shape the world around them, and enable everyone to play their part. The Team has taken the 6 themes of public participation (converse, inform, consult, involve, collaborate and empower) from the Powered by People Plan and has built a specification that ensures that all types of participation will be covered by each deep engagement partner. It is important to note however, that these methods are specific Public Health methods of engagement and therefore cannot be used for wider council engagement.

The Communities Team will be harnessing the knowledge of deep engagement partners to identify local need, map community assets, co-produce solutions, create awareness of the solutions and evaluate the impact of the solutions. The team will be commissioning five ethnic, three faith, two LGBTQ+ and three disability deep engagement partners. Two of the five ethnic communities include Black African and Black Caribbean populations who will be required to participate in BLACHIR-related projects. The overall aims of the engagement partners are to:

- Increase awareness on community experiences of health inequalities.
- Improve community health literacy.
- Enhance community capability for collective control of programme to address health inequalities.
- Bring the community voice, including seldom-heard voices, to strategy and policy development to address health inequalities more effectively.
- To utilise existing community strengths and capabilities to identify and provide solutions for the communities' health and wellbeing.

Specifically, the deep engagement partners will be:

- Delivering 4 focus groups a year to gather insight into the community over a wide range of health topics

- Disseminating key public health information within the community
- Delivering one health inequality project per year
- Upskilling staff members by accessing the Communities Team's Community Leadership Training and linking them to the Bolder Healthier Champions programme
- Contributing to the BCIF by providing resources which can be added to the intelligence library, and by offering access to the community for organisations who are piloting the BCIF.

Next steps:

The deep engagement partner proposal has been approved through the PPAR process in February 2024. The Communities Team are now working with Corporate Procurement to prepare a final Strategy Report and Invitation to Tender documents for an anticipated tender launch in March 2024. The partners should be secured by June 2024 and will be commissioned for a total of three-years.

6 Summary and next steps

The report has updated the Health and Wellbeing Board of the progress of BLACHIR implementation by the ICS, BCC and BLACHIR community engagement partners. There has been progress made in many areas of the project by the newly developed BLACHIR Team. The team has been well supported by the new independent co-chairs who have tightened processes and ensured better integration of BCC with the ICS and the engagement partners. The BLACHIR team have begun conversations with partners to discuss the future of BLACHIR and how learning and actions can be embedded and expanded across all ethnic groups experiencing inequalities in health outcomes. It is proposed that a workshop is delivered in September 2024 to bring together the BLACHIR taskforce, Board with Health and Wellbeing Board partners to agree the longer term approach to holding the system to account for ongoing efforts to address inequalities in our diverse communities.

Next steps: The key activity being delivered over the coming months includes:

1. Further development of key priority areas:
    a. **Trust and Transparency** – The Birmingham Cultural Intelligence and Cultural Humility and Safety frameworks will be piloted across 2024/25.
    b. **Better data** – Develop easy read and translated versions; commission focus groups and exploration of tribal identity questions in Q1 24/25
    c. **Health checks and campaigns** – Focus groups to be commissioned to assess minority ethnic communities' perceptions of health checks; develop a health campaigns toolkit.
2. End of project reports by the community engagement partners.
3. Work will commence in quarter 2 to plan the evaluation of the projects delivered within the BLACHIR programme.
4. System-wide workshop to explore how to embed and sustain the work of BLACHIR moving forward – September 24.

5. Compliance Issues

5.1 HWBB Forum Responsibility and Board Update

As per the agreed governance structure, we will provide an update to the Health and Wellbeing Board every 6 months throughout the duration of the implementation project. The update will include information on progress and will highlight any issues or risks that may hinder required outputs and outcomes that the health and wellbeing board may be able to help to address.

5.2 Management Responsibility

Dr Justin Varney - Director of Public Health, Birmingham City Council
Helen Harrison - Assistant Director, Birmingham City Council
Ricky Bhandal - Service Lead for Communities Team, Birmingham City Council
Dr Nike Arowobusoye - Independent Co-Chair for BLACHIR Implementation
Sola Afuape - Independent Co-Chair for BLACHIR Implementation
Joe Merriman - Senior Public Health Officer, Communities team
Vacant – Ethnic Disparities Public Health Officer, Communities team

5.3 Finance Implications

Funding for the BLACHIR project for financial year 23/24 has been supported by the COM-F fund which reserved £200,000 for BLACHIR spend. The Public Health budget also created a £100,000 budget line for BLACHIR activity.

5.31. The BLACHIR implementation is now supported through three BLACHIR-specific roles:

i. Two independent co-chairs from 17/07/2023 to 09/07/2024 at an approximated cost:

- financial year 23/24 - £46,260.57 per person (£92,521.14 total)
- financial year 24/25 - £18,141.40 per person (£36,282.80 total)

ii. One BLACHIR Senior Programme Officer from 21/08/2023 to 23/02/2024. *Total cost financial year £57,475.00*

5.32. The BLACHIR implementation is also supported through 3 community engagement partners at a total cost of £160,000 until the 31st of March 2024.

5.33. As part of the aim to explore citizens' perceptions of NHS Health Checks, Public Health will be funding 10 focus groups. Participants for the focus groups will be minority ethnic communities, including Black Africans and Black Caribbeans. The maximum spend for this will be £25,000.

5.4 Legal Implications

There are not currently any legal implications.

5.5 Equalities Implications (Public Sector Equality Duty)

The essence of the BLACHIR project is to reduce health inequalities affecting our Black African and Black Caribbean populations in the city. Many of the programmes under the key areas for action, such as the Cultural intelligence and humility will also have a wider equalities impact.

6. Risk Analysis			
Identified Risk	**Impact (0-5) and *score after mitigation***	**Probability (0-5) and *score of mitigation***	**Mitigation**
Progress on key priority actions - Some Task and Finish deadlines have not been met due to changes and vacancies in the BLACHIR team which has delayed the delivery of some actions, due to staffing changes (see below), this has the potential to impact reputationally with the local community.	3 *2*	5 *5*	Key actions are being put in place to pick up work on delayed deadlines, PH will continue to fund community engagement to ensure full development of all T&F products and are working with key stakeholders and citizens to keep them informed. Additional capacity has been put into the BLACHIR team and work is being closely aligned to the BCC EBEB and the Birmingham Race Inequalities Group pledges.
BCC Task Force meetings - BCC Task Force has not met due to staffing changes, so there is a risk of delay to the delivery of the opportunities for action related to BCC.	3 *2*	5 *4*	Actions have been mapped to the opportunities for action and work is being done and to consider how to align with other Council forums including the CCWIF and strategies included Everyone's Battle, Everyone's Business.
Community engagement - There is a risk that communities are not given the opportunity to be fully engaged in all co-production stages when delivering priority area products. The contracts with the current community partners ends in March 2024.	5 *3*	4 *2*	Continue to work with community engagement partners and agree forward plan of engagement requirements. Explore options for ongoing commissioning of engagement partners.
Impact of section 114 on delivery - There is a risk that the financial climate within BCC impacts on delivery. There is the risk that it may limit the capacity of some colleagues to engage	5 *4*	4 *3*	Systems and processes are in place to ensure projects can continue, advance planning by the BLACHIR team will ensure continuity, however, we do need to recognise that the timelines may be impacted in order to maintain quality and impact.

with BLACHIR activity due to pressures of delivery on savings targets			

Appendices
1.1 BLACHIRIB terms of reference 1.2 39 Opportunities for Action 1.3 BLACHIR Report Template 1.4 BCC Standard Demographic Questionnaire

Background Papers
The Birmingham and Lewisham African and Caribbean Health Inequalities review-BLACHIR Report

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

- **Flo Hobbs -** Public Health Graduate, Healthy Behaviours and Communities
- **Helen Harrison** - Assistant Director, Healthy Behaviours and Communities
- **Dr Justin Varney,** Director of Public Health
- **Ricky Bhandal** - Service Lead for Communities Team, Birmingham City Council
- **Nonso Nwaiwu -** Senior Public Health Officer, BLACHIR
- **Joe Merriman -** Senior Public Health Officer, Communities team
- **Dr Onyi Okonkwo** – Chair of BSol ICS BLACHIR Taskforce

Birmingham City Council Task force **Appendix 2**

Terms of Reference

Background

Birmingham City Council and Lewisham Council completed a review of health inequalities affecting the Black African and Black Caribbean communities in Birmingham and Lewisham. The Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR) has been endorsed by both Lewisham and Birmingham's health and wellbeing boards. The report was published in March 2022. Both Councils are now working with partners in their localities to implement the opportunities for action identified by the review. The BLACHIR implementation board is charged with the responsibility of implementing the overarching plan. The BLACHIR BCC task force will report to the BLACHIR implementation board and ensure that relevant opportunities for action and findings from the review are implemented within the Council.

1. Purpose

1.1 The Birmingham City Council (BCC) BLACHIR task force alongside the Integrated Care Systems BLACHIR taskforce are sub-groups of the BLACHIR implementation board, which reports to the Creating City without Inequalities forum (CCWIF) and the Birmingham Health and Wellbeing Board.

1.2 The BCC BLACHIR task force will drive and monitor the implementation of the BLACHIR findings and opportunities for action within the Council.

2. Objectives

The task force has the following objectives:

2.1 To work in collaboration within the council using the 39 opportunities for action from the BLACHIR report as a framework for effecting the required change.

2.2 To identify risks and develop and deliver an action plan to ensure that BLACHIR opportunities for action are being achieved across the whole Council.

2.3 To develop mechanisms for monitoring and reviewing progress against the implementation plan within the Council.

2.4 To influence relevant BCC teams and ensure their commitment, shared responsibility, and accountability towards the delivery on the opportunities for actions.

2.5 To provide operational direction for the BLACHIR implementation programme within the Council; seek alignment with other BCC programs, boards, and partnerships relevant to the work.

2.6 To ensure effective engagement to support the work to embed best practice within BCC teams and communities.

3. Principles

The task force expects all members to:

3.1 Commit to co-develop delivery plans and lead on the implementation of the BLACHIR opportunities for action within their Team, Division or Directorate, as per the delegated authority by their Director, and share / report on their progress to the taskforce.

3.2 Support the aims and objectives of the task force to progress work focused on achieving the required change and tangible outcomes relating to the implementation of the BLACHIR opportunities for action and prevention of further exacerbation of inequalities faced by Black African and Black Caribbean people in Birmingham.

3.3 Consult and/or inform the task force of team changes (including any changes in representation) that may impact on collective working.

3.4 Follow and work within the performance management framework to review and monitor progress as agreed by the BLACHIR Implementation Board and CCWIF.

3.5 Proactively manage risk and acknowledge the principle of shared risk in the context of partnership working.

3.6 Drive the BLACHIR agenda within the council through promoting service transformation and improvement within their respective teams.

3.7 Report on progress on allocated/ agreed actions in a timely manner.

3.8 Share relevant information and promote collaborative and innovative work.

4. Membership

4.1 The task force will have a core group of representatives from key teams within the Birmingham City Council that will have the responsibility to monitor the implementation of BLACHIR opportunities for action across various teams within the Council.

4.2 The membership of the BCC BLACHIR taskforce is listed in appendix 1

4.3 The task force requires its members to:

- Have sufficient delegated authority to make decisions in relation to the BLACHIR implementation programme on behalf of their Team, Division or Directorate.
- Attend all meetings, or in exceptional circumstances, to arrange for a suitable named delegate to attend in their place. In case of delegating, the nominee should be appropriately briefed prior to attending the meeting and have sufficient delegated authority to make decisions on behalf of their Team, Division or Directorate.
- Represent the views of their nominating team, to keep their nominating Team, Division, or Directorate to keep them informed about progress and to communicate the outcomes of the task force meetings to their various teams.

4.4 The membership of the task force may be reviewed as necessary. New members maybe invited provided that:

4.4.1 The member is a member of a Team or Division within BCC who is in a position to drive the implementation of the relevant BLACHIR opportunities for action within their Team, Division or Directorate.

4.4.2 any new member can demonstrate to the satisfaction of the task force the contribution that they can make to the overriding aims and objectives; and

4.4.3 in deciding whether to admit any new member, the task force shall consider the resulting size and composition were the new member to be admitted.

4.5 Other persons may attend task force meetings and or be invited in as expert advisors with the agreement of the co-chairs.

5 Meetings (Frequency and Support)

5.4 The task force will meet every month for 1 hour. Other special meetings may be held as deemed necessary at the discretion of the co-chairs.

5.5 Members will be requested to contribute agenda items in advance of the meetings.

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

5.7 Action notes of all meetings of the task force will be circulated within 10 working days following the meeting.

5.8 The task force support will be provided by Public Health Inclusion Health Team.

5.9 The taskforce will be monitored and accountable to the BLACHIR Implementation board and the Creating a City without Inequality Forum, a sub forum of the Health and Wellbeing Board with reporting arrangements as follows (see overleaf):

6 Decisions and escalation

6.4 Any recommendations and decisions commensurate with the task force remit will be arrived at by consensus and recorded in the action notes.

6.5 Significant decisions and risks impacting on the progress of the implementation will need to be escalated to the BLACHIR Implementation Board or CCWIF when necessary.

7 Conflicts of Interest

7.4 Whenever a representative has a conflict of interest in a matter to be decided at a meeting of the task force, the representative concerned shall declare such interest at or before discussions begin on the matter, the Chair shall record the interest in the minutes of the meeting and unless otherwise agreed by the task force that representative shall take no part in the decision-making process.

8 Review

8.4 These terms of reference will be reviewed annually, considering views expressed by relevant partner agencies.

Appendix 1

BIRMINGHAM CITY COUNCIL TASKFORCE MEMBERSHIP FOR BLACHIR

Representative Role/Organisation	Name	Email address
Co-Chair	Marcia Reid – Team leader, Child employment	marcia.reid@birmingham.gov.uk
Youth Deputy Chair	Victor Agbontean – former advisory board member, CCWIF youth member	Victoragbontean5@gmail.com
Representative from Housing, BCC	Helen Shervington - - Housing Strategy & Modernisation Service Manager/ Birmingham Financial Inclusion Partnership Deputy Lead	helen.shervington@birmingham.gov.uk
Representative from Community Safety BCC	Pamela Powis (tbc)	Pamela.powis@birmingham.gov.uk
Representative from Birmingham Children's Trust	Lorraine Donovan - Equalities and Diversity Manager	lorraine.donovan@birminghamchildrenstrust.co.uk
Representative from Knowledge, Evidence and Governance BCC	Rebecca Howell-Jones – Service Lead, Knowledge	rebecca.howell-jones@birmingham.gov.uk
Representative from Adults and Social Care	Maria B Gavin – Assistant Director, Quality and Improvement	maria.b.gavin@birmingham.gov.uk
Representatives from BLACHIR Team	Nonso Nwaiwu – Programme Senior Officer Pamela Okakpu – Public Health grad	Nonso.nwaiwu@birmingham.gov.uk Pamela.okakpu@birmingham.gov.uk
Representative from children and families directorate, including education and skills BCC	Razia Butt - Independent Education Adviser • Education & Skills Juliet Faulkner - Senior Youth Worker • Education & Skills	razia.butt@birmingham.gov.uk juliet.c.faulkner@birmingham.gov.uk
Digital and customer services	Junior Bucknor – Team manager (tbc)	Junior.Bucknor@birmingham.gov.uk
Citizen Involvement Officer Digital and Customer Services	Simon Furze – Citizen Involvement Officer	Simon.Furze@birmingham.gov.uk
Representative from PH Communities team, BCC	Joseph Merriman – Program Senior Officer Ricky Bhandal – Service Lead	Joseph.merriman@birmingham.gov.uk Ricky.bhandal@birmingham.gov.uk

Representative, PH health protection team, BCC	Helen Bissett – Program senior officer	Helen.Bissett@birmingham.gov.uk
Representative from the PH Adults team, BCC	Juliet Grainger – Service Lead David Miller – Senior Officer	Juliet.Grainger@birmingham.gov.uk David.M.Miller@birmingham.gov.uk
Representative from PH CYP team, BCC	Joann Bradley – Service lead Kathy Lee – Program senior officer	Joann.Bradley@birmingham.gov.uk Kathy.Lee@birmingham.gov.uk
Representative from Equalities and Cohesion, BCC	Suwinder Hundal – Head of BCC equalities and cohesion Arif Sain – EDI lead on delivery	Suwinder.Hundal@birmingham.gov.uk Arif.Sain@birmingham.gov.uk
Representative from the public health directorate	Justin Varney – Director of Public Health Helen Harrison – Assistant director	Justin.varney@birmingham.gov.uk Helen.harrison@birmingham.gov.uk
HR & OD	tbc	

Item 9 – Appx 3 – BLACHIR 39 Opportunities for Action

Theme	Opportunities for action	ICS or BCC Task Force	Proposed BCC Lead Team	Proposed ICS Lead Team	Action lead(s)	Contact details	SMART Goal	Progress against SMART goal	Any support required	Additional info
Racism and Discrminati-on	1. Pilot the removal of the colour language from ethnic coding and evaluate the impact on participation and experience of data collection.	BCC	PH (DPH, ADPH and PH Grads)	N/A	Justin Varney	justin.varney@birmingham.gov.uk	Demographic monitoring questionnaire has been created and to be embedded in PH service and wider BCC. Evaluate impact of questionnaire in wider use	Questionnaire has been co-developed and will be taken through to core BCC services		
	2. Pilot the integration of discrimination and racism into the approaches to adverse childhood experiences and recognise this both in the assessment of children's needs and in the design of interventions to mitigate these adverse impacts	BCC	Director Children and Families BCC & Birmingham Children's Partnership?	N/A						
	3. Review staff equality and diversity training to ensure that this is a core part of the delivery of training, co-delivered by diverse individuals with lived experience	ICS and BCC	PH - Deputy Director and Workforce Development Team?	Equality, Diversity and Inclusion Team - Birmingham and Solihull ICB			1. Consider embedding cultural humility framework in mandatory staff training once tested and piloted? (BCC) 2. The ICS EDI Strategy is being developed and is planning to embed key BLACHIR themes	2. The launch of the Strategy is set for Autumn		
	4. Work with education partners for all ages and local communities to explore how ethnic diversity can be further integrated into education to reflect the diverse cultures and various	BCC	Director Children and Families BCC & Birmingham Children's Partnership	N/A						

Theme	Opportunities for action	ICS or BCC Task Force	Proposed BCC Lead Team	Proposed ICS Lead Team	Action lead(s)	Contact details	SMART Goal	Progress against SMART goal	Any support required	Additional info
	perspectives of history and experience.									
Maternity, parenthood, and early years	5. Address any gaps in existing Maternity and Paediatric Health Professionals' training including topics on cultural awareness, learning from lived experience, awareness of inclusion practices and policies, and awareness of trauma caused by racism and discrimination and how to deliver sensitive care.	ICS	N/A	Birmingham Women's and Childrens Hospital; Bsol LMNS; BSol All age Immunisations and Vaccinations			1. 10% of workforce undertaking culturally approporiate training (Birmingham Women's and Children's) 2. Achieving a 20% attendance rate of new bookers from a global majority background for parental pre-booking classes (Bsol LMNS) 3. Improve avoidable illnesses and increase levels of health protection and well being by targeting low uptake wards and communities thereby improving health inequalities and health outcomes. (BSol All age Immunisations and Vaccinations)			
	6. Co-design online tool with communities to collect information on beliefs, cultural practices and traditions from ethnic groups. This resource could then be used for training to inform practice and communication with patients and service users.	ICS	N/A	ICS - Team TBC						
	7. Improve data collection by specific ethnicity in maternity and early years services considering the differences in ethnic background and nationality. Work with professionals	ICS	N/A	BSol All age Immunisations and Vaccinations			Improve avoidable illnesses and increase levels of health protection and well being by targeting low uptake wards and communities thereby improving health inequalities and health outcomes. (BSol All age Immunisations and Vaccinations)			

Theme	Opportunities for action	ICS or BCC Task Force	Proposed BCC Lead Team	Proposed ICS Lead Team	Action lead(s)	Contact details	SMART Goal	Progress against SMART goal	Any support required	Additional info
	who represent the ethnic minority groups to ensure a sensitive approach when collecting data.									
	8. Support all women who are migrants, refugees, and asylum seekers, particularly those with no access to public funds, to access appropriate care during and post pregnancy, through appropriate support and protecting them from relocation or eviction	ICS	N/A	1. University Hospitals Birmingham 2. Bsol LMNS 3. BSol All age Immunisations and Vaccinations			1. To deliver against the 900 recommendations in the Maternity and Neonatal Improvement Programme (University Hospitals Birmingham) 2. Reduce infant mortality rates among women from global majority backgrounds, particularly those with no access to public funds within the next 12 months, by providing comprehensive support and empowerment throughout their maternity journey. (BSol LMNS) 3. Improve avoidable illnesses and increase levels of health protection and well being by targeting low uptake wards and communities thereby improving health inequalities and health outcomes. (BSol All age Immunisations and Vaccinations)			
	9. Develop culturally specific and appropriate weaning support initiatives for Black African and Black Caribbean parents.	ICS	N/A	ICS - Team TBC						
Children and Young People	10. Provide guidance and support for Black African and Black Caribbean parents and young people on applications and transition to secondary school and further education, including online information, support liaison officers, summer	ICS	N/A	Sandwell and West Birmingham NHS Trust			At least two social prescribing meetings to be set with the support of Flourish, across the next year, to support Black families with their child's education.			

Theme	Opportunities for action	ICS or BCC Task Force	Proposed BCC Lead Team	Proposed ICS Lead Team	Action lead(s)	Contact details	SMART Goal	Progress against SMART goal	Any support required	Additional info
	schools on core subjects and finance advice.									
	11. Commission and develop culturally appropriate and accessible services, including schools-based support, for Black African and Black Caribbean young men and women to increase capability, capacity and trust to engage with services. This should be specifically actioned for mental health services and for sexual and reproductive health services and take into account issues around gender exploitation and gender based violence.	ICS	N/A	1. Developing ICS skills and scaling up 2. Vulnerable populations			1. Supporting the investment in the COVID workforce in support of dialogue, vaccine confidence and Health and Well Being conversations in our most deprived communities /aligned to low uptake. (Developing ICS skills and scaling up) 2. Supporting community groups with specific well being sessions and preventable health care/early intervention offers (vulnerable populations)			
	12. Review educational approach and opportunity for targeted intervention to increase academic achievement for Black African and Black Caribbean children and young people	ICS	N/A	Sandwell and West Birmingham NHS Trust			At least two social prescribing meetings to be set with the support of Flourish, across the next year, to support Black families with their child's education.			

Theme	Opportunities for action	ICS or BCC Task Force	Proposed BCC Lead Team	Proposed ICS Lead Team	Action lead(s)	Contact details	SMART Goal	Progress against SMART goal	Any support required	Additional info
	13. Address low pay and associated poverty for frontline workers who are of Black African and Black Caribbean ethnicity.	ICS	N/A	1. Equality, Diversity and Inclusion Team - Birmingham and Solihull ICB 2. Birmingham and Solihull Mental Health NHS Foundation Trust			1.a Create and implement a talent management plan to improve the diversity of executive and senior leadership teams (by June 2024) and evidence progress of implementation (by June 2025) (Equality, Diversity and Inclusion Team - Birmingham and Solihull ICB) 1.b Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan. This should include the creation of career pathways into the NHS such as apprenticeship programmes and graduate management training schemes (by October 2024). (Equality, Diversity and Inclusion Team - Birmingham and Solihull ICB) 1.c Impact should be measured in terms of social mobility across the integrated care system (ICS) footprint. (Equality, Diversity and Inclusion Team - Birmingham and Solihull ICB) 2. Closing the shortlisting gap between global majority and white applicants, who are 1.3 times more likely to be shortlisted. (Birmingham and Solihull Mental Health NHS Foundation Trust)			
	14. Work with trusted community centres and spaces to provide violence-free, accessible, and attractive youth provision for access to wider opportunities, including through existing contracts and partnerships with Black-owned businesses and leaders.	BCC	Director Children and Families BCC & Birmingham Children's Partnership	N/A						

Theme	Opportunities for action	ICS or BCC Task Force	Proposed BCC Lead Team	Proposed ICS Lead Team	Action lead(s)	Contact details	SMART Goal	Progress against SMART goal	Any support required	Additional info
	15. Collaborate with Black African and Black Caribbean communities and their leadership on addressing air quality issues and continue with the in-depth work already in place with explicit consideration of these communities	BCC	Inclusive Growth	N/A	Sally James	sally.james@birmingham.gov.uk	Focus groups that includes Black African and Black Caribbean citizens that raises awareness on air quality, why air quality is important to people and what people can do about poor air quality (estimated March 2024)			
	16. Put in place interventions for Black African and Black Caribbean children and young people that address specific inequalities (e.g. sickle cell disease services), ensuring proportionate targeting and equality assessments of whole population interventions for issues they are disproportionately impacted by (e.g. low traffic neighbourhoods and school streets).	ICS	N/A	University Hospitals Birmingham			Roll out of training on Sickle Cell via Early learning for healthcare (Elfh) Moodle package to senior clinical decision makers by October 2023			
Ageing well	17.Provide targeted and culturally appropriate screening services for Black African and Black Caribbean older adults.	NHS England through BCC-PH	NHS England (through BCC-PH)	N/A	Juliet Grainger	juliet.grainger@birmingham.gov.uk	Commission focus groups including Black African and Black Caribbean people (including those aged 65+) eligible for health checks, to obtain feedback of experiences of health checks of Black African and Black Caribbean citizens by March 2024			

Theme	Opportunities for action	ICS or BCC Task Force	Proposed BCC Lead Team	Proposed ICS Lead Team	Action lead(s)	Contact details	SMART Goal	Progress against SMART goal	Any support required	Additional info
	18. Campaign to raise awareness and increase uptake of community-based NHS health checks in Black African and Black Caribbean older adults.	NHS England through BCC-PH	NHS England (through BCC-PH)	N/A	Juliet Grainger	juliet.grainger@birmingham.gov.uk	Commission focus groups including Black African and Black Caribbean people (including those aged 65+) eligible for health checks, to obtain feedback of experiences of health checks of Black African and Black Caribbean citizens by March 2024	DPH and spend control submitted, Adults and BLACHIR Team meeting to outline specification	Supported by Nonso Nwaiwu and Joe Merriman	
	19. Assess the availability of culturally aware services for mental health and evaluate current services to determine how they meet the needs of older Black African and Black Caribbean adults.	ICS	N/A	Birmingham Community Health Care		-	1. To analyse the style of communication of the Diabetes service appointment letters. Liaising with Aston university to agree timescales, and to ensure that our written communication to patients and service users is accessible 2. Thematic review of diabetes letters. BCHC to develop health literacy through our letters in order to imbed Public Health messages. To analyse the style of communication of the Diabetes service appointment letters to ensure that our written communication to patients and service users is accessible.			
	20.Support initiatives to improve uptake of vaccinations in older Black African and Black Caribbean people, focusing on areas of higher deprivation.	ICS	N/A	1. BSol All age Immunisations and Vaccinations 2. Professionals uptake 3. Developing ICS skills and scaling up 4. Vulnerable populations 5. Avoidable illness and			1. Improve avoidable illnesses and increase levels of health protection and well being by targeting low uptake wards and communities thereby improving health inequalities and health outcomes. (BSol All age Immunisations and Vaccinations) 2a. Engagement through ASC locality fora (6 fora) (professionals uptake) 2b. Ensure collaboration with LA colleagues via existing governance structures 2c. Improvement over the previous year for frontline health and social care staff in % 3. Supporting the investment in the COVID workforce in support of dialogue, vaccine confidence and			

Theme	Opportunities for action	ICS or BCC Task Force	Proposed BCC Lead Team	Proposed ICS Lead Team	Action lead(s)	Contact details	SMART Goal	Progress against SMART goal	Any support required	Additional info
				health protection 6. Health promotion			Health and Well Being conversations in our most deprived communities /aligned to low uptake. 4. Supporting community groups with specific well being sessions and preventable health care/early intervention offers (vulnerable populations) 5. Promoting and developing the revised primary care offer for expanded cohorts and health promotion campaign (avoidable illness and health protection) 6. Development of an all age comms campaign segmented by the audiences we serve (health promotion)			
	21. Use life course approach and consider relevant findings from this Review to develop interventions that help to mitigate health inequalities experienced by Black African and Black Caribbean older people.	ICS	N/A	University Hospitals Birmingham		-	Roll out of training on Sickle Cell via Early learning for healthcare (Elfh) Moodle package to senior clinical decision makers by October 2023			
Mental health & wellbeing	22. Coproduce awareness campaigns for Black communities to promote a better understanding of different mental illnesses, facilitate early interventions and self-referral in collaboration with carers, families, health services, community and faith centres.	BCC	PH Mental Wellbeing	N/A	Jane Itangata	jane.itangata@birmingham.gov.uk	Ensure that Black African and Black Caribbean communities are included as part of the coproduction of the Mentally Healthy City Strategy for Birmingham by including BLACHIR community engagement partners. The Suicide Prevention strategy will be developed by October 2024 with the overall strategy to be completed by April 2025,"			

