BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD

**TUESDAY, 17 MARCH 2020 AT 15:00 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 Chairman to advise/meeting to note that this meeting will be webcast for live or subsequent broadcast via the Council's Internet site (www.civico.net/birmingham) 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 that they must declare all relevant pecuniary and non pecuniary interests arising from any business to be discussed at this meeting. If a disclosable pecuniary interest is declared a Member must not speak or take part in that agenda item. Any declarations will be recorded in the minutes of the meeting.

3   APOLOGIES

To receive any apologies.

4   EXEMPT INFORMATION – POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC

a) To highlight reports or appendices which officers have identified as containing exempt information within the meaning of Section 100I of the Local Government Act 1972, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report.
**Item No. 5 - Private part of Minutes - Exempt Paragraph 4
Item No. 24 - Exempt Paragraph 3
Item No. 25 - Exempt Paragraph 3**
b) To formally pass the following resolution:-
RESOLVED – That, in accordance with Regulation 4 of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012, the public be excluded from the meeting during consideration of those parts of the agenda designated as exempt on

the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information.

5   **MINUTES AMD MATTERS ARISING**

To confirm and sign the Minutes of the meeting held on the 21 January 2020.

6   **ACTION LOG (15.05 - 15:10)**

To confirm the action log as current and correct and address any issues.

7   **CHAIR'S UPDATE**

To receive an oral update.

8   **PUBLIC QUESTIONS**

Members of the Board to consider questions submitted by members of the public.
The deadline for receipt of public questions is 5pm on the 10 March 2020. Questions should be sent to: HealthyBrum@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 Internet site (www.civico.net/birmingham). **NB: The questions and answers will not be reproduced in the minutes.**

9   **BETTER CARE FUND 2019/20 PLAN (15:15 - 15:20)**

Mike Walsh, Service Lead for Adults Social Care, Birmingham City Council, will present the item

10   **CREATING A MENTALLY HEALTHY CITY FORUM UPDATE (15:20 - 15:35)**

Elizabeth Griffiths, Assistant Director for Public Health, Birmingham City Council, will present the item

11   **JSNA CORE DATA SET- CHILDREN AND YOUNG PEOPLE CHARTER (15:35 - 15:50)**

Ralph Smith, Service Lead for Public Health, Birmingham City Council, will present the item.

12   **PRE-CONCEPTION CONVERSATION (15:50 - 15:55)**

Dr Marion Gibbon, Interim Assistant Director for Public Health, Birmingham City Council, will present the item

24 COMPLEX LIVES, FULFILLING FUTURES - DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2019/20 (16:35 - 16:50)

Item Description

25 UPDATE ON JSNA CORE DATA SET- WORKING AGE ADULTS CHAPTER (16:50 -17:00)

Item Description

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD TUESDAY, 21 JANUARY 2020

MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON TUESDAY 21 JANUARY 2020 AT 1500 HOURS IN COMMITTEE ROOMS 3 AND 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM B1 1BB

PRESENT: -

Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and Chair of Birmingham Health and Wellbeing Board
Councillor Kate Booth, Cabinet Member for Children's Wellbeing
Andy Cave, Chief Executive, Healthwatch Birmingham
Chief Superintendent Stephen Graham, West Midlands Police
Dr Peter Ingham, Clinical Chair, NHS Birmingham and Solihull CCG
Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG
Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS Foundation Trust
Toby Lewis, Chief Executive, Sandwell and West Birmingham NHS Trust
Dr Robin Miller, Head of Department, Social Work and Social Care, Health Services Management Centre, University of Birmingham
Peter Richmond, Chief Executive, Birmingham Social Housing Partnership
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Dr Justin Varney, Director of Public Health, Birmingham City Council

ALSO PRESENT:-

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG
Paul Campbell, Acting Service Lead for Public Health, Birmingham City Council
Harvir Lawrence, Director of Planning and Delivery, Birmingham and Solihull CCG
Errol Wilson, Committee Services

The Chair invited the Board members who were present to introduce themselves.

****

NOTICE OF RECORDING/WEBCAST

432   The Chair advised, and the Committee noted, that this meeting would be webcast for live or subsequent broadcast via the Council's Internet site (www.civico.net/birmingham) and that members of the press/public may

record and take photographs except where there are confidential or exempt items.

_____

DECLARATIONS OF INTERESTS

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

_____

APOLOGIES

434   Apologies for absence were submitted on behalf of Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Charlotte Bailey, Executive Director Strategic Partnerships, Birmingham and Solihull Mental Health Trust
Carly Jones, Chief Executive, SIFA FIRESIDE
Andy Couldrick, Chief Executive, Birmingham Children's Trust
Professor Graeme Betts, Director for Adult Social Care and Health Directorate
Sarah Sinclair, Interim Assistant Director, Children and Young People Directorate
Dr Ian Sykes, Sandwell and West Birmingham CCG, but (Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG as substitute)
Gaynor Smith, Senior Employer and Partnership Leader, Birmingham and Solihull District, Department for Work and Pensions

_____

EXEMPT INFORMATION – POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC

Members highlighted the following report and appendix which officers had identified as containing exempt information within the meaning of Section 100I of the Local Government Act 1972, and where officers considered that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report:

Item 5 – Private part of Minutes – Exempt Paragraph 4
Item 19 – Exempt paragraph 3
Item 20 – Exempt paragraph 3

435   **RESOLVED** –

That, in accordance with Regulation 4 of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012, the public be excluded from the meeting during consideration of those parts of the agenda designated as exempt on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information.

MINUTES AND MATTERS ARISING

Stephen Raybould enquired about the agenda items from the cancelled meetings as a result of the pre-election period and what the intention was in relation to these items. The Chair advised that these items would be brought presented to a future Board meeting.

436   **RESOLVED: -**

That the Minutes of the meeting held on 24 September 2019, having been previously circulated, were confirmed and signed by the Chair.
_____

ACTION LOG

437   The following Action Log was submitted:-

(See document No. 1)

Dr Justin Varney, Director of Public Health introduced the item and advised that there was one Red Rag item around Changing Places. They had done the action in relation to engaging with the Commonwealth Games structure workstream to ask them to integrate Changing Places into the planned buildings. The bit that was outstanding was the piece around community engaging formally with the rest of the partners to ask them to do the same in relation to any future new build. They would start to create this as a normal expectation of any new development in Birmingham or with refurbishment.

The other action on the grid which was still outstanding, but there had been action after the papers were submitted for publication was the promotion of public questions, but they had done some work to promote the opportunity of public questions through social media and had also asked colleagues from the Board to continue to raise this through community forums. He reiterated that those who were watching the meeting could submit a public question for the Board to respond to at each meeting and they were encouraging the members of the public to use that as an opportunity to put their questions directly to the partnership.
_____

CHAIR'S UPDATE

438   The Chair gave the following brief update: -
         ➢ Last week at Full City Council they had a discussion on the Council Plan Priorities and Councillors Booth and Councillor Jayne Francis along with her set out an overview on delivery of two of the Council Plan priorities for which they were the portfolio leads.
         ➢ The two priorities reported om were Birmingham was an inspirational city to grow up in and Birmingham was a fulfilling city to aged well in. She added that it was an interesting and lively discussion and colleagues questioned and raised concerns in relation to the two priorities. They had a long way to go but were on a transformational journey and there were areas where through working more closely, they were making

modernising practices and through earlier interventions improving outcomes for the citizens.

➤ The Chair highlighted that she had presented the Suicide Prevention Strategy and collectively as the Health and Wellbeing Board had an ambition to reduce deaths from suicide as part of a wider ambition to become a mentally healthy city. This was an emotive discussion and unanimously across the Chamber, they came together to approve the motion and vision set out in the strategy.

➤ As a Health and Wellbeing Board (HWB), they will be looking at that strategy through the Mentally Healthy City and they will be reporting back to the Board at least once or twice per year.

_____

PUBLIC QUESTIONS

439   The Chair stated that they had been trying but were not getting the questions as they would like, but they would continue trying and would review this again. Andy Cave enquired whether there was any comms messages that they could use to help promote to the message to the public and if something could be put together for them that would be helpful.

Tom Fellowes, Nuffield Health, the UK's largest not for profit health and wellbeing provider and a registered charity, enquired who they could talk to about their schools wellbeing programme which was a free service for schools as they were struggling to access schools in Birmingham. They believed that by working with the HWB they would be able to target those who were in dire need. Their schools wellbeing programme was aimed at the four pillars of health and wellbeing focussing on the emotional wellbeing of children. This was offered free of charge to schools around the city. They also offer a number of other flagship programmes as part of their charitable status, joint pain programmes for patients suffering from joint pains to try and alleviate the demand on the NHS services and was developing a programme around cystic fibrosis and a number of other areas.

The Chair advised that any questions coming to the HWB, needed to be submitted prior to the meeting being held so that a full response could be given at the meeting.

Dr Varney advised that there were a number of providers offering schools wellbeing programmes in the city and there were significant updates by schools and they had several of them that were well evaluated. The competitive market in which he as a Public Health Director perhaps the Health Department encouraged schools to be aware of what was available, but they did not preferentially promote any product over another as there were a lot on the market offering a holistic approach. He added that Mr Fellowes was welcome to email him outside the meeting for further information and they could add that to the general communications that they do to schools.

Dr Varney further stated that it had been mentioned in previous HWB that the work they were currently doing to scope thrive education, colleagues in the West Midlands would be aware that there was a thriving work framework that was for employers to take action on health and wellbeing following discussions

with various educational leads they identified that there was a gap after various after the national Healthy Schools programme. They were in the scoping phase of that piece of work and would bring that back to the Board as part of the Mentally Healthy City Forum which was the group overseeing it. This was scheduled for March/April 2020 and this would then allow them to move forward or not with that piece of work.

At this point the engagement from all of the educational providers and the approach was looking for nursery provision through university to adult education was positive. There was a huge appetite across our schools and education providers but was also a crowded market of providers and they were encouraging schools as commissioners to look at the evidence base behind provision and be critical around what they provide in the outcomes. They would welcome anyone coming into that market providing an evidence-based model.

_____

CREATING A HEALTHY FOOD CITY FORUM - UPDATE

The following report was submitted:-

(See document No. 2)

Dr Justin Varney, Director of Public Health, Birmingham City Council made introductory comments in relation to the report and highlighted the following:-

1. The Big Firm Birmingham Food Conversation – this was launched in October 2019 and was a yearlong conversation with the city about the food system of the city. This had many different components. The ones that were highlighted had progressed far.

2. They had commissioned 40 different focus groups from a large group of different community organisations. The focus groups were exploring citizens relationship with foods.

3. The focus groups were lesbians and gays; focus groups with under 18 boys and under 18 girls separately to look at gender difference in young adults; focus groups with people who arrive in Birmingham within the last two years and focus groups with migrants who arrived over 10 years ago in the city to look at the different relationships and beliefs system about foods.

4. There was a huge amount of information and they had one report left to come and they were in the process of working through those and looking at some of the key findings.

5. Concerning the LGBT focus group there was an interesting reflection that many of the messages they gave the system about food was based in the context of family and particularly in the context of parents and children. A lot of the national campaigns were about what you give to kids and that was the reason they had the healthy food environment and households.

6. The members of the focus group stated that they did not have children predominantly they lived on their own they did not have family and that the messages being put out about giving children health food did not apply to them.

7. The other focus group report he had read so far were predominantly from a set of African citizens, reflecting that they knew what health food was, but they wanted to eat healthy food in the context of their cultural heritage. They wanted to cook food and did not want ready meals, but when they were looking for it, they had to pay a higher price as they had to go to an African focused supermarket or they had to make do with a white British diet option. This was about access to culturally appropriate food at affordable price.

8. Another element was the Birmingham Food Survey which was being run as an open survey and anyone including Board members could take part. Currently 370 people had completed the survey which had 80 questions and take about fifteen minutes to complete. They had taken the first 260 responses and did an analysis and this highlighted that a large proportion of citizens did not recognise the national guidelines on what healthy meals looked like.

9. The Eat Well Guide, which was the national guidelines, they asked them both by naming them they showed them a picture whether they recognised them and the response was no. Almost 60% of people took part in that survey. Another thing that stood out was how few of the citizens regularly drink any water. Very few were drinking more than a glass of water per day which raises a number of questions for them.

10. The Childhood Obesity Trailblazer Programme (COTP) which was a three-armed programme supported by national government and the Local Government Association (LGA) PHE looking at how they could change the food environment of the city. This was looking at it through the lens of how they could change the economic environment of food businesses in the city so that they were better able to offer healthy safe affordable food in every community in the city, not just in the rich areas.

11. The second element was how they looked at the skills escalator or the skills pipeline so that what they were doing through schools, colleges and universities to ensure that the people coming out who wanted to work in the food industry had the right skill set, but also people who were coming through the apprenticeship pipeline had a better awareness of health and wellbeing through the spiral of health and wellbeing curriculum.

12. The third element was looking at how they could capture data to understand the food system in the city. The work that they did with Birmingham Big Food Hunt in June identified that they knew little about what the citizens were buying and throwing away. If they did not know this, how were they going to tackle the challenge of obesity, because it was known that the driver of obesity was poor nutrition, yet they knew nothing about nutrition in the city.

13. Dr Varney referred to the partnership work with Pune, India which was a project called BINDI Project that linked across with our relationship with the Milan Urban Food Policy Pact (MUFPP) and the Deleuze Network which were two international network of cities working on food. With Pune, they had been working on the food survey and they had completed their survey.

14. They got to 5000 households, but they were working towards a more modest sum, but the Pune survey mirrors some of the questions in the Birmingham survey, so they were able to do some comparisons particularly about hot food takeaway delivery Apps.

15. Some of the things that the Pune survey highlighted was that they were unable to find the socio-economic gradient in the use of those Apps. This showed that people were as likely to order takeaway from a *Deliveroo* or *Uber Eats* or *Just Eat* in the slums in Pune as they were in the high-rise apartments.

16. This shocked the researchers as this was not what they were expecting. The area that Pune had most interest on was the work with food retail and street food retail and looking at how they could learn from each other.

In response to questions, Dr Varney made the following statements:-

a. Dr Varney undertook to circulate the LinkedIn group link to the Board and added that the information could be obtained by going into the LinkedIn group and creating a city Birmingham and they would find the information.
b. All of the forums had a LinkedIn group and they had committed that all of the forums will place information on the LinkedIn group to make it transparent and accessible and to enable any citizen that wanted to engage in this conversation to join in the conversation because they would only move this city if they move it together.
c. The survey was opened at the moment, but they had closed it briefly after Christmas to take the data off and then re-opened it. What they were planning to do to help publicised that, was to use Fizz Free February campaign and they were talking with the dentist, pharmacist and GPs across the city to help publicise that through their TVs in their waiting rooms, through their patient interactions.
d. They had spoken with the schools and children's centres and would be using this month-long conversations and wanted people to think before they open a can of pop as they know it contributes to the largest amount of sugar to children's diet and it damages all of our teeth.
e. The aim for this month to try putting it aside. If they could do Dry January, perhaps they could do Fizz Free February for children. In the councils that had done this, many families used this as an opportunity to have a conversation about where this had come from.
f. Too often we open a bottle of pop and not think about it or what it was doing to the environment. They will also be talking about the supply chain and the global impact of the soft drinks industry as well as the personal impact on our teeth and on our waistline.

g. In terms of the coordination with other strategic structures in the city, the advantage they had in Birmingham was that Birmingham led several of the key workstreams if that ask was to be made, particularly the structure one.

h. They were leading the work on regulation and licensing. There were two elements that started – the Healthy City Planning Toolkit which was being piloted through the Perry Barr development and this was now being used in the evaluation of the first pilot.

i. They were looking to publish that over the next couple of months the planning toolkit and all the evidence of good practice nationally and some of the international information. It was not just about food, but about crime and violence, age friendly, child friendly and older adults friendly approaches in one single toolkit.

j. This was a large piece of work that was finally coming to fruition. They were encouraging other partners in the Commonwealth Games Partnership Team to use this in the same way.

k. There was a Public Health Advisory Group which sat under the Chief Executive Group of the Commonwealth Games which he co-chairs with Public Health England's Regional Centre Director, Sir Robertson and that group was explicitly trying to coordinate Public Health ASK so that they were all on the same sheet.

l. They had a slight advantage in Birmingham as he (Dr Varney) was the Lead Director of Public Health for the Commonwealth Games on behalf of the West Midlands Director of Pub Health.

m. In essence, at the moment, the focus was trying to build on the environment infrastructure piece and the regulation and licensing pieces within the remit of what was local decision making.

n. There were some things like the sponsorship packages which were international decisions on behalf of the Commonwealth bodies which, although they had expressed views, they had no control over, but within the regional footprint there was a strong alignment and they were ensuring that they were asking multiple things of multiple people.

440   **RESOLVED: -**

I. The Board noted the function, priorities and actions of the forum;

II. Identified whether any of the other forums share and/or can support the priorities; and

III. Where appropriate, offered guidance as to how best this joint working and/or support could be implemented.

_____

JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) DEEP DIVES – PROGRESS REPORT

The following report was submitted:-

(See document No. 3)

Paul Campbell, Acting Service Lead, Public Health, Birmingham City Council made introductory comments relating to the report and advised that within the City Council they took a two-pronged approach to the Joint Strategic Needs Assessment (JSNA). They had the Core Data Set which will cover the general

public giving a high level of the broad overview, but they were aware that they were a diverse city dealing with lots of different populations. What they thought was beneficial was that they had the Deep Dives that came specifically on those on the interest groups.

Mr Campbell drew the attention of the Board to the information contained in the report and highlighted the topics for the first four years as detailed in paragraph 4.2 of the report.

In response to questions and comments, Dr Varney and Mr Campbell made the following comments:-

i.   The point of the Deep Dives was in essence to raise the issues from looking at the evidence from the data of the focus groups. The work that the focus groups had done had highlighting this as an issue and the reflection was not just that individuals may not have had that conversation, but also that professionals may not necessarily be having the conversation with them.

ii.   This resonate with what the national and international evidence was showing and also some of the work … but the work around end of life care in the NHS which strongly encourages health care professionals to have a much earlier conversation about death and dying.

iii.   The other aspect of this was an interesting reflection that the team would be asked to bring back at the next update the focus groups where they had challenges was commissioning them. There were some particular communities where repeatedly they were finding that when they were going out to market, for focus groups, people were not coming forward so organisations were not applying.

iv.   Now they were in the fourth or fifth round of the focus groups commissioning they were getting a clear idea about which particular communities they were struggling to find organisations that providers would facilitate. This was something where they would welcome a partnership discussion as it raises a concern about how those individuals within those communities voices were being heard.

v.   In terms of what they find, care plans were not routinely put in place for people during end of life situations. It known from the evidence that the vast majority of people would prefer to die at home, however, this did not happen and this was a strange disparity that people were not able to die in the manner and place.

vi.   In terms of what they would recommend around that there was some work going on with Birmingham and Solihull End of Life Oversight Group and they would like to feed into and influence that and see how they could assist in getting the message wider to the health and social care communities.

Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG commented on the end of life death and dying and stated that when the work started, he did not connect the research with that point to the STP work and to check that that connection was being made with a substantial work that linked in to that point that was made. He requested sight of the document before publication as he had not seen anything yet.

The Chair voiced concerns that they were saying in the report that they were struggling to get that information, but that the information was out there and the veterans were a group of people that absolutely and utterly love to talk. They also had a veteran champion in the City Council, Councillor Mike Sharpe who was good at this and former Councillor Anita Ward and they just needed to ask. There were groups such as the Salvation Army. They had also stated that on the 2 January, there was a closing date as they were going out to procurement for another group to help to do the work.

The Chair commented that she was not certain they were working in collaboration with anyone and doing this in isolation would get the results that they were getting.

Dr Varney continued

vii. The veterans work had been actively engaged with the veterans group in the Council through the development piece and through Suwinder Bains, Lead Officer for supporting that group. They were well sighted. They did go to market for nine different focus groups that they were looking to commission with different groups of veterans.

viii. They were conscious that one of the challenges they had with any of these areas was that they go back to the same group of people every time and it was those that shout the loudest got heard.

ix. They talked about veterans as a homogeneous group, they were looking for a focus group with veterans with physical disabilities; a separate focus group with mental health issues which they were able to award; a veterans group with those discharged within the last two years; a veterans group with those discharged more than 10 years ago that they were able to award; a group with non-British armed force veterans.

x. Veterans living in the city from other armed forces – they were unable to award that; a group with female veterans, they were able to award that BME veterans group they were able to award; with people who had left the service early and people who had left ahead of their normal discharge through medical reasons, they were unable to award that and a focus group with reservist and they were able to award that.

xi. Of the nine they were able to award contracts to half of the focus groups, but there were significant gaps. One of the things they were reflecting on having gone through that market tender they could go in with more niche and identify people working with some of the partners, but it did reflect some of the challenges.

xii. They did not want to view veterans as a homogeneous group and this was the reason, they added this focus group on this level of granularity, to try and explore the different experience of being a veteran as too often it was the people that left the armed forces several years ago and we ignore the voices of those who were recent leavers and some of the differences of experience particularly for women; BME and those who were from armed forces not from the UK.

xiii. They were actively addressing, and if other members from the Board had any other ideas about people, they could approach they could contact Dr Varney or any members of the team.

In response to a question from the Chair, Dr Peter Ingham advised that he felt engaged with the process as he had met with both Sue … and Elizabeth Griffiths on two occasions and they had sent him through the draft report which he had read and commented on the document. Dr Ingham added that he had some communication with the RAF Benevolent Fund earlier this week which he had forwarded to the team and they were trying to visit the Barberry Centre initially but were not able to do so. Stephen Raybould commented that in response to the challenges, BVSC could get them to where they needed to get to in terms of specific communities. The commissioning process did not support engagement with small communities, but there might be something they could do to smooth this over.

441   **RESOLVED: -**

That the Board noted the progress.

_____

NHS LONG TERM PLAN – BIRMINGHAM AND SOLIHULL CCG

The following report was submitted:-

(See document No. 5)

Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG informed the Board that the NHS Long Term Plan – Birmingham and Solihull CCG was to be treated as a draft as they had not yet agreed the final *touches* around the finance. Technically the Plan had not yet been signed off by NHS England and Improvement. They were not far off agreement, but they would not go into what the issues were through the middle of interactive negotiations with bodies as it was outside of the public remit. The balance for them was between doing all of the business as usual that they needed to do and addressing the grossing business as usual as well as addressing the new issues that the Plan had asked them to look at. Mr Jennings advised that Ms Harvir Lawrence, Director of Planning and Delivery, Birmingham and Solihull CCG will be talking us through the strategic level rather that a detailed level that the Plan seeks to address.

Harvir Lawrence, advised that the purpose of the presentation was to seek support from the HWB in terms of the direction of travel based on the Long-Term Plan.

Ms Lawrence then made the following statements:-

a) The National Long-Term Plan was published in January 2019 and provided the national direction of travel alongside a set of national must do requirements in terms of key transformational enablers for delivering a set of health priorities over a 10-year period.
b) Later in July 2019, The National Technical Guidance was published and the Guidance document asked STP to produce a series of documents to describe how they intend to deliver the commitments of the National LTP over a five-year period as the system.
c) In response to that they had produced a five-year delivery plan for Birmingham and Solihull and wanted to ensure that that plan aligned

with the STP Strategy. They did not want to push this piece of work to the side but wanted to ensure that there were alignment and Birmingham and Solihull LTP flowed through the STP Strategy and reflected their local priorities.

d) The long-term plan for the system was essentially a set of delivery plans to implement transformation improve quality and safety with a shift on prevention and delivering better outcomes. This was so that they could capture some of the major inequalities that exists at the moment. Another significant focus of the plan was that they were continuing to work together as a system. It refers to the direction of travel around developing themselves and the integrated care system.

e) In terms of the development approach, early on the plan was health focussed when it was published nationally, but they recognised that they needed to work with their partners in local government to enable them to support and help them deliver their local priorities.

f) They ensured that they were engaged with system partners across health and council in the development and co-design of the plan. They wanted to ensure that they used an inclusive and collaborative approach. They had set up a governance around that and stakeholders from their partner organisations formed a group that held the reign on producing the LTP for the system.

g) Throughout the process they had engaged with Birmingham and Solihull Health and Wellbeing Boards and had also commissioned an insight into public views for the plan through a piece of work with Healthwatch Birmingham. This piece of work showed what the public wanted to see in our plan was aligned with the vision and priorities in terms of prevention self-care and improving access.

h) Another thing they did as part of developing the plan was to have a robust confirm and challenge process. They had brought together a group of external stakeholders to be their critical review and challenge the developing of the plan.

i) They had held two critical review meetings with that group which was helpful in testing out the business plan as to whether it was local enough for Birmingham and Solihull, whether it addressed the priorities and challenges within the system. This helped to shape what the what the plan looked like today. This approach was commended by our regulators in terms of our inclusivity and challenge.

j) With regards to finance, the plan was still considered as a draft as discussions were still on-going with NHS England and Improvement. Within the plan there was a set of key themes that were outlined. The plan was comprehensive as it sat at around 260 pages which may seem lengthy, but they had a complex system – they had a set of challenges, numerous partners that needed to be involved and they needed to ensure that they were responding to each of the commitments and requirements that were being set out nationally.

k) It was felt that the plan told the Birmingham and Solihull story. They had a real focus on aligning it to the STP Strategy with a particular focus on place, prevention and the life courses as set out in the STP plan.

l) The structure of the plan was in line with the life courses the STP Strategy, but they wanted to ensure that they captured the key enabling things that would support delivery of those national requirements. They had thread this through those workforce development, finance, digital

transformation, research social value etc. which were golden threads throughout the whole plan.

m) It was prudent to carry out a risk assessment and had set out some strategic risks within the plan and the mitigations around that and they had also undertaken an equality impact assessment which had indicated that the overall development was positive. In tandem to this they had also produced a public summary so that when they come to launch/publish the plan they will be setting that out through their communication along with the full plan.

n) In terms of where they were with the matrices, there was a performance framework that was set out that underpinned the plan, but these were national matrices which the system was required to deliver. There was a total of 31 matrices across the whole plan and were based across the programme on life courses.

o) As part of developing the plan, they were able to commit to delivering the majority of the matrices, but there were a few exception areas where they were able to fully commit due to further work that was required in those areas. Additional funding was needed to be able to fully commit to those. These exceptions had been agreed locally with their regional teams NHS England and Improvement.

p) In terms of the next steps, discussions were continuing with the regulators to be able to sign off the plan. Once this was done, they would be able to launch the plan and there was guidance that was due to come out nationally and how they go about doing that. The other process that was starting soon was their routine process around operational planning.

q) The guidance nationally was to be published next Monday 20 January 2020 and Tuesday 21 January 2020. They were now entering into the annual planning process in developing a system operational plan which would be due for the regulators – the draft towards the end of February and then the final plan by the end of the financial year and they will need to have agreed contracts with their provider organisation by then.

r) They would also be looking at the assurance and governance framework that sits around the plan where they could report back on their delivery and track progress. This was currently being reviewed. Once they had looked at communications and engagement aligned to the individual initiatives and programmes within the plan and they will follow due process in terms of their obligations around communication and engagement and consultation. The individual delivery plans were being developed.

Dr Robin Miller commented that it was a long plan, the NHS Plan was an extensive plan, but he felt it was well articulated, accessible and the … structured well complemented the team on doing such a good job. Good to see reference to HWB as part of their scrutiny he enquired whether they were able to add a bit more detail as people may not know what HWB was. Dr Miller enquired what they think HWB would add to their scrutiny functions. Dr Miller referred to page 80 of the document " our systematic approach …" He added that this was something he had felt that they had worked on for a long time and health care services. He enquired whether Ms Lawrence could articulate what it was that they wanted

In response to questions and comments, Ms Lawrence made the following statements: -

1. In terms of the HWBs roles in overseeing the plan and what they would like from the Boards, was the objective view that goes beyond health and being able to offer a level of scrutiny that challenges them and test that they were on track and delivering the plan.
2. It helps in strengthening and having a robust governance in place and ensuring that the appropriate mitigating actions were being taken if there were any slippage.
3. They wanted to work in full transparency with their partners and have the HWB as part of that process and seeing the information and data that they also see as part of the scrutinise delivery of the plan.
4. Paul Jennings stated that one of the things they were keen about in terms of their work with the STP was to maintain a crucial link with local government and the HWB was the place where the care system came together with local government.
5. Although they recognised their contributions to prevention and reducing inequality in health, they knew that where that really happened was to the paths where local government touches and unless they came together under the HWB with Public Health they would not meet their objectives.

   At this juncture, the Chair welcomed Toby Lewis, Chief Executive, Sandwell and West Birmingham NHS Trust to the HWB.
   Mr Lewis stated that his question came from a plan STP viewpoint and enquired where they felt the plan positioned the system in terms of particularly in employment poverty. He added that his question was specific to what commitment they were feeling able to give within this plan to the real living wage given the intention of the city to be potentially declared as the first real living wage city in the UK. He further stated added that the STP he was a part of were nudging towards committing towards a living wage system.

   Mr Jennings advised that this was the conversation they were having through the HR Directors Forum across the STP, but it was not yet in the plan. They were having that conversation given the status of University Hospitals Birmingham (UHB) with 21,000 employees now which was the most significant employer after the City council.

   Ms Lawrence continued

6. In response to Dr Miller's question around development, culture and the maturity of the system she stated that he was correct as there was a lot of work that had been done and it was felt that a lot of work was being done in terms of the individual organisations in terms of addressing culture.
7. It was known that there had been a lot of change through the Birmingham and Solihull system with the merger of the three CCGs, the merger of UHB and the other developments. The reference around immaturity was around the ICS work in terms of the direction they wanted to go in in terms of developing themselves as a single system.

8. There was still some way to go, but there was a lot of work happening over recent years in terms of working in an integrated way with health and local authority partners – mental health and children's – where they were working in an integrated way and what they wanted to see was this happening at that scale and with the move towards place-based working.

Dr Varney commented that he was pleased of the way they had worked together. It was a series of sprint and a marathon to get here. It was important for the HWB to be aware that working with the STP and the CCG, they had established a Prevention Board which with Nigel and he as co-chairs will help them move forward. He added that this was one of the things that they were keen to work through to have that Board formally linked to the HWB moving forward.

They were actively talking to the Black Country STP around what their approach might be and whether they would mirror that model as the Black Country had six Directors of Public Health. This was slightly complicated to work through, but he felt that it was worth the Board being aware that they had established that as a particular governance space to ensure that the HWB and the Public Health agenda and the STP and CCG were all on the same page and had some inter-connections.

The Chair expressed thanks to Ms Lawrence and colleagues for being so inclusive. She stated that as a Councillor she felt that they had *bent over backwards* to ensure they were a part of this process. They also came in to see the other Cabinet Members and did a special meeting with them due to the timescales for the other Cabinet Members who had agreed the draft Plan at that time. The Chair commented that she cautiously welcome the five-year Plan, but that she was aware that they had a long way to go, but she knows that they will get there. The Chair stated that she was in agreement with Dr Varney's comments as there were lots of opportunities to do the joined-up work and the challenges that was needed. The Chair further stated that she was in agreement with Dr Miller's comments as the document was an easy read.

The Chair expressed well done to Harvir Lawrence and colleagues and Paul Jennings for the work they had done concerning the document.

442 **RESOLVED: -**

The Board agreed to support the direction of the Long-Term Plan to enable the respective councillor members (Councillor Hamilton) and officers (Dr Justin Varney and Graham Betts) to approve the Plan at the STP.

_____

WEST BIRMINGHAM ALLIANCE UPDATE

The following report was submitted for information:-

(See document No. 6)

Toby Lewis, Chief Executive, Sandwell and West Birmingham NHS Trust introduced the item and advised that many partners around the table were already involved what was now the Ladywood and Perry Barr Integrated Care Partnership (ICP).

Mr Lewis drew the Board's attention to the infographics appended to the report. Setting the ICP in the west of Birmingham in the context of the West Birmingham, Black Country and STP, the battle plan was to tackle poverty – described as healthier people, being a decent employer, the Third Sector as being the best place to work. It was important as an STP team and with the assistance of the HWB, that they keep these things in the order he had just described them. Whilst it may have seemed obvious, it took a lot of arguments to get it into that order, in a system where STP and ICS were migrating towards being the delivery arm of the local NHS system, which was happier talking about NHS systems than it was about inequality.

Recognising that the governance of the STP was in the process of changing from the end of March 2020, they would expect the five places to migrate to a position where the STP was no longer governed by its constituent organisations coming together which was now in the Black Country and West Birmingham, towards a position where they had the maturity to pick up Dr Miller's point, to have each of the places represented and to have the headline governance of the STP, formally on a place basis, not on an organisational basis. He stated that he was pleased to say that the City Council, Primary Care Networks (PCN) and the NHS bodies had agreed a representative model which meant that the west of Birmingham was represented in the STP as a whole. To reflect Dr Varney's point from the earlier item of trying to ensure that the STP in the Black Country and West Birmingham was *essentially built place up rather than ICS down* as nothing else made sense. It was their intention to try and build *bottom up not top down,* but it would *need constant gardening* to make that truly work.

Mr Lewis advised that the report described two things – The first was that there were five bullet points (paragraph 4.2.3 on page 424 of the agenda pack) that sets out the sort of things that they had been discussing over the last year and a half, but with different velocity and different participation by different agencies. It was hoped that the five things, whilst they were not priorities for change reflected a common-sense approach to try to get things to move forward for our populations.

> ➢ Firstly, that they understand that population as it was more than a statistical thing, a feeling and a listening thing aided by both Healthwatch Birmingham and the Third Sector.
> ➢ Secondly that they build on the asset-based approach that the Council had adopted and has been a feature of the number of discussions that had taken place across the west of Birmingham.
> ➢ Fourthly, they did not focus on money as the currency, not because they object to talk about money, but because the real currency of the partnership was time.
> ➢ When they talk about moving services around and what they could do better for isolated older people, or how they sustain genera l practice, they were really having a conversation about how they could use abuse misuse each other's time either by patients, carers or service providers and the smarter they could be about the time they save and the time they devout to care, the better and this was really the currency.
> ➢ The next thing was to get ready for the Midland Metropolitan Hospital which was a partnership endeavour rather than a Sandwell and West Birmingham endeavour. They had signed the contract they had done

that before but they were now expecting to open in 2022 and that releases the resource into the wider system and they needed to ensure that it work.

➢ The final point was essentially the priorities that the partners had chosen. These were priorities that could be added to but were not came to as a shortlist without some thought. They intend to focus on obesity and end of life care. The language for public presentation may change, but that was where they think the partnership would make a difference.

➢ As they develop the governance and they signed off in draft forms in terms of reference at their last meeting, other priorities would come into place and the things listed in the Birmingham and Solihull plan would be considered there and they were all good things and there was no rational reason why one would not want to adopt all or many of those things. Those two areas were the initial focus of work which was much of a learning thing as well as a doing thing as they have got to work out as a set of partners how to work together.

➢ All of the partners round the West Birmingham Alliance Table work together for many years. The question was whether they could deliver a better outcome to people and this was an activity that they were working out what they might do differently, specifically in those two spaces to get a new and better result. They were not averse to adding additional priorities but were cautious about ending up saying they were going to do everything and ending up doing nothing.

In the discussion that followed, the following were amongst the principal points made: -

i. Mr Lewis noted the Chair's question concerning obesity and stated that the answer to how they got to it was through discussions with the clinicians involved on the basis that it was something that they felt that the partners could do together and could make a difference that then unlocked either resource and/or wellbeing in the population.

ii. When compared with Sandwell for example, it was not the standout health issue faced by partners, but it was sense that in an arear where currently there was not enough collective endeavour, therefore more could be done. The conversation was particularly focussed on children rather than adults. But the answer to the how question was the collective will of the clinical community and partners round the table.

iii. Dr Varney commented that they were glad that they had now established a clearer partnership for both Council and particularly the health department with the partnership as he thought that there was a lot where they were working across the city particularly in the areas of prevention of obesity recognising that as he alluded to the work that they did when he presented Food City.

iv. The focus was *on turning off the tap* of some of these challenges which ties in with the role around poverty and depravation driving inequalities particularly in parts of west Birmingham.

v. The question was around the space where they had significant inequality particularly in Ladywood around COPDs chronic-airways disease and cardio-vascular disease, where clinical management and early identification could be really quick wins.

vi. The question … was yes, they welcomed the broader partnership piece, but also in the context of where they fit in that in closing the gap on

clinical management space as it was not clear from the meetings held so far how that sits.

vii.   Mr Lewis stated that to offer one view, once they had agreed as a group of people was that they would have a meaningful partnership. They needed to have a part one and a part two conversation. The conversation was these were the things they tried to manage in common which they probably could not do if they were not working together. The other was areas where an organisation … had a priority and it was entitled to ask for assistance or listening time for everybody else – the issue of everybody in the partnership was probably two or three partners.

viii.   If we were smart about using data particularly live data, and data regarding people being in contact with services or not that the smart use of the services would be a distinguishing character particularly to pick up the point Dr Varney made that that was where pointing more of our efforts to better identify cohort people would be smart. We might hold ourselves to account for becoming pre-outstanding the way we use live data in common.

Richard Kirby offered the following reinforcing observations -

➢ Birmingham Community Healthcare NHS Foundation Trust which he was a part of was part of the partnership and he underlined with what Mr Lewis had stated about how they were trying to put it together.

➢ There was a structural bit and it was recognised that whilst they were at a point where west Birmingham was in one STP, but remaining as part of the city of Birmingham, this structure gives us a way of managing those interfacing intentions so that the early years team that was on the ground that could reflect the kind of priorities coming out of the STP around this work but could also sit within the context of the Birmingham wide service, without that becoming impossible to manage.

➢ The Midland Metropolitan Hospital issue was important as he was involved when it came out in 2010 a big change in the way services work in that part of the city having a framework for them to do that sensibly was important. The obesity issue was their way of saying getting children off to a good start in life matters to us.

➢ Some of the Black Country discussions might work with that and it may not be the biggest issue in Birmingham, but if it provokes some hard thinking about how the public sector in that part of the city helps parents to support children to get the best start in life they could that was what really mattered.

Stephen Raybould stated that in terms of obesity one of the system challenges for the NHS to reach out beyond its institutional boundaries and picking something that gives it no choice but to do was helpful. Even though it might not be reinforced entirely in terms of geography, as a system this was helpful and was welcomed in that part of the city.

The Chair commented that they wanted Mr Lewis to attend the Board meetings as for too long they were guessing what was happening. The partnership work that was happening was a positive way forward. Sometimes if you could not get what was needed and you could get 50% or 60% until you get it serves the

people of this city.   The Chair again welcomed Mr Lewis to the Board where he could share what was happening in that part of the city.

In response to a question from the Chair, Mr Kelly stated that there was a compare and contrast exercise in saying what was best for Birmingham and how do they ensured that they were finding solutions that levelled up across the city. He added that there was work to do in ensuring that they structured the conversation and that the intention was there. Once they got the data and their ideas together, they needed to look across the city and see where there was best practice and be opened to sharing that so there was no exclusion.

As an HWB they could hold the NHS to account for focussing on the outcomes, not just clinical outcomes but human outcomes that would be helpful. The systems could look different in west Birmingham, but what mattered was whether they delivered the outcomes that people were entitled to expect. If they could collectively stay focused on that it would be helpful to all.

(At 1638 hours, Paul Jennings advised that he and Richard Kirby had to leave the meeting as they had a prior engagement).

443   **RESOLVED: -**

The Board noted the opportunities created by joint working in the locality.
_____

HEALTH AND WELLBEING FORUM UPDATES

444   The following report was submitted for information:-

(See document No. 7)

Dr Justin Varney, Director of Public Health, Birmingham City Council advised that this item was for information and that there were written papers providing updates for the other forums.
_____

PUBLIC HEALTH GRANT BUDGET UPDATE

445   The following report was submitted for information:-

(See document No. 8)

Dr Justin Varney, Director of Public Health, Birmingham City Council advised that this item was for information and was approved by Cabinet in December for the reallocation of the grant .
_____

FORWARD PLAN REVIEW

446   The following report was submitted for information:-

(See document No. 9)

Dr Miller requested that somewhere in the Forward Plan (FP) time be allocated for discussing social prescribing as this was a key development around Primary Care Networks (PCN). As he interface between the statutory sector and the voluntary community sector as he felt that it would be an interesting example of one dynamic in their system that they could explore in the FP.

Dr Varney stated that the last time that the Board met it was discussed in a presentation. They subsequently had discussions with the CCG about where social prescribing was and it was felt that it was too early to bring it for discussion to this Board. The different PCN were in a different position across the city. However, through the Forums there had been more detailed discussions about how social prescribing was being implemented and connected with those programmes. They would go back to the CCGs about putting this back on the agenda as they were keen to have that conversation.

The Chair suggested that this be placed on the agenda for summer to give the PCNs time to get themselves together. Stephen Raybould stated that unless they got ahead of the implementation there was not much of an opportunity to influence as there were significant challenges around where people were going to go and the destination for prescribing. It would be useful to provide these earlier rather than when there was a problem.

Dr Varney stated that they had repeatedly and publicly through this Board highlighted the tensions with national policy on social prescribing and the funding provided to the NHS to fund someone to write the prescription. They had a conversation about the failure to provide adequate resource through the public health grant through the local government or through the voluntary and community sector to provide what was actually being prescribed. He highlighted that there were specific partnership groups that exist. The Adults Social Prevention Group had been looking specifically at social prescribing in the context of adults.

There was no social prescribing currently in the city for children and young people and this was something they were thinking about and was in discussions with the CCGs. The Chair advised that nationally they were having the same problems – this was not something that was set in stone and would change with time. To rush to try and do it now when the health service was uncertain of what was happening was not the right time. March 2020 was too early to have this item on the agenda, but for the next meeting in summer they were hoping to have some information concerning the issue.

_____

FINALISE AGENDA FOR THE NEXT MEETING

447   This was as detailed in the Forward Plan.

_____

OTHER URGENT BUSINESS

448   None submitted.

_____

DATE OF NEXT BIRMINGHAM HEALTH AND WELLBEING BOARD MEETING

449   It was noted that the next Birmingham Health and Wellbeing Board meeting will be held on Tuesday 17 March 2020 at 1500 hours, in Committee Rooms 3&4, Council House, Victoria Square, Birmingham, B1 1BB.

_____

EXCLUSION OF THE PUBLIC

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

Exempt Paragraph 4

_____

BIRMINGHAM HEALTH & WELLBEING BOARD

	Action Log 2019	
Rag rating :	Overdue	
	In progress	
	Complete	

Index No	Date of entry	Agenda Item	Action or Event	Named owner	Target Date	Date Completed	Outcome/Output	Comments	RAG
IAN12a	18/06/2019	Changing places	Maria Gavin to see whether changing places can be a specific requirement for Commonwealth Games new-builds	Maria Gavin	24/09/2019	30/12/2019		Maria raised the issue of changing places with the CWG leads. New facilities fall under the Organising Committee not the Council I believe. She has asked to join the accessibility forum which is just starting – and which considers all aspects of accessibility (e.g. access for people with sensory impairments, LD) as well as some of the physical requirements. So we are flagging the need for this wherever we can. Quite a few of the facilities are temporary rather than new build though, so we are also encouraging organisers to think about mobile facilities. So we are continuing to promote the need for changing places to be included at as many forums as we can	RED
	24/09/2019	NHS LONG TERM PLAN: BSOL CCG RESPONSE	Set up a Special Health and Wellbeing Board	Errol Wilson	08/10/2019	30/09/2019	Meeting arranged for 11/11/2019, subsequently cancelled due to Purdah. Presentation item for January 2020 Board		GREEN
	24/09/2019	PUBLIC QUESTIONS	Increase activity around the comms for Public Questions by liaising with partners	Paul Campbell	21/01/2020			Public Health have committed to tweeting and sharing via Forum networks	
	24/09/2019	SUICIDE PREVENTION STRATEGY	To ensure that the when the Suicide Strategy Action Plan gets updated, it is sent around to board members.	Mo Phillips	26/11/2019	26/11/2019	Updated version provided as part of Forum update.	Continue updates in that manner until finalised.	GREEN

007579/2020

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

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

IAN12c	18/05/2019	Changing places	Board Chair to write to the Neighbourhoods Directorate to support the implementation of changing places in parks.	Chair/PH	24/09/2019
IAN13a	30/07/2019	Live Healthy Live Happy STP update report	Birmingham and Solihull STP to work with local elected members around awareness raising of ICS & PCNs – what they mean and the implications.	Paul Jennings	26/11/2019
IAN13b	30/07/2019	Live Healthy Live Happy STP update report	The Board raised concern that changes to West Birmingham area could cause destabilisation for the system and the citizen experience Commissioners and providers agreed to meet outside of the meeting and report back to Board on how we get to an integrated system – particular reference to equity of provision for West Birmingham.	Paul Jennings	26/11/2019

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

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

18/09/2019	Letter sent by Cllr Hamilton		
26/11/2019	Presentation item for Board 26 November 2019.		
26/11/2019	Presentation item for Board 26 November 2019.		

