Birmingham and Solihull Integrated Care System
Caring about healthier lives

NHS
Birmingham and Solihull

A Bolder, Healthier Future for the People of Birmingham and Solihull

Strategy for Health and Care 2023 - 2033

"We have the biggest opportunity in a generation for the most radical overhaul in the way health and social care services in Birmingham and Solihull are designed and delivered."

Our ambition is that in Birmingham and Solihull we close the gaps, we address the holes in life expectancy...and make a difference to people's lives. We do this through working in partnership, so that people experience health and social care in ways that work for them. We're a partnership of change that is building a better future together.

Dr Justin Varney, Director of Public Health, Birmingham City Council

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Introduction

The fact that 40% of Birmingham and 12% of Solihull residents live in the most deprived communities in Britain and that one in three children in Birmingham are living in poverty cannot, and should not, be something we accept.

These are not just statistics – they directly impact on the lives of people in our communities - life expectancy in the most deprived areas of Solihull being 12.8 years lower for men and 11.1 years lower for women, while Birmingham has the highest infant mortality rate of all local authorities in the country.

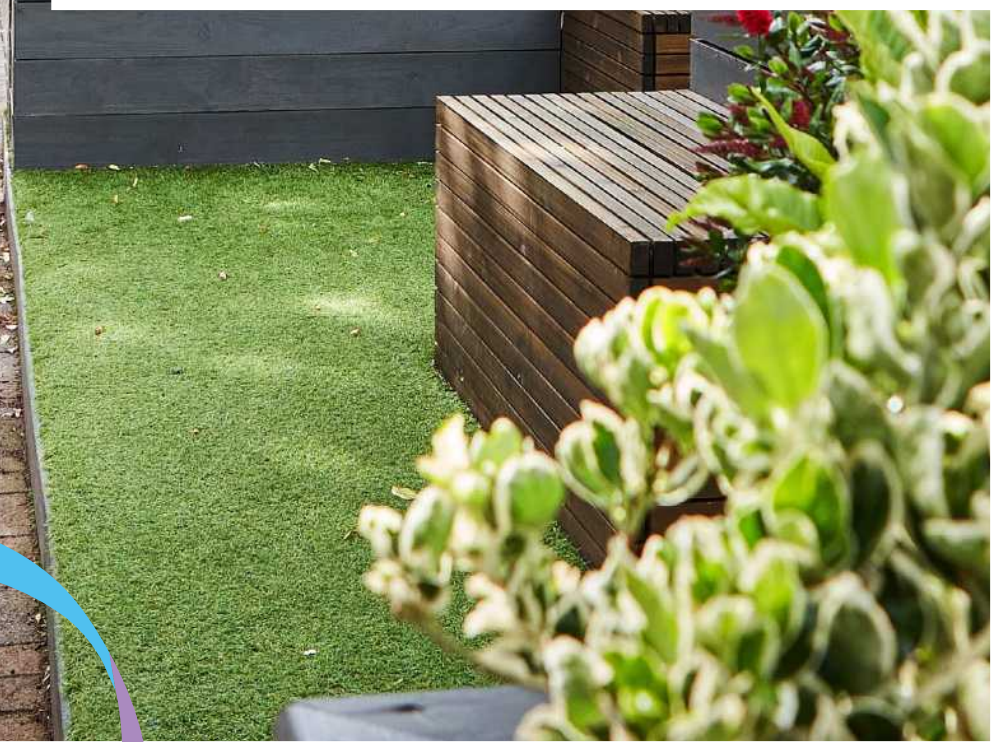
We can and must act to improve this, and in doing so improve the life chances for the people and families we serve.

While the social care and health challenges faced by different neighbourhoods and communities across Birmingham and Solihull may vary dramatically – all have one thing in common: they can be much better addressed by creating the strong platform for local authorities, the NHS, the voluntary, community, faith and social enterprise (VCFSE) sector and other partners to work in a joined-up way delivering a shared vision to tackle inequality and genuinely improve the life chances of the citizens they serve.

It has always been true that where these organisations work well together much more can be achieved, but the 2022 Health and Care Act introduced new legislative measures that will make it much easier for health and care organisations to deliver joined-up care for people in the future.

The Act has created 41 Integrated Care Systems (ICSs) which are made up of two components: Integrated Care Boards with responsibility for planning and funding the NHS; and Integrated Care Partnerships - bringing together a broad set of system partners, including local government, VCFSE sector, NHS organisations and others to develop a health and care strategy for the area.

This 10-year Integrated Health and Care Strategy has been developed by the Integrated Care Partnership for the Birmingham and Solihull ICS, setting out our vision for the future and the improvements that we want to see over the next ten years for everyone who lives, works and receives care within Birmingham and Solihull.



"It's aim is a simple one: to improve life expectancy for the people of Birmingham and Solihull."

Our strategy identifies the five key clinical condition areas which, through sustained improvements in outcomes, will give us the best opportunity to achieve that aim; but this can only be done by transforming the planning and delivery of health and social care in Birmingham and Solihull and by working alongside our communities as an integral partner at the heart of the change we need to achieve.

The five clinical condition areas are:

- **Circulatory Disease**
- **Infant Mortality**
- **Respiratory Disease**
- **Cancer**
- **Mental Health**

In its Inception Framework published in February 2022 the Birmingham and Solihull Integrated Care System made a commitment to engage with local communities and frontline staff in every major piece of work they do: this strategy has been developed throughout 2022 after extensive consultation and discussion with citizens, partner organisations and frontline professionals from across Birmingham and Solihull.

As part of that consultation, we've run a variety of different online and in-person events through engagement leads in NHS Trusts, the voluntary sector, trade unions, webinars run by our Directors of Public Health and our health and care scrutiny committees in Birmingham and Solihull.

We've made a big effort to ensure every voice can be heard – our online content around the strategy has been produced in six languages and we've worked with 18 voluntary, community, faith and social enterprise groups to run engagement sessions targeting the 'seldom heard' communities.

A full and detailed report on the outcomes from that engagement will be published alongside this strategy.

But amongst the many messages our citizens and colleagues repeatedly emphasised was the need to be ambitious in both the short and long term, and to create a strategy that could stand the test of any future health or social care re-organisations.

Ultimately, we want to eradicate health inequalities and increase life expectancy and comorbidity-free life expectancy for everyone in Birmingham and Solihull.

Getting there won't be easy, especially given that Birmingham and Solihull is one of the most challenged areas for health inequality in the country. However, by setting ambitious goals to be achieved by 2033 and ensuring everything we do in the coming years helps to achieve those goals, we can make a very real difference to people's lives.

Over the course of the next 10 years we want to ensure that we:

- **increase life expectancy at birth and at 65 years for all; to at least be on a par with West Midlands average in 2033;**
- **increase healthy (disability-free) life expectancy for all; to at least be on a par with West Midlands average in 2033;**
- **reduce gaps in life expectancy between the least and most deprived and between different ethnic groups;**

We'll only be able to achieve these goals by developing a vision that enables real ambition for everyone involved in designing and delivering health and social care and creating the space to shift much more of our focus onto tackling the determinants of poor health and improving outcomes, year by year, as we strive toward delivering our aims. This strategy gives us that vision and charts a new course for an integrated approach to planning and delivering health and care in Birmingham and Solihull.

Professor Patrick Vernon
Interim Chair
Birmingham and Solihull
Integrated Care Board

Councillor Mariam Khan
Joint Chair
Birmingham and Solihull Integrated Care Partnership Board

Councillor Karen Grinsell
Joint Chair
Birmingham and Solihull Integrated Care Partnership Board

Understanding the scale of our challenge

Birmingham and Solihull Integrated Care System (ICS) supports 1.36 million people, with more than 1.14 million people living in Birmingham and more than 217,000 in Solihull. The infographic helps give some context to the diversity of our populations. The ICS is privileged to serve a globally diverse population but also one which has significant health needs and inequality.

The fundamental purpose of the ICS is to improve the health of the people it serves. The core challenge for Birmingham and Solihull ICS is that too many people die before they should from causes that are potentially preventable and that too many people are living for too long in poor health, including many with long-term conditions, which could be improved by better management. These gaps exist within both local authority areas.

> *"Have they (BME communities) been engaged? No, they have not. Have they actually understood what services are available and how to get a service? No. It's not about ignorance, it's actually about ignorance within the system that doesn't empower people to know what the support mechanisms are."*
>
> Naeem Qureshi, Sparkbrook resident

Figure 1: A table showing the life expectancy at birth of people born in Birmingham and Solihull compared to the West Midlands and England averages

	Birmingham	Solihull	West Midlands	England
Life expectancy at birth (2018-20)				
Male	*75.8*	*79.1*	*77.6*	*78.7*
Female	*80.5*	*83.1*	*81.8*	*82.6*
Life expectancy at birth (2018-20)				
Male	*59.2*	*67.4*	*61.9*	*63.1*
Female	*60.2*	*65.7*	*62.6*	*63.9*
Disability free life expectancy at birth (2018-20)				
Male	*60.2*	*63.1*	*61.6*	*62.4*
Female	*58.3*	*61.0*	*59.9*	*60.9*
Inequality in life expectancy at birth (2018-20)				
Male	*9.5*	*11.6*	*10.1*	*9.7*
Female	*6.2*	*10.1*	*7.9*	*7.9*


Sweet
69p
2 for £1

A picture of our population in 2021

Birmingham and Solihull Integrated Care System
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Total population (2021)

1,361,158 living in 513,000 households

96,800 Students (2021 Census)

Sexual orientation

2.8% of our population identify as lesbian, gay, bisexual, another non-heterosexual identity.

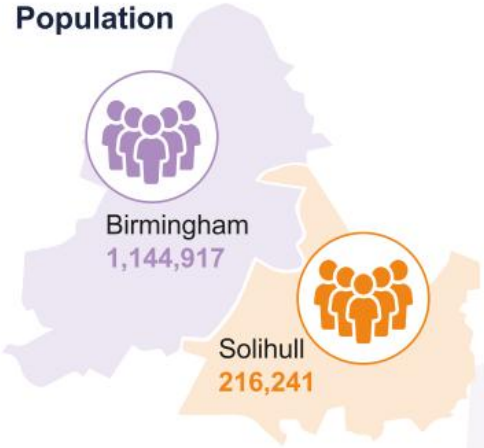
Under 18yrs conception rate (2020)

<18 Years

16.1

8.1

Population



Disability (2011 Census)

17.3 / 17.2 — Disabled under the **Equality Act**

8.1 / 7.3 — Disabled under the **Equality Act: Day-to-day activities limited a lot**

9.2 / 10.0 — Disabled under the **Equality Act: Day-to-day activities limited a little**

Economic activity status

9.9 5.0

Economically active (excluding full-time students):
9% Unemployed in total

Economically active (excluding full-time students):
91.7% in employment in total

91.0 95.2

Diabetes

8.9

Birmingham and Solihull patients are recorded as having diabetes

68.7

Number of patients with diabetes who had a foot examination.

Flu 2021/22 - vaccine uptake

65 UP 78.4

Pregnant 28.7

50→65 In a clinical risk group 60.6

Physical health checks

47

Percentage of patients in Birmingham and Solihull on SMI registers were in receipt of all six elements of the health checks in the 12 months to the end of December 2022.