Theme	Opportunities for action	ICS or BCC Task Force	Proposed BCC Lead Team	Proposed ICS Lead Team	Action lead(s)	Contact details	SMART Goal	Progress against SMART goal	Any support required	Additional info
	23. Ensure practitioners use culturally competent (cultural understanding) trauma informed patient-centred engagement styles and interventions.	ICS	N/A	Birmingham and Solihull Mental Health NHS Foundation Trust		-	Achieve 10% organisation takeup of cultural competency toolkit			
	24. Ensure mental health workers acknowledge service users' personal histories of racism and recognise them as trauma to enable more effective intervention.	ICS	N/A	ICS - Team TBC		-				
	25. Promote cultural competency training within healthcare services, the criminal justice system, and the police force.	ICS	N/A	1. University Hospitals Birmingham 2. Sandwell and West Birmingham NHS Trust 3. BSol All age Immunisations and Vaccinations		-	1a. Roll out of training on Sickle Cell via Early learning for healthcare (Elfh) Moodle package to senior clinical decision makers by October 2023 (University Hospitals Birmingham) 1b. To increase clinical staff awareness of patient cultural heritage by rolling out training across clinical areas (University Hospitals Birmingham) 2. For the next year the number of hospital staff that should be trained should be 30% or more, starting with high conflict areas such as ED & Maternity and then onto AMU and onwards. (Sandwell West and Birmingham Trust) 3. Improve avoidable illnesses and increase levels of health protection and well being by targeting low uptake wards and communities thereby improving health inequalities and health outcomes. (BSol All age Immunisations and Vaccinations)			

Theme	Opportunities for action	ICS or BCC Task Force	Proposed BCC Lead Team	Proposed ICS Lead Team	Action lead(s)	Contact details	SMART Goal	Progress against SMART goal	Any support required	Additional info
	26. Apply the use of culturally competent language, including using language that considers stigma within communities, such as 'wellbeing' rather than 'mental health'.	BLACHIR-IB	TBC	TBC		-				
Healthier behaviours	27. Work with Black African and Black Caribbean communities and organisations to co-create and deliver culturally appropriate and accessible support on positive health behaviours including health literacy training, social prescribing initiatives and group interventions.	ICS	N/A	1. Birmingham Community Health Care 2. BSol All age Immunisations and Vaccinations		-	1. Adult Community Services (ACS) to work with Black African and Black Caribbean communities and organisations to co-create and deliver culturally appropriate and accessible support on positive health behaviours, including health literacy training, social prescribing initiatives and group interventions. Outcomes: increased patient satisfaction and contribution to individual care and services provision 2. Improve avoidable illnesses and increase levels of health protection and well being by targeting low uptake wards and communities thereby improving health inequalities and health outcomes. (BSol All age Immunisations and Vaccinations)	Deep engagement partners specification developed		
	28.Explicitly recognise racism and discrimination as a driver of ill health and put in place training and systems to enable trauma-informed practice and services.	HEE (through BCC-PH)	HEE (through BCC-PH)	N/A		-				
	29.Provide long-term investment for trusted Black African and Black Caribbean grass roots organisations such	ICS	N/A	BSol All age Immunisations and Vaccinations		-	Improve avoidable illnesses and increase levels of health protection and well being by targeting low uptake wards and communities thereby improving health inequalities and health			

Theme	Opportunities for action	ICS or BCC Task Force	Proposed BCC Lead Team	Proposed ICS Lead Team	Action lead(s)	Contact details	SMART Goal	Progress against SMART goal	Any support required	Additional info
	as faith groups, schools, voluntary and community sector organisations to deliver community-led interventions.						outcomes. (BSol All age Immunisations and Vaccinations)			
	30. Work with faith settings to understand and utilise the positive role faith plays in healthier behaviour decision making.	ICS and BCC	PH & Equalities team	BSol All age Immunisations and Vaccinations	Ricky Bhandal	ricky.bhandal@birmingham.gov.uk	1. Production of Healthy Faith Settings Toolkits following feedback from faith engagement partners by January 2024 and commission deep engagement partners (faith) by April 2024 (BCC) 2. Improve avoidable illnesses and increase levels of health protection and well being by targeting low uptake wards and communities thereby improving health inequalities and health outcomes.	Toolkits have been sent to Design Team for final design		
	31. Address the evidence deficit in interventions for Black African and Black Caribbean communities through targeted investment in research, including capacity and skills development for community providers in 'action research' to concurrently deliver and evaluate interventions.	ICS and BCC	PH - Communities Team	BSol All age Immunisations and Vaccinations	Ricky Bhandal	ricky.bhandal@birmingham.gov.uk	1. Deep engagement partners will be supported with an academic partner who will support them in insight research and PH evaluation 2. Improve avoidable illnesses and increase levels of health protection and well being by targeting low uptake wards and communities thereby improving health inequalities and health outcomes.	Deep engagement partners specification developed		
	32. Undertake insight research with members of smaller Black African and Black Caribbean populations (e.g. Somali, Ethiopian and Eritrean) to understand health literacy needs.	BCC	City Observatory & PH	N/A	Ricky Bhandal	ricky.bhandal@birmingham.gov.uk	Co-production of kickstart projects to address health inequalities and gathering insight on Nigerian, Somali and Caribbean populations in response to Community Health Profiles	Work is being delivered and all contracts will be complete by February 2024		

Theme	Opportunities for action	ICS or BCC Task Force	Proposed BCC Lead Team	Proposed ICS Lead Team	Action lead(s)	Contact details	SMART Goal	Progress against SMART goal	Any support required	Additional info
Emergency care, preventable mortality and long-term physical health conditions	33. Ensure culturally appropriate data collection and analysis for service planning, monitoring and evaluation that distinguishes by ethnicity and gender for Black African and Black Caribbean populations	ICS	N/A	1. Birmingham Women's and Children's Hospital 2. Primary Care - Birmingham and Solihull ICB 3. University Hospitals Birmingham		-	1. Health Dashboard on key health inequalities to develop a standardised approach to culturally appropriate data collection (Birmingham Women's and Childrens Hospital) 2. Development of database (with PCNs meeting lower recording threshold supported to meet upper threshold) (Primary Care - Birmingham and Solihull ICB) 3. Achieve a reduction of 10% of DNA amongst BME groups by April 2024 (University Hospitals Birmingham)			
	34. Ensure that the engagement of Black African and Black Caribbean communities is meaningful and valued. This should include direct engagement and collaboration with representative organisations that is done in a way which is respectful, transparent and accessible, and considers and values participants' time and commitments. Mechanisms for doing this could include:	BCC	PH - Communities and Inclusion Health	N/A	Ricky Bhandal	ricky.bhandal@birmingham.gov.uk	Deep engagement partners will be adopting the Powered by People Plan in engaging with communities. Faith and ethnic partners to be commissioned by April 2024	Deep engagement partners specification developed		
	35. Ensure prevention services are fair, appropriate and consider the needs of Black African and Black Caribbean populations, and	BCC	PH - BLACHIR Team		Nonso Nwaiwu	nonso.nwaiwu@birmingham.gov.uk	Creation of health campaigns toolkit that outlines how to target health interventions at Black African and Black Caribbean citizens			

Theme	Opportunities for action	ICS or BCC Task Force	Proposed BCC Lead Team	Proposed ICS Lead Team	Action lead(s)	Contact details	SMART Goal	Progress against SMART goal	Any support required	Additional info
	there is proactive work to address issues with health literacy.									
Wider determinants of health	36. Consider cultural and religious influences when developing interventions to address the wider determinants of health inequalities for Black African, Black Caribbean and Black-Mixed ethnic minority groups.	BCC	DPH & PH inequalities/Inclusion health		Ricky Bhandal	ricky.bhandal@birmingham.gov.uk	Commissioned deep engagement partners for faith and ethnic communities that will include Black-ethnic groups by April 2024	Deep engagement partners specification developed		
	37. Collaborate with government agencies and institutions to remove issues ethnic minorities face when in contact with the justice system and ensure these agencies work to address health inequalities.	BCC	PH - Inclusion Health		Monika Rozanski	monika.rozanski@birmingham.gov.uk				
	38. Conduct more research to understand the impacts of the food environment and food poverty on health and wellbeing of Black African and Black Caribbean communities, and devise strategies to address the structural issues at a community level.	BCC	PH - Food		Sarah Pullen	sarah.pullen@birmingham.gov.uk	1. Share guidance on culturally appropriate foods and food parcels available at food banks, including if people receiving these food parcels are aware of preparing and cooking with these foods items (completed) 2. Creation of Black African and Black Caribbean Eatwell Guides within 24/25 (to be explored if this is 1 guide for both or 2 individual guides (1) African and (2) Caribbean	Initial drafts to be piloted with community organisations in 24/25 - gain feedback on suitability of Eatwell Guides		

Theme	Opportunities for action	ICS or BCC Task Force	Proposed BCC Lead Team	Proposed ICS Lead Team	Action lead(s)	Contact details	SMART Goal	Progress against SMART goal	Any support required	Additional info
	39. Take action to address employment inequalities and issues around racism and discrimination in the public sector. Offer more protection for key workers from Black African, Black Caribbean and Black-Mixed ethnic backgrounds in health or other highrisk occupations.									

Birmingham City Council

BLACHIR IMPLEMENTATION HIGHLIGHT REPORT

Please complete and report form to Nonso.Nwaiwu@birmingham.gov.uk

Stream Project Name	**Pick tick box.** ICS BLACHIR taskforce ☐ BCC BLACHIR taskforce ☐ Key Action Lead ☐ Community engagement partner☐			
Report Owner			**Period Covered**	
Project Outline				
Project Manager			**Report Date**	
Summary workstream commentary: **High-level summary on progress, achievements, risks. Rationale for RAG**			**Overall Status RAG**	**Key** On track / Minor delays / issues / Significant delays / issues

Key progress for this period:

Planned activities for next month:

BCC Standard Demographic Questions

Version 1.8 September 2023

The following questions should be integrated into data collection across consultations, surveys, delivered, commissioned or funded services, they reflect the commitment of the Council, Health and Wellbeing Board and NHS Integrated Care System to better understand inequalities and equity of access in services and their impact on citizens lives.

We will continue to develop and evolve these questions as we work with citizens and partners to strengthen our understanding of diversity and inclusion in our city.

This version (1.6) has been developed based on national standard questions and modifications have been tested with a citizen involvement panel. Following this engagement we have included a narrative section for questions which may be used to support greater understanding of the question.

We plan to develop an easy read and translated versions over 2023/24.

Questions should not be modified but the selection of questions should be tailored to the use and setting. If you have feedback on this question set or would like to request additional standardised questions please contact justin.varney@birmingham.gov.uk

Core Demographic Questions

These are standard questions to be included to monitor the protected characteristics, they cover:

- Age
- Gender & Gender Identity
- Sexual Orientation
- Faith & Religion
- Disability
- Ethnicity
- Pregnancy
- Relationship/Marriage
- Postcode

In line with the commitments of Everybody's Battle, Everybody's Business we encourage all services and commissioned providers to adopt these in both internal and customer data collection.

A standard introduction section wording and section about data protection has been provided. Each question is also provided with some accompanying text which may be used to give context if needed, depending on the format of the data collection.

Question wording should NOT be altered and all questions should include a Do Not Wish to Answer option

Why we are asking you information about your identity?

Birmingham City Council is committed to promoting equality and eliminating unlawful discrimination, and we are aiming to achieve diversity in the range of people we involve, commission, procure and deliver to. You do not have to answer these questions, and we understand that some of this information is personal and sensitive in nature. However, gathering this data helps us to know if we are succeeding in involving different groups of people, deliver services and to change our approach where gaps are found.

Data protection

The information you provide is anonymous and will not be stored with any identifying information about you. We may use anonymised statistics and data to inform discussions about improving the diversity and inclusivity. However, no information will be published or used in any way which allows an individual to be identified. All details are held in accordance with the Data Protection Act 1998.

The information that we are asking you to provide is informed by our duties under the Equality Act 2010, and includes information about your age, race, disability, faith, sex and sexual orientation.

If you would like this information in an alternative format, or would like help in completing the form, please contact us *[include email address].*

Age

Age is a legally protected characteristic under the Equality Act 2010.

If appropriate single year age categories can be used but otherwise 5yrs or 10yrs can be used depending on the sample/user group:

Please select the age group that reflects your age:

Single Year	OR	
OR	**5yr bands**	
10yrs bands	0-4yrs	55-59yrs
0-9yrs	5-9yrs	60-64yrs
10-19yrs	10-14yrs	65-69yrs
20-29yrs	15-19yrs	70-74yrs
30-39yrs	20-24yrs	75-79yrs
40-49yrs	25-29yrs	80-84yrs
50-59yrs	30-34yrs	85-89yrs
60-69yrs	35-39yrs	>90yrs
70-79yrs	40-44yrs	
80-89yrs	45-49yrs	
>90yrs	50-54yrs	

Do Not Wish to Answer

Gender & Gender Identity

Gender refers to the characteristics of women, men, girls and boys that are socially constructed. This includes norms, behaviours and roles associated with being a woman, man, girl or boy, as well as relationships with each other. As a social construct, gender varies from society to society and can change over time.

Gender interacts with but is different from sex, which refers to the different biological and physiological characteristics of females, males and intersex persons, such as chromosomes, hormones and reproductive organs. Gender and sex are related to but different from gender identity. Gender identity refers to a person's deeply felt, internal and individual experience of gender, which may or may not correspond to the person's physiology or designated sex at birth. (World Health Organisation definition)

Gender and Gender Reassignment are legally protected characteristics under the Equality Act 2010.

What is your gender?

- Male
- Female
- Non-binary
- Other (free text box)
- Do not wish to answer.

Is the gender you identify with the same as your sex registered at birth?

- Yes
- No
- Do not wish to answer.

Source: ONS Modified

Sexual Orientation (if users >16yrs)

Sexuality and sexual orientation is about who someone feels physically and emotionally attracted to. This can be romantic or emotional attraction, or both. (NSPCC definition)

Sexual orientation is a legally protected characteristic under the Equality Act 2010.

Which of the following best describes your sexual orientation?

- Straight or Heterosexual
- Gay or Lesbian
- Bisexual
- Other sexual orientation (Free text box)
- Do not wish to answer

Source: ONS

Faith & Belief

Religion can be explained as a set of beliefs concerning the cause, nature, and purpose of the universe, especially when considered as the creation of a superhuman agency or agencies, usually involving devotional and ritual observances, and often containing a moral code governing the conduct of human affairs. (BBC definition)

Religion is a legally protected characteristic under the Equality Act 2010.

What is your religion?

- No religion
- Christian
- Buddhist
- Hindu
- Jewish
- Muslim
- Sikh
- Agnostic
- Atheist
- Other religion (Free text box)
- Do not wish to answer.

Source: ONS Census

Disability

You're disabled under the Equality Act 2010 if you have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities. 'Substantial' is more than minor or trivial, eg it takes much longer than it usually would to complete a daily task like getting dressed and'long-term' means 12 months or more, eg a breathing condition that develops as a result of a lung infection. People with progressive conditions can be classified as disabled and under the legislation some specific conditions are classified as disabled from the day of diagnosis (HIV, cancer or multiple sclerosis). (HMG)

Disability is a legally protected characteristic under the Equality Act 2010.

Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more?

- Yes
- No
- Do not wish to answer

Source: ONS Census

If Yes

Now we are going to ask you some questions about your ability to do different activities on a regular basis, (think about days which are more difficult for you as well as good days):

- Do you have difficulty seeing, even if wearing glasses?
- Do you have difficulty hearing, even if using a hearing aid?
- Do you have difficulty walking or climbing steps?
- Do you have difficulty remembering or concentrating?
- Do you have difficulty with self-care such as washing all over or dressing?
- Do you experience fits or seizures?
- Using your usual (customary) language, do you have difficulty communicating for example understanding or being understood by others?

Source: Washington Group Short Set (WGSS) modified

Do any of your conditions or illnesses reduce your ability to carry out day to day activities?

- Yes, a lot
- Yes, a little
- Not at all
- Do not wish to answer.

Source: ONS Census

Please can you indicate which of the options below is closest to your personal situation, please tick all that apply:

- I have autism
- I have dyslexia
- I am neurodivergent
- Does not apply
- Do not wish to answer

Ethnicity & Race

Ethnicity is defined as “the social group a person belongs to, and either identifies with or is identified with by others, as a result of a mix of cultural and other factors including language, diet, religion, ancestry and physical features traditionally associated with race" (Bhopal 2004). Ethnicity is self-defined and may change over time, it overlaps with the legally protected racial identity but is a broader term.

Race is a legally protected characteristic under the Equality Act 2010. Race is defined under the Act as being part of a group of people who are identified by their nationality, citizenship, colour, national or ethnic origins.

We recognise that for some of our communities tribal identity is important and yet is not routinely collected. Across the world there are over 360 recognised tribal communities with distinct customs, traditions and in some cases specific tribal laws or regulations. We have started to ask about tribal identity to better understand this aspect of identity so that we can better support the needs of our citizens and staff.

What is your ethnic group? If you have mixed ethnicity, please select which combination of ethnicities describes you best.

- White British
- Other White
- Bangladeshi
- Chinese
- Indian
- Pakistani
- Other Asian
- African
- Caribbean
- Black British
- Other Black
- Arab
- Latin American
- Irish
- Gypsy or Irish Traveller
- Roma
- Central and Eastern European
- Western and Southern European
- Any other ethnic group – free text box
- Do not wish to answer

Source: Modified ONS Census

What is your country/countries of heritage? E.g. England, Nigeria, Poland

- Free text box

Source: BCC

Pregnancy

Understanding if you are currently pregnant and taking part in this questionnaire helps us to recognise the needs of pregnant women.

Pregnancy is a legally protected characteristic under the Equality Act 2010.

Are you currently pregnant?

- Yes
- No
- Not Applicable
- Do not wish to answer

Source: BCC

Relationship Status

Understanding your relationship status helps us consider how we are meeting the needs of our citizens and our responsibilities under the Equality legislation.

Marriage and civil partnership are legally protected characteristics under the Equality Act 2010.

What is your legal marital or registered civil partnership status?

- Single
- Never married and never registered a civil partnership
- Married
- In a registered civil partnership
- Separated, but still legally married
- Separated, but still legally in a civil partnership
- Divorced
- Formerly in a civil partnership which is now legally dissolved
- Widowed
- Surviving partner from a registered civil partnership
- Do not wish to answer

Who is (was) your legal marriage or registered civil partnership to?

- Someone of the opposite sex
- Someone of the same sex
- Do not wish to answer

Source: ONS Census

Postcode of residence

The first section of your post code provides us with a sense of the area of the city that you live in and the first number of the second section allows us to narrow this down to a smaller area, but not to your specific house or flat.

What is your postcode of your main residence?

First section e.g. B1, B14, B42				First number of 2nd section e.g 23,5,14

- Do not wish to answer

Source: BCC

Additional Questions

These questions may be used and we aim to continue to grow this standard set of question wording so that we are consistent in our approach across the City.

Employment

Understanding whether you are working or not, or if you are retired or a student, helps us understand more about your economic circumstances.

In the last seven days were you doing any of the following?

- Working as an employee
- Self-employed or freelance
- Temporarily away from work ill, on holiday or temporarily laid off
- On parental leave including maternity leave
- Doing any other kind of paid work
- Actively looking for any kind of paid work
- Retired
- Studying
- Unpaid Carer
- Long-term sick or disabled
- Other (free text box)
- Do not wish to answer

Source: Modified ONS Census

Caring Responsibilities

We recognise that caring impacts significantly on people's lives, whether you are the main person responsible for a child (a primary carer) or you are providing unpaid care to a family member to help them with things like shopping or dressing themselves.

Do you look after, or give any help or support to anyone because they have a long-term physical or mental health condition or illness, or problems related to old age? (exclude anything you are paid for as employment)

- No
- Yes – 9 hours a week or less
- Yes – 10-19 hours a week
- Yes – 20-34 hours a week
- Yes – 35-49 hours a week
- Yes – 50 hours a week or more
- Do not wish to answer

Source: ONS Census

Are you the primary carer for any children, if you care for more than one child then please tick all the age groups that apply?

- Yes for children under 5yrs old
- Yes for children between 5-10yrs old
- Yes for children between 10-18yrs old
- No
- Do not wish to answer

Source: BCC

Lived Experience

We know that there are many experiences in life that can have long lasting impacts on you, sadly many of them negative. We want to better understand which of the common experiences that we know can disadvantage people in their lives you have personally experienced.

Which of the following have you personally experienced? Please select any that apply.

- Homelessness
- Criminal Justice System i.e. ex-offender
- Local authority care system i.e care leaver
- Armed forces i.e veterans
- Sex work
- Modern slavery
- Drug or alcohol addiction
- None of these
- Other – free text box
- Do not wish to answer

Source: BCC

Living Arrangements

We recognise that who you live with can have a big impact on your life and whether you have support at home when you need it. We want to better understand your living arrangements to help us plan our support services.

Do you currently live?

- Alone
- With a partner
- With children
- With family members
- In shared accommodation unsupported
- In shared accommodation support e.g. care home/shared lives
- Do not wish to answer

Source: BCC

	Agenda Item: 13
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**28th March 2024**
TITLE:	**Pharmaceutical Needs Assessment (PNA) Update – Supplementary Statement**
Organisation	**Birmingham City Council**
Presenting Officer	**Rebecca Howell-Jones**

Report Type:	**Approval**

1. Purpose:
1.1. To provide an update on the changes to the availability of pharmaceutical services in Birmingham.

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

3. Recommendation

3.1. Note the changes to pharmaceutical provision since the publication of the PNA and agree to publish a supplementary statement.

3.2. Agree to re-establishing the PNA Steering Group (details and terms of reference will be presented to Health and Wellbeing Board).

4. Report Body

Background

4.1. A PNA is a statutory requirement of Health and Wellbeing Boards (HWB) in England; its purpose is to assess the current provision of pharmaceutical services in an area and the 'need' for such services now and in the future.

4.2. The Health and Social Care Act 2012 outlines the duty of local authorities, through the local HWB, to produce a PNA for their population. The PNA should be informed by the Joint Strategic Needs Assessment (JSNA) process and any other relevant needs assessments that identify a role for pharmaceutical services in addressing health needs.

4.3. Birmingham HWB and Solihull HWB made joint arrangements for their PNA which was published last year: Birmingham and Solihull PNA 2022 to 2025 | Birmingham City Council.

4.4. The assessment concluded that there were no gaps in provision at the time or in the future (over the next three years) for pharmaceutical services.

Updating of PNAs and Supplementary Statements

4.5. Birmingham Health and Wellbeing Board is required to produce a new PNA if it identifies changes to the need for pharmaceutical services, which are of a significant extent. This could be due to changes to[1]:

- the number of people in the area who require pharmaceutical services,
- the demography of the area, or
- risks to the health or wellbeing of people in the area (both residents and visitors).

4.6. Supplementary statements are statements of fact; they do not make any assessment of the impact the change may have on the need for pharmaceutical services. They are an update of what the PNA says about the availability of pharmaceutical services. An assessment of need can only be achieved through a review of the PNA.

Changes to provision across Birmingham

4.7. There have been changes to pharmacy provision across Birmingham compared with the published PNA. These changes can be categorised into four areas (full details in Appendix 1):

[1] PNAs: Information pack for local authority health and (publishing.service.gov.uk)

- Opening or closing of pharmaceutical premises -There have been ten pharmacy closures. The total number of community pharmacies is now 263 (down from 273 when the PNA was published).
- Non-significant changes in the location of service provision - There have been six relocations of service provision.
- Changes in ownership or trading name - 32 pharmacies changed their ownership or trading name.
- Notification to change of core opening hours - 22 pharmacies changed their core hours from the pharmaceutical list. In terms of total weekly hours, some have increased and some have decreased.

4.8. Pharmacies that have closed are in areas that are relatively well served and accessible by car and public transport. There are still more pharmacies per 100,000 people (23.1 down from 23.8) than in England (20.5 in 2022). There are now 263 community pharmacies in Birmingham.

4.9. Local systems are unable to procure or commission new pharmacies. Opening new pharmacies depends on contractors coming forward to apply to open a premises.

4.10. The HWB is required to explain changes to the availability of pharmaceutical services in Birmingham.

4.11. It is thought that producing a new PNA would be a disproportionate response to these changes. However, it is recommended that Health and Wellbeing Board issues a supplementary statement explaining the change in pharmacy services. This is based on the following guidance: Pharmaceutical needs assessments: Information pack for local authority health and wellbeing boards (publishing.service.gov.uk)

4.12. Producing a new PNA would have financial implications, including identifying a budget to outsource a provider through a competitive tender process to conduct a new PNA on behalf of the HWB. It would also involve identifying capacity to support the procurement and commissioning process and the monitoring and overseeing of the development of the new PNA.

4.13. Once published, the supplementary statement becomes part of the PNA and is referred to by NHS England when it determines applications for inclusion in a pharmaceutical list. Therefore, supplementary statements are published alongside the PNA.

4.14. The supplementary statement is included in Appendix 1.

4.15. Unless the PNA needs to be produced sooner (see 4.5), the development of the next update (2025-2028) will commence in 2024. Therefore, it is recommended that the PNA Steering Group should be established based on the terms of reference published in the most recent PNA: Birmingham and Solihull PNA 2022 to 2025 | Birmingham City Council. Full details and an updated terms of reference will be presented to Health and Wellbeing Board for approval.

5. Compliance Issues
5.1. HWBB Forum Responsibility and Board Update
None.
5.2. Management Responsibility
The Birmingham HWB has a statutory duty to publish a PNA every three years and update the PNA as required.
5.3. Finance Implications
There are no financial implications. Any costs relating to risks that the board needs to consider can be met from within ringfenced public health grant. The PNA supports NHS England to make decisions about market entry.
5.4. Legal Implications
5.5. The Health and Social Care Act 2012 established health and wellbeing boards. It also transferred responsibility to develop and update pharmaceutical needs assessments from primary care trusts to health and wellbeing boards with effect from 1 April 2013. At the same time responsibility for using pharmaceutical needs assessments as the basis for determining market entry to a pharmaceutical list transferred from primary care trusts to NHS England and NHS Improvement. 5.6. The NHS Act 2006 (the "2006 Act"), amended by the Health and Social Care Act 2012, sets out the requirements for health and wellbeing boards to develop and update pharmaceutical needs assessments and gives the Department of Health and Social Care powers to make regulations. The relevant extract from the 2006 Act can be found below. 5.7. 128A Pharmaceutical needs assessments (1) Each Health and Well-being Board must in accordance with regulations— (a) assess needs for pharmaceutical services in its area, and (b) publish a statement of its first assessment and of any revised assessment. (2) The regulations must make provision— (a) as to information which must be contained in a statement; (b) as to the extent to which an assessment must take account of likely future needs; (c) specifying the date by which a Health and Well-being Board must publish the statement of its first assessment; (d) as to the circumstances in which a Health and Well-being Board must make a new assessment. (3) The regulations may in particular make provision— (a) as to the pharmaceutical services to which an assessment must relate; (b) requiring a Health and Well-being Board to consult specified persons about specified matters when making an assessment; (c) as to the manner in which an assessment is to be made; (d) as to matters to which a Health and Well-being Board must have regard when making an assessment.

Source: Pharmaceutical needs assessments: Information pack for local authority health and wellbeing boards (publishing.service.gov.uk)
5.8. Equalities Implications (Public Sector Equality Duty)
No negative impacts regarding groups with protected characteristics were identified in PNA. The closure of pharmacies may have people certain groups, such as disabled people, older adults, and those with pregnancy and maternity characteristics. However, Health and Wellbeing Board cannot mitigate this beyond publishing a supplementary statement.

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Changes in pharmacy provision may affect patients' access to pharmaceutical services.	Medium	Medium	Continue to monitor the number of closures, relocations, and changes in core hours.

Appendices

Appendix 1 – Birmingham PNA Supplementary Statement (February 2024)

Background Papers

Birmingham and Solihull PNA 2022 to 2025 | Birmingham City Council.

The following people have been involved in the preparation of this board paper:
Aidan Hall, Service Lead (Governance), Public Health, Birmingham City Council
Avneet Gharial, Senior Officer (Governance), Public Health, Birmingham City Council
Dawn Hannigan, Support Officer (Governance), Public Health, Birmingham City Council

Birmingham Health and Wellbeing Board (HWB) Pharmaceutical Needs Assessment (PNA):

Supplementary Statement Update: February 2024

Supplementary statement no.	1
Date authorised by Birmingham Health and Wellbeing Board	
Date supplementary statement published	

Birmingham Health and Wellbeing Board (HWB) Pharmaceutical Needs Assessment (PNA)

Birmingham Health and Wellbeing Board (HWB) is responsible for developing a Pharmaceutical Needs Assessment (PNA). PNAs are a statutory requirement and must be updated at least every three years. The PNA is a report on the present needs for pharmaceutical services. It is used to identify any gaps in current services or improvements that could be made in future pharmaceutical service provision.