Birmingham
Health and Wellbeing
Board

	Agenda Item: 9
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**17 March 2020**
TITLE:	**BETTER CARE FUND PLAN 2019/20**
Organisation	**Birmingham City Council**
Presenting Officer	**Michael Walsh – Head of Service, Strategy & Integration**

Report Type:	**Approval**

1.	**Purpose:**
	To approve the Better Care Fund Plan 2019/20.

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

3.	**Recommendation**
3.1	To approve the Better Care Fund Plan 2019/20.

007580/2020

4.	**Report Body**

4.1	**Context**
	Each year NHS England requires the submission of a Better Care Fund (BCF) Plan to outline the areas of income and investment expected within the BCF. The Birmingham Better Care Fund Plan (**Appendix 1**) has been completed with colleagues from Birmingham & Solihull CCG and Sandwell & West Birmingham CCG.
4.2	**Current Circumstance**
	As part of the structure for the Better Care Fund approval for the Better Care Fund Plan is required from the Health and Wellbeing Board on an annual basis.
4.3	**Next Steps / Delivery**
	Delivery of the Better Care Fund Plan 2019/20 will be monitored including progress against the BCF metrics on a regular basis through the Better Care Fund Executive.

5.	**Compliance Issues**

5.1	*HWBB Forum Responsibility and Board Update*
	The Better Care Fund Plan will be monitored through the Better Care Fund Executive and the Better Care Fund Programme Board.
5.2	*Management Responsibility*
	The Better Care Fund Executive will provide regular reports to the Health and Wellbeing Board.

6.	**Risk Analysis**
	There are no identified risks with the plan as the funding and expenditure information has be jointly agreed between the council, Sandwell & West Birmingham CCG and Birmingham & Solihull CCG.

Identified Risk	Likelihood	Impact	Actions to Manage Risk

Appendices
1.   Better Care Fund Plan 2019/20

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

Michael Walsh, Head of Service, Strategy & Integration
(Michael.walsh@birmingham.gov.uk)

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.

2. It is sectioned out by sheet name and contains the description of the information required, cell reference for the question and the 'checker' column which updates automatically as questions within each sheet are completed.

3. The checker column will appear 'Red' and contain the word 'No' if the information has not been completed. Clicking on the corresponding 'Cell Reference' column will link to the incomplete cell for completion. Once completed the checker column will change to 'Green' and contain the word 'Yes'

4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to

6. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to england.bettercaresupport@nhs.net

3. Please note that in line with fair processing of personal data we collect email addresses to communicate with key individuals from the local areas for various purposes relating to the delivery of the BCF plans including plan development, assurance, approval and provision of support.

We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

4. Strategic Narrative (click to go to sheet)

This section of the template should set out the agreed approach locally to integration of health & social care. The narratives should focus on updating existing plans, and changes since integration plans were set out until 2020 rather than reiterating them and can be short. Word limits have been applied to each section and these are indicated on the

1. Approach to integrating care around the person. This should set out your approach to integrating health and social care around the people, particularly those with long term health and care needs. This should highlight developments

2 i. Approach to integrating services at HWB level (including any arrangements at neighbourhood level where relevant). This should set out the agreed approach and services that will be commissioned through the BCF. Where schemes are new or approaches locally have changed, you should set out a short rationale.

2 ii. DFG and wider services. This should describe your approach to integration and joint commissioning/delivery with wider services. In all cases this should include housing, and a short narrative on use of the DFG to support people with care needs to remain independent through adaptations or other capital expenditure on their homes. This should include

3. How your BCF plan and other local plans align with the wider system and support integrated approaches. Examples may include the read across to the STP (Sustainability Transformation Partnerships) or ICS (Integrated Care Systems) plan(s) for your area and any other relevant strategies.

You can attach (in the e-mail) visuals and illustrations to aid understanding if this will assist assurers in understanding

5. Income (click to go to sheet)

007580/2020

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's Better Care Fund (BCF) plan and pooled budget for 2019/20. On selected the HWB from the Cover page, this sheet will be pre-populated with the minimum CCG contributions to the BCF, DFG (Disabled Facilities Grant), iBCF (improved Better Care Fund) and Winter Pressures allocations to be pooled within the BCF. These cannot be edited.

2. Please select whether any additional contributions to the BCF pool are being made from Local Authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be utilised to include any relevant carry-overs from the

3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.

4. For any questions regarding the BCF funding allocations, please contact England.bettercaresupport@nhs.net

6. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and utilised to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Condition 2

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme

- This is free text field to include a brief headline description of the scheme being planned.

4. Scheme Type and Sub Type:

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available at the end of the table (follow the link to the description section at the top of the main expenditure table).

- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.

- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.

- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.

5. Planned Outputs

- The BCF Planning requirements document requires areas to set out planned outputs for certain scheme types (those which lend themselves to delivery of discrete units of delivery) to help to better understand and account for the activity funded through the BCF.

- The Planned Outputs fields will only be editable if one of the relevant scheme types is selected. Please select a relevant

6. Metric Impact

- This field is collecting information on the metrics that a chem will impact on (rather than the actual planned impact on the metric)

- For the schemes being planned please select from the drop-down options of 'High-Medium-Low-n/a' to provide an indicative level of impact on the four BCF metrics. Where the scheme impacts multiple metrics, this can be expressed by selecting the appropriate level from the drop down for each of the metrics. For example, a discharge to assess scheme might have a medium impact on Delayed Transfers of Care and permanent admissions to residential care. Where the

7. Area of Spend:

- Please select the area of spend from the drop-down list by considering the area of the health and social system which is most supported by investing in the scheme.

- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.

- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.

- We encourage areas to try to use the standard scheme types where possible.

8. Commissioner:

- Identify the commissioning entity for the scheme based on who commissions the scheme from the provider. If there is a single commissioner, please select the option from the drop-down list.

- Please note this field is utilised in the calculations for meeting National Condition 3.

- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns alongside.

9. Provider:

- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.

- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

10. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop-down list
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the
11. Expenditure (£) 2019/20:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
12. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2019/20 and will inform the understanding of planned spend for the iBCF and Winter Funding grants.

7. HICM (click to go to sheet)

National condition four of the BCF requires that areas continue to make progress in implementing the High Impact Change model for managing transfers of care and continue to work towards the centrally set expectations for reducing DToC. In the planning template, you should provide:

- An assessment of your current level of implementation against each of the 8 elements of the model – from a drop-

- Your planned level of implementation by the end March 2020 – again from a drop-down list

A narrative that sets out the approach to implementing the model further. The Narrative section in the HICM tab sets out furthe

8. Metrics (click to go to sheet)

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2019/20. The BCF requires plans to be agreed for the four metrics. This should build on planned and

1. Non-Elective Admissions (NEA) metric planning:

- BCF plans as in previous years mirror the latest CCG Operating Plans for the NEA metric. Therefore, this metric is not collected via this template.

2. Residential Admissions (RES) planning:

- This section requires inputting the information for the numerator of the measure.

- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.

- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from ONS subnational population projections.

- The annual rate is then calculated and populated based on the entered information.

- Please include a brief narrative associated with this metric plan

3. Reablement (REA) planning:

- This section requires inputting the information for the numerator and denominator of the measure.

- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).

- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.

- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

- Please include a brief narrative associated with this metric plan

4. Delayed Transfers of Care (DToC) planning:

- The expectations for this metric from 2018/19 are retained for 2019/20 and these are prepopulated.

- Please include a brief narrative associated with this metric plan.

- This narrative should include details of the plan, agreed between the local authority and the CCG for using the Winter Pressures grant to manage pressures on the system over Winter.

9. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2019/20 for further details.

The Key Lines of Enquiry (KLOE) underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.

2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

10. CCG-HWB Mapping (click to go to sheet)

The final sheet provides details of the CCG - HWB mapping used to calculate contributions to Health and Wellbeing Board level non-elective activity figures.

Better Care Fund 2019/20 Template

2. Cover

Version 1.1

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2019/20.
- 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:	Michelle Webb
E-mail:	michelle.m.webb@birmingham.gov.uk
Contact number:	07736 454535
Who signed off the report on behalf of the Health and Wellbeing Board:	Graeme Betts

Will the HWB sign-off the plan after the submission date?	Yes
If yes, please indicate the date when the HWB meeting is scheduled:	26/11/2019

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
*Area Assurance Contact Details:	Health and Wellbeing Board Chair	Cllr	Paulette	Hamilton	paulette.hamilton@birmingham.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Paul	Jennings	paul.jennings3@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		Sharon	Liggins	sliggins@nhs.net
	Local Authority Chief Executive		Clive	Heaphy	clive.heaphy@birmingham.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Graeme	Betts	graeme.betts@birmingham.gov.uk
	Better Care Fund Lead Official		Louise	Collett	louise.collett@birmingham.gov.uk
	LA Section 151 Officer		Rebecca	Hellard	rebecca.hellard@birmingham.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->	Associate Director of Integration		Helen	Kelly	hkelly@nhs.net
	Director of Integration		Karen	Helliwell	khelliwell@nhs.net
	Head of Service - Commissioning		Michael	Walsh	michael.walsh@birmingham.gov.uk

*Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Please see the Checklist below for further details on incomplete fields	

	Complete:
2. Cover	Yes
4. Strategic Narrative	Yes
5. Income	Yes
6. Expenditure	Yes
7. HICM	Yes
8. Metrics	Yes
9. Planning Requirements	Yes

<< Link to the Guidance sheet

Checklist

2. Cover   ^^ Link back to top

	Cell Reference	Checker
Health & Wellbeing Board	D13	Yes
Completed by:	D15	Yes
E-mail:	D17	Yes
Contact number:	D19	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	D21	Yes
Will the HWB sign-off the plan after the submission date?	D23	Yes
If yes, please indicate the date when the HWB meeting is scheduled:	D24	Yes
Area Assurance Contact Details - Role:	C27 : C36	Yes
Area Assurance Contact Details - First name:	F27 : F36	Yes
Area Assurance Contact Details - Surname:	G27 : G36	Yes
Area Assurance Contact Details - E-mail:	H27 : H36	Yes

Sheet Complete	Yes

4. Strategic Narrative   ^^ Link back to top

	Cell Reference	Checker
A) Person-centred outcomes:	B20	Yes
B) (i) Your approach to integrated services at HWB level (and neighbourhood where applicable):	B31	Yes
B) (ii) Your approach to integration with wider services (e.g. Housing):	B37	Yes
C) System level alignment:	B44	No

Sheet Complete	Yes

5. Income   ^^ Link back to top

	Cell Reference	Checker
Are any additional LA Contributions being made in 2019/20?	C39	Yes
Additional Local Authority	B42 : B44	Yes
Additional LA Contribution	C42 : C44	Yes
Additional LA Contribution Narrative	D42 : D44	Yes
Are any additional CCG Contributions being made in 2019/20?	C59	Yes
Additional CCGs	B62 : B71	Yes
Additional CCG Contribution	C62 : C71	Yes
Additional CCG Contribution Narrative	D62 : D71	Yes

Sheet Complete	Yes

6. Expenditure

	Cell Reference	Checker
Scheme ID:	B22 : B271	Yes
Scheme Name:	C22 : C271	Yes
Brief Description of Scheme:	D22 : D271	Yes
Scheme Type:	E22 : E271	Yes
Sub Types:	F22 : F271	Yes
Specify if scheme type is Other:	G22 : G271	Yes
Planned Output:	H22 : H271	Yes
Planned Output Unit Estimate:	I22 : I271	Yes
Impact: Non-Elective Admissions:	J22 : J271	Yes
Impact: Delayed Transfers of Care:	K22 : K271	Yes
Impact: Residential Admissions:	L22 : L271	Yes
Impact: Reablement:	M22 : M271	Yes
Area of Spend:	N22 : N271	Yes
Specify if area of spend is Other:	O22 : O271	Yes
Commissioner:	P22 : P271	Yes
Joint Commissioner %:	Q22 : Q271	Yes
Provider:	S22 : S271	Yes
Source of Funding:	T22 : T271	Yes
Expenditure:	U22 : U271	Yes
New/Existing Scheme:	V22 : V271	Yes

Sheet Complete		Yes

7. HICM

	Cell Reference	Checker
Priorities for embedding elements of the HCIM for Managing Transfers of Care locally:	B11	Yes
Chg 1) Early discharge planning - Current Level:	D15	Yes
Chg 2) Systems to monitor patient flow - Current Level:	D16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Current Level:	D17	Yes
Chg 4) Home first / discharge to assess - Current Level:	D18	Yes
Chg 5) Seven-day service - Current Level:	D19	Yes
Chg 6) Trusted assessors - Current Level:	D20	Yes
Chg 7) Focus on choice - Current Level:	D21	Yes
Chg 8) Enhancing health in care homes - Current Level:	D22	Yes
Chg 1) Early discharge planning - Planned Level:	E15	Yes
Chg 2) Systems to monitor patient flow - Planned Level:	E16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Planned Level:	E17	Yes
Chg 4) Home first / discharge to assess - Planned Level:	E18	Yes
Chg 5) Seven-day service - Planned Level:	E19	Yes
Chg 6) Trusted assessors - Planned Level:	E20	Yes
Chg 7) Focus on choice - Planned Level:	E21	Yes
Chg 8) Enhancing health in care homes - Planned Level:	E22	Yes
Chg 1) Early discharge planning - Reasons:	F15	Yes
Chg 2) Systems to monitor patient flow - Reasons:	F16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Reasons:	F17	Yes
Chg 4) Home first / discharge to assess - Reasons:	F18	Yes
Chg 5) Seven-day service - Reasons:	F19	Yes
Chg 6) Trusted assessors - Reasons:	F20	Yes
Chg 7) Focus on choice - Reasons:	F21	Yes
Chg 8) Enhancing health in care homes - Reasons:	F22	Yes

Sheet Complete		Yes

8. Metrics

	Cell Reference	Checker
Non-Elective Admissions: Overview Narrative:	E10	Yes
Delayed Transfers of Care: Overview Narrative:	E17	Yes
Residential Admissions Numerator:	F27	Yes
Residential Admissions: Overview Narrative:	G26	Yes
Reablement Numerator:	F39	Yes
Reablement Denominator:	F40	Yes
Reablement: Overview Narrative:	G38	Yes

	Checker
Sheet Complete	Yes

9. Planning Requirements

	Cell Reference	Checker
PR1: NC1: Jointly agreed plan - Plan to Meet	F8	Yes
PR2: NC1: Jointly agreed plan - Plan to Meet	F9	Yes
PR3: NC1: Jointly agreed plan - Plan to Meet	F10	Yes
PR4: NC2: Social Care Maintenance - Plan to Meet	F11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Plan to Meet	F12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Plan to Meet	F13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F15	Yes
PR9: Metrics - Plan to Meet	F16	Yes
PR1: NC1: Jointly agreed plan - Actions in place if not	H8	Yes
PR2: NC1: Jointly agreed plan - Actions in place if not	H9	Yes
PR3: NC1: Jointly agreed plan - Actions in place if not	H10	Yes
PR4: NC2: Social Care Maintenance - Actions in place if not	H11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Actions in place if not	H12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Actions in place if not	H13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H15	Yes
PR9: Metrics - Actions in place if not	H16	Yes
PR1: NC1: Jointly agreed plan - Timeframe if not met	I8	Yes
PR2: NC1: Jointly agreed plan - Timeframe if not met	I9	Yes
PR3: NC1: Jointly agreed plan - Timeframe if not met	I10	Yes
PR4: NC2: Social Care Maintenance - Timeframe if not met	I11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Timeframe if not met	I12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Timeframe if not met	I13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I15	Yes
PR9: Metrics - Timeframe if not met	I16	Yes

	Checker
Sheet Complete	Yes

Better Care Fund 2019/20 Template

3. Summary

Selected Health and Wellbeing Board: Birmingham

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£11,407,088	£11,407,088	£0
Minimum CCG Contribution	£83,211,137	£83,211,137	£0
iBCF	£60,321,014	£60,321,014	£0
Winter Pressures Grant	£5,600,295	£5,600,295	£0
Additional LA Contribution	£1,437,025	£1,437,025	£0
Additional CCG Contribution	£9,185,414	£9,185,414	£0
Total	£171,161,973	£171,161,973	£0

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£23,665,644
Planned spend	£48,861,707

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£33,003,489
Planned spend	£33,003,489

Scheme Types

Assistive Technologies and Equipment	£5,551,527
Care Act Implementation Related Duties	£3,195,325
Carers Services	£1,360,932
Community Based Schemes	£13,511,877
DFG Related Schemes	£11,407,088
Enablers for Integration	£2,125,604
HICM for Managing Transfer of Care	£9,271,634
Home Care or Domiciliary Care	£16,952,052
Housing Related Schemes	£0
Integrated Care Planning and Navigation	£994,839
Intermediate Care Services	£3,259,819
Personalised Budgeting and Commissioning	£0
Personalised Care at Home	£36,266,613
Prevention / Early Intervention	£5,782,878
Residential Placements	£61,344,871
Other	£136,914
Total	£171,161,973

HICM >>

		Planned level of maturity for 2019/2020
Chg 1	Early discharge planning	Mature
Chg 2	Systems to monitor patient flow	Mature
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Mature
Chg 4	Home first / discharge to assess	Mature
Chg 5	Seven-day service	Mature
Chg 6	Trusted assessors	Mature
Chg 7	Focus on choice	Mature
Chg 8	Enhancing health in care homes	Mature

Metrics >>

Non-Elective Admissions	Go to Better Care Exchange >>
Delayed Transfer of Care	

Residential Admissions

		19/20 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	550.3119613

Reablement

		19/20 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	0.658914729

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
	PR8	Yes
Metrics	PR9	Yes

Better Care Fund 2019/20 Template

4. Strategic Narrative

Selected Health and Wellbeing Board: | Birmingham

Please outline your approach towards integration of health & social care:

When providing your responses to the below sections, please highlight any learning from the previous planning round (2017-2019) and cover any priorities for reducing health inequalities under the Equality Act 2010.

Please note that there are 4 responses required below, for questions: A), B(i), B(ii) and C)

Link to B) (i)
Link to B) (ii)
Link to C)

A) Person-centred outcomes
Your approach to integrating care around the person, this may include (but is not limited to):
- Prevention and self-care
- Promoting choice and independence

Remaining Word Limit:	1038

Older people and their carers need to get help from health and social care quickly and whenever they need it. Our joint vision is for older people in Birmingham to be as happy and healthy as possible, living self-sufficient, independent lives and having choice and control over what they do and what happens to them. This vision was set in recognition that our current models of support fit older people into narrow bands of available services but future support needs to be more personalised to enable older people to live the life they choose. Our strategy to provide a range of support for older people and their carer's in Birmingham over the next five years centres on three themes:

1. Prevention
2. Early Intervention
3. Personalised ongoing support

As the three themes overlap, we will ensure that support is fully joined up so older people will be able to access the right care at the right time in the right place in order to be as independent and as well as possible at all times.

These approaches are supported by joint planning around workforce, estates (buildings) and information sharing and use of technology. We are calling this a 'network of community support' and we are working with the relevant specialists to identify the best ways to work together.

Personalisation as opposed to 'one size fits all' is at the centre of our thinking and in all three themes we aim to put the person at the centre of advice, assessment and planning approaches. Whoever is in contact with an older person or their carers will:

• Work in partnership with them to find out what they want and need to achieve and understand what motivates them
• Focus on a person's own strengths and help them realise their potential to be healthy and happy, regain independence and remain independent for as long as possible
• Build the person's knowledge, skills, resilience and confidence
• Learn to observe and guide and not automatically intervene
• Support positive risk taking
• Promote the use of joint, health or social care personalised budgets or direct payments

This transformation is focusing on providing 'joined up' support across organisations so that older people do not experience duplication of services, gaps in provision or delays in accessing support.   This includes being open to new ways of delivering services and we will make the most of the strengths of our partner organisations from the public, private, voluntary and community sectors so there will be no 'wrong door' throughout the system.

In order to properly support older people, there must be recognition across the city's wide range of partner organisations of a shared responsibility to make this strategy a reality.

(i) Your approach to integrated services at HWB level (and neighbourhood where applicable), this may include (but is not limited to):
- Joint commissioning arrangements
- Alignment with primary care services (including PCNs (Primary Care Networks))
- Alignment of services and the approach to partnership with the VCS (Voluntary and Community Sector)   ^^ Link back to top

Remaining Word Limit:	242

Our BCF governance is aimed at delivering integrated commissioning - key areas for 19/20 are the procurement of our joint equipment stores, single carers service /support. As part of Birmingham older People's programme we have a transofrmation programme called Early intervention - the transformed service offer will be commissioned via the BCF.

31 Primary Care Networks (PCNs) have been agreed within Birmingham through close working with our at scale providers of General Practice as a foundation for creating strong PCNs. In consultation with primary care leaders and incoming clinical directors we have formed a PCN development plan focused on three components. In the first stage newly forming PCNs will be provided with support to develop their infrastructure, leadership and capacity. The second stage will focus on delivering the extended model of primary care and the seven specifications. Across Birmingham considerable good practice exists both in relation to the delivery of an extended model of primary care and the seven specifications. A key component of our strategy for developing PCNs will be the use of public health data and other intelligence to ensure that services delivered at a local level are appropriate to the needs of the local community. This will mean that the distribution of services across Birmingham may not be equal but it will be fair, equitable and relevant to the needs of local people.

Transforming the way that we plan and deliver services via the creation of an agreed set of local needs led priorities will allow us to work more closely with people; understand the way they live, and bring teams and services together for them to create more local and personalised packages of care and support. The third component of the PCN development plan will focus on integration.

A core aim of the PCN is to provide a footprint which other community and social care services can connect with. As part of our development of primary care we will build effective local delivery partnerships which bring together community providers for the benefit of local people. The work of these partnerships will be underpinned by an effective model for multi-disciplinary working, developed with reference to good practice.

Prevention – your health and happiness

Alongside the PCNs we have already commenced organising services in local communities to help older people to manage their own health and wellbeing. Good quality information and advice will help people to identify and access the support that they need in order to continue living good lives and help to prevent issues such as social isolation.

We believe that keeping people connected keeps them well physically and mentally. Social isolation and loneliness is a huge issue; central to our vision will be developing ways which help older people connect both with each other and with different generations for mutual support, activities and fun.

Developing our 'social prescribing' models, for example, GPs prescribing a course of exercise classes rather than medication, supported by 'guided conversation' techniques is focused on helping people think about their needs in order to get the support they require. .

We are building on the Carer's Offer that has already been made and improvements such as establishing the Carer's Hub that is already building links with greater numbers of carers to ensure they receive the assessments and support available to them.

(ii) Your approach to integration with wider services (e.g. Housing), this should include:

- Your approach to using the DFG to support the housing needs of people with disabilities or care needs. This should include any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the   ^^ Link back to top

Remaining Word Limit: | 665

The DFG continues to provide support and assistance to citizens who require adaptations within their own home, to ensure that they are able to remain living as independent as possible. The DFG has continued to see a growth in the number of applications received for support each year.   The work undertaken as part of the Early Intervention programme is also highlighting areas in which a cit-wide Housing Assistance Policy could further support citizens to remain within their own homes. This year sees Birmingham commence the development of a Birmingham Housing Assistance Policy that willl seek to extend the range of support available to citizens within Birmingham. The policy will look to also address the technological developments that are captured within the Birmingham Adult Social Care Technology and Equipment Strategy.

C) System level alignment, for example this may include (but is not limited to):
- How the BCF plan and other plans align to the wider integration landscape, such as STP/ICS plans
- A brief description of joint governance arrangements for the BCF plan   ^^ Link back to top

| Remaining Word Limit: | | 1004 |

Birmingham's local plans are supplemented by the alignment with the Birmingham and Solihull Sustainability and Transformation Partnership (STP), workstreams of the West Midlands Combined Authority and Council Plans.

BSol STP Board transformation priorities have been agreed which include the development of our future operating model for an Integrated Care System (ICS). A draft ICS vision and narrative has been co-produced and we are part of the national accelerator programme. The establishment of the ICS core team and a baseline of integrated working has been completed. In addition, external support has been commissioned to support governance options for an ICS. BSol STP have agreed at Chief Executive level to develop delivery of an ICS. A CEO led ICS portfolio has been established which includes Executive Director led programmes covering governance and leadership, Integrated care models /Inequalities priorities, Change Management /Improvement Integrated Strategic Commissioning/Provider Alliance.

Examples of work together are piloting integrated care delivery models successfully secured £755k national money to support a mental health support team inSouth Birmingham as well as one in north Solihull. BSol STP are one of 3 national pilots to reduce avoidable admissions for people with dementia to care homes.

The STP Priority Ageing Well and Later Life is delivered via the Birmingham Older Peoples Programme Board (BOPP) which is charied by the Director of Adult Social Care. The workstreams within BOPP are, in the main, commissioned via the BCF are ambition it to develop the BCF to deliver integrated commissioning for all of BOPP. In September 2018, the Birmingham Better Care Fund commissioned Newton to with the team leading the BSol STP Early Intervention Work stream to develop a new model of care that would ultimately achieve better outcomes for thousands of older people. This approach has provided benefits for system working which are forming part of the learning within the STP/ICS.

In Birmingham joint governance arrangements through the use of Section 75 agreements are in place for the BCF pooled fund and for mental health, children's and learning disability commissioning. Governance is provided by the Commissioning Executive Board and activity overseen by the Birmingham BCF Programme Board. These are in turn accountable to the CCG Governing Body and Birmingham Health and Wellbeing Board.

The Health and Wellbeing Board receives quarterly performance reports on the BCF Plan delivery, and approves the plan before submission. The board is chaired by the Cabinet Member for Social Care and Health on behalf of the Leader of the Council.

There is a strong track record of use of an Integrated Programme Management Office approach, to provide structure and transparency on project work across partner organisations. This includes BCF Plan projects. Our local approach to integrated commissioning continues to be reviewed and developed. Work is underway to develop structured workplans, appropriate governance and accountability and clear alignment to priorities, strategies and plans to underpin the commissioning activity undertaken.

Better Care Fund 2019/20 Template

5. Income

Selected Health and Wellbeing Board: Birmingham

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Birmingham	£11,407,088
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£11,407,088**

iBCF Contribution	Contribution
Birmingham	£60,321,014
Total iBCF Contribution	**£60,321,014**

Winter Pressures Grant	Contribution
Birmingham	£5,600,295
Total Winter Pressures Grant Contribution	**£5,600,295**

Are any additional LA Contributions being made in 2019/20? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
Birmingham	£1,437,025	Community loan equipment service and dementia
Total Additional Local Authority Contribution	**£1,437,025**	

CCG Minimum Contribution	Contribution
NHS Birmingham and Solihull CCG	£70,182,170
NHS Sandwell and West Birmingham CCG	£13,028,967
Total Minimum CCG Contribution	**£83,211,137**

Are any additional CCG Contributions being made in 2019/20? If yes, please detail below	Yes

Additional CCG Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
NHS Birmingham and Solihull CCG	£7,982,350	Baseline position
NHS Birmingham and Solihull CCG	£1,203,064	Anticipated Additional Social Care Allocation
Total Addition CCG Contribution	**£9,185,414**	
Total CCG Contribution	**£92,396,551**	

	2019/20
Total BCF Pooled Budget	**£171,161,973**

Funding Contributions Comments	
Optional for any useful detail e.g. Carry over	

Please note that the split of the CCG Minimum Contribution between Birmingham & Solihill CCG and Sandwell & West Birmingham CCG above is before 2017-18 practice moves adjustment. Whilst the overall total remains unchanged the split agreed between both parties after practice moves is £71,145k and £12,066k (total £83,211k) respectively. This issue was raised in the previous 2017-19 plan and it is understood that the template cannot be amended for such adjustments.

Scheme Type	Description	Sub Type
Assistive Technologies and Equipment	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Digital participation services).	Telecare Wellness Services Digital Participation Services Community Based Equipment Other
Care Act Implementation Related Duties	Funding planned towards the implementation of Care Act related duties.	Deprivation of Liberty Safeguards (DoLS) Other
Carers Services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. This also includes the implementation of the Care Act as a sub-type.	Carer Advice and Support Respite Services Other
Community Based Schemes	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood level (eg: Integrated Neighbourhood Teams)	
DFG Related Schemes	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes.	Adaptations Other

Enablers for Integration	Schemes that build and develop the enabling foundations of health and social care integration encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.	
High Impact Change Model for Managing Transfer of Care	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM as such, is included in this section.	Chg 1. Early Discharge Planning Chg 2. Systems to Monitor Patient Flow Chg 3. Multi-Disciplinary/Multi-Agency Discharge Teams Chg 4. Home First / Discharge to Access Chg 5. Seven-Day Services Chg 6. Trusted Assessors Chg 7. Focus on Choice Chg 8. Enhancing Health in Care Homes Other - 'Red Bag' scheme Other approaches
Home Care or Domiciliary Care	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.	
Housing Related Schemes	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.	

Integrated Care Planning and Navigation	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches like Single Point of Access (SPoA) and linking people to community assets. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams and the HICM for managing discharges, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.	Care Coordination Single Point of Access Care Planning, Assessment and Review Other
Intermediate Care Services	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.	Bed Based - Step Up/Down Rapid / Crisis Response Reablement/Rehabilitation Services Other

Personalised Budgeting and Commissioning	Various person centred approaches to commissioning and budgeting.	Personal Health Budgets Integrated Personalised Commissioning Direct Payments Other
Personalised Care at Home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.	
Prevention / Early Intervention	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.	Social Prescribing Risk Stratification Choice Policy Other
Residential Placements	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.	Supported Living Learning Disability Extra Care Care Home Nursing Home Other
Other	Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.	

Better Care Fund 2019/20 Template

7. High Impact Change Model

Selected Health and Wellbeing Board: | Birmingham

Explain your priorities for embedding elements of the High Impact Change Model for Managing Transfers of Care locally, including:
- Current performance issues to be addressed
- The changes that you are looking to embed further - including any changes in the context of commitments to reablement and Enhanced Health in Care Homes in the NHS Long-Term Plan
- Anticipated improvements from this work

The HICM is primarily being delivered via the system wide Early Intervention (EI) programmes and Enhanced Support to Care Homes programme. Priorities include change 3, 4 and 6 - delivered via EI. Change 5 we are procuring a 7 day joint equipment loan service which will support 7 day discharges. Change 8 - dedicated programme initially focused on developing a partnership approach with care homes providing effective support and education via a dedicated support to care homes team.

		Please enter current position of maturity	Please enter the maturity level planned to be reached by March 2020	If the planned maturity level for 2019/20 is below established, please state reasons behind that?
Chg 1	Early discharge planning	Mature	Mature	
Chg 2	Systems to monitor patient flow	Mature	Mature	
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Mature	Mature	
Chg 4	Home first / discharge to assess	Mature	Mature	
Chg 5	Seven-day service	Mature	Mature	
Chg 6	Trusted assessors	Mature	Mature	
Chg 7	Focus on choice	Mature	Mature	
Chg 8	Enhancing health in care homes	Mature	Mature	

Better Care Fund 2019/20 Template

8. Metrics

Selected Health and Wellbeing Board: | Birmingham

8.1 Non-Elective Admissions

	19/20 Plan	Overview Narrative
Total number of specific acute non-elective spells per 100,000 population	**Collection of the NEA metric plans via this template is not required** as the BCF NEA metric plans are based on the NEA CCG Operating plans submitted via SDCS.	Early Intervention (EI) Transformation programme is delivering an Older People Assessment Liaison Service (OPAL) which will provide a comprehensive assessment for older people and has demonstrated a reduction in NEA, in south Birmingham and Solihull. This is being rolled out across the city. EI Community are integrated health and social care teams delivering a Home First approach via access to rapid response service to provide additional support for people who do not necessarily require a hospital admission, develop access to step up intermdiate care beds. Dedicated support to care homes - providing support and advice to care homes to meet the needs of their residents. NHS111 alternative pathway development to avoid a conveyance to hospital - ensure Directory of Service is up to date.

Please set out the overall plan in the HWB area for reducing Non-Elective Admissions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Plans are yet to be finalised and signed-off so are subject to change; **for the latest version of the NEA CCG operating plans at your HWB footprint please contact your local Better Care Manager (BCM)** in the first instance or write in to the support inbox:
ENGLAND.bettercaresupport@nhs.net

8.2 Delayed Transfers of Care

19/20 Plan	Overview Narrative

Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	120.4	Early Intervention initial diagnostic indicated that 5,500 older people discharged per year in Birmingham with complex needs receive a measurably more independent package of ongoing care. Our foucs on improving discharge pathways and focusing on reducing delays, these complex patients also stay in hospital for, on average, 4 fewer days. Integrated working was been prototyped in Queen Elizabeth Hospital discharge hub, with good results, this is now being rolled out at Birmingham Heartlands and Good Hope Hospital. This also links to ensure we have the right capacity and capability in our Early Intervention Community Team to deliver a home first model and our Early Intervention intermediate care beds. Key actions over winter to address DTOC include: • Rolling out of the Early Intervention in the Community Team • Rolling out the Early Intervention Discharge hub model to Heartlands and Good Hope sites from September. • The Urgent Care Operational Group to monitor system capacity and flow (including DTOC) on a weekly basis, via the Discharge Hub Group • Reviewing the Patient Choice Policy • Development of IV services, to support patients in the community, instead of an acute setting • Implementing a trusted assessor model for short term community beds • 7 new short term community assessment beds have been commissioned to support patients who typically may need continued funded health support - these beds will enable assessment outside of an acute setting • Implementing a single referral hub for short term assessment and intermediate care beds	**Please set out the overall plan in the HWB area for reducing Delayed Transfers of Care to meet expectations set for your area. This should include any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric. Include in this, your agreed plan for using the Winter Pressures grant funding to support the local health and care system to manage demand pressures on the NHS, with particular reference to seasonal winter pressures.**

Please note that the plan figure for Greater Manchester has been combined, for HWBs in Greater Manchester please comment on individuals HWBs rather than Greater Manchester as a whole.

Please note that due to the merger of Bournemouth, Christchurch and Poole to a new Local Authority will mean that planning information from 2018/19 will not reflect the present geographies.

8.3 Residential Admissions

		18/19 Plan	19/20 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	406	550	Having reviewed our methodology for this measure we note that the numerator provided for 2018/19 should have been the annual rate target. Admissions to long-term nursing and residential care have trended downwards in recent years. In particular this is driven by a reduced use of long-term residential placements. This trend is being accelerated by a greater focus on prevention and maintaining people in their own homes. The introduction of the "3 conversations" model for social care has been a key factor in reduced use of residential care. This model is now being rolled out to hospital discharge teams.
	Numerator	600	826	
	Denominator	147,944	150,097	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2016 based Sub-National Population Projections for Local Authorities in England;

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

8.4 Reablement

		18/19 Plan	19/20 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	84.9%	65.9%	The system has experienced difficulties with the data sharing required to accurately measure this outcome. As a result we are currently reporting only on outcomes achievedx by BCC Enablement Service. However, as the multi-disciplinary Early Intervention Community Teams are established across the city we will transition to reporting based on the outcomes achieved by these teams. The early impact of the team that is operational in one locality is positive in terms of numbers of people returning home and remaining home.
	Numerator	637	170	
	Denominator	750	258	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

Selected Health and Wellbeing Board: | Birmingham

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	PR1	A jointly developed and agreed plan that all parties sign up to	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Do the governance arrangements described support collaboration and integrated care? Where the strategic narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure, metric and HICM sections of the plan been submitted for each HWB concerned?	Yes			
	PR2	A clear narrative for the integration of health and social care	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that covers: - Person centred care, including approaches to delivering joint assessments, promoting choice, independence and personalised care? - A clear approach at HWB level for integrating services that supports the overall approach to integrated care and confirmation that the approach supports delivery at the interface between health and social care? - A description of how the local BCF plan and other integration plans e.g. STP/ICSs align? - Is there a description of how the plan will contribute to reducing health inequalities (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics under the Equality Act 2010? This should include confirmation that equality impacts of the local BCF plan have been considered, a description of local priorities related to health inequality and equality that the BCF plan will contribute to addressing. Has the plan summarised any changes from the previous planning period? And noted (where appropriate) any lessons learnt?	Yes			
	PR3	A strategic, joined up plan for DFG spending	Is there confirmation that use of DFG has been agreed with housing authorities? Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home. In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Yes			
NC2: Social Care Maintenance	PR4	A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Yes			
NC3: NHS commissioned Out of Hospital Services	PR5	Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Yes			
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	Is there a plan for implementing the High Impact Change Model for managing transfers of care?	Does the BCF plan demonstrate a continued plan in place for implementing the High Impact Change Model for Managing Transfers of Care? Has the area confirmed the current level of implementation and the planned level at March 2020 for all eight changes? Is there an accompanying overall narrative setting out the priorities and approach for ongoing implementation of the HICM? Does the level of ambition set out for implementing the HICM changes correspond to performance challenges in the system? If the current level of implementation is below established for any of the HICM changes, has the plan included a clear explanation and set of actions towards establishing the change as soon as possible in 2019-20?	Yes			

Agreed expenditure plan for all elements of the BCF	PR7	Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?	Have the planned schemes been assigned to the metrics they are aiming to make an impact on? Expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (tick-box) Is there an agreed plan for use of the Winter Pressures grant that sets out how the money will be used to address expected demand pressures on the Health system over Winter? **Has funding for the following from the CCG contribution been identified for the area?** - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Yes		
	PR8	Indication of outputs for specified scheme types	Has the area set out the outputs corresponding to the planned scheme types (Note that this is only for where any of the specified set of scheme types requiring outputs are planned)? (auto-validated)	Yes		
Metrics	PR9	Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?	Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric? Is there a proportionate range of scheme types and spend included in the expenditure section of the plan to support delivery of the metric ambitions for each of the metrics? Do the narrative plans for each metric set out clear and ambitious approaches to delivering improvements? **Have stretching metrics been agreed locally for:** - Metric 2: Long term admission to residential and nursing care homes - Metric 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement	Yes		

CCG to Health and Well-Being Board Mapping for 2019/20

HWB Code	LA Name	CCG Code	CCG Name	% CCG in HWB	% HWB in CCG
E09000002	Barking and Dagenham	07L	NHS Barking and Dagenham CCG	90.7%	87.4%
E09000002	Barking and Dagenham	08F	NHS Havering CCG	6.9%	8.3%
E09000002	Barking and Dagenham	08M	NHS Newham CCG	0.4%	0.6%
E09000002	Barking and Dagenham	08N	NHS Redbridge CCG	2.5%	3.5%
E09000002	Barking and Dagenham	08W	NHS Waltham Forest CCG	0.1%	0.1%
E09000003	Barnet	07M	NHS Barnet CCG	91.1%	92.1%
E09000003	Barnet	07P	NHS Brent CCG	2.0%	1.8%
E09000003	Barnet	07R	NHS Camden CCG	1.0%	0.7%
E09000003	Barnet	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000003	Barnet	07X	NHS Enfield CCG	3.0%	2.4%
E09000003	Barnet	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000003	Barnet	08D	NHS Haringey CCG	2.2%	1.6%
E09000003	Barnet	08E	NHS Harrow CCG	1.2%	0.8%
E09000003	Barnet	06N	NHS Herts Valleys CCG	0.0%	0.1%
E09000003	Barnet	08H	NHS Islington CCG	0.2%	0.1%
E09000003	Barnet	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.1%
E08000016	Barnsley	02P	NHS Barnsley CCG	94.6%	98.1%
E08000016	Barnsley	02X	NHS Doncaster CCG	0.3%	0.4%
E08000016	Barnsley	03A	NHS Greater Huddersfield CCG	0.2%	0.2%
E08000016	Barnsley	03L	NHS Rotherham CCG	0.3%	0.3%
E08000016	Barnsley	03N	NHS Sheffield CCG	0.2%	0.4%
E08000016	Barnsley	03R	NHS Wakefield CCG	0.4%	0.6%
E06000022	Bath and North East Somerset	11E	NHS Bath and North East Somerset CCG	93.5%	98.3%
E06000022	Bath and North East Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.9%
E06000022	Bath and North East Somerset	11X	NHS Somerset CCG	0.2%	0.5%
E06000022	Bath and North East Somerset	99N	NHS Wiltshire CCG	0.1%	0.3%
E06000055	Bedford	06F	NHS Bedfordshire CCG	37.7%	97.4%
E06000055	Bedford	06H	NHS Cambridgeshire and Peterborough CCG	0.4%	1.9%
E06000055	Bedford	04G	NHS Nene CCG	0.2%	0.6%
E09000004	Bexley	07N	NHS Bexley CCG	93.4%	89.8%
E09000004	Bexley	07Q	NHS Bromley CCG	0.1%	0.1%
E09000004	Bexley	09J	NHS Dartford, Gravesham and Swanley CCG	1.4%	1.5%
E09000004	Bexley	08A	NHS Greenwich CCG	7.2%	8.4%
E09000004	Bexley	08L	NHS Lewisham CCG	0.1%	0.1%
E08000025	Birmingham	15E	NHS Birmingham and Solihull CCG	78.4%	81.7%
E08000025	Birmingham	05C	NHS Dudley CCG	0.2%	0.0%
E08000025	Birmingham	05J	NHS Redditch and Bromsgrove CCG	3.1%	0.4%
E08000025	Birmingham	05L	NHS Sandwell and West Birmingham CCG	39.2%	17.8%
E08000025	Birmingham	05Y	NHS Walsall CCG	0.5%	0.1%
E06000008	Blackburn with Darwen	00Q	NHS Blackburn with Darwen CCG	88.9%	95.8%
E06000008	Blackburn with Darwen	00T	NHS Bolton CCG	1.2%	2.3%
E06000008	Blackburn with Darwen	00V	NHS Bury CCG	0.2%	0.2%
E06000008	Blackburn with Darwen	01A	NHS East Lancashire CCG	0.7%	1.7%
E06000009	Blackpool	00R	NHS Blackpool CCG	86.4%	97.6%
E06000009	Blackpool	02M	NHS Fylde & Wyre CCG	2.1%	2.4%
E08000001	Bolton	00T	NHS Bolton CCG	97.3%	97.5%
E08000001	Bolton	00V	NHS Bury CCG	1.5%	1.0%
E08000001	Bolton	00X	NHS Chorley and South Ribble CCG	0.2%	0.1%
E08000001	Bolton	01G	NHS Salford CCG	0.6%	0.5%
E08000001	Bolton	02H	NHS Wigan Borough CCG	0.8%	0.9%
E06000058	Bournemouth, Christchurch and Poole	11J	NHS Dorset CCG	52.4%	99.7%
E06000058	Bournemouth, Christchurch and Poole	11A	NHS West Hampshire CCG	0.2%	0.3%
E06000036	Bracknell Forest	15A	NHS Berkshire West CCG	0.5%	2.0%
E06000036	Bracknell Forest	15D	NHS East Berkshire CCG	26.1%	96.9%
E06000036	Bracknell Forest	99M	NHS North East Hampshire and Farnham CCG	0.6%	1.0%
E06000036	Bracknell Forest	10C	NHS Surrey Heath CCG	0.2%	0.1%
E08000032	Bradford	02N	NHS Airedale, Wharfdale and Craven CCG	67.2%	18.4%
E08000032	Bradford	02W	NHS Bradford City CCG	98.9%	23.9%
E08000032	Bradford	02R	NHS Bradford Districts CCG	98.0%	56.3%
E08000032	Bradford	02T	NHS Calderdale CCG	0.2%	0.0%
E08000032	Bradford	15F	NHS Leeds CCG	0.9%	1.4%
E08000032	Bradford	03J	NHS North Kirklees CCG	0.2%	0.0%
E09000005	Brent	07M	NHS Barnet CCG	2.3%	2.4%
E09000005	Brent	07P	NHS Brent CCG	89.7%	86.4%
E09000005	Brent	07R	NHS Camden CCG	3.9%	2.8%
E09000005	Brent	09A	NHS Central London (Westminster) CCG	1.3%	0.7%
E09000005	Brent	07W	NHS Ealing CCG	0.5%	0.6%
E09000005	Brent	08C	NHS Hammersmith and Fulham CCG	0.6%	0.4%
E09000005	Brent	08E	NHS Harrow CCG	5.9%	4.0%
E09000005	Brent	08Y	NHS West London (K&C & QPP) CCG	4.3%	2.7%
E06000043	Brighton and Hove	09D	NHS Brighton and Hove CCG	97.9%	99.7%
E06000043	Brighton and Hove	09G	NHS Coastal West Sussex CCG	0.1%	0.2%
E06000043	Brighton and Hove	99K	NHS High Weald Lewes Havens CCG	0.3%	0.1%
E06000023	Bristol, City of	11E	NHS Bath and North East Somerset CCG	0.1%	0.0%
E06000023	Bristol, City of	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	49.3%	100.0%
E09000006	Bromley	07N	NHS Bexley CCG	0.2%	0.1%
E09000006	Bromley	07Q	NHS Bromley CCG	94.6%	95.1%
E09000006	Bromley	07V	NHS Croydon CCG	1.2%	1.4%
E09000006	Bromley	08A	NHS Greenwich CCG	1.4%	1.2%
E09000006	Bromley	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000006	Bromley	08K	NHS Lambeth CCG	0.1%	0.2%
E09000006	Bromley	08L	NHS Lewisham CCG	1.9%	1.8%
E09000006	Bromley	99J	NHS West Kent CCG	0.1%	0.2%