Ethnicity (2019 ONS estimates)

	Birmingham	Solihull
① Asian, Asian British or Asian Welsh	31.0%	11.0%
② Black, Black British, Black Welsh, Caribbean or African	11.0%	1.8%
③ Mixed or Multiple ethnic groups	4.8%	3.5%
④ White	48.6%	82.2%
⑤ Other ethnic group	4.5%	1.5%

3.9% of people cannot speak English well or at all, this is **just under 48,000 people**

Faith and religion

Christian	36.7%
Muslim	26.0%
No religion	25.5%
Not answered	6.0%
Sikh	2.8%
Hindu	2.1%
Other religion	0.5%
Buddhist	0.4%
Jewish	0.1%

Cancer

Birmingham and Solihull ICB had **6,384 emergency admissions** with cancer, with a rate of **406 admissions per 100,000 population** compared to 514 Nationally.

There were over **5,317 new cases of cancer diagnosed** across Birmingham & Solihull. This is a rate of **344 per 100,000 patients** compared to a National rate of 456.

All information provided by the 2021 Census

Birmingham and Solihull statistics · Birmingham statistics · Solihull statistics

A picture of our population in 2021

Birmingham and Solihull Integrated Care System
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Age (2021 ONS population estimates)

Poverty £

People in Birmingham **earn £49 a week less than the national average in full-time employment** whereas in Solihull they **earn on average £80.4 a week more**. In both areas, there are **significant disparities between those on the highest and lowest income**.

Unemployment

70,900 workless households across Birmingham and Solihull.

5.3% of people with health conditions or illness >12 months are unemployed in Birmingham and Solihull compared to **2.8% nationally**, and **49.7% are economically inactive**.

(Apr 21-Mar 22)

Children in relative low income families (under 16yrs)

97,119 children

Infant Mortality Rate (2018-2020)

Patients with known coronary heart disease immunised against flu (2020/21)

7 GP practices achieved **more than 90% coverage** and **15 GP practices** achieved **less than 60% coverage**

Women aged 25-49yrs who have had a cervical cancer screen in the last 3.5 years (2020/21)

22 GP practices have **over 75%** and **11 practices** have **less than 50%**

Child development

Percentage of children with a good level of development – Early years foundation stage (2021/22)

Percentage of children achieving a good level of development at the end of reception (2018/19)

Young people aged 16-17yrs not in education, employment or training (NEET) (2020)

2,820 young people

Patients with severe mental health issues having a comprehensive care plan (2020/21)

25 GP practices had a care plan in place for over **90% of patients** whilst **74 GP practices** had it in place for **less than 50% of patients** with severe mental health issues

Population vaccination coverage

MMR one dose by 2yrs old (2021/22)

Hospital admissions caused by injuries in children 0-14yrs (intentional & unintentional) (2020/21)

All information provided by the 2021 Census

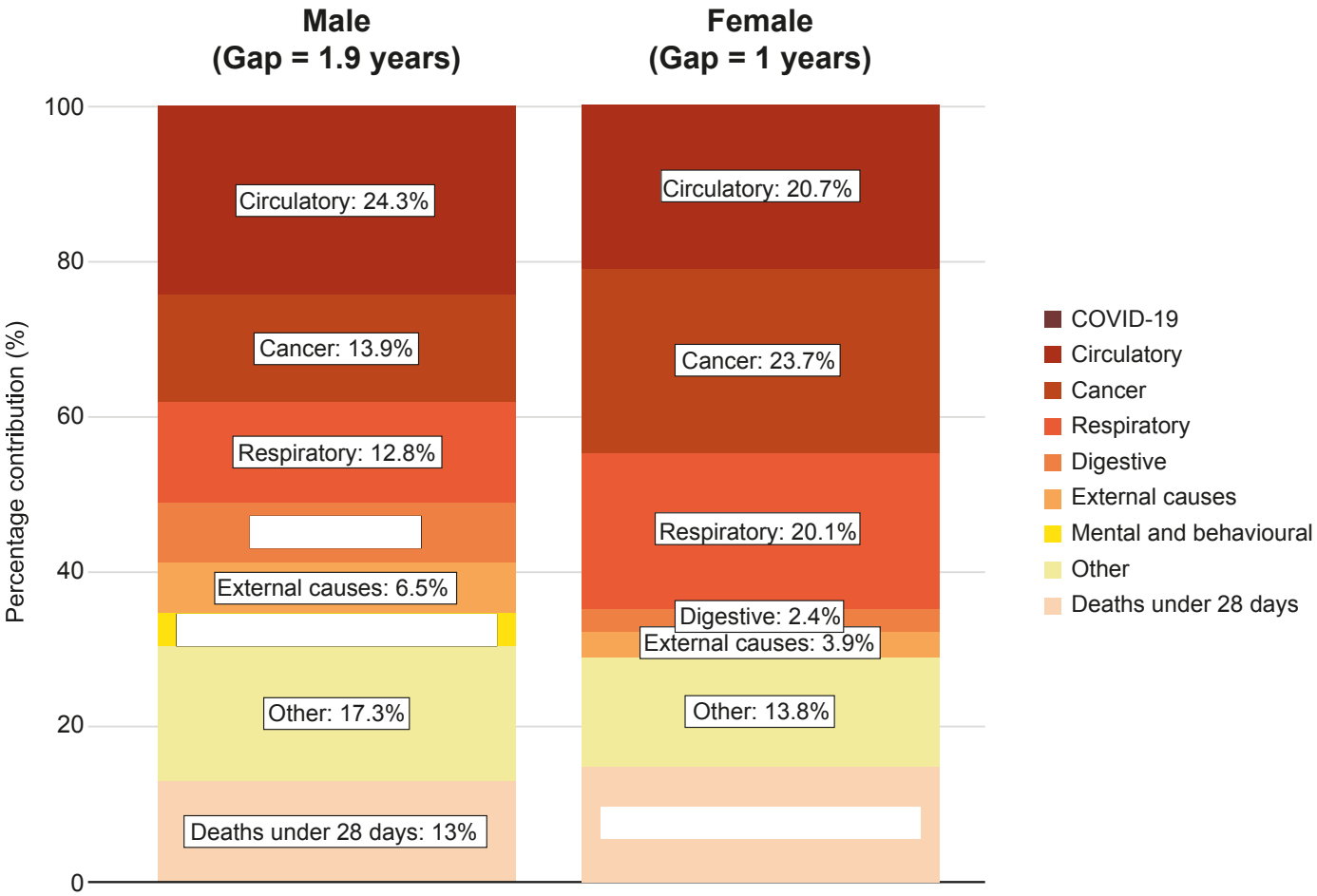
Birmingham and Solihull statistics · Birmingham statistics · Solihull statistics

Understanding the scale of our challenge

The gap in life expectancy in Birmingham and Solihull populations links strongly to diseases which are either preventable, or at least adaptable to not be fatal. The main diseases causing inequalities in life expectancy are infant death, lung disease, heart disease and cancer. It is important we also remember the connection between physical and mental health as mental health issues can also be a cause of potentially preventable death.

Figure 2:

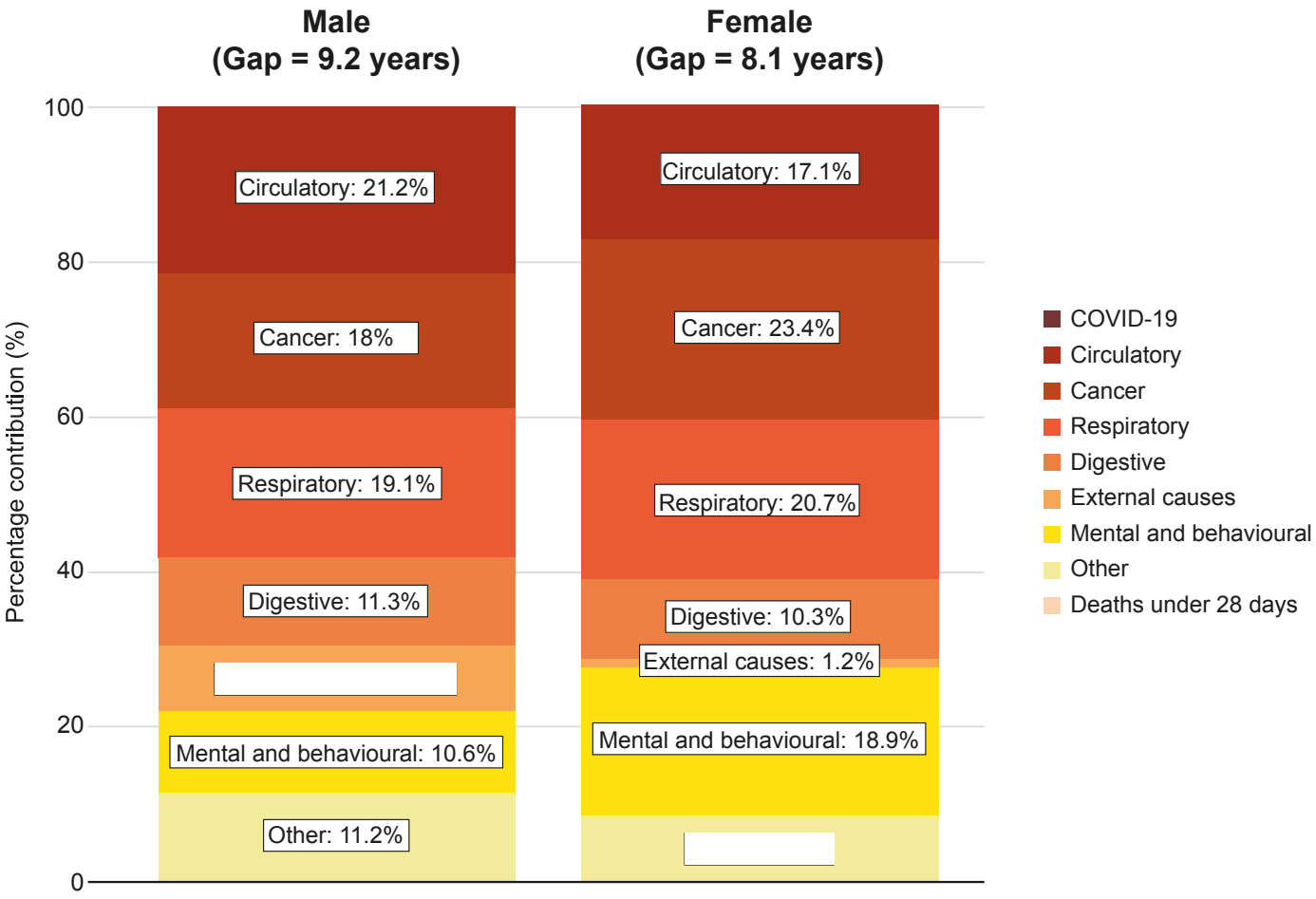
Scarf Chart showing the different types of disease causing the gap in life expectancy between Birmingham and England (2017-19)



Understanding the scale of our challenge

Figure 3:

Scarf Chart showing the different types of diseases causing the gap in life expectancy within Solihull (2017-19)



The pattern of drivers of the life expectancy gap are pretty consistent across years, however the pandemic did have an impact and the 2020-21 provisional charts reflect this (Figure 4 and 5). It is important to keep in mind that those most likely to die due to Covid-19 are the elderly, those with chronic diseases especially high blood pressure and diabetes, smokers and those carrying excess weight, many of the same groups with the highest risk of death from circulatory, cancer and respiratory disease as well.