The PNA will be used to make decisions when applications for new pharmacies are received and for the commissioning of other services that could be delivered by community pharmacies and other providers.

In 2022, Soar Beyond Ltd was contracted by Birmingham City Council and Solihull Metropolitan Borough Council to produce the Birmingham and Solihull (BSOL) PNA 2022 to 2025.

Birmingham Health and Wellbeing Board (HWB) Supplementary Statement:

The HWB Board has a statutory responsibility to publish and keep up to date the PNA for the population in its area through supplementary statements. Supplementary statements are a way of updating what the PNA says about the availability of pharmaceutical services and once issued becomes part of the PNA. Supplementary statements cannot provide updates on pharmaceutical needs which is done every three years through a review of the PNA.

Summary

This Supplementary Statement updates the PNA for Birmingham HWB summarised into four categories:

Opening or closing of pharmaceutical premises
There have been 10 pharmacy closures.

Non-significant changes in the location of service provision
There were 6 relocations of service provision.

Changes in ownership or trading name
32 pharmacies changed their ownership or trading name.

Notification to change of core opening hours
22 pharmacies changed their core hours from the pharmaceutical list.

Closing of a pharmacy

The following 10 pharmacies have been removed from the pharmaceutical list for the area of Birmingham Health and Wellbeing Board with effect from that date:

Pharmacy owner:	Boots UK Ltd
Pharmacy address:	102 New Street, Birmingham, B2 4HQ
Pharmaceutical services:	Community pharmacy
Services opening times:	Opening hours (Mon-Fri) 09:00-18:00 Opening hours (Sat) 08:30-17:00 Opening hours (Sun) 11:00-17:00
Closure details:	The pharmacy will cease to provide pharmaceutical services on 29/10/2022

Pharmacy owner:	Boots UK Ltd
Pharmacy address:	80-82 Boldmere Rd Sutton Coldfield West Midlands B73 5TJ
Pharmaceutical services:	Community pharmacy
Services opening times:	Opening hours (Mon-Fri) 09:00-17:00 Opening hours (Sat) 08:30-17:30 Opening hours (Sun) closed
Closure details:	The pharmacy will cease to provide pharmaceutical services on 03/06/2023

Pharmacy owner:	Jhoots Healthcare Ltd
Pharmacy address:	1533 Stratford Road Hall Green Birmingham West Midlands B28 9JA
Pharmaceutical services:	Community pharmacy
Services opening times:	Opening hours (Mon-Fri) 09:00-18:00 Opening hours (Sat) closed Opening hours (Sun) closed
Closure details:	The pharmacy will cease to provide pharmaceutical services on 22/11/2022

Pharmacy owner:	Jhoots Healthcare Ltd
Pharmacy address:	Raddlebarn Road Selly Oak Birmingham West Midlands B29 6HQ
Pharmaceutical services:	Community pharmacy
Services opening times:	Opening hours (Mon-Fri) 09:00-18:00 Opening hours (Sat) closed Opening hours (Sun) closed
Closure details:	The pharmacy will cease to provide pharmaceutical services on 22/11/2022

Pharmacy owner:	Lloyds Pharmacy Ltd
Pharmacy address:	Frankly Beeches Road, Northfield, Birmingham, West Midlands, B31 5AA
Pharmaceutical services:	Community pharmacy
Services opening times:	Opening hours (Mon-Fri) 08:00-21:00 Opening hours (Sat) 08:00-21:00 Opening hours (Sun) 08:00-21:00
Closure details:	The pharmacy will cease to provide pharmaceutical services on 22/04/2023

Pharmacy owner:	Lloyds pharmacy
Pharmacy address:	30 Mere Green Road, Sutton Coldfield, West Midlands, B75 5BT (in Sainsbury)
Pharmaceutical services:	Community pharmacy
Services opening times:	Opening hours (Mon-Fri) 07:00-23:00 Opening hours (Sat) 08:00-22:00 Opening hours (Sun) 10:00-16:00
Closure details:	The pharmacy will cease to provide pharmaceutical services on 06/06/2023

Pharmacy owner:	Boots pharmacy Ltd
Pharmacy address:	87 High Street Erdington Birmingham West Midlands B23 6SA
Pharmaceutical services:	Community pharmacy
Services opening times:	Opening hours (Mon-Fri) 09:00-17:30 Opening hours (Sat) 09:00-17:30 Opening hours (Sun) closed
Closure details:	The pharmacy will cease to provide pharmaceutical services on 30/07/2022

Pharmacy owner:	Raija Ltd
Pharmacy address:	6 Dyas Road, Kingstanding, B448SF
Pharmaceutical services:	Community pharmacy
Services opening times:	Opening hours (Mon-Fri) 08:45-18:15 Opening hours (Sat) closed Opening hours (Sun) closed
Closure details:	The pharmacy will cease to provide pharmaceutical services on 27/09/2022

Pharmacy owner:	Boots UK Ltd
Pharmacy address:	1104, Warwick Road, Acocks Green, Birmingham, B27 6BH
Pharmaceutical services:	Community Pharmacy
Services opening times:	Opening hours (Mon-Fri) 08:30-14:00, 15:00-17:30 Opening hours (Sat) 08:30-14:00, 15:00-17:30 Opening hours (Sun) closed
Closure details:	The pharmacy will cease to provide pharmaceutical services on 02/03/2024

Pharmacy owner:	Boots UK Ltd
Pharmacy address:	1005 Alcester Road South, Maypole, Birmingham B14 5JA
Pharmaceutical services:	Community Pharmacy
Services opening times:	Opening hours (Mon-Fri) 09:00-12:00 & 13:00-18:00 Opening hours (Sat) 09:00-17:00 Opening hours (Sun) closed
Closure details:	The pharmacy will cease to provide pharmaceutical services on 06/04/2024

Change in location of service provision

There have been 6 non-significant changes in location of service provision from the pharmaceutical list for the area of Birmingham Health and Wellbeing Board with effect from that date:

Pharmacy Owner:	Jhoots Chemist Ltd
Previous address:	High Street, Harborne, Birmingham, B17 9QE
New address:	131 High Street, Harborne, Birmingham, B17 9NP
Changes from:	28th April 2022

Pharmacy Owner:	Masters UK Ltd
Previous address:	55 Nechells Park Road, Birmingham, B7 5PR
New address:	56A Nechells Park Road, Birmingham, B7 5PR
Changes from:	21st March 2022

Pharmacy Owner:	Asif Healthcare Ltd T/A Asif's Pharmacy
Previous address:	29, Alum Rock Road, Birmingham, B8 1LR will
New address:	8 Alum Rock Road, Birmingham, West Midlands, B8 1JA
Changes from:	14th November 2022

Pharmacy Owner:	Xtreme Pharmacy
Previous address:	199 Birchfield Road, Perry Barr, Birmingham, B19 1LL
New address:	62 Witton Road, Birmingham, West Midlands, B6 6LE
Changes from:	15th July 2023

Pharmacy Owner:	Express Healthcare Services Ltd T/A Express Healthcare Services
Previous address:	First floor, 99 spring Road, Tyseley, Birmingham, West Midlands, B11 3DJ
New address:	4 poplar Road, Birmingham, West Midlands, B11 1UH
Changes from:	6th December 2021.

Pharmacy Owner:	Saini Pharmacy
Previous address:	82-84 Lea Village, Kitts Green, Birmingham B33 9SD
New address:	292 Kitts Green Road, Lea Village, Birmingham B33 9SA
Changes from:	27th June 2023

Changes of ownership or trading name

There were 32 pharmacies that changed ownership from the pharmaceutical list for the area of Birmingham Health and Wellbeing Board will be amended with effect from that date:

Original pharmacy owner:	Adams Pharmacy
New pharmacy owner:	MIM Healthcare Limited
Pharmacy address:	50-51 Nechells Park Road, Birmingham, B7 5PR
Change in ownership date:	4th January 2023

Original pharmacy owner:	Evergreen Pharmacy Ltd
New pharmacy owner:	Aspire Pharm Ltd
Pharmacy address:	694 Yardley Wood Road, Kings Heath, Birmingham
Change in ownership date:	1st June 2022

Original pharmacy owner:	Hingley Pharmacy
New pharmacy owner:	JMA Pharma Ltd
Pharmacy address:	Yardley Green Road, Bordesley Green, Birmingham, B9 5PU
Change in ownership date:	12th October 2022

Original pharmacy owner:	Jhoots Pharmacy
New pharmacy owner:	Jhoots Pharmacy Ltd t/a Jhoots Pharmacy
Pharmacy address:	808-810 Pershore Road, Selly Park, Birmingham, B29 7LS
Change in ownership date:	2nd December 2022

Original pharmacy owner:	Lloyds Pharmacy
New pharmacy owner:	Billesley Pharmacy
Pharmacy address:	698 Yardley Wood, Road, Birmingham, B13 0HY
Change in ownership date:	21st August 2023

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	LP SD Twenty Five Limited
Pharmacy address:	401 Highfield Road, Yardley Wood, Birmingham, B14 4DU
Change in ownership date:	13th June 2022

Original pharmacy owner:	Lloyds Pharmacy

New pharmacy owner:	Twilight UK Ltd
Pharmacy address:	128/130 High Street, Kings Heath, Birmingham, B14 7LG
Change in ownership date:	1st June 2023

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	USM Healthcare Ltd
Pharmacy address:	Sherwood House Medical Practice, 9 Sandon Road, Edgbaston, West Midlands, B17 8DP.
Change in ownership date:	14th June 2023

Original pharmacy owner:	Lloyds Pharmacy
New pharmacy owner:	USM Healthcare Ltd
Pharmacy address:	Summerfield Health Centre, Winson Green Road, Birmingham B18 7AL
Change in ownership date:	31st May 2023

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	Relinquo Holdings Ltd
Pharmacy address:	Stockland Green Medical Centre, Reservoir Road, Erdington, Birmingham, B23 6DJ
Change in ownership date:	1st February 2023

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	LP SD Thirty One Limited
Pharmacy address:	32-32a High Street, Erdington, Birmingham, B23 6RH
Change in ownership date:	20th June 2023

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	Pan Healthcare Ltd t/a Pan Pharmacy
Pharmacy address:	2154A-2156 Coventry Road, Sheldon, Birmingham, B26 3JB
Change in ownership date:	2nd May 2023

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	Pan Healthcare Limited t/a Pan Pharmacy
Pharmacy address:	2222 Coventry Road, Sheldon, Birmingham, B26 3JH
Change in ownership date:	4th July 2023

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	Firoz Healthcare Ltd
Pharmacy address:	175 Weoley Castle Road, Selly Oak, Birmingham, B29 5QH
Change in ownership date:	24th April 2023

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	Shiraz & Sons Ltd
Pharmacy address:	17 Faraday Avenue, Quinton, Birmingham, B32 1JP
Change in ownership date:	1st October 2022

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	RJR Chem Ltd
Pharmacy address:	10 Glebe Farm Road, Stechford, Birmingham, B33 9LZ
Change in ownership date:	3rd March 2023

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	Saini Healthcare Ltd
Pharmacy address:	82-84 Lea Village, Kitts Green, Birmingham, B33 9SD
Change in ownership date:	27 June 2023

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	Rhodium Pharma Ltd t/a Beeches Pharmacy
Pharmacy address:	81 Thornbridge Ave, Great Barr, Birmingham, B42 2PW
Change in ownership date:	14th February 2023

Original pharmacy owner:	Hollyhill Centre
New pharmacy owner:	Apothecare Group Ltd t/a Frankley Pharmacy at Hollyhill Centre
Pharmacy address:	18 Arden Road, Rubery, Rednal, Birmingham, B45 0JA
Change in ownership date:	Lloyds Pharmacy Ltd

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	Pharmacy2Home Ltd t/a Healthcare Pharmacy & Travel Clinic
Pharmacy address:	416 Birmingham Road, Wylde Green, Sutton Coldfield, West Midlands, B72 1YJ
Change in ownership date:	1st April 2023

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	LP SD Seventeen Limited
Pharmacy address:	Ley Hill Surgery, 228 Lichfield Road, Four Oaks, Sutton Coldfield, West Midlands B74 2UE
Change in ownership date:	12th August 2023

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	USM Medical Services Ltd
Pharmacy address:	9 Walmley Close, Sutton Coldfield, B76 1NQ
Change in ownership date:	16th May 2023

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	IPHARM (UK) LTD t/a Ipharm Pharmacy
Pharmacy address:	794 Washwood Heath Road, Birmingham, B8 2JL
Change in ownership date:	1st November 2022

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	JMA Pharma Ltd t/a M Pharmacy
Pharmacy address:	Yardley Green Medical Centre, Yardley Green Road, Bordesley Green, Birmingham, B9 5PU
Change in ownership date:	1st February 2023

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	LP SD Twenty Nine Limited
Pharmacy address:	280 Vicarage Road, Kings Heath, Birmingham B14 7NH
Change in ownership date:	26th June 2023

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	AGPharmplus Ltd t/a A.G Pharmacy
Pharmacy address:	1160 Warwick Road, Acocks Green, Birmingham, B27 6BP
Change in ownership date:	12th June 2023

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	WM Brown (Kingshurst) Ltd
Pharmacy address:	228-230 Wychall Road, Northfield, Birmingham, B31 3AU
Change in ownership date:	28th April 023

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	Castle Vale Pharma Ltd
Pharmacy address:	3 Tangmere Square, Tangmere Drive, Castle Vale, Birmingham, B35 7QX
Change in ownership date:	12th May 2023

Original pharmacy owner:	Zenith Pharmacy
New pharmacy owner:	Pan Healthcare Ltd t/a Pan Pharmacy
Pharmacy address:	2154A-2156 Coventry Road, Sheldon, Birmingham, B26 3JB
Change in ownership date:	2nd May 2023

Original pharmacy owner:	Lloyds Pharmacy Ltd
New pharmacy owner:	LP SD Twenty Five Limited
Pharmacy address:	401 Highfield Road, Yardley Wood, Birmingham, B14 4DU
Change in ownership date:	4th August 2023

Original pharmacy owner:	Well Pharmacy
New pharmacy owner:	MBA Pharma Ltd
Pharmacy address:	110 Church Lane, Handsworth Wood, Birmingham, B20 2ES
Change in ownership date:	9th December 2023

Original pharmacy owner:	LP SD Thirty One Ltd
New pharmacy owner:	Clinpharm Care Ltd t/a Manor Pharmacy
Pharmacy address:	32-32A High Street, Erdington, Birmingham B23 6 RH
Change in ownership date:	1st January 2024

Change of Core Hours

There were 22 pharmacies that changed their core hours from the pharmaceutical list for the area of Birmingham Health and Wellbeing Board will be amended with effect from that date:

Reduced Core Hours:

Pharmacy owner:	Tesco Stores Ltd
Pharmacy address:	Camden Street, Hockley, Birmingham, B18 7NZ
Original services opening times:	Opening hours (Mon) 08:00-22:30, (Tues - Fri) 06:30-22:30 Opening hours (Sat) 06:30-22:00 Opening hours (Sun) 11:00-17:00 **Total weekly opening hours: 100**
New services opening times:	Opening hours (Mon-Fri) 09:00-21:00 Opening hours (Sat) 09:00-21:00 Opening hours (Sun) 11:00-17:00 **Total weekly opening hours: 78**
Changes to core service:	• Reduced weekly opening times: -18 hours and 30 minutes (Mon-Fri) • Reduced opening times: -3 hours and 30 minutes (Sat) • A total reduction of 22 hours a week
Date effective from:	29th August 2023

Pharmacy owner:	Tri Healthcare (UK) Ltd Al-Shifa Pharmacy
Pharmacy address:	Unit 8, 164 Lozells Road, Birmingham, B19 2SX
Original services opening times:	Opening hours (Mon-Fri) 08:00-23:30 Opening hours (Sat) 09:00-23:30 Opening hours (Sun) 12:00-23:00 **Total weekly opening hours: 100**
New services opening times:	Opening hours (Mon-Fri) 09:00-21:00 Opening hours (Sat) 11:00-14:00, 17:00-21:00 Opening hours (Sun) 09:00-20:00 **Total weekly opening hours: 78**
Changes to core service:	• Reduced weekly opening times: -15 hours (Mon-Fri) • Reduced opening times: -7 hours (Sat) • A total reduction of 22 hours a week
Date effective from:	29th August 2023

Pharmacy owner:	Pearl Pharmacy Ltd Ward End Pharmacy
Pharmacy address:	617 Washwood Heath Road, Ward End, Birmingham, B8 2HB
Original services opening times:	Opening hours (Mon-Fri) 08:00-23:00 Opening hours (Sat) 09:00-23:00 Opening hours (Sun) 09:00-20:00 **Total weekly opening hours: 100**
New services opening times:	Opening hours (Mon-Fri) 09:00-13:00, 14:00-21:00 Opening hours (Sat) 15:00-21:00 Opening hours (Sun) 09:00-20:00 **Total weekly opening hours: 72**
Changes to core service:	• Reduced weekly hours: -20 hours (Mon-Fri) • Reduced opening times: -8 hours (Sat) • A total reduction of -28 hours a week
Date effective from:	16th October 2023

Pharmacy owner:	Sparkhill Pharmacy
Pharmacy address:	805-807 Stratford Road, Sparkhill, B11 4DA
Original services opening times:	Opening hours (Mon-Fri) 07:00-22:00 Opening hours (Sat) 08:00-22:00 Opening hours (Sun) 09:00-20:00 **Total weekly opening hours: 100**
New services opening times:	Opening hours (Mon-Fri) 09.00-21.00 Opening hours (Sat) 09.00-21.00 Opening hours (Sun) 09.00-20.00 **Total weekly opening hours: 83**
Changes to core services:	• Reduction of weekly opening times: -15 hours (Mon-Fri) • Reduction of opening times: -2 hours (Sat) • Total reduction of 17 hours a week
Date effective from:	30th October 2023

Pharmacy owner:	Hyatt Pharmacy
Pharmacy address:	49 Bristol Road, Edgbaston, Birmingham, B5 7TU
Original services opening times:	Opening hours (Mon) 07.00-23.00 Opening hours (Tues-Fri) 06.00-23.00 Opening hours (Sat) 07:00-23:00 Opening hours (Sun) Closed **Total weekly opening hours: 100**
New services opening times:	Opening hours (Mon-Fri) 09:00-21:00 Opening hours (Sat) 09.00-21.00 Opening hours (Sun) Closed **Total weekly opening hours: 72**

Changes to core service:	• Reduction of weekly opening times: -24 hours (Mon-Fri) • Reduction of opening times: -4 hours (Sat) • Total reduction of -28 hours a week
Date effective from:	9th November 2023.

Pharmacy owner:	Medisina Pharmacy
Pharmacy address:	11 Canford Close, Highgate, Birmingham, B12 0YU
Original services opening times:	Opening hours (Mon) 07:00-23:00 Opening Hours (Tues – Fri) 06.00-23.00 Opening hours (Sat) 07.00-23.00 Opening hours (Sun) Closed **Total core hours open 100 hours**
New services opening times:	Opening hours (Mon – Fri) 09.00-21.00 Opening hours (Sat) 09.00-21.00 Opening hours (Sun) Closed **Total core hours open 72 hours**
Changes to core service:	• Reduction in weekly opening times: -4 hours (Mon) • Reduction in weekly opening times: -20 hours (Tues - Fri) • Reduction in opening times: -4 hours (Sat) • Total reduction of -28 hours a week
Date effective from:	19th February 2024

Pharmacy owner:	M W Phillips Chemist
Pharmacy address:	434 KINGSTANDING ROAD, BIRMINGHAM B44 9SA
Original services opening times:	Opening hours (Mon - Fri) 08.30-18.30 Opening hours (Sat) 09.00-13.00 Opening hours (Sun) Closed **Total core hours open 54 hours**
New services opening times:	Opening hours (Mon – Fri) 09.00-13.00 & 14.00-18.00 Opening hours (Sat) Closed Opening hours (Sun) Closed **Total core hours open 40 hours**
Changes to core service:	• Reduction in weekly opening times: -2 hours (Mon - Fri) • Reduction in opening times: -4 hours (Sat) • Total reduction of -14 hours a week
Date effective from:	1st March 2024

Pharmacy owner:	Heathfield Pharmacy
Pharmacy address:	147A Heathfield Road, B19 1HL
Original services opening times:	Opening hours (Mon - Fri) 08.00-23.00 Opening hours (Sat) 09.00-23.00 Opening hours (Sun) 12.00 – 23.00 **Total core hours open 100 hours**
New services opening times:	Opening hours (Mon – Fri) 09.00-21.00 Opening hours (Sat) 10.00 – 14.00 & 17.00 – 21.00 Opening hours (Sun) 09.00 – 20.00 **Total core hours open 79 hours**
Changes to core service:	• Reduction in weekly opening times: -15 hours (Mon - Fri) • Reduction in opening times: -6 hours (Sat) • Total reduction of -21 hours a week
Date effective from:	7th February 2024

Pharmacy owner:	Clinpharm Care Ltd t/a Manor Pharmacy
Pharmacy address:	32-32A High Street, Erdington, Birmingham B23 6RH
Original services opening times:	Opening hours (Mon - Fri) 09.00-18.30 Opening hours (Sat) 09.00-13.00 Opening hours (Sun) 10.00-17.00 **Total core hours open 58.30 hours**
New services opening times:	Opening hours (Mon) 09.00-13.00 &14.30-18.30 Supplementary hours (Mon) 13.00-14.30 Opening hours (Tues-Fri) 09.00-12.00 & 14.30-18.30 Supplementary Hours (Tues-Fri)12.00-14.30 Opening hours (Sat) 09.00-13.00 Opening hours (Sun) Closed **Total core hours open 51.30 hours**
Changes to core service:	• Reduction in opening times hours (Sun) 7 hours • Total reduction of hours a -7 hours week
Date effective from:	5th March 2024

Increased core hours:

Pharmacy owner:	Chesters Pharmacy
Pharmacy address:	123 Shard End Crescent, Shard End, Birmingham B34 7AZ
Original services opening times:	Opening hours (Mon-Fri) 09:00-17:00 Opening hours (Sat) closed Opening hours (Sun) closed **Total weekly opening hours: 40**
New services opening times:	Opening hours (Mon-Fri) 08:30-18:30 Opening hours (Sat) closed Opening hours (Sun) closed **Total weekly opening hours: 50**
Changes to core service:	• Total weekly opening hours increased by +10 hours (Mon-Fri)
Date effective from:	29th September 2023

Pharmacy owner:	Heartlands Pharmacy
Pharmacy address:	2 Towpath Close Bordesley Village Centre Bordesley Birmingham B9 4QA
Original services opening times:	Opening hours (Mon-Fri) 09:00-18:00 (Wed) 09:00-13:00 Opening hours (Sat) Closed Opening hours (Sun) Closed **Total core hours open: 40**
New services opening times:	Opening hours (Mon-Fri) 09:00-18:00, (Wed) 09:00-14:00 Opening hours (Sat) Closed Opening hours (Sun) Closed **Total core hours open: 41**
Changes to core service:	• Total weekly hours increased by +1 hour (Wed)
Date effective from:	6th October 2023

Pharmacy owner:	Knights Pharmacy
Pharmacy address:	5 Alvechurch Road, West Heath, Birmingham B31 3JW
Old services opening times:	Opening hours (Mon-Fri) 09:00-13:00,14:00-18:00 Opening hours (Sat) Closed Opening hours (Sun) Closed **Total weekly opening hours: 40**
New services opening times:	Opening hours (Mon-Fri) 09:00-13:00,14:00-19:00 Opening hours (Sat) 09:00-13:00, 13:30-16:00 Opening hours (Sun) Closed **Total weekly opening hours: 51.5**
Changes to core service:	• Increase of weekly opening times: +5 hours (Mon-Fri) • Increase of opening times: +6.5 hours (Sat)

	• A total increase of 11.5 hours a week
Date effective from:	1st September 2023

Pharmacy owner:	A+ Pharmacy
Pharmacy address:	311 Bordesley Green East, Birmingham, B33 8QF
Original services opening times:	Opening hours (Mon-Fri) 09:00-17:00 Opening hours (Sat) Closed Opening hours (Sun) Closed **Total core hours open: 40**
New services opening times:	Opening hours (Mon-Fri) 09:00-19:00 Opening hours (Sat) 09:00-13:00 Opening hours (Sun) Closed **Total core hours open: 54**
Changes to core service:	• Increase of weekly opening times: +10 hours (Mon-Fri) • Increase of opening times: +4 hours (Sat) • A total increase of +14 hours a week
Date effective from:	16th November 2023

Pharmacy owner:	Boots UK Ltd
Pharmacy address:	44-46 Gracechurch Shopping Centre The Parade Sutton Coldfield West Midlands B72 1PD
Original services opening times:	Opening hours (Mon-Fri) 09:00-12:00, 13:00-18:00 Opening hours (Sat) 10:00-14:00 Opening hours (Sun) 10:30:16:30 **Total weekly opening hours: 40**
New services opening times:	Opening hours (Mon-Fri) 09:00-12:00, 13:00-18:00 Supplementary opening hours (Mon-Fri) 12:00-13:00 Supplementary opening hours (Sat) 09:00-14:00 Supplementary opening hours (Sun) 10:30-16:30 **Total core hours open 56 hours**
Changes to core service:	• Increase of weekly opening times: +5 hours (Mon-Fri) • Increase of opening times: +5 hours (Sat) • Increase of opening times: +6 hours (Sun) • A total increase of +16 hours a week
Date effective from:	4th November 2023.

Pharmacy owner:	Knights Pharmacy
Pharmacy address:	5 Alvechurch Road, West Heath, Birmingham B31 3JW
Original services opening times:	Opening hours (Mon-Fri) 09.00-13:00, 14:00-18:00 Opening hours (Sat) Closed

	Opening hours (Sun) Closed **Total weekly opening hours: 40**
New services opening times:	Opening Hours (Mon-Fri) 09:00-13:00, 14.00-18.00 Supplementary Hours (Mon-Fri) 18.00-19.00 Supplementary Hours (Sat) 09.00-13.00, 13.30-16.00 Opening hours (Sun) Closed **Total weekly opening hours: 51.5**
Changes to core service:	• Increase in weekly opening times: +5 hours (Mon-Fri) • Increase in opening times: +6.5 hours (Sat) • Opening Hours (Mon-Fri) 09:00-13:00, 14.00-18.00 • Total increase of +11.5 hours a week
Date effective from:	1st February 2023.

Pharmacy owner:	Pershore Road Pharmacy
Pharmacy address:	71 Pershore Road, Edgbaston, Birmingham B5 7NX
Original services opening times:	Opening hours (Mon-Fri) 09:00-17:00 Supplementary opening hours (Sat) 09:00-14:00 Opening hours (Sun) Closed **Total weekly opening hours: 40**
New services opening times:	Opening hours (Mon-Fri) 09:00-18:00 Opening hours (Sat) 09:00-14:00 Opening hours (Sun) closed **Total weekly opening hours: 50 hours**
Changes to core service:	• Increase of weekly opening times: +5 hours (Mon-Fri) • Increase of opening times: +5 hours (Sat) • A total increase of +10 hours a week
Date effective from:	9th October 2023.

Pharmacy owner:	Twilight Pharmacy
Pharmacy address:	128-130 High street, Kings Heath, Birmingham, B14 7LG
Original services opening times:	Opening hours (Mon-Fri) 09:00-17:00 Opening hours (Sat) Closed Opening hours (Sun) Closed **Total weekly opening hours open: 40**
New services opening times:	Opening hours (Mon-Fri) 09:00-17:00 Supplementary opening hours (Mon-Fri) 17.00-20.00 Supplementary opening hours (Sat) 09.00-18.00 Supplementary opening hours (Sun) 10.00-17.00 **Total weekly opening hours: 71**
Changes to core service:	• Increase of weekly opening times: +15 hours (Mon-Fri) • Increase of opening times: +9 hours (Sat)

	• Increase of opening times: +7 hours (Sun) • A total increase of +31 hours a week
Date effective from:	30th October 2023.