E10000002	Buckinghamshire	06F	NHS Bedfordshire CCG	0.6%	0.5%
E10000002	Buckinghamshire	14Y	NHS Buckinghamshire CCG	94.4%	94.9%
E10000002	Buckinghamshire	15D	NHS East Berkshire CCG	1.4%	1.2%
E10000002	Buckinghamshire	06N	NHS Herts Valleys CCG	1.2%	1.4%
E10000002	Buckinghamshire	08G	NHS Hillingdon CCG	0.7%	0.4%
E10000002	Buckinghamshire	04F	NHS Milton Keynes CCG	1.3%	0.7%
E10000002	Buckinghamshire	04G	NHS Nene CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Q	NHS Oxfordshire CCG	0.6%	0.7%
E08000002	Bury	00T	NHS Bolton CCG	0.8%	1.2%
E08000002	Bury	00V	NHS Bury CCG	94.0%	94.3%
E08000002	Bury	01A	NHS East Lancashire CCG	0.0%	0.2%
E08000002	Bury	01D	NHS Heywood, Middleton and Rochdale CCG	0.4%	0.5%
E08000002	Bury	14L	NHS Manchester CCG	0.6%	2.0%
E08000002	Bury	01G	NHS Salford CCG	1.4%	1.9%
E08000033	Calderdale	02R	NHS Bradford Districts CCG	0.4%	0.6%
E08000033	Calderdale	02T	NHS Calderdale CCG	98.4%	98.9%
E08000033	Calderdale	03A	NHS Greater Huddersfield CCG	0.3%	0.3%
E08000033	Calderdale	01D	NHS Heywood, Middleton and Rochdale CCG	0.1%	0.1%
E10000003	Cambridgeshire	06F	NHS Bedfordshire CCG	1.1%	0.7%
E10000003	Cambridgeshire	06H	NHS Cambridgeshire and Peterborough CCG	71.8%	96.7%
E10000003	Cambridgeshire	06K	NHS East and North Hertfordshire CCG	0.8%	0.7%
E10000003	Cambridgeshire	99D	NHS South Lincolnshire CCG	0.3%	0.0%
E10000003	Cambridgeshire	07H	NHS West Essex CCG	0.2%	0.1%
E10000003	Cambridgeshire	07J	NHS West Norfolk CCG	1.6%	0.4%
E10000003	Cambridgeshire	07K	NHS West Suffolk CCG	4.0%	1.4%
E09000007	Camden	07M	NHS Barnet CCG	0.2%	0.3%
E09000007	Camden	07P	NHS Brent CCG	1.3%	1.9%
E09000007	Camden	07R	NHS Camden CCG	83.9%	88.9%
E09000007	Camden	09A	NHS Central London (Westminster) CCG	5.6%	4.8%
E09000007	Camden	08C	NHS Hammersmith and Fulham CCG	0.4%	0.3%
E09000007	Camden	08D	NHS Haringey CCG	0.5%	0.6%
E09000007	Camden	08H	NHS Islington CCG	3.2%	3.0%
E09000007	Camden	08Y	NHS West London (K&C & QPP) CCG	0.3%	0.2%
E06000056	Central Bedfordshire	06F	NHS Bedfordshire CCG	56.6%	95.0%
E06000056	Central Bedfordshire	14Y	NHS Buckinghamshire CCG	0.8%	1.5%
E06000056	Central Bedfordshire	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E06000056	Central Bedfordshire	06N	NHS Herts Valleys CCG	0.4%	0.9%
E06000056	Central Bedfordshire	06P	NHS Luton CCG	2.3%	1.9%
E06000056	Central Bedfordshire	04F	NHS Milton Keynes CCG	0.1%	0.1%
E06000049	Cheshire East	15M	NHS Derby and Derbyshire CCG	0.1%	0.3%
E06000049	Cheshire East	01C	NHS Eastern Cheshire CCG	96.4%	50.2%
E06000049	Cheshire East	05G	NHS North Staffordshire CCG	1.1%	0.6%
E06000049	Cheshire East	01R	NHS South Cheshire CCG	98.6%	45.8%
E06000049	Cheshire East	01W	NHS Stockport CCG	1.6%	1.2%
E06000049	Cheshire East	02A	NHS Trafford CCG	0.2%	0.1%
E06000049	Cheshire East	02D	NHS Vale Royal CCG	0.6%	0.2%
E06000049	Cheshire East	02E	NHS Warrington CCG	0.7%	0.4%
E06000049	Cheshire East	02F	NHS West Cheshire CCG	1.9%	1.2%
E06000050	Cheshire West and Chester	01C	NHS Eastern Cheshire CCG	1.2%	0.7%
E06000050	Cheshire West and Chester	01F	NHS Halton CCG	0.2%	0.0%
E06000050	Cheshire West and Chester	01R	NHS South Cheshire CCG	0.5%	0.2%
E06000050	Cheshire West and Chester	02D	NHS Vale Royal CCG	99.4%	29.5%
E06000050	Cheshire West and Chester	02E	NHS Warrington CCG	0.4%	0.3%
E06000050	Cheshire West and Chester	02F	NHS West Cheshire CCG	96.9%	69.1%
E06000050	Cheshire West and Chester	12F	NHS Wirral CCG	0.3%	0.3%
E09000001	City of London	07R	NHS Camden CCG	0.2%	7.0%
E09000001	City of London	09A	NHS Central London (Westminster) CCG	0.1%	2.5%
E09000001	City of London	07T	NHS City and Hackney CCG	1.8%	70.4%
E09000001	City of London	08C	NHS Hammersmith and Fulham CCG	0.0%	1.2%
E09000001	City of London	08H	NHS Islington CCG	0.1%	3.6%
E09000001	City of London	08V	NHS Tower Hamlets CCG	0.4%	15.0%
E09000001	City of London	08Y	NHS West London (K&C & QPP) CCG	0.0%	0.2%
E06000052	Cornwall & Scilly	15N	NHS Devon CCG	0.3%	0.6%
E06000052	Cornwall & Scilly	11N	NHS Kernow CCG	99.7%	99.4%
E06000047	County Durham	00D	NHS Durham Dales, Easington and Sedgefield CCG	97.0%	52.4%
E06000047	County Durham	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.0%
E06000047	County Durham	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.1%	0.0%
E06000047	County Durham	13T	NHS Newcastle Gateshead CCG	0.7%	0.7%
E06000047	County Durham	00J	NHS North Durham CCG	96.7%	46.3%
E06000047	County Durham	00P	NHS Sunderland CCG	1.2%	0.6%
E08000026	Coventry	05A	NHS Coventry and Rugby CCG	74.5%	99.8%
E08000026	Coventry	05H	NHS Warwickshire North CCG	0.4%	0.2%
E09000008	Croydon	07Q	NHS Bromley CCG	1.6%	1.3%
E09000008	Croydon	07V	NHS Croydon CCG	95.3%	93.2%
E09000008	Croydon	09L	NHS East Surrey CCG	2.9%	1.3%
E09000008	Croydon	08C	NHS Hammersmith and Fulham CCG	0.2%	0.0%
E09000008	Croydon	08K	NHS Lambeth CCG	3.0%	3.0%
E09000008	Croydon	08R	NHS Merton CCG	0.8%	0.4%
E09000008	Croydon	08T	NHS Sutton CCG	0.8%	0.4%
E09000008	Croydon	08X	NHS Wandsworth CCG	0.5%	0.5%

E10000006	Cumbria	01K	NHS Morecambe Bay CCG	54.0%	36.6%
E10000006	Cumbria	01H	NHS North Cumbria CCG	99.9%	63.4%
E06000005	Darlington	00C	NHS Darlington CCG	98.2%	96.1%
E06000005	Darlington	00D	NHS Durham Dales, Easington and Sedgefield CCG	1.2%	3.2%
E06000005	Darlington	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.2%
E06000005	Darlington	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.6%
E06000015	Derby	15M	NHS Derby and Derbyshire CCG	26.5%	100.0%
E10000007	Derbyshire	02Q	NHS Bassetlaw CCG	0.2%	0.0%
E10000007	Derbyshire	15M	NHS Derby and Derbyshire CCG	70.9%	92.6%
E10000007	Derbyshire	05D	NHS East Staffordshire CCG	7.9%	1.4%
E10000007	Derbyshire	01C	NHS Eastern Cheshire CCG	0.3%	0.0%
E10000007	Derbyshire	04E	NHS Mansfield and Ashfield CCG	2.1%	0.5%
E10000007	Derbyshire	04L	NHS Nottingham North and East CCG	0.3%	0.0%
E10000007	Derbyshire	04M	NHS Nottingham West CCG	5.1%	0.6%
E10000007	Derbyshire	03N	NHS Sheffield CCG	0.5%	0.4%
E10000007	Derbyshire	01W	NHS Stockport CCG	0.1%	0.0%
E10000007	Derbyshire	01Y	NHS Tameside and Glossop CCG	13.9%	4.3%
E10000007	Derbyshire	04V	NHS West Leicestershire CCG	0.5%	0.2%
E10000008	Devon	15N	NHS Devon CCG	65.7%	99.2%
E10000008	Devon	11J	NHS Dorset CCG	0.3%	0.3%
E10000008	Devon	11N	NHS Kernow CCG	0.3%	0.2%
E10000008	Devon	11X	NHS Somerset CCG	0.4%	0.3%
E08000017	Doncaster	02P	NHS Barnsley CCG	0.3%	0.3%
E08000017	Doncaster	02Q	NHS Bassetlaw CCG	1.5%	0.6%
E08000017	Doncaster	02X	NHS Doncaster CCG	96.8%	97.8%
E08000017	Doncaster	03L	NHS Rotherham CCG	1.5%	1.2%
E08000017	Doncaster	03R	NHS Wakefield CCG	0.1%	0.2%
E06000059	Dorset	11J	NHS Dorset CCG	46.0%	95.6%
E06000059	Dorset	11X	NHS Somerset CCG	0.6%	0.9%
E06000059	Dorset	11A	NHS West Hampshire CCG	1.7%	2.5%
E06000059	Dorset	99N	NHS Wiltshire CCG	0.7%	1.0%
E08000027	Dudley	15E	NHS Birmingham and Solihull CCG	0.1%	0.6%
E08000027	Dudley	05C	NHS Dudley CCG	93.3%	90.7%
E08000027	Dudley	05L	NHS Sandwell and West Birmingham CCG	3.9%	6.9%
E08000027	Dudley	06A	NHS Wolverhampton CCG	1.8%	1.5%
E08000027	Dudley	06D	NHS Wyre Forest CCG	0.8%	0.3%
E09000009	Ealing	07P	NHS Brent CCG	1.8%	1.6%
E09000009	Ealing	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000009	Ealing	07W	NHS Ealing CCG	86.9%	90.4%
E09000009	Ealing	08C	NHS Hammersmith and Fulham CCG	5.5%	3.1%
E09000009	Ealing	08E	NHS Harrow CCG	0.4%	0.3%
E09000009	Ealing	08G	NHS Hillingdon CCG	0.7%	0.5%
E09000009	Ealing	07Y	NHS Hounslow CCG	4.7%	3.5%
E09000009	Ealing	08Y	NHS West London (K&C & QPP) CCG	0.7%	0.4%
E06000011	East Riding of Yorkshire	02Y	NHS East Riding of Yorkshire CCG	97.3%	85.1%
E06000011	East Riding of Yorkshire	03F	NHS Hull CCG	9.2%	7.9%
E06000011	East Riding of Yorkshire	03M	NHS Scarborough and Ryedale CCG	0.7%	0.2%
E06000011	East Riding of Yorkshire	03Q	NHS Vale of York CCG	6.6%	6.8%
E10000011	East Sussex	09D	NHS Brighton and Hove CCG	1.0%	0.6%
E10000011	East Sussex	09F	NHS Eastbourne, Hailsham and Seaford CCG	100.0%	34.7%
E10000011	East Sussex	09P	NHS Hastings and Rother CCG	99.7%	33.3%
E10000011	East Sussex	99K	NHS High Weald Lewes Havens CCG	98.1%	29.6%
E10000011	East Sussex	09X	NHS Horsham and Mid Sussex CCG	2.8%	1.2%
E10000011	East Sussex	99J	NHS West Kent CCG	0.8%	0.7%
E09000010	Enfield	07M	NHS Barnet CCG	1.0%	1.2%
E09000010	Enfield	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000010	Enfield	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E09000010	Enfield	07X	NHS Enfield CCG	95.2%	90.9%
E09000010	Enfield	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000010	Enfield	08D	NHS Haringey CCG	7.7%	6.9%
E09000010	Enfield	06N	NHS Herts Valleys CCG	0.1%	0.2%
E09000010	Enfield	08H	NHS Islington CCG	0.2%	0.1%
E10000012	Essex	07L	NHS Barking and Dagenham CCG	0.1%	0.0%
E10000012	Essex	99E	NHS Basildon and Brentwood CCG	99.8%	18.2%
E10000012	Essex	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.0%
E10000012	Essex	99F	NHS Castle Point and Rochford CCG	95.2%	11.5%
E10000012	Essex	06K	NHS East and North Hertfordshire CCG	1.6%	0.6%
E10000012	Essex	08F	NHS Havering CCG	0.3%	0.0%
E10000012	Essex	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000012	Essex	06Q	NHS Mid Essex CCG	100.0%	25.5%
E10000012	Essex	06T	NHS North East Essex CCG	98.6%	22.7%
E10000012	Essex	08N	NHS Redbridge CCG	2.9%	0.6%
E10000012	Essex	99G	NHS Southend CCG	3.3%	0.4%
E10000012	Essex	07G	NHS Thurrock CCG	1.4%	0.2%
E10000012	Essex	08W	NHS Waltham Forest CCG	0.5%	0.1%
E10000012	Essex	07H	NHS West Essex CCG	97.1%	19.8%
E10000012	Essex	07K	NHS West Suffolk CCG	2.3%	0.4%

E08000037	Gateshead	13T	NHS Newcastle Gateshead CCG	38.5%	97.7%
E08000037	Gateshead	00J	NHS North Durham CCG	0.9%	1.2%
E08000037	Gateshead	00L	NHS Northumberland CCG	0.5%	0.8%
E08000037	Gateshead	00N	NHS South Tyneside CCG	0.3%	0.2%
E08000037	Gateshead	00P	NHS Sunderland CCG	0.0%	0.1%
E10000013	Gloucestershire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.1%	0.1%
E10000013	Gloucestershire	11M	NHS Gloucestershire CCG	97.6%	98.6%
E10000013	Gloucestershire	05F	NHS Herefordshire CCG	0.5%	0.1%
E10000013	Gloucestershire	10Q	NHS Oxfordshire CCG	0.2%	0.2%
E10000013	Gloucestershire	05R	NHS South Warwickshire CCG	0.6%	0.2%
E10000013	Gloucestershire	05T	NHS South Worcestershire CCG	1.1%	0.5%
E10000013	Gloucestershire	99N	NHS Wiltshire CCG	0.2%	0.2%
E09000011	Greenwich	07N	NHS Bexley CCG	5.1%	4.2%
E09000011	Greenwich	07Q	NHS Bromley CCG	1.1%	1.3%
E09000011	Greenwich	08A	NHS Greenwich CCG	89.2%	89.3%
E09000011	Greenwich	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000011	Greenwich	08L	NHS Lewisham CCG	4.4%	4.9%
E09000011	Greenwich	08Q	NHS Southwark CCG	0.1%	0.1%
E09000012	Hackney	07R	NHS Camden CCG	0.7%	0.7%
E09000012	Hackney	09A	NHS Central London (Westminster) CCG	0.2%	0.2%
E09000012	Hackney	07T	NHS City and Hackney CCG	90.2%	93.8%
E09000012	Hackney	08C	NHS Hammersmith and Fulham CCG	0.5%	0.4%
E09000012	Hackney	08D	NHS Haringey CCG	0.6%	0.7%
E09000012	Hackney	08H	NHS Islington CCG	4.6%	3.7%
E09000012	Hackney	08V	NHS Tower Hamlets CCG	0.5%	0.6%
E06000006	Halton	01F	NHS Halton CCG	98.2%	96.5%
E06000006	Halton	01J	NHS Knowsley CCG	0.2%	0.3%
E06000006	Halton	99A	NHS Liverpool CCG	0.3%	1.1%
E06000006	Halton	02E	NHS Warrington CCG	0.7%	1.1%
E06000006	Halton	02F	NHS West Cheshire CCG	0.6%	1.1%
E09000013	Hammersmith and Fulham	07P	NHS Brent CCG	0.3%	0.5%
E09000013	Hammersmith and Fulham	07R	NHS Camden CCG	0.1%	0.1%
E09000013	Hammersmith and Fulham	09A	NHS Central London (Westminster) CCG	2.5%	2.5%
E09000013	Hammersmith and Fulham	07W	NHS Ealing CCG	0.6%	1.1%
E09000013	Hammersmith and Fulham	08C	NHS Hammersmith and Fulham CCG	82.8%	87.6%
E09000013	Hammersmith and Fulham	07Y	NHS Hounslow CCG	0.5%	0.7%
E09000013	Hammersmith and Fulham	08X	NHS Wandsworth CCG	0.2%	0.3%
E09000013	Hammersmith and Fulham	08Y	NHS West London (K&C & QPP) CCG	6.5%	7.2%
E10000014	Hampshire	15A	NHS Berkshire West CCG	1.7%	0.6%
E10000014	Hampshire	09G	NHS Coastal West Sussex CCG	0.2%	0.1%
E10000014	Hampshire	11J	NHS Dorset CCG	0.5%	0.3%
E10000014	Hampshire	15D	NHS East Berkshire CCG	0.2%	0.0%
E10000014	Hampshire	10K	NHS Fareham and Gosport CCG	98.5%	14.3%
E10000014	Hampshire	09N	NHS Guildford and Waverley CCG	2.9%	0.5%
E10000014	Hampshire	99M	NHS North East Hampshire and Farnham CCG	76.5%	12.4%
E10000014	Hampshire	10J	NHS North Hampshire CCG	99.2%	15.9%
E10000014	Hampshire	10R	NHS Portsmouth CCG	4.4%	0.7%
E10000014	Hampshire	10V	NHS South Eastern Hampshire CCG	95.6%	14.6%
E10000014	Hampshire	10X	NHS Southampton CCG	5.1%	1.0%
E10000014	Hampshire	10C	NHS Surrey Heath CCG	0.8%	0.0%
E10000014	Hampshire	11A	NHS West Hampshire CCG	97.7%	39.1%
E10000014	Hampshire	99N	NHS Wiltshire CCG	1.3%	0.4%
E09000014	Haringey	07M	NHS Barnet CCG	1.0%	1.4%
E09000014	Haringey	07R	NHS Camden CCG	0.6%	0.6%
E09000014	Haringey	09A	NHS Central London (Westminster) CCG	0.1%	0.1%
E09000014	Haringey	07T	NHS City and Hackney CCG	3.1%	3.2%
E09000014	Haringey	07X	NHS Enfield CCG	1.3%	1.4%
E09000014	Haringey	08C	NHS Hammersmith and Fulham CCG	0.4%	0.3%
E09000014	Haringey	08D	NHS Haringey CCG	87.7%	91.0%
E09000014	Haringey	08H	NHS Islington CCG	2.5%	2.1%
E09000015	Harrow	07M	NHS Barnet CCG	4.3%	6.4%
E09000015	Harrow	07P	NHS Brent CCG	3.6%	4.8%
E09000015	Harrow	07W	NHS Ealing CCG	1.3%	2.1%
E09000015	Harrow	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000015	Harrow	08E	NHS Harrow CCG	89.7%	84.1%
E09000015	Harrow	06N	NHS Herts Valleys CCG	0.2%	0.5%
E09000015	Harrow	08G	NHS Hillingdon CCG	1.8%	2.0%
E09000015	Harrow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%

E06000001	Hartlepool	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.6%
E06000001	Hartlepool	00K	NHS Hartlepool and Stockton-On-Tees CCG	32.4%	99.4%
E09000016	Havering	07L	NHS Barking and Dagenham CCG	3.5%	2.9%
E09000016	Havering	08F	NHS Havering CCG	91.7%	96.2%
E09000016	Havering	08M	NHS Newham CCG	0.1%	0.2%
E09000016	Havering	08N	NHS Redbridge CCG	0.6%	0.7%
E09000016	Havering	07G	NHS Thurrock CCG	0.1%	0.0%
E06000019	Herefordshire, County of	11M	NHS Gloucestershire CCG	0.3%	0.9%
E06000019	Herefordshire, County of	05F	NHS Herefordshire CCG	98.2%	97.3%
E06000019	Herefordshire, County of	05N	NHS Shropshire CCG	0.3%	0.5%
E06000019	Herefordshire, County of	05T	NHS South Worcestershire CCG	0.8%	1.3%
E10000015	Hertfordshire	07M	NHS Barnet CCG	0.2%	0.0%
E10000015	Hertfordshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000015	Hertfordshire	14Y	NHS Buckinghamshire CCG	0.2%	0.1%
E10000015	Hertfordshire	06H	NHS Cambridgeshire and Peterborough CCG	2.1%	1.6%
E10000015	Hertfordshire	06K	NHS East and North Hertfordshire CCG	97.0%	46.5%
E10000015	Hertfordshire	07X	NHS Enfield CCG	0.5%	0.1%
E10000015	Hertfordshire	08E	NHS Harrow CCG	0.6%	0.1%
E10000015	Hertfordshire	06N	NHS Herts Valleys CCG	98.0%	50.7%
E10000015	Hertfordshire	08G	NHS Hillingdon CCG	2.2%	0.6%
E10000015	Hertfordshire	06P	NHS Luton CCG	0.4%	0.0%
E10000015	Hertfordshire	07H	NHS West Essex CCG	0.8%	0.2%
E09000017	Hillingdon	14Y	NHS Buckinghamshire CCG	0.0%	0.1%
E09000017	Hillingdon	07W	NHS Ealing CCG	5.2%	6.9%
E09000017	Hillingdon	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000017	Hillingdon	08E	NHS Harrow CCG	2.2%	1.8%
E09000017	Hillingdon	08G	NHS Hillingdon CCG	94.3%	89.8%
E09000017	Hillingdon	07Y	NHS Hounslow CCG	1.1%	1.0%
E09000018	Hounslow	07W	NHS Ealing CCG	5.4%	7.4%
E09000018	Hounslow	08C	NHS Hammersmith and Fulham CCG	1.2%	0.9%
E09000018	Hounslow	08G	NHS Hillingdon CCG	0.2%	0.2%
E09000018	Hounslow	07Y	NHS Hounslow CCG	88.2%	87.1%
E09000018	Hounslow	09Y	NHS North West Surrey CCG	0.3%	0.4%
E09000018	Hounslow	08P	NHS Richmond CCG	5.7%	3.8%
E09000018	Hounslow	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.1%
E06000046	Isle of Wight	10L	NHS Isle of Wight CCG	100.0%	100.0%
E09000019	Islington	07R	NHS Camden CCG	4.9%	5.4%
E09000019	Islington	09A	NHS Central London (Westminster) CCG	0.5%	0.5%
E09000019	Islington	07T	NHS City and Hackney CCG	3.4%	4.2%
E09000019	Islington	08C	NHS Hammersmith and Fulham CCG	0.5%	0.5%
E09000019	Islington	08D	NHS Haringey CCG	1.2%	1.5%
E09000019	Islington	08H	NHS Islington CCG	89.1%	87.9%
E09000020	Kensington and Chelsea	07P	NHS Brent CCG	0.0%	0.1%
E09000020	Kensington and Chelsea	07R	NHS Camden CCG	0.2%	0.3%
E09000020	Kensington and Chelsea	09A	NHS Central London (Westminster) CCG	4.0%	5.4%
E09000020	Kensington and Chelsea	08C	NHS Hammersmith and Fulham CCG	1.2%	1.7%
E09000020	Kensington and Chelsea	08Y	NHS West London (K&C & QPP) CCG	63.9%	92.5%
E10000016	Kent	09C	NHS Ashford CCG	100.0%	8.3%
E10000016	Kent	07N	NHS Bexley CCG	1.3%	0.2%
E10000016	Kent	07Q	NHS Bromley CCG	0.9%	0.2%
E10000016	Kent	09E	NHS Canterbury and Coastal CCG	100.0%	14.1%
E10000016	Kent	09J	NHS Dartford, Gravesham and Swanley CCG	98.3%	16.5%
E10000016	Kent	09L	NHS East Surrey CCG	0.1%	0.0%
E10000016	Kent	08A	NHS Greenwich CCG	0.2%	0.0%
E10000016	Kent	09P	NHS Hastings and Rother CCG	0.3%	0.0%
E10000016	Kent	99K	NHS High Weald Lewes Havens CCG	0.6%	0.0%
E10000016	Kent	09W	NHS Medway CCG	6.1%	1.1%
E10000016	Kent	10A	NHS South Kent Coast CCG	100.0%	12.9%
E10000016	Kent	10D	NHS Swale CCG	99.8%	7.1%
E10000016	Kent	10E	NHS Thanet CCG	100.0%	9.1%
E10000016	Kent	99J	NHS West Kent CCG	98.7%	30.4%
E06000010	Kingston upon Hull, City of	02Y	NHS East Riding of Yorkshire CCG	1.3%	1.4%
E06000010	Kingston upon Hull, City of	03F	NHS Hull CCG	90.8%	98.6%
E09000021	Kingston upon Thames	08J	NHS Kingston CCG	86.9%	95.9%
E09000021	Kingston upon Thames	08R	NHS Merton CCG	1.1%	1.3%
E09000021	Kingston upon Thames	08P	NHS Richmond CCG	0.7%	0.8%
E09000021	Kingston upon Thames	99H	NHS Surrey Downs CCG	0.7%	1.2%
E09000021	Kingston upon Thames	08T	NHS Sutton CCG	0.1%	0.1%
E09000021	Kingston upon Thames	08X	NHS Wandsworth CCG	0.3%	0.7%
E08000034	Kirklees	02P	NHS Barnsley CCG	0.1%	0.0%
E08000034	Kirklees	02R	NHS Bradford Districts CCG	1.0%	0.7%
E08000034	Kirklees	02T	NHS Calderdale CCG	1.4%	0.7%
E08000034	Kirklees	03A	NHS Greater Huddersfield CCG	99.6%	54.7%
E08000034	Kirklees	15F	NHS Leeds CCG	0.1%	0.3%
E08000034	Kirklees	03J	NHS North Kirklees CCG	98.9%	42.4%
E08000034	Kirklees	03R	NHS Wakefield CCG	1.5%	1.3%

E08000011	Knowsley	01F	NHS Halton CCG	1.0%	0.8%
E08000011	Knowsley	01J	NHS Knowsley CCG	86.8%	88.2%
E08000011	Knowsley	99A	NHS Liverpool CCG	2.4%	8.0%
E08000011	Knowsley	01T	NHS South Sefton CCG	0.1%	0.1%
E08000011	Knowsley	01X	NHS St Helens CCG	2.3%	2.8%
E09000022	Lambeth	07R	NHS Camden CCG	0.2%	0.1%
E09000022	Lambeth	09A	NHS Central London (Westminster) CCG	0.9%	0.6%
E09000022	Lambeth	07V	NHS Croydon CCG	0.7%	0.8%
E09000022	Lambeth	08C	NHS Hammersmith and Fulham CCG	0.6%	0.4%
E09000022	Lambeth	08K	NHS Lambeth CCG	85.5%	92.2%
E09000022	Lambeth	08R	NHS Merton CCG	1.0%	0.6%
E09000022	Lambeth	08Q	NHS Southwark CCG	1.9%	1.6%
E09000022	Lambeth	08X	NHS Wandsworth CCG	3.5%	3.7%
E09000022	Lambeth	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.0%
E10000017	Lancashire	02N	NHS Airedale, Wharfdale and Craven CCG	0.2%	0.0%
E10000017	Lancashire	00Q	NHS Blackburn with Darwen CCG	11.1%	1.5%
E10000017	Lancashire	00R	NHS Blackpool CCG	13.6%	1.9%
E10000017	Lancashire	00T	NHS Bolton CCG	0.3%	0.0%
E10000017	Lancashire	00V	NHS Bury CCG	1.4%	0.2%
E10000017	Lancashire	00X	NHS Chorley and South Ribble CCG	99.8%	14.5%
E10000017	Lancashire	01A	NHS East Lancashire CCG	99.0%	30.0%
E10000017	Lancashire	02M	NHS Fylde & Wyre CCG	97.9%	13.8%
E10000017	Lancashire	01E	NHS Greater Preston CCG	100.0%	16.6%
E10000017	Lancashire	01D	NHS Heywood, Middleton and Rochdale CCG	0.9%	0.2%
E10000017	Lancashire	01J	NHS Knowsley CCG	0.1%	0.0%
E10000017	Lancashire	01K	NHS Morecambe Bay CCG	44.1%	12.1%
E10000017	Lancashire	01T	NHS South Sefton CCG	0.5%	0.0%
E10000017	Lancashire	01V	NHS Southport and Formby CCG	3.2%	0.3%
E10000017	Lancashire	01X	NHS St Helens CCG	0.5%	0.0%
E10000017	Lancashire	02G	NHS West Lancashire CCG	96.9%	8.7%
E10000017	Lancashire	02H	NHS Wigan Borough CCG	0.7%	0.2%
E08000035	Leeds	02N	NHS Airedale, Wharfdale and Craven CCG	0.1%	0.0%
E08000035	Leeds	02W	NHS Bradford City CCG	1.1%	0.2%
E08000035	Leeds	02R	NHS Bradford Districts CCG	0.5%	0.2%
E08000035	Leeds	15F	NHS Leeds CCG	97.7%	98.8%
E08000035	Leeds	03J	NHS North Kirklees CCG	0.3%	0.0%
E08000035	Leeds	03Q	NHS Vale of York CCG	0.6%	0.2%
E08000035	Leeds	03R	NHS Wakefield CCG	1.4%	0.6%
E06000016	Leicester	03W	NHS East Leicestershire and Rutland CCG	2.1%	1.8%
E06000016	Leicester	04C	NHS Leicester City CCG	92.8%	95.5%
E06000016	Leicester	04V	NHS West Leicestershire CCG	2.8%	2.7%
E10000018	Leicestershire	03V	NHS Corby CCG	0.5%	0.0%
E10000018	Leicestershire	15M	NHS Derby and Derbyshire CCG	0.4%	0.6%
E10000018	Leicestershire	03W	NHS East Leicestershire and Rutland CCG	85.5%	39.8%
E10000018	Leicestershire	04C	NHS Leicester City CCG	7.2%	4.1%
E10000018	Leicestershire	04N	NHS Rushcliffe CCG	5.4%	1.0%
E10000018	Leicestershire	04Q	NHS South West Lincolnshire CCG	5.6%	1.1%
E10000018	Leicestershire	05H	NHS Warwickshire North CCG	1.6%	0.4%
E10000018	Leicestershire	04V	NHS West Leicestershire CCG	96.2%	53.1%
E09000023	Lewisham	07Q	NHS Bromley CCG	1.4%	1.5%
E09000023	Lewisham	09A	NHS Central London (Westminster) CCG	0.2%	0.2%
E09000023	Lewisham	08A	NHS Greenwich CCG	2.1%	1.9%
E09000023	Lewisham	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000023	Lewisham	08K	NHS Lambeth CCG	0.3%	0.4%
E09000023	Lewisham	08L	NHS Lewisham CCG	91.5%	92.0%
E09000023	Lewisham	08Q	NHS Southwark CCG	3.9%	3.9%
E10000019	Lincolnshire	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.3%
E10000019	Lincolnshire	03W	NHS East Leicestershire and Rutland CCG	0.2%	0.1%
E10000019	Lincolnshire	03T	NHS Lincolnshire East CCG	99.2%	32.0%
E10000019	Lincolnshire	04D	NHS Lincolnshire West CCG	98.6%	29.9%
E10000019	Lincolnshire	04H	NHS Newark & Sherwood CCG	2.4%	0.4%
E10000019	Lincolnshire	03H	NHS North East Lincolnshire CCG	2.7%	0.6%
E10000019	Lincolnshire	03K	NHS North Lincolnshire CCG	4.9%	1.1%
E10000019	Lincolnshire	99D	NHS South Lincolnshire CCG	90.8%	19.6%
E10000019	Lincolnshire	04Q	NHS South West Lincolnshire CCG	93.3%	16.1%
E08000012	Liverpool	01J	NHS Knowsley CCG	8.5%	2.7%
E08000012	Liverpool	99A	NHS Liverpool CCG	94.4%	96.3%
E08000012	Liverpool	01T	NHS South Sefton CCG	3.3%	1.0%
E06000032	Luton	06F	NHS Bedfordshire CCG	2.3%	4.5%
E06000032	Luton	06P	NHS Luton CCG	97.3%	95.5%
E08000003	Manchester	00V	NHS Bury CCG	0.4%	0.1%
E08000003	Manchester	01D	NHS Heywood, Middleton and Rochdale CCG	0.5%	0.2%
E08000003	Manchester	14L	NHS Manchester CCG	90.9%	95.6%
E08000003	Manchester	00Y	NHS Oldham CCG	0.9%	0.4%
E08000003	Manchester	01G	NHS Salford CCG	2.5%	1.1%
E08000003	Manchester	01W	NHS Stockport CCG	1.7%	0.8%
E08000003	Manchester	01Y	NHS Tameside and Glossop CCG	0.4%	0.2%
E08000003	Manchester	02A	NHS Trafford CCG	4.0%	1.6%

E06000035	Medway	09J	NHS Dartford, Gravesham and Swanley CCG	0.2%	0.2%
E06000035	Medway	09W	NHS Medway CCG	93.9%	99.5%
E06000035	Medway	10D	NHS Swale CCG	0.2%	0.0%
E06000035	Medway	99J	NHS West Kent CCG	0.2%	0.3%
E09000024	Merton	07V	NHS Croydon CCG	0.5%	0.9%
E09000024	Merton	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000024	Merton	08J	NHS Kingston CCG	3.4%	2.9%
E09000024	Merton	08K	NHS Lambeth CCG	1.0%	1.7%
E09000024	Merton	08R	NHS Merton CCG	87.7%	80.9%
E09000024	Merton	08T	NHS Sutton CCG	3.3%	2.6%
E09000024	Merton	08X	NHS Wandsworth CCG	6.6%	10.8%
E06000002	Middlesbrough	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.2%	0.2%
E06000002	Middlesbrough	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.3%
E06000002	Middlesbrough	00M	NHS South Tees CCG	52.3%	99.5%
E06000042	Milton Keynes	06F	NHS Bedfordshire CCG	1.5%	2.5%
E06000042	Milton Keynes	04F	NHS Milton Keynes CCG	95.5%	96.2%
E06000042	Milton Keynes	04G	NHS Nene CCG	0.6%	1.3%
E08000021	Newcastle upon Tyne	13T	NHS Newcastle Gateshead CCG	58.9%	95.2%
E08000021	Newcastle upon Tyne	99C	NHS North Tyneside CCG	5.9%	4.0%
E08000021	Newcastle upon Tyne	00L	NHS Northumberland CCG	0.8%	0.8%
E09000025	Newham	07L	NHS Barking and Dagenham CCG	0.5%	0.3%
E09000025	Newham	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000025	Newham	07T	NHS City and Hackney CCG	0.1%	0.0%
E09000025	Newham	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000025	Newham	08M	NHS Newham CCG	96.6%	97.3%
E09000025	Newham	08N	NHS Redbridge CCG	0.3%	0.2%
E09000025	Newham	08V	NHS Tower Hamlets CCG	0.2%	0.2%
E09000025	Newham	08W	NHS Waltham Forest CCG	1.7%	1.4%
E10000020	Norfolk	06H	NHS Cambridgeshire and Peterborough CCG	0.7%	0.7%
E10000020	Norfolk	06M	NHS Great Yarmouth and Waveney CCG	47.7%	12.2%
E10000020	Norfolk	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000020	Norfolk	06V	NHS North Norfolk CCG	100.0%	18.6%
E10000020	Norfolk	06W	NHS Norwich CCG	100.0%	25.2%
E10000020	Norfolk	99D	NHS South Lincolnshire CCG	0.2%	0.0%
E10000020	Norfolk	06Y	NHS South Norfolk CCG	98.9%	24.1%
E10000020	Norfolk	07J	NHS West Norfolk CCG	98.4%	18.5%
E10000020	Norfolk	07K	NHS West Suffolk CCG	2.6%	0.7%
E06000012	North East Lincolnshire	03T	NHS Lincolnshire East CCG	0.8%	1.2%
E06000012	North East Lincolnshire	03H	NHS North East Lincolnshire CCG	95.9%	98.6%
E06000012	North East Lincolnshire	03K	NHS North Lincolnshire CCG	0.2%	0.2%
E06000013	North Lincolnshire	02Q	NHS Bassetlaw CCG	0.2%	0.2%
E06000013	North Lincolnshire	02X	NHS Doncaster CCG	0.0%	0.1%
E06000013	North Lincolnshire	02Y	NHS East Riding of Yorkshire CCG	0.0%	0.1%
E06000013	North Lincolnshire	04D	NHS Lincolnshire West CCG	1.0%	1.3%
E06000013	North Lincolnshire	03H	NHS North East Lincolnshire CCG	1.4%	1.4%
E06000013	North Lincolnshire	03K	NHS North Lincolnshire CCG	94.9%	96.9%
E06000024	North Somerset	11E	NHS Bath and North East Somerset CCG	1.6%	1.5%
E06000024	North Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	21.8%	98.3%
E06000024	North Somerset	11X	NHS Somerset CCG	0.0%	0.2%
E08000022	North Tyneside	13T	NHS Newcastle Gateshead CCG	1.0%	2.6%
E08000022	North Tyneside	99C	NHS North Tyneside CCG	93.2%	96.3%
E08000022	North Tyneside	00L	NHS Northumberland CCG	0.7%	1.1%
E10000023	North Yorkshire	02N	NHS Airedale, Wharfdale and Craven CCG	32.5%	8.3%
E10000023	North Yorkshire	00C	NHS Darlington CCG	1.3%	0.2%
E10000023	North Yorkshire	02X	NHS Doncaster CCG	0.2%	0.1%
E10000023	North Yorkshire	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.1%
E10000023	North Yorkshire	01A	NHS East Lancashire CCG	0.1%	0.0%
E10000023	North Yorkshire	02Y	NHS East Riding of Yorkshire CCG	1.4%	0.7%
E10000023	North Yorkshire	03D	NHS Hambleton, Richmondshire and Whitby CCG	98.3%	22.8%
E10000023	North Yorkshire	03E	NHS Harrogate and Rural District CCG	99.8%	26.2%
E10000023	North Yorkshire	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.1%
E10000023	North Yorkshire	15F	NHS Leeds CCG	0.9%	1.3%
E10000023	North Yorkshire	01K	NHS Morecambe Bay CCG	1.9%	1.0%
E10000023	North Yorkshire	03M	NHS Scarborough and Ryedale CCG	99.3%	19.2%
E10000023	North Yorkshire	03Q	NHS Vale of York CCG	32.6%	18.8%
E10000023	North Yorkshire	03R	NHS Wakefield CCG	2.0%	1.2%
E10000021	Northamptonshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000021	Northamptonshire	06H	NHS Cambridgeshire and Peterborough CCG	1.6%	1.9%
E10000021	Northamptonshire	03V	NHS Corby CCG	99.2%	9.8%
E10000021	Northamptonshire	05A	NHS Coventry and Rugby CCG	0.3%	0.2%
E10000021	Northamptonshire	03W	NHS East Leicestershire and Rutland CCG	2.0%	0.8%
E10000021	Northamptonshire	04F	NHS Milton Keynes CCG	3.1%	1.2%
E10000021	Northamptonshire	04G	NHS Nene CCG	98.8%	84.9%
E10000021	Northamptonshire	10Q	NHS Oxfordshire CCG	1.1%	1.0%
E10000021	Northamptonshire	99D	NHS South Lincolnshire CCG	0.9%	0.2%
E06000057	Northumberland	13T	NHS Newcastle Gateshead CCG	0.3%	0.5%
E06000057	Northumberland	01H	NHS North Cumbria CCG	0.1%	0.1%
E06000057	Northumberland	00J	NHS North Durham CCG	0.2%	0.2%
E06000057	Northumberland	99C	NHS North Tyneside CCG	0.9%	0.6%
E06000057	Northumberland	00L	NHS Northumberland CCG	97.9%	98.7%