Understanding the scale of our challenge

Figure 4:

Scarf Chart showing the different types of disease causing the gap in life expectancy within Birmingham (2020-21)

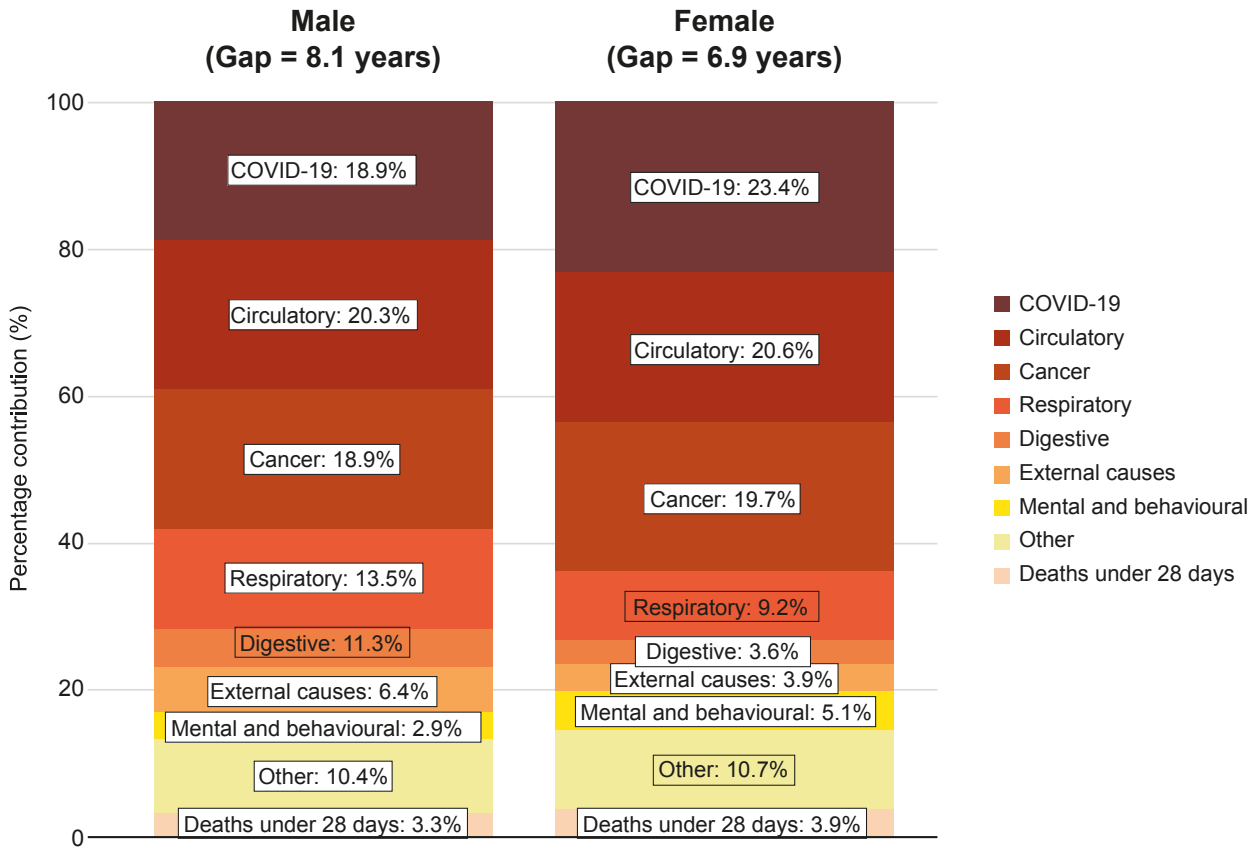
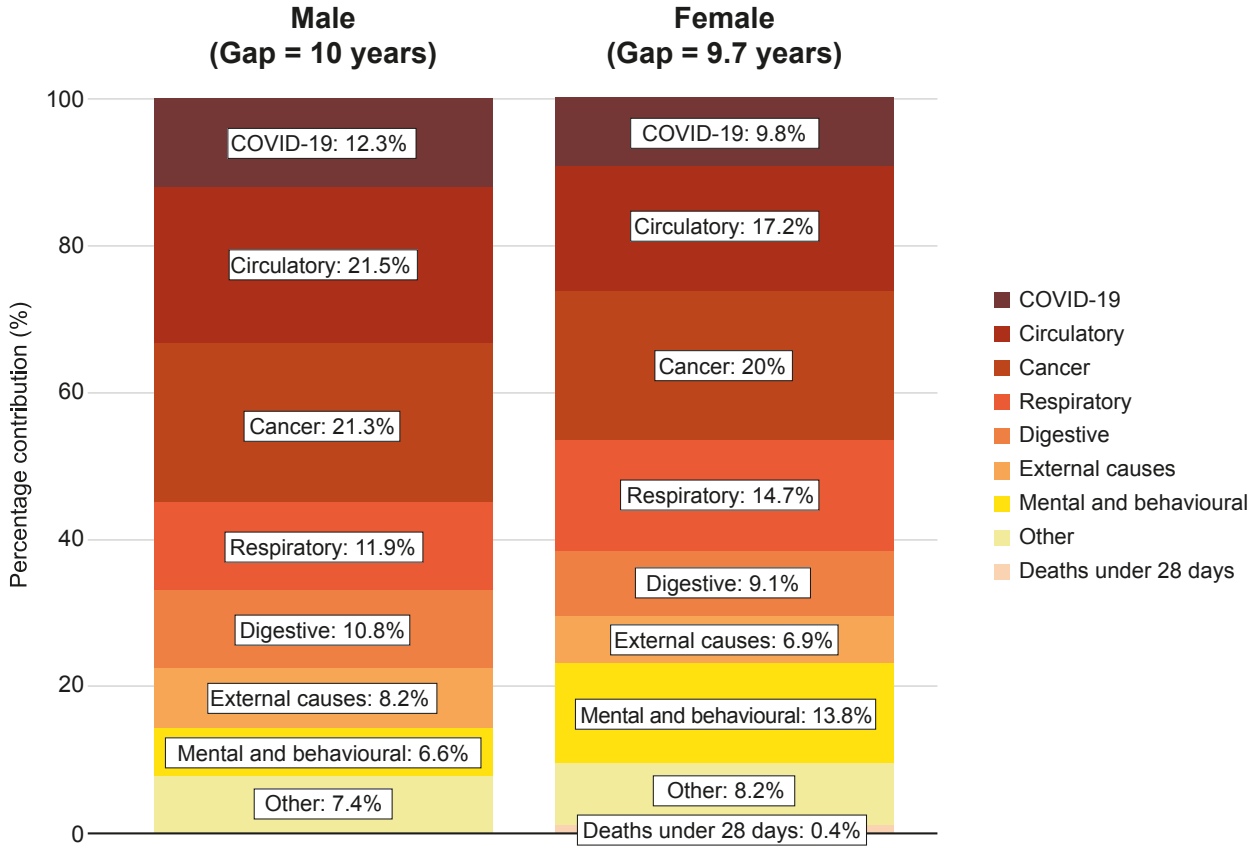


Figure 5:

Scarf Chart showing the different types of diseases causing the gap in life expectancy within Solihull (2020-21)



Understanding the scale of our challenge

> *"The best community experience has to be our green spaces, which should be protected and cherished in this increasingly busy world. A walk in the park for me is the easiest way to relax and take in what little nature we have in our busy lifestyles. Keep them clean, tidy and safe as they are an oasis of calm for us."*
>
> Kingstanding resident

As well as how long people live for, as a system we want to work to make sure people live as long as possible in good health. Too many people live for too long in poor physical or mental health with significant impacts on their quality of life and ability to work.

This consolidates into five key clinical condition areas which, through sustained improvements in outcomes, will give us the best opportunity to achieve that aim: but this can only be done by transforming the planning and delivery of health and social care in Birmingham and Solihull and by working alongside our communities as an integral partner at the heart of the change we need to achieve.

The five clinical condition areas are:

- **Circulatory Disease**
- **Infant Mortality**
- **Respiratory Disease**
- **Cancer**
- **Mental Health**

As an ICS Partnership we want to see the system work together to maximise the impact of health and social care to reduce these potentially preventable deaths and diseases through clear and coherent action at pace and scale, including taking into account Core20PLUS5 for adults and children.

Research has demonstrated that about 20% of health is directly a result of access to care and treatment, 40% to behaviours such as smoking, alcohol, inactivity and diet, and 40% to the wider determinants of health such as employment, education and the built environment.

Bowel cancer: the perfect pathway

Meet 48-year-old Aisha from Washwood Heath.

Aisha is a busy working mum of three and also cares for her elderly parents at home.

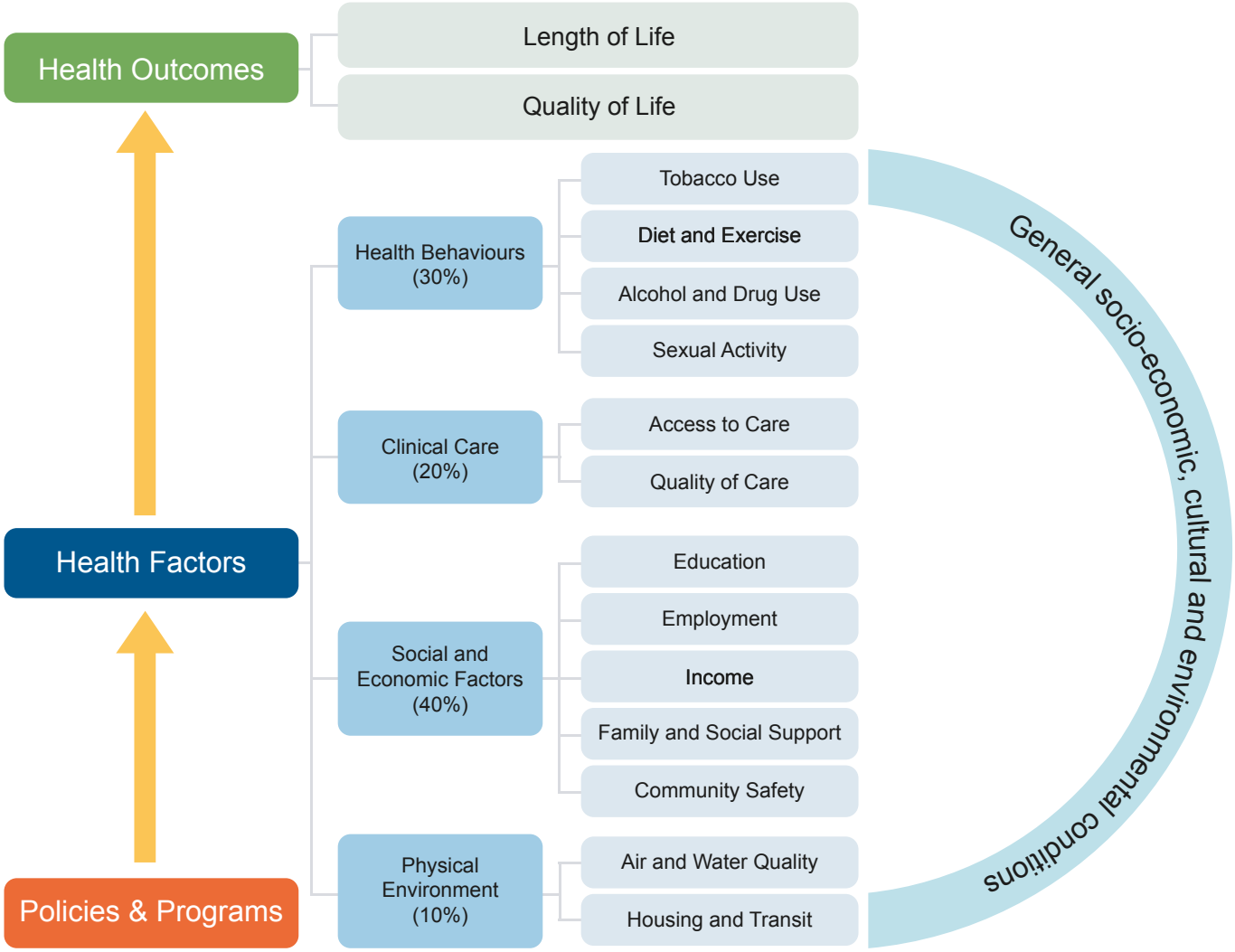
Aisha has recently been feeling more tired than normal and is struggling to manage the demands of work and home life. Over the last week she has noticed blood in her poo.