Pharmacy owner:	Your Local pharmacy
Pharmacy address:	238 Wheelwright Road, Erdington, Birmingham B24 8EH
Original services opening times:	Opening hours (Mon-Fri) 09:00-17:30 Opening hours (Sat) Closed Opening hours (Sun) Closed **Total weekly opening hours open: 42.30**
New services opening times:	Opening hours (Mon-Fri) 09:00-17:00 Supplementary opening hours (Mon, Tues, Thurs, Fri) 17.00-17.30 Supplementary hours (Wed) 17.00 – 19.00 Supplementary opening hours (Sat) 10.00-14.00 Supplementary opening hours (Sun) Closed **Total weekly opening hours: 48**
Changes to core service:	• Increase of weekly opening times: + 1.30 hours (Mon-Fri) • Increase of opening times: +4 hours (Sat) • A total increase of +5.30 hours a week
Date effective from:	7th March 2024

Opening time changes:

Pharmacy owner:	SRC Locum Ltd
Pharmacy address:	775 Stratford Road, Sparkhill, Birmingham, B11 4DG
Original services opening times:	Opening hours (Mon-Fri) 08:00-21:00 Opening hours (Sat) 08:00-23:59 Opening hours (Sun) 00:01-19:00 **Total weekly opening hours: 100**
New services opening times:	Opening hours (Mon) 08:00-23:00, (Tue-Fri) 07:00-23:00 Opening hours (Sat) 07:00-23:00 Opening hours (Sun) 11:00-16:00 **Total weekly opening hours: 100**
Changes to core service:	• Opening times have changed • Total weekly opening hours: unchanged
Date effective from:	15th August 2023

Pharmacy owner:	Fakir Pharmacy Cannon Hill
Pharmacy address:	200 Edward Road, Cannon Hill, Balsall Heath, Birmingham, B12 9LY
Original services opening times:	Opening hours (Mon-Fri) 07:30-22:30 Opening hours (Sat) 07:30-22:30 Opening hours (Sun) 09:00-19:00 **Total weekly opening hours: 100**
New services opening times:	Opening hours (Mon-Thur) 07:00-22:30 (Fri) 06:30-22:30 Opening hours (Sat) 06:30-22:30 Opening hours (Sun) 11:00-17:00 **Total weekly opening hours: 100**
Changes to core services:	• Opening times have changed • Total weekly opening hours: unchanged
Date effective from:	6th September 2023

Pharmacy owner:	Barkat Pharmacy
Pharmacy address:	775 Stratford Road, Sparkhill, Birmingham, B11 4DG
Original services opening times:	Opening hours (Mon-Fri) 08:00-21:00 Opening hours (Sat) 08:00-23:59 Opening hours (Sun) 00:01-19:00 **Total core hours open: 100**
New services opening times:	Opening hours (Mon-Fri) 07:00-23:00 Opening hours (Sat) 07:00-23:00 Opening hours (Sun) 11:00-16:00 **Total core hours open: 100**

Changes to core service:	• Opening times have changed • Total weekly opening hours: unchanged
Date effective from:	11th October 2023

Pharmacy owner:	Manor Pharmacy
Pharmacy address:	1756-1758 Coventry Road, Yardley, Birmingham B26 1PB
Original services opening times:	Opening hours (Mon-Fri) 09.00-18.00 Opening hours (Sat) 09.00-17.30 Opening hours (Sun) closed **Total core hours open 53.30**
New services opening times:	Opening hours (Mon-Fri) 09.00-12.00 & 14.00-18.00 Supplementary Opening Hours (Mon – Fri) 12.00-14.00 Opening hours (Sat) 09.00-12.30 & 15.00-16.30 Supplementary Opening Hours (Sat)12.30-15.00 & 16.30-17.30 Opening hours (Sun) Closed **Total core hours open 53.30**
Changes to core service:	• Opening times haven't changed overall • Total weekly opening hours: unchanged
Date effective from:	7th February 2024

	Agenda Item: 14
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**28th March 2024**
TITLE:	**EXECUTIVE BOARD RECOMMENDATIONS TO FULL HEALTH AND WELLBEING BOARD**
Organisation	**Executive Board of Birmingham HWB**
Presenting Officer	**Dr Clara Day**

Report Type:	**Approval**

1. Purpose:

1.1. To present members of the Health and Wellbeing Board with the recommendations from the Executive Board.

2. Implications (tick all that apply):

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

3. Recommendation

3.1. For members of the Health and Wellbeing Board to note and approve the recommendations from the Executive Board.

4. Report Body

4.1. Background

To better facilitate the responsibilities of the Health and Wellbeing Board, an Executive Board has been established to support the streamlining of decision making by the Health and Wellbeing Board.

The first Executive Board meeting was held virtually at 12pm on Monday 18th December 2023. The attendance list and summary of recommendations can be found below:

Dr Clara Day (Chair)
Cllr Matt Bennett
Helen Price
Jo Tonkin
James Thomas
Alan Butler (presenting)
Aidan Hall (presenting)
Alex Quarrie-Jones (support)

N.B. There was no Executive Board meeting in February 2024 as the January 2024 Health and Wellbeing Board was cancelled and any items to be considered were deferred to the March 2024 meeting. There will also be no Executive Board meeting in April 2024 as the following Health and Wellbeing Board meeting will be occurring in early May 2024.

4.2. Agenda

A copy of the full agenda can be found in the appendices of this report. Agenda items that were discussed are below:

- Executive Board – Terms of Reference and Operating Model
- Better Care Fund Quarter 2 Report
- Pharmaceutical Needs Assessment (PNA) Update

4.3. Recommendations

For each discussed agenda item, there is a recommendation to the Health and Wellbeing Board and a rationale for this recommendation. These can be seen below:

Item	Recommendation	Rationale	Members present
2. Executive Board Introduction – ToR and	To note the Terms of Reference and Operating Model for the Executive Board	The Executive Board will help the full Health and Wellbeing Board be more effective without increasing the workload for members.	Dr Clara Day (Chair) Cllr Matt Bennett Helen Price Jo Tonkin

Operating Model			James Thomas
3. Better Care Fund Q2 Report	To note the Q2 report but ask for more clear reporting on the governance for the Better Care Fund Programme Board's metrics.	The BCF's metric around avoidable admissions is not on track. However, this is partially due to admissions around asthma and respiratory diseases, and so a unique situation that can be resolved. There has also been an overspend relating to Sevacare who provide homecare after discharge from hospital. While there are mitigations in place to resolve this overspend, Board members were keen to understand the governance structure that would help to prevent these issues in future.	Dr Clara Day (Chair) Cllr Matt Bennett Helen Price Jo Tonkin James Thomas
4. Pharmaceutical Needs Assessment (PNA) Update	1) To re-establish the PNA Steering Group to monitor changes in current provision and plan for the next PNA (2025-2028) 2) Link the PNA Steering Group to the ICB's commissioning of pharmacy provision.	Since the publication of the current PNA in 2022, there have been some minor changes to pharmacy provision, including 8 community pharmacy closures. The Local Pharmaceutical Committee has advised that there is still adequate provision in Birmingham but that the publication of a supplementary statement to the PNA may help to highlight these changes. Publication would be best co-ordinated through a PNA Steering Group that would then be in place to commence the delivery of the next PNA. It was also noted by the Chair that there is a sizeable churn within community pharmacies but that these pharmacies are controlled more locally now and so a PNA Steering Group should benefit from linking to the ICB. This item will be presented in full at the Health and Wellbeing Board meeting in March 2024.	Dr Clara Day (Chair) Cllr Matt Bennett Helen Price Jo Tonkin James Thomas

5. Compliance Issues

5.1. HWBB Forum Responsibility and Board Update

The Executive Board will submit a summary of its recommendations to every Health and Wellbeing Board that follows its meeting.
5.2. Management Responsibility
N/a
5.3. Finance Implications
N/a
5.4. Legal Implications
N/a
5.5. Equalities Implications (Public Sector Equality Duty)
N/a

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
N/a	N/a	N/a	N/a

Appendices

HWB Executive Board Agenda – December 2023

Executive Board Terms of Reference and Operating Model
Appx 1 - Executive Board Terms of Reference and Operating Model
Appx 2 – HWB Executive Board Terms of Reference
Appx 3 – EB ToR and Model Presentation slides

Better Care Fund Q2 Report
Appx 4 - Better Care Fund 2023-2025 Q2 Report
Appx 5 - Better Care Fund 2023-2025 Q2

The following people have been involved in the preparation of this board paper:
Alex Quarrie-Jones, Senior Officer (Governance), Public Health, Birmingham City Council

	Agenda Item: Executive Board Paper
Report to:	**Birmingham Health & Wellbeing Board – Executive Board**
Date:	**18 December 2023**
TITLE:	**Executive Board Terms of Reference and Operating Model**
Organisation	**Health and Wellbeing Board**
Presenting Officer	**Aidan Hall**

Report Type:	**Information**

1. Purpose:

1.1. To update the Executive Board on the proposed approach to supporting Health and Wellbeing Board.

2. Implications (tick all that apply):

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

3. Recommendation (For Executive Board)

3.1. Note and support the terms of reference and operating model for the Executive Board.

4. Report Body

4.1. Health and Wellbeing Board (HWB) is committed to continuous improvement to improve the health and well-being of Birmingham's communities. This includes additional sessions and meetings as appropriate.

4.2. At the previous Health and Wellbeing Board Development Day (May 2023), members gave feedback about the amount of time available for discussion and the number of items (and papers) at meetings.

4.3. Suggestions were made to establish an Executive Board to provide the whole board membership with more space and time for strategic discussion and thematic agenda items. A Terms of Reference (Appendix 1) was presented to Health and Wellbeing Board in September 2023.

4.4. To better facilitate the responsibilities of the Health and Wellbeing Board, the Executive Board has been established to support the streamlining of decision making by the Health and Wellbeing Board.

4.5. The Executive Board will consider papers on behalf of, make recommendations to, the full Health and Wellbeing Board. An operating model for how this will work in practice is included in Appendix 2.

4.6. Fundamentally, this Executive Board will allow the Health and Wellbeing Board to allocate more time to major strategic decisions and thematic discussions.

4.7. Health and Wellbeing Board agreed to establish the Executive Board and review its progress and impact after six months.

5. Compliance Issues
5.1. HWBB Forum Responsibility and Board Update
5.1.1. None
5.2. Management Responsibility
5.2.1. The Health and Wellbeing Board is responsible for its continuous improvement and development. 5.2.2. Governance support will be led by the Service Lead (Governance) with oversight from the Director of Public Health.

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Lack of engagement and buy-in to the proposed changes	Low	High	The proposed changes are the result of feedback from Board Members. Members are receiving feedback and the proposed action plan for comment and discussion before formal agreement.

Appendices
Appx 1 - Executive Board Terms of Reference Appx 2 – Terms of Reference and Model – Summary Presentation

The following people have been involved in the preparation of this board paper:
Aidan Hall, Service Lead (Governance) Public Health, Birmingham City Council

Birmingham Health and Wellbeing Board

Terms of Reference: Executive Board

Overview

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

Purpose

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

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

Frequency and Structure of Meetings

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

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

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

Recommendation summaries will include:

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

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

Scope

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

Membership

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

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

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

Quorum

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

Voting

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

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

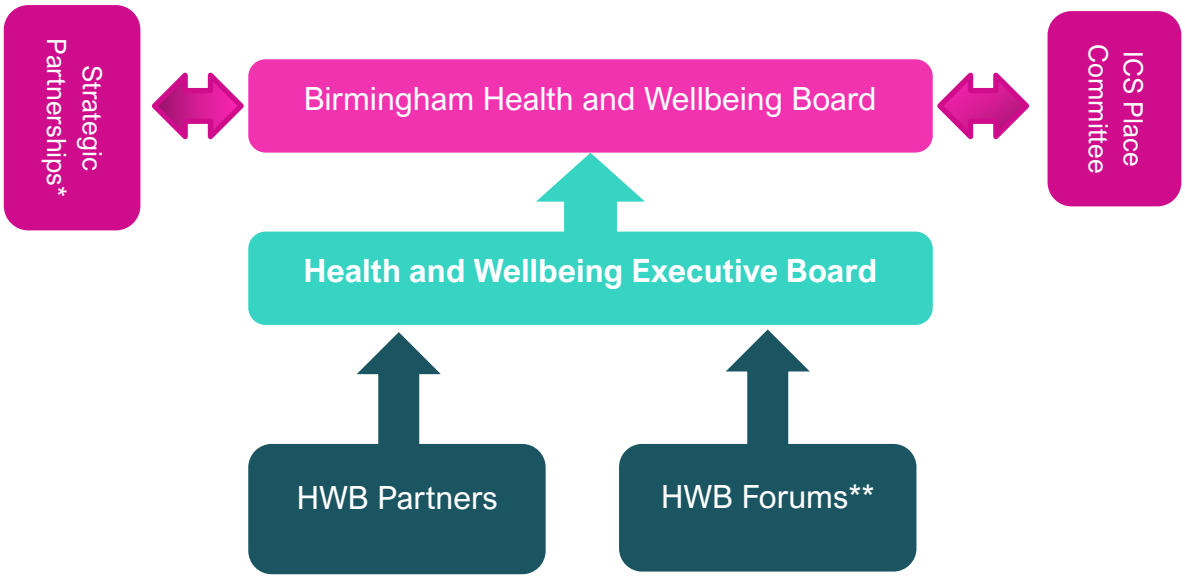
Substitutes

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

HWBoard@birmingham.gov.uk

Executive Board Arrangements

Figure 1: Governance structure for Health and Wellbeing Board



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

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

Date of Approval/Next Review

The governance, membership and Terms of Reference of the Executive Board will be reviewed after 6 months following approval at Health and Wellbeing Board on 26 September 2023.

Appendix 1: Examples of appropriate items for HWB Executive Board

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

Birmingham Health and Wellbeing Board – Executive Board Terms of Reference and Operating Model

Background

- At the previous Health and Wellbeing Board Development Day (May 2023), members gave feedback about the amount of time available for discussion and the number of items (and papers) at meetings.
- Suggestions were made to establish an Executive Board to provide the whole board membership with more space and time for strategic discussion and thematic agenda items.
- A Terms of Reference was presented to Health and Wellbeing Board in September 2023.
- Health and Wellbeing Board agreed to establish the Executive Board but review its progress and impact after six months.

Terms of Reference (Summary)

- To better facilitate the responsibilities of the Health and Wellbeing Board, the Executive Board has been established to support the streamlining of decision making by the Health and Wellbeing Board.
- The Executive Board will consider papers on behalf of, make recommendations to, the full Health and Wellbeing Board.
- **The Executive Board will allow the Health and Wellbeing Board to allocate more time to major strategic decisions and thematic discussions.**

Terms of Reference (Summary) cont.

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

Recommendation summaries will include:

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

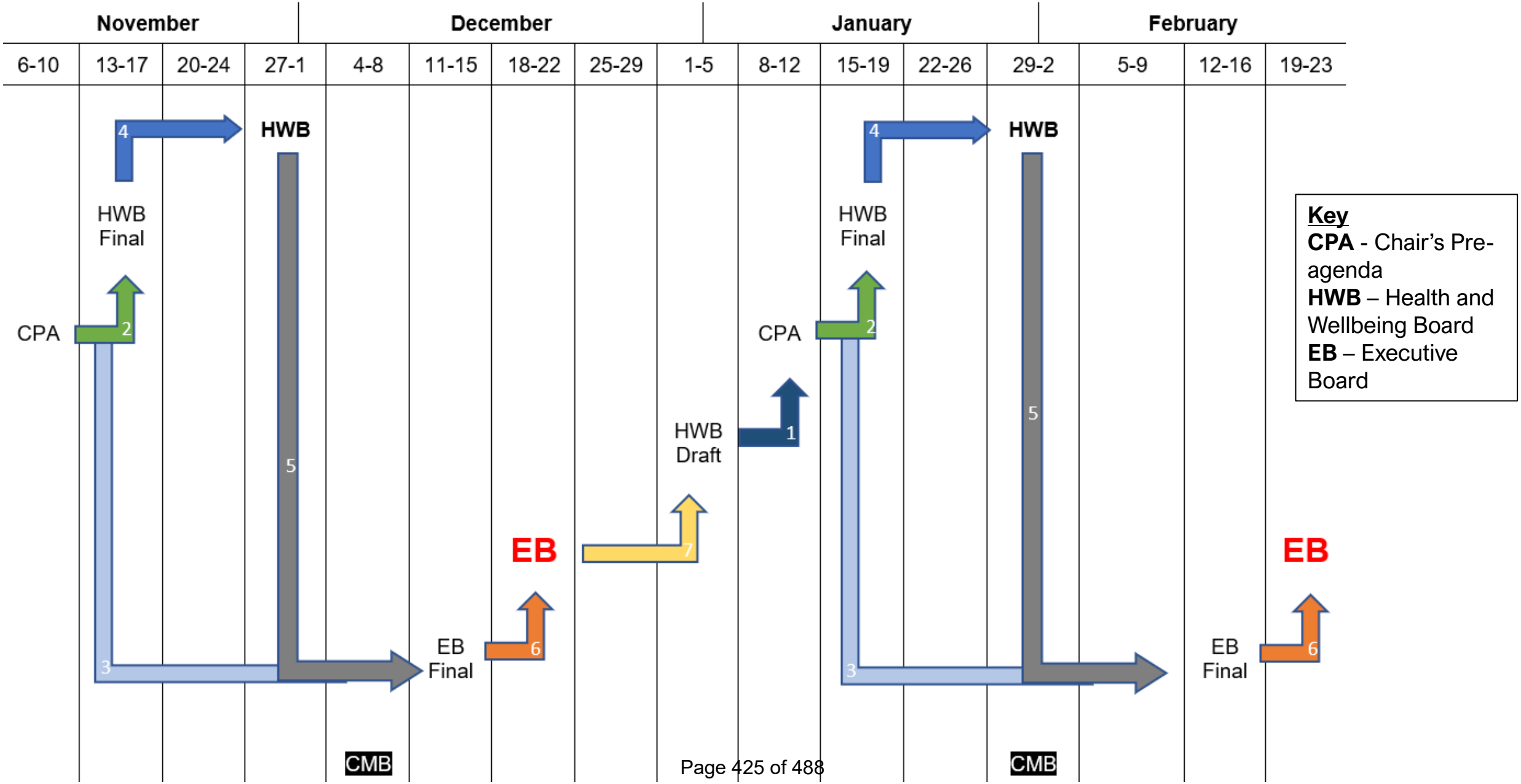
If there are no items to be considered by the Executive Board, they will not be required to meet before a full Health and Wellbeing Board meeting.

Recommendation Summaries

Item	Recommendation	Rationale	Members present
2. Executive Board Introduction – ToR and Operating Model			
3. Better Care Fund Q2 Report			
4. Pharmaceutical Needs Assessment (PNA) Update			

Executive Board Operating Model

1. Papers that have been received for Full Board meeting (based on HWB Forward Plan/ Work Programme) are collated and shared with Chair and Vice Chair.
2. Papers finalised for Full Board meeting.
3. As the agenda is agreed for Full Board, it is also agreed for the following Executive Board.
4. Papers published in advance of Full Board meeting on CMIS.
5. Any actions or matters following the Full Board can be added to the Executive Board agenda.
6. Executive Board papers circulated at least 5 working days before the meeting.
7. Summary of discussion and actions from Executive Board are included in the draft HWB papers.


November
December
January
February
6-10
13-17
20-24
27-1
4-8
11-15
18-22
25-29
1-5
8-12
15-19
22-26
29-2
5-9
12-16
19-23
4
HWB
HWB Final
CPA
2
5
3
CMB
EB Final
EB
6
HWB Draft
1
7
4
HWB
HWB Final
CPA
2
5
3
CMB
EB Final
EB
6
Key
CPA - Chair's Pre-agenda
HWB – Health and Wellbeing Board
EB – Executive Board

Reviewing the Executive Board

- Health and Wellbeing Board agreed to establish the Executive Board but review its progress and impact after six months. This includes the governance, membership and Terms of Reference.
- The Board has also agreed to undertake at least one **HWB development session** annually, with the next one provisionally scheduled for May 2024.
- Health and Wellbeing Board members will also have an opportunity to provide ongoing feedback following each meeting (Full Board and Executive Board).
- Provide feedback on today's meeting here: Birmingham Health and Wellbeing Board - Executive Board Meeting Feedback (December 2023)

	Agenda Item: Executive Board Paper
Report to:	**Birmingham Health & Wellbeing Board – Executive Group**
Date:	**18 December 2023**
TITLE:	**Better Care Fund update (Including Q2 Report)**
Organisation	**Birmingham City Council**
Presenting Officer	**Michael Walsh**

Report Type:	**Information**

1. Purpose:

1.1. To report to the Health and Wellbeing Board the current status, progress and issues relating to the Better Care Fund.
1.2. Present the BCF Quarter 2 Report.

2. Implications (tick all that apply):

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

3. Recommendation

3.1. That the Board makes note of the report and Q2 update.

4. Report Body

Key messages

4.1. Financial pressures on the BCF are significant. This is due to an overspend of £1.9million on the Sevacare EICT contract for home care discharge. A working group has been set up to explore and implement options to rectify this.
4.2. Commissioning of partner organisation to support the rollout of the Integrated Neighbourhood Teams programme is underway. Tenders to be assessed in December and go-live targeted for January,
4.3. Locality Hubs model is being further developed and linked to INTs. Funding agreed for hubs in the East and West localities.
4.4. Mental Health Homeless Pilot has been extended until 31st March 2024
4.5. BCF Quarter 2 Report submitted. Key reporting measures are:
4.6. Avoidable admissions currently not on track, however levels are dropping. High asthma admissions contributing to this.
4.7. Discharge to normal place of residence is on track.
4.8. Falls reduction target is on track.
4.9. Residential admissions is on track.

Planned Activities

- December 5th: Assessment panel and provider interviews for Integrated Neighbourhood Teams operational rollout support.
- January: Go-live of the INT rollout programme.
- Working group to review operating model, and develop and implement options to reduce overspend on the Sevacare EICT contract.
- Locality Hubs in East and West localities will be rolled out between November and March.

5. Compliance Issues

5.1. HWBB Forum Responsibility and Board Update

5.1.1. N/A

5.2. Management Responsibility

5.2.1. N/A

6. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
N/A			

Appendices
BCF Quarter 2 report

HM Government

NHS England

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

2. Cover

Version 3.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Birmingham	
Completed by:	Mike walsh	
E-mail:	michael.walsh@birmingham.gov.uk	
Contact number:	07730 281349	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Tue 28/11/2023	<< Please enter using the format, DD/MM/YYYY

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC Discharge Fund tab.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D Hospital Discharge	Yes
5.3 C&D Community	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Birmingham

Has the section 75 agreement for your BCF plan been finalised and signed off?	No
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off	01/01/2024

Confirmation of National Conditions			**Checklist**
National Conditions	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter:**	Complete:
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Birmingham

National data may be unavailable at the time of reporting. As such, please use data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2023-24 planning				For information - actual performance for Q1	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
		Q1	Q2	Q3	Q4					
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	302.8	291.7	330.2	310.9	368.0	Not on track to meet target	Asthma admissions have not reduced below winter levels (previous 2 quarters) and are higher than the same period 22/23. Eplispy admissions were at the highest this quarter across the pas 15 months.	Whilst ACSC admissions were above plan in each of the first 3 months of this financial year, in Jul23, they have fallen below the plan.	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	94.4%	94.8%	94.3%	93.3%	94.56%	On track to meet target	The Quarter 1 plan has been met.	Qtr 1 performance is higher than across Qtr1 in the previous 2 years.	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				2,212.2	507.4	On track to meet target	The Falls Quarter 1 plan has been achieved and is currently on plan for July 23.	Local monitoring is now in place to count monthly Falls as per BCF/Fingertips definition to keep full track of latest position.	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				679		On track to meet target	Permanent admissions to residential care are currently below the numbers (and rate) planned at this stage in the year according to local monitoring. However, the numbers are subject to monthly updates (upwards), so the final reported position at year end may change.	Local monitoring is in place with monthly updates to report latest position. Increasing support for people who do fund their own care.	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				80.4%		Data not available to assess progress	This remains challenging in being able to accurately report on this target but data and information sharing have improved to enable better reporting	No local monitoring in place.	Yes

Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Birmingham

5.1 Assumptions

	Checklist Complete:
1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include how learning from the last 6 months was used to arrive at refreshed projections?	
We have reviewed our forecast for demand across a number of areas in the plan. We have noted the actual demand for P2 beds from hospital discharges over the first two quarters and have identified that this wa	Yes
2. Please outline assumptions used to arrive at refreshed projections (including to optimise length of stay in intermediate care and to reduce overprescription of care). Please also set out your rationale for trends in demand for the next 6 months (e.g how have you accounted for demand over winter?)	
Demand:	
In respect of demand for P2 beds we have assumed that demand for the winter period will be in excess of the actual demand recorded during the first 2 quarters - which has been an average of 306 referrals per mo	Yes
Capacity:	
At present we have assumed that the currently commissioned capacity will be adequate - although contingency plans are in place in increase capacity if required from January onwards. A further review of the plan v	Yes
3. What impact have your planned interventions to improve capacity and demand management for 2023-24 had on your refreshed figures? Has this impact been accounted for in your refreshed plan?	
Increased forecast demand for Reablement and Rehabiliation at home from the community reflects a planned commnity pathway to prevent hospital discharges.	Yes
4. Do you have any capacity concerns or specific support needs to raise for the winter ahead?	
We have not planned to surge P2 beds to the same levels as the past 3 winters. This will be monitored on an ongoing basis.	Yes
5. Please outline any issues you encountered with data quality (including unavailable, missing, unreliable data).	
No specific data issues have been identified. Systems are in place to track and report on demand and capacity.	Yes
6. Where projected demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?	
As noted in Q2, there is likely to be increased demand for P2 beds over the coming months. Plans are being mobilised for an additional 20 beds if required from January onwards.	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and question & answer document

5.1 Assumptions

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- actual demand in the first 6/7 months of the year
- modelling and agreed changes to services as part of Winter planning or following the Market Sustainability and Improvement Fund announcement
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

5.2 and 5.3 Summary Tables

The tables at the top of the next two tabs show a direct comparison of the demand and capacity for each area, by showing = (capacity) – (demand). These figures are pre-populated from the previous template as well as calculating new refreshed figures as you complete the template below. **Negative figures show insufficient capacity and positive figures show that capacity exceeds demand.**

5.2 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record their refreshed expectations of monthly demand for supported discharge by discharge pathway.

Data from the previous capacity and demand plans will be auto-populated, split by trust referral source. You will be able to enter your refreshed number of expected discharges from each trust alongside these. The first table may include some extra rows to allow for areas who are recording demand from a larger number of referral sources. If this does not apply to your area, please ignore the extra lines.

This section in the previous template asked for expected demand for rehabilitation and reablement as two separate figures. It was found that, by and large, this did not work well for areas so the prepopulated figures for these service types have been combined into one row. Please enter your refreshed expectations for rehabilitation and reablement as one total figure as well.

Virtual wards should not be included in intermediate care capacity because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, please select the relevant trust from the list.

From the capacity and demand plans collected in June 2023, it emerged that some areas had difficulty with estimating demand and capacity for Pathway 0 (social support). By social support, we are referring to lower level support provide outside of formal rehabilitation and reablement or domiciliary care. This is often provided by the voluntary and community sector. Demand estimates for this service type should only include discharges on Pathway 0 that require some level of commissioned low-level support and not all discharges on Pathway 0. If it is not possible to estimate figures in relation to this please put 0 rather than defaulting to all Pathway 0 discharges.

5.2 Capacity - Hospital Discharge

This section collects refreshed expectations of capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS) (pathway 0)
- Reablement & Rehabilitation at home (pathway 1)
- Short term domiciliary care (pathway 1)
- Reablement & Rehabilitation in a bedded setting (pathway 2)
- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

The recently published Intermediate Care Framework sets out guidance on improving capacity, and use of this capacity. You should refer to this in developing your refreshed BCF Capacity and Demand plans.

As with the 2023-24 template, please consider the below factors in determining the capacity calculation. Typically, this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay.

Caseload (No. of people who can be looked after at any given time).

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility.

Please consider using median or mode for Length of Stay where there are significant outliers.

Peak Occupancy (percentage) - What was the highest levels of occupancy expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

The template now asks for the amount of capacity you expect to secure through spot purchasing. This should be capacity that is additional to the main estimate of commissioned/contracted capacity (i.e. the spot purchased figure should not be included in the commissioned capacity figure). This figure should represent capacity that your local area is confident it can spot-purchase and is affordable, recognising that it may impact on people's outcomes and is unlikely to be best value for money and local areas will be working to reduce this area of spend in the longer term.

5.3 Demand - Community

This section collects refreshed expectations of demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. As with the previous template, referrals are not collected by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the 2023-25 Planning Requirements.

The units can simply be the number of referrals.

As with all other sections, figures from the 2023-24 template will be auto-populated into this section.

5.3 Capacity - Community

This section collects refreshed expectations of capacity for community services. You should input the expected available capacity across health and social care for different service types. As with the hospital discharge sheet, data entered in the assured BCF plan template has been prepopulated for reference. You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to
support recovery, including Urgent Community Response and VCS support. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Please see the guidance on 'Demand – Hospital Discharge' for information on why the capacity and demand estimates for rehabilitation and reablement services is now being collected as one combined figure. Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay.

Caseload (No. of people who can be looked after at any given time).

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility.

Please consider using median or mode for Length of Stay where there are significant outliers.

"Peak Occupancy (percentage) - What was the highest levels of occupancy expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services."