E06000018	Nottingham	04K	NHS Nottingham City CCG	89.9%	95.4%
E06000018	Nottingham	04L	NHS Nottingham North and East CCG	4.6%	2.0%
E06000018	Nottingham	04M	NHS Nottingham West CCG	4.1%	1.1%
E06000018	Nottingham	04N	NHS Rushcliffe CCG	4.3%	1.5%
E10000024	Nottinghamshire	02Q	NHS Bassetlaw CCG	97.1%	13.5%
E10000024	Nottinghamshire	15M	NHS Derby and Derbyshire CCG	1.5%	1.8%
E10000024	Nottinghamshire	02X	NHS Doncaster CCG	1.6%	0.6%
E10000024	Nottinghamshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000024	Nottinghamshire	04D	NHS Lincolnshire West CCG	0.4%	0.1%
E10000024	Nottinghamshire	04E	NHS Mansfield and Ashfield CCG	97.9%	22.5%
E10000024	Nottinghamshire	04H	NHS Newark & Sherwood CCG	97.6%	15.6%
E10000024	Nottinghamshire	04K	NHS Nottingham City CCG	10.1%	4.6%
E10000024	Nottinghamshire	04L	NHS Nottingham North and East CCG	95.1%	17.2%
E10000024	Nottinghamshire	04M	NHS Nottingham West CCG	90.8%	10.2%
E10000024	Nottinghamshire	04N	NHS Rushcliffe CCG	90.3%	13.6%
E10000024	Nottinghamshire	04Q	NHS South West Lincolnshire CCG	0.7%	0.1%
E10000024	Nottinghamshire	04V	NHS West Leicestershire CCG	0.1%	0.0%
E08000004	Oldham	01D	NHS Heywood, Middleton and Rochdale CCG	1.5%	1.4%
E08000004	Oldham	14L	NHS Manchester CCG	0.8%	2.1%
E08000004	Oldham	00Y	NHS Oldham CCG	94.5%	96.3%
E08000004	Oldham	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E10000025	Oxfordshire	15A	NHS Berkshire West CCG	0.5%	0.3%
E10000025	Oxfordshire	14Y	NHS Buckinghamshire CCG	2.4%	1.8%
E10000025	Oxfordshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000025	Oxfordshire	04G	NHS Nene CCG	0.1%	0.1%
E10000025	Oxfordshire	10Q	NHS Oxfordshire CCG	97.4%	96.5%
E10000025	Oxfordshire	05R	NHS South Warwickshire CCG	0.6%	0.2%
E10000025	Oxfordshire	12D	NHS Swindon CCG	2.7%	0.9%
E06000031	Peterborough	06H	NHS Cambridgeshire and Peterborough CCG	23.0%	96.3%
E06000031	Peterborough	99D	NHS South Lincolnshire CCG	5.1%	3.7%
E06000026	Plymouth	15N	NHS Devon CCG	22.1%	100.0%
E06000044	Portsmouth	10K	NHS Fareham and Gosport CCG	1.5%	1.4%
E06000044	Portsmouth	10R	NHS Portsmouth CCG	95.6%	98.4%
E06000044	Portsmouth	10V	NHS South Eastern Hampshire CCG	0.2%	0.2%
E06000038	Reading	15A	NHS Berkshire West CCG	35.3%	99.4%
E06000038	Reading	10Q	NHS Oxfordshire CCG	0.2%	0.6%
E09000026	Redbridge	07L	NHS Barking and Dagenham CCG	4.9%	3.3%
E09000026	Redbridge	08C	NHS Hammersmith and Fulham CCG	0.1%	0.1%
E09000026	Redbridge	08F	NHS Havering CCG	0.8%	0.7%
E09000026	Redbridge	08M	NHS Newham CCG	1.4%	1.7%
E09000026	Redbridge	08N	NHS Redbridge CCG	92.3%	89.4%
E09000026	Redbridge	08W	NHS Waltham Forest CCG	3.3%	3.1%
E09000026	Redbridge	07H	NHS West Essex CCG	1.8%	1.7%
E06000003	Redcar and Cleveland	03D	NHS Hambleton, Richmondshire and Whitby CCG	1.1%	1.1%
E06000003	Redcar and Cleveland	00M	NHS South Tees CCG	47.3%	98.9%
E09000027	Richmond upon Thames	08C	NHS Hammersmith and Fulham CCG	0.5%	0.5%
E09000027	Richmond upon Thames	07Y	NHS Hounslow CCG	4.9%	7.0%
E09000027	Richmond upon Thames	08J	NHS Kingston CCG	1.6%	1.5%
E09000027	Richmond upon Thames	08P	NHS Richmond CCG	91.7%	90.3%
E09000027	Richmond upon Thames	99H	NHS Surrey Downs CCG	0.0%	0.1%
E09000027	Richmond upon Thames	08X	NHS Wandsworth CCG	0.4%	0.7%
E08000005	Rochdale	00V	NHS Bury CCG	0.7%	0.6%
E08000005	Rochdale	01A	NHS East Lancashire CCG	0.2%	0.3%
E08000005	Rochdale	01D	NHS Heywood, Middleton and Rochdale CCG	96.5%	96.6%
E08000005	Rochdale	14L	NHS Manchester CCG	0.6%	1.6%
E08000005	Rochdale	00Y	NHS Oldham CCG	0.9%	1.0%
E08000018	Rotherham	02P	NHS Barnsley CCG	3.3%	3.1%
E08000018	Rotherham	02Q	NHS Bassetlaw CCG	1.0%	0.4%
E08000018	Rotherham	02X	NHS Doncaster CCG	1.1%	1.2%
E08000018	Rotherham	03L	NHS Rotherham CCG	97.9%	93.5%
E08000018	Rotherham	03N	NHS Sheffield CCG	0.8%	1.7%
E06000017	Rutland	06H	NHS Cambridgeshire and Peterborough CCG	0.0%	0.3%
E06000017	Rutland	03V	NHS Corby CCG	0.2%	0.5%
E06000017	Rutland	03W	NHS East Leicestershire and Rutland CCG	9.9%	86.3%
E06000017	Rutland	99D	NHS South Lincolnshire CCG	2.6%	11.5%
E06000017	Rutland	04Q	NHS South West Lincolnshire CCG	0.4%	1.4%
E08000006	Salford	00T	NHS Bolton CCG	0.2%	0.3%
E08000006	Salford	00V	NHS Bury CCG	1.8%	1.4%
E08000006	Salford	14L	NHS Manchester CCG	1.1%	2.5%
E08000006	Salford	01G	NHS Salford CCG	94.1%	94.6%
E08000006	Salford	02A	NHS Trafford CCG	0.2%	0.2%
E08000006	Salford	02H	NHS Wigan Borough CCG	0.9%	1.1%
E08000028	Sandwell	15E	NHS Birmingham and Solihull CCG	1.9%	7.0%
E08000028	Sandwell	05C	NHS Dudley CCG	3.0%	2.7%
E08000028	Sandwell	05L	NHS Sandwell and West Birmingham CCG	55.1%	88.6%
E08000028	Sandwell	05Y	NHS Walsall CCG	1.7%	1.3%
E08000028	Sandwell	06A	NHS Wolverhampton CCG	0.3%	0.3%
E08000014	Sefton	01J	NHS Knowsley CCG	1.8%	1.0%
E08000014	Sefton	99A	NHS Liverpool CCG	2.9%	5.3%
E08000014	Sefton	01T	NHS South Sefton CCG	96.0%	51.6%
E08000014	Sefton	01V	NHS Southport and Formby CCG	96.8%	41.9%
E08000014	Sefton	02G	NHS West Lancashire CCG	0.3%	0.1%

E08000019	Sheffield	02P	NHS Barnsley CCG	0.8%	0.4%
E08000019	Sheffield	15M	NHS Derby and Derbyshire CCG	0.2%	0.4%
E08000019	Sheffield	03L	NHS Rotherham CCG	0.4%	0.2%
E08000019	Sheffield	03N	NHS Sheffield CCG	98.5%	99.1%
E06000051	Shropshire	05F	NHS Herefordshire CCG	0.4%	0.3%
E06000051	Shropshire	05G	NHS North Staffordshire CCG	0.5%	0.3%
E06000051	Shropshire	05N	NHS Shropshire CCG	96.7%	95.4%
E06000051	Shropshire	01R	NHS South Cheshire CCG	0.4%	0.3%
E06000051	Shropshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.2%	0.9%
E06000051	Shropshire	05T	NHS South Worcestershire CCG	1.0%	1.0%
E06000051	Shropshire	05X	NHS Telford and Wrekin CCG	2.3%	1.4%
E06000051	Shropshire	02F	NHS West Cheshire CCG	0.1%	0.1%
E06000051	Shropshire	06D	NHS Wyre Forest CCG	0.8%	0.3%
E06000039	Slough	14Y	NHS Buckinghamshire CCG	1.8%	6.2%
E06000039	Slough	07W	NHS Ealing CCG	0.0%	0.1%
E06000039	Slough	15D	NHS East Berkshire CCG	33.8%	93.4%
E06000039	Slough	08G	NHS Hillingdon CCG	0.0%	0.1%
E06000039	Slough	07Y	NHS Hounslow CCG	0.0%	0.1%
E06000039	Slough	09Y	NHS North West Surrey CCG	0.0%	0.1%
E08000029	Solihull	15E	NHS Birmingham and Solihull CCG	17.0%	98.9%
E08000029	Solihull	05A	NHS Coventry and Rugby CCG	0.0%	0.1%
E08000029	Solihull	05J	NHS Redditch and Bromsgrove CCG	0.4%	0.3%
E08000029	Solihull	05L	NHS Sandwell and West Birmingham CCG	0.0%	0.1%
E08000029	Solihull	05R	NHS South Warwickshire CCG	0.4%	0.4%
E08000029	Solihull	05H	NHS Warwickshire North CCG	0.2%	0.2%
E10000027	Somerset	11E	NHS Bath and North East Somerset CCG	3.1%	1.1%
E10000027	Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.3%
E10000027	Somerset	15N	NHS Devon CCG	0.2%	0.5%
E10000027	Somerset	11J	NHS Dorset CCG	0.5%	0.7%
E10000027	Somerset	11X	NHS Somerset CCG	98.5%	97.3%
E10000027	Somerset	99N	NHS Wiltshire CCG	0.1%	0.1%
E06000025	South Gloucestershire	11E	NHS Bath and North East Somerset CCG	0.8%	0.6%
E06000025	South Gloucestershire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	28.2%	97.5%
E06000025	South Gloucestershire	11M	NHS Gloucestershire CCG	0.8%	1.8%
E06000025	South Gloucestershire	99N	NHS Wiltshire CCG	0.0%	0.1%
E08000023	South Tyneside	13T	NHS Newcastle Gateshead CCG	0.0%	0.2%
E08000023	South Tyneside	00N	NHS South Tyneside CCG	99.2%	99.2%
E08000023	South Tyneside	00P	NHS Sunderland CCG	0.3%	0.6%
E06000045	Southampton	10X	NHS Southampton CCG	94.9%	99.5%
E06000045	Southampton	11A	NHS West Hampshire CCG	0.2%	0.5%
E06000033	Southend-on-Sea	99F	NHS Castle Point and Rochford CCG	4.8%	4.7%
E06000033	Southend-on-Sea	99G	NHS Southend CCG	96.7%	95.3%
E09000028	Southwark	07R	NHS Camden CCG	0.3%	0.3%
E09000028	Southwark	09A	NHS Central London (Westminster) CCG	2.5%	1.6%
E09000028	Southwark	08C	NHS Hammersmith and Fulham CCG	0.7%	0.5%
E09000028	Southwark	08K	NHS Lambeth CCG	6.6%	7.7%
E09000028	Southwark	08L	NHS Lewisham CCG	2.1%	2.0%
E09000028	Southwark	08Q	NHS Southwark CCG	94.1%	87.9%
E09000028	Southwark	08X	NHS Wandsworth CCG	0.1%	0.1%
E08000013	St. Helens	01F	NHS Halton CCG	0.2%	0.1%
E08000013	St. Helens	01J	NHS Knowsley CCG	2.6%	2.3%
E08000013	St. Helens	01X	NHS St Helens CCG	91.2%	96.3%
E08000013	St. Helens	02E	NHS Warrington CCG	0.1%	0.1%
E08000013	St. Helens	02H	NHS Wigan Borough CCG	0.7%	1.2%
E10000028	Staffordshire	15E	NHS Birmingham and Solihull CCG	0.3%	0.4%
E10000028	Staffordshire	04Y	NHS Cannock Chase CCG	99.3%	14.9%
E10000028	Staffordshire	15M	NHS Derby and Derbyshire CCG	0.5%	0.5%
E10000028	Staffordshire	05C	NHS Dudley CCG	1.4%	0.5%
E10000028	Staffordshire	05D	NHS East Staffordshire CCG	92.1%	14.7%
E10000028	Staffordshire	01C	NHS Eastern Cheshire CCG	0.6%	0.1%
E10000028	Staffordshire	05G	NHS North Staffordshire CCG	95.1%	23.4%
E10000028	Staffordshire	05N	NHS Shropshire CCG	1.0%	0.3%
E10000028	Staffordshire	01R	NHS South Cheshire CCG	0.5%	0.1%
E10000028	Staffordshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	96.2%	23.6%
E10000028	Staffordshire	05V	NHS Stafford and Surrounds CCG	99.5%	16.7%
E10000028	Staffordshire	05W	NHS Stoke on Trent CCG	8.8%	2.9%
E10000028	Staffordshire	05X	NHS Telford and Wrekin CCG	1.0%	0.2%
E10000028	Staffordshire	05Y	NHS Walsall CCG	1.6%	0.5%
E10000028	Staffordshire	05H	NHS Warwickshire North CCG	1.1%	0.2%
E10000028	Staffordshire	06A	NHS Wolverhampton CCG	2.6%	0.8%
E10000028	Staffordshire	06D	NHS Wyre Forest CCG	0.2%	0.0%
E08000007	Stockport	01C	NHS Eastern Cheshire CCG	1.6%	1.1%
E08000007	Stockport	14L	NHS Manchester CCG	1.1%	2.2%
E08000007	Stockport	01W	NHS Stockport CCG	94.9%	96.5%
E08000007	Stockport	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E06000004	Stockton-on-Tees	00C	NHS Darlington CCG	0.4%	0.2%
E06000004	Stockton-on-Tees	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.4%	0.6%
E06000004	Stockton-on-Tees	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.1%
E06000004	Stockton-on-Tees	00K	NHS Hartlepool and Stockton-On-Tees CCG	66.9%	98.4%
E06000004	Stockton-on-Tees	00M	NHS South Tees CCG	0.4%	0.7%

E06000021	Stoke-on-Trent	05G	NHS North Staffordshire CCG	3.3%	2.7%
E06000021	Stoke-on-Trent	05V	NHS Stafford and Surrounds CCG	0.5%	0.3%
E06000021	Stoke-on-Trent	05W	NHS Stoke on Trent CCG	91.2%	97.1%
E10000029	Suffolk	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.2%
E10000029	Suffolk	06M	NHS Great Yarmouth and Waveney CCG	52.3%	16.3%
E10000029	Suffolk	06L	NHS Ipswich and East Suffolk CCG	99.6%	52.9%
E10000029	Suffolk	06T	NHS North East Essex CCG	1.4%	0.6%
E10000029	Suffolk	06Y	NHS South Norfolk CCG	1.1%	0.3%
E10000029	Suffolk	07H	NHS West Essex CCG	0.1%	0.0%
E10000029	Suffolk	07K	NHS West Suffolk CCG	91.1%	29.7%
E08000024	Sunderland	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.9%	0.9%
E08000024	Sunderland	13T	NHS Newcastle Gateshead CCG	0.5%	0.9%
E08000024	Sunderland	00J	NHS North Durham CCG	2.2%	1.9%
E08000024	Sunderland	00N	NHS South Tyneside CCG	0.5%	0.3%
E08000024	Sunderland	00P	NHS Sunderland CCG	98.5%	96.0%
E10000030	Surrey	07Q	NHS Bromley CCG	0.4%	0.1%
E10000030	Surrey	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000030	Surrey	09H	NHS Crawley CCG	6.6%	0.7%
E10000030	Surrey	07V	NHS Croydon CCG	1.3%	0.4%
E10000030	Surrey	15D	NHS East Berkshire CCG	3.4%	1.2%
E10000030	Surrey	09L	NHS East Surrey CCG	96.6%	14.1%
E10000030	Surrey	09N	NHS Guildford and Waverley CCG	94.0%	16.9%
E10000030	Surrey	09X	NHS Horsham and Mid Sussex CCG	1.5%	0.3%
E10000030	Surrey	07Y	NHS Hounslow CCG	0.7%	0.2%
E10000030	Surrey	08J	NHS Kingston CCG	4.5%	0.7%
E10000030	Surrey	08R	NHS Merton CCG	0.3%	0.0%
E10000030	Surrey	99M	NHS North East Hampshire and Farnham CCG	23.0%	4.2%
E10000030	Surrey	10J	NHS North Hampshire CCG	0.1%	0.0%
E10000030	Surrey	09Y	NHS North West Surrey CCG	99.4%	29.5%
E10000030	Surrey	08P	NHS Richmond CCG	0.7%	0.1%
E10000030	Surrey	10V	NHS South Eastern Hampshire CCG	0.1%	0.0%
E10000030	Surrey	99H	NHS Surrey Downs CCG	97.4%	23.8%
E10000030	Surrey	10C	NHS Surrey Heath CCG	98.9%	7.6%
E10000030	Surrey	08T	NHS Sutton CCG	1.2%	0.2%
E10000030	Surrey	99J	NHS West Kent CCG	0.2%	0.0%
E09000029	Sutton	07V	NHS Croydon CCG	1.0%	1.9%
E09000029	Sutton	08J	NHS Kingston CCG	3.5%	3.4%
E09000029	Sutton	08K	NHS Lambeth CCG	0.1%	0.2%
E09000029	Sutton	08R	NHS Merton CCG	6.3%	6.7%
E09000029	Sutton	99H	NHS Surrey Downs CCG	1.3%	1.9%
E09000029	Sutton	08T	NHS Sutton CCG	94.7%	85.6%
E09000029	Sutton	08X	NHS Wandsworth CCG	0.2%	0.3%
E06000030	Swindon	11M	NHS Gloucestershire CCG	0.0%	0.2%
E06000030	Swindon	12D	NHS Swindon CCG	96.0%	98.2%
E06000030	Swindon	99N	NHS Wiltshire CCG	0.7%	1.5%
E08000008	Tameside	14L	NHS Manchester CCG	2.2%	5.8%
E08000008	Tameside	00Y	NHS Oldham CCG	3.6%	3.9%
E08000008	Tameside	01W	NHS Stockport CCG	1.8%	2.3%
E08000008	Tameside	01Y	NHS Tameside and Glossop CCG	85.2%	88.0%
E06000020	Telford and Wrekin	05N	NHS Shropshire CCG	1.8%	2.9%
E06000020	Telford and Wrekin	05X	NHS Telford and Wrekin CCG	96.7%	97.1%
E06000034	Thurrock	07L	NHS Barking and Dagenham CCG	0.3%	0.3%
E06000034	Thurrock	99E	NHS Basildon and Brentwood CCG	0.2%	0.3%
E06000034	Thurrock	08F	NHS Havering CCG	0.2%	0.4%
E06000034	Thurrock	07G	NHS Thurrock CCG	98.5%	99.0%
E06000027	Torbay	15N	NHS Devon CCG	11.7%	100.0%
E09000030	Tower Hamlets	07R	NHS Camden CCG	1.1%	0.9%
E09000030	Tower Hamlets	09A	NHS Central London (Westminster) CCG	0.5%	0.3%
E09000030	Tower Hamlets	07T	NHS City and Hackney CCG	0.9%	0.9%
E09000030	Tower Hamlets	08C	NHS Hammersmith and Fulham CCG	0.8%	0.5%
E09000030	Tower Hamlets	08H	NHS Islington CCG	0.2%	0.1%
E09000030	Tower Hamlets	08M	NHS Newham CCG	0.2%	0.2%
E09000030	Tower Hamlets	08V	NHS Tower Hamlets CCG	98.9%	96.9%
E08000009	Trafford	14L	NHS Manchester CCG	2.7%	7.0%
E08000009	Trafford	01G	NHS Salford CCG	0.1%	0.1%
E08000009	Trafford	02A	NHS Trafford CCG	95.7%	92.7%
E08000009	Trafford	02E	NHS Warrington CCG	0.1%	0.1%
E08000036	Wakefield	02P	NHS Barnsley CCG	0.9%	0.6%
E08000036	Wakefield	15F	NHS Leeds CCG	0.4%	1.0%
E08000036	Wakefield	03J	NHS North Kirklees CCG	0.6%	0.3%
E08000036	Wakefield	03R	NHS Wakefield CCG	94.5%	98.0%
E08000030	Walsall	15E	NHS Birmingham and Solihull CCG	1.1%	4.8%
E08000030	Walsall	04Y	NHS Cannock Chase CCG	0.7%	0.3%
E08000030	Walsall	05L	NHS Sandwell and West Birmingham CCG	1.6%	3.1%
E08000030	Walsall	05Y	NHS Walsall CCG	92.8%	90.4%
E08000030	Walsall	06A	NHS Wolverhampton CCG	1.4%	1.4%
E09000031	Waltham Forest	07T	NHS City and Hackney CCG	0.4%	0.4%
E09000031	Waltham Forest	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000031	Waltham Forest	08D	NHS Haringey CCG	0.1%	0.1%
E09000031	Waltham Forest	08M	NHS Newham CCG	1.3%	1.7%
E09000031	Waltham Forest	08N	NHS Redbridge CCG	1.4%	1.4%
E09000031	Waltham Forest	08W	NHS Waltham Forest CCG	94.3%	96.1%

E09000032	Wandsworth	09A	NHS Central London (Westminster) CCG	0.9%	0.6%
E09000032	Wandsworth	08C	NHS Hammersmith and Fulham CCG	1.0%	0.6%
E09000032	Wandsworth	08J	NHS Kingston CCG	0.1%	0.0%
E09000032	Wandsworth	08K	NHS Lambeth CCG	3.2%	3.5%
E09000032	Wandsworth	08R	NHS Merton CCG	2.8%	1.6%
E09000032	Wandsworth	08P	NHS Richmond CCG	1.3%	0.7%
E09000032	Wandsworth	08X	NHS Wandsworth CCG	88.3%	92.6%
E09000032	Wandsworth	08Y	NHS West London (K&C & QPP) CCG	0.7%	0.4%
E06000007	Warrington	01F	NHS Halton CCG	0.3%	0.2%
E06000007	Warrington	01G	NHS Salford CCG	0.5%	0.6%
E06000007	Warrington	01X	NHS St Helens CCG	2.2%	2.0%
E06000007	Warrington	02E	NHS Warrington CCG	97.6%	97.0%
E06000007	Warrington	02H	NHS Wigan Borough CCG	0.2%	0.2%
E10000031	Warwickshire	15E	NHS Birmingham and Solihull CCG	0.2%	0.5%
E10000031	Warwickshire	05A	NHS Coventry and Rugby CCG	25.2%	21.5%
E10000031	Warwickshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000031	Warwickshire	04G	NHS Nene CCG	0.2%	0.2%
E10000031	Warwickshire	10Q	NHS Oxfordshire CCG	0.3%	0.3%
E10000031	Warwickshire	05J	NHS Redditch and Bromsgrove CCG	0.7%	0.2%
E10000031	Warwickshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	0.8%	0.3%
E10000031	Warwickshire	05R	NHS South Warwickshire CCG	96.1%	45.8%
E10000031	Warwickshire	05H	NHS Warwickshire North CCG	96.7%	30.7%
E10000031	Warwickshire	04V	NHS West Leicestershire CCG	0.5%	0.3%
E06000037	West Berkshire	15A	NHS Berkshire West CCG	30.0%	97.6%
E06000037	West Berkshire	10J	NHS North Hampshire CCG	0.7%	0.9%
E06000037	West Berkshire	10Q	NHS Oxfordshire CCG	0.2%	1.1%
E06000037	West Berkshire	99N	NHS Wiltshire CCG	0.1%	0.4%
E10000032	West Sussex	09D	NHS Brighton and Hove CCG	1.1%	0.4%
E10000032	West Sussex	09G	NHS Coastal West Sussex CCG	99.5%	57.5%
E10000032	West Sussex	09H	NHS Crawley CCG	93.4%	14.0%
E10000032	West Sussex	09L	NHS East Surrey CCG	0.3%	0.0%
E10000032	West Sussex	09N	NHS Guildford and Waverley CCG	3.1%	0.8%
E10000032	West Sussex	99K	NHS High Weald Lewes Havens CCG	1.1%	0.2%
E10000032	West Sussex	09X	NHS Horsham and Mid Sussex CCG	95.7%	25.9%
E10000032	West Sussex	10V	NHS South Eastern Hampshire CCG	4.1%	1.0%
E10000032	West Sussex	99H	NHS Surrey Downs CCG	0.6%	0.2%
E09000033	Westminster	07P	NHS Brent CCG	1.3%	2.0%
E09000033	Westminster	07R	NHS Camden CCG	3.0%	3.4%
E09000033	Westminster	09A	NHS Central London (Westminster) CCG	79.3%	71.3%
E09000033	Westminster	08C	NHS Hammersmith and Fulham CCG	0.6%	0.6%
E09000033	Westminster	08K	NHS Lambeth CCG	0.1%	0.2%
E09000033	Westminster	08Y	NHS West London (K&C & QPP) CCG	23.1%	22.6%
E08000010	Wigan	00T	NHS Bolton CCG	0.2%	0.1%
E08000010	Wigan	01G	NHS Salford CCG	0.8%	0.6%
E08000010	Wigan	01X	NHS St Helens CCG	3.8%	2.2%
E08000010	Wigan	02E	NHS Warrington CCG	0.4%	0.2%
E08000010	Wigan	02G	NHS West Lancashire CCG	2.8%	1.0%
E08000010	Wigan	02H	NHS Wigan Borough CCG	96.7%	95.7%
E06000054	Wiltshire	11E	NHS Bath and North East Somerset CCG	0.9%	0.4%
E06000054	Wiltshire	15A	NHS Berkshire West CCG	0.2%	0.2%
E06000054	Wiltshire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.5%
E06000054	Wiltshire	11J	NHS Dorset CCG	0.3%	0.4%
E06000054	Wiltshire	11M	NHS Gloucestershire CCG	0.4%	0.5%
E06000054	Wiltshire	11X	NHS Somerset CCG	0.3%	0.4%
E06000054	Wiltshire	12D	NHS Swindon CCG	1.3%	0.6%
E06000054	Wiltshire	11A	NHS West Hampshire CCG	0.1%	0.2%
E06000054	Wiltshire	99N	NHS Wiltshire CCG	96.7%	96.8%
E06000040	Windsor and Maidenhead	15A	NHS Berkshire West CCG	0.4%	1.3%
E06000040	Windsor and Maidenhead	14Y	NHS Buckinghamshire CCG	0.3%	1.1%
E06000040	Windsor and Maidenhead	15D	NHS East Berkshire CCG	34.1%	96.9%
E06000040	Windsor and Maidenhead	09Y	NHS North West Surrey CCG	0.2%	0.5%
E06000040	Windsor and Maidenhead	10Q	NHS Oxfordshire CCG	0.0%	0.2%
E06000040	Windsor and Maidenhead	10C	NHS Surrey Heath CCG	0.1%	0.0%
E08000015	Wirral	02F	NHS West Cheshire CCG	0.4%	0.3%
E08000015	Wirral	12F	NHS Wirral CCG	99.7%	99.7%
E06000041	Wokingham	15A	NHS Berkshire West CCG	31.5%	97.0%
E06000041	Wokingham	15D	NHS East Berkshire CCG	1.0%	2.6%
E06000041	Wokingham	10Q	NHS Oxfordshire CCG	0.1%	0.4%
E08000031	Wolverhampton	05C	NHS Dudley CCG	1.3%	1.5%
E08000031	Wolverhampton	05L	NHS Sandwell and West Birmingham CCG	0.1%	0.3%
E08000031	Wolverhampton	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.8%	1.4%
E08000031	Wolverhampton	05Y	NHS Walsall CCG	3.4%	3.5%
E08000031	Wolverhampton	06A	NHS Wolverhampton CCG	93.8%	93.4%
E10000034	Worcestershire	15E	NHS Birmingham and Solihull CCG	0.9%	2.0%
E10000034	Worcestershire	05C	NHS Dudley CCG	0.7%	0.4%
E10000034	Worcestershire	11M	NHS Gloucestershire CCG	0.5%	0.6%
E10000034	Worcestershire	05F	NHS Herefordshire CCG	0.9%	0.3%
E10000034	Worcestershire	05J	NHS Redditch and Bromsgrove CCG	95.8%	27.7%
E10000034	Worcestershire	05N	NHS Shropshire CCG	0.3%	0.1%
E10000034	Worcestershire	05R	NHS South Warwickshire CCG	2.3%	1.1%
E10000034	Worcestershire	05T	NHS South Worcestershire CCG	97.2%	49.3%
E10000034	Worcestershire	06D	NHS Wyre Forest CCG	98.3%	18.6%
E06000014	York	03E	NHS Harrogate and Rural District CCG	0.2%	0.1%
E06000014	York	03Q	NHS Vale of York CCG	60.2%	99.9%

Produced by NHS England using data from National Health Applications and Infrastructure Services (NHAIS) as supplied by NHS Digital.

Creating a Mentally Healthy City

Developing an upstream approach to mental health and wellbeing

Dr Justin Varney
Director of Public Health
Justin.Varney@birmingham.gov.uk

Tuesday 4th February 2020

Making a positive difference everyday to people's lives

Birmingham City Council

007581/2020

Our Ambition As A City

Birmingham – a city of growth where every child, citizen and place matters

- Birmingham is an entrepreneurial city to learn, work and invest in

- Birmingham is an aspirational city to grow up in

- Birmingham is a fulfilling city to age well in

- Birmingham is a great city to live in

- Birmingham residents gain the maximum benefit from hosting the Commonwealth Games

- Birmingham as a green and sustainable city

Making a positive difference everyday to peoples lives

PAGE 2

Birmingham City Council

Birmingham City Council Plan: 2018-2022
Challenges and opportunities

BIRMINGHAM HAS
1,141,000 CITIZENS
46% UNDER 30

Our population is expected to rise to 1.3 million by 2039 (15% rise from most and 24% predicted rise in adults aged 85+ by 2028.

90 DIFFERENT LANGUAGES ARE SPOKEN

Birmingham has a young and richly diverse population with 25% of the population under 18 and 42% from Black and Minority Ethnic communities.

OUTSIDE OF LONDON
OUR CITY IS THE **MOST** ETHNICALLY & **CULTURALLY DIVERSE**

1,789 CHILDREN IN CARE (UNDER 18)

1 in 3 children live in poverty and there is a gap in life expectancy between the wealthiest and poorest wards. English is not the first language for 42% of school children.

1,836 FAMILIES SUPPORTED BY FAMILY SERVICES*

Unemployment is higher than the UK average – 6.4% in Birmingham compared to 2.6% in the UK.
Unequal employment rates across Birmingham – e.g. Hodge Hill at 46% compared to 76% in Sutton Coldfield.
Air pollution causes up to 900 premature deaths (deaths before the age of 75) per year.

61,818 COUNCIL HOUSES

89,000 new homes are needed by 2023; street homelessness is on the rise and 1 in 88 people (12,785) are homeless.

MOST RAPIDLY IMPROVING CITY

to live and work in with exciting new developments in Birmingham city centre, delivering almost 13,000 new homes, over 60,000 jobs and adding £2billion to the local economy.

COMMONWEALTH GAMES

will reposition Birmingham globally.

GENERATING

£526m

for the regional economy and creating 1,000 new homes.

Wide ranging lively cultural offer, including world class theatres, Town Hall and Symphony Hall and a rich tapestry of festivals.

CITIZENS' TOP PRIORITIES

#1 Clean Streets (57%)
#2 Refuse Collection (38%)
#3 Child Protection and Safeguarding (37%)
#4 Road and Pavement Repairs (37%)
#5 Care and Support for Older and Disabled People (36%)

HOME TO OVER
20 MUSEUMS
571 PARKS
More than any other European city
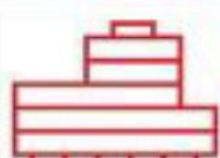
4 MILLION VISITORS TO
CITY'S 37 LIBRARIES ANNUALLY

12,373 ADULTS (18+) RECEIVING LONG TERM SUPPORT

35 MILES OF WATERWAYS MORE CANALS THAN VENICE

HOME TO **5** UNIVERSITIES
with 87,400 students (aged 16-64).

IN 2017, MORE THAN
12,000 NEW COMPANIES OPENED THEIR DOORS FOR NEW BUSINESS IN BIRMINGHAM

Birmingham City Council

MENTAL HEALTH IN BIRMINGHAM
WORKING TOWARDS A MENTALLY HEALTHY CITY:

Birmingham City Council

DRIVERS

ADVERSE CHILDHOOD EXPERIENCES

5,963

Children (0-5yrs) were referred to Childrens Centres were affected by ACEs (Aug 17-18)

LONELINESS

11.6%

Pensioners live alone in Birmingham

EMPLOYMENT

74.3% BIRMINGHAM **56.3%**

5.5 — Average gross weekly income Birmingham £532.50 England £571.10 — 14.3

79.8% ENGLAND **70.5%**

POVERTY

CHILDREN IN LOW INCOME HOUSEHOLDS
27.6% B'HAM
17.0% ENG

INCOME DEPRIVED OLDER PEOPLE
28.2% B'HAM
17.9% ENG

IMPACT ON MENTAL HEALTH

Estimated number of women with severe depression in pregnancy

510

Based on 30 women affected in every 1,000 deliveries

10.3% of 5-16yr olds are estimated to have a mental health disorder

2.19% of school age children have social, emotional or mental health needs

Adults in Birmingham who are registered with their GP as having a diagnosis of depression

9.2 %

Average for England is 9.9%

6.3% of GP patients have a long term mental health condition

1.19% of GP patients have a severe mental illness

4.1% of Adults in Birmingham report low satisfaction with their lives

8.8% of Adults in Birmingham report low levels of happiness

OUTCOMES

SUICIDE RATES IN BIRMINGHAM

11.3

4.1

Age-standardised rate of suicides per 100,000 adults (3yr average)

YEARS OF LIFE LOST THROUGH SUICIDE

50.8

14.2

Age-standardised rate of suicides per 10,000 adults aged 15-74yrs (3yr average)

60.4 Gap in the employment rate between those in contact with secondary mental health services and the overall employment rate

64.0 % Of adults in contact with secondary care mental health services who live in stable and appropriate accommodation

NHS MENTAL HEALTH SERVICES SPEND BY BIRMINGHAM & SOLIHULL CCG

£258.9 million

2017/18 Actual Spend

£2.16 BILLION

Is the estimated cost to the Birmingham economy each year.

Mental Health and Wellbeing

The World Health Organization (2005) defines mental health as "a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" Wellbeing has been defined as "individuals' perceptions of the quality of their relationships with other people, their neighbourhoods, and their communities"

Birmingham
City Council

Five Pillars of Well-Being

Purpose

Liking what you do each day and being motivated to achieve your goals

Social

Having supportive relationships and love in your life

Financial

Managing your economic life to reduce stress and increase security

Community

Liking where you live, feeling safe and having pride in your community

Physical

Having good health and enough energy to get things done daily

5

HEALTHWAYS

Making a positive difference everyday to people's lives

Birmingham City Council

PAGE 6

"*Mental wellness is a balance of the mental, physical, spiritual, and emotional.*

This balance is enriched as individuals have:

***PURPOSE** in their daily lives whether it is through education, employment, care-giving activities, or cultural ways of being and doing; **HOPE** for their future and those of their families that is grounded in a sense of identity, unique Indigenous values, and having a belief in spirit; a sense of **BELONGING** and connectedness within their families, to community, and to culture; and finally a sense of **MEANING** and an understanding of how their lives and those of their families and communities are part of creation and a rich history.*"

First Nations Mental Wellness Continuum Framework

Making a positive difference everyday to people's lives

PAGE 7

Birmingham City Council

Our Emerging Vision and Ambition

"Birmingham is a mentally healthy city with a thriving and flourishing population that reflects the diversity of our citizens where everyone feels like they belong, and their lives have meaning and purpose that gives them hope for the future."

Making a positive difference everyday to people's lives

PAGE 8

Birmingham
City Council

Governance Process

Birmingham City Council
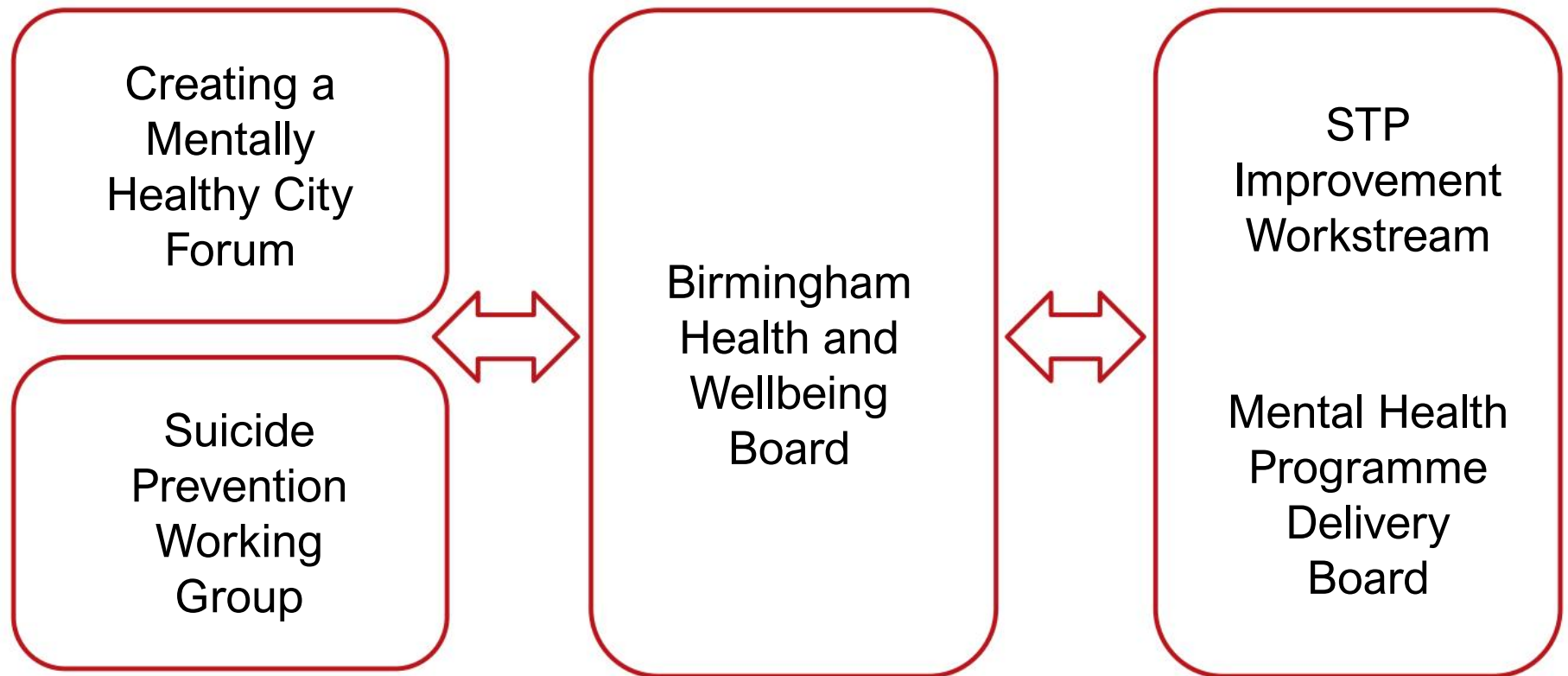
Creating a Mentally Healthy City Forum

- Sub-group of Health and Wellbeing Board chaired by the Cabinet Member for Adult Social Care and Health, formally established in September 2019.

- Multi-agency group with representation from NHS, community & voluntary sector, business sector and academic sector.

- Has one sub-committee – Suicide Prevention Advisory Group which is focused on delivery of the Suicide Prevention Strategy.

- Twice a year there is a wider workshop with a broader group of stakeholders, in 2020 these are focused on diversity and inclusion aspects of mental wellbeing.

- Meets bi-monthly and reports to the Health and Wellbeing Board twice a year in detail and bi-monthly in written update.

- Collaborating to sign up to the Mental Health Prevention Concordat.

Making a positive difference everyday to people's lives

Birmingham City Council

Looking ahead

- Explore potential to develop a framework for creating a mentally healthy city to help navigate and find synergies between activity.

- Map current activity across the partnership.

- Strengthen our understanding of mental wellbeing in the context of diversity and inclusion.

- Maximise the potential of the Commonwealth Games to improve mental wellness of the city.

Making a positive difference everyday to people's lives

Birmingham City Council

@BhamCityCouncil

@birminghamcitycouncil

@bhamcitycouncil

Making a positive difference everyday to people's lives

Birmingham
City Council

Birmingham Health and Wellbeing Board

	Agenda Item: 10
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**17 March 2020**
TITLE:	**CREATING A MENTALLY HEALTHY CITY FORUM**
Organisation	**Public Health, Birmingham City Council**
Presenting Officer	**Elizabeth Griffiths. Assistant Director, Public Health**

Report Type:	**Information**

1.	**Purpose:**
	This is an update report for the Creating a Mentally Healthy City Forum. It details the progress that Birmingham is making towards creating a mentally healthy city with a thriving and flourishing population.

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

3.	**Recommendation**

3.1 It is recommended that the Board:

- notes progress made by the Creating a Mentally Healthy City Forum

- agrees to support the identified priorities of the Forum and promote: and,

- ensure constituent organisations are represented at and participating in Mentally Health City events moving forwards.

4.	Report Body

4.1   Context

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

4.1.2   The Chair of the Creating a Mentally Healthy City (CMHC) Forum is Cllr Paulette Hamilton, Cabinet Member for Health and Social Care. Forum membership includes strategic partners from statutory organisations: NHS, PHE, Police, Fire, Academic bodies, Third Sector, Voluntary and Faith organisations. The various organisations will focus on what needs to be done locally, and at pace.

4.1.3   Membership will be reviewed from time to time to ensure 'best fit' of people who can contribute strategically to specific areas. Members will be co-opted so we can deliver on our action plans and deliver specific aspects of the Health and Wellbeing priorities on mental wellbeing.

4.1.4   This Forum will link with the Health and Wellbeing Board's other Forums (City without Inequality/Healthy Food City/An Active City/Health Protection). The objectives of the 'Creating a Mentally Healthy City Forum are to:

- Oversee the support and development and delivery of a strategic action plan/framework to deliver a measurable impact on citizens lives in Birmingham.
- Develop an insight into the "mentally healthy" need and gaps through the Joint Strategic Needs Assessment (JSNA) process.
- Foster and develop partnership arrangements to deliver improvements in health and wellbeing for citizens of Birmingham.
- Work in a matrix fashion with partners from other sub-Forums to ensure all are on course to make a difference to the citizens of Birmingham and deliver on outcomes.
- Work with community groups and voluntary organisations to ensure their voices are heard on matters of mental wellbeing.

4.1.5   The CMHC Forum will meet bi-monthly and workshops with a wider stakeholder group will be held twice per year. The Birmingham Suicide Prevention Advisory Group, a sub-committee of the CMHC, meets bi-monthly and a representative from Birmingham Public Health attends the Solihull Suicide Prevention Group meetings to share learning and knowledge.

4.1.6   Documents and information will be shared with the CMHC Forum LinkedIn Group and all members will be invited to Workshops to ensure inclusivity and ensure we seek the views and experience of mental wellbeing as its invaluable to the success of creating a mentally healthy City.

4.1.7   The CMHC Forum's current priority areas for action are:

- Establishment of a proactive Creating a Mentally Healthy City Advisory Group and developing workshops.
- Full Council ratification of the Birmingham Suicide Prevention Strategy.
- Partner ownership and progression of Actions from the Birmingham Suicide Prevention Strategy and the implementation of a robust monitoring, review and reporting system.
- Developing a Prevention Concordat for Better Mental Health

4.1.8   The CMHF has made progress towards these priorities as follows:

4.2   Creating a Mentally Healthy City Workshop

4.2.1   On 15 January 2020 the Forum's wider stakeholder half day workshop took place. It was the first of two planned Workshops for 2020 and the focus was on 'Diversity, Inclusion and Intersectionality, and how they relate to Mental Health and Wellbeing'

4.2.2   There were three sub-workshops:

A.   **First Class Legacy** working with local communities and specialising in youth engagement particularly in our BAME / mainly Caribbean/Black African communities.

B.   **The Delicate Mind** working with the Muslim community with a focus on managing depression and other mental health problems caused by societal issues in faith communities.

C.   **Birmingham LGBT**, the City's leading charity advocating for, and supporting, our lesbian, gay, bisexual and trans communities.