Read Aisha's perfect pathway here

Understanding the scale of our challenge

Figure 6:

What causes systematic differences in health outcomes?



Source: Adapted from the County Health Ranking Model. Note: % figures are estimates and averages, the relative controbution for an individual's life will be unique to them For illustrative purposes only.

Across the first 60% there is significant evidence and practice that can be brought to bear to reduce the inequalities in life expectancy through the work of health and social care organisations and professionals alongside others in the public and community sector. Whilst other key partners including local Health and Wellbeing Boards, the West Midlands Combined Authority and Police and Crime Commissioner – as well as national government – are key to helping us to address the 40% driven by the wider determinants of health, there are also important contributions the ICS partners can make as anchor organisations in this space as well.

> *"I don't have a great deal of faith in the (health and) care system because they failed my daughter miserably. We had so many problems leaving childhood (services) and going into adult services... it was horrendous because it seemed as thought they don't share details, they don't share information....we were saying the same thing over and over again."*
>
> Kiran Williams, parent of children with Learning Disabilities, Moseley Resident

Understanding the scale of our challenge

Our challenge is how we organise ourselves better in the future to ensure that everything we do in health and social care is taking into account – and having a measurable impact on – helping people to live longer and healthier lives.

We already have local Health and Wellbeing Boards in Birmingham and in Solihull which oversee Joint Strategic Needs Assessments - setting out the key challenges for each place, and using data 'deep dives' and locality profiles which identify more specific opportunities for action.

This strategy builds on the consultation and engagement that has co-created the Creating a Bolder Healthier City Strategy for Birmingham, the Tackling Health Inequalities: a blueprint for Solihull and Solihull's Health and Well-being Strategy 2019-22.

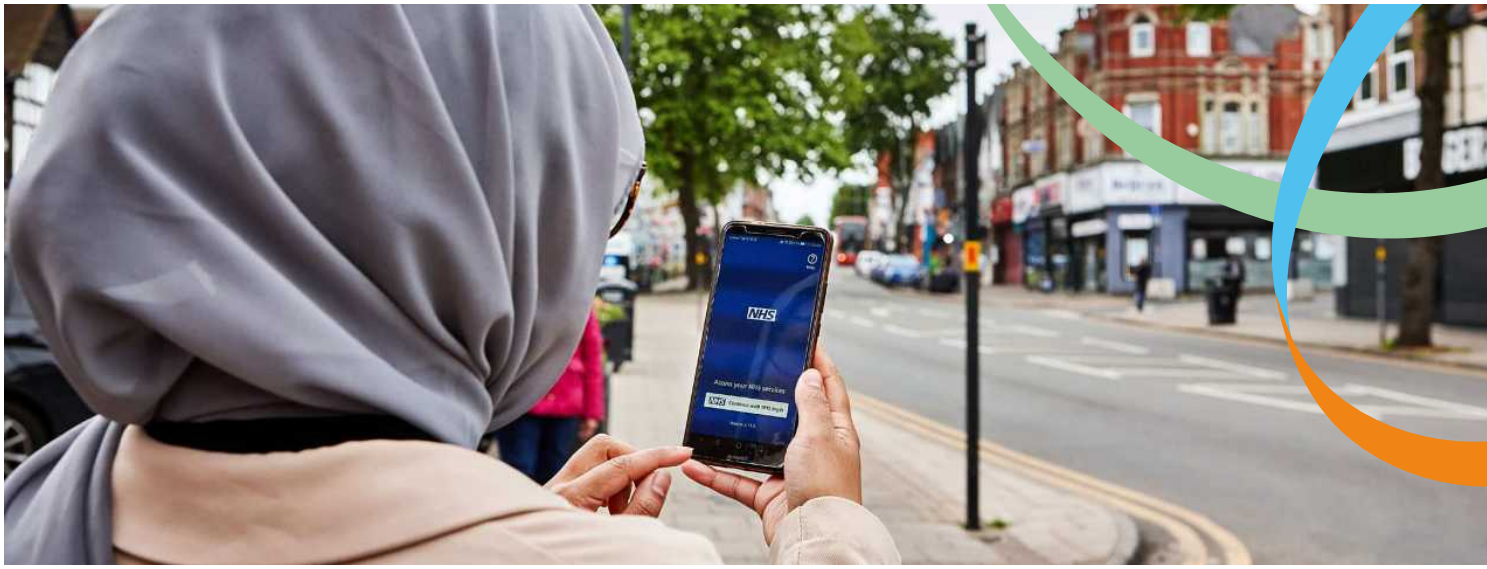
The summary of the two strategies clearly shows the overlapping priorities and these align with the ICS Inception Framework and the priorities and approaches set out in this document.

Understanding the scale of our challenge

Summary of Health and Wellbeing Board Strategy Priorities for Birmingham and Solihull and areas of shared priority

Level	Maternity & Early Years	School aged children & Youth	Working age adults	Older Adults	Diversity & Inclusion	Wider Determinants
Shared	Infant Mortality Childhood immunisation School readiness	Childhood immunisation	Suicide prevention Reduce depression and anxiety Physical activity	Ageing well approach Healthy life expectancy at 65yrs	Better data and analysis to increase understanding Carer support	Maximise benefits of green space & built environment Promote healthy housing Active transport
Common principles	Community collaboration, Integrated delivery, better use of data and analysis, safeguarding, anchor organisations					
Birmingham	Oral Health Healthy Start Vouchers	Childhood obesity Accident prevention	5-a-day/nutrition Health literacy	Dementia detection Falls prevention Excess winter deaths Musculoskeletal disease	LGBTQ+ mental health Ethnic inequalities in diabetes & CVD	
Solihull	Infant and parental mental health	Youth training, support and employment	Employment and support for people with LD and MH issues	Social connectedness and isolation	Learning disabilities and autism Mental health	Net Zero

Our vision and ambition



Our vision, as a partnership, is that the people of Birmingham and Solihull live longer, healthier and happier lives, whilst **our ambition** is that this is something to be realised for every community and every person, not just those who have social and economic advantages.

We want to ensure that everyone is supported from birth to their end of life in ways that are culturally safe and give them control, dignity, and choice.

Through the actions of our partnership, we should strive to ensure that those who are vulnerable, disadvantaged or disabled by society will be safeguarded, protected, enabled and empowered to achieve their full potential.

Case Study

Tackling obesity in people with a learning disability

Obesity contributes to many diseases including heart disease, cancer and mental health and rates of obesity are higher in people with a learning disability. 80% of people with a learning disability do less physical activity than recommended and they are also four times more likely to die from an avoidable medical cause than the general population.

In 2021, Birmingham City Council Public Health used a government grant to pilot new adult weight management programmes for people with a learning disability, sensory and mobility impairment.

Lifestyle company Beezee Bodies were commissioned to develop a bespoke 12-week programme that included one-to-one support and advice around diet, exercise and mental and physical health. The programme was co-created with people with learning disabilities, sensory and mobility impairment, as well as carers and healthcare professionals, and was delivered in both home and community settings.

149 of the 167 adults recruited to the programme completed it and 88% of all participants lost weight. There was a 44% increase in average mental wellbeing score from before and after the programme and all participants increased the number of days they did physical activity – going from 0.2 days at the beginning of the programme to an average 3 days at the end.

As the grant funding came to an end the Council looked at how to mainstream the funding for a sustainable future targeted programme.

Our vision and ambition

We should work with all our local communities to really understand what matters most to them and involve them in determining what will help to improve their wellbeing, health and care. This builds on the innovation of the Community Health Profiles and BLACHIR review and the empowering of communities and citizens thinking about place, identity and experience.

But it's not just our communities that matter: it's our staff. All the evidence shows that a happy and engaged workforce is more productive and will deliver better services and outcomes for the people they serve. All our partner organisations need to demonstrate how they support and respect they staff and how they engage them in delivering the ambitions set out in this strategy.

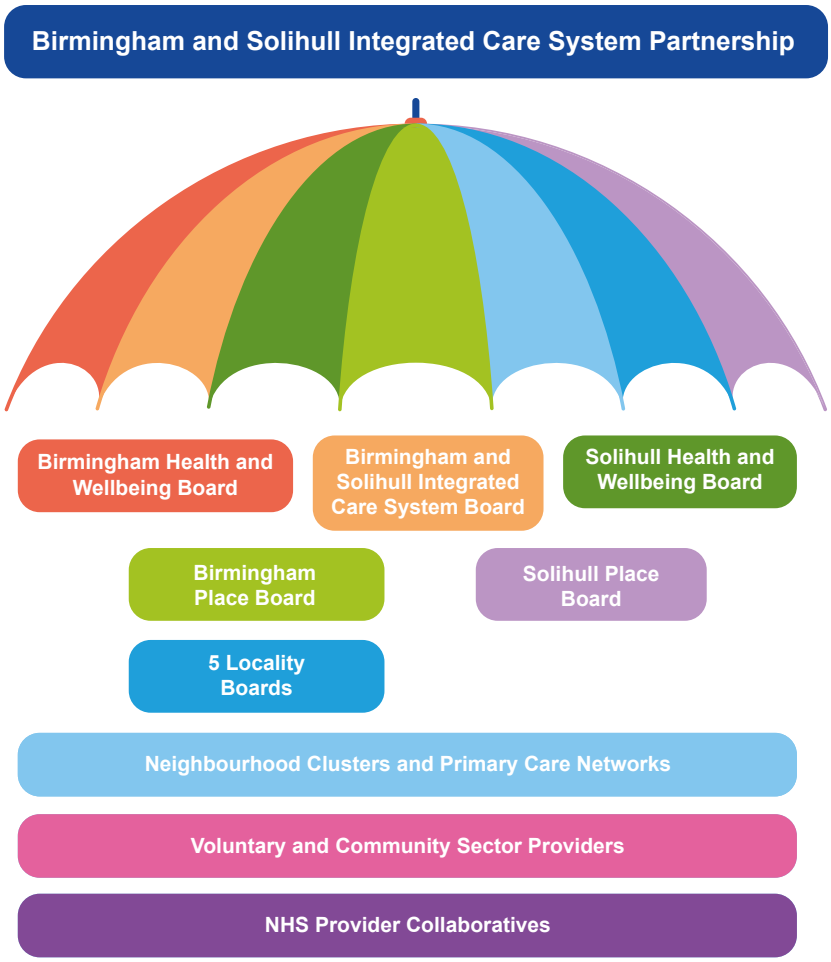
As a system, we play an active role in improving quality of life through our wider role as employers and anchor institutions.

We see this at different levels from neighbourhoods to the overall gaps between our ICS and the England average, different identity communities such as LGBT+, ethnic and disabled communities and different communities of experience such as veterans, carers and sex workers. We also recognise the intersectionality between these.