Complete:

Better Care Fund 2023-24 Capacity & Demand Refrresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Birmingham

Hospital Discharge

Capacity - Demand (positive is Surplus)

Capacity - Demand (positive is Surplus)	Previous plan Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Refreshed capacity surplus. Not including spot purchasing Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Refreshed capacity surplus (including spot puchasing) Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS) (pathway 0)	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Reablement & Rehabilitation at home (pathway 1)	69	143	68	221	90	69	143	68	221	90	69	143	68	221	90
Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	-42	-42	-51	-23	-67	0	0	0	0	0	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Capacity - Hospital Discharge

Service Area	Metric	Prepopulated from plan: Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Refreshed planned capacity (not including spot purchased capacity Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Capacity that you expect to secure through spot purchasing Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Checklist Complete:
Social support (including VCS) (pathway 0)	Monthly capacity. Number of new clients.	135	135	135	135	135	135	135	135	135	135	0	0	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new clients.	800	800	800	800	800	800	800	800	800	800	0	0	0	0	0	Yes
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new clients.	360	360	360	360	360	360	360	360	360	360	0	0	0	0	0	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new clients.	3	3	3	3	3	3	3	3	3	3	0	0	0	0	0	Yes

Demand - Hospital Discharge

Pathway	Trust Referral Source	Prepopulated from plan: Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Please enter refreshed expected no. of referrals: Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Checklist
Social support (including VCS) (pathway 0)	**Total**	**130**	**130**	**130**	**130**	**130**	**130**	**130**	**130**	**130**	**130**	
	OTHER	16	16	18	16	16	16	16	18	16	16	Yes
	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	114	114	112	114	114	114	114	112	114	114	Yes
	(blank)											Yes
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	(blank)											Yes
Reablement & Rehabilitation at home (pathway 1)	**Total**	**731**	**657**	**732**	**579**	**710**	**731**	**657**	**732**	**579**	**710**	Yes
	OTHER	91	80	99	73	86	91	80	99	73	86	Yes
	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	640	577	633	506	624	640	577	633	506	624	Yes
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Short term domiciliary care (pathway 1)	**Total**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	Yes
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Reablement & Rehabilitation in a bedded setting (pathway 2)	**Total**	**402**	**402**	**411**	**383**	**427**	**360**	**360**	**360**	**360**	**360**	Yes
	OTHER	50	49	56	48	52	50	50	50	50	50	Yes
	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	352	353	355	335	375	310	310	310	310	310	Yes
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	(blank)											Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	**Total**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	Yes
	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	3	3	3	3	3	3	3	3	3	3	Yes
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Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Birmingham

Community	Previous plan					Refreshed capacity surplus:				
Capacity - Demand (positive is Surplus)	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	6	45	6	88	19	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0

Capacity - Community		Prepopulated from plan:					Please enter refreshed expected capacity:					Checklist Complete:
Service Area	Metric	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Social support (including VCS)	Monthly capacity. Number of new clients.	8	8	8	8	8	8	8	8	8	8	Yes
Urgent Community Response	Monthly capacity. Number of new clients.	1630	1685	1788	1673	1787	1630	1685	1788	1673	1787	Yes
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	400	400	400	400	400	400	400	400	400	400	Yes
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	7	10	5	5	8	7	10	5	5	8	Yes
Other short-term social care	Monthly capacity. Number of new clients.	2	2	2	2	2	5	5	5	5	5	Yes

Demand - Community	Prepopulated from plan:					Please enter refreshed expected no. of referrals:					
Service Type	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Social support (including VCS)	8	8	8	8	8	8	8	8	8	8	Yes
Urgent Community Response	1630	1685	1788	1673	1787	1630	1685	1788	1673	1787	Yes
Reablement & Rehabilitation at home	394	355	394	312	381	400	400	400	400	400	Yes
Reablement & Rehabilitation in a bedded setting	7	10	5	5	8	7	10	5	5	8	Yes
Other short-term social care	2	2	2	2	2	5	5	5	5	5	Yes

	Agenda Item: 15
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**28th March 2024**
TITLE:	**Birmingham and Solihull Child Death Review Team and Child Death Overview Panel (CDOP) Annual Report 2022-23**
Organisation	**Birmingham & Solihull Integrated Care System**
Presenting Officer	**Mel McKenzie**

Report Type:	**Information**

1. Purpose:

1.1. To note the Birmingham and Solihull CDOP Annual Report for 2022-23.

2. Implications (tick all that apply):

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

3. Recommendation

3.1. For Health and Wellbeing Board members to note the Annual Report for 2022-23 for the Birmingham and Solihull CDOP.

4. Report Body

4.1. The Child Death Review Team (CDRT) is a multi-professional group that is part of the wider Safeguarding Team at NHS Birmingham and Solihull Integrated Care Board (ICB).

4.2. They are responsible for the co-ordination of a joint agency response (JAR) in the case of unexpected child deaths. They are also responsible for convening the Child Death Overview Panel (CDOP). This panel is a multi-agency, independent panel which reviews the circumstances of the child's death.

4.3. In the period from 1st April 2022 to 31st March 2023, there 45 child deaths subject to a JAR; 36 children were resident in Birmingham and 9 children were resident in Solihull.

4.4. 27 child deaths requiring a JAR were reviewed and closed at CDOP during this period. 19 of these child deaths were male and 8 child deaths were female. 22 deaths had modifiable factors involved (e.g. substance misuse, self-harm, poor home accommodation) and 5 deaths did not include modifiable factors.

4.5. 140 deaths in total were reviewed by Birmingham CDOP in 2022-23. The majority of these deaths are in infants under the age of 1 year.

4.6. The recommendations in this annual report for next year (2023/24) were:

4.6.1. To ensure BCH implements joint Child Death Review Meetings (CDRM) for all deaths.

4.6.2. Continued close working with Public Health. Thematic analysis of consanguinity and the impact on infant mortality.

4.6.3. Gain a greater understanding of parent/carer experience of the JAR process by collecting their feedback and using this to inform/improve service provision.

5. Compliance Issues

5.1. HWBB Forum Responsibility and Board Update

The Birmingham & Solihull Child Death Review Team will provide the Health and Wellbeing Board with its annual report as an update on an annual basis.

5.2. Management Responsibility

Birmingham & Solihull Child Death Review Team

5.3. Finance Implications

N/a
5.4. Legal Implications
N/a
5.5. Equalities Implications (Public Sector Equality Duty)
N/a

6. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
None identified			

Appendices
Appx 1 – Child Death Overview Panel Annual Report 2022-23

Background Papers

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

Mel McKenzie, CDRT Co-ordinator, Birmingham & Solihull ICS

2023 Annual Report of the Birmingham and Solihull Child Death Review Team and Child Death Overview Panel

Terminology

CDOP	Child Death Overview Panel
CDRT	Child Death Review Team
CDRM	Child Death Review Meeting
PMRT	Perinatal Mortality Review Tool
SUDIC	Sudden and Unexpected Death in Infancy or Childhood
JAR	Joint Agency Response
NCMD	National Child Mortality Database
HSIB	Healthcare Safety Investigation Branch
BSol	Birmingham and Solihull

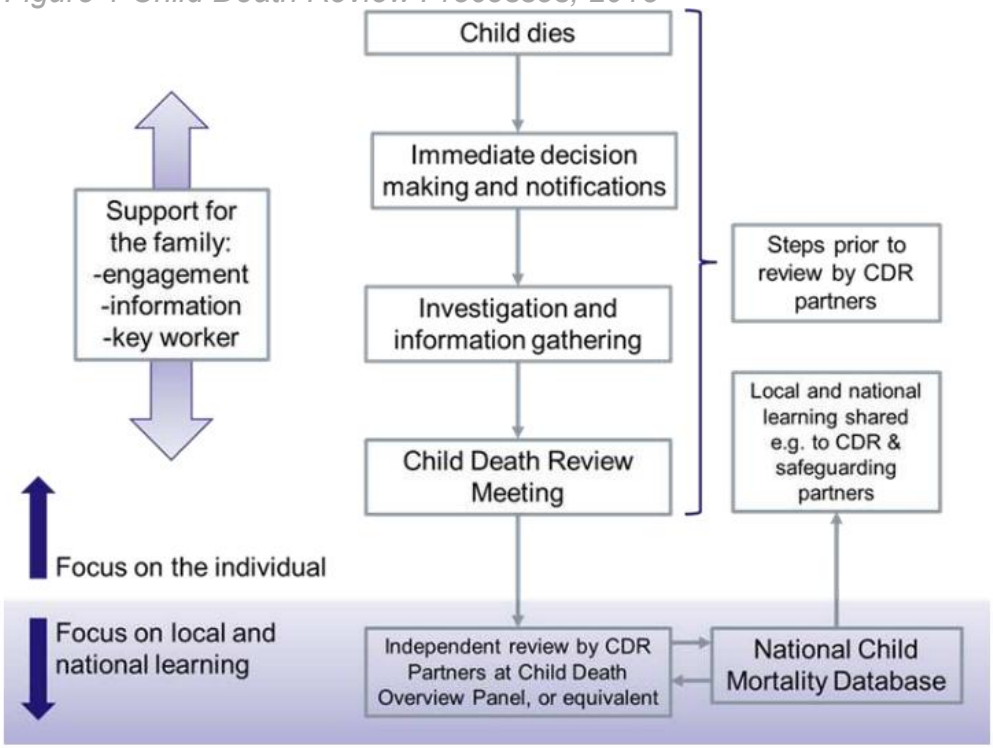
Layout of Annual Report

1.0 Introduction

Working Together to Safeguard Children (2018)[1] outlines the governance arrangements of the statutory duty to review deaths of children resident in the City Council's area or resident elsewhere but Looked After by the City Council. The Child Death Review Partners during 2022-23 were NHS Birmingham and Solihull Integrated Care Board.

The Statutory and Operational Child Death Review guidance [2] set out the responsibilities of the Child Death partners and details explicit operational guidance. The Flow Chart in the guidance (Figure 1) illustrates the full process of a child death review. It identifies the responsibility of the local review by professionals involved in the care of the child (Child Death Review Meeting) and the review of an independent multi-agency panel (Child Death Overview Panel - CDOP) organised by the Child Death review Partners. These processes were implemented during the CDOP year 2019-20.

Figure 1 Child Death Review Processes, 2018



1.1 Time period

The CDOP year follows the financial year reporting period. This annual report covers the period from 01 April 2022 to 31 March 2023.

2.0 The Birmingham and Solihull Child Death Review Team

The multi-professional Child Death Review Team (CDRT) is part of the Safeguarding Team at NHS Birmingham and Solihull Integrated Care Board (ICB). Birmingham and Solihull CDOP is managed by the CDRT. The offices for the CDRT are at the Wesleyan Building in Birmingham. The meetings were a mixture of virtual and face to face; the Neonatal Panel meetings were all virtual and the General/SUDIC meetings were face to face meetings where possible (a few were hybrid where individuals could only attend virtually).

The CDRT are directly responsible for the co-ordination of the Joint Agency Response (JAR) to unexpected child deaths (SUDIC – Sudden and Unexpected Death in Infancy or Childhood) for both Birmingham and Solihull resident children. The CDRT oversees CDR services provided by NHS Trusts.

Terms of reference for the CDRT are available here:
https://www.birminghamsolihull.icb.nhs.uk/application/files/3616/6791/8309/Terms_of_Reference_for_BSol_Child_Death_Review_Team_2021.pdf

2.1 CDRT staff

Dr Joanna Garstang	Designated Doctor for Child Death
Dr Helen Chaplin	Designated Doctor for Safeguarding – Lead for Neonatal Deaths
Sarah Ashburn	Designated Nurse Safeguarding Children (Lead for Child Death)
Sue Cope	Designated Nurse Safeguarding Children (Lead for Child Death)
Melisha McKenzie	CDRT Co-Ordinator
Joanne Fox	CDRT Administrator
Helen Foster	CDRT Administrator

CDOP membership

Di Rhoden	BSOL ICB Head of Safeguarding, Chair
Dr Joanna Garstang	Designated Doctor for Child Death
Dr Helen Chaplin	Designated Doctor for Safeguarding – Lead for Neonatal Deaths
Sarah Ashburn	Designated Nurse Safeguarding Children (Lead for Child Death)
Sue Cope	Designated Nurse Safeguarding Children (Lead for Child Death)
Melisha McKenzie	CDRT Co-Ordinator
Dr Yasmin Hussain	Named GP for Safeguarding, BSol ICB
Dr Anjana Ranjit	Named GP for Safeguarding, BSol ICB
Dr Michael Plunkett	Named Doctor for Safeguarding, General Paediatrician, University Hospital Birmingham

Birmingham:

Dr Marion Gibbon	Assistant Director of Public Health
DI Joseph Davenport	Ladywood Public Protection Unit, West Midlands Police
Paul Nash	Head of Service, Independent Review, Birmingham Children's Trust
Emma-Louise Hodgson	Safeguarding Service Team Manager (interim), Birmingham City Council
Katie Meah	Senior Reviewer – LeDeR, BSOL ICB

Solihull:

Denise Milnes	Interim Head of Children's Public Health, Solihull Metropolitan Borough Council
Hasina Miah	Independent Reviewing Officer, Children's Services, Solihull Metropolitan Borough Council
Natasha Chamberlain	Senior Education Improvement Adviser, Solihull Metropolitan Borough Council
DI Jim Edmunds	Child Public Protection Unit – Solihull and Coventry, West Midlands Police

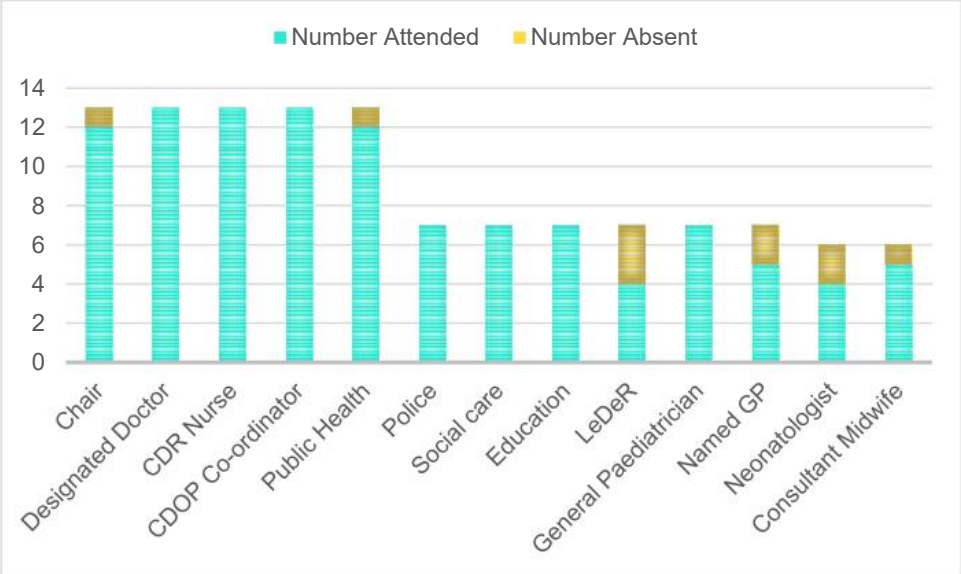
Neonatal Meetings:

Dr Vikki Fradd	Consultant Neonatologist, University Hospitals Birmingham
Karen McGuigan	Matron for Maternity Governance, University Hospitals Birmingham
Dr Lucy Green	Consultant Neonatologist, Birmingham Women's and Children's Hospital
Jasmine Cajee	Consultant Midwife, Birmingham Women's and Children's Hospital

2.2 Proportion of meetings attended by CDOP members

There were 6 Neonatal panels, 6 General/SUDIC(Birmingham) and 1 General/SUDIC (Solihull) panels. Not all panel members are required for every meeting. The chart below shows what proportion of meetings the panel members were present at or absent from, out of the total number they were asked to attend. On one meeting the Chair could not attend but the Designated Doctor was able to chair the meeting instead. All meetings were quorate.

Figure 2 Number of panel members present at each meeting



3.0 Local Child Death Review Meetings (CDRM)

The statutory guidance requires that all child deaths should be reviewed at a local CDRM. With the exception of deaths requiring a Joint Agency Response (JAR), which are directly managed by the CDRT, it is the responsibility of the health care trust caring for the child at the time of death to hold the CDRM.

Birmingham Community Healthcare Trust holds CDRM for children who die under their palliative care team; Acorns hospice contributes to these reviews.

University Hospitals Birmingham holds CDRM for children dying in the hospital, and for neonatal deaths.

City and Sandwell Hospitals hold CDRM for children dying in the hospital, and for neonatal deaths.

Birmingham Women and Children's Hospitals hold CDRM for neonatal deaths. For non-neonatal deaths they have an established mortality review programme for deaths at Birmingham Children's Hospital but this only considers provision of care during recent treatment within the hospital; these meetings are not compliant with the Working Together to Safeguard Children (2018) Statutory Guidance. This lack of compliance has been escalated within the ICB. BWCH are planning to start holding CDRM and will be supported by the CDRT in this, however there has been little progress to date. The lack of CDRM at BWCH remains a major concern and is on the risk register.

For neonatal deaths where the baby was transferred antenatally or postnatally, a joint PMRT between both Hospital Trusts has been established.

All trusts have found challenges in having primary care and other agencies join CDRM. The CDRT are reminding trusts of this requirement and supporting them to invite the appropriate professionals.

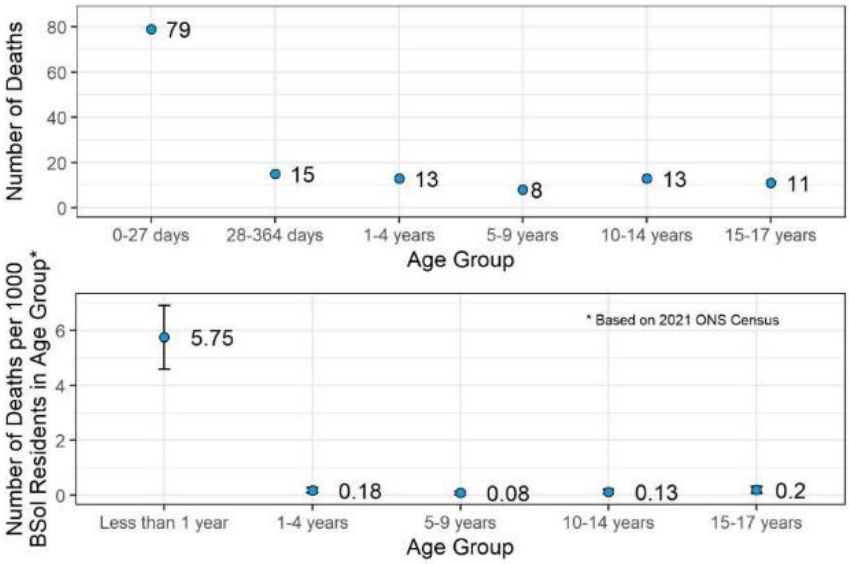
4.0 The Demographic and Geographical Breakdown

Data from the 2021 ONS census was used to determine the size of different demographic groups in BSol to enable mortality rates to be estimated for each of these groups. The demographics studied include the child's age, sex, ethnicity, socioeconomic deprivation, geographical location. Once the rates are calculated for each group, a standardised proportion p-test is used to determine if the observed inequalities are statistically significant.

4.1 Age

The majority of the CDOP deaths were from babies aged 0-27 days. As a result, babies less than one year of age have a much larger mortality rate than older children at 5.75 per 1000 BSol residents aged less than one.

Figure 3 – (Top) number of deaths in each age group. (Bottom) Estimated mortality rate for each age group estimated using 2021 ONS census data.

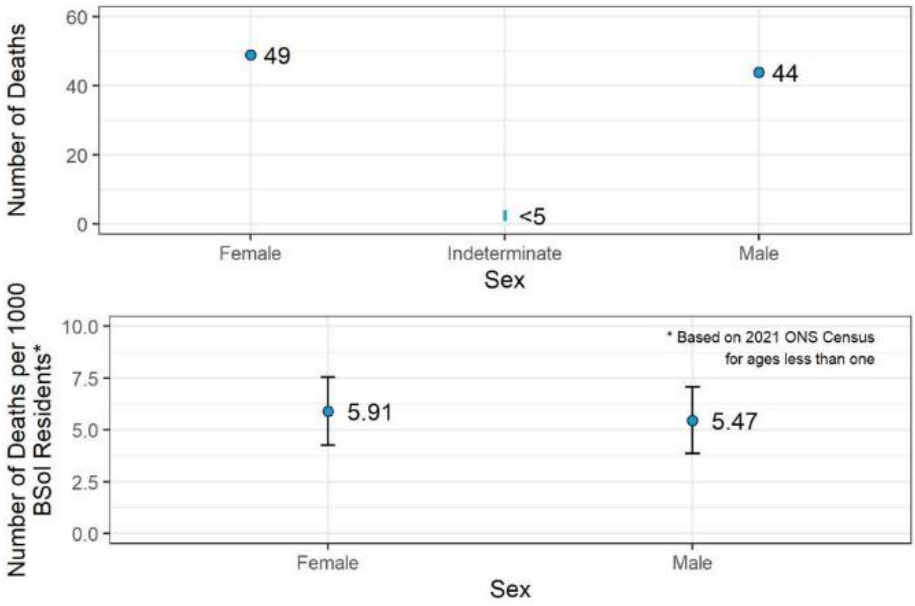


4.2 Sex

4.2.1 Infants

As discussed previously, and shown in Figure 4 below, there were more female baby deaths (49) reviews than male (44). Since the number of female and male babies aged less than one in BSol is roughly the same, this means that the estimated mortality rate was also slightly higher for female babies (5.9 per 1000 usual residents aged less than one year old) than for male babies (5.5 per 1000 usual residents aged less than one year old). However, this difference was not found to be statistically significant. For the cases with indeterminate sex, it was not possible to calculate an estimated mortality rate since this group is not included in the ONS census data.

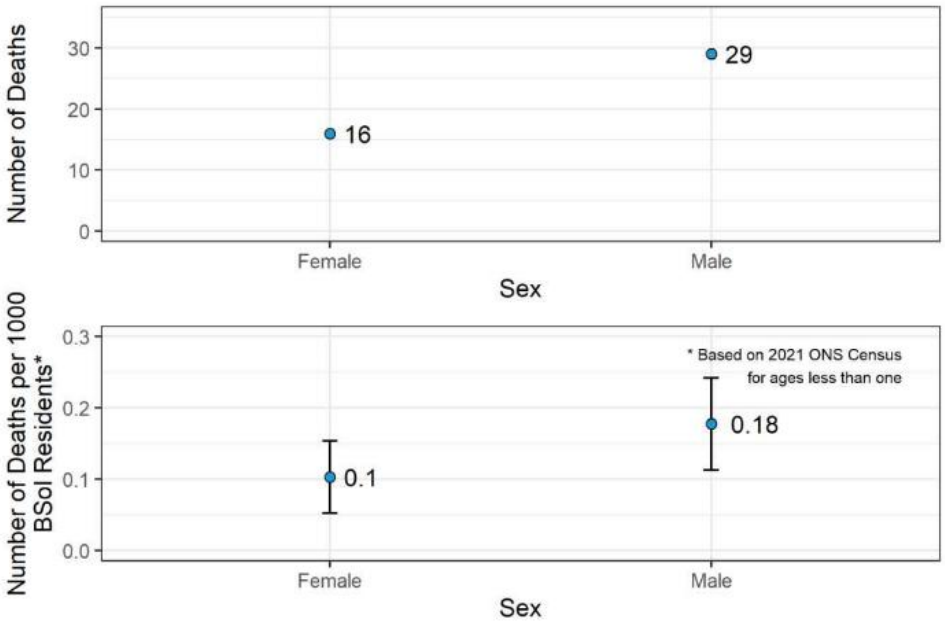
Figure 4 – (Top) number of infant deaths by sex. (Bottom) Estimated infant mortality rate for each sex using 2021 ONS census data.



4.2.2 Children

For children aged one to seventeen years the opposite trend was seen. As shown in Figure 5 below, there were more male child deaths (29) reviews than female deaths (16). This resulted in male children having a higher estimated mortality rate (0.18 per 1000 usual residents aged less than one year old). This was found to be significantly higher (p=0.04) than the mortality rate for female children (0.1 per 1000 usual residents aged less than one year old).

Figure 5 – (Top) number of child (aged 1-17) deaths by sex. (Bottom) Estimated child mortality rate for each sex using 2021 ONS census data.

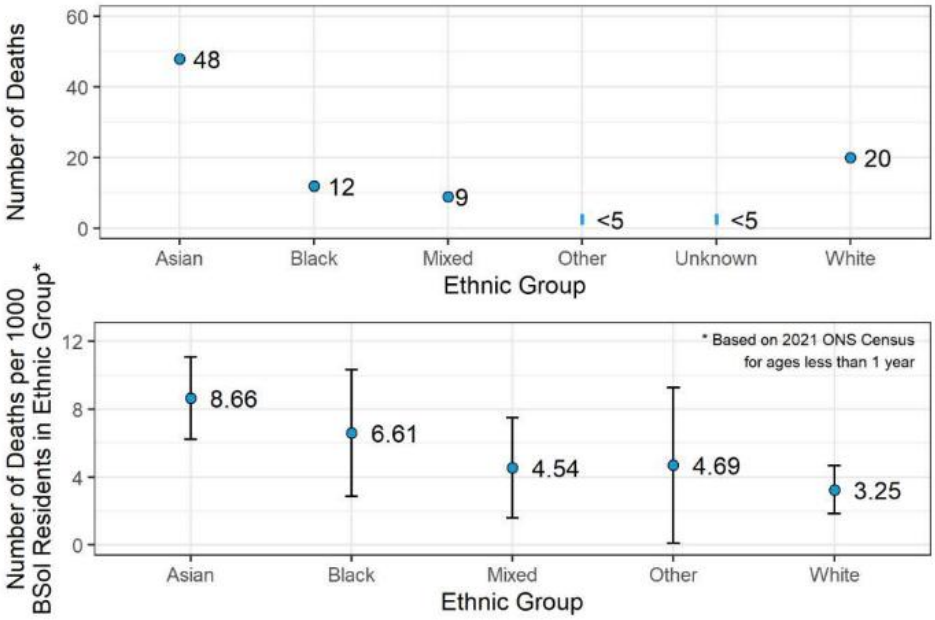


4.3 Ethnicity

4.3.1 Infants

As shown in Figure 6 below, the infant mortality rate was estimated to be the highest for Asian and Black mothers at 8.7 and 6.6 deaths per 1000 usual residents less than one year old respectively. These are significantly higher than the rate for White mothers of 3.3 per 1000 usual residents less than one year old ($p<0.001$ and $p=0.02$ respectively).

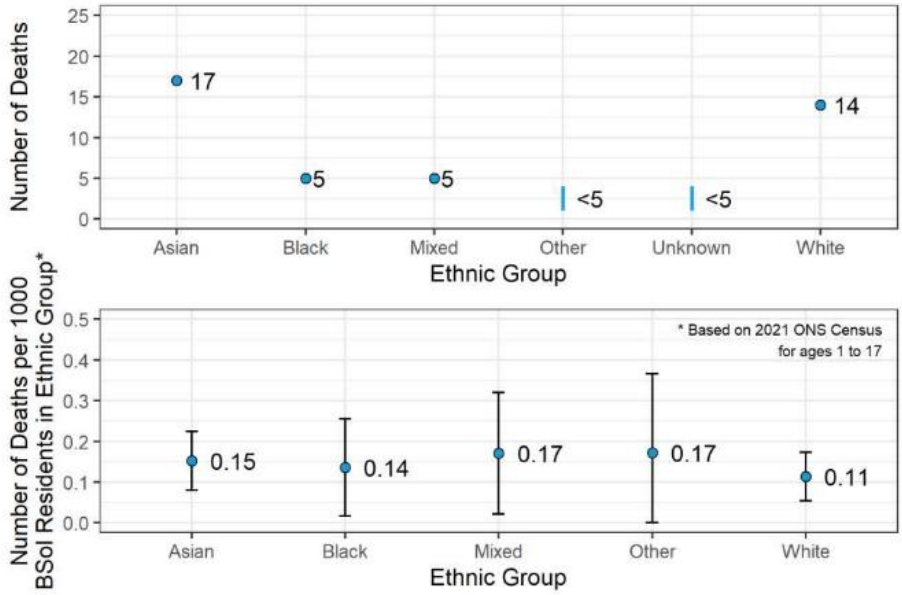
Figure 6 – (Top) number of infant deaths by ethnic group. (Bottom) Estimated infant mortality rate for each ethnic group using 2021 ONS census data.



4.3.2 Children

As seen in Figure 7 below, child mortality rates were highest for mothers of Mixed and Other ethnicity, both with a rate of 0.17 per 1000 usual residents aged one to seventeen. The lowest child mortality rate was for White mothers at 0.11 per 1000 usual residents aged one to seventeen. However, the differences between these rates were not found to be statistically significant in this data.

Figure 7 – (Top) number of child (aged 1-17) deaths by ethnic group. (Bottom) Estimated child mortality rate for each ethnic group using 2021 ONS census data.



4.3.3

For the cases where the ethnicity was not known, it was not possible to calculate an estimated mortality rate since this group is not included in the ONS census data.