4.2.3   Positive feedback was received. Participants welcomed the diversity of workshops and appreciated the opportunity to discuss and gain knowledge of the issues not openly discussed. In particular, participants valued the opportunity to discuss the stigma attached to mental health.

4.2.4   The presentations and workshops highlighted the need for an emphasis on *'intersectionality'* with different groups and in particular for the need to work together enable culturally informed and competent services to develop to prevent inequality and disengagement with services. The CMHC will be taking this line of action forward over the coming year.

4.2.5   The next CMHC Workshop will be in July 2020 and the focus will be on 'Disability and Mental Health'.

4.3   Birmingham Suicide Prevention Strategy

4.3.1   The Birmingham Suicide Prevention Strategy has been ratified by Full Council. The strategy supports action by bringing together knowledge about groups at higher risk of suicide, applying evidence through effective interventions and recognises the autonomy of local organisations to decide

what will work best in Birmingham with its ambition for zero suicides.

4.3.2   Suicide is preventable. The latest figures for Birmingham indicate suicide rates are significantly lower than the England average and the lowest of the Core City's. But there is no room for complacency and at a time when we have economic pressures on the general population, we need to take specific actions, as outlined on the strategy.

4.3.3   The Birmingham Suicide Prevention Strategy has been co-produced with high profile partners like the Coroner, Network Rail, NHS, Police, voluntary, community, business and academic sectors of the City and with the support of Public Health England and NHS England. It is sits alongside national strategy and informed and based on a combination of local and national evidence and data.

4.3.4   The strategy sets out a series of key priorities for action across the partnership under six core area: -

- Reducing the risk of suicide in high risk groups
- Improving mental health in specific groups
- Reducing the means of suicide
- Providing better information and support to those bereaved or affected by suicide
- Support the media in developing sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

4.3.5   The Birmingham Suicide Prevention Strategy was formally approved through the Health and Wellbeing Board. Full Council agreed the Strategy on the 06/11/2019; support was received from elected members across all parties to support the delivery of the strategy moving forward.

4.3.6   The Advisory Group chaired by BCC is multi-agency and reports to the CMHC Forum and will oversee the delivery of the collaborative action plan to deliver the Birmingham Suicide Prevention Strategy.

4.3.7   It last met on the 10/02/2020 and meets bi-monthly. It focuses on Regional and National updates and feedback on assigned actions from a wide range of partners including Network Rail, Birmingham and Solihull Women's Aid, NHS Birmingham and Solihull Clinical Commissioning Trust and Common Unity.

4.3.8   The Advisory Group has developed an Action Plan for delivery of the strategy.

4.4   Polish and Eastern European Communities.

4.4.1   In Birmingham, in addition to the nationally recognised high-risk groups, the data shows that we have a high risk of suicides amongst individuals working in skilled trades like construction and amongst citizens born in Poland and Eastern European countries.

4.4.2   To better understand this, work is underway with Polish and Eastern European communities, and the groups that are most engaged with them, as

well as with service providers to ensure mental health and wellbeing services are culturally appropriate/sensitive.

4.4.3   During October 2019 an 'Expression of Interest' (EOI) was submitted to the Local Government Association (LGA) as an offer for bespoke support from the national programme team for up to 12 councils and partners, who self-identified as facing significant delivery challenges around suicide prevention was on offer. The submission was successful; Birmingham was one of the Councils selected.

4.4.4   The EOI expressed a strong desire of the sub-committee of the CMHC Forum to help organisations from across the City understand our Polish and Eastern European citizens perspectives on suicide, self-harm and mental health. These are important issues for the City given that these communities are overrepresented in local suicide statistics.

4.4.5   LGA expert assistance with delivering the half day workshop with the City and partners on 26th February 2020 was greatly appreciated. The LGA funded the venue, offered expert advice with preparing for the event and facilitated on the day. Other expert guest speakers were CEO from the Polish Ex-Pats Society and the Slovak-Club who are both really interested in attending.

4.4.6   A bespoke Action Plan will be produced in relation to the local Polish & Eastern European Communities, addressing and taking forward opportunities and challenges in suicide prevention, self-harm and mental wellbeing in a sensitive and culturally beneficial way.

4.4.7   The CMHC Forum is keen to build good working relations with Warsaw in Poland. A telephone conference is to be arranged; to discuss concerns, documents and ambitions. Progress to date with Birmingham's ambition to be a mentally healthy City with zero suicide will be shared as Warsaw, as they are hoping to be able to undertake similar programmes with their stakeholders and communities.

4.5   **Prevention Concordat for Better Mental Health.**

4.5.1   The Creating a Mentally Healthy City Forum's has identified as a priority that Birmingham will develop a local response and formally submit a fully supported Prevention Concordat for Better Health.

4.5.2   The Prevention Concordat for Better Mental Health is the guiding principle that supports improvement in mental health and wellbeing, promotes good mental and physical health and reduces inequalities by working with a range of organisation in the public and private sectors, voluntary organisations, and communities and includes:

- Promoting good mental health and wellbeing across the City's population
- Working with partners in preventing the growth and increase of mental health
- Preventing suicide, and improving mental health and wellbeing

4.5.3 The purpose is to highlight that Birmingham City Council is working collaboratively with statutory partners, Third, Voluntary, and Faith organisations, towards making the City a place where everyone can enjoy good mental and physical heath, citizens can live independent and active lives, and children can have the best start in life with clear pathways to achieving success and realising their full potential. A City where people can make positive choices and take control of their wellbeing.

4.6   Next Steps / Delivery

The Creating a Mentally Healthy Forum is leading with pace in a wide range of areas as follows.

4.6.1   Suicide Prevention

- The Action Plan is progressive and illustrates the solid partnership and shared vision for promoting good mental health and prevention within the City. It will be shared with Elected Members and CMHC Board members as it develops.

- A template has been sent out to all members for them to update which will provide a clear snapshot of current services being provided, to avoid duplication and this will enable the group to update on their actions in a clear and uniform way.

- Real Time Surveillance: A Data Sharing Agreement with the Coroner is in development so that all sudden death information will be released to the Suicide Prevention Advisory Group as soon as it becomes available to enable a responsive intelligence led approach to suicide prevention as well as a cross-partnership approach to bereavement services.

- Two other specific actions to highlight are the City's partnership with Warsaw in Poland to share learning and collaborate on addressing suicide prevention in Polish communities, and the Council securing support from the Association of Directors of Public Health and the Local Government Association to accelerate this work through an expert lead work shop and developing specific Action Plan.

4.6.2   Seldom Heard Voices

- Tenders will be sought to host various focus groups – one will focus specifically on suicide prevention and mental wellness in Polish & Eastern European Communities.

4.6.3   Concordat for Better Mental Health

- The Draft Prevention Concordat for Better Mental Health is to be presented, at the earliest opportunity to Birmingham City Council's Cabinet.

- The Prevention Concordat endorsed by all working partners in CMHC Forum, by signing a Pledge to work together as soon as it has been

approved.

- The Prevention Concordat will be launched after sign-off and a Strategic Plan will be drawn up to reflect the Concordat as a working document.

4.7   In Summary:

4.7.1   Stakeholders of the Creating a Mentally Healthy City Forum and its sub-committee the Suicide Prevention Advisory Group have agreed to commit to prioritising making Birmingham a mentally healthy city and improve specific aspects of citizens mental health.

4.7.2   The CMHC Forum will oversee and support the development and delivery of the strategic action plan/framework to deliver a measurable impact upon citizens in Birmingham by 2020 and regularly brief the Health and Wellbeing Board on progress.

4.7.3   A collaborative and whole system approach is being taken to support every citizen to thrive, have a sense of self, hope, connection and wellbeing.

4.7.4   Birmingham is committed to becoming a City where everyone can enjoy good mental and physical health. A place where people can make positive choices and take personal control of their wellbeing and flourish to the best of their ability.

---

5.   Compliance Issues

5.1   HWBB Forum Responsibility and Board Update

5.1.1   A bi-monthly update brief to be provided to the Health and Wellbeing Board on progress to ensure steady progress and any issue or risks highlighted that may hinder required outputs and outcomes.

5.1.2   An annual progress delivery Report will be presented on activities of the Forum to the Health and Wellbeing Board and Full Council, at their request, on the progress regarding the Suicide Prevention Action Plan.

5.2   Management Responsibility

Mo Phillips. Lead: 'People'
Wider Determinants of Health and Wellbeing. Birmingham Public Health

6.	Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**	
Stakeholders/partners fail to deliver on their assigned Actions	Medium	Medium	Robust monitoring and reporting mechanisms to ensure collaborate working to promote positive workable solutions specific to creating a mentally healthy city and suicide prevention.	

Appendices

Appendix 1 - Terms of Reference Creating a Mentally Healthy City Forum.

Appendix 2 - Suicide Prevention Strategy

Appendix 3 - Draft Mental Health Concordat

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

Mo Phillips   -   Service Manager: Lead 'People' Public Health
Elizabeth Griffiths   -   Assistant Director of Public Health

TERMS OF REFERENCE

Creating a Mentally Healthy City Forum

1. PURPOSE

1.1 The 'Creating a Mentally Healthy City' Forum is a sub-committee of the statutory Health and Wellbeing Board. This Forum will focus on developing a public health approach to mental health and wellbeing in the City, delivering the Public Mental Health Compact, and evolving an evidence-based approach to mental wellbeing that supports every citizen to thrive.

1.2 The 'Creating A Mentally Healthy City' Forum will provide a link between the Health and Wellbeing Board and the NHS Mental Health Pathways Programme Board and NHS Mental Health Partnership Stakeholder Board.

1.3 Its purpose is to enable local partnership between the Local Authority, NHS, third and voluntary sector organisations, Faith Groups, the business community, and the wider Public Health sector. These organisations will work as a collective to deliver specific characteristics of the Health and Wellbeing priorities for Birmingham - namely Mental Wellbeing and Mental Wellness.

2. OBJECTIVES

The overarching objectives of this sub-group, 'Creating a Mentally Healthy City', are:

2.1 To agree an Action Plan/Framework that will be the focus of the sub-group, enabling the measurement of impact and improvement in local communities in relation to prevention, and the promotion of mental wellbeing by 2020

2.2 To work in partnership to implement the evidence-based approaches which create positive mental health and wellbeing, working upstream to increase mental wellness and reduce the need for clinical interventions

2.3 To provide a strategic direction and seek alignment with the work being undertaken through a range of other relevant work programmes and Boards

2.4 To contribute to the development of the Joint Strategic Needs Assessment (JSNA)

2.5 To agree the level of partnership engagement that will measure the impact and improvements in how we work in promoting mental wellbeing

2.6 To progress the delivery of a Report on the activities of the Forum to the Health and Wellbeing Board on an annual basis

1

007581/2020

2.7 To promote best practice and sharing of ideas including collaboration that lead to maximising of external funding opportunities

2.8 To collaborate and share local information and intelligence between partners and stakeholders that will lead to better relationships with local communities

3. PRINCIPLES

The Forum expects all partner agencies to:

3.1 Embrace the aims and objectives of the Forum

3.2 Consult and/or inform the Forum over organisational changes (including any changes in representation) that may impact on collective working

3.3 Follow and work within the performance management framework agreed by Forum partners

3.4 Proactively manage risk and acknowledge the principle of shared risk in the context of partnership working

3.5 Own the health and wellbeing inequalities agenda through promoting and driving service transformation and improvement within their respective services and organisations

3.6 Report on progress on mutually agreed actions

.

3.7 Share relevant information and promote collaborative and innovative work

4. MEMBERSHIP

The Chair of the Board will be the Birmingham City Council Cabinet Member with a portfolio for Health

4.1 The Forum will have a core group of organisations that will play a key role and will have the responsibility to improve the specific aspects/focus of the Forum in relationship to the health and wellbeing of the population of Birmingham.

4.2 Forum Members will have the responsibility for communicating the Group's business through their respective organisation communication channels

4.3 Each Lead Officer will have responsibility for specific theme areas and items in the Forum Action Plan and to report on these to the sub-committee

2

4.4　Membership will be continuously reviewed, and the Forum reserves the right to co-opt individuals for specific areas as necessary provided that:

(a)　any such new member can demonstrate to the satisfaction of the Forum the contribution that they can make to the overriding aims and objectives; and

(b)　in deciding whether to admit any such new member the Board shall have regard to the resulting size and composition of the Board were the new member to be admitted

4.5　If a member of the group misses three consecutive meeting without giving notice their membership on the sub-committee will be reviewed

4.6　The Forum requires its members to:

4.6.1　Have the authority to make decisions on behalf of their organisation in relation to mental wellbeing, or to be able to seek and secure decisions within a given timescale as agreed by the Forum

4.6.2　Attend all meetings or, in exceptional circumstances, to arrange for a suitable named delegate to attend as a representative. Delegated representative should be suitably briefed prior to the meeting and have the authority to make decisions in the same capacity as a core member

4.6.3　Have responsibility for representing the views of their nominating organisations and keep their nominating organisation apprised of any actions taken, and decisions and progress made by the Forum

4.6.4　Ensure that actions on delivery and progress are carried out promptly on any actions and strategies agreed by the Forum

4.6.7　Have positive and constructive discussions in order to achieve workable solutions to common issues

Other persons may attend meetings of the Board with the agreement of the Chair and/or Deputy Chair

The core membership of the Forum can be seen at APPENDIX A.

Membership list of other invited participants can be seen at APPENDIX B:

3

5. MEETINGS AND WORKING ARRANGEMENTS

5.1   The Forum will meet every two months scheduled for two hours. Additional meetings may be held as necessary at the discretion of the Chair should commissioning decisions drive the Agenda

5.2   Chairing arrangements will be agreed by the Chair of the Health and Wellbeing Board

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

5.4   Action Notes of all meetings of the Forum (including a record of attendance and any conflict of interest) will be approved and circulated within 10 working days before the next meeting

5.5   The Forum administrative support will be provided by the Public Health Division and will have responsibility for arranging meetings, note-taking, and disseminating supporting information to the Forum Members

5.6   The Forum will be monitored and accountable to the Health and Wellbeing Board through the agreed reporting arrangements

5.7   Forum Members will be requested to contribute to a Forward Plan that will be used to develop the Agenda for the meeting

5.8   The Forum may establish a 'Task and Finish' Group as agreed by the Forum Co-Chairs

6.   DECISIONS

6.1   Recommendations and decisions will be arrived at by consensus and these will be recorded in the action notes and on the Action Log.

7.   CONFLICTS OF INTEREST

7.1   If a representative has a conflict of interest in a matter to be decided at a meeting of the Forum, the representative concerned shall declare such interest at or before discussions begin on the matter. The Chair shall ask for this conflict to be recorded in the actions notes and unless otherwise agreed by the Forum that representative shall take no part in the decision-making process.

8. REVIEW

8.1 These Terms of Reference will be reviewed annually for updating purpose and to express the views of relevant partner agencies.

5

APPENDIX A:

Core Membership

	NAME	ROLE/ORGANISATION
Chair	Cllr Paulette Hamilton	Cabinet Member for Health and Social Care, Birmingham City Council
Deputy Chair	Dr Justin Varney	Director of Public Health, Birmingham City Council
Public Health Technical Advisor	Mo Phillips	Service Manager, Wider Determinants of Health and Wellbeing, Public Health, Birmingham City Council
NHS Commissioner Representative	Joanne Carney	Associate Director Joint Commissioning, Birmingham and Solihull Clinical Commissioning Group
Academic Representative	Dr Adam Benkwitz	Head of Sport and Health, and Social Care, Newman University
	Dr Karen Newbigging	Director of Impact & Knowledge Exchange; Lecturer Health Service Management Centre; and Director of Institute for Mental Health UoB
BVSC Representative	Helen Wadley	Chief Executive Officer, Birmingham MIND
Schools Forum	Bev Mabey	Washwood Heath Multi Academy Trust

6

APPENDIX B:

Other Essential Members

	NAME	ROLE/ORGANISATION
BCC	Cllr Diane Donaldson	Local Councillor
BCC	Cllr Mick Brown	Local Councillor
Strategic Collaborative Partner	Dr Yasmin Akram	Consultant in Public Health, West Midlands Combined Authority
NHJS Provider	Salma Yaqoob	Birmingham & Solihull Mental Health NHS Foundation Trust
NHS Commissioner	Paul Russell	Sandwell and West Birmingham CCG
NHS Provider	Elizabeth England	Sandwell and West Birmingham CCG
Birmingham Voluntary Sector	Joy Doal	Anawim – Women Working Together
Birmingham Voluntary Sector	Launa Brooks	PAPYRUS
Strategic Partner Public Health England	Paul Sanderson	Health and Wellbeing Programme Lead
Police and Crime Commissioner's Office	Carl Binns	Policy, Health and Wellbeing
Faith Group	Dr Peter Rookes	BCF Faiths Promoting Health and Wellbeing
Birmingham Children's Trust	Dawn Roberts	Assistant Director
Birmingham City Council	Anju Dhir	Culture Change, Organisational Development - HR
Birmingham City Council	Kalvinder Kohli	Commissioning Adult Social Care

7

BIRMINGHAM SUICIDE PREVENTION STRATEGY

2019-2024

4

007581/2020

CONTENTS

2

EXECUTIVE SUMMARY

Death through suicide reflects the ultimate loss of hope and leaves a significant and lasting impact on families, communities, employers and society.

Prevention suicide requires partnership working across the breadth of society and building on the 2012 national strategy this strategy has been developed through a co-production partnership between the Council and a wide range of organisations as a shared approach to reducing deaths through suicide.

Although in Birmingham the rate of suicide is low compared to other cities, and the national rates, there is a shared ambition to maintain the lowest rate of suicide of any of the core cities in England and continue to reduce deaths through suicide in the City over the next decade through a Zero Suicide approach.

The Birmingham Suicide Prevention Strategy is a co-produced strategy that sits alongside national strategy and is based on a combination of local and national evidence and data. In Birmingham in addition to the nationally recognized high risk groups we also have higher rates of suicide among individuals working in skilled trade occupations like construction and among citizens born in Poland and Eastern European countries.

The Strategy sets out a series of key priority areas for action across the partnership under six core areas:

Reducing the risk of suicide in high-risk groups

Improving mental health in specific groups

Reducing access to means of suicide

Provide better information and support to those bereaved or affected by suicide

Support the media in delivering sensitive approaches to suicide and suicidal behaviour

Support research, data collection and monitoring

The Birmingham Suicide Prevention Working Party that will be the driving partnership group that will enable and oversee delivery of the action plan that underpins these priorities and will report into the Health and Wellbeing Board through the Director of Public Health.

We are confident through the shared action of partners, communities and citizens Birmingham will achieve its ambition to reduce the rate of suicide in the city to zero.

BIRMINGHAM
WORKING TOWARDS A SUICIDE FREE CITY

THE NATIONAL PICTURE

In 2017 there were **5,821** suicides registered in the UK, an age standardised rate of **10.1** deaths per 100,000

Male Suicide Rate
15.5 deaths per 100,000

Female Suicide Rate
4.9 deaths per 100,000

AGE SPECIFIC RATES

24.8 Age 45-49 — The highest age specific suicides rates within these age groups — **6.8** Age 50-54
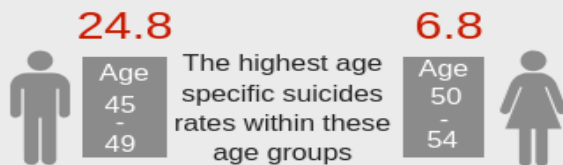
ACCESS TO SERVICES

two thirds of people who die through suicide have been in contact with Services

one third of people have had no contact - **young men** are the most likely to be among this third.

THE LOCAL PICTURE

In 2015/17 there were **205** suicides registered in Birmingham, which equates to **70** deaths per year

Male Suicide Rate
11.3 deaths per 100,000

Female Suicide Rate
4.1 deaths per 100,000

53% of suicides in Birmingham over the last 10 years have taken place in the **home**

76% of suicides in Birmingham are men

residents born in **Poland** and **Eastern Europe** have a higher rate of suicide.

30.5 deaths per 10,000 occur in the **Skilled Trades Occupations** **42,000** people in Birmingham work in this sector

3,700 mental health in-patient admissions during 2017/18

AT RISK & VULNERABLE

Men have a... **3x** greater risk of suicide than women

4.7 households per 1,000 households are in temporary accommodation

Self-harm is the single biggest indicator of suicide risk

in Birmingham **1,977** individuals presented to A&E with self-harm in 2017/18

Nationally... **45%** of suicides involved patients with a history of alcohol misuse and **33%** had a history of drug misuse.

There is growing evidence of increased rates of mental health problems, self-harm, and suicidal thoughts among **LGBT** people.

4

INTRODUCTION

Every suicide is one too many.

The death of someone by suicide has devastating effects on families, friends, workplaces and communities. For each person that dies this way at least 10 people are affected and only 1 in 3 who take their life are known to Mental Health Services[1].

Suicide is one of the leading causes of years of life lost (YLL)[2]; in Birmingham as well as across England and in terms of absolute numbers suicide is 4th highest cause of YLL (2014-2016), behind infant mortality, coronary heart disease and lung cancer.

There is an associated economic cost and the average cost per suicide for those of working age is £1.7 million in England[3], which includes intangible costs (loss of life to the individual, the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and funerals[4]. But above all, suicide is preventable and by working together we can reduce this tragic loss of life and provide better support for those left behind.

In 2012, the UK Government published a national strategy 'Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives' which set out overall objectives of:

•   A reduction in suicide rate in the general population in England

•   Better support for those bereaved or affected by suicide

The Birmingham Suicide Prevention Strategy builds on this to set out priorities for action and a shared ambition for the city to reduce deaths through suicide, as part of our wider ambition to become a mentally healthy city.

The Strategy is a collaboration between organisations, communities and citizens to take collective and individual action over the next five years to significantly reduce the rate of suicide in the city, address inequalities in suicide by focusing on those in highest risk groups, and improve care and support for those affected by suicide.

---

[1] Local Suicide Prevention Planning
[2] Preventing Suicide in England: a cross-government outcomes strategy to save lives 2012:
https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england
[3]No health without mental health: A cross-Government mental health outcomes strategy for people of all ages
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215808/dh_123993.pdf.
[4] Knapp, Martin and McDaid, David and Parsonage, Michael (2011) Mental health promotion and mental illness prevention: the economic case. 15972. Department of Health, London, UK.

5

CONTEXT OF SUICIDE AND SUICIDE PREVENTON

The context of suicide and suicide prevention is set out in terms of policy at local and national levels as well as the picture from the data and research nationally and the evidence from cities.

Policy Context

The Five Year Forward View for Mental Health set the ambition that by 2020/21 the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels. This included development and delivery of local multi-agency suicide prevention plans.

In 2012 the Department of Health released its national suicide prevention strategy Preventing Suicide in England. The National Strategy identified six key areas for action to support delivery of objectives. These six areas provide the themes for our local approach and are being used as the basis for the Birmingham suicide prevention action plan which accompanies this strategy.

The NHS Long Term Plan [5] contains suicide prevention & reduction ambitions including the following;

- Suicide reduction will remain a NHS priority
- Full coverage across the country of the existing suicide reduction programme
- Design and roll out of a Mental Health Safety Improvement Programme with a focus on suicide prevention and reduction for mental health inpatients
- Use of decision support tools to increase our ability to deliver personalised care and predict future behaviour, such as risk of self-harm or suicide.
- Bereavement support for families and staff bereaved by suicide , who are likely to have experienced extreme trauma and are at heightened risk of crisis themselves, which will be rolled out to all areas of the country.
- A new approach to the longer term management of self-harm

There have been a number of other national publications to support this strategy; such as:

- Preventing suicide in England: Third progress report (2017)[6]
- Public Health England's Local suicide prevention planning practical resource (2016)[7]

---

[5] https://www.longtermplan.nhs.uk/online-version/
[6] Department of Health (England). Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives. 2017.
[7] Public Health England Local suicide prevention planning: A Practice resource:
https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan

6

- National Confidential Inquiry into Suicide and Homicide Report: Suicide by children and young people (2017) [8]
- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2017) [9]
- Public Health England: Support after a suicide: A guide to providing local services: National Suicide Prevention Alliance (2017)[10]

These publications, alongside stakeholder engagement and the local data have informed the development of this strategy. This local strategy will in time align with the wider action plan to support a Mentally Healthy City and the Health Inequalities Framework for Birmingham which will be developed over 2019/20.

---

[8] Suicide by children and young people in England. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2017.
[9]The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report: England, Northern Ireland, Scotland and Wales.
October 2017. University of Manchester
[10] Public Health England: Support after a suicide: A guide to providing local services: National Suicide Prevention Alliance
https://www.gov.uk/government/publications/support-after-a-suicide-a-guide-to-providing-local-services

7

The Picture of Suicide

The picture of suicide in England is limited because the data is drawn from death certification.

For many years the coroner has had to be certain beyond reasonable doubt that the death was through suicide before confirming this on the death certificate, this has probably led to an under-estimate of the scale of suicide. However in 2017/18 the guidance for coroners changed to allow 'death through suicide' to be based on reasonable judgement and this is likely to see an increase in the number of deaths attributed to suicide.

It is important to also recognise that although there may be a link between self-harm and suicide, the data on self-harm reflects a larger group of people, some of who have no intention of dying.

The National Picture

Suicides have seen an overall decreasing trend since time series began. However male suicides remain significantly higher than females. Suicide rates are higher among specific groups of occupation as well as specific population groups such as lesbian, gay, bisexual and trans people, ethnic minority people and refugee and asylum seekers.

The highest rates regionally are seen in the North of England. With the West Midlands close to the England average. The lowest rates are in London.

In 2017[11] there were 5,821 suicides registered in the UK, an age-standardised rate of 10.1 deaths per 100,000 population. The UK male suicide rate of 15.5 deaths per 100,000 was the lowest since time-series began in 1981; for females, the UK rate was 4.9 deaths per 100,000, this remains consistent with the rates seen in the last 10 years. Males accounted for three-quarters of suicides registered in 2017 (4,382 deaths), which has been the case since the mid-1990s. Suicide is currently the most significant cause of death among Males below the age of 50 and young people aged 5 to19[12].

The highest age-specific suicide rate was 24.8 deaths per 100,000 among males aged 45 to 49 years; for females, the age group with the highest rate was 50 to 54 years, at 6.8 deaths per 100,000.

A third of people who die through suicide have been in contact with mental health services before their death, a further third have been in contact with primary care

---

[11]https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2017registrations
[12] ONS: Deaths Registered in England and Wales (series DR): 2017

8

services but the remaining third have had no contact with services. Young men are the most likely to be among the third with no contact with services before their death. In 2017 hanging or strangulation was the most common method for suicide followed by poisoning.

Data is lacking on how many suicide attempts are among those previously bereaved by suicide, but research suggests around 1 in 10 bereaved people have made an attempt[13].

Non-fatal self-harm is one the strongest risk factors for subsequent suicide. The data on self-harm is based on clinical data from presentation to healthcare services, so is likely to be an underestimate of the actual number of people affected. Evidence suggests that the UK has one of the highest rates of self-harm in Europe[14] and for all age groups the annual prevalence is approximately 0.5%[15] of the population experience self-harm.

Self-harm is most common among young people with the highest rates of hospital admissions due to self-harm in the 15-19 age group. (648.6 admissions per 100,000 in 2017/18[16]).

Research also shows us that girls are twice as likely to self-harm than boys[17] and admission rates for girls almost doubled in two decades, from 7,327 in 1997 to 13,463 in 2017.

---

[13] Pitman AL, Osborn DP, Rantell K, King MB. Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults. BMJ open. 2016 Jan 1;6(1):e009948.

[14] Horrocks, J., House, A. & Owens, D. (2002). Attendances in the accident and emergency department following self-harm; a descriptive study. University of Leeds, Academic Unit of Psychiatry and Behavioural Sciences.

[15] NICE (2003). "Self-harm in over 8s: long term management." Clinical Guideline 133. Available at: https://www.nice.org.uk/guidance/cg133/resources/selfharm-in-over-8s-longterm-management-35109508689349

[16]https://fingertips.phe.org.uk/search/self%20harm#page/3/gid/1/pat/6/par/E12000005/ati/102/are/E08000025/iid/92796/age/6/sex/4

[17] Morgan C, Webb RT, Carr MJ, Kontopantelis E, Green J, Chew-Graham CA, Kapur N, Ashcroft DM. Incidence, clinical management, and mortality risk following self harm among children and adolescents: cohort study in primary care. bmj. 2017 Oct 18;359:j4351.

9

The Local Picture

The latest figures in Birmingham indicate the suicide rate to be significantly lower than the England average[18].(fig 1)

The number of death registrations for suicide and injuries of undetermined intent in 2015-17 was 205[19] which equates to around 70 per year. Rates for Birmingham are similar to some of nearest statistical neighbours[20], but lower than most.

Fig 1: Age standardised rate of suicide (all persons) per 100,000 population 2015-17 (3yr average) Source: PHE Fingertips
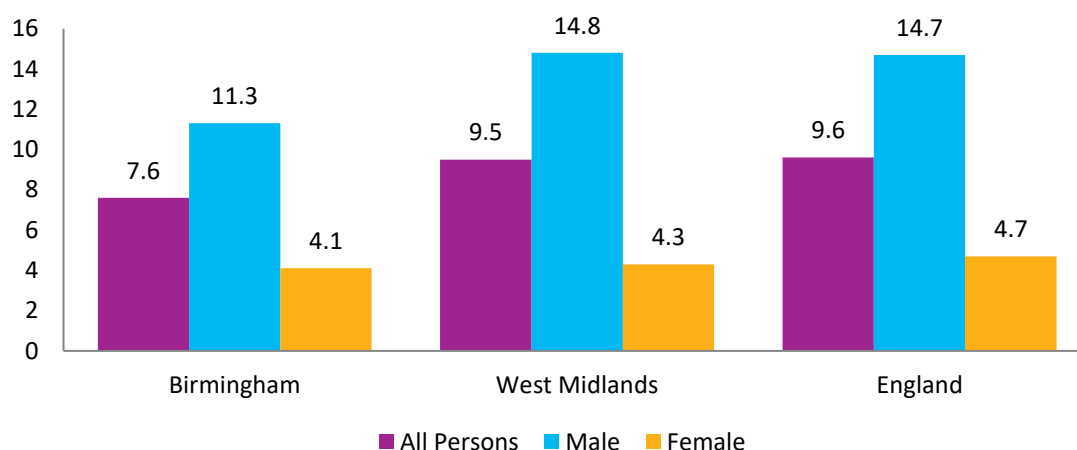
There has been some fluctuation in the 3 year rate for Birmingham as in 2014 due to a backlog of coroners cases being processed within a single year, however this has now rebalanced and the current trend is in line with the previous 3yr rate.

Compared to the rest of the West Midlands, Core cities group and the CIPFA comparator group, the 3 year rate of suicide in the city is one of the lowest, (fig 2). However it is important to note that because of the size of the city the overall count of suicides across the three years is second highest and in one year, on average, there are more deaths through suicide in Birmingham than across the whole three year period in Solihull.

Fig 2: Comparison map and table of Age standardised rate of suicide (all persons) per 100,000 population 2015-2017 (3yr average) across the West Midlands region

---

[18] https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/0/gid/1938132828/pat/6/par/E12000005/ati/102/are/E08000025

[19] Public Health Outcomes Framework indicator 4.10.

[20] CIPFA nearest neighbours - https://www.cipfa.org/policy-and-guidance/publications/n/nearest-neighbour-model-england

10

Map of County & UAs in England for Suicide: Age-standardised rate per 100,000 population (3 year average) (Persons) (Directly standardised rate - per 100,000 2015- 17)
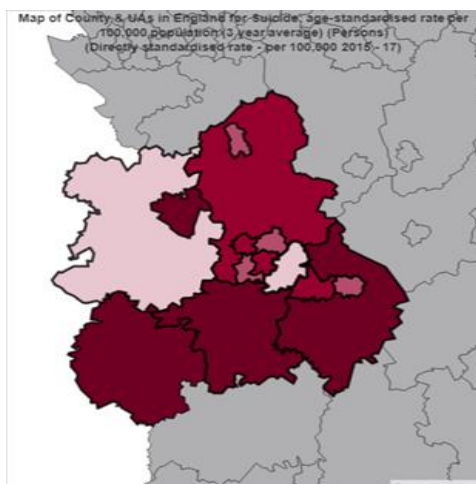
	Count	Rate
Birmingham	205	7.6
Shropshire	67	8.0
Coventry	76	8.8
Walsall	65	9.1
Dudley	77	9.4
Solihull	52	9.5
Staffordshire	225	9.7
Wolverhampton	66	9.9
Sandwell	86	10.4
Worcestershire	165	10.8
Warwickshire	169	11.3
Herefordshire	59	11.7

Source: Fingertips, Public Health England

Compared to the Core Cities group Birmingham currently has the lowest rate of suicide and across the CIPFA comparison group (a group of demographically matched areas) the 3yr rate of suicide in the city is one of the lowest, (fig 3).

Fig 3: Comparison tables of Age standardised rate of suicide (all persons) per 100,000 population 2015-2017 (3yr average) across the Core Cities and the CIPFA nearest neighbours group for Birmingham

	Rate
Core City Average	**11.8**
Leeds	11.8
Bristol	10.6
Liverpool	9.9
Manchester	9.3
Nottingham	9.2
Sheffield	7.7
Birmingham	**7.6**

	Rate		Rate
CIPFA Average	**10.8**		
Salford	12.3	Nottingham	9.2
Bolton	11.9	Walsall	9.1
Leeds	11.8	Bradford	9.0
Bristol	10.6	Leicester	8.9
Sandwell	10.4	Coventry	8.8
Liverpool	9.9	Sheffield	7.7
Wolverhampton	9.9	**Birmingham**	**7.6**
Kirklees	9.4	Derby	7.3

Public Health England's suicide prevention profile[18] highlights that Birmingham has high levels of some of the recognised risk factors for suicide but despite this has lower overall rates of suicide than other areas in the West Midlands and Core Cities.

Fig 4: Some of the Suicide Prevention Risk Factors - Birmingham

MARITAL BREAK DOWN

12.5% of adults are living in single person housholds
(2011)

LOW HAPPINESS SCORE

8.8% of adults have a low happiness score

4.1% report a low level of life satisfaction

19.0% report a high anxiety score
(2017/18)

CRIME & VIOLENCE

6.4 young people (10-18yrs) per 1,000 in the youth justice system

24.2 domestic abuse-related crimes and incidents per 1,000 adults recorded by the police

(2017/18)

SEVERE MENTAL ILLNESS

1.19% of GP patients have a severe mental health illness
(2017/18)

HOMELESSNESS

4.7 households per 1,000 households in Birmingham are in temporary accommodation (17/18)

MARITAL BREAK DOWN

10.7% of adults are divorced or separated
(2011)

SOURCE: PHE SUICIDE FINGERTIPS TOOL

When we explore the detail of the deaths through suicide in Birmingham it highlights some important differences:

12

- 76% of suicides in Birmingham are men and they most commonly occur in ages 30-49, for women the largest age group is 40-49. (fig 5)

- Birmingham residents born in Poland and Eastern Europe have a higher rate of suicide compared to people born in the UK; however this may not account for recent migration trends and is likely to be a reflection of the larger numbers of working age males in the denominator population. (fig 6)

- 53% of suicides in the last 10 years have taken place at home. Other common locations were other residential properties (6%), public green spaces (4%), canals or rivers (4%), railways (4%). Hospitals were recorded as place of death in 16% of suicides, with no further information on where the suicide took place

  Methods of suicide were similar to national rates, with hanging or suffocation accounting for 63% of male and 44% of female suicides since 2007; poisoning was more common for females than males (31% vs 15%)

- Similar to national patterns, occupations with higher numbers of suicides in Birmingham were skilled trades, process plant and machine operatives and elementary occupations. (fig 7)

- Nationally, students had a lower rate of suicides than the general population. This appears to also be true for Birmingham according to local analysis

Figure 5: Population pyramid showing age and sex distribution of deaths due to suicide and undermined injury, Birmingham residents, 2007-2017
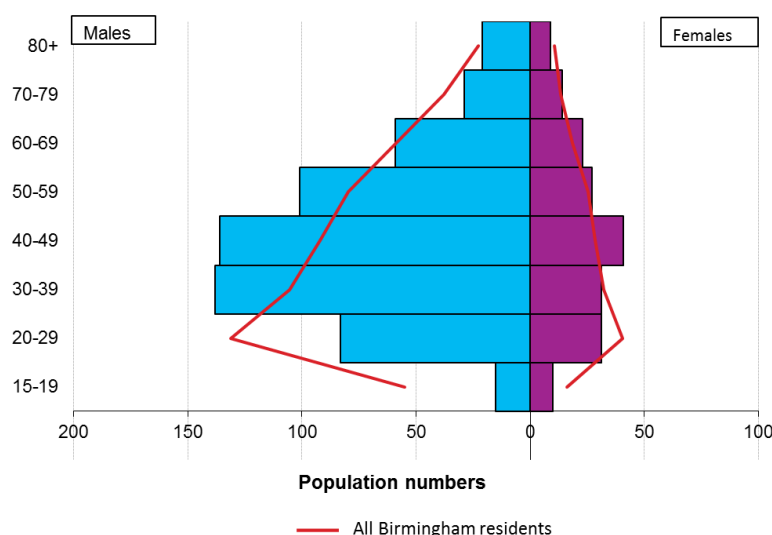
Source: Primary Care Mortality Data, NHS Digital

Figure 6: Crude suicide rate by country of birth, Birmingham residents, 2007-2017
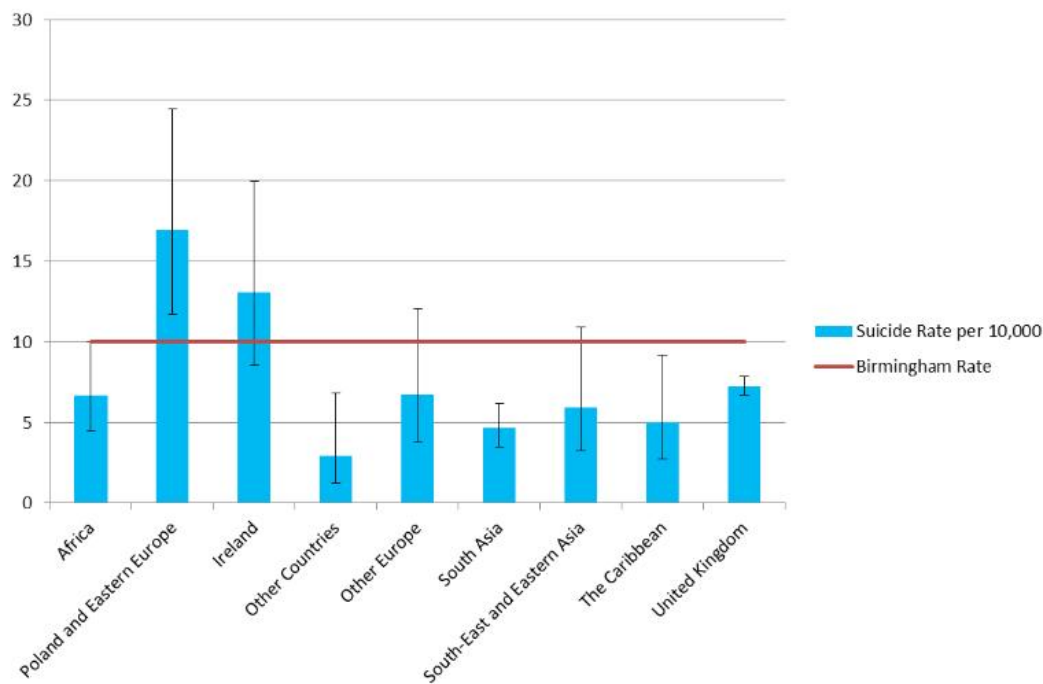
Denominator Source: ONS Detailed Country of Birth Analysis from the 2011 Census

Figure 7: Crude suicide rate by occupation group (males and females), Birmingham residents, 2007-2017
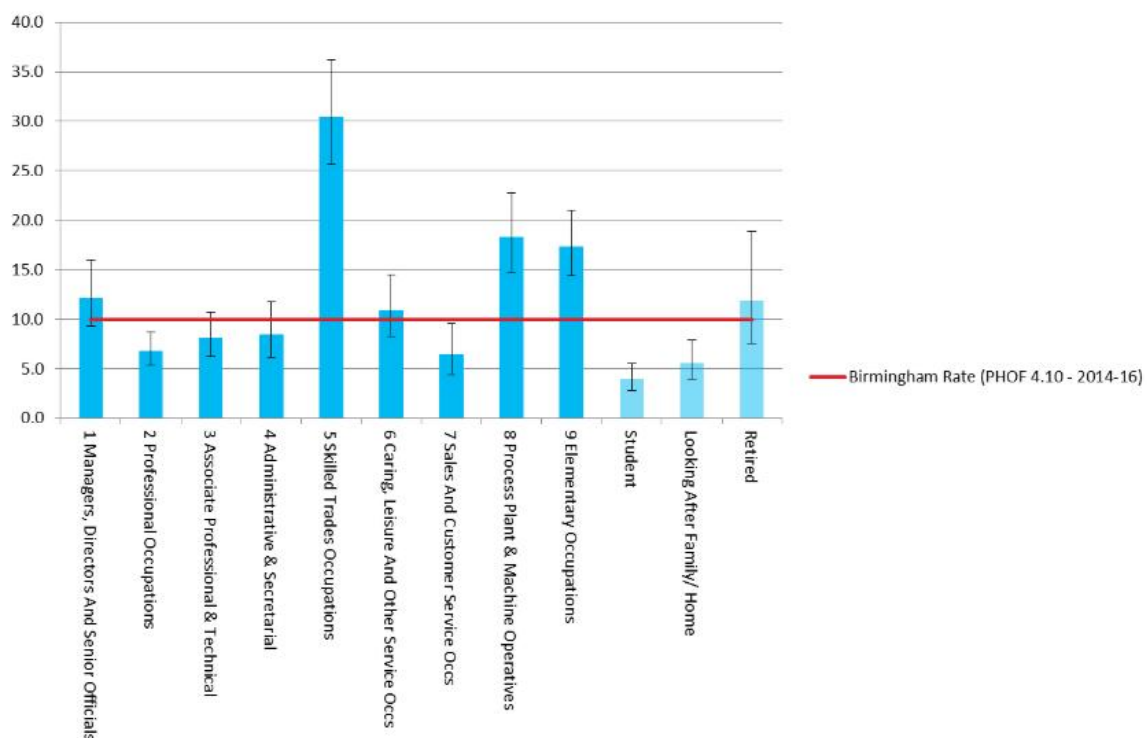
Denominator Source: NOMIS annual population Survey Employment by occupation Apr 17 to Mar 18, and Economic inactivity table
https://www.nomisweb.co.uk/reports/lmp/la/1946157186/report.aspx#tabjobs

14

OUR SUICIDE PREVENTION AMBITION

Our ambition for this strategy is to **maintain the lowest rate of suicide of any of the core cities[21] in England and continue to reduce deaths through suicide in the City over the next decade through a Zero Suicide approach**

We will achieve this ambition through collaboration and working together at every level of the city and in every community, family and workplace, focusing our efforts in six key areas (building on the National Suicide Prevention Strategy):

1. **Reduce the risk of suicide in key high-risk groups**

2. **Tailor approaches to improve mental health in specific groups**

3. **Reduce access to the means of suicide**

4. **Provide better information and support to those bereaved or affected by suicide**

5. **Support the media in delivering sensitive approaches to suicide and suicidal behaviour**

6. **Support research, data collection and monitoring**

We can achieve a step change in suicide prevention and mental wellbeing but only if we all step up to act. It is important that we take action across all six areas simultaneously in order to effect change.

---

[21] Major cities are defined as being the 'Core City Group' reflecting the largest cities in England. This allows us to benchmark progress against comparable populations and urban context.

OUR PRIORITIES

Priority One: Reduce the risk of suicide in key high-risk groups

The inclusion of specific high risk groups within this strategy is underpinned by findings of the National Confidential Inquiry[22], National Strategy and local intelligence.