Subsidiarity is at the heart of our approach: doing things as locally as possible to deliver better outcomes for people and making the most of the partnerships, knowledge, assets and capability in different parts of our system.

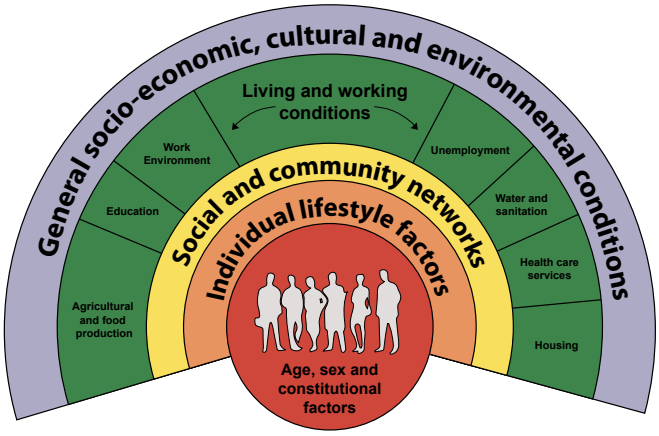
We want to ensure that the ambitions set out in this strategy don't just sit on a shelf – they drive and guide every aspect of policy and delivery in the ICS. This will require continued leadership to drive those ambitions, which will be delivered through the two Health and Wellbeing Board Strategies and specific ICS strategies such as the Learning Disabilities and Autism strategies. The ICS Partnership Strategy sits as an umbrella above these delivery strategies and frameworks to complement them and demonstrate the synergies in principles and practice.

However our ambition can only be achieved working in partnership across boundries, between organisations and with people. It is essential that all layers of the ICS understand this and model true partnership behaviours.



> *"You feel helpless in yourself and you need that help...but it's really a shame that you can't get joined up (services) to help you to do that, if you could, it would be a different situation altogether."*
>
> Jane Cousins, Fordbridge Resident, Solihull

Our partnerships



Source: Dahlgren and Whitehead, 1991

Organisational boundaries mean little to patients, carers and the public but we all want to experience high quality service delivered in ways that are culturally safe and intelligent by staff who are valued and care about them.

As a partnership we recognise the broad range of organisations who play a role in the delivery of health and social care in Birmingham and Solihull. We also recognise the importance of the ICS governance structures working with these organisations as equal partners rather than playing upon historical power dynamics based on headcounts or commissioning power.

In our integrated system, the voice of local community pharmacy should be as important to the governance decision making as that of the largest acute trust and it is important that the emerging governance structures value and listen differently from the past.

We want to see people at the centre of our approach and this means at every layer of the governance of the ICS system there should be clear and transparent approaches to inclusion of people's voices and consideration of representation and marginalisation.

Delivering our ambition for people to live healthier, happier and longer lives will require action across treatment and care, prevention and early intervention in every setting for short and medium term gain. It will also require upstream action as a partnership to fundamentally rewire the landscape of our places, both physical and social, to enable healthier futures in the long term. This is in line with the drivers of health which are well recognised by Dahlgren and Whitehead (1991) and subsequent reports including the Marmot reviews and set against – and will need to respond to – a challenging socio-economic backdrop.

Frailty: the perfect pathway

Meet Patrick from Solihull.

Patrick is an 82-year-old widower who lives alone. His daughter lives in Australia but his neighbours keep an eye on him.

After a fall at home he needs some extra support and is worried he might need to go into hospital – find out how a multidisciplinary team supports him to stay happy and healthy in his own home here

Read Patrick's perfect pathway here

Our shared objectives

Creating cohesion in how services are delivered locally can only happen if all organisations who contribute to health and care delivery are united around a set of clear objectives.

Throughout our consultation on the development of this strategy, six clear objectives emerged. They are:

Reduce inequalities

We will be intentional in acting to reduce inequalities in everything that we do as a system. We will consider inequalities in the context of place, identity and experience and work to close the gaps in our understanding, working with communities as well as with data and monitoring systems. We will use audit and needs assessments to check on progress and to demonstrate we are making real change and working towards closing the unacceptable gaps in care, treatment and outcomes for people.
We will be a system that tackles variation in clinical practice and outcomes proactively and has visible quality improvement as a core priority for every partner. We will work with communities in closing the gaps we find.

Case Study

Empowering young women to make healthy life choices

Health Hacks is an initiative developed by NHS Ladywood and Perry Barr Locality Partnership (LPBLP) and Birmingham City Council Public Health in response to high levels of smoking in pregnancy and maternal obesity, poor maternal outcomes and high rates of infant mortality. The approach involves co-production with secondary school students to discuss what factors can lead to better health outcomes in pregnancies.

Events with students - girls in the first instance - focus on developing action to improve health behaviours and identifying and discussing early detection of problems. The main aim is empower young women to make healthy life choices that minimise infant mortality risk factors.

Presentations from health professionals provide up-to-date information about infant mortality, and information on the current scale and likely future trends in genetic problems caused by social and cultural factors in Birmingham. The events bring together a wide variety of partners and introduce students to a range of different health professions.

Through the sessions, the young people have become empowered around their own reproductive health and also become advocates within their families.

Our shared objectives

Deliver integration for people

We will work together as a system to deliver joined up integrated services and experiences of prevention, treatment and care. We will enable fluid and secure movement of data between partners to support people getting the best care and support and we will work with service users to continually improve our systems and delivery. We will deliver cost and delivery efficiencies that work for people and their needs through improved integration and performance management.

Protect people from harm

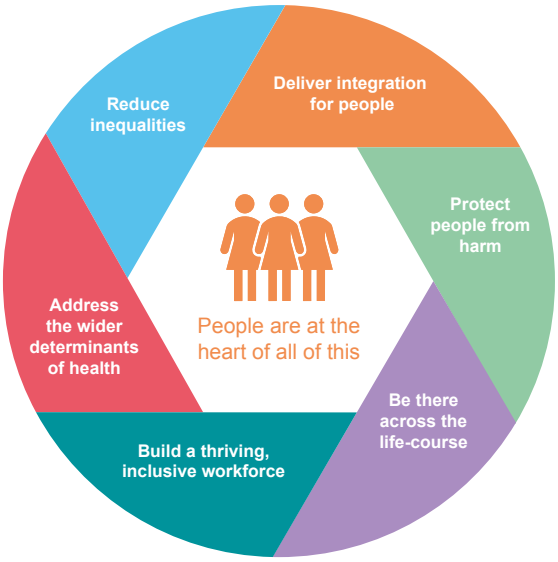
We will be a system that actively protects people from harm, from our robust clinical governance framework to our integrated approaches to infection control, immunisation and screening and the work we do together on early intervention and prevention. We will also be a system that is prepared for emergencies and acts quickly to protect our people from harm. We take seriously our commitment as corporate parents and guardians of the vulnerable and we want to see this visible at every level of the ICS system.

Be there across the life course

Whilst we recognise the importance of the early years and rightly invest in giving every child in Birmingham and Solihull the best start in life, our responsibility doesn't stop there. We are committed to being there for people as they grow, age and die. This spans our partnership work through the health and wellbeing board, addressing environmental change through the layers of primary prevention, early intervention and secondary and tertiary intervention, right up to the end of life.

Our role is to ensure that health does not become a barrier to achieving your potential whatever your impairments, and we want to be a system that enables everyone to participate fully.

> *"If I had a magic wand, I would like somebody who was there consistently..putting the needs of these vulnerable people first. I would like it to be more accessible, and not just via the Internet because not everyone has access to a computer or is computer literate."*
>
> Parent of children with learning disabilities, Birmingham



Special educational needs and disability (SEND): the perfect pathway

Meet The Jenkins Family from Hall Green.

Isla is 11 and lives at home with her Mum, Dad and younger brother Leo, who has Autism.

Isla has recently moved to her new secondary school and is struggling to cope with the increased demands and complexity of interacting with peers as well as with the size of the school environment which she finds difficult to navigate. She has been upset and distressed when she comes home despite appearing to cope in the school day.

Read Isla's perfect pathway here

Our shared objectives

Build, develop and retain a great, inclusive workforce

We want to be a system that at every layer is playing its role anchoring communities and providing great employment to a diverse local workforce that delivers great services. We want every ICS partner to be intentional in tackling workplace racism, homophobia, transphobia and discrimination and demonstrate active improvement in the experience of our staff at every level.

Contribute to the wider determinants of health

The ICS is a major employer and purchaser and is a significant physical presence in place and it will play a significant role in addressing the wider determinants of health such as employment, education and environmental sustainability through its intentional actions at every level.

As a collection of large anchor organisations, the ICS recognises its role in promoting wider regional economic growth.

Case Study

Boosting career prospects for North Solihull citizens

Solihull Recruitment and Training Centre is based in Chelmsley Wood Shopping Centre and provides an employment support service for local citizens as well as working with local businesses recruit to their vacancies. Citizens can access a range of training opportunities on site and can also get advice on health, financial, housing or travel services.

Amber left school with good passes in GCSEs and was interested in a career in the NHS. Amber was living in a workless, single-parent household, with a younger sibling. She had no work experience and no access to a computer so was referred to Solihull Council's employment and skills team as she wanted help to apply for a health and social care apprenticeship. She had put together a very basic CV, so the employment team worked with Amber to enhance it to better reflect her skills, knowledge and experience. They also found her three apprenticeships to apply for within easy travelling distance. Amber completed her applications in the Centre, with support and advice from her employment adviser. She was due to attend a healthcare careers fair to talk to prospective employers, but to her delight, found out that she had been offered an apprenticeship with a local NHS Trust. She remained in regular contact with her adviser to ensure that she is well prepared to start her new role.

Creating the conditions to enable greater focus prevention

> *"There is a disconnect between health bodies.. and other agencies and community stakeholders (like charities) doing the same thing but they do it in parallel universes. They're not doing it collectively, collaboratively so that we can .... get a better return on the investment we receive ...and ensure that people who are in need get access to that support."*
>
> Sparkbrook resident

The ICS is a partnership and to deliver the ambitions of this strategy will require all involved to completely reimagine how they work together in the future.

Achieving common goals across health will require closer working than ever before, greater inter-dependency, co-production and stronger trust between organisations as we adapt to this new way of working.

But joint working has to be more than just agreeing on a set of ambitions: it requires changing the way we commission and deliver services, from shared funding, collaborative commissioning and localised multi-disciplinary teams designed around people and their lives.

The ICS should work across the system to maximise cross-boundary working by putting a real focus on developing an integrator model which delivers against it's aim to create locally-based health and social care teams through the provision of Integrated Neighbourhood Teams.

Given the current pressures, in part created by Covid-19, on access to services, the ICS should look to use the development of service integrators not only to address the immediate issue of access but to create the time and space for teams to be able to give real focus to the prevention agenda in the future.

Joint working will be fundamental at a delivery level. We should expect to see integrated services that feel connected and seamless for those using them and whilst we recognise there is much to do to achieve this, it is a core aim of the ICS partnership.

Key to this will be **subsidiarity**, the principle that things should be done at the level of the system that is most relevant, effective and efficient, and that by doing this, these actions at every level work together to contribute to the overall ambition of the ICS.

Governance and oversight for Integrated Neighbourhood Teams should, over time, also be delivered as locally as possible through Place Committees. As Place Committees develop they will set the direction for Integrated Teams and have direct commissioning powers for elements of their work.

MSK: the perfect pathway

Meet The Wilson Family from Erdington.