4.4 Deprivation

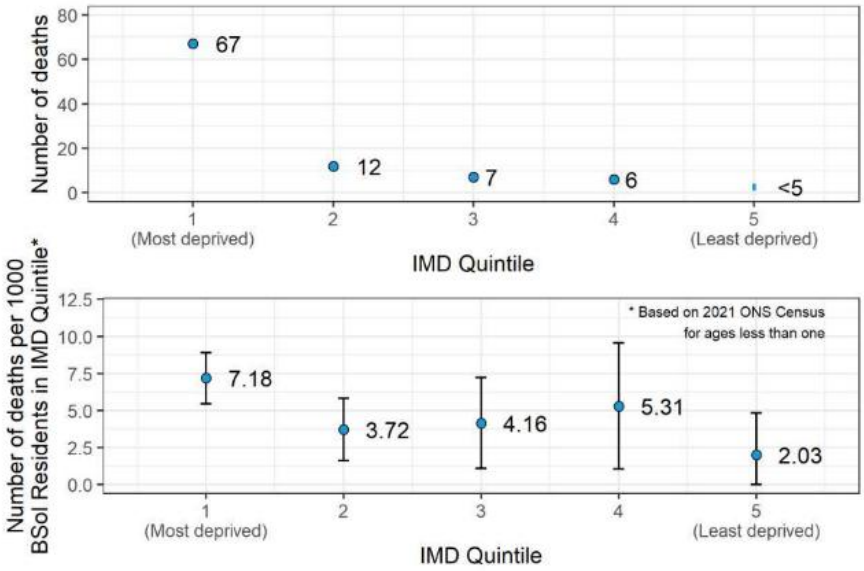
Due to the small number of deaths in areas of low deprivation, it was decided to combine the cases from areas in the 60% least deprived areas to be used as the reference rate in p-testing.

4.4.1 Infants

As seen from Figure 8 below, most of the infant deaths occurred in most deprived areas. This is, in part, due to the large percentage of Birmingham and Solihull neighbourhoods falling into this most-deprived category.

However, again 2021 Census data can be used to estimate the infant mortality rate in each IMD quintile. Figure 8 shows that infants in the most deprived quintile had the highest mortality rate at 7.2 per 1000 usual residents aged less than one. This is significantly higher (p=0.02) than for those living in the 60% least deprived quintiles at 4.0 per 1000 usual residents aged less than one.

Figure 8 – (Top) number of infant (aged less than one) deaths by IMD Quintile. (Bottom) Estimated infant mortality rate for each IMD Quintile using 2021 ONS census data.

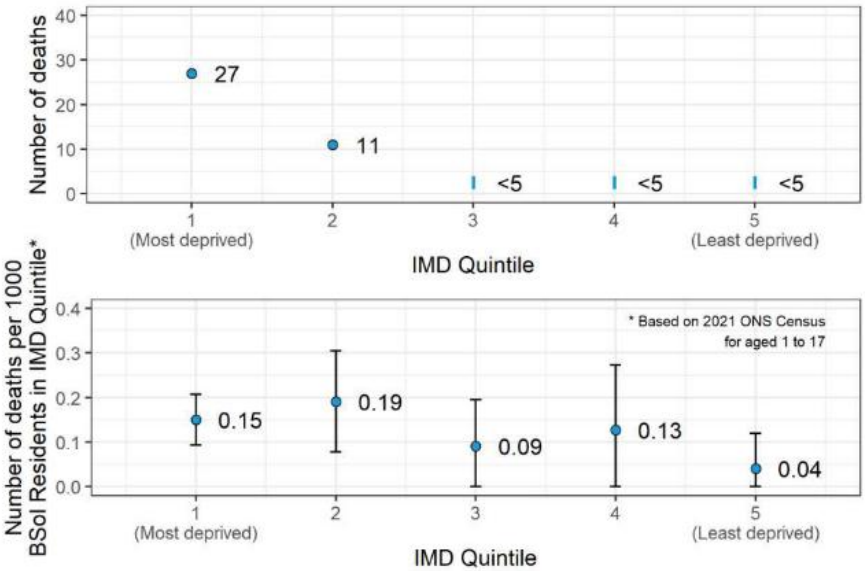


4.4.2 Children

Similarly for children older than one year, the number of deaths was much higher for those living in the most deprived quintile, as shown in Figure 9. However, the difference is smaller than for infants.

Estimating the mortality rate using 2021 census data, the difference between the most deprived and least deprived areas is again smaller than for the case of infants. The most deprived and second most deprived quintiles had child mortality rates of 0.15 and 0.19 per 1000 usual residents aged 1 to 17 compared a combined rate of 0.09 per 1000 usual residents for the remaining three quintiles. However, this difference was less statistically significant (p=0.09 and p=0.05 for quintiles 1 and 2 respectively).

Figure 9 – (Top) number of child (aged 1-17) deaths by IMD Quintile. (Bottom) Estimated child mortality rate for each IMD Quintile using 2021 ONS census data.



4.5 Geography

The infant and child mortality rates were also estimated for each of the BSol's 12 parliamentary constituencies. In this case, we compare the rate for each constituency to the BSol average to determine if the difference is statistically significant.

4.5.1 Infants

For the whole of BSol, the average infant mortality rate was 5.8 per 1000 usual residents less than one year old. As seen from Figure 10 below, Hodge Hill and Ladywood both had infant mortality rates of 9.4 per 1000 usual residents less than one year old. This is significantly higher than the BSol average (p=0.05).

The calculated infant mortality rates are also visualised as a heat map across BSol, as shown in Figure 11.

Figure 10 – (Top) number of infant (aged less than one) deaths by BSol parliamentary constituency. (Bottom) Estimated infant mortality rate for each BSol parliamentary constituency using 2021 ONS census data.

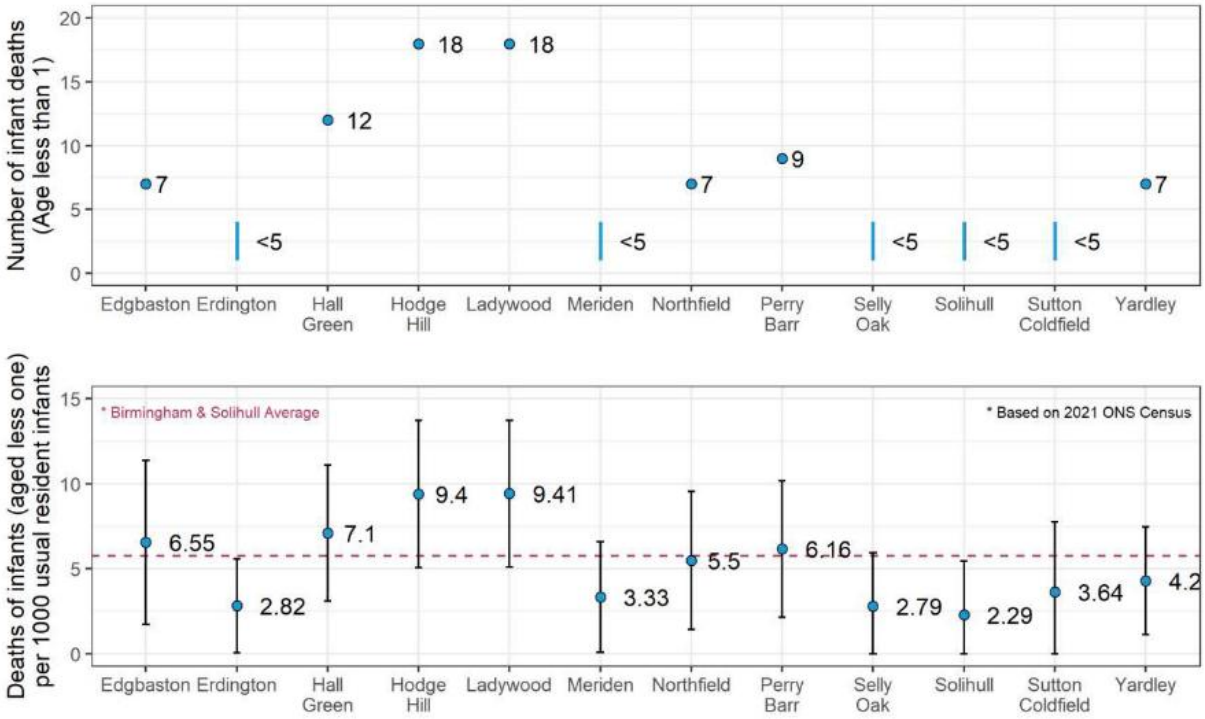
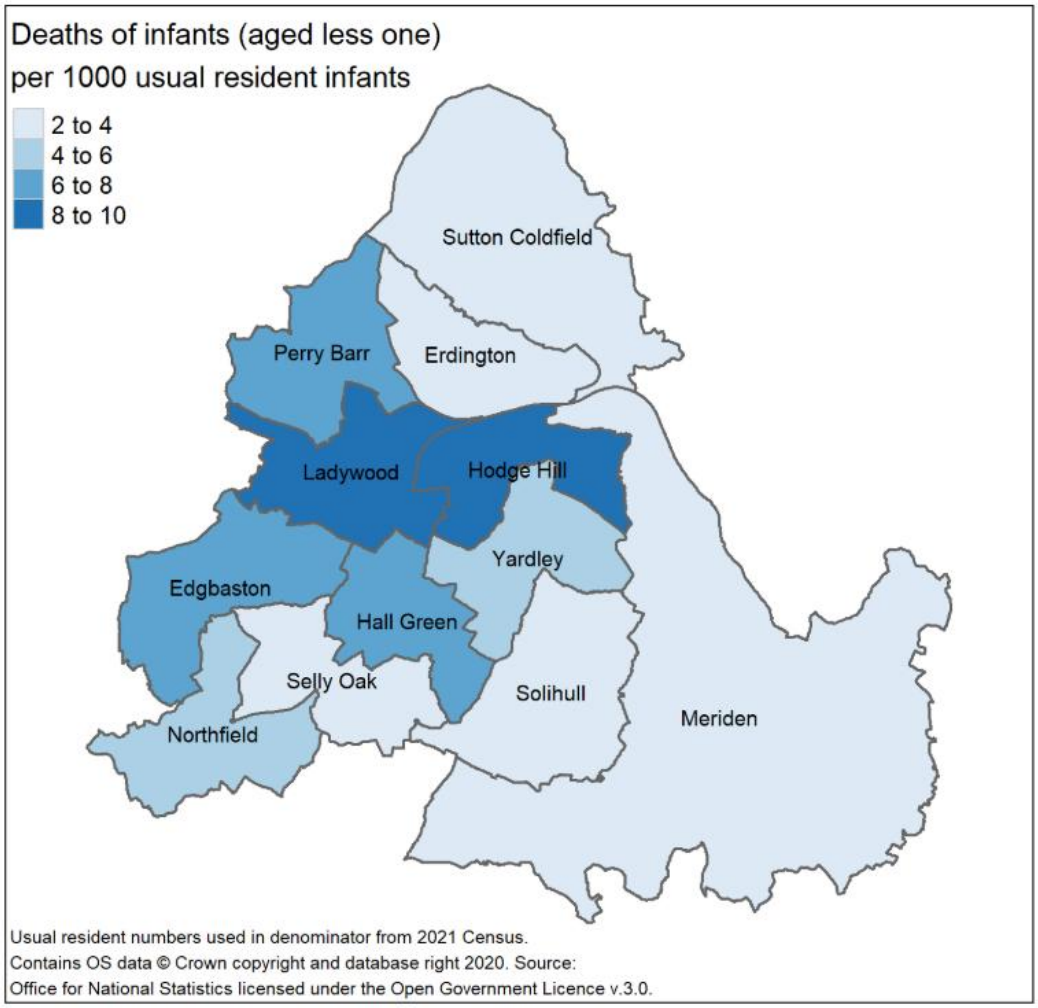


Figure 11 – Heat map of the estimated infant mortality rate for each BSol parliamentary constituency using 2021 ONS census data.



4.5.2 Children

For the whole of BSol, the average infant mortality rate was 0.14 per 1000 usual residents aged one to seventeen. As shown in Figure 12 below, except for Selly Oak which had no reviews of child deaths in the period, Yardley was the only constituency to significantly deviate from the BSol average with a child mortality rate of 0.33 per 1000 usual residents aged one to seventeen ($p = 0.01$).

The calculated child mortality rates are also visualised as a heat map across BSol, as shown in Figure 13.

Figure 12 – (Top) number of child (aged 1-17) deaths by BSol parliamentary constituency. (Bottom) Estimated child mortality rate for each BSol parliamentary constituency using 2021 ONS census data.

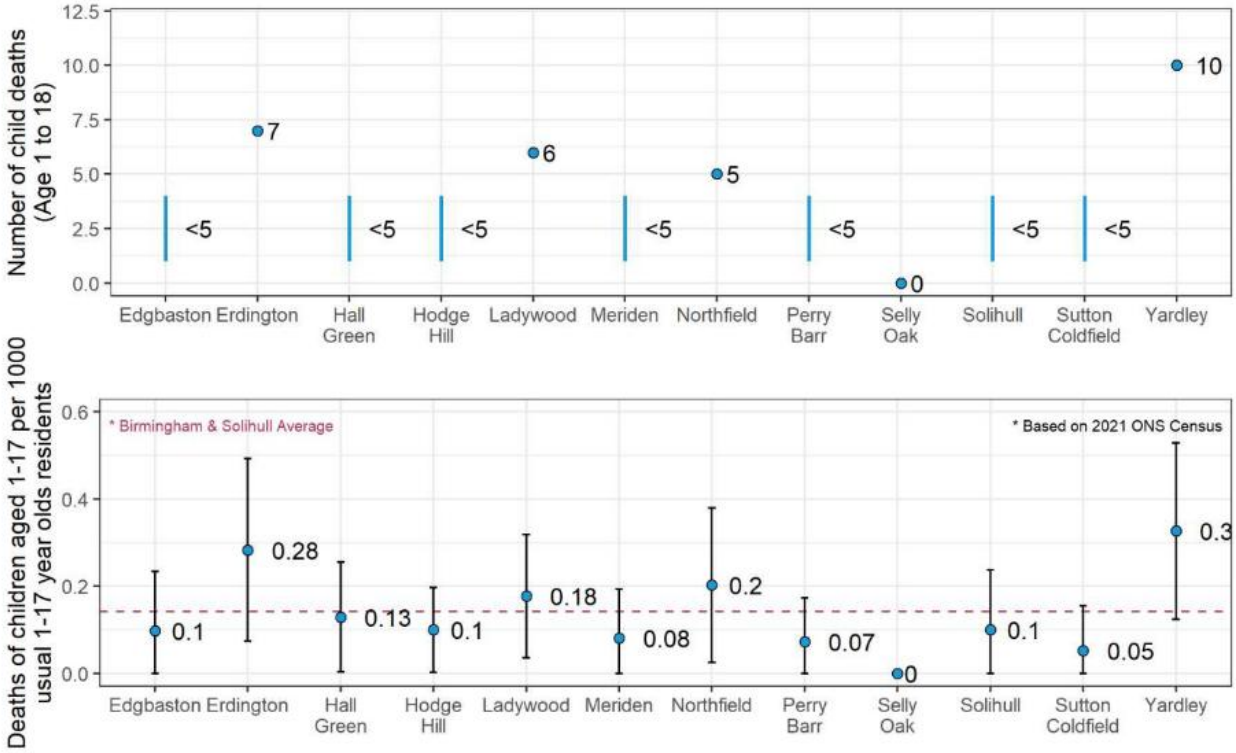
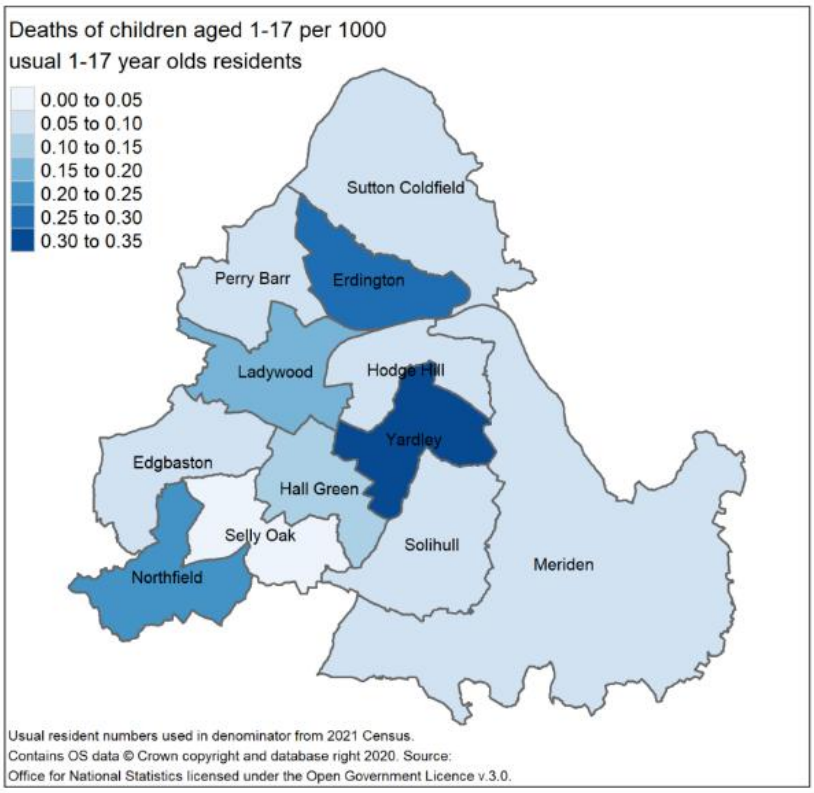


Figure 13 – Heat map of the estimated child mortality rate for each BSol parliamentary constituency using 2021 ONS census data.



5.0 Joint Agency Response (JAR)

The CDRT provides oversight and administrative support for any death which requires a JAR. The JAR should be started if a child's death:

- is or could be due to external causes;
- is sudden and there is no immediately apparent cause (incl. SUDIC);
- occurs in custody, or where the child was detained under the Mental Health Act;
- where the initial circumstances raise any suspicions that the death may not have been natural;
- in the case of a stillbirth where no healthcare professional was in attendance

There is a consultant Paediatrician from either Birmingham Community Healthcare NHS Trust or University Hospitals Birmingham NHS Trust on call 24 hours per day to support the JAR and ensure that joint home visits with the police can take place as soon as possible. This on-call duty is alongside existing clinical commitments so although the Paediatrician is always available for advice they may not be immediately available for home visits. During working hours, the lead nurse on-call from the CDRT will accompany the Paediatrician.

Each SUDIC case has an allocated lead nurse from the CDRT who co-ordinates the response with the SUDIC Paediatrician. This includes but is not limited to supporting parents/carers, attending the initial and final multi-agency meetings, safeguarding, referring cases for Local Safeguarding Child Practice Reviews where indicated, liaising with governance teams and updating providers. The CDRT nurses also lead on deaths caused by homicide cases, Road Traffic Collisions and those that occur abroad.

All agencies follow the 2016 Kennedy Guidelines[3] for investigation of SUDIC. A local Birmingham multi-agency guideline was agreed between West Midlands Police, the Birmingham Coroner and BSol CCG in May 2021.

5.1 JAR audit

Joint Agency Response (JAR) Audit 2022-23

The JAR is audited annually to provide assurance that the response is compliant with national standards. A summary of the audit is presented here. It takes a minimum of 4 months (and often much longer) to complete a JAR due to the length of time needed for post-mortem reports to be completed, therefore few cases from 2022-23 will have completed the JAR process yet.

5.2 Audit of JAR deaths occurring year 2022-23

This audit of the Joint Agency Response (JAR) is for Birmingham and Solihull (BSol) child deaths between 1st April 2022 and 31st March 2023 inclusive.

There were 45 child deaths subject to a JAR; of these 36 children were resident in Birmingham and 9 children were resident in Solihull. This was an increase in child deaths compared to the previous two years; the total number of JARs in 2021-22 was 28 and in 2020-21 was 27. Twelve of the JARs were in the month of December 2022 which included a major incident. To add context to this 20 JARs occurred within the same 3 month period.

This had a huge impact on the workload and emotional well-being of not only the BSol CDRT but also the wider multi-agency work force and healthcare providers within the region. It is acknowledged that the multi-agency work force and regional healthcare providers would have also responded to JARs outside of the BSOL area. The CDRT thanks all involved for their hard work and support.

Figure 14a) shows the gender, 14b) the ethnicity and 14c) the age bracket of the child deaths requiring a JAR.

Figure 14a - Gender of children requiring a JAR

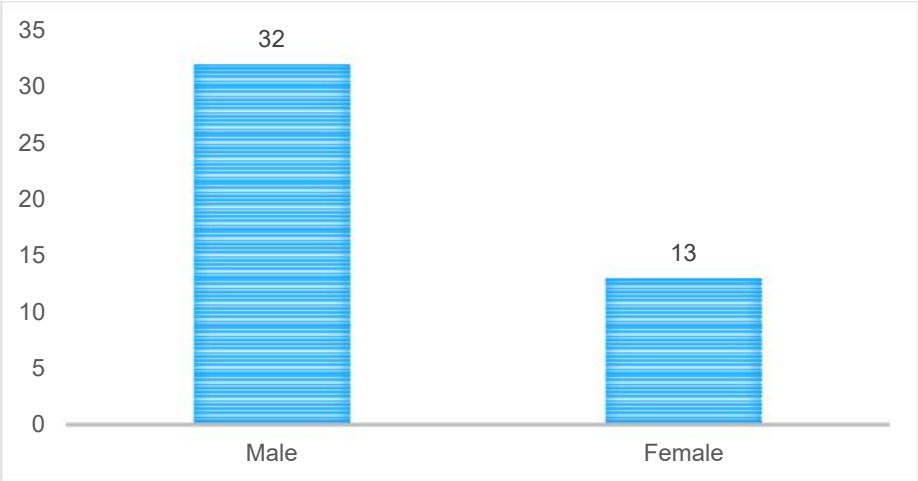


Figure 14b – Ethnicity of children requiring a JAR

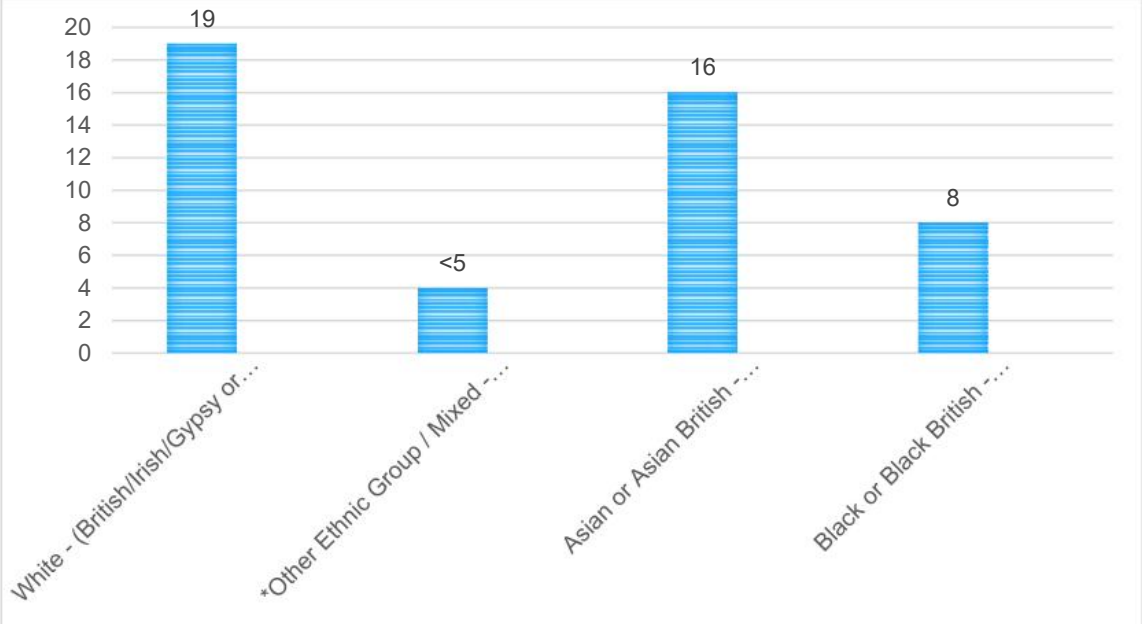
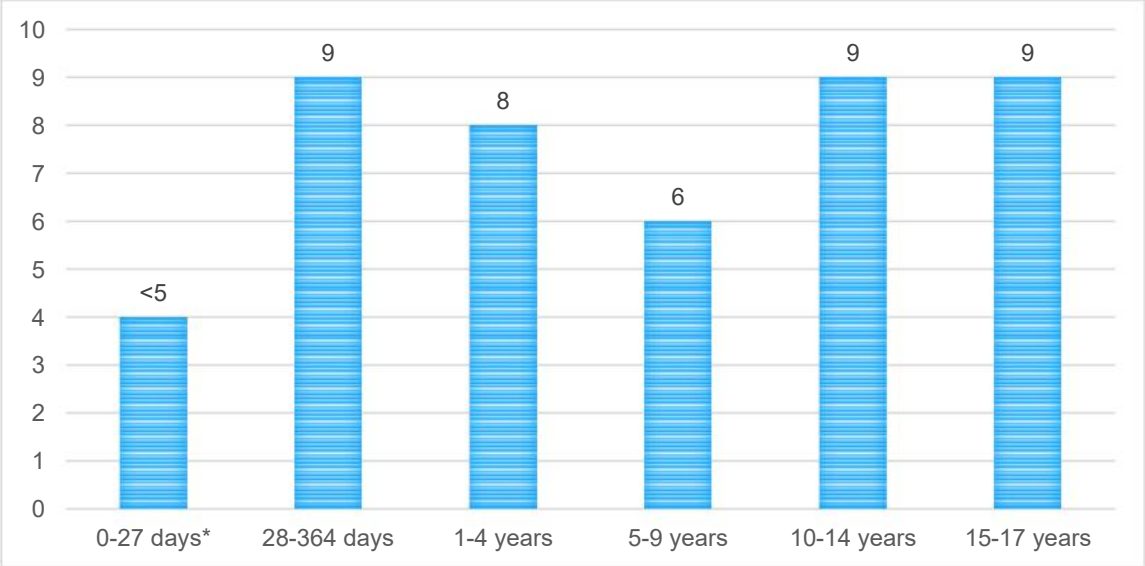


Figure 14c – Age of children requiring a JAR



Emergency Department attendance

36 of 45 children were taken to the ED. The remainder included deaths which occurred as inpatients and some taken directly to the mortuary.

Joint Agency Response home visit

21 joint agency home visits with Health professionals and West Midlands Police (WMP) took place. 12 home visits were conducted by WMP only due to potential criminal investigations. 11 home visits were not required as the deaths occurred in a public place, care home or Hospital.

SUDIC (Sudden unexpected/unexplained death in childhood) Paediatrician Report

30 JARs required a written report from the SUDIC Paediatrician for the Coroner; this was completed in all cases.

SUDIC Paediatricians provided a written report for the Coroner for 30 children, the remainder did not require reports as the deaths were homicide, trauma or a Medical Certificate for Cause of Death (MCCD) was issued without a post-mortem examination.

Timeframe of initial JAR meeting from date of death

The range of the initial JAR meetings was 0-9 days with a median of 3.5 days. These meetings can be deferred for school age children in the school holidays if there are no safeguarding concerns so key school staff can attend.

Attendance at initial JAR meeting

Attendance at initial JAR meetings was good by all core agencies. Health attended all of the meetings. WMP and Childrens services attended 39/40 and Coroner's investigators attended 29/40.

Local Child Safeguarding Practice Review (LCSPR) referral

9 of the child deaths were referred to the Serious Cases Review Subgroup of the Safeguarding Partnership. All referred cases had a Rapid Review and a LCSPR was undertaken in 8 cases.

Children's Services involvement

11 children were previously known to Children's services prior to their death, but not currently receiving support. 5 children were either on Child in Need plan or receiving Early Help Support at the time of their death. A smaller number were on a Child Protection plan at the time of their death. 23 children had not had any involvement with Children's services prior to their death. Following the initial JAR meeting 7 Section 47 enquiries were opened for 7 families , and a small number had Section 17 enquiries initiated.

5.3 Audit of JAR deaths reviewed at CDOP year 2022-23

27 child deaths requiring JAR were reviewed and closed at CDOP during year 2022-23.

19 of these child deaths were male and 8 child deaths were female.
Figure 15a) shows the CDOP year the child death occurred; 15b) the CDOP category of the child death and 15c) if modifiable factors were identified.