- **Men**

  Men have a 3 times greater risk of suicide than women, in Birmingham this risk is highest among working age men between 30-49yrs.

  In Birmingham there are an estimated 414,319 men[23], the current 3yr average rate of suicide in men in the city is 11.3/100,000, meaning over the last three years and estimated 47 men have died through suicide.

  Men are a large and diverse group of the population. However focusing on raising awareness of mental health issues and suicide amongst men and reducing the stigma on men talking about their mental health can be effective interventions.

- **People with a history of self-harm**

  Self-harm, including attempted suicide, is the single biggest indicator of suicide risk.

  In Birmingham in 2017/18 1,977 individuals presented to A&E with self-harm.

  There is already NICE guidance on the treatment of self-harm which includes psychosocial assessment and mental health liaison support in the emergency department. Psychiatric Liaison service is specialist multidisciplinary mental health service, working within all acute hospitals in Birmingham for people that present at A&E.

  Alongside this important provision it is important that clinical commissioners ensure that good local data is driving service improvement to minimise the risk for this group when they present in the emergency department or in primary care.

---

[22] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report: England, Northern Ireland, Scotland and Wales.
[23] ONS Mid-Year population Estimates 2017 – Males aged 18+

16

- **People with alcohol and drug-related problems**

  Nationally 45% of suicides involved patients with a history of alcohol misuse, 33% had a history of drug misuse.

  13.6%[24] of adults in Birmingham are binge drinkers of alcohol, and while this is lower than the national average it still represents approximately 115,469 adults in the city. A further 1.66% are dependent drinkers, approximately 14,094 adults.

  There are around 6,666 individuals in treatment for drug use[25].

  There is existing NICE guidance on dual diagnosis, i.e. substance misuse and mental health issues, and it is important that our drug and alcohol support services and mental health services are working closely together to support individuals and reduce the risk of suicide through the care pathway.

- **People in the Care of Mental Health Services (including in-patients)**

  Around 60-70 inpatients die by suicide per year nationally. Of all patients who died through suicide in the first week after discharge in 2017, the highest number occurred on the second (19%) and third (21%) day.

  There were 3,700 mental health in-patient admissions during 2017/18in Birmingham[26], although some of these represent readmission of the same individuals, each admission is an opportunity to intervene and prevent suicide after discharge.

  The national campaign for all mental health trusts to achieve Zero suicides provides an excellent framework for action and Birmingham Mental Health Trust will need to work with partners across primary and secondary care to achieve this and reduce the risk for in-patients and patients supported by community services.

In addition local data indicates two specific high-risk groups identified by place of birth and occupation:

- **Birmingham residents born in Poland and Eastern Europe**

  According to the last census there were approximately 16,562 Birmingham residents born in Poland and Eastern Europe and this figure is likely to be

---

[24] PHE Local Alcohol Profiles for England
[25] PHE Public Health Profiles : Adults in treatment at specialist drug misuse services
[26] Hospital Episode Statistics (ICD10 codes F00-F99)

higher today. This group has the highest suicide rate by country of Birth and is two thirds higher than the City's population as a whole

By the nature of being a thriving city there is some churn in the population with people moving into the city and leaving the city but there is a growing population who have moved into Birmingham from Poland and Eastern Europe. We need to work with these communities and the groups that are most engaged with them as well as with service providers to ensure mental health and wellbeing services are culturally appropriate.

- **People in skilled trades occupations (e.g. construction industry)**

  In Birmingham the rate of suicide among men and women in skilled trade occupations, like construction, is three times the average for the city.

  It is estimated that 42,000 people in Birmingham work in a skilled trade[27].

  Birmingham is a city with a significant amount of construction and building development, providing jobs for local people as well as attracting transient trades people from outside the city. We have to work with employers, developers and trade professional bodies to raise awareness of suicide and reduce the risks associated with the workplace.

Although these are in many ways broad categories of individuals, by addressing them in a focused way there is likely to be a positive impact on the general mental wellbeing of the city and reduce the risk of suicide.

---

[27] NOMIS Annual Population Survey by SOC2010 2017/18

18

Priority Two: Tailor approaches to improve mental health in specific groups

As well as targeting high-risk groups, another way to reduce suicide is to improve the mental health of the population. For this whole population approach to reach all those who might need it, the national strategy recommends tailored measures to improve the mental health of groups with particular vulnerabilities or problems with access to services.

The groups highlighted in the national strategy are:

- **Children and young people, specifically looked after children, care leavers and children and young people in the youth justice system**

  Children and young people have an important place in the strategy. Too many children are developing poor mental well-being and the risk of suicide is greater when children have mental health issues. Looked after children and care leavers are between four and five times more likely to self-harm in adulthood.

In Birmingham when we focus on the highest risk groups of children and young people, this is the scale of the population in 2017:

> 1,838 Looked after children[28]
> 726 Care Leavers [29]
> 870 Children and young people in the youth justice system

Focusing our efforts on preventing suicide among these children and young people who are at highest risk will have a broader positive impact on the wider population of children and young people.

- **Survivors of abuse or violence, including sexual abuse**

  There is a strong link between individuals experiencing violence and abuse and suicide, which is why it is important that there are coherent and evidence based services of support for people enduring violence and abuse.

  We know from the research into adverse childhood events (ACE) that the impact of abuse, neglect and violence can play out across a lifetime. While there is no routinely collected data on the distribution of those with defined

---

[28] DfE Children Looked After in England Local Authority Tables 2017
[29] DfE Children Looked After in England Local Authority Tables 2017 - Number of children who ceased to be looked after during the year

19

ACES in Childhood, commissioned surveys[30] [31] suggest that almost half (47%) of Adults (aged 18-69) had at least one of these experiences in childhood. In Birmingham this could potentially equate to almost 350,000 adults.

Over 40,000[32] individuals experience domestic abuse in the City and it is important that all of our specialist support services are actively thinking about the mental health and wellbeing of clients.There are also 31,692 people affected by violent crime in the city in 2017/18[33] and as well as considering the physical impact of this violence it is essential that commissioners and service providers address the short and long term psychological impact.

- **Veterans**

In Birmingham there are an estimated 93,000 veterans[34].

The Council and many partner organisations are signatories to the Armed Forces Community Covenant which sets out a commitment to address the needs of veterans and provides an important opportunity to specifically think about the needs of this group of individuals.

- **People living with long-term conditions and disability**

There is a strong evidence of an association between long-term health conditions and poor mental health.

In Birmingham approximately 198,000 people are living with a long-term health condition or disability[35]. Nationally two thirds of people with a long term physical health condition also have a co-morbid mental health problem, mostly anxiety and depression. Therefore we would estimate at least 130,680 people are living with mental health problems and long term health conditions. It is important that we consider the mental health and wellbeing of individuals with long term conditions, especially chronic pain, and clinical and social care professionals are actively talking about mental health issues, especially where physical health is deteriorating.

---

[30] ACEs in Blackburn with Darwin Council –with Liverpool John Moores University 2014 https://www.blackburn.gov.uk/Pages/aces.aspx
[31] Hughes K et al. Relationships between adverse childhood experiences and adult mental well-being: results from an English national household survey. BMC public health. 2016
[32] Birmingham Domestic Abuse Prevention Strategy 2018 – 2023 https://www.birmingham.gov.uk/downloads/file/10086/domestic_abuse_prevention_strategy_2018_-_2023
[33] Police.UK – Reported Violence and Sexual Offences 2017/18 (to September) Extrapolated from published rate using ONS mid-year population data
[34] 2011 Census (ONS) estimates 11% – applied to Birmingham Population
[35] https://www.nomisweb.co.uk/census/2011 (table KS301EW)

20

- **People with untreated depression**

People who have untreated depression are at increased risk of suicide and self-harm and around half of all completed suicides are related to depressive and other mood disorders (ICD-10 F3)[36]. Only around 1 in 3 people with depression receive treatment, and there are inequalities in treatment seeking behaviour and receipt of treatment.[37] With around 55,000[38] adults on the primary care depression registers of Birmingham GPs, there may potentially an additional 110,000 people who are not in receipt of treatment and at higher risk of suicide than those receiving help.

We need to increase awareness of the signs and symptoms of depression and ensure that people are aware of the support available and how to access it themselves or to signpost others.

- **People who are especially vulnerable due to social and economic circumstances**

There are strong links between mental ill-health and social factors like unemployment, debt, social isolation, family breakdown and bereavement. Adults aged between 16 and 59 who live alone for example are significantly more likely to have common mental disorders (CMD) than those who live with others. There are also marked differences in CMD prevalence among labour market cohorts. Using age-standardised figures, the CMD rate in employed people is 15.2% (aged 18-64) compared to 28.8% in the unemployed and 33% among people who are economically inactive[34]. Birmingham's claimant rate is the highest of all of the core cities at 7.3%, and economic data shows around 37,000 are unemployed and seeking work with an additional 217,000 people economically inactive[39] . Between these two cohorts there may be around 82,000 in a vulnerable position suffering with CMD.

We need to work to improve the advice and support available to people who are more vulnerable due to their circumstances. This means delivering mental health support together with practical advice in front line services (such as debt, benefits and housing), with mental health awareness embedded within service delivery.

- **Lesbian, gay, bisexual and transgender people**

---

[36] Bachmann S. Epidemiology of suicide and the psychiatric perspective. International journal of environmental research and public health. 2018 Jul;15(7):1425.

[37] Adult Psychiatric Morbidity Survey 2014: NHS Digital

[38] Quality and Outcomes Framework 2017-18 Recorded Disease Prevalence Table 2: Depression

[39] Economically Inactive – includes full time students, looking after family and those unable to work for health reasons

21

Between 2-5%[40] of the population nationally identify as lesbian, gay, bisexual and/or trans, however data from the GP patient survey in 2017[41] would suggest in Birmingham the figure is between 2.5- 3.9% .

Nationally and internationally there is evidence of increased rates of mental health problems, self-harm and suicidal thoughts among LGBT people, especially LGBT young people[42]. In Birmingham, it is estimated, that between 17,563 and 43,908[43]identify as LGBT based on the national estimates.

Addressing these issues requires action across the whole system and is as much about ensuring that mental health services are accessible and culturally competent to support LGBT people as tackling the discrimination and harassment that add to the burden of mental ill health.

- **Black, Asian and minority ethnic groups**

People from Black, Asian and minority ethnic groups often face cultural stigma around mental health problems and there are inequalities in access to health services. Research suggests that Black Adults for example have the lowest treatment rate of any ethnic group[44] but have higher rates of serious mental illness such as psychosis[45]. There is also evidence that some immigrant groups may be at higher risk of suicide. In a review Non-European immigrant women (including Black African and South Asian) were at the highest risk for suicide attempts. Risk factors among migrants and ethnic minorities were found to be: language barriers, worrying about family back home, and separation from family[46].

42% of the population of Birmingham come from a non-white British ethnic background[47]; in some parts of the city non-white ethnic groups are becoming the majority population, however there remain issues with culturally competent services and issues of stigma and discrimination around mental health within some ethnic minority communities.

We need to work with communities to reduce stigma around mental health and suicide as well as bridge the gap between service providers and communities to ensure individuals in need are able to access support.

---

[40] Annual Population Survey (2017 data), Office for National Statistics
[41] NHS GP Patient Survey (2017). IPSOS Mori. https://gp-patient.co.uk/surveysandreports2017
[42] NIESR Report: Inequality among lesbian, gay bisexual and transgender groups in the UK 2016
[43] Calculated on Birmingham Population 16 and over
[44] Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital
[45] Kirkbride, J et al. Psychoses, ethnicity and socio-economic status. The British Journal of Psychiatry, 2006 193(1), 18–24
[46] Forte A et al. Suicide risk among immigrants and ethnic minorities: a literature overview. International journal of environmental research and public health. 2018
[47] ONS Census 2011: KS201

22

- **Refugees and asylum seekers.**

  People who are refugees and asylum seekers may require additional support as a result of trauma that they may have experienced in their country of origin or during their journey to the UK

  There are approximately 1,800 asylum seekers in Birmingham, though this figure fluctuates during the year being accommodated by the government and awaiting a decision on their asylum claim. This is in addition to people who have already been granted refugee status (or some other leave to remain) and have settled within the City… Support for refugee communities is inconsistent but delivered through a range of voluntary, community and public sector agencies and services.

  The Home Office and its contracted providers (Serco and Migrant Help from September 2019) are responsible for the welfare of asylum seekers they are accommodating and supporting. Once people leave that accommodation those duties come to an end and it is the responsibility of mainstream public sector services to identify, engage with and support refugee communities who may be experiencing crisis or at risk of crisis. Mental health is a consistent concern – including awareness and self-help, cultural sensitivities, visibility in and engagement with the health system, as well as specific and relevant services for refugee communities and it is vital that we maintain this focus.

- **People in Contact with the Criminal Justice System**

  People who come into contact with the criminal justice system are high risk of for suicidal behaviour and self-harm[48] and experience many of the risk factors associated with these behaviours such as mental illness, adverse life events, drug and alcohol misuse and relationship breakdown as well as the effects of incarceration, and adjustment to life after release. We need to ensure an efficient and consistent approach across all partner organisations involved in the Criminal Justice System, to recognise and support poor mental health and other risks.

---

[48] Borschmann R, Young JT, Moran PA, et al. Self-harm in the criminal justice system: A public health opportunity. The Lancet Public Health. 2018 Jan 1;3(1):e10-1.

Priority Three: Reduce access to the means of suicide

Restricting access to the means of suicide is an important component of this strategy. It is a well evidenced and effective area of suicide prevention particularly in cases of impulsive suicide, where if the means are not easily available at the time of crisis the suicidal impulse may pass[49] [50].

The most common methods of suicide in both Birmingham and England are hanging, suffocation and poisoning.

Addressing access requires action at many different levels, including:

- Considering risk of suicide in the planning, design and refurbishment of housing and public spaces and facilities (e.g. car parks) for both new and change of use facilities for vulnerable people near to high risk locations.

- Mapping potential high risk sites through reviewing self-harm data and reports from health and police services and take action to reduce risk e.g. barriers, signage.

- Increase awareness of suicide risk, and steps to intervene, in staff working in high risk areas e.g. park wardens, traffic wardens.

- Reduce the risk of medication stockpiling through safer prescribing practice, especially for patients in high risk groups.

- Support retailers and vendors to consider suicide risk in the sale of potentially fatal gases and liquids.

Reducing access in many ways is one of the simplest steps that we can take but because of the variety of ways in which individuals die through suicide it is an area which requires continual review and collaboration between partners as things progress.

---

[49] Florentine JB and Crane C (2010) Suicide prevention by limiting access to methods: a review of theory and practice. Social Science & Medicine 70(10): 1626–1632
[50] HM Government: Preventing Suicide in England; A cross-government outcomes strategy to save lives

24

Priority Four: Provide better information and support to those bereaved or affected by suicide

For those bereaved by suicide the impact is severe.

Families and friends who are bereaved are at highest risk of mental health problems but it can have also have a profound effect on the local community or on the workplace/school or college where the individual was.

For every life lost at least 10 people are affected, with research suggesting that this could be as high as 135[51] people in need of support. Based on the number of suicides in Birmingham we would estimate that between 700 and 9,500 people affected by suicide are in need of support annually.

There is no national specialist service for those bereaved by suicide in the NHS but there are many charities which provide support and advice to bereaved individuals.

It is important that all organisations in the city think about how they can support individuals who are bereaved, including when that bereavement is through suicide, this includes:

- Employers utilising the evidence based toolkits in suicide post-vention from Public Health England and Business in the Community

- Promoting the 'Help at Hand' resource to relatives when a death occurs alongside the 'Waiting Room Resource Key' to support signposting to help.

- Working between public sector and third sector partners to ensure an appropriate bereavement support service that recognises the specific aspects of death through suicide with consideration of capacity, real time referral and data sharing requirements.

- Considering public awareness campaigns to raise awareness of the support available for individuals affected by a death through suicide.

---

[51] Cerel, Julie, et al. "How many people are exposed to suicide? Not six." Suicide and Life-Threatening Behaviour (2018).

Priority Five: Support the Media in delivering sensitive approaches to suicide and suicidal behaviour

How the media portrays suicide and what is reported can have a significant influence on behaviours and attitudes.

The way in which the UK media has reported suicide has changed fundamentally over the years – in part due to charities, like Samaritans working in the area of suicide prevention.

Ultimately, we can only reduce the numbers of suicides each year if we continue to talk about the issue and the media has an important role in educating the public on suicide prevention and are able to utilise mass readership and viewing to publicise sources of help and support available. However inappropriate reporting may put vulnerable individuals at risk, effect the bereaved and may lead to imitative behaviour.

Research consistently demonstrates that risk significantly increases if details of suicide methods are reported, or if the coverage is extensive or sensationalised.

The media need to continue to cover this important topic but this need to be done without putting vulnerable people at risk.

We need to work with local and regional media, especially considering media focused on high-risk communities, to increase awareness of national guidelines on responsible reporting of deaths through suicide and promoting a positive and culturally sensitive discussion in the media about mental health issues.

26

Priority Six: Support research, data collection and monitoring

Accurate and timely data on suicides statistics is vital for understanding patterns and behaviours, reducing risk and informing action to prevent future suicides. Such intelligence will also provide some of the measures of success for this strategy.

Currently there is a limited source of information and intelligence regarding local suicides to inform prevention activity in the city. However there are future opportunities to develop a system of real time surveillance with partners.

We have to work together across the partnership supporting this strategy to develop more a coherent and robust picture of suicide and self-harm and the related risk factors in the city to support service planning and monitor the impact of this strategy on outcomes and risk reduction.

MOVING INTO ACTION

Governance & Accountability

Tackling suicide requires major action from a wide range of organisations working in partnership.

We recognise that our NHS commissioning and provider partners have geographies which extend beyond the geographical boundary of the city, most often with Solihull.

Ultimately there is shared responsibility between the NHS and the Council for delivery of this strategy. This shared responsibility comes together through the statutory Health and Wellbeing Boards and the Mentally Healthy City sub-board that is being established in 2019/20. The Mentally Healthy City sub-board will link with the NHS STP Mental Health Delivery Board which reports up through the NHS governance framework and both will draw on the external stakeholder Mental Health Partnership Group.

The Suicide Prevention Working Group will oversee the delivery of the action plan and monitor progress against the plan. This group will report to the Mental Health Programme Delivery Board and the Health and Wellbeing Board through the Mentally Healthy City Sub-Board. Annex 2 sets out the current terms of reference.

The Suicide Prevention Working Group will oversee delivery of an annual action plan that will be signed off by the Director of Public Health on behalf of the Health and Wellbeing Board and the Clinical Commissioning Group.

Measuring Success

Fortunately suicide is still a relatively infrequent occurrence, however we will track progress for this strategy through metrics linked to our ambition.

Our ambition is to maintain the lowest suicide rate of the core cities in England and achieve a zero deaths through suicide ambition over the next decade; these will be monitored through the national indicators on 3yr rolling rates and counts published by PHE.

Alongside these indicators we are also developing through the action plan for 2019/20 a suite of metrics to track progress against the priority areas for action.

28

Principles for Action

Across the implementation of this strategy we have agreed a set of core principles which are shared across the partnership, these are:

1. We are open to share and learn as we implement action to move forward the strategy in the city.

2. We recognise the inequalities in mental health and self-harm that sit behind the picture of suicide and will work collectively to address these.

3. We understand that the implementation of this strategy will require action by all partner organisations, by communities and by citizens working together.

4. We are committed to keeping citizens at the centre of what we do.

Action Plan Development

The Suicide Prevention Working Group will be responsible for co-developing an annual action plan which will be approved by the Director of Public Health for Birmingham City Council, in consultation with the chairs of Health and Wellbeing Board and STP/CCG Boards.

Keeping Citizens at the centre

We are committed to keep Citizens at the centre of what we do as we move forward this work and therefore the final section of this strategy is dedicated to the voices of citizens affected by suicide and self-harm.

'When I look back over the period of time leading up to my suicide attempt, I realise I actually hit all the 'high risk' markers. A holistic approach is needed rather than a 'tick box' one. If a person is saying no to thinking of acting on suicidal thoughts, yet all the indicators point to significant risk factors, such as recent abuse or assault, significant depression, a major life circumstance, a history of self-harm including drug misuse, every effort should be made to ensure safety of that individual. My own personal experience is that I would have benefitted from Increased input from a community mental health team, a link between mental health and drug misuse teams, my doctor not supplying large quantities of medication on prescription at once and retailers being giving training to be made aware of potentially fatal means being sold.'

'My life took a desperate turn when I lost my job and got into debt. I couldn't face life failing my family. I had enough medication from my Doctor to end it. They would be better without me. If I hadn't been found as soon as I was, my children would have been growing up without their Daddy and this haunts me every day. I was scared to tell anyone how I felt because I thought my children would be taken into care. Looking back, I wasn't a danger to anyone, only myself. Maybe I wouldn't have got that far if it wasn't such a stupidly scary thing to talk about or if people could talk to me without being scared themselves. People are too scared to even say the word.'

30

ANNEXES

1. Membership of the Suicide Prevention Working Group

2. Suicide Prevention Working Group TOR

ANNEX 1 – Suicide Prevention Working Group Membership[52]

Name	Organisation
Justin Varney	Director of Public Health - BCC
Duncan Vernon	Public Health - BCC
Amanda Lambert	Public Health - BCC
Dennis Wilkes	Public Health - BCC
Jenny Riley	Public Health - BCC
Mo Philips	Public Health - BCC
Elaine Woodward	NHS England
Helen Wadley	Birmingham MIND
Paul Sanderson	PHE
Kerry Webb	BSMHFT
Joanne Carney	BSOL CCG
Gemma Coldicott	BSOL CCG
Jennifer Weigham	BSOL CCG
Dario Silverstro	BSOL CCG
Clare Walker	Solihull MBC
Elaine Kirwan	BWC NHS FT
Lisa McGowan	BWC NHS FT
Sean Russell	WMCA
Karen Edwards	NHS England
Dave Brown	PAPYRUS
Lesley Hales	CRUSE Birmingham

---

[52] As at May 2019

32

ANNEX 2 – Suicide Prevention Working Group Terms of Reference

Terms of reference Birmingham Suicide Prevention Working Group

1. Aim

The Birmingham Suicide Prevention Working Group aims:

• to reduce the rate of suicide and self-harm within Birmingham

• to provide a forum for successful multi-agency partnership working at strategic and operational level

• to work across STP area Birmingham and Solihull

2. Objectives

To facilitate and promote joined up partnership arrangements where appropriate in ensuring effective working to reduce suicide rates across STP area

3. Responsibilities

• to develop and agree a multi-agency suicide prevention strategy and action plan for Birmingham (and work across/with Solihull's strategy and plan)

• to monitor the implementation of the suicide prevention strategy

• to review and update the strategy as appropriate

• to inform and influence commissioning of specific projects and initiatives to meet the aims of the suicide prevention strategy over and above routine MH commissioning by CCGs

• to commission and analyse an annual statistical and intelligence update

• to publicise ongoing work and recent developments

• to facilitate partnership working between organisations represented on the Working Group

• to influence the work of all agencies and individuals who could help prevent suicide and self-harm, including those with lived experience.

4. Membership

To ensure that as many people and organisations are aware of, and involved in, suicide prevention this group has two types of members:

• those that regularly attend the meetings of the working group

• those who don't regularly attend the meetings, but are on the circulation list and may attend the meetings on an ad-hoc basis.

[regular attenders must include one representative from each of the Task and Finish groups; member from each political party; DPH, PHE/NHSE, Solihull, CCG, MH Trust, VCSE]

[Others who are to be included in the circulation list who may attend on an ad hoc basis include emergency services; police; fire; CJS; railways]

5. Accountability

This group will report to the local Health and Wellbeing Board, the appropriate STP board, and Health Committees within the Council.

6. Administrative support

Public Health will provide the Chair and the admin support for the Group initially until further review.

7. TOR approval and review date

Terms of reference will be reviewed every two years. The next review date will be Feb 2021.

8. Frequency of Meetings

Meetings of the working group will be held quarterly (unless otherwise agreed by the working group). Where possible, meetings will be held in different venues across Birmingham.

34

Prevention Concordat for Better Mental Health: information required from signatories to the Consensus Statement

We are delighted that you are interested in becoming a signatory to the [Prevention Concordat for Better Mental Health Consensus Statement](). You will be joining a number of organisations who have committed to working together to prevent mental health problems and promote good mental health through local and national action.

The Prevention Concordat registration process

Step 1. Complete the local Prevention Concordat action plan template below (Attach any supporting documents that you may want to share**)**

Step 2. Senior leader/CEO of organisation to commit and sign up to approved action plan

Step 3 e-mail your submission to publicmentalhealth@phe.gov.uk

Step 4. Confirmation of receipt

Step 5. A panel will review and approve action plans submitted within one month of submission date;

- o wave 6 – Friday 17th May 2019
- o wave 7 – Monday 17th June 2019
- o wave 8 – Wednesday 17th July 2019

NB: the team are currently reviewing the process for approving action plans and intend to have a digital process set up moving forward. Please see below.

Registration form

Please answer the questions below:

Lead contact name	Dr Justin Varney
Lead contact details	Email: Justin.Varney@birmingham.gov.uk Telephone number:-07892786305 Mehnaz Begum, PA – 0121 303 3672
Job title of lead officer	Director of Public Health
Name of organisation / partnership	Birmingham City Council
Local authority area (base/head office)	Birmingham City Council, Council House, Victoria Square, Birmingham
Post code	B1 1BB
Weblink	www.birmingham.gov.uk/publichealth

1

	https://birmingham.connecttosupport.org
Twitter handle	@Healthybrum
Who are you representing? *(e.g. Individual organisation, collaboration, partnership, Local Authority, Clinical Commissioning Group, community group and other, please name)*	Birmingham City Council (LA) Birmingham and Solihull Clinical Commissioning Groups (NHS) Birmingham Community Healthcare Trust (NHS Provider arm) Birmingham Children's Trust (BCC) NHS Trusts (Mental Health & Acute Providers) NHS England, Midlands Region Health Education England Public Health England Sustainability and Transformation Plan (STP) SIFA Fireside for the Homeless (Voluntary sector) West Midlands Police West Midlands Fire Service People with lived experience and their carers Those working in the community and voluntary sector. Birmingham MIND University of Birmingham Birmingham City University Newman University Greater Birmingham Chambers of Commerce Birmingham Voluntary Service Council (BVSC) Faith Groups
Please tell us more about your organisation's work (no more than 150 words)	Birmingham City Council is working to make the City a place where everyone can enjoy good mental and physical health, citizens can live independent, healthy and active lives, and children can have the best start in life with clear pathways to achieving success and realising their full potential. A place where people can make positive choices and take control of their wellbeing. The Organisation is making it a City where investment is encouraged thereby creating jobs for all, and is working towards bridging the inequalities gaps. We are working towards reducing social isolation and homelessness, and making the City a clean and green space. There is ongoing work to improve access to Mental Health services for the most vulnerable and disadvantaged groups through the programmes mentioned in the JSNA and the Suicide Prevention Strategy, as well as the work being done on City without Inequalities.
What are you currently doing that promotes better mental health?	In addition to the above, we are additionally working in a partnership of strategic stakeholders who are committed to making Birmingham a Mentally Healthy City where everyone can have: • a purpose in life • a sense of belonging • good economic lives that are free from stress while increasing financial security • community pride so families can live and feel safe • good mental and physical health to get through each day

	We are building relationships with our citizens including vulnerable people via community engagements in 69 Local Wards and working with Local Councillors. We also have a well-established Health and Wellbeing Board and a newly-formed strategic sub-committee that is dedicated to Mental Health. We have established a working group by bringing together people who are community champions, work in voluntary organisations, Third Sector organisations, as well as strategic partners and other stakeholders to ensure we reach every citizen in the City to achieve our objective of Creating a Mentally Healthy City. Three Workshops have been established for the first year in addition to five sub-committee Forum meetings with strategic partners. The aim is to agree a framework for a whole system approach to a mentally healthy City and develop the Joint Strategic Needs Assessment (JSNA). The Forum will be established to enable partners from Local Authority, NHS organisations, Academic Bodies, Children Service, third sector organisations, and the wider Public Health sector to work collaboratively on health and wellbeing priorities and improving mental health and wellbeing for Birmingham. The Forum will meet bi-monthly. We are partnering with West Midlands Combined Authority in implementing the Thrive at Work; Thrive Through Schools; Thrive in Education programmes. https://www.wmca.org.uk/media/1420/wmca-mental-health-commission-thrive-full-doc.pdf
Do you have or are you intending on producing a mental health plan or a mental health needs assessment.	**Yes** ☒ **No** ☐ If yes, please specify: **The JSNA** The JSNA is currently in development. Several mental health related JSNA documents are available for Birmingham. These cover mental health issues in relation to children and young people and working age adults. The current JSNA programme will also include sections regarding mental health through the life course. **The Birmingham Suicide Prevention Strategy** https://birmingham.cmis.uk.com/birmingham/Decisions/tabid/67/ctl/ViewCMIS_DecisionDetails/mid/391/Id/2f404ad6-7ddb-471c-ab8a-62d560d198e1/Default.aspx **Thrive Wellbeing Programme:** https://www.wmca.org.uk/media/1420/wmca-mental-health-commission-thrive-full-doc.pdf
The Prevention Concordat for better mental health highlights the five-domain framework for local action **Please describe what are you planning to commit to in the next 12 months for your area** *(see * page 3 for examples to support completion of this section)***;**	

3

1. Leadership and Direction	We have a Local Authority-led sub-committee of the Health and Wellbeing Board that will work alongside the NHS and other partners on developing a Concordat for making Birmingham a Mentally Healthy City.
	Birmingham City Council Public Health Division will lead a group of partners, stakeholders from the NHS commissioning and provider arms; Department for Work and Pensions; Third Sector organisations e.g. BVSC; West Midlands Police; West Midlands Fire Service; Academic Bodies; and representatives from volunteer groups and community champions. All will work as a collective to deliver specific aspects of the Health and Wellbeing priorities on mental wellbeing. There will be five sub-committee Forums and three Workshops within the first year, to be reviewed annually.

HEALTH & WELLBEING BOARD

- Creating a Mentally Healthy City
  - STP & relevant sub-Board
- Creating a City without Inequality
- Creating an Active City
- Creating a Healthy Food City

We will oversee and support the development and delivery of a strategic action plan to deliver a measurable impact on citizens' lives by 2020.

2. Understanding local need and assets	Develop the insight into the needs and gaps around the Mental Health and Wellbeing of the people of Birmingham by consolidating existing data and evidence, enriching it with service users' stories and feedback under the JSNA work programme. Following a fact-finding Workshop an Outline Action Plan will be put in place, to be drawn up by strategic members of the Forum.
	There is a section in the JSNA that addresses Mental Health and includes key statistics through the life course that includes children, working age adults and those who are older. It covers Diversity, Inclusion, BAME, LGBT, Perinatal Mental Health, Carers, the homeless and Inequalities. Trends and future analysis is also a key feature.
3. Working together	As a result of the Workshop on Creating a Mentally Healthy City, stakeholders and partners have agreed to commit to prioritising making Birmingham a mentally healthy city and improve the mental health of it' citizens across the age range. The Forum will focus on

	our vision to create a City where everyone, at every age, can thrive and live in good health, employment, with fulfilled active lives in relation to their health and wellbeing. Membership of the Forum will be reviewed from time to time to ensure the 'best fit' of people who can contribute strategically on specific areas are involved. From time to time, members will be co-opted so we can deliver on our action plan. Each member of the Forum will have responsibility for themed areas in the Forum Strategic Action Plan. Actions and achievements will be reported to the Health and Wellbeing Board annually. Members will also have responsibility for communicating the business of the Forum to their respective organisation and follow through on agreed priorities. Organisations will be asked to commit to the agreement as set out in the Prevention Concordat for Better Mental Health and will be asked to sign a Pledge document to that effect. The Forum will be instrumental to the delivery of the Action Plan. The establishment of the Group has already been agreed by the Health and Wellbeing Board which demonstrates partners and stakeholders' commitment to this agenda. A Terms of Reference (ToR) has been agreed by the Forum.
4. Taking action	The Objectives of the Health and Wellbeing 'Creating a Mentally Healthy City' Forum are: • Oversee and support the development and delivery of a strategic action plan/framework to deliver a measurable impact on citizens lives in Birmingham to be in place by 2020 • Develop an insight into the needs and gaps through a Joint Strategic Needs Assessment (JSNA) process • Progress actions and report on projects and achievements to the Health and Wellbeing Board on an annual basis • Foster and develop partnership arrangements to deliver improvements in health and wellbeing for citizens of Birmingham • Other delegated responsibilities from the Health and Wellbeing Board will be acted upon with due thoroughness • Working with partners from the other four sub-committees (Creating a City without Inequality; Creating a Healthy Food City; Creating an Active City; Health Protection Forum) to ensure we are on course to make a difference to the citizens of Birmingham and deliver on outcomes • Work with community groups and voluntary organisations to ensure their inclusion, that their voices are heard on matters of mental wellbeing, and that they can play an active role in managing their mental health and wellbeing .
5. Defining success	The Joint Strategic Needs Assessment and the Prevention Concordat for better Mental Health/Action Plan are the foundation of a rigorous programme of work involving our strategic partners from the NHS, PHE, Local Authority, Academic Bodies, Third Sector, Voluntary Sector and people with lived-lives who are

5

	working tirelessly to be ambassadors and contributors to our work, enabling us to deliver on our actions. Engaging with all partners and stakeholders to ensure successful delivery is key to our success.
	Our success will be defined by measurable outcomes as a result of evaluation. We will share our best practice and lessons learned working with partners, stakeholders and the people with lived experience of mental health issues as they continue to help shape our work in making Birmingham a Mentally Healthy City.
What is the impact you are looking to measure and how do you think you will measure it?	As we build momentum, we aim to address further issues over the whole life cycle and develop a comprehensive public health approach aimed at reducing the burden and impact of mental ill health. We are looking to measure our achievement in reaching people such as BAME groups (Afro-Caribbean, South Asian, Chinese; Polish and Eastern Europeans); LGBT; other migrant groups; and the homeless, and how effective we have been during the first 12 months in identifying and working with these communities

For most of the actions we know there is an evidence base although for some it may not be as well defined. To this end, a programme of evaluation will be used to assess and report on how effectively each action will be implemented, how these actions will strengthen pathways leading to equalities, and how we achieve outcomes with financial constraints.

[Feedback from our first Workshop indicate we should be working upstream by encouraging citizens to engage with their communities, be more open and inclusive about diversity and mental health, in order to enable a robust support system to be put in place where help is at hand whenever needed]

This evaluation will need to be undertaken thoroughly and over a reasonable period. It is likely that we will commission an evaluation programme, working with organisations that have the requisite expertise in evaluation work. |

Is your organisation/ partnership happy to provide key impact headlines when contacted related to the commitment specified?   **Yes** ☒   **No** ☐

The purpose of this information is to support us to measure progress of the programme and inspire others. Information requests will not occur more than once a year.

Upload signature and organisation logo	

In your submission please attach any additional documents that you may want to share to support your commitments e.g. strategies, plans project outlines.

Leadership and Direction

The Public Health Division at Birmingham City Council is a lead organisation for Mental Health within the partnership to promote good mental wellbeing and prevention of mental ill-health. There is a shared vision that all in the partnership have signed up to working towards a mentally healthy City. We are committed to prevention and promoting good mental heath with clear direction and leadership.

This partnership aims to build good working relationships with communities where local people can challenge others on the progress being made in delivering and address issues around mental wellness.

We have a Mental Health Champion, Councillor Paulette Hamilton who, in her role as an Elected Member, demonstrates local political leadership and support for the Concordat. Cllr Hamilton is:

- Cabinet Member for Health and Social Care
- Chair of Birmingham Health and Wellbeing Board
- Member of City Board
- Vice Chair of the West Midlands Combined Authority Health and Wellbeing Board
- Vice Chair of the Community Wellbeing Board at the Local Government Association (LGA)

The partnership has a shard vision for promoting good mental health and prevention within the community. Regular engagement within local partnerships is in place via the 'Creating a Mentally Healthy City' Forums and Workshops which includes partners, stakeholders, Third and Voluntary sector organisations.

We have 'Thrive in the Workplace' that will ensure that employers are promoting good mental wellbeing to all staff.

Understanding Local Needs and Assets

There is a Local Authority led Joint Strategic Needs Assessment (JSNA) with a mental health prevention focus, currently a work in progress. We have a mental health equity audit in place across the partnership and collaborative analysis of local information and intelligence sharing. We also have real time surveillance of suicide data. We are engaging with communities and with experts working within local communities to gain insight into their needs and assets.

The Mental Health Needs Assessment of locally targeted population, along with the Suicide Prevention Strategy, will focus on Black, Asian, and Minority Ethnic (BAME), LGBT, prison population, voluntary organisations, and will include working with parents and young people.

There is on-going engagement with communities to gain insight into their needs as well as assets that can be utilised for the benefit of their communities.

We are fully engaged with communities and building relationships with individuals, Faith, sporting groups, families, and local organisations with a view to fact-finding on issues related to mental health and wellbeing and how these issues have influence local population wellness.

Engage in local community events, some of which will be driven by Public Health. These events will create opportunities that will enable citizens to share their views on services and participate in decision-making on matters about their health and wellbeing.

Working together

Collaborative working across sectors on both 'upstream' mental health intervention and 'downstream' local organisations to align plans for a joint programme of work. Cllr Paulette Hamilton, who is a member of a national network of elected member Mental Health Champions, supported by the Centre for Mental Health, chairs the Mental Health sub-group as well as the Health and Wellbeing Board.

We are dedicated to working more strategically with our partners and stakeholders, Third Sector organisations and the voluntary sector, along with people with lived experience of mental health issues.

We are in a multi-agency strategic partnership with Birmingham & Solihull CCG; Birmingham and Solihull Mental Health NHS Foundation Trust; Birmingham Voluntary Service Council (BVSC); Healthwatch; Birmingham Community Healthcare Trust (BCHC); Birmingham Children's Trust; West Midlands Police/Police and Crime Commissioners Office; West Midlands Combined Authority, Academic Bodies, and SIFA Fireside. These organisations are now engaged in working together on 'Creating a Mentally Healthy City' as member organisations of the Forum.

On a strategic level, we have built relationships with a wide-ranging group of partners who have influence in defined areas and specific roles in mental health programme delivery. Partners are from the NHS, Third and voluntary sector organisations, work and employment. Children services, law enforcement, and homeless organisations.

Taking Actions

We have in production a Joint Strategic Needs Assessment (JSNA) which captures a system-wide mental health need. We also have a Suicide Prevention Strategy to integrate mental health prevention into partnership plans and strategies. We have engaged with people who have lived experiences and have set up Workshops where they can contribute to the design of services. These are all City-wide initiatives

Working in partnership with our internal colleagues from HR Organisation and Development on the *Thrive at Work* for all employees within the organisation (see link: https://www.wmca.org.uk/media/1420/wmca-mental-health-commission-thrive-full-doc.pdf) as well as *Thrive Through Education*, to be commissioned by the Public Health Division aimed specifically at schools in support of teachers and pupils on identification and prevention of mental health issues e.g. stress, anxiety, depression, ADHD, and conduct disorder.

Delivery of an organisational plan and/or strategy that has clear identified priorities and resources to support implementation as well as building the workforce's knowledge and skills in promoting the prevention of mental health issues.

Defining Success

Agreed outputs and outcomes across all partners and stakeholders that will ensure delivery of the Action Plan, level of partnership engagement e.g. Workshops, Focus Groups, that will measure the impact and improvements in how we work together in engaging local people on promotion of mental wellbeing.

The Focus Group Creating a Mentally Healthy City to agree an Action Plan that will be used for delivering preventative measure to local communities. The resultant impact and improvement will be measured in relation to mental wellbeing.

9

	Agenda Item: 11
Report to:	Birmingham Health & Wellbeing Board
Date:	17 March 2020
TITLE:	JSNA CORE DATA SET – CHILDREN AND YOUNG PEOPLE CHAPTER
Organisation	Birmingham City Council
Presenting Officer	Ralph Smith, Service Lead, Knowledge Evidence and Governance

Report Type:	Presentation

1.	Purpose:	
	To update the Board on the progress of the core Birmingham Joint Strategic Needs Assessment (JSNA) Children and Young People Chapter.	

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

3.	Recommendation

3.1 It is recommended that the Health and Wellbeing Board:

- Approve the publication of the Children and Young People Chapter of the Birmingham Core JSNA.

- Note that the other three sections; 'Working age adults' 'Older people' and 'Wider determinants of health', will follow.

007583/2020

4.	**Report Body**

4.1	**Context**

4.1.1   The Board heard in private session at their January 2020 meeting how the core Birmingham JSNA Children and Young People Chapter had progressed. The draft was approved of and was sent through formal Council governance structures for information; namely the Corporate Leadership Team, the Executive Management Team and Cabinet.

4.2	**Current Circumstance**

4.2.1   The document was presented at these meetings and now needs to be adopted formally as a Birmingham Health and Wellbeing Board core JSNA chapter.

4.3	**Next Steps / Delivery**

4.3.1   Children and Young People Chapter, once approved, it will be posted on the Birmingham City Council, Public Health Division website; and distributed and advertised widely.

4.3.2   The status and timetable for the remaining three sections is

'Working age adults' - This has also been re-written using a revised structure, like the 'Children and Young People' chapter. A draft version has been prepared and has been circulated for comment. A final version will be presented in a private session of the HWBB on 17 March 2020.

'Older people' - this has undergone a revision based on the structure used in the previous two chapters. The draft document will be circulated to internal and external partners for comment. The chapter will be presented at the July 2020 HWBB meeting.

'Wider determinants of health' - this will undergo revision based on the new structure used in the chapters above.

5.	**Compliance Issues**

5.1	*HWBB Forum Responsibility and Board Update*

The development of the JSNA, both core and deep dives, is managed by the JSNA steering group.

5.2	*Management Responsibility*

Ralph Smith, Service Lead, Knowledge Evidence and Governance

6.	Risk Analysis			

Further delay in publication. Changes suggested at presentations.

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

Appendices
1.   The Birmingham Core JSNA Children and Young People Chapter

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

Ralph Smith, Service Lead, Knowledge Evidence and Governance,
ralph.smith@birmingham.gov.uk

Children and Young People

2019 Joint Strategic Needs Assessment

V3.7 - January 2020

007583/2020

Version Control	Date	Amendments	Lead Authors
V0.1	25/10/2019	Draft version	Andy Evans and Ralph Smith, Public Health Knowledge Evidence and Governance Team, BCC
V3.0	01/11/2019	Final Draft	Dr Justin Varney Director of Public Health Paul Campbell PH KEG Lead
V3.2	19/12/2019	Amended final draft incorporating comments, including; • Children's Trust • BSOL CCG • Children's Transformation Programme • Education and Skills	Ralph Smith
V 3.3	20/12/2019	Children and the justice system focus added	Ralph Smith
V 3.4	07/01/2020	Final draft version for Health and Wellbeing Board	Ralph Smith
V 3.5	09/01/2020	Final version for Health and Wellbeing Board (private)	Ralph Smith
V3.6	27/01/2020	Version for BCC CLT	Ralph Smith
V3.7	12/02/2020	Version for BCC EMT, including comments from CLT. Final version for HWBB 17/03/2020 Final version for Cabinet 17/03/2020	Ralph Smith

Other Public Health Contributors:

Justin Varney	Director of Public Health
Chris Baggott	Service Lead
Mudassar Dawood	Officer Public Health
Paul Campbell	Public Health Knowledge Evidence and Governance Lead
Jenny Riley	Senior Officer Public Health
Mohan Singh	Senior Officer Public Health
Jeanette Davis	Officer Public Health
Susan Lowe	Public Health Knowledge Evidence and Governance Lead
Fiona Grant	Service Lead
Dennis Wilkes	Assistant Director
Rachel Chapman	Public Health Specialty Registrar

Executive Summary

Birmingham is committed to becoming a city where every child and young person can achieve their potential.