Mike is 61. He's a gas engineer and watches more golf than he plays since his back pain started a few months ago. Mike lives with his wife Priya (56) who works in a school and they have a 19-year-old son Arjun, who is training to be an accountant.

Read Mike's perfect pathway here

> *"People say 'prevention is better than cure' so it's knowing what can be done at the very beginning before having to come to a GP practice...informing people where they can go to get the help that they need."*
>
> Adilla Jones,
> Health Inequalities Champion, Hall Green Primary Care Network

Case Study

Asthma Friendly Schools

To boost the support offered by primary care to families of children with asthma, Ladywood and Perry Barr Locality Partnership has been teaming up with education and community partners in West Birmingham to put more power in the hands of families and the people who support them.

Currently working with 10 schools and BLESST youth club in West Birmingham, they have developed a model for 'Asthma Friendly' schools and youth clubs, in which all children with asthma have an up-to-date personalised asthma plan, staff are asthma-trained, parents are empowered, fellow pupils are sensitive and supportive, and the school is working in partnership with the local authority to improve local air quality.

The initiative involves in-school events and promotional webinars, offering educational talks and clinics with pupils and/or parents on topics such as how to use inhalers, triggers for asthma and how to request a personalised asthma plan. The framework also encourages pupils to be asthma champions and to present their learning at assemblies, to help demystify the condition and raise awareness amongst their peers.

Anecdotal feedback from schools and families who have already benefitted has been wholly positive, with school heads sharing how asthma is now better understood by staff and students, and asthma is neither something to be afraid of, nor stigmatised.

We also know that building systems and pathways needs us to also work with people to empower and enable them to navigate them when they need help.

Across the ICS we will need every organisation to actively consider access, inclusion, cultural safety and health literacy. The ICS should consider and act upon the findings of the deep dive Needs Assessments and recommendations from these reports, including the Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR) and the various Healthwatch reports.

Innovation, evidence and research should be at the heart of our evolving approach to the challenges we face and the opportunities to deliver our ambition at scale and pace. We want to see the ICS be confident in its use of data and we expect the ICS to be brave in exploring in depth the inequalities in outcomes and the variation in practice across the system.

Overall, the biggest impact the ICS can have is to create the focus around the determinants of poor health, maximise the care and prevention in clinical pathways and provide leadership and vision around improving outcomes in our communities.

Therefore the ICS should prioritise creating an Outcomes Framework to drive this approach. This should be centrally developed initially, but responsibility and ownership of this Framework should shift to Place Committees over time as they mature in their role.

> *"I would make young person services more young person-centred...sometimes they just address the adult and don't speak to the young person the whole appointment, How are you supposed to reach these clinical outcomes when you're not even involving the young person in their own decisions and their own care?"*
>
> Beth Dennis, Chair, Young Person Advisory Group

Case Study

Detecting and treating cancer early

In 2022, as part of a national programme, a pilot launched in Birmingham to identify signs of lung cancer early, targeting those most at risk of the disease.

Early diagnosis is key to effective treatment, particularly for lung cancer. Yet currently around 75% of lung cancers are diagnosed at a late stage (stages 3 and 4).

If diagnosed earlier (stages 1 and 2), 70% of lung cancer patients will survive for at least a year, compared to around 14% for people diagnosed with the most advanced stage of the disease.

In Birmingham, the Targeted Lung Health Check (TLHC) programme launched in Washwood Heath, which is one of the most deprived areas of the country, and lung cancer is more prevalent in areas of high deprivation.

The TLHC programme is available to residents aged 55 to 74 who have a history of smoking or have other lung or heart conditions.

Eligible residents receive an invitation via post and initially they will have an appointment with a lung health nurse, either over the phone or face-to-face. People considered to have a higher risk of lung cancer will then be offered a low-dose CT scan in a mobile truck, conveniently located in their local area.

If a cancer is detected, the patient will be referred to secondary care, for further scans and treatment – the hope is that through earlier detection, there is a much greater chance of successful and less invasive treatment.

How will we know if we're having an impact?

There are **five big differences** we should expect to see in the way we work if we succeed in delivering the changes outlined in this strategy. They are:

1. Fully integrated health and social care that is based around the person in local communities

This would mean that people engaging with health and social care services will not have to repeat information because there will be connected data sharing between providers that respects confidentiality and prioritises individuals' needs.

> *"One of the biggest challenges and one of the things that can hold up improvements is not having that ease of information sharing. The voluntary sector, the NHS, the ICB and ICS partners need to have the agreements in place."*
>
> VCFSE Respondent, ICS Strategy Engagement Report

We would also see services designed to join up around patients through more 'one stop shop' clinics, so that people who need support can see multiple professionals in the same site on the same day, rather than having to juggle multiple appointments in different locations.

For some services, this may mean fully integrated teams with integrated management and terms and conditions, but it may also mean aligned or co-located services, and this will depend on the service.

2. Prevention is embedded in every step of every pathway to prevent disease and reduce the impact of ill health on lives

The full breadth of the health and social care system will be proactive in taking action on prevention at every stage of life and in every care pathway, this will be about preventing disease but also about supporting changes that reduce the risk of complications and improving health in those living with long term conditions.

We recognise that early help is more effective at supporting people to live happier, healthier lives than treatment to repair and recover, and as an ICS we will invest more proactively in early help, early intervention and prevention before people become clinically unwell or require social care support. In some cases this will only be able to defer need but in others it may prevent it completely and this will free up other resources and so is both the ethical and economic thing to do.

This means that people will be able to have conversations about what support they need in any setting across the system and the professionals talking with them will know how to connect them with support available.

> *"It's about relationships really, so to build a strong relationship across our locality is the way forward... I think there's a lot of scope for us to work together but for me, it's that local relationship building that's got to work."*
>
> VCFSE Sector respondent, ICS Strategy Engagement Report

Social prescribing, community navigators and cultivating and supporting trusted sources of information and advice are key to delivering this in an integrated way from welfare advice to wellbeing support.

We plan for this to be clearly set out in the commissioning and monitoring of services, as well as in how we train and educate our health and social care workforce so they are skilled to have enabling and empowering conversations. We will working in partnership with community organisations to support their knowledge and expertise alongside where we are commissioning service provision as a system.

Screening, vaccination and health checks are fundamental to prevention and we expect there to be rapid improvement so that the variation and inequalities in uptake and in clinical practice across our neighbourhoods and between communities of identity and experience disappear.

3. A diverse and successful workforce across health and social care that delivers high quality care and rewarding career opportunities for all

Birmingham and Solihull health and social care system will become employers of choice, offering careers and experiences that value and support inclusion and enables local employment that is rewarding and fulfilling.

Across the system we will be confident that the evidence-base of what works is being implemented routinely and when mistakes happen we can demonstrate rapid learning and implement changes to avoid future issues.

Fully implementing evidence-based care will lead to fewer patients developing complications and reduce the burden on health and social care services through better management. This is especially important to reduce inequalities and will also mean we have staff who are culturally intelligent in their practice and treat every person in a holistic way.

People using our services feel that they are receiving high quality care and the number of complaints sets a new, much lower baseline because people are confident in the care they receive and are involved in their care decisions individually and are involved in service decisions as local communities.

4. Achieve financial sufficiency through better use of skill mix, evidence-based practice and using research and insight at pace to improve outcomes

Every organisation has to balance the finances - the health and social care system is no different, and the ICS will achieve financial sufficiency through the changes we plan.

We will be a system that is much better at using skill mix, while recognising the paradox of delegation, creating more complex demands on higher skilled staff. Professionals will feel valued and supported to deliver care within their sphere of competency and with clear risk management and clinical governance.

We will also maximise the efficiency of our public sector estate, working across the health, local government, police, education and other public sectors to embed services in spaces that work for communities in joined up ways.

This means that people will be able to access care more easily from a diverse range of professionals and volunteers that provide care and support across the full week, in a range of community and health settings. It means that simple things can be done closer to home or work and only those health issues which need to go to our most specialist centres go there.

Through a strong and consistent approach to prevention and early intervention and better integrated services we will reduce financial waste across the system and improve the experience for service users.

5. Making a positive impact through every health and social care provider's actions on the wider determinants of health and reducing inequalities

Across health and social care we will use our role as anchor organisations in communities to employ locally, supporting local education pathways to successful careers, and buy locally to help the local economy.

We will be active with our existing partnerships such as health and wellbeing boards, supporting the leadership of both Councils, and others to work on the wider determinants such as housing, employment and education. The ICS will be visible in employing locally with a real Living Wage* and a strong approach to supporting training and development that helps reduce inequalities in employment as well as health outcomes. With the local community safety partnerships we will have played an active role in improving community safety and cohesion and where there are unique opportunities such as East Birmingham and North Solihull Investment Zone to drive change, we will be visible and active partners.

People from different communities will feel confident accessing services because they will know that health and social care professionals are culturally intelligent in the way they deliver care and understand the impact of experiences such as racism, homelessness and caring responsibilities on health and wellbeing.

> *"The NHS staff have to be anti-racist, not just less racist."*
>
> Birmingham community member, BLACHIR Report 2022

* Employing organisations should be accredited through the Living Wage Foundation.

Measuring success

It is essential that we have a clear metric dashboard for measuring the progress against this strategy. This will need to sit in synergy with the national ICS outcomes frameworks and local Health and Wellbeing Board Strategy dashboards. These metrics are hosted by Birmingham City Observatory

In setting out how we will measure success we are taking the subsidiarity model in our approach, so as the ICS Partnership we are defining the metrics against which we want to see progress and the anticipated direction of travel, but we expect the ICS Board and Place Boards to define the target outcomes and the trajectory to achieving significant change by 2033.

Also, in setting out our long and medium term metrics we recognise the challenges of the continually changing landscape of the public sector, the major impact of socio-economic factors and the changing demographics of our communities and we aim to revisit these every two years to ensure these remain relevant and appropriate to achieving our vision and ambition as a system.

We have included specific metrics focused on equality, diversity and inclusion which reflect our globally diverse population and the real inequalities between different communities of identity and experience as well as between geographical places.

> *"The main improvements I'd like to see are access to care in your local community without having to travel and the same comparable services, with comparable waiting times and access requirements across both Birmingham and Solihull. I would like services to be more joined up and to have that communication."*
>
> Heather Delaney, Chair and Director, Solihull Parent Carer Voice

ICS level long term metrics – ten year trajectory of change

↑
- Life expectancy at birth and at 65yrs
- Disability-free life expectancy at birth and at 65yrs

↓
- Inequalities in life expectancy within Place and between communities of identity
- Prevalence of excess weight in adults and children

Place and locality level medium term metrics – five year trajectory of change

↑
- Uptake of antenatal screening
- Children achieving good level of development at the end of Reception & at 2-2.5yrs
- Increase the proportion of cancer cases diagnosed at stage 1 or 2
- Estimated dementia diagnosis rate in >65yrs olds
- Older adults still at home within 91 days from discharge to reablement

↓
- Prevalence of cardiovascular disease
- Emergency admissions for cardiovascular disease, especially for stroke and heart attack
- Prevalence of diabetes
- Emergency admissions for chronic obstructive pulmonary disease (COPD)
- Infant mortality
- Hospital admissions caused by injuries and asthma in children
- Cancer mortality (all causes)
- Prevalence of smoking
- Suicide and self-harm rates
- Adults with a long term musculoskeletal health problem
- Emergency hospital admissions due to a fall in adults aged over 65yrs

Community inequality medium term metrics – five year or less trajectory of change

Communities of identity inequalities

We recognise the inequalities affecting communities of identity across Birmingham and Solihull and the need to drive specific action to address these through addressing structural discrimination as well as culturally intelligent commissioning and delivering cultural safety across all our services. There remain several communities of identity, such as faith, gender identity and sexual orientation, where routine data collection is limited and we are committed to closing these gaps in the first two years of the strategy and expanding this set of metrics to cover as a minimum the legally protected characteristics.