Figure 15a - JAR deaths reviewed 2022-23: CDOP year of death

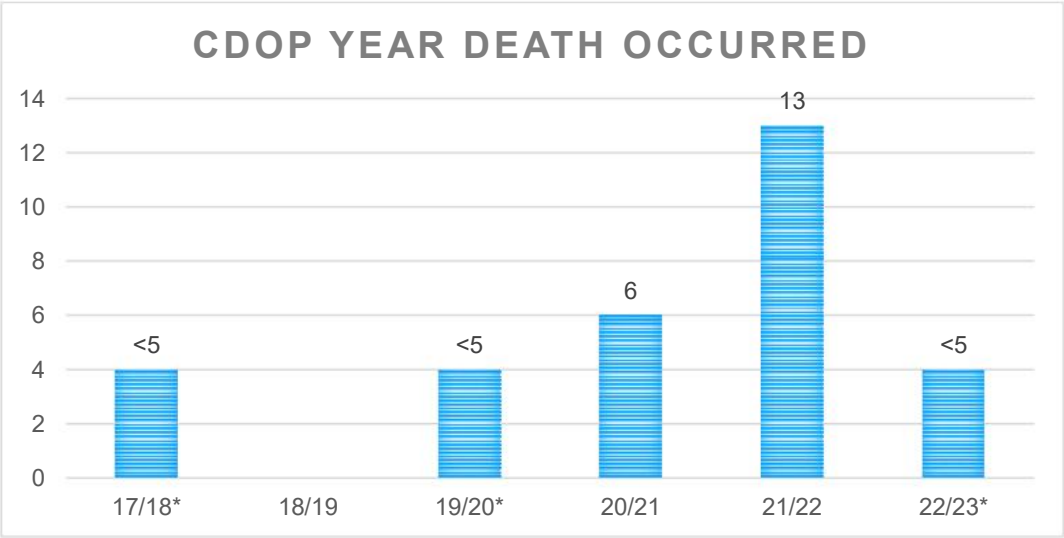
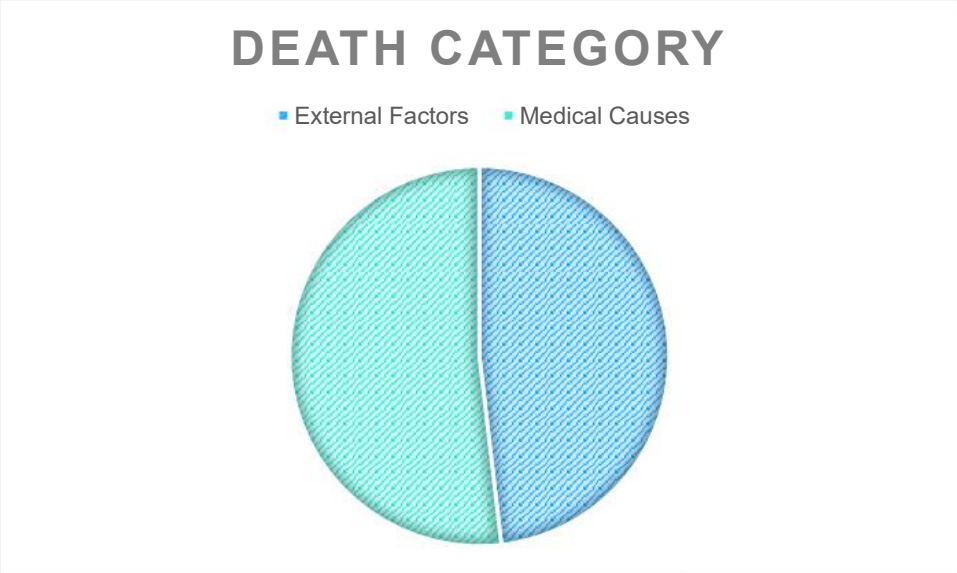
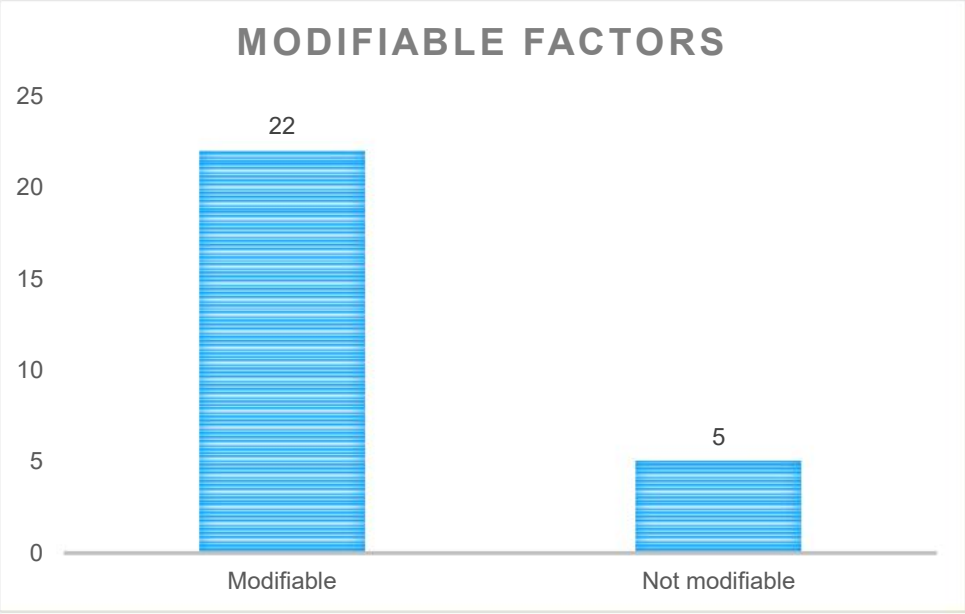


Figure 15b - JAR deaths reviewed 2022-23: category of death



1. Deliberately inflicted injury, abuse or neglect	External Factors
2. Suicide or deliberate self-inflicted harm	
3. Trauma and other external factors	
4. Malignancy	Medical Causes
5. Acute medical or surgical condition	
6. Chronic medical condition	
7. Chromosomal, genetic and congenital anomalies	
8. Perinatal/neonatal event	
9. Infection	
10. Sudden unexpected, unexplained death	

Figure 15c - JAR deaths reviewed 2022-23: modifiable factors



Modifiable factors

CDOP identified modifiable factors relating to children's intrinsic vulnerabilities including substance misuse, self-harm, risk taking/challenging behaviour, and lack of support for gender identity concerns.

Modifiable factors in the social environment included parental recognition and management of physical and mental illness, parental separation, young carers, knife crime, chaotic home circumstances and social isolation.

Modifiable factors in the physical environment related to unsafe driving, poor home accommodation and lack of safety equipment.

There were many cases with modifiable factors relating to service provision. These included poor communication between health professionals, poor communication with families including not using interpreters, lack of face-to-face consultations due to COVID and inadequate discharge planning. Specific safeguarding service issues included not following Was Not Brought (WNB) policies, not considering the Voice of the Child, lack of domestic abuse awareness, lack of multi-agency working and failure to follow escalation policies.

Final Case Discussions (FCD)

The purpose of the FCD is to analyse all information received, discuss on-going support for the family (and professionals if necessary) and identify any learning or recommendations for agencies/providers/services. These are held to conclude the JAR investigation, as such they are effected by the time scales for serious incident investigations, results of post-mortems and the conclusion of any criminal trials/LSCPR reports. FCDs were held in 18 cases.

The range of the length of time until the FCD meetings were 2 days (combined initial and final case discussion) to 19 months, with a median of 7.5 months. 9 cases did not require a FCD due to complex criminal investigations, combined initial and final JAR meetings, or the FCD had been completed prior to case transfer from Solihull, Coventry and Warwickshire CDOP.

Final home visit

At the end of the JAR investigation families are offered a final home visit by the Lead SUDIC Nurse and SUDIC Paediatrician. This is an opportunity to discuss the post mortem report, the outcome of the JAR investigation, any identified learning or recommendations and ongoing support.

24 families were offered a final home visit following the conclusion of the JAR; 11 families accepted and 13 declined. A few families could not be offered a final visit as they were in prison. The SUDIC nurses remain in contact with families throughout the JAR investigation.

Local Child Safeguarding Practice Review (LCSPR)

A LSCPR was held for 6 of the 27 reviewed cases.

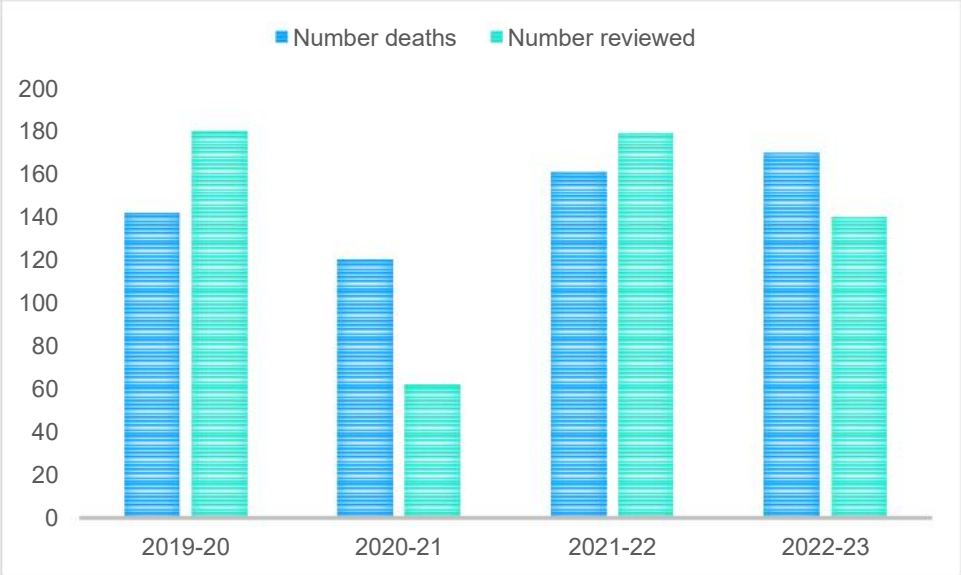
Children's Services

17 of the 27 children were previously known or known at the time of death to Children's Services and the remaining 10 were not known at all.

6.0 All Deaths Reviewed by BSol CDOP

140 deaths were reviewed by Birmingham CDOP, compared to 179 in 2021-22, 62 in 2020-21 and 180 in 2019-20. COVID was the reason for the reduction in reviews in 2020-21, with several CDOP meetings cancelled and delays in getting the information required from acute hospitals. These have been caught up over the last two years. The reduced number of reviews in 2022-23 is likely to reflect the lower child death rate during COVID. There were 170 deaths in 2022-23, 161 deaths in 2021-22, and 120 in 2020-21. This is illustrated in Figure 16.

Figure 16 Number of deaths vs number reviewed at CDOP 2019-20 until 2022-23



The majority of deaths are in infants under the age of 1 year. The breakdown of ages is shown in Figure 17a with data for 2019-20 and 2020-21 shown for comparison. Figure 17b shows the gender (where this was determinable).

Figure 17a Age of children reviewed at CDOP 2022-23 with 2021-22 for comparison

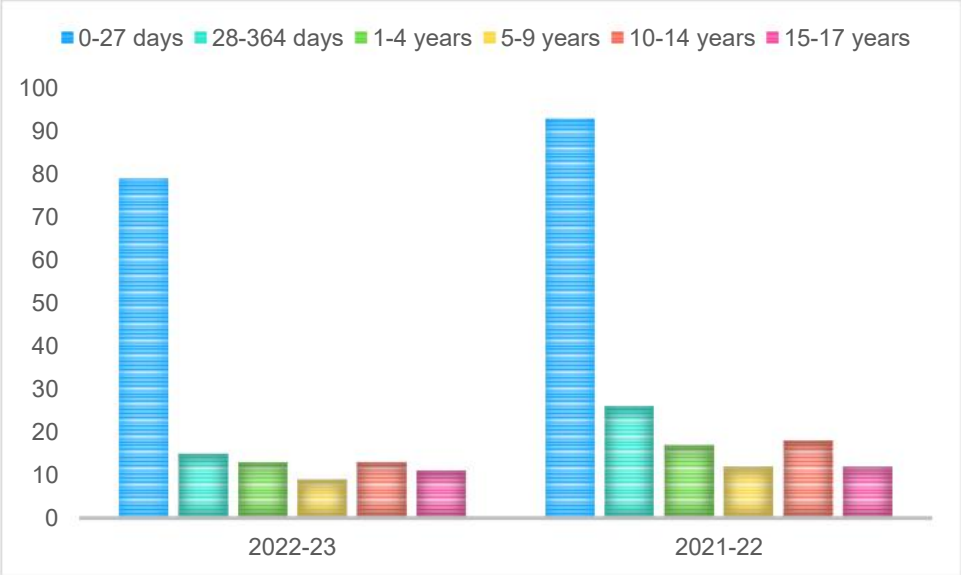
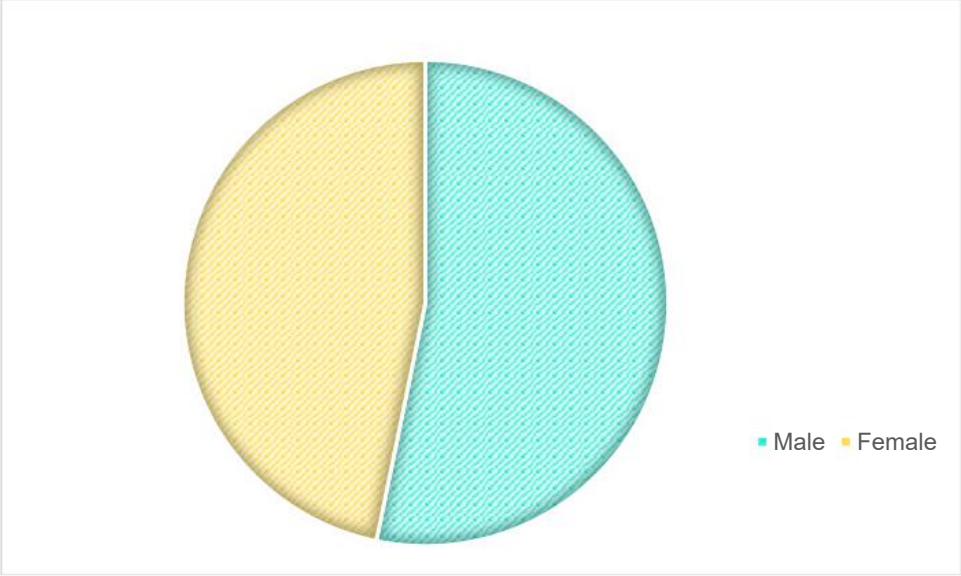


Figure 17b Gender of children reviewed at CDOP 2022-23

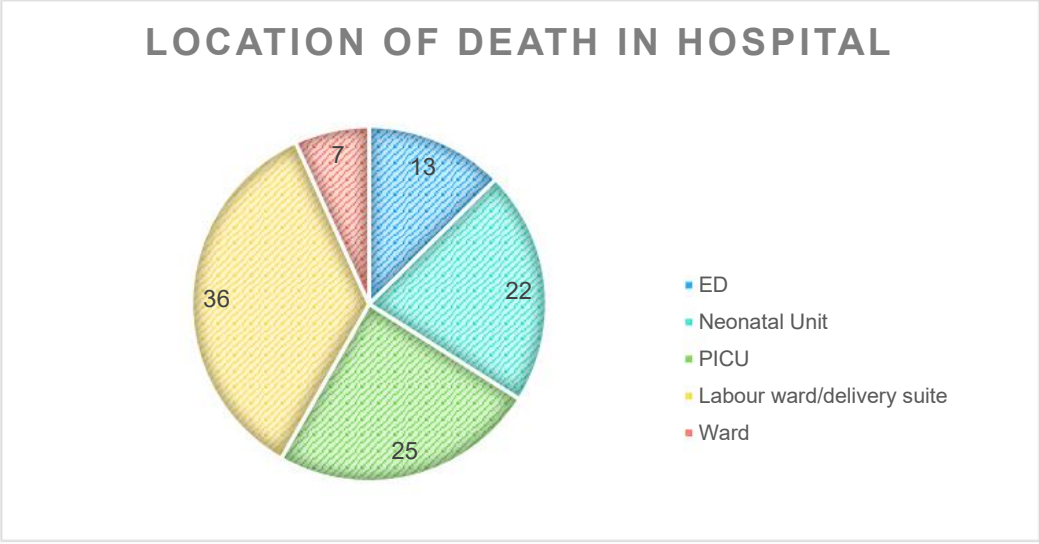


The median time for a review to be completed was 321 days (range 124 -1783). This compares to 360 days (range 91-1472) in 2021-22. For 2022-23 the median time from date of death to CDRM is 72 days, and the median time from CDRM to CDOP case closure is 236 days. There are often lengthy delays while CDOP wait to receive information from hospitals, particularly for mortality reviews to be completed at Birmingham Children's Hospital, in part due to their multi-layered mortality review process. Further delays are also unavoidable if there are criminal investigations, prosecutions or Child Safeguarding Practice Reviews.

6.1 Place of death

The majority of the deaths occurred in hospital (80%) or at home (15%) with a small number occuring in a hospice, apublic place or abroad. Most of the hospital deaths occurred on labour ward, PICU or the Neonatal Unit. This is illustrated in Figure 18.

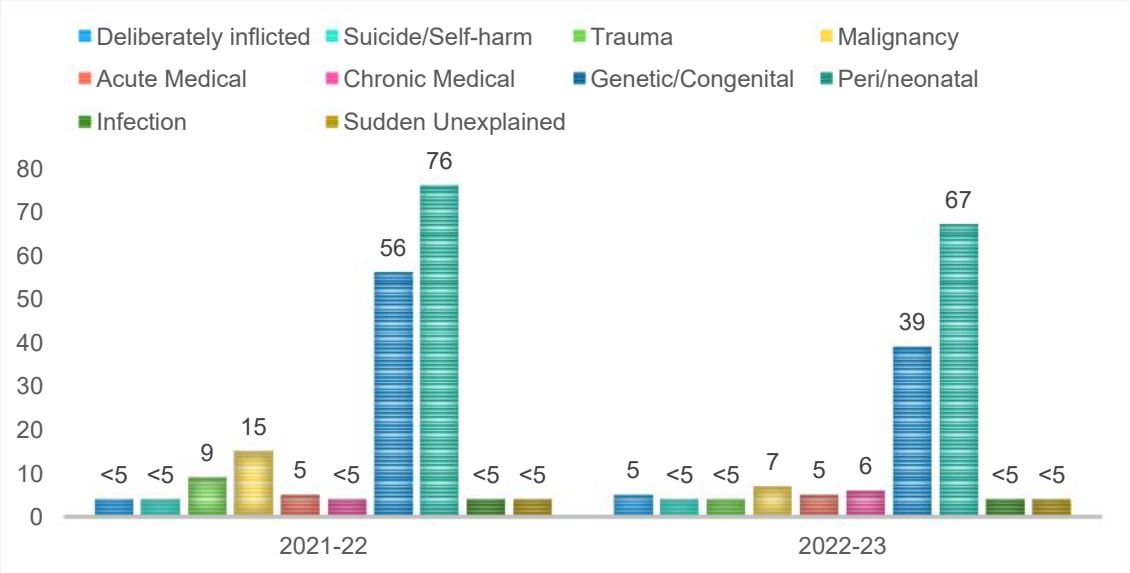
Figure 18 Location of hospital death 2022-23



6.2 Cause of death and modifiable factors

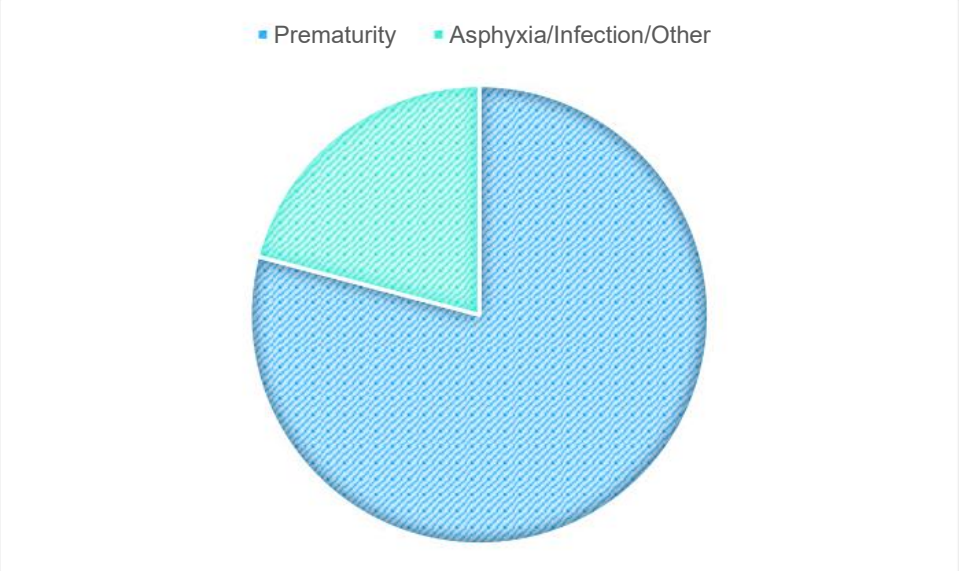
CDOP categorises deaths into broad categories, the frequency of deaths in each category varies with age as shown in Figure 19.

Figure 19 Causes for death 2022-23, with 2021-22 for comparison



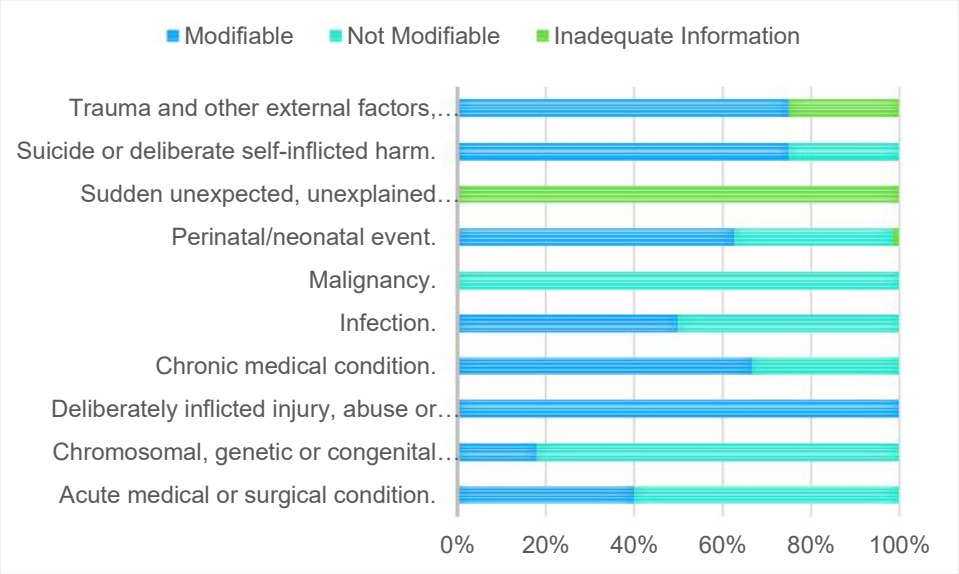
The Peri/Neonatal deaths are further subdivided into categories as detailed in Figure 20.

Figure 20 Sub-categorisation of Peri/Neonatal deaths, 2022-23



CDOP consider whether each death is preventable based on the presence of modifiable factors. These are defined as '… factors in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.' In total 59/179 (33%) of deaths had modifiable factors, which is similar to 2020-21 (34%). The proportion of each category with modifiable factors is illustrated in Figure 21.

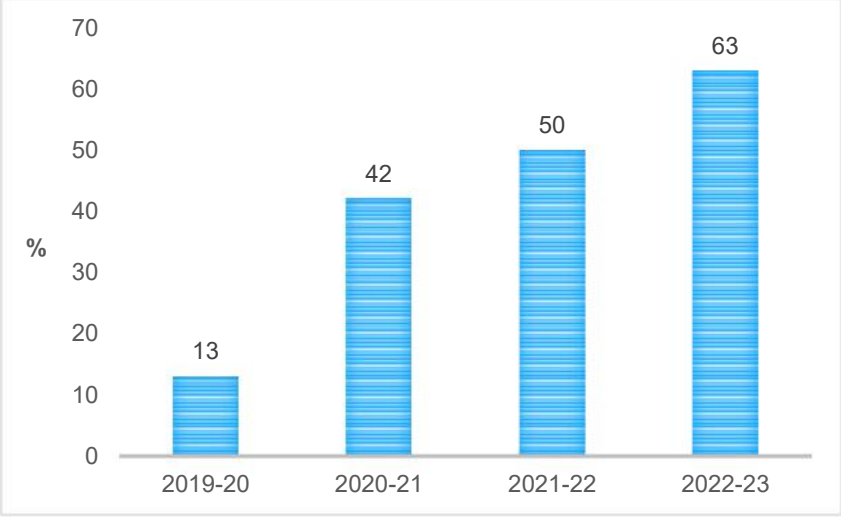
Figure 21 Modifiable factors and category of death 2022-2023



6.3 Modifiable factors for Perinatal and Neonatal Deaths

Notably, 63% (42/67) of our perinatal/neonatal deaths had one or more modifiable factor recognised. There has been a steady increase in this over the last 2 years, as demonstrated in Figure 22.

Figure 22 Percentage of Perinatal and Neonatal Deaths with modifiable factors from 2019-20 until 2022-23



We now receive high quality information in the form of the hospital completed Perinatal Mortality Review Tool (PMRT)[4], which is an evidence based template for reviewing stillbirths and neonatal deaths born after 22 weeks gestation. In addition to this, deaths of term babies (over 37 weeks gestation) who died within the first week of life were also reviewed by the Healthcare Safety Investigation Branch (HSIB)[5] and these reports were also reviewed as part of the CDOP process.

We hold specialist neonatal CDOPs, with consultant neonatologists and specialist midwives present enabling clinical experts to contribute to reviews. In Birmingham, there are three NHS Trusts with maternity hospitals: Birmingham Women's Hospital, Heartlands Hospital (University Hospitals Birmingham) and City Hospital. We hold separate CDOP meetings for cases from each hospital, with clinicians from the other hospital attending to review cases; this ensures both clinical expertise and a high degree of scrutiny with independent experts.

Some cases had more than one modifiable factor identified. There were 42 cases where modifiable factors were identified, and a total of 71 modifiable factors were identified within them.

Similarly to 2021-22, most of the modifiable factors identified in perinatal and neonatal deaths were related to suboptimal maternal health, namely maternal smoking (increasing risk of premature delivery and low birth weight) and maternal weight (obesity or underweight). There were some modifiable factors with service provision regarding antenatal care (e.g. not being referred to Preterm Prevention Clinic when indicated in national guidance, not being persistent enough when women did not attend appointments), intrapartum care (around the time of birth, e.g. incorrect monitoring/misinterpretation of cardiotocography monitoring, not giving or delay in giving Magnesium Sulphate or steroids when indicated) and with neonatal care (e.g. extremely premature babies being born in hospital that did not have tertiary NNU and then requiring transportation, which is associated with worse outcomes). The modifiable factors for perinatal and neonatal deaths are shown in Figures 23a and 23b.