The city has a higher fertility rate than the England and West Midlands average, and a larger proportion of the population aged under 18 years.

Birmingham has the largest proportion of children aged 0-5 years of any local authority in England. The ward with the largest proportion of children 0-5 years and young people age 6-19 years is Alum Rock, and the ward with the smallest proportion of 0-19 years is Sutton Wylde Green.

The population of children and young people in Birmingham are more ethnically diverse than the older population of the city and this diversity increases with every cohort of children born.

Birmingham faces significant challenges in pregnancy reflected in the persistently high rates of still birth and infant mortality, this reflects issues of genetics, late presentation and poor engagement with antenatal services, substance misuse and smoking in pregnancy.

Across Early Years there is consistent evidence highlighting the need to address infant feeding, oral health and mental wellbeing through evidence-based parenting support, and an urgent need for improvement in Early Years services performance and data collection.

In Birmingham there are 27 state funded nursery schools, 295 state funded primaries, 80 state funded secondaries, 7 state funded all-through schools and 27 state funded special schools. A larger proportion of children in education in Birmingham have special educational needs than the England average, and there is also a higher rate of children in care than England. Through the school years there is positive evidence of closing the gap for academic achievement. Our young people are less likely than others in the region and nationally to smoke and more likely to eat fruit and vegetables. However, they have persistent challenges around mental wellbeing, unhealthy weight and inactivity.

The evidence shows that children and young people facing additional challenges consistently have worse health outcomes, whether these are children with disabilities, children in care (CIC), lesbian, gay, bisexual or trans youth or those who have faced adverse childhood experiences. However, in Birmingham there is some positive evidence that Birmingham is closing this gap for some of these children for some outcomes, and the trend is moving in the right direction.

Based on current trends, Birmingham will continue to need to invest in children and young people's services to: meet expanding demand and increasing diversity; navigate successfully the transitions especially for those facing additional challenges; and embed prevention and early intervention at every stage from conception to adulthood to support our children to thrive as they grow.

BAME children

54.0% Birmingham
20.8% England
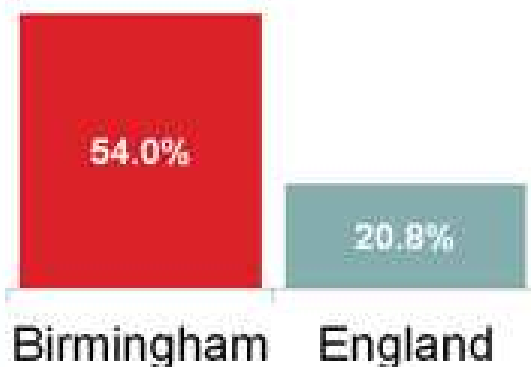
Infant mortality – 2017 vs 2010

Birmingham 1.9 per 1000 increase

England 0.4 per 1000 decrease

Special Educational Needs and Disability (SEND)

3.20% Birmingham
2.90% England
2.40% Core Cities

Average Attainment 8 score at KS4 for looked after children in Birmingham

1.4 above England average

Smoking prevalence at age 15

4.4% Birmingham
8.2% England

Children in low income families 2006-2016

15% GAP
11% GAP

Table of Contents

Conception and Pregnancy

Key Statistics

In 2018 there were 15,916 live births in Birmingham (table 1); this is the lowest number of live births since 2013. There is a general downward trend in fertility rates and an upward trend in the average age of mothers in Birmingham; however, these are not yet significant enough to be certain that they represent a consistent change in fertility in the city. Compared to the West Midlands and England, Birmingham remains significantly more fertile, accounting for just under a quarter of all the live births in the region (23.7%).

Table 1: Live births and fertility rates in Birmingham 2013-2018[1]

	Birmingham						West Midlands	England
	2013	**2014**	**2015**	**2016**	**2017**	**2018**	**2018**	**2018**
Total Number of Live Births	17,421	16,927	16,828	17,404	16,506	15,916	67,282	625,651
Crude birth rate	16.0	15.4	15.1	15.4	14.5	13.9	11.4	11.2
General fertility rate (GFR)	71.1	68.8	67.8	69.2	65.3	62.8	61.6	59.2
Total fertility rate (TFR)	2.07	2.01	1.98	2.02	1.90	1.83	1.76	1.70
Standardised mean age of mother	30.0	30.2	30.4	30.6	30.7	30.9	30.1	30.6

Source: (ONS 2019 via NOMIS)

Fertility rates vary widely by ward in Birmingham. The generalised fertility rate for 2017 (GFR) is highest in Heartlands ward (89.6 live births per 1,000 females aged 15 to 44) and lowest in Bournbrook & Selly Park ward (15.5 per 1,000).

These fertility rates do not match the age demographics of the female population in each ward; with Bournbrook & Selly Park ward having one of the highest total female populations but the lowest fertility rate and equally one of our mid-range wards Heartlands having a high fertility rate. However, much of the female population in Bournbrook & Selly Park ward are female university students which could explain the lower fertility rate. A full table of ward data can be found in the appendix at the end of the document.

---

[1] Crude Birth Rate (CBR) is the number of live births occurring among the population of a given geographical area during a given year, per 1,000 mid-year total population of the given geographical area during the same year. General Fertility Rate (GFR) is the number of live births per 1,000 women of reproductive age (ages 15 to 49 years) per year. Total Fertility Rate (TFR) is the average number of children that would be born to a woman over her lifetime if she survived from birth to the end of her reproductive life and her fertility is the same as the age-specific fertility rates for the full duration of her reproductive life.

Diversity and Inclusion

The average age of mothers in Birmingham has been steadily increasing since 2013 and in 2018 the percentage of live births to mothers aged over 30 years in Birmingham (52.5%) is now greater than the West Midland average (50.4%) but still below the England average (56.1%), see table 2.

Table 2: 2018 Live births in Birmingham, England and West Midlands

	Birmingham (Total)	Birmingham (%)	West Midlands	England
Total Live Births	15,916		67,282	625,651
Age of Mother				
Mother aged under 20	498	3.1%	3.4%	2.8%
(Mother aged under 18)	(122)	(0.8%)	(0.8%)	(0.6%)
Mother aged 20-24	2,404	15.1%	16.1%	13.7%
Mother aged 25-29	4,657	29.3%	30.2%	27.4%
Mother aged 30-34	4,885	30.7%	30.4%	32.5%
Mother aged 35-39	2,827	17.8%	16.4%	19.1%
Mother aged 40-44	584	3.7%	3.3%	4.1%
Mother aged 45 and over	61	0.4%	0.3%	0.4%

Source: (ONS 2019 via NOMIS)

Between the three maternity provider hospital trusts there is little difference between the age profile of women attending the different hospitals.

Teenage Conceptions

We focus on the number of young women becoming pregnant because in general these are unplanned pregnancies and reflect how well as a city we are supporting young people to have healthy relationships, supporting access to contraception and helping young people make informed choices about becoming parents. The research shows that becoming pregnant (conception) under the age of 18 years can have a negative impact on the life chances of both the mother and the child, so there is significant effort put into supporting young women to delay pregnancy until they are older.

The rate of conceptions for young women in Birmingham aged 15-17 years is comparable to the England average (19.4 compared to 17.8 per 1,000 in 2017) which is good, especially as Birmingham has a very young population. The wards with the highest rates of teenage conception in Birmingham appear to be similar in having high levels of deprivation and a relatively low proportion of the population from BAME (Black, Asian and minority ethnic) groups.

Because of the small numbers of teenage conceptions there is limited data available on the demographics of this group, however nationally the evidence in the Teenage Pregnancy Prevention Framework suggests that the following are risk factors for teenage conception:

- Poverty
- Persistent school absence by year 9
- First sex before 16 years of age

- Children in care and care leavers
- Lesbian or bisexual experience
- Alcohol use
- Previous pregnancy
- Mother was a teenage parent

45.9% of teenage conceptions in Birmingham in 2017 ended in a termination of pregnancy which was a lower rate than the West Midlands (47.4%) and lower than England (52%), figure 1.

Figure 1: Conceptions in women aged under 18 per 1,000 females aged 15-17
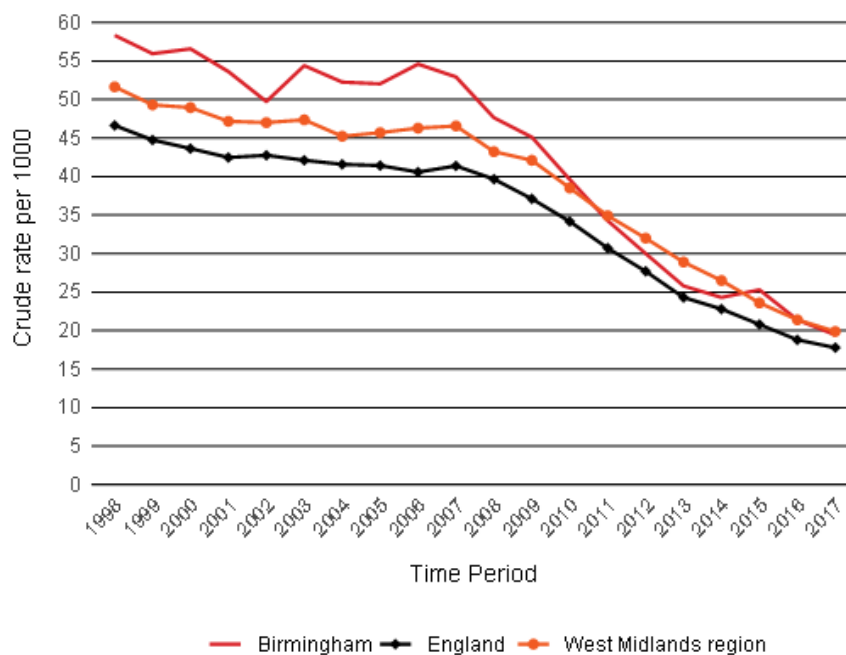
Source: ONS

In 2016/17 57.4% of mothers who gave birth in Birmingham were from black or ethnic minority communities, this is significantly higher than the West Midlands (31.3%) or England (23.3%). There is some difference between hospital trusts serving Birmingham, although all three trusts have a lower proportion of women with a white ethnicity than the England average across maternity trusts (table 3).

The information available on the country of birth of mothers shows that in 2017 58% of births in Birmingham were to mothers born in England. The second most common country of birth for new mothers in Birmingham was Pakistan (11.3%), there were 149 different countries of birth recorded in total. Just over 85% of new mothers in Birmingham in 2017 were born in the top 10 of these 149 countries.

Birmingham is the 6th most deprived local authority in England. Data on deprivation, using the Index of Multiple Deprivation, is reported through the Maternity Services Dashboard by NHS hospital trust (see table 4).

Table 3: Percentage of women of different ethnic groups at time of booking in a Birmingham Hospital Trust providing Maternity Services (March 2019)

	Birmingham Women & Children's Trust	University Hospitals Birmingham Foundation Trust	Sandwell & West Birmingham Hospitals Trust	England Maternity Services Average	Total population of Birmingham (2011 Census)
White	41%	45%	33%	64%	57.9%
Asian/Asian-British	26%	28%	28%	9%	26.6%
Black/ Black British	8%	5%	13%	4%	9.0%
Mixed	2%	3%	4%	2%	4.4%
Other ethnic group	7%	7%	5%	4%	2.0%
Not known	2%	0%	0%	3%	
Not stated	4%	6%	17%	11%	
Missing	10%	7%	1%	2%	
Count	810	760	840		

Source: NHS Digital Maternity Dashboard

Table 4: Percentage of women of different deprivation groups at time of booking in Birmingham Hospital Trusts providing Maternity Services (March 2019)

	Birmingham Women & Children's Trust	University Hospitals Birmingham Foundation Trust	Sandwell & West Birmingham Hospitals Trust
Most deprived (IMD deciles 1 & 2)	49%	62%	65%
Least deprived (IMD deciles 9 & 10)	6%	7%	0%
Count	810	760	840

Source: NHS Digital Maternity Dashboard

We do not currently have routine data from services or published through national data collection on disability, sexual orientation, gender identity or faith for mothers at the time of birth. Analysis by these characteristics is important, to ensure that services are meeting the needs of parents in the city.

Maternal and Foetal Outcomes

In comparison with the rest of England, Birmingham has poorer outcomes for several measures of maternal health and infant health: maternal mortality, stillbirth, low birth weight, very low birth weight and infant mortality.

Maternal Mortality

A maternal death is defined internationally as the death of a woman during or up to six weeks (42 days) after the end of pregnancy (whether the pregnancy ended by termination, miscarriage or a birth, or was an ectopic pregnancy) through causes associated with, or exacerbated by, pregnancy (World Health Organisation 2010). In 2018 there were no maternal deaths in Birmingham that met this definition.

Stillbirth

The stillbirth rate is defined as foetal deaths occurring after 24 weeks of gestation (before 24 weeks the death is classified as a miscarriage). In the period 2015-17 the rate of stillbirths in Birmingham was higher than England (6 compared to 4.3 per 1,000 live births) and remained consistent between 2010-12 and 2015-17. Nationally, stillbirths are more common to mothers in the most deprived 10% of communities, compared to those in the least deprived (5.3 compared to 3.7 per 1,000 live births).

The proportion of stillbirths where the mother was in the 15 to 19 age group was 7.8% (2017). The proportion of all live births to mothers in this age group was 3.3%. Similarly, the proportion of stillbirths where the mother was aged 40 or over was 11.1% against 3.9% of all live births to women in this age group. The proportion of stillbirths to women born in Pakistan and India was also higher than the proportion of live births to women born in these countries.

The Birmingham United Maternity and Newborn Partnership (BUMP) improvement programme is currently undertaking a specific programme of work looking at maternal inequalities between different cultures and ethnicities.

Risk factors associated with stillbirth are: social inequality, maternal obesity, maternal age and ethnicity, smoking during pregnancy, previous history of stillbirth, and infections during pregnancy. At least some of these could be classed as lifestyle related behaviours that are modifiable through Public Health interventions.[2]

Low Birth Weight

Low birth weight (LBW) is associated with an increased risk of infant mortality and stillbirth and longer-term health issues. LBW is defined as the percentage of all births (live and stillbirths) with a recorded birth weight under 2500g, as a percentage of all live births with a stated birth weight. Birmingham has a larger percentage of low birth weight babies (9.7%) than the West Midlands (8.7%).

The primary cause of LBW is premature birth, however there are other risk factors such as the baby not growing correctly within the womb (intrauterine growth

---

[2] Infant Mortality and Stillbirth in the UK

restriction), or the mental health of the mother. Additionally, LBW is more prevalent in Asian, Black or Mixed ethnicities.[3] These risk factors are also applicable to very low birth weight.

Very Low Birth Weight

Very low birth weight is a subset of low birth weight, reported as the percentage of all births (live and stillbirths) with a recorded birth weight under 1500g as a percentage of all live births with stated birth weight. The most recently published data on very low birth weight is from 2016 where 1.98% of live births in Birmingham had a very low birth weight, being higher than both the West Midlands (1.67%) and England (1.22%) average. It is of concern that the percentage of very low birth weight births has risen substantially since 2014 (1.62%) and this reinforces the need for strong engagement with parents in the antenatal period to support a healthy pregnancy.

Infant Mortality

The infant mortality rate is the number of infants dying before their first birthday per 1,000 live births; it is normally reported as a rate over a 3 year period. The Birmingham infant mortality rate in the period 2015-17 was nearly double the England average (7.8 compared to 3.9 per 1,000 live births). There were 398 infant deaths in Birmingham during this period and the rate is the second highest in the West Midlands region behind Stoke-on-Trent.

There are three recognised sub-categories within infant mortality:

- Early neonatal – the first 0 to 6 days after birth
- Late neonatal – 7 to 28 days after birth
- Post neonatal – 28 to the end of the first year of life

Nationally, most babies die within the early neonatal period. In Birmingham, the percentage of infant deaths during this initial period after birth in 2015/17 was 63% of all infant deaths, 14% were late neonatal and 23% were postnatal.

The cause of death varies between early and late neonatal. The older the infant the more likely the deaths are not immaturity related i.e. 63% of all early neonatal deaths were related to their gestation at time of birth, whereas this fell to 32% for late neonatal deaths. Equally, congenital diseases increased as a cause of death between the two categories of death and dropped even further in the post neonatal deaths. The same was true for deaths within the asphyxia, anoxia or trauma grouping.

Risk factors associated with infant mortality are low birth weight, smoking at time of pregnancy, teenage pregnancy, breastfeeding, mother's country of birth, consanguinity and congenital abnormalities deprivation and maternal age.

Various studies examining consanguinity and congenital abnormalities have identified significantly higher mortality rates in Birmingham Pakistani and Bangladeshi mothers compared to White Europeans [4]

---

[3] https://www.babycentre.co.uk/a1033196/low-birth-weight-in-babies

Abortion/Termination of Pregnancy

Termination of pregnancy (abortion) is a proxy measure for unwanted or unplanned pregnancy, although some terminations are due to medical issues with the foetus. As such this measure can be viewed similarly to teenage pregnancy in reference to how well we are delivering services around conception planning.

The age standardised abortion rate in Birmingham in 2018 (18 per 1,000 female population aged 15 – 44) is significantly higher than the national average (17.5 per 1,000).[5] Rates in Birmingham were lower than England for the 18 – 24 age groups but higher for the 25+ age groups. This suggests that there are issues around accessing contraception and family planning support for women age 25+.

National rates of termination of pregnancy are higher in areas with more deprivation and this might also be the case for Birmingham, but we do not have data to analyse this in more detail.

Health Risks in Pregnancy

Smoking in Pregnancy

Smoking in pregnancy can be dangerous to both mother and baby and increase the risk of complications during pregnancy, birth and the baby's early years.

In 2017/18 the proportion of Birmingham women smoking at the time of delivery was 8.2%, lower than the England average (10.8%) which can be seen in figure 2. Nationally the proportion of women who smoke at the time of delivery is higher in the most deprived 10% of communities, compared to the least deprived decile (11.8% compared to 7.2%). The rate of smoking at delivery fell in Birmingham between 2010/11 and 2015/16 but has since levelled off, mirroring the national trend.

Figure 2: Mothers smoking at time of delivery

---

[4] Infant and Perinatal Mortality in the West Midlands: Public Health England 2016

[5] Abortion statistics for England and Wales: 2018 Department of Health and Social Care
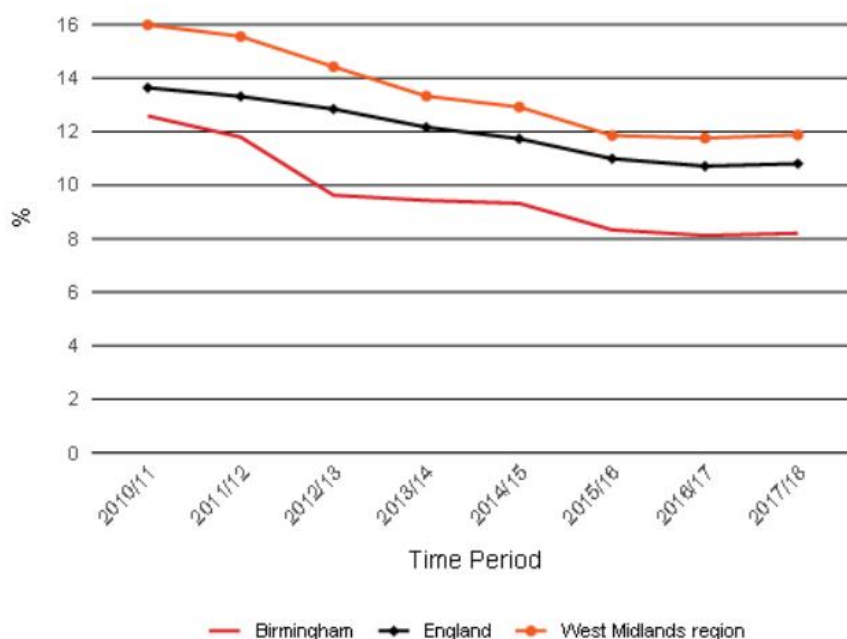
Source: PHE / NHS Digital

Smoking at delivery data needs to be interpreted with caution. The rate for Local Authorities is estimated, based on figures collected for Clinical Commissioning Groups (CCGs). Furthermore, the latest reported data for Birmingham and Solihull CCG recorded 13.2% of maternities as smoking status unknown.[6] Many of our residents are part of Sandwell & West Birmingham CCG where the unknown percentage was 10.2%.

Obesity in Pregnancy

Carrying excess weight (overweight and obesity) during pregnancy can cause problems for both mother and baby during pregnancy. We define excess weight as having a body mass index greater than 25, the higher the BMI the greater the risk. It is best for women to have a healthy weight before they become pregnant. Carrying excess weight does increase the risk of miscarriage, blood clots and pre-eclampsia, diabetes and complications during childbirth.

In the UK[7] 21.3% of the antenatal population are estimated as being obese and less than half of pregnant women (47.3%) having a body mass index (BMI) within the normal range. In the context of Birmingham this would mean that in 2018 an estimated 3,390 live births were to obese mothers.

Antenatal booking data from NHS Digital suggests that maternal obesity is higher in Birmingham than the UK average and higher than the West Midlands average, especially for morbidly obese and obese categories of excess weight (table 5).

---

[6] NHS Digital SATOD data visualisation tool
[7] RCOG Care of Women with Obesity in Pregnancy (Green-top Guideline No. 72)

Table 5: Weight categories at antenatal booking for women resident in Birmingham 2017/18 [8]

	Birmingham		West Midlands		England	
	Count	%	Count	%	Count	%
Morbidly obese	2,270	11.7%	4,190	5.5%	19,010	2.8%
Obese	3,370	17.3%	11,815	15.4%	102,400	15.1%
Overweight	4,595	23.6%	16,235	21.2%	153,215	22.5%
Normal	6,325	32.6%	24,300	31.7%	258,295	38.0%
Underweight	450	2.3%	1,720	2.2%	22,765	3.3%
Unknown	2,420	12.5%	18,280	23.9%	124,210	18.3%

Source: Maternity Service Data Set NHS Digital

Data from the NHS Digital Maternity Outcome Dashboard for March 2019 demonstrates that across all three trusts providing maternity services for Birmingham women, there is a higher proportion of obese and overweight women giving birth at Sandwell and West Birmingham Hospital Trust (table 6). University Hospital Birmingham Foundation Trust has a higher than average percentage of missing data. This data quality issue has been a trend since December 2018 and is of concern.

Table 6: Percentage of women of different weight groups at time of booking in Birmingham Hospital Trusts providing Maternity Services (March 2019)

	Birmingham Women & Children's Trust	University Hospitals Birmingham Foundation Trust	Sandwell & West Birmingham Hospitals Trust	England Average
Obese	23%	21%	25%	19%
Overweight	28%	25%	29%	24%
Healthy Weight	38%	33%	39%	40%
Underweight	2%	2%	3%	2%
Missing	9%	19%	4%	15%
Count of Women Booked	810	760	840	

Source: NHS Digital Maternity Dashboard

Alcohol Consumption During Pregnancy

The Chief Medical Officers for the UK recommend that if you're pregnant or planning to become pregnant, the safest approach is not to drink alcohol at all to keep risks to your baby to a minimum.

Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink, the greater the risk.

Data from NHS Digital suggests that less than 0.5% of women drink alcohol regularly at the time of their antenatal booking appointment, however this still equates to 310 women whose pregnancy is at risk because of alcohol use.

---

[8] Copyright © 2016 Health and Social Care Information Centre. The Health and Social Care Information Centre is a non-departmental body created by statute, also known as NHS Digital. iViewPlus Maternity Services Data Set Extracted October 2019

Substance Misuse During Pregnancy

Using drugs while pregnant creates significant risks to both mother and foetus. These risks include premature and underweight babies, stillborn births and birth defects. Data from NHS Digital reports 270 women were currently using drugs at the point of antenatal booking and 1,310 reported having previously used drugs at some point [9].

Complex Social Factors

The NHS collects data on women who have complex social risk factors at the time of antenatal booking, particularly alcohol or drug misuse, recent migrant or asylum seeker status, difficulty reading or speaking English, aged under 20 or domestic abuse. By identifying these women who are at increased risk the NHS can prioritise support and advice in line with NICE clinical guidelines[10].

17.5% of women who booked antenatally in 2017/18 were identified as having complex social needs in Birmingham which was above the England value of 9.4%.[11] Data from the Maternity Services Dashboard shows that there is some variation in the percentage of women with complex social factors between the three maternity providers. Birmingham Women and Children's Hospital Trust reported 10% of women identified as having complex needs in March 2019; compared to 21% at Sandwell and West Birmingham Hospital Trust and 15% at University Hospital Foundation Trust.

Mental Health Prediction and Risk

As part of the antenatal booking appointment the midwife undertakes a mental health risk assessment by asking a series of standard questions as part of a general discussion about a woman's mental health and wellbeing. NICE recommends the following questions:

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?
- Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious or on edge?
- Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?

The Royal College of General Practitioners estimates that up to one in five women and one in ten men are affected by mental health problems during pregnancy and the first year after birth. Unfortunately, only 50% of these are diagnosed. Without appropriate treatment, the negative impact of mental health problems during the

---

[9] NHS Digital: Maternity Services Dataset

[10] NICE. Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. Clinical guideline [CG110]

[11] Copyright © 2016 Health and Social Care Information Centre. The Health and Social Care Information Centre is a non-departmental body created by statute, also known as NHS Digital. iViewPlus Maternity Services Data Set Extracted October 2019

perinatal period is enormous and can have long-lasting consequences on not only women, but their partners and children too. However, this is not inevitable. When problems are diagnosed early and treatment offered promptly, these effects can be mitigated.[12]

Data for Birmingham was not available at the time of publication of the JSNA; however, the Public Health Team will continue negotiations to secure access to this data and hope to report locally as and when this becomes possible.

Service Models

Birmingham's maternity services are provided by Birmingham Women's Hospital, Good Hope Hospital, Heartlands Hospital and Sandwell & West Birmingham Hospitals NHS Trust (at City Hospital), provide a shared model of care with midwives, community services and primary care.

The NHS Saving Babies' Lives Care Bundle, launched by NHS England to reduce the rate of stillbirth and early neonatal death by incentivising the reduction of smoking in pregnancy, and raising awareness and improving monitoring of foetal growth and movement, has been implemented in Birmingham. This is accompanied by the development of a systematic approach to maternity care – a partnership of two maternity providers to deliver care using the same pathways in a more community orientated approach. The improvement programme to deliver this approach is overseen by the Birmingham United Maternity and Newborn Partnership (BUMP) partnership of commissioners and providers.

The commissioned NHS Maternity services are aligning into Local Maternity Systems sharing common standards, a model of community personalised risk-stratified care and any specialist facilities or skills. Personalised mother-centred care is also a standard, including choice and shared decision making. The systems also attempt to raise standards of care and improve outcomes by reducing adverse events such as stillbirth, difficulties during labour, and death of the baby during and after birth. The two large maternity services in Birmingham and Solihull have been collaborating as an early adopter of this approach since 2016. Full adoption is planned for 2020 with the impact and benefit being measurable in 2023.

An important feature of this approach is the collaborative partnership with those working in the Early Years System, establishing and sustaining support for parents and the development of the infant. In particular, this includes: the threat from tobacco smoking; support to establish sound infant feeding practices (breast and bottle feeding); and uptake of immunisation (by the mother during pregnancy and the child in the first five years of life).

Maternity Service Data

There are many maternity service indicators but two significant ones in the context of population health are the rate of late antenatal booking and the uptake of antenatal screening.

---

[12] https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/perinatal-mental-health-toolkit.aspx

Late Antenatal Booking

NICE Quality Standard for Antenatal Care (2016) recommends that women should have received their first antenatal booking appointment before 10 weeks of gestation (70 days). Across the three maternity providers in Birmingham there is some variation in the proportion of women late booking in March 2019 (table 7), with women in SWBHT booking later than at UHBFT and women booking at BWCT booking significantly later, but this may reflect the case mix of women attending BWCT which is a centre of excellence, providing specialist services for more complex pregnancies for the whole region.

Table 7: Percentage of Women at different gestation days at time of booking in Birmingham Hospital Trust providing Maternity Services (March 2019)

	Birmingham Women & Children's NHS Trust (BWCT)	University Hospitals Birmingham Foundation Trust (UHBFT)	Sandwell & West Birmingham Hospitals Trust (SWBHT)	England Average
<70 days	43%	59%	56%	56%
71-90 days	38%	22%	20%	28%
91-140 days	14%	11%	15%	9%
> 141 days	5%	8%	10%	8%
Missing	0%	0%	0%	0%
Count	810	760	840	

Source: NHS Digital Maternity Dashboard

Method of Delivery

Method of delivery can reflect both the complexity of the case mix in maternity as well as the quality of care. The Maternity Dashboard reports on a monthly basis the different percentage of delivery by NHS hospital trust, the level of spontaneous delivery is highest at Sandwell and West Birmingham Hospital Trust (table 8).

Table 8: Percentage of different methods of delivery in Birmingham Hospital Trust providing Maternity Services (March 2019)

	Birmingham Women & Children's NHS Foundation Trust	University Hospitals Birmingham Foundation Trust	Sandwell & West Birmingham Hospitals Trust
Elective caesarian section	11%	8%	11%
Emergency caesarian section	18%	20%	15%
Spontaneous delivery	47%	56%	63%
Instrumental delivery	14%	11%	9%
Other	9%	5%	3%
Missing data	0%	0%	0%

Source: NHS Digital Maternity Dashboard

Skin to Skin Contact at One Hour

The proportion of babies who are given skin to skin contact with their birth mother within an hour of birth is used as an indicator of quality of care as it is an important step towards developing a strong bond between mother and child. Across the three providers there has been some variation over 2018/19.

The Women and Children's NHS Foundation Trust has historically had a high percentage of missing data but from January 2019 this dropped dramatically and in March 2019 80% of babies were achieving skin to skin with their mothers within an hour of birth.

Sandwell and West Birmingham Hospitals Trust has consistently had about a third of data missing for this metric and at March 2019 66% of babies were achieving skin to skin within an hour in this trust. The picture is very similar at University Hospitals Foundation Trust. There is a clear need to improve recording of this metric at both Sandwell and West Birmingham and University Hospitals Foundation Trust.

Uptake of Antenatal and Newborn Screening

There is a national antenatal screening programme which offers women the opportunity for both blood and ultrasound screening to reduce risk to both mother and foetus and identify potential birth defects. The screening tests are undertaken by maternity services.

The National Antenatal Screening programme includes:

- Antenatal blood tests for Rubella, HIV, Syphilis and Hepatitis B
- Antenatal ultrasound screening for fetal anomalies
- Antenatal Sickle Cell and Thalassaemia testing for higher risk couples
- Newborn Blood Spot Screening testing for genetic conditions like cystic fibrosis
- Newborn and infant physical examination programme checking babies physically within 72hrs of birth

Of the NHS Trusts who service the Birmingham population the 2018/19 quarter four coverage of antenatal infectious disease screening and antenatal sickle cell and thalassaemia screening coverages were reported at 99.4% or better against a threshold of 95%.

For the same reporting period the completion of laboratory requests showed marginally more variation, but no Trust reported less than the threshold of 97%, and newborn and infant physical examination coverage was reported by the Trusts as 97-99% against a threshold of 95%.

Future Trends

Population projections from ONS revised in 2014 have predicted a 1% rise in births year on year in Birmingham until 2021. Since 2014 our actual births have been below the projected rate, mirroring the national picture. Although there has been a recent slight decline in fertility rates it is slower than the national decline and the overall fertility in Birmingham remains significantly higher than England.

Early Years 0-5 years

Key Statistics

There were an estimated 100,690 children aged 0 to 5 years in Birmingham in 2018, this equates to 8.8% of the total population of the city. 51.3% of this population are male and 48.7% are female; this differs from the overall population where 49.5% are male and 50.5% are female

The largest population was in Alum Rock ward with 3,060 in this age group; the smallest in Sutton Wylde Green ward with a 5 and under population of 510 (2017 data). Lozells ward has the highest male population of 54.7%, and Stirchley ward the highest female population of 54.5%

The number of children aged under 5 years living in poverty [13] is very high in Birmingham at 29% - with the England figure being 20% (of children in families claiming child benefit). End Child Poverty published figures in May 2019 showed that 41% of Birmingham children were living in households in poverty, compared to 30% nationally (poverty was defined as household income adjusted to account for household size, is less than 60% of the median, with all poverty rates calculated after housing costs). Within this there is significant variance between different parts of Birmingham with Small Heath ward at 62% and Sutton Wylde Green at 16%.[14]

Diversity and Inclusion

The last record of population by ethnicity is the 2011 census. The breakdown of broad ethnic groups of the age 0 to 4 population from the 2011 census is in the table 9 below (single year of age data is not available to calculate 0-5). However, there could have been significant changes in the ethnic mix for this age group since 2011.

Table 9: Ethnic profile of children aged 0- 4

Ethnic Group	% of Population aged 0-4	Total Birmingham %
White	40.1%	57.9%
Mixed/multiple ethnic group	10.7%	4.4%
Asian/Asian British	35.2%	26.6%
Black/African/Caribbean/Black British	10.6%	9.0%
Other ethnic group	3.3%	2.0%

Source: 2011 Census

During 2018, 2,050 new migrants aged 0 to 5 registered with a GP in Birmingham; with the majority coming to the city from Romania, Italy, Pakistan and India.   This figure was slightly higher than 2017 at 2,035. Many of these new migrants located to Soho and Jewellery Quarter, Ladywood and Alum Rock wards.

---

[13] Children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income. HM Revenue and Customs (Personal Tax Credits: Related Statistics – Child Poverty Statistics)
[14] http://www.endchildpoverty.org.uk/poverty-in-your-area-2019/

We do not currently have data on the profile of the 0-5 years age group by other demographic aspects such as disability, faith and gender identity in Birmingham.

National data would suggest that 8% of children have a disability[15], although some of these children will develop disability during their childhood. In this age group this would equate to over 8,000 children with a disability in the city.

Faith can have a role in the context of childhood health outcomes and further work is needed to explore this in Birmingham given the cultural diversity of the city.

International research[16] suggests that about 1 in 100 births are children whose bodies differ from standard male or female presentations which can be in many different forms, usually due to genetics, and there are more that have genetic differences that come into the classification of intersex. This could potentially affect over 1,000 children in the city in this age group. Although most people with intersex variations are physically healthy, they may experience physical, mental, sexual and reproductive health and wellbeing issues related to their particular intersex variation. Therefore there is a need for those responsible for their care to understand the range of health issues affecting people with intersex variations and how these issues differ according to an individual's particular variations.

Birmingham Service Model

Birmingham is committed to becoming a child friendly city where every child achieves the best start in life and where services work together to improve outcomes for children.

Birmingham City Council commissions a partnership model of health and wellbeing services for early years (0-5 years) based on the national Healthy Child Programme. The service is currently provided by Birmingham Forward Steps (BFS). BFS is a partnership of Birmingham Community Healthcare Trust, Barnardos, Spurgeons, the Springfield Project and St Pauls Community Trust. It integrates health visiting services and children's centres into a ten district model to allow services to flex capacity to meet the needs of more vulnerable children while ensuring the statutory universal checks and support to all infants and young children in the city.
Outcomes for BFS include ensuring all children are supported through the mandated checks of child development, supporting effective parenting including breastfeeding, healthy weaning, active play and increasing uptake of the Healthy Start voucher scheme, and safeguarding vulnerable children.
Early identification and appropriate intervention when children are identified as having developmental delay or disability are important. Some conditions, such as autism, do not present with signs and symptoms until children are 2-3 years old; others like cerebral palsy vary significantly between children and it is only as the child grows that child professionals can assess what support will be needed. Where children are identified through the statutory developmental and educational assessments they are referred to the multi-disciplinary Child Development Centres.

---

[15] ONS Family Resources Survey: financial year 2016/17. 22/04/2018

[16] Intersex society of North America: How Common is intersex.

The City Council has a duty to support access to 15 hours of free nursery educational placements for all children aged 3-4 years old and for children aged 2 in families on low incomes. There is national funding to support the uptake of these opportunities, at no cost to the family, which is channeled through the City Council. Birmingham had high levels of take-up for 3 and 4 year olds in 2018 (92%, national 94%), and this rate of take-up has remained steady over the last four years (although take-up for 2 year olds is 62 per cent which is below the national average)[17].

General health service provision is through General Practice, one of the key aspects of primary care support for infants and children is the childhood immunisation programme which protects children against preventable diseases that can cause illness, school absence, hospitalization, disability and in some cases death. The routine immunisation schedule is determined nationally and commissioned locally by NHS England and NHS Improvement with support from an embedded Public Health England team.

For children and young people, the schedule includes immunisations delivered in at least eight blocks or age groups; most are delivered before children start school, but some are delivered between 12 and 14 years of age. All of the immunisations for infants and pre-school children are provided in GP Practices. The vaccinations for Primary and Secondary school children are delivered in school by local school age immunisation services (SAIS).

All GP Practices in Birmingham provide the universal immunisation schedule described above, and one SAIS provides the school-age vaccinations. The seasonal flu vaccination for children is delivered in different settings depending on age: vaccinations for those aged 2-3 years are provided by General Practices; school-age (all Primary school children from 2019) child flu vaccinations are provided by the Birmingham SAIS provider. Community pharmacies provide flu vaccinations, but only for people over 18 years old.

Service Performance Data

The national Child Health Programme sets out five mandatory checks which provide good proxies for how well the service is meeting the needs of children and families. The performance data for 2018/19 Q3 is shown in table 10 below.

Table 10: Performance data for mandated checks, 2018/19 Q3

Mandated Check Description	Birmingham	West Mid	England
Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days by a Health Visitor	88.5%	86.5%	89.1%
Percentage of infants who received a 6-8 week review by the time they were 8 weeks	90.1%	90.9%	85.6%
Percentage of children who received a 12 month review by the time they turned 12 months	58.4%	71.2%	75.7%
Percentage of children who received a 2-2½ year review	59.8%	75.2%	78.0%
Percentage of children completed the 2-2½ year review using the Ages and Stages	N/A	82.4%	92.5%

---

[17] Take-up of free early education entitlements Research report. Dept for Education

Questionnaire (ASQ-3).			

Source: PHE Health Visitor Service Delivery Metrics (Experimental Statistics) Quarter 4 2018/19

Birmingham's performance in terms of completion of mandated checks was similar or above England for the NBV and 6-8 week checks but significantly below for 12 month and 2-2½ year review (see table 10).

There were data quality issues in Birmingham which prevented the reporting of the proportion of children in Birmingham who completed the 2-2½ year review using the Ages and Stages Questionnaire (ASQ-3).

In addition to the statutory checks there are two other key service indicators for health and wellbeing; breastfeeding and health start vouchers/vitamins.

Breastfeeding

Breastfeeding has benefits that can last well into adulthood, and the longer the period of breastfeeding the greater and longer lasting the impact. Breastfeeding reduces the baby's risk of infections, diarrhoea, vomiting, childhood leukaemia, obesity, and cardiovascular disease during adulthood.[18]

In 2016/17, 71.1% of Birmingham mothers gave their babies breast milk in the first 48 hours after delivery, below the England average of 74.5%. The Birmingham breastfeeding initiation rate has increased slightly over recent years from 68.6% in 2010/11 to 71.1% in 2016/17 but has remained consistently below the England average.

Nationally rates of breastfeeding initiation are lower in the most deprived 10% of communities than in the least deprived 10% (68.8% compared to 81.2%). A similar differential is evident for breastfeeding coverage at age 6-8 weeks (40.2% in the most deprived, 51.5% in least deprived).

In Birmingham, in 2015, 51% are still breastfeeding at age 6-8 weeks, which was a higher rate that the England average of 43%.

Unfortunately, due to data quality issues with Birmingham Forward Steps in relation to more recent breastfeeding data, we are unable to confirm if these breastfeeding rates have been maintained.

Uptake of the Healthy Start Voucher Scheme

The Healthy Start scheme provides vouchers for pregnant women and parents with children under 4 years of age in receipt of certain benefits to help buy some basic foods. This important means-tested scheme provides vouchers to spend with local retailers [19]

Take up in the most recent reporting period (September 2019) in Birmingham was 60% of eligible families, which was above the national average of 54.2% and the West Midlands average of 57.2%. However, this still means that 40% of eligible families aren't taking up this free support for their children.

---

[18] https://www.nhs.uk/conditions/pregnancy-and-baby/benefits-breastfeeding/
[19] Healthy Start

Uptake of Healthy Start Vitamins

Birmingham City Council funds universal provision of the vitamins to help reduce the stigma of the scheme and improve uptake. The voucher scheme provides a means for this vulnerable group to access vitamins with a variety of health benefits that are known to be more prevalent in more deprived communities, and assists with child growth, healthy bones and healthy teeth. For quarter 2, 2018/19, 23% of the cohort of mothers and parents claimed their vitamins [20]

Childhood Immunisation

In 2017/18, 87.6% of Birmingham children received a single MMR vaccination by aged two and 81.6% have received two doses by aged five, both below the England average (91.2% and 87.2% respectively) and below the target rate of 95% recommended for herd immunity (table 11). Figures fell between 2010/11 and 2012/13 in Birmingham before recovering slightly by 2013/14 and then falling back by 2017/18.

Vaccination coverage in Birmingham in 2017/18 was below the target rate of 95% and below national and regional averages for most of the recommended childhood vaccinations. This is concerning given the recent outbreaks of vaccine preventable diseases that have occurred in the United Kingdom.

Table 11: Coverage for childhood vaccinations 2017/18

Vaccination	Birmingham	England	West Midlands
Dtap / IPV / Hib (1 year old)	90.1%	93.1%	92.8%
Dtap / IPV / Hib (2 years old)	93.1%	95.1%	95.6%
Hepatitis B (1 year old)	100.0%		
Hepatitis B (2 years old)	100.0%		
Hib / Men C booster (5 years old)	91.5%	92.4%	94.1%
Hib / MenC booster (2 years old)	87.4%	91.2%	90.8%
HPV vaccination coverage for one dose (females 12-13 years old)	81.3%	86.9%	88.1%
MMR for one dose (2 years old)	87.6%	91.2%	91.2%
MMR for one dose (5 years old)	93.7%	94.9%	95.7%
MMR for two doses (5 years old)	81.6%	87.2%	87.6%
PCV	90.8%	93.3%	93.6%
PCV booster	87.2%	91.0%	91.0%

Source: PHE Fingertips

The uptake of the seasonal flu vaccine for those aged 2 to 3 years old in Birmingham in 2017/18 was 38.2%. This was the worst performance in the West Midlands and well below the national target rate of 65%.

Key Outcomes

Early years education measures are a useful indication of early development and school readiness and reflect overall how well the partners in the city are supporting the health and wellbeing of children in this early stage of life.

---

[20] Birmingham Public Health.

In 2017/18, 67.7% of children attending a Birmingham school achieved a good level of development at the end of reception compared to 72.1% for England. Girls were more likely than boys to achieve a good level of development (74.6% compared to 61.2%). Compared to other core cities Birmingham is in the middle of the group, doing better than Leeds but worse than Newcastle-Upon-Tyne (figure 3).

Figure 3: School Readiness: the percentage of children achieving a good level of development at the end of reception

Source: PHE Fingertips

Between 2012/13 and 2017/18 the percentage of Birmingham pupils achieving a good level of development has increased from 49.6% to 67.7%.

The proportion of children achieving a good level of development by the end of reception varies by ethnic group (table 12). The proportion in 2018 was highest for mixed ethnicity pupils and lowest for Chinese ethnicity pupils, however there were a relatively small number of pupils recorded with Chinese ethnicity (103) so this may be vulnerable to distortion. The variance in development suggests there may be a need to target some early years and educational interventions towards addressing inequalities by ethnicity, particularly to close the gap between the city and the West Midlands and England averages.