Ethnic inequalities

- Ensuring continuity of maternity care of women from ethnic communities and from the most deprived groups
- Uptake of cancer screening by ethnic communities
- Uptake of immunisation across the life course by ethnic communities

- Inactivity in people from ethnic communities compared to the national average
- Inequality gap in type 2 diabetes between different ethnic communities
- Ethnic pay gap in ICS organisations

Gender inequalities

- Uptake of long acting reversible contraception (LARC)

- Teenage conception rate in under 18yr olds
- Domestic violence and abuse related incidents and crime
- Physical inactivity rates in women and girls
- Gender pay gap in ICS organisations

Disability inequalities

- People with learning disabilities and those living with severe mental illness (SMI) receive annual health checks
- Carers receive an annual health check

- Inactivity in people with long term conditions and disabilities
- Smoking in adults with long term mental health conditions

LGBT+ inequalities

- Ensure LGBT+ people with common mental health issues receive timely and culturally sensitive support through IAPT and specialist services (IAPT dataset)

Community inequality medium term metrics – five year or less trajectory of change

Economic inequalities

We recognise the deep and entrenched inequalities between the most deprived and the most affluent populations and the need to maintain and accelerate our work to address these, both through increasing the money in people's pockets as well as considering the financial and social barriers to services and support.

- Uptake of healthy start vouchers
- Uptake of cancer screening in the most deprived communities
- Uptake of immunisation across the life course in the most deprived communities
- Proportion of ICS organisations, and contracted organisations, who are accredited Living Wage employers*

- Children living in relative low income families (under 16yrs)
- Fuel poverty
- Young people not in education, employment or training

Inclusion health populations inequalities

Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery. There are currently limited indicators that are routinely collected and we hope that the ICS will develop a fuller suite of metrics over the first five years of the strategy to build on these.

- Immunisation and vaccination coverage in inclusion health populations
- Early identification of blood borne viruses e.g. HIV, Hepatitis
- Children in care immunisations
- Supported adults with learning disabilities in paid employment

- Drug and alcohol admissions and related deaths
- Children on child protection plans
- Re-offending levels

* % of employers and contracted organisations accredited through the framework of the Living Wage Foundation. Living wage is also the core focus of the Health of the Region Task Group at the WMCA and this metric aligns with their trajectory.

Getting started

A focus on five key clinical indicators to help improve life expectancy

This strategy sets out an ambition to give the people of Birmingham and Solihull longer, happier and healthier lives so they can achieve their potential without health being a barrier.

But achieving this ambition is going to require early focus, leadership and a clear route map to support everyone in health and care to play an active part in contributing toward this.

While life expectancy is a long term indicator driven by many elements, there are five key areas where, if we can provide focus and accelerated change, we can make an early start to meeting our ambition. They are:

- **Circulatory Disease**
- **Infant Mortality**
- **Respiratory Disease**
- **Cancer**
- **Mental Health**

In each disease area there are multiple strands of action spanning prevention, treatment to end of life care. Addressing the disparities in life expectancy requires work at every stage from prevention of risk factors like smoking, through early identification using tools like screening and opportunistic testing and then reducing risk at every stage of the clinical pathway to give people the best quality of life and the best opportunity for a long and healthy life.

Figure 7:

An example of how we can prevent and reduce the risk of, and improve outcomes for, those living with cardiovascular disease

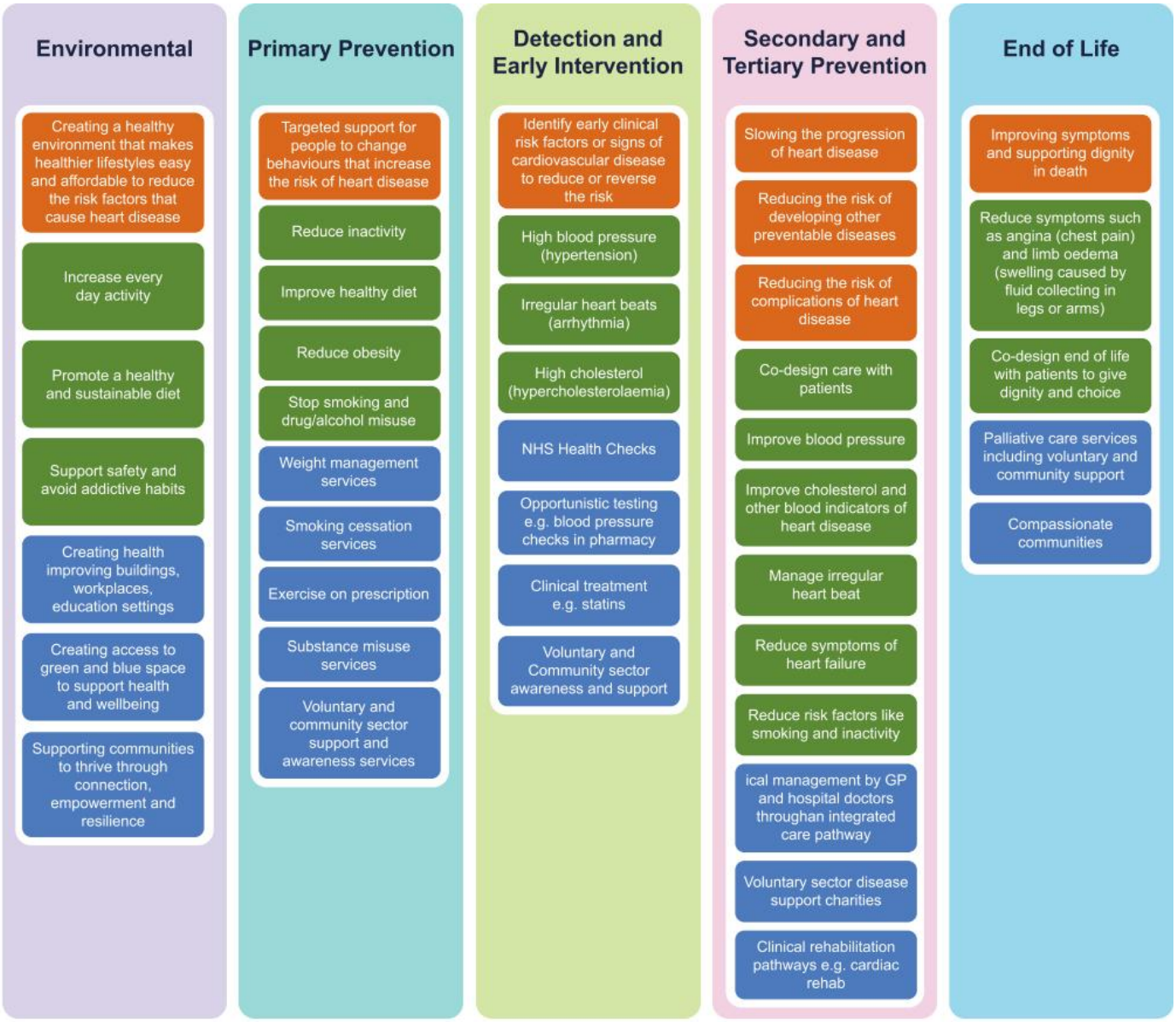


Figure 8:

An example of some of the existing metrics which can be used to monitor how our changes have an impact on cardiovascular disease outcomes

The indicators that have been identified to track progress for the ICB map into these domains although it is recognised that there are some areas where local indicators will need to be developed to improve the depth of understanding.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Café Nariano's
HELLO
THE HIGH STREET
JOIN THE KINGS HEATH BUSINESS ASSOCIATION
CREATIVITY IS JUST INTELLIGENCE HAVING FUN
Forever Young

Getting started

Addressing the improvements we need to see across each of these five requires action that will impact both long and short term and the ICS Partnership expects to see a relentless drive to address inequalities within each of these five areas.

In each area we are expecting to see action in 2023/24 under the following priorities to start this process of change:

1. UNDERSTANDING OUR COMMUNITIES

We expect to see explicit use of local data in each condition area to explore and understand racial inequalities and other identity and experience linked inequalities as well as geographic inequalities and this data driving service improvement and better outcomes.

2. MAKING EVERY CONTACT COUNT FOR PREVENTION

We expect to see all health and social care professionals completing basic e-learning for behaviour change and those in clinical contact roles completing additional training on brief advice for smoking cessation and physical activity in line with NICE guidelines. This will lay the foundation for organisations across the ICS to start to monitor and report on the use of primary prevention in pathways.

3. GET THE BASICS RIGHT

We expect to see each of the five clinical pathways complete and publish at least two audits based on NICE guidelines across the full footprint of the ICS i.e. integrated audit across primary, secondary and social care. Too often in the glare of new technology and the pressure of service reform the basics fall short and this will demonstrate a commitment to evidence based quality improvement.

4. LEARN FROM OUR MISTAKES

We expect the ICS to publish an annual report demonstrating the implementation of learning from the recommendations made through the statutory death panels e.g. Adult Safeguarding Reviews, Child Death Overview Panel, Domestic Homicide Panel, Deaths through Alcohol or Drugs Review and the LeDeR Programme (Learning from lives and deaths - People with a learning disability and autistic people).

Case Study

Helping people to make lasting lifestyle changes

A pilot programme which focussed on prevention has helped people in Solihull to live healthier lives and empowered them to make practical and effective lifestyle changes.

In a partnership between the five Primary Care Networks (PCNs), Gateway Family Services, Community Pharmacy, Public Health and Solihull Together Board, three Integrated hubs in Solihull were set up to focus on delivering lifestyle interventions, health checks and group consultation.

Through data held by GP practices, the pilot targeted people who would benefit most, such as those with a high blood pressure reading or a long-term condition.

Citizens were invited to a lifestyle check, provided by Gateway Family Services, which included weight and blood pressure checks. As required, Gateway could then refer people for tailored support around weight loss, healthy eating, reducing stress and smoking cessation. Following the intervention the patient was referred back to their GP for review.

This partnership approach ensured that patient care was managed through their GP practice, but with the benefit of a multidisciplinary team to carry out the checks and intervention.

The pilot successfully identified those at high risk - of the 135 people that took up the offer of the health check, 1 in 5 were identified as having a high blood pressure that required medical intervention or referral back to their GP and five individuals were identified as having atrial fibrillation (irregular heart rate).

Nearly half of all those who took part were referred on to other support services either provided through the partners involved or through an external service.

To expand this programme further it would benefit from being part of place based working for large scale vision and resource.

Our expectations as a partnership

The ICS Partnership expects that the ICS Board will respond to this strategy through the ICS Operating Framework and its underpinning strategies.

Through the monitoring of the dashboard of indicators, the ICS Partnership will assess impact of this operating framework on outcomes, alongside the ICS Board reporting on delivery of financial and performance improvements, in line with national and regional NHS expectations and the national NHS mandate.

The Partnership will be looking for explicit progress on integration and quality improvement within the first 24 months of the ICB activity, especially to address variation in clinical outcomes in both primary and secondary care, and be able to demonstrate progress in enabling and empowering people, patients and citizens to shape these improvements.

We recognise the workforce challenges and increasing burden of need and demand; this will require a radical change in the way we approach care.