Figure 23a Modifiable factors for perinatal and neonatal deaths: Broad category

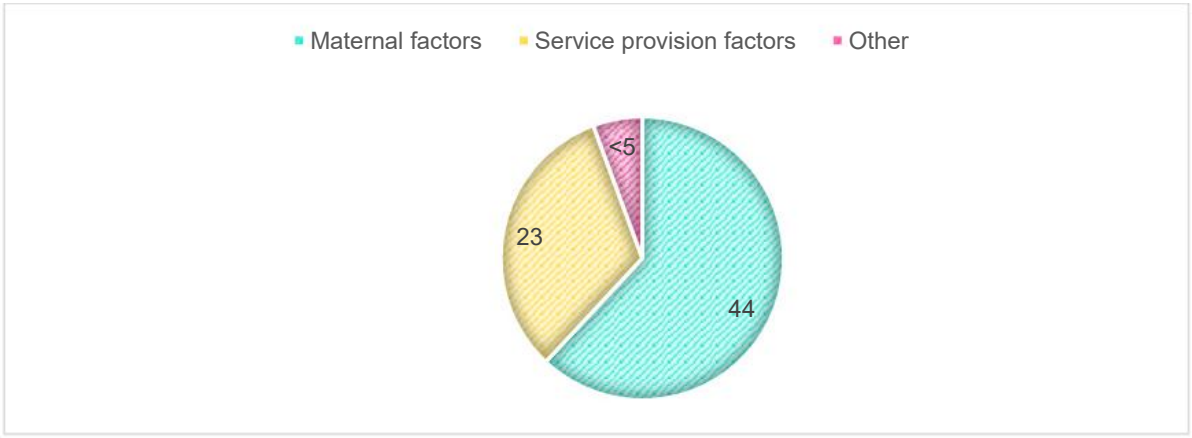
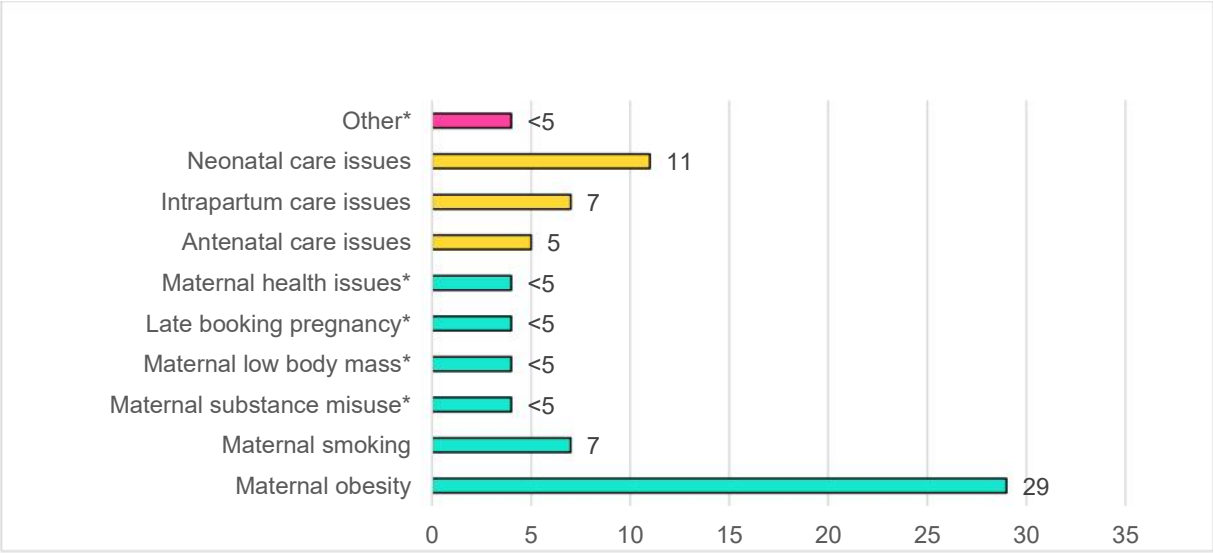


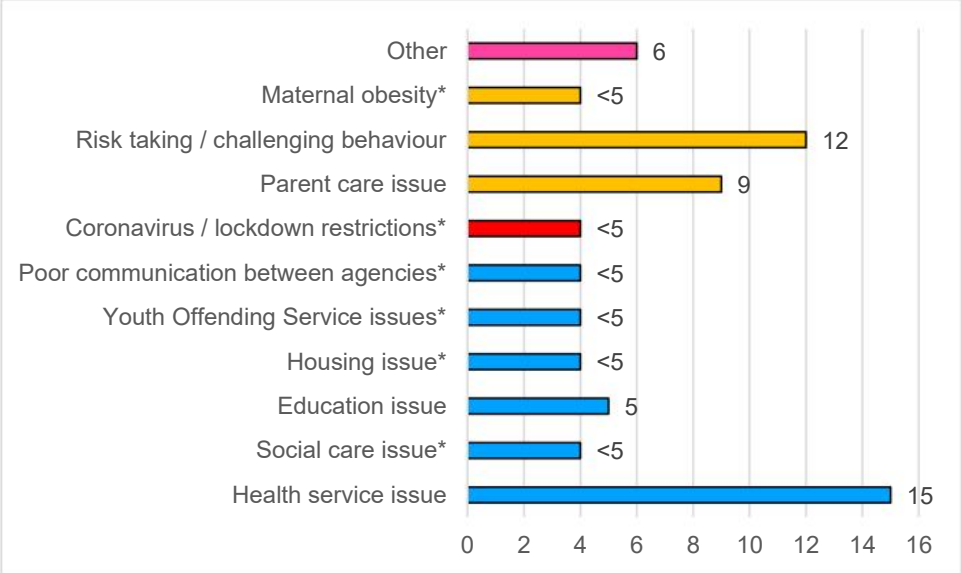
Figure 23b Modifiable factors for perinatal and neonatal deaths: Subcategory (numbers <5)*



6.4 Modifiable factors in other deaths (excluding perinatal and neonatal deaths)

Out of the 73 other (non-neo/perinatal) deaths, modifiable factors were identified in 25 cases. Some cases had more than one modifiable factor identified; there were 64 modifiable factors in total. Figure 24 demonstrates the themes of these factors.

Figure 24 Modifiable factors for 'other' (non-neo/perinatal) deaths (number <5)*



Modifiable factors in health service provision included delay in diagnosis, delays in transfer to tertiary centers, delay in follow up and management of WNB (Was Not Brought).

Modifiable factors in other (non health) service provision included school exclusions, delay in housing adaptations, cases not escalated to MASH (Multi Agency Safeguarding Hub) when indicated, and poor communication between agencies.

Several deaths involved risk taking behaviors in either the child or in those responsible for the child's death. A separate analysis of adolescent deaths below in Section 7 of this report explores this in more detail.

Parental consanguinity was noted to be present in 11 of the 39 Congenital/Chromosomal deaths. In 10 of these cases the consanguinity was felt to be contributory to the death. These were not classified as modifiable, in line with NCMD guidance[6].

6.5 Learning from deaths

66/140 (47%) reviews identified relevant learning, even though in most cases this would have made no difference to the outcome for that child. This is an increase compared to 2021-22 where 35% reviews identified learning. This increase is likely to be due to concerted effort by the CDR team to ensure all learning is captured on the eCDOP analysis form (as this was one of the objectives set for this year following the 2021-22 Annual Report).

Much of the learning was identified by provider trusts at internal CDRM or through the Healthcare Safety Investigation Branch.

Key learning was identified in deaths from asthma. This resulted in development of training for primary care, and following a Serious Case Review of one of the deaths resulted in 7 minute briefing on Childhood Asthma and Neglect, and a video was produced to increase awareness 'Managing Asthma in Children'.

Learning from congenital/chromosomal deaths included the need to offer genetic testing and post mortems even if baby is on a palliative pathway from the outset, as this may have implications for planning future pregnancies. Also identified learning included the need for earlier involvement of palliative care team (at the antenatal stage) for babies with likely non-survivable congenital anomalies identified on antenatal scans.

Learning from Peri/Neonatal deaths included optimizing maternal care in threatened preterm labour, management and training on CTG use/interpretation, following Neonatal Life Support guidelines, and importance of 'Golden Hour'. Golden Hour is the concept that neonates being admitted to a neonatal unit should have interventions like placing Intravenous lines, giving fluids and antibiotics and setting up monitoring all completed as soon as possible with no avoidable delay to allow a hands-off eyes-on approach meaning that the baby can then be left to rest with minimal handling (excessive handling is associated with poorer outcomes).

6.6 Learning from what went well

As well as learning from what went wrong, it is also an important role of CDOP to review and highlight positive factors in provision and examples of best practice. 36/140 deaths reviewed had examples of positive service provision or best practice. Examples included members of staff coming to work on their days off to help and good joint working with hospital teams and palliative care.

7.0 Adolescent Deaths

This year we took a closer look at our adolescent deaths (aged 10-17 years). A higher proportion of adolescent deaths were male (67%), compared to deaths across all ages (where 53% were male). A higher proportion were unexpected (58%) compared to deaths across all ages (19%). In fact, over 50% of all unexpected deaths occurred in adolescents (14/27) demonstrating this is a vulnerable age. Risk taking behaviours were a theme particularly in the non-natural deaths (Categories 1-3: deliberately inflicted, suicide/self-harm, trauma). Figure 25 demonstrates a) age, b) gender c) if death was expected or unexpected and d) CDOP categorisation of death.

Figure 25a Adolescent deaths: Age category at time of death

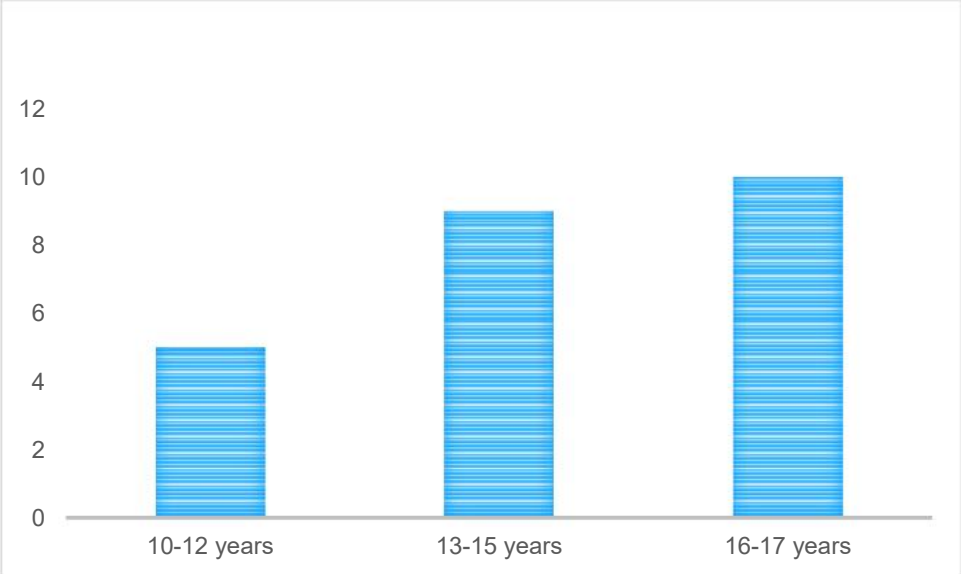


Figure 25b Adolescent deaths: Gender

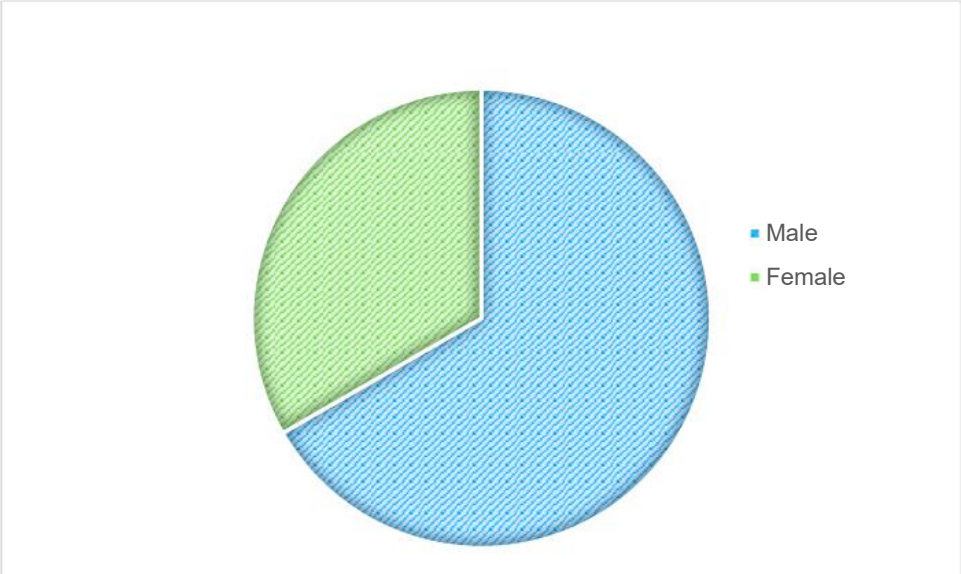


Figure 25c Adolescent deaths: Expected or unexpected death

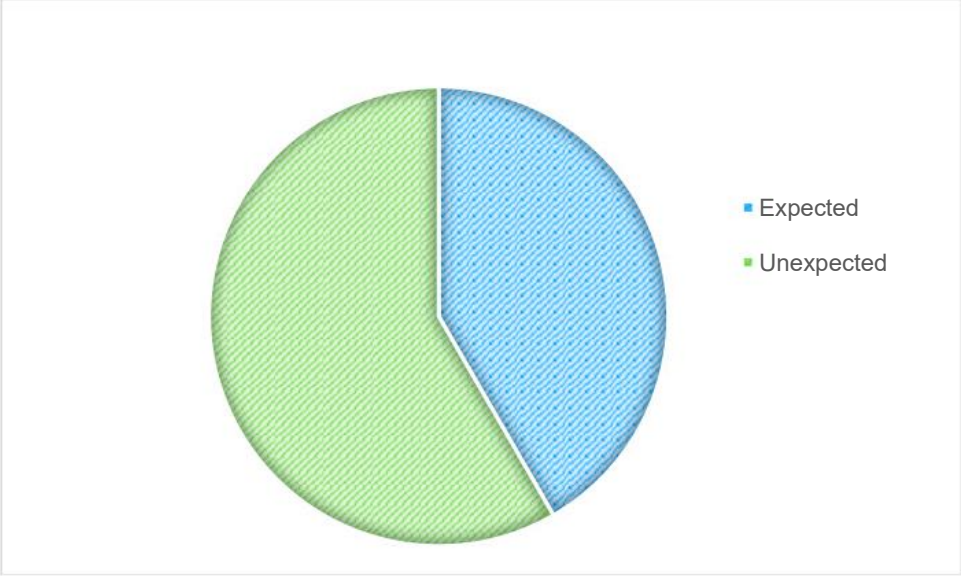
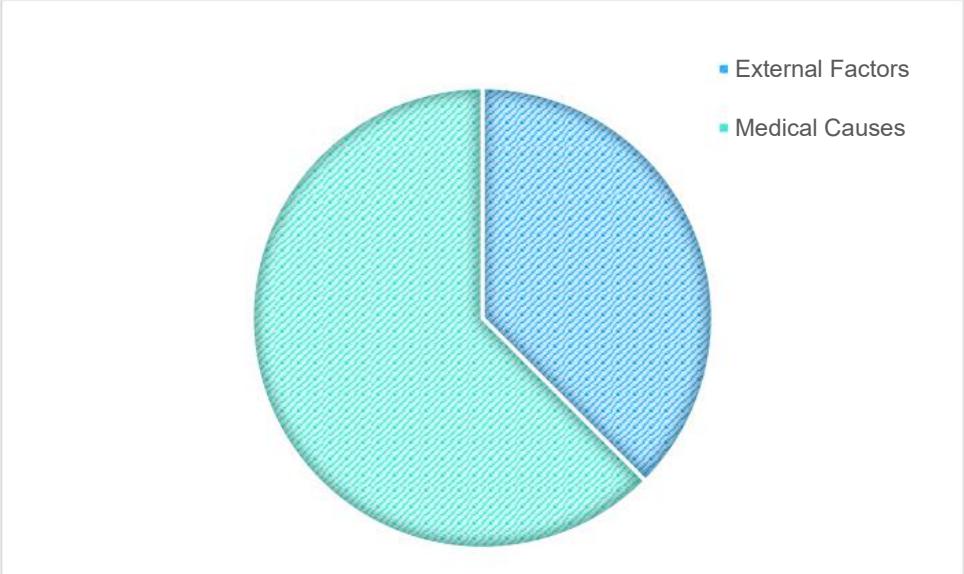


Figure 25d Adolescent deaths: CDOP category of death



1. Deliberately inflicted injury, abuse or neglect	External Factors
2. Suicide or deliberate self-inflicted harm	
3. Trauma and other external factors	
4. Malignancy	Medical Causes
5. Acute medical or surgical condition	
6. Chronic medical condition	
7. Chromosomal, genetic and congenital anomalies	
8. Perinatal/neonatal event	
9. Infection	
10. Sudden unexpected, unexplained death	

8.0 Learning Disability Mortality Review (LeDeR) - 2022-23

The Birmingham and Solihull (BSOL) Child Death Overview Panel (CDOP) reports deaths of children with a learning disability to LeDeR via the online referral form and provides core information about the child. CDOP is a statutory requirement under Working Together 2018. The purpose of CDOP is to review the interventions leading up to and surrounding all child deaths and ensure that any learning from those deaths is implemented effectively by partners. Additional CDOP documentation containing details regarding the circumstances leading to death is submitted following the comprehensive review at CDOP. This analysis form is then uploaded to the LeDeR database. The analysis form lists any common contributory factors leading to deaths:

- Factors that may have contributed to the vulnerability, ill health or death of the child
- Modifiable factors that may reduce the risk of future child deaths
- Learning points and issues identified in the review
- Recommendations and actions that may inform and support local, regional or national learning

This information is submitted to the LeDeR platform and themes and trends are collated for the city.
As of 1st July 2023, LeDeR policy relating to the deaths of children and young people under the age of 18 is changing. There will no longer be any requirement for deaths of children with a learning disability to also be notified to LeDeR.

This change is being made because it is important that the deaths of children with a learning disability and autistic children are reviewed by the national mandated processes that look at the deaths of all children.

Autism will be added to the national child mortality review child notification which will enable more in-depth analysis of the deaths of autistic children and young people for the first time.

The approach will reduce duplication of effort for systems. There will no longer be an expectation that the analysis forms from child death reviews are uploaded by ICBs into the LeDeR web platform.

There will be greater opportunity for the analysis of the deaths of children with a learning disability and autistic children – via the NCMD and via the LeDeR programme, working with our academic partners. The NCMD have been commissioned to do a thematic review of children with a learning disability and autistic children which is expected to be published in Autumn 2024.

There will be a data sharing agreement between NCMD and Kings College London (KCL) so data will still flow to LeDeR and it can be included in the annual report for analysis.

Relationships between LeDeR governance and child death review panels should be strengthened with agreements in place which enable the sharing of learning to improve services for people with a learning disability and autistic people of all ages.

ICB's will need to take a decision as to how to manage child deaths review currently in the LeDeR system in progress.

Total number of deaths in this period – 170
Number of LeDeR referrals – 16 (9.4%)
10 of these deaths were expected and 6 were subject to the Joint Agency Response process as these deaths were not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death.
Of the 16 cases that have been referred 9 had appropriate Advanced Care Plans (ACP) in place.
Reviews completed – 7

Age range	
5 - 7	<5
8 - 10	5
11 - 13	7
14 - 17	<5

Gender	
Male	8 – 50%
Female	8 – 50%

Ethnicity	
White British / Other	5
Asian/Asian British	9
Other Ethnic Group / Mixed	<5

Classification of death at CDOP	
Chromosomal, genetic or congenital anomaly	<5
Chronic medical condition	<5
Acute medical or surgical condition	<5
Cases not yet reviewed at CDOP	9

Modifiable factors	
Modifiable factors	<5
No modifiable factors	<5
Not yet reviewed at CDOP	9

Modifiable factors Modifiable are defined as 'those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced.
Themes throughout the cases include;

- Good communication between agencies involved with the child and family
- Parents/carers engagement with services
- Excellent provision of care
- Constraints of Coronavirus restrictions on face-to-face appointments
- Palliative Care team receiving debrief sessions from BCH Chaplaincy

9.0 Progress towards targets

In our last annual report we stated the following targets for this year as:

1. To ensure BCH implement joint CDRM for all deaths

Significant support has been given to assist implementation. Some joint CDR meetings have occurred, and the benefit has been acknowledged. BCWH have made a business case for a co-ordinator to assist in implementation. However this has not been achieved yet and so remains a target for 2023-24.

2. To continue to catch up on cases delayed due to the Covid-19 pandemic
   This has been addressed and there is now no backlog related to Covid-19

3. Ensure that all lessons learnt from the whole death review process are captured on eCDOP Analysis Form.
   This is evidence from the increased proportion of cases with lessons learnt as detailed in Section 5.5

4. Ensure all CDRM are multi-agency and external professionals invited

   The CDOP Co-Ordinator advises the Trusts who should attend the CDRM from external agencies and we are assured that they are invited.

5. To provide Joint Agency Response (JAR) training for health, police and coroners staff
   A joint training day on the JAR was held in July with police, coroners, paediatricians and nurses, providing general refresher training and focusing on the most challenging JAR cases.

6. Closer working with public health. Completing thematic analysis of deaths:
   a. Consanguinity
   b. Deaths compared to social deprivation
   c. Perinatal deaths and maternal health

   Joint working with Public Health has enabled us to statistically analyse the data gathered at CDOP in more detail. Public Health colleagues worked closely with the CDRT to compile this report, and their support in this was very gratefully received. Information from infant mortality and the link to preconceptual maternal health has informed the Public Health strategy for BSol. Consanguinity was not analysed but will be addressed in 2024.

10.0 Recommendations for 2023-24

1. To ensure BCH implement joint CDRM for all deaths
2. Continued close working with public health. Thematic analysis of Consanguinity and the impact on infant mortality.
3. To gain greater understanding of parent/carer experience of the JAR process by collecting their feedback and using this to inform/improve service provision.

11.0 Conclusion

The year 2022-23 has been a challenging year for the CDR team with some difficult peaks in SUDIC in December 2022-Jan 2023 including a major incident. This had a huge impact on the team, and supporting each other was key during this time. Restorative supervision has been organized for administrative staff and the child death nurses receive psychological supervision.

The quality of information available to CDOP when cases are reviewed has improved significantly. Whilst this has led to better recognition of modifiable factors and more learning arising from deaths, this rich information also leads to associated challenges as CDOP meetings and the associated preparation takes much more time.

Over the coming year we aim to continue to work more closely with our Public Health colleagues, so that the data we gather can inform strategies to reduce childhood (and in particular the infant) mortality rates in Birmingham and Solihull.

12.0 References

1. HM Government. Working Together to Safeguard Children. London: Department for Education, 2018
2. HM Government. Child Death Review Statutory and Operational Guidance (England). In: Department for Health and Social Care, ed. London, 2018.
3. Sudden unexpected death in infancy and childhood, 2nd Edition, November 2016, The Baroness Helena Kennedy QC
4. National Perinatal Epidemiology Unit. Perinatal Mortality Review Tool / Parent Engagement Tools 2020 [Available from: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials.
5. Healthcare Safety Investigation Branch, Maternity Investigations. https://www.hsib.org.uk.
6. https://www.ncmd.info/wp-content/uploads/2023/01/NCMD-Guidance-on-Consanguinity.pdf

Acknowledgements to Dr David Ellis and Jeanette Davis for their contribution to the statistics provided for this report.

BIRMINGHAM HEALTH AND WELLBEING BOARD

Item 16 - Creating a Bolder Healthier City (2022-2030): Indicator Updates

The Health and Wellbeing Strategy has a series of ambitious targets for 2030. Each ambition is linked to an indicator that will be used to monitor progress and measure our impact. This update informs the Health and Wellbeing Board (HWB) of data that has been recently updated (since the previous HWB). The Power BI dashboard, which contains data for all indicators (including trends) can be viewed by clicking on the image below.

Click to view the dashboard

Recent Updates: 03 January 2024 – 01 February 2024

Indicator	Theme	Date updated
Suicide rate (persons) per 100,000	Theme 2: Mental Wellness and Balance	01 February 2024
Excess winter deaths index (Persons, All ages)	Life Course: Ageing and Dying Well	31 January 2024
Rate of long-term musculoskeletal problems	Life Course: Living, Working and Learning Well	27 December 2023
Breastfeeding prevalence at 6-8 weeks after birth - current method	Theme 1: Healthy and Affordable Food	15 January 2024
Percentage of children achieving a good level of development at the end of Reception	Life Course: Getting the Best Start in Life	15 January 2024
Rate of first-time entrants (10-17 years) to the youth justice system	Life Course: Getting the Best Start in Life	15 January 2024
Emergency Hospital Admissions for Intentional Self-Harm per 100,000	Theme 2: Mental Wellness and Balance	15 January 2024
TB incidence (three year average) (Persons, All ages)	Theme 5: Protect and Detect	31 January 2024

Life expectancy (Female)	Headline Indicators: Life Expectancy	29 January 2024
Life expectancy (Male)	Headline Indicators: Life Expectancy	29 January 2024
Life expectancy at 65 (Female)	Headline Indicators: Life Expectancy	29 January 2024
Life expectancy at 65 (Male)	Headline Indicators: Life Expectancy	29 January 2024
Percentage of adult carers who have as much social contact as they would like (65+ yrs)	Life Course: Ageing and Dying Well	23 January 2024
Abdominal Aortic Aneurysm Screening - Coverage (Male, 65)	Theme 5: Protect and Detect	23 January 2024
Cancer screening coverage - bowel cancer (Persons, 60-74 yrs)	Theme 5: Protect and Detect	22 January 2024
Cancer screening coverage - breast cancer (Female, 53-70 yrs)	Theme 5: Protect and Detect	22 January 2024
Cancer screening coverage - cervical cancer (aged 25 to 49 years old) (Female, 25-49 yrs)	Theme 5: Protect and Detect	22 January 2024
Admission episodes for alcohol-related conditions (Broad definitions) per 100,000	Theme 2: Mental Wellness and Balance	17 January 2024
Under 75 mortality rate from heart disease (Persons, 3 year range)	Life Course: Living, Working and Learning Well	16 January 2024
Infant mortality rate	Life Course: Getting the Best Start in Life	16 January 2024
Emergency hospital admissions due to falls in people aged 65 and over (Persons, 65+ yrs)	Life Course: Ageing and Dying Well	15 January 2024

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

Board Members:

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

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

Committee Board Manager Landline: 0121 303 9844 Email: Louisa.Nisbett@birmingham.gov.uk	**Business Support Manager for Governance & Compliance** Landline:0121 303 4843 Mobile: 07912793832 Email: Tony.G.Lloyd@birmingham.gov.uk

Forward Plan: 2023/24

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

Date	Strategic Priority	Item	Lead	Purpose	Format	HWB Lead
HWB Meeting: 26 September 2023 Draft paper deadline: 29th August 2023	JSNA	**Joint Strategic Needs Assessment (JSNA) Update**	Rebecca Howell-Jones	JSNA Update	Report	Dr Justin Varney
	Protect and detect	**Fast Track Cities+ Update**	Becky Pollard	Update	Report	Dr Justin Varney
	HWB Development	**HWB Development Day Feedback and Next Steps**	Dr Justin Varney	Discussion	Presentation	Councillor Mariam Khan
	Mental Wellness and Balance; Protect and Detect; Ageing and Dying Well	**Primary Care Enabling Strategy**	Paul Sherriff / Dr Sunando Ghosh	Discussion	Report	Dr Clara Day
HWB Meeting: 28th November 2023 **Draft paper deadline: 31st October 2023**	Healthy and Affordable Food	**Creating a Healthy Food City Forum Annual Update**	Sarah Pullen	Update	Presentation	Dr Justin Varney
	Life Course	**Birmingham and Solihull Winter Pressures Update**	Mandy Nagra	Update	Report	Dr Clara Day
	Life Course	**Midlands Met Hospital Update**	Tammy Davies	Update	Presentation	Richard Beeken
	Active at Every Age and Ability	**Draft Physical Activity Strategy and Consultation**	Humera Sultan	Update	Presentation	Dr Justin Varney
	Getting the Best Start in Life	**Birmingham Children and Young People's Partnership Written Update**	Colin Michel	Written Update	Report	Helen Price

Date	Strategic Priority	Item	Lead	Purpose	Format	HWB Lead
	JSNA	**Creating a Bolder Healthier City (2022-2030) - Indicator Updates**	Aidan Hall	Written Update	Report	Dr Justin Varney
Executive Board - EB 18th December	HWB Development	**Terms of Reference and Model**	Aidan Hall	Update	Presentation	Dr Justin Varney
	HWB Development	**Better Care Fund Q2 Report**	Mike Walsh	Approval	Report	Prof Graeme Betts
	JSNA	**Pharmaceutical Needs Assessment Update**	Aidan Hall	Update	Report	Dr Justin Varney
HWB Meeting: 30th January 2024 **Draft paper deadline: 2nd January 2024** **Cancelled**						

Date	Strategic Priority	Item	Lead	Purpose	Format	HWB Lead
HWB Meeting: 28 March 2024 **Draft paper deadline:** 27th February 2024	Closing the Gap	**BLACHIR Update**	Helen Harrison	Update	Presentation	Dr Justin Varney
	HWB Development	**BSol ICB Joint Forward Plan (JFP)**	Rob Checketts	Discussion	Report	Clara Day
	Active at Every Age and Ability	**Physical Activity Strategy**	Humera Sultan	Approval	Report	Dr Justin Varney
	JSNA	**Pharmaceutical Needs Assessment Update – Supplementary Statement**	Rebecca Howell-Jones	Approval	Report	Dr Justin Varney
	HWB Development	**Executive Board papers (December)**	Clara Day	Approval	Report	Clara Day
	JSNA	**DPH Annual Report 2023-24**	Dr Justin Varney	Discussion	Report	Dr Justin Varney
	Getting the Best Start in Life	**CDOP Annual Report 2022-23**	Mel McKenzie	Written update	Report	Clara Day
	JSNA	**Indicator Updates**	Aidan Hall	Written update	Report	

Date	Strategic Priority	Item	Lead	Purpose	Format	HWB Lead
HWB Meeting: 9 May 2024 **Draft paper deadline:** 9th April 2024	Closing the Gap	**Creating a City without Inequality Forum Annual Update**	Monika Rozanski	Update	Presentation	Dr Justin Varney
	Ageing and Dying Well	**Better Care Fund Q3 report**	Mike Walsh	Approval	Report	Prof Graeme Betts
	Ageing and Dying Well	**Compassionate Cities Update**	Becky Pollard	Update	Presentation	Dr Justin Varney
	JSNA	**Learning Disabilities Deep Dive (JSNA)**	Luke Heslop	Approval	Report	Dr Justin Varney
	HWB Development	**Birmingham Place Committee Update**	Mike Walsh	Discussion	Presentation	Prof Graeme Betts
	Protect and Detect	**Measles Update**	Funmi Oluboyede	Update	Presentation	Dr Justin Varney
	JSNA	**Indicator Updates**	Aidan Hall	Written update	Report	

Standard Agenda

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

Notes

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

Public Questions

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