The ICS research and innovation approach should reference the ICS Partnership strategy and have a clear focus on addressing some of the data insufficiencies, especially around granular data on ethnicity, sexual orientation and faith in performance data sets. This sits alongside a programme of deep dive explorations of inequalities in outcomes and service uptake in different communities.

We plan to refresh this strategy in 2025/26 once the ICS is more fully established and we have addressed some of the data and intelligence gaps to better understand need across our communities, however the Partnership will review the strategy each time a new Joint Strategic Needs Assessment is published by our partner local authorities.

As a Partnership we are committed to supporting the ICS through our leadership and oversight to ensure that the people of Birmingham and Solihull are supported to live healthy, happy and longer lives through our combined efforts as a system.

> *"We know that we're only going to be able to deliver the change we want to see, and that local residents want to see, by working together in partnership."*
>
> Ruth Tennant, Director of Public Health, Solihull MBC

Annex A: New legal duties strengthen our approach

There are a number of specific legal duties the ICS needs to be aware of in delivering its work, some of which will strengthen its ability to focus on tackling inequalities and improving outcomes.

Equality Act 2010

Public sector equality duty with three arms: i) prevent unlawful discrimination, ii) advance equality of opportunity, and iii) foster good relations between people who share a protected characteristic and those who do not

Specific equality duties on publishing equality information and setting and publishing equality objectives

Health and Care Act 2022

The Health and Care Act 2022 will introduce a range of obligations on NHS bodies in relation to health inequalities.

Tackling inequalities in outcomes, experience and access is one of the four key purposes of an ICS, supported by specific duties.

New ICB obligations on health inequalities

A new duty on health inequalities for ICBs: 'Each integrated care board must, in the exercise of its functions, have regard to the need to (a) reduce inequalities between persons with respect to their **ability to access health services**, and (b) reduce inequalities between patients with respect to the **outcomes achieved for them by the provision of health services.'**

A new **quality of service** duty on ICBs which includes addressing health inequalities.

A duty to **promote integration** where this would reduce inequalities in access to services or outcomes achieved.

Duties on ICBs in relation to several other areas which require consideration of health inequalities – in making wider decisions, **planning, performance reporting**, publishing certain reports and plans, **annual reports and forward planning.**

In addition, each ICB will be subject to an **annual assessment** of its performance by NHS England, which will assess how well the ICB has discharged its functions in relation to a range of matters including reducing health inequalities, improving quality of service, and public involvement and consultation.

Annex A

Committing to transparency: new requirements to publish inequalities data for ICBs, Trusts and Foundation Trusts

NHS England must publish a statement about use of information on inequalities in access and outcomes, setting out the powers available to bodies to collect, analyse and publish such information, and views about how the powers should be exercised.

NHS bodies should publish annual reports describing the extent to which NHS England steers on inequalities information have been addressed.

These new requirements sit alongside the existing duties on the NHS under the NHS Act 2006 and subsequent legislation as well as duties that require the NHS to actively contribute and participate in relation to:

- **Duties on equality and health inequalities under the Equality Act 2010 and the Health and Social Care Act 2012.**
- **Duties in relation to children in relation to the Children Act 1989 and 2004**
- **Duties on crime prevention and safeguarding including under the Domestic violence, Crime and Victims Act 2004 and as a Category 1 responder under the Civil Contingencies Act.**
- **Duties in relation to protecting staff under the Health and Safety at Work Act 1974 and training of staff under the Health Services and Public Health Act 1968**

Annex B: Full Glossary[1]

ICS – Integrated Care Systems

An ICS brings NHS providers, Clinical Commissioning Group (CCGs), local authorities and voluntary sector partners together to collaboratively plan and organise how health and care services are delivered in their area. There are currently 42 ICSs across England and each covers a population size of 1 to 3 million. The goal is that ICSs will remove barriers between organisations to deliver better, more joined-up care for local communities. Birmingham and Solihull ICS is our local ICS.

ICP - ICS Health and Care Partnership

The second part of the statutory ICS will be the ICS Health and Care Partnership. With a wider membership than the ICS NHS Body, the Partnership will bring together health, social care, public health and wider partners to develop a broader strategic health, public health and social care plan for the ICS. The ICS NHS Body will need to take this plan into account when making decisions about health care provision.

Provider collaborative

A provider collaborative is made up of several organisations coming together to make collective decisions about the design and delivery of health and care services. This collaboration can take place "horizontally" or "vertically". A horizontal collaborative may take place at ICS level or across several ICSs, between trusts delivering the same type of services such as non-specialist acute care. A vertical collaboration may happen at "place" level (see below) – for example between an acute trust and primary or community care. NHSE/I want every trust to be part of at least one or more provider collaborative, as they see collaboration as the best way to drive improvement.

Place

Most health and care services need to be planned, designed and delivered on a smaller geographic footprint and population size than the ICS. This means that within each ICS there are several smaller planning footprints – termed "places" – where health and care organisations come together to improve patient pathways and deliver more joined up care. In BSol ICS there are two Place Boards, one for Birmingham and one for Solihull, these align with the local authority boundaries.

Locality

In Birmingham, because of its large size, there are five locality partnerships, these focus on delivering change at a smaller geographic footprint than the Birmingham Place Board. Each locality covers two electoral footprints, e.g. North Locality includes Sutton Coldfield and Erdington. Each locality partnership is supported by a locality manager. The localities in Birmingham are East, West, Central, North and South.

Neighbourhood

Within each 'locality' and within Solihull's place governance structures, there are several neighbourhoods, which cover a smaller population size of roughly 30,000 to 50,000 people. They often focus on integrating primary, community and social care through multidisciplinary teams and joint working arrangements. Neighbourhoods are therefore key to the NHS's commitment to deliver more care as close to home as possible.

PCN– Primary Care Networks

A PCN brings together a group of local GP practices with other primary and community care organisations to join up health and care services at neighbourhood level. They were established in July 2020 to help stabilise general practice by using economies of scale, overcome barriers between primary and community services, and develop population health approaches. PCNs are still in development, but more mature networks are now able to deliver more joined up care for patients by developing multidisciplinary teams and recruiting additional roles to ease workload pressures.

Health inequalities

Health inequalities are defined as systematic, unfair and avoidable differences in health between different people within society.

Health disparities

Health disparities simply means health differences; whereas health inequalities points specifically to health disparities that are unfair and avoidable – that we can do something about.

Inclusion groups[2]

Inclusion health is a term used to describe people who are socially excluded and experience multiple risk factors for poor health such as poverty, violence and complex trauma. This can include people who experience homelessness, drug and alcohol dependence, Gypsy, Roma and Traveller communities, sex workers, victims of modern slavery, refugees, asylum-seekers and undocumented migrants. People belonging to inclusion health groups may experience stigma and discrimination and are not consistently included in electronic records such as healthcare databases. They frequently suffer from multiple ongoing health problems and face barriers to accessing healthcare. They may not be registered with a GP or have any information recorded about their health problems in health records. This leads to extremely poor health outcomes, often much worse than the general population, and contributes to increasing health inequalities.

[1] Adapted from https://nhsproviders.org/media/691164/system-working-glossary-for-governors.pdf

[2] Definition from Long read: winter vaccination for inclusion health groups - UK Health Security Agency (blog.gov.uk)

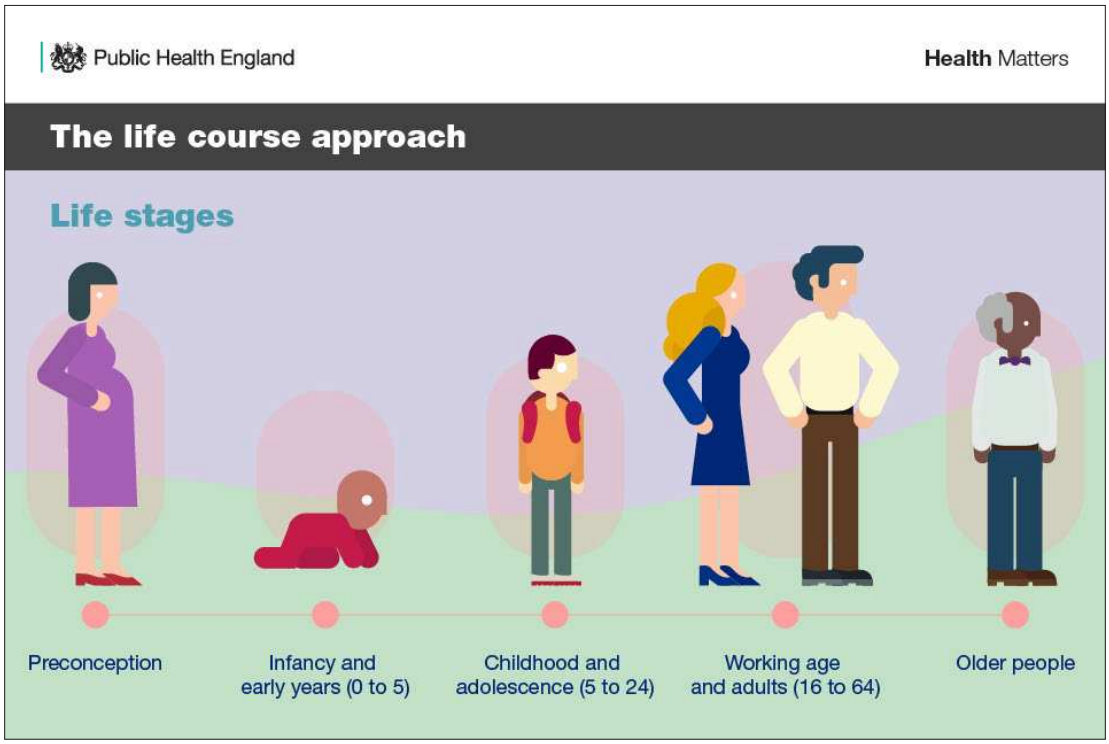
Annex B: Full Glossary[1]

Lifecourse[3]

A person's physical and mental health and wellbeing are influenced throughout life by the wider determinants of health. These are a diverse range of social, economic and environmental factors, alongside behavioural risk factors which often cluster in the population, reflecting real lives. All these factors can be categorised as protective factors or risk factors. Unlike a disease-oriented approach, which focuses on interventions for a single condition often at a single life stage, a life course approach considers the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing. A life course approach values the health and wellbeing of both current and future generations and recognises that protective and risk factors interplay over the lifespan and that maintaining good functional ability is best achieved through actions at every stage of life.

Figure 5:

The Life Course Approach (PHE 2020)



Health outcomes

Health outcomes are a change in the health status of an individual, group or population, which is attributable to an intervention.

Mortality

Mortality refers to the number of deaths that have occurred due to a specific illness or condition. Mortality is often expressed as a mortality rate, this is the number of deaths due an illness divided by the total population at that time of people who could get the illness.

Morbidity

Morbidity is a term that is used to describe the state of having a specific illness or condition, this can be acute or long term.

Co-morbidity describes when an individual has more than one conditions at the same time e.g. high blood pressure and diabetes.

Morbidity can be presented in two ways:

Incidence – the number of new cases of an illness or a condition within a population over a defined period of time, this can also be a rate or proportion of people within the population with the condition

Prevalence – this is the proportion of the population that has a condition or illness, it includes new and existing cases and can be calculated at a specific point in time or over time. It is usually presented as a percentage or a rate.

[3] Definition from Health matters: Prevention - a life course approach - GOV.UK (www.gov.uk)


Shirley Park