Table 12: Children achieving early a good level of development by the end of reception in Birmingham, West Midlands and England 2018

Ethnicity	Birmingham	West Midlands	England
White	68%	70%	71%
Mixed	69%	68%	72%
Asian	65%	65%	68%
Black	65%	66%	68%
Chinese	60%	67%	76%
All Pupils	**66%**	**68%**	**70%**

Source: DfE: Early years foundation stage profile (EYFSP) results by pupil characteristics: 2018

The proportion of children with special educational needs (SEND) achieving a good level of development is significantly lower than the proportion across all pupils: 21% for pupils receiving Special Educational Needs (SEN) support and 5% for pupils with a statement or educational healthcare plan (EHCP). In England 27% of pupils with SEN support achieved the development goal but only 4% with a statement or EHCP, so the city is doing better than England for EHC but not as well for SEN supported children.

The number of children accessing early years support services (Education) has been increasing over the past 5 years. In academic year 2017/18, there were 2,067 children notified to Early Years Inclusion Support. During 2017/18 the priority SEND need area most in demand in the 0-5 age range was communication and interaction.

Developmental Progress Outcomes

Data quality issues mean that we are unable to monitor child development through the ages and stages questionnaire. The same issue has also prevented us monitoring breastfeeding rates at 6 to 8 weeks since 2015.

Health Outcomes

Lack of access to primary care data limits the monitoring of health outcomes across all age groups. The only prevalence data available through primary care data sources are for those conditions where there is a disease specific Quality and Outcomes Framework (QOF) register. There are no such registers specific to the 0 to 5 age group. Primary care immunisations data is only shared at a local authority aggregated coverage rate by immunisation type and therefore prevents more in-depth analysis of inequalities.

Hospital Episode Statistics (HES) for A&E attendances recorded 60,834 A&E attendances by children aged 0 to 5 in 2017/18. Of these attendances 34.3% did not have a valid primary diagnosis recorded.[21] The table 13 shows the top 10 valid primary diagnoses recorded for the attendances. While some of these may be impossible to eliminate entirely there is potential to reduce these admissions though

---

[21] Approximately half without a valid code were coded using ICD10 disease classification which is not standard for A&E diagnosis classification. This is due to Heartlands Hospital using ICD10 rather than the standard A&E diagnosis classification method.

infection control (specifically in reference to infectious diseases) and other measures.

Table 13: Top 10 valid primary diagnosis recorded for A&E attendances for Birmingham children aged 0-5

A&E Primary Diagnosis	Number of Attendances	% of Total Attendances
Respiratory conditions	11,522	18.9%
Gastrointestinal conditions	4,576	7.5%
Diagnosis not classifiable	3,403	5.6%
ENT conditions	2,454	4.0%
Head injury	1,948	3.2%
Infectious disease	1,836	3.0%
Laceration	1,828	3.0%
Dermatological conditions	1,727	2.8%
Dislocation/fracture/joint injury/amputation	1,550	2.5%
Contusion/abrasion	1,228	2.0%

Source: NHS Digital: HES

There is also potential for A&E attendances to be reduced by better signposting to more appropriate front line service for attendances that fit the NHS definition of "first attendance with some recorded treatments or investigations all of which may have been reasonably provided by a GP, followed by discharge home or to GP care."[22]

Hospital Episode Statistics record demographic factors such as age, home address (aggregated to lower super output layer level) and ethnicity. In future years there may be value in analysing these data in more detail to explore differences across the city in different geographies and different demographic groups.

ONS, via NHS Digital, provide local authorities each year with a breakdown of deaths amongst various age groups. During 2015/17 Birmingham had a total of 59 deaths between the ages of 1 to 5. Causes varied considerably and numbers in each cause where very low. The main five causes were in related to diseases starting at birth: spinal muscular atrophy, cerebral palsy and heart issues due to congenital anomalies. The other main causes where cancers and traffic accidents. Male children accounted for 53% of these deaths.

Future Trends

Office for National Statistics (ONS) population projections made in 2016 predicted that the age 0 to 4 population in Birmingham would increase by 3.3% (2,945) between 2019 and 2029. Nationally the population in this age group is predicted to fall during the same period. Birmingham can therefore expect a greater demand for early years services in the future relative to other areas in England.

---

[22] NHS Digital: Non-urgent A&E attendances

School Years

Key Statistics

The 2019 school census recorded 114,564 children at primary schools, 71,218 at secondary school and 10,317 in sixth form in Birmingham.

As at October 2019 Birmingham had 1,431 children listed as home educated. It is usual for this figure to increase throughout the year until July when the year 11 pupils are removed from the list. Estimates suggest that in 2018 there may have been around 53,000 - 58,000 home educated children in England; the number appears to have increased in recent years.[23]

There were an estimated 220,635 children aged 5 to 18 years in Birmingham in 2018, this equates to 19.3% of the total population of the city. 51.6% of this population are male and 48.4% are female; this differs from the overall population where 49.5% are male and 50.5% are female

The largest population was in Alum Rock ward in 2017 with 7,163 in this age group; the smallest in Sutton Trinity ward with a 5 to 18 population of 1,225. From a ward perspective South Yardley ward has the highest male population of 54.5%, and Bournville and Cotteridge ward the highest female population of 50.5%

Diversity and inclusion

The gender split is mostly even other than for sixth form students, where girls make up 56.3% of the student count.

The 2019 school census recorded 42.1% of pupils as disadvantaged, 28.3% as eligible for free school meals and 41.9% with English as an additional language.

We have limited data on the proportion of school aged children who have long term health conditions and/or disabilities. The proportion of pupils at Birmingham's schools with Education Health Care Plans (EHCP) and Special Education Need (SEN) support gives an indication of the level of need. EHCPs address the health and social care needs of the child or young person as well as their educational needs and can be in force from the ages of 0-25. SEN support which is extra or different help from that provided as part of the school's usual curriculum without a formal assessment process.

Table 14: Proportion of pupils at Birmingham schools with EHCP and SEN support

Proportion of Pupils	Birmingham	England	English Core Cities
Primary pupils with EHCP	1.1%	1.4%	0.8%
Primary pupils with SEN support	15.0%	12.4%	14.2%
Secondary pupils with EHCP	1.3%	1.6%	1.2%
Secondary Pupils with SEN support	11.7%	10.6%	11.9%

Source: DfE, 2018

---

[23] Alternative Provision, Attendance & Independent Education, Birmingham City Council

The proportion of pupils at Birmingham's primary schools with EHCPs is similar to the national average and to the other English core cities (table 14).[24] The proportion of pupils receiving SEN support is higher than the national average but similar to the other core cities. The proportion of pupils at secondary schools with EHCPs and SEN support is similar to the national average and to the other English core cities. A greater number of pupils are categorised under the moderate learning difficulty category than nationally, leading to concern that children's needs are not being accurately identified. Birmingham also has 27 state-funded special schools attended by 2.2% of school population. This is a higher proportion than for England or the core cities. Demand for these places is high and additional provision is used outside the city.

A large proportion of school age children live in areas classified as deprived. Over 50% of Birmingham lower super output areas (LSOAs) were ranked in the top two national deciles for income deprivation affecting children in the 2019 indexes of multiple deprivation. The most deprived areas are concentrated in the central and the southern margins of the city. However, the overall percentage of children entitled to free school meals has fallen from 31.9% (2012) to 24.2% (2018) and the gap between the city and the region has closed by 4 percentage points; the gap with England proportion has closed by 4.4 percentage points.

We do not have any local data on sexual orientation, gender identity or faith on school aged children.

Unhealthy Behaviours

Smoking

Most smokers start smoking when they are children and those who start smoking earliest are more likely to become heavy smokers and find giving up harder.[25] With the known impacts of smoking on health it is therefore a priority for public health to help minimise the rates of smoking in school age children. A survey of persons aged 15 years old shows that nationally the proportion of young people who say they are a regular smoker fell from 20% in 2006 to 7% in 2016 [26].

Figure 4 shows that in Birmingham 4.4% of persons aged 15 years responding to the What About YOUth (Way) survey in 2015 said they were a current smoker (3.1% regular smoker, 1.3% occasional smoker) compared to the England average of just over 8%.

---

[24] Children and Young People with Special Education Needs and/or Disability in Birmingham; Joint Strategic Needs Assessment 2018-19
https://www.birmingham.gov.uk/downloads/file/7884/special_educational_needs_and_disability_2018
[25] ASH Young People & Tobacco
[26] Smoking, Drinking and Drug Use among Young People in England: NHS Digital survey

Figure 4: Smoking prevalence at age 15 - current smokers (WAY survey) 2015

Source: What About YOUth (WAY) survey, 2014/15

Substance misuse

The use of recreational drugs by young people is a risk to mental health including potential increases in suicide, depression and disruptive behaviour disorders. In the rolling three year period 2015/16 to 2017/18 (figure 5) the rate of admissions to hospital due to substance misuse by those aged 15-24 in Birmingham was below the England average (56.0 compared to 87.9 per 100,000). Whilst the rate of admissions in England increased since 2008/09, rates in Birmingham have remained consistent.

Results from the national WAY survey (2014/15) indicated that the proportion of those aged 15 years old in Birmingham who had taken drugs in the previous month was lower than the national average.

Figure 5: Hospital admissions due to substance misuse (15-24 years)
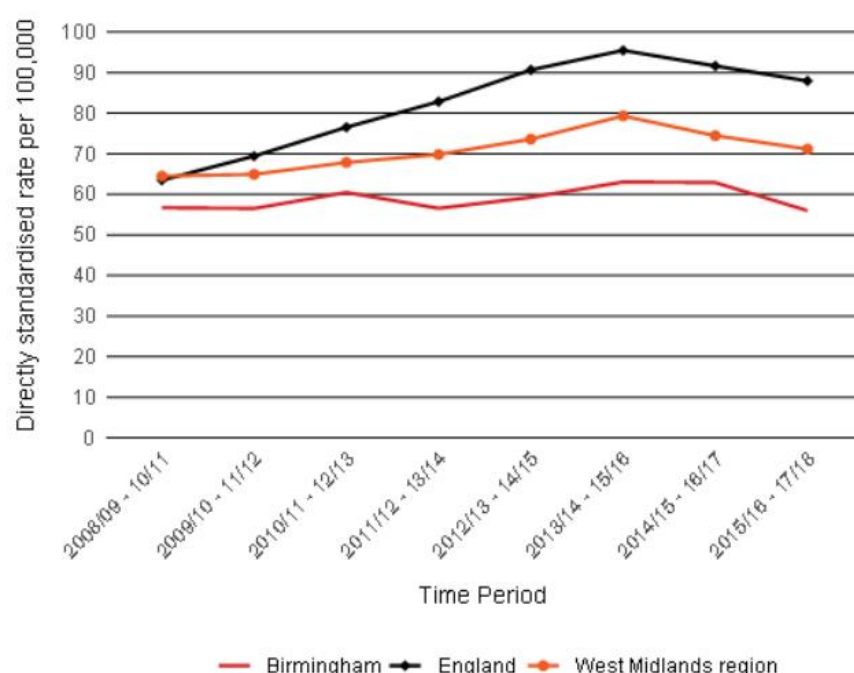
Source: Hospital Episode Statistics NHS Digital

There is strong evidence that teenage drinking affects brain development and is linked with increased health risks though the increased likelihood of teenagers who drink getting into fights or engaging in unprotected sex.[27] Results from the WAY survey (2014/15) indicated that the proportion of those aged 15 years old in Birmingham who were regular drinkers was lower than the national average (2.8% vs 6.2%). The proportion who had been drunk in the previous four weeks was also lower than the national average (6.3% vs 14.6%).

At 15.4 per 100,000 , the Birmingham under 18 alcohol specific hospital admission rate was below the England average (32.9 per 100,000) and lower than all core cities, other than Sheffield, in the three years 2015/16 to 2017/18. The rate is significantly below the England average for males (9.0 vs 26.4 per 100,000) and females (22.1 vs 39.6 per 100,000).

The overall under 18 alcohol rates of admission have trended downwards significantly since 2008/09 (figure 6), which is broadly comparable with England. However, the decline in admissions has slowed in the last two years.

---

[27] The Drinkaware Trust. Teenage drinking

Figure 6: Admission episodes for alcohol-specific conditions - Under 18s over time
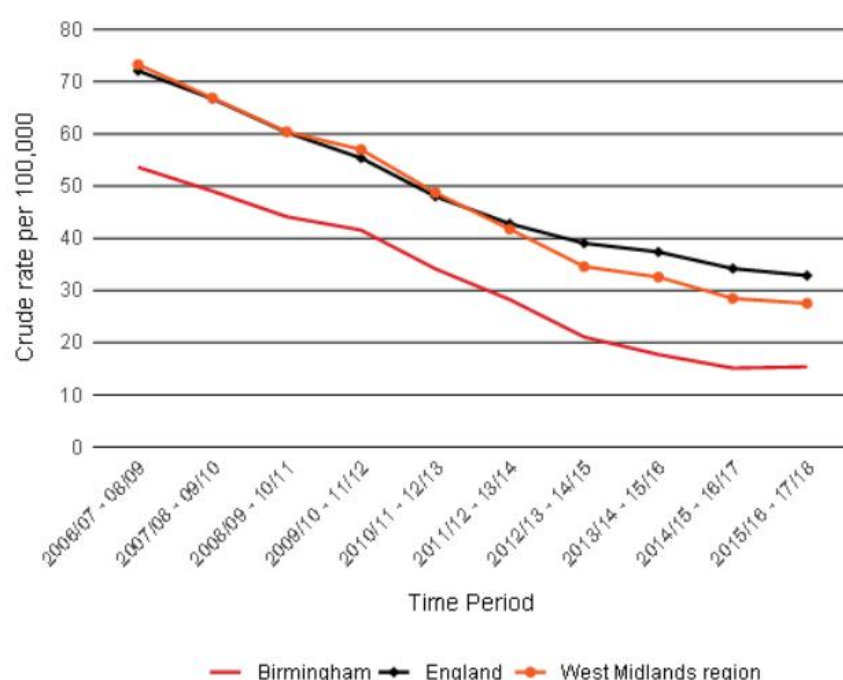
Source: Hospital Episode Statistics NHS Digital

Healthy eating

Children require the right nutrients for healthy growth and development and should therefore be consuming a healthy balanced diet in line with the Eatwell guide.[28] In 2014/15, 54.1% of those aged 15 years old in Birmingham reported that they eat five portions or more of fruit or vegetables a day compared to the England average of 52.4%, see figure 7. We don't have local data on the consumption of other nutrition indicators like fat, salt and sugar, that are directly associated with health conditions like high blood pressure (hypertension), cardiovascular disease, type two diabetes and cancer. There is a need for better knowledge of the city's food intake by children as the obesity data presented elsewhere suggests it is not healthy.

Nationally, those aged 15 years old from the least deprived backgrounds are more likely than those from the most deprived neighbourhoods to eat healthily (55.8% compared to 51.3%), with some variations also evident among young people from different ethnic backgrounds (49.5% Black, 51.1% White, 60.3% Asian). Increased ethnic diversity of young people in the city maybe a protective factor in terms of fruit and vegetable consumption.

.

---

[28] British Nutrition Foundation. School Children

Figure 7: Percentage who eat 5 portions or more of fruit and veg per day at age 15

Source: What About YOUth (WAY) survey, 2014/15

Physical activity

In 2014/15 only 12.3% of those aged 15 years old in Birmingham reported that they were physically active for at least one hour per day seven days a week compared to the England average of 13.9%. The Active Lives Survey only collects data on young people over 16 years, however the 17/18 data set shows that young people aged 16-24 years are more inactive (17.7%) than in England (15.4%). A smaller proportion in Birmingham are achieving the recommended levels of physical activity to improve health, only 68.4% compared to 75.4% in England.

Physical activity levels in children are linked with mental health outcomes and the likelihood of continuing to be physically active as an adult.[29] Nationally, 15 year olds from the least deprived backgrounds are more likely than those from the most deprived neighbourhoods to meet the recommended target for physical activity (14.3% compared to 12.3%), with some variations also evident among young people from different ethnic backgrounds (14.4% White, 12.2% Black, 9.5% Asian).

Obesity

Obesity in children often carries over into adulthood leading to avoidable ill health or premature mortality and can also have a detrimental effect on mental health and wellbeing through bullying and loss of self-esteem. In 2017/18 the percentage of obese Birmingham children at reception and year six is above the England average and among the highest in the West Midlands. In reception 11.3% are classified as obese (9.5% England); in year six 25.6% are classified as obese (20.1% England).

---

[29] Department of Health and Social Care, Llwodraeth Cymru Welsh Government, Department of Health Northern Ireland and the Scottish Government. UK Chief Medical Officers' Physical Activity Guidelines 2019

Nationally, year six children from the most deprived 10% of the population are more than twice as likely to be classified as obese as those in the least deprived 10% of the population (26.8% compared to 11.7%). There are also differences between ethnic groups (highest among those from a Black/Black British background) as well as between boys and girls (22.2% compared to 18.0%).

In the last few years the number of children classified as obese in reception has remained broadly consistent in Birmingham and England. By contrast, like England as a whole, obesity levels in year six have trended upward (2007/08 22.1%, 2017/18 25.6%) (figure 8).

Figure 8: Year 6 prevalence of obesity (Including severe obesity)
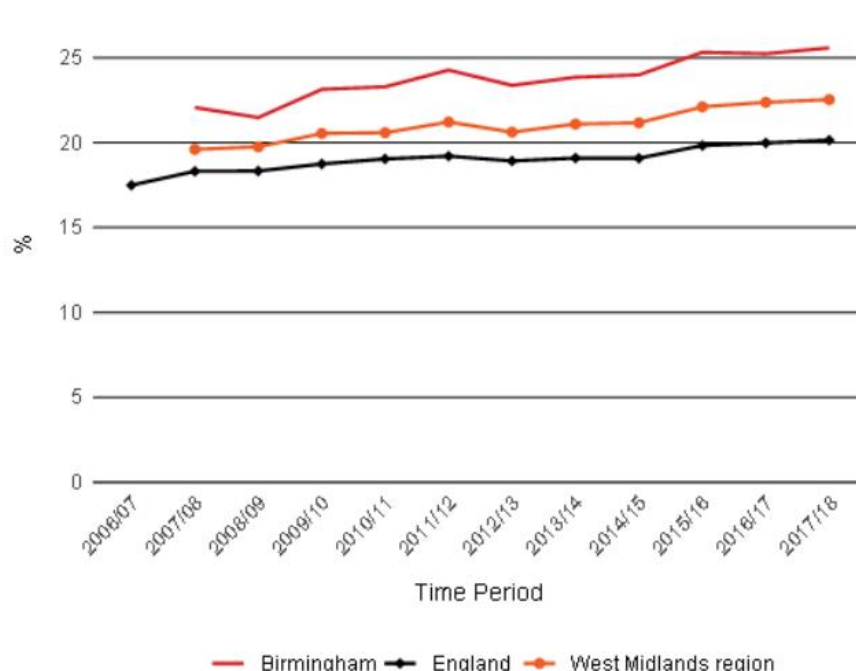
Source: NCMP / Public Health England

Mental Health of School Aged Children

Mental health problems affect about 1 in 10 children and young people. They include depression, anxiety and conduct disorder, and are often a direct response to what is happening in their lives.[30] Alarmingly, however, 70% of children and young people who experience a mental health problem have not had appropriate interventions at a sufficiently early age.

The emotional wellbeing of children is just as important as their physical health. Good mental health allows children and young people to develop the resilience to cope with whatever life throws at them and grow into well-rounded, healthy adults.

The Mental Health of Children and Young People Survey 2017 finds that nationally, one in eight children and young people aged 5 to 19 years have at least one mental disorder. The prevalence of mental health problems rises with age, with 9.5% of

---

[30] Mental Health Foundation – Children & Young People

children age 5-10 years experiencing a mental disorder compared to 16.9% of those aged 17-19 years old. Emotional disorders are the most prevalent type of mental health problem experienced by those aged 5-19 years old (8.1% of all children), followed by behavioural disorders (4.6%) and hyperactivity disorders (1.6%).

In Birmingham the estimated prevalence of mental health disorders in children and young people (5-16 years) is 10.3% (England 9.2%, West Midlands 9.7%) (table 15).

Table 15: Estimated prevalence of mental health conditions in children and young people

	Birmingham Estimated %	Modelled number of young people affected in 2018 (5-16 years population = 190,397)	West Midlands %	England %
Mental health disorders in children & young people 5-16 years	10.3%	19,611	9.7%	9.2%
Prevalence of emotional disorders aged 5-16 years	4.0%	7,616	3.8%	3.6%
Prevalence of conduct disorders in 5-16 years olds	6.4%	12,185	5.9%	5.6%
Prevalence of hyperkinetic disorders in 5-16 years olds	1.7%	3,237	1.6%	1.5%
Potential number of cases of eating disorders in 16-24 years	N/A	21,518	N/A	N/A
Potential number of cases of ADHD in 16-24 years	N/A	22,414	N/A	N/A

Source: PHE Fingertips Children and Young People's Mental Health

As well as age and gender, a child's background and circumstances have a significant bearing on rates of mental health disorders, with prevalence higher among:

- White British children compared to those from the Asian/Asian British or Black/Black British ethnic groups
- Those living in low income families – (7% among children in most affluent families compared to 15% in the least affluent)
- Those living with a parent with a mental health disorder
- Those who have experienced an adverse life event
- Those who have low levels of social support, smaller social networks, and those not participating in clubs or organisations

Although Birmingham has a lower proportion of white British children than the England average, the city has a higher proportion of low income families (27.6% of children under 16 years live in low-income families), a higher rate of children living in households with a parent in drug treatment and a higher rate of children in care than the England averages. Overall, we would expect to see a higher rate of mental health conditions in children in the city than England because of the increased risk factors.

Figure 9 shows the Birmingham rate of hospital admissions for mental health conditions in children and young people in 2017/18 was lower than the England average (76.4 compared to 84.7 per 100,000). In Birmingham the rate among males was substantially higher than females. Compared to the core cities group, the rate of admission for mental health conditions is third highest.

Figure 9 Hospital admissions for mental health conditions aged 0-17 years 2017/18
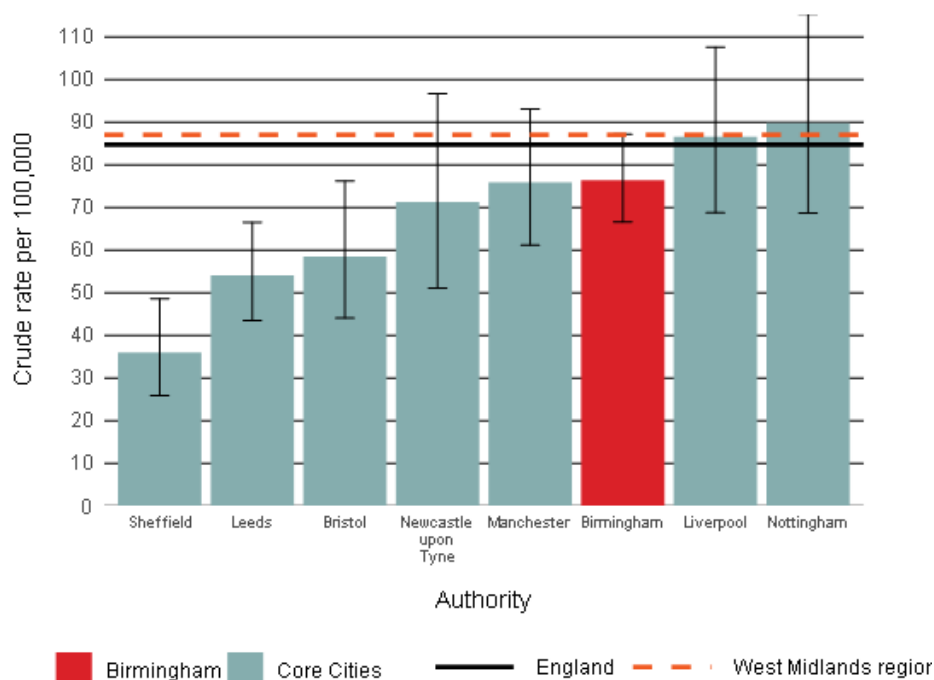
Source: Hospital Episode Statistics NHS Digital

Rates of admission for self-harm in the city are lower than the rates for the West Midlands and England. There has been a gradual fall in the rates of self-harm in Birmingham since 2011/12 to 2017/18, this has been most stark for those aged 15-19 years old and those aged 20-24 years old (figure 10).

Figure 10: Rate of hospital admissions for self-harm in Birmingham, by age group, between 2011/12 and 2017/18
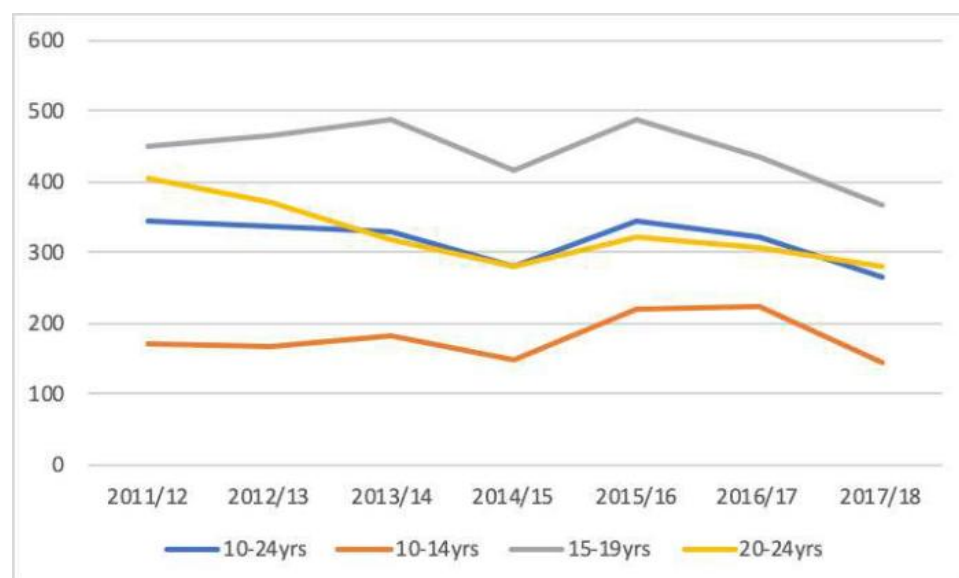
Sources: PHE Fingertips drawn from HES data

Physical Health of School Aged Children

Asthma is the most common long-term medical condition among children and young people in the UK.[31] It is the most common cause for emergency hospital admissions for children and young people but there is strong evidence that many acute asthma episodes are preventable.[32] Emergency admissions for asthma for children aged 0 to 9 were significantly higher in Birmingham than the national average in 2017 (378.3 per 100,00 vs 255.8 per 100,000).

Accidental injuries are one of the most common causes of death in children over one year of age and more than two million children under the age of 15 attend Accident and Emergency (A&E) departments each year due to accidents in and around the home, many of which could have been prevented.[33] The rate of A&E attendances by children aged 5 to 9 in Birmingham was higher than the England average in the period 2016/17 (317.2 per 100,000 vs 305.7 per 100,000). The rates of A&E attendances during the same period for children aged 10 to 14 and all children under the age of 18 were broadly comparable to the England average. Further analysis of reasons for attendance has not been completed at this point as the quality of clinical coding within A&E data is known to be poor.

---

[31] NHS England - Childhood asthma
[32] Nuffield Trust. Child asthma admissions: part of a 'care-failure' iceberg
[33] RoSPA – Accidents to children

The rate of children killed or seriously injured (KSI) in road accidents in Birmingham in 2014-16 was higher than the England average for both the 6 to 10 age group (21.3 per 100,000 vs 14.8 per 100,000) and the 11 to 15 age group (46.4 per 100,000 vs 32.6 per 100,000). A Road Safety Strategy for Birmingham has been developed.[34] It sets out an action plan to reduce the number and severity of road traffic accidents, with a focus on the most vulnerable road users in the city.

The strategy is a partnership project and the action plan will be delivered by the Birmingham Road Safety Partnership, which includes key partners, West Midlands Police, West Midlands Fire Service, community organisations, and third sector organisations such as RoSPA.

Wider Determinants

There are many different factors that affect health including poverty, housing, education, crime and these are called the wider determinants of health.

Evidence linking child poverty and long term health outcomes is very strong.[35] HMRC data shows that in 2016, 27.6% of all Birmingham children aged 0-15 years lived in low-income families compared to the England average of 17.0%. Birmingham has the 6th highest proportion in England. The proportion of Birmingham children aged 0-15 years old in families with low-income increased slightly in 2016. However, the rate has generally been declining between 2006 and 2015 although it remains higher than the England rate and the gap between the city and the nation is not closing (figure 11).

Figure 11: % of children in low income families (under 16 years)
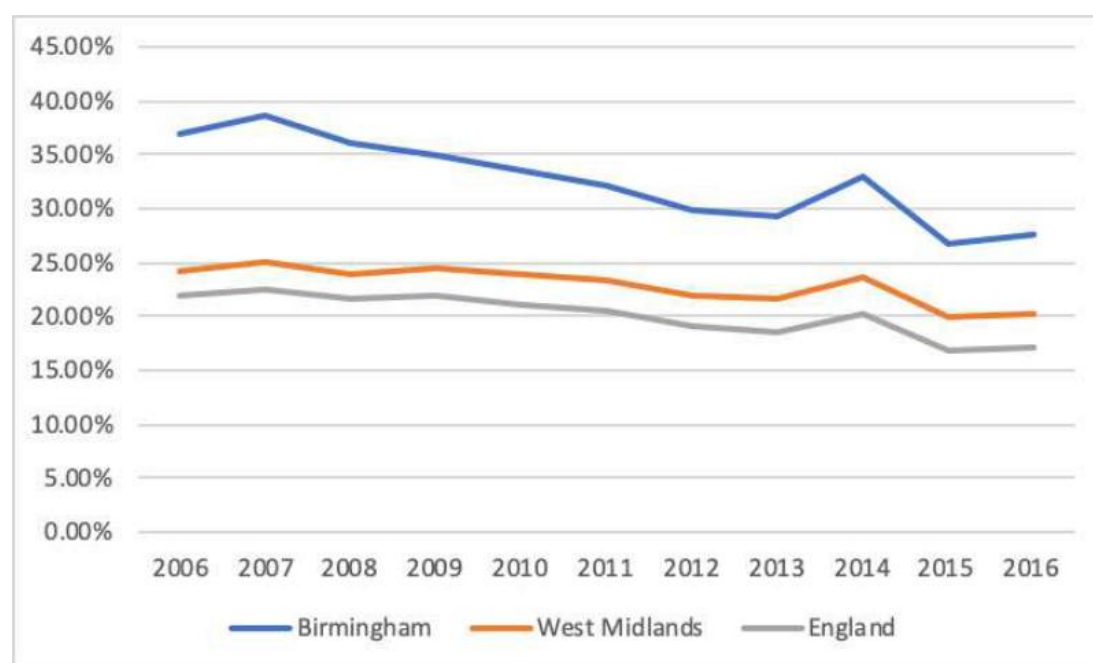
Source: PHE Fingertips drawn from HMRC Personal Tax Credits: Related Statistics - Child Poverty Statistics

---

[34] Birmingham road safety strategy
[35] End Child Poverty - Child poverty facts and figures

The link between education and health is two way. The quality of educational experience impacts on health outcomes[36] and health outcomes impact on educational outcomes.[37]

Links between school attendance, unhealthy behaviours and health outcomes are well documented.[38,39] Measures of pupil absence are less favourable at Birmingham schools than the England average. For instance, in 2017/18, 13% of pupils of all ages attending a Birmingham school were classified as persistent absentees compared to the England average of 11.2%. The rate among primary school pupils in Birmingham (11%) is the highest in the West Midlands and 7th highest nationally.

Figure 12: Secondary school fixed period exclusions: rate per 100 pupils 2016/17
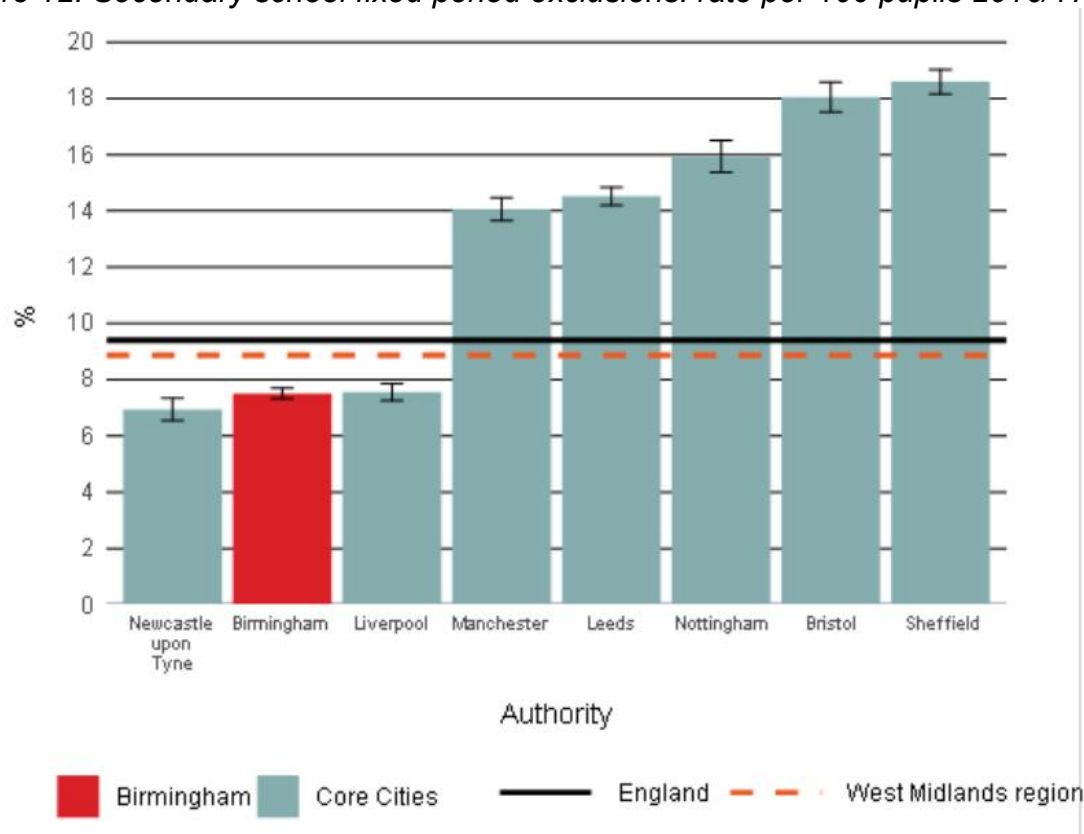
Source: Department for Education

Secondary schools account for over 80% of all exclusions, with the most common reasons being persistent disruptive behaviour, physical assault against a pupil and verbal abuse/threatening behaviour against an adult. The proportion of primary school pupils in Birmingham receiving fixed term and permanent exclusion from school is above the England average and among the highest in the West Midlands. The proportion of secondary school pupils in Birmingham receiving fixed term exclusions from school is below the England average (see figure 12 above) and the

---

[36] The Health Foundation. How do our education and skills influence our health?
[37] Suhrcke M, de Paz Nieves C (2011). The impact of health and health behaviours on educational outcomes in highincome countries: a review of the evidence. Copenhagen, WHO Regional Offi ce for Europe.
[38] The Link Between School Attendance and Good Health. Allison MA, Attisha E; Council On School Health. Pediatrics. 2019 Feb 143(2)
[39] The British Psychological Society. Behaviour Change: School attendance, exclusion and persistent absence

proportion receiving permanent exclusions is broadly comparable the England average.

Excluded young people are more likely to be unemployed, develop severe mental health problems and go to prison. They are also more at risk of exploitation, in particular sexual exploitation, which then leads to increased missed episodes of education. Recent analysis revealed that official data is only the tip of the iceberg in terms of the full extent of exclusion. The number of pupils educated in schools for excluded pupils (termed as Alternative Provision, for example pupil referral units, plus independent, unregistered or illegal schools) is five times higher than the number of officially permanently excluded pupils (2013/14 to 2016/17) [40]

Studies have shown that time spent not in education, employment or training (NEET) can have a detrimental effect on physical and mental health.[41] In 2017 9.2% of those aged 16-17 years old in Birmingham were known to be NEET or their activity was unknown (figure 13). This is higher than the England average of 6.0% and the West Midlands regional average of 6.4%. Like England as a whole, males in Birmingham are more likely to be NEET than females (11.1% compared to 7.2%).

Figure 13: Those aged 16-17 years old not in education, employment or training (NEET) or whose activity is not known

---
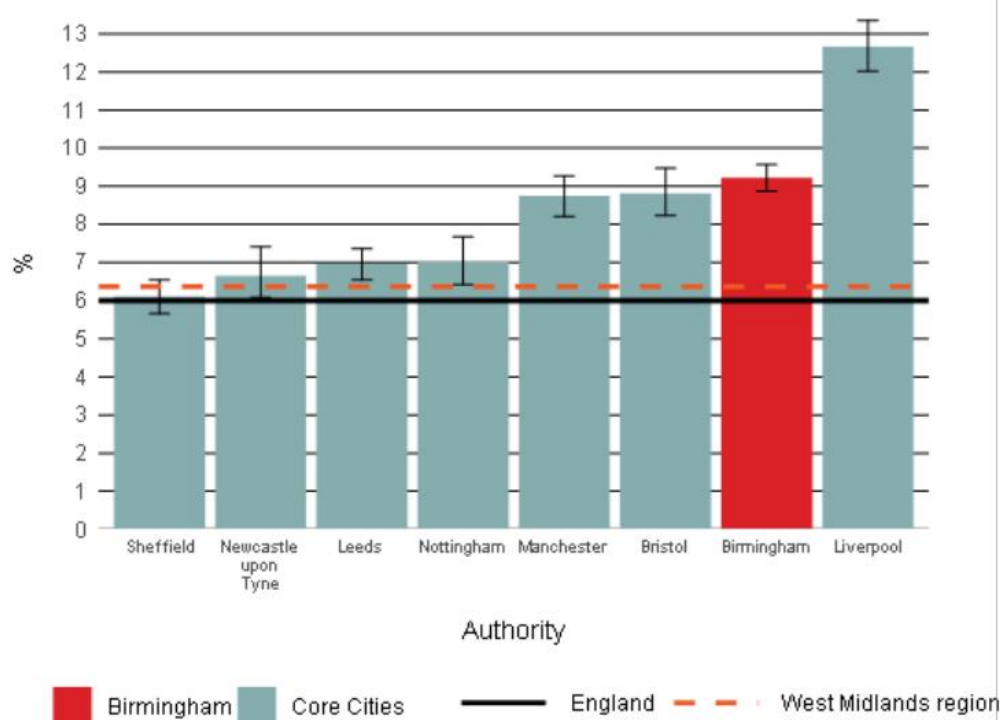
[40] Making The Difference. Breaking the Link Between School Exclusion and Social Exclusion. Institue for Public Policy Research.
[41] House of Commons Library 2018. Briefing Paper: NEET: Young People Not in Education, Employment or Training

Birmingham Service Models

Birmingham has commissioned a new School Health Support Service in 2019 which sets out to contribute to the following outcomes:

- Reduce pupil absence
- Reduce first time entrants into the youth justice system
- Reduce the number of those aged 16-18 years old not in education, employment or training (NEET)
- Identification of health needs to support schools utilising the early help system
- Active participation in the safeguarding system with children who have an identified health need.
- Implementation of National Child Measurement Programme (NCMP).

The new, three-year contract started in September 2019, and the service provider is Birmingham Community Healthcare NHS Foundation Trust.

Birmingham City Council provides a Special Education Needs Assessment and Review Service (SENAR). This has responsibility for the Education Health and Care plans (EHCP) assessment process in the city. EHCPs address the health and social care needs of the child or young person as well as their educational needs and can be in force from the ages of 0-25. More in depth analysis of SEND needs and service models is detailed in the [Birmingham City Council SEND JSNA 2018-19](#).

Birmingham City Council currently commissions a universal smoking cessation service for individuals to access via a GP or Pharmacy who is contracted to deliver this service and it available for individuals from the age of 12 and over.

Aquarius Action Projects provides young people's substance misuse treatment services in Birmingham. They offer support to anyone under 18 years who has a substance misuse problem, or who are affected by parental (or guardian) substance misuse.

Forward Thinking Birmingham is the provider of mental health services for people up to the age of 25 in Birmingham. This is done through a partnership of four organisations that have come together to support children, young people and families in Birmingham, also working with organisations in the voluntary and community sector.

The NewStart programme is currently working with 66 secondary schools in Birmingham using a whole school approach to help schools identify earlier those pupils who may be vulnerable to poor mental health and build resilience in order to improve academic, social and emotional outcomes.

The national human papillomavirus (HPV) immunisation programme was introduced in 2008 for secondary school year 8 females (12 to 13 years of age) to protect them against the main causes of cervical cancer and extended to year 8 males in 2019/20. This programme is commissioned by NHS England and Improvement via the School Age Immunisation Service.

School Nursing Service Performance Data

School Nursing Service

Key contract outcomes from the previous school health support contract include:

In 2017/18 total NCMP participation rates for Birmingham were 98%, compared with a national average of 95%.

In 2017/18 NCMP data, the prevalence of obesity in Birmingham reception pupils was 10.4 % against a national prevalence of 9.5%.

2017/18 NCMP data, the prevalence of obesity in Birmingham year 6 pupils was 25.6% against a national prevalence of 20.1%.

Performance data, in line with the above outcomes for the new service, as detailed in service models above, will be available from January 2020.

Smoking cessation

During 2018/19, a total of 177 smokers aged 24-years and under accessed stop smoking support via local pharmacies, with approximately 1 in 5 (n = 35) of these smokers being under 18-years of age. Most of these clients were white British (66%), with the other third comprising a variety of BAME groups.

One in every five (n = 37) of these clients managed to quit smoking at 4-weeks, with 46% of these individuals remaining abstinent at 12-weeks post quit (n = 17).

The most common treatment choice consisted of behavioural support and nicotine replacement therapy (88%).

Substance Misuse Services

Aquarius reported in 2019 that they have contact with between 150 and 200 persons under the age of 18 each year at any one time and between 700 and 800 over the course of a year. The bulk of the referrals are in relation to alcohol (70%), cannabis (75%), and alcohol and cannabis combined (60%), although there are an increasing number of referrals for legal highs such as Black Mamba and Exodus Damnation.[42]

Aquarius have also highlighted that there are differences in the persons engaging with services in Birmingham compared to nationally:

- 38% in mainstream education compared to 50% nationally
- Solvent use 5%, compared to 3% nationally
- 32% NEET, compared to 19% nationally
- 41% White British, compared to 75% nationally
- 16% exposed to domestic violence
- 67% Triggering action from the SDQ (Mental Health Screening tool)

---

[42] https://aquarius.org.uk/

HPV Vaccination

Human Papilloma Virus (HPV) vaccination coverage in Birmingham schools, is provided by the School Age Immunisation Service (SAIS), and consists of two doses by the age of 13 to 14.

From September 2019, all 12- and 13-year-olds in school Year 8 will be offered the HPV vaccine as part of the national NHS program. This means that boys have been added to the programme that has vaccinated girls for the last few years.

It helps protect against illnesses caused by HPV, including:

- cervical cancer
- some mouth and throat (head and neck) cancers
- some cancers of the anal and genital areas
- genital warts

In England, girls and boys aged 12 to 13 years will be routinely offered the first HPV vaccination when they're in school Year 8.

The second dose is normally offered 6 to 12 months after the first (in school Year 8 or Year 9). It's important to have both doses to be protected. Those who missed their HPV vaccination in school Year 8 can continue to have the vaccine up to their 25th birthday.

Current performance is 77.2% coverage, which is below the target of 90% and below the England level of 83.8%. This is the lowest level for local authorities within the West Midlands.

Future Trends

Office for National Statistics (ONS) population projections made in 2016 predicted that the Birmingham population would increase between 2019 and 2029 by 1.8% in the 5 to 9 age group, 4.7% in the 10 to 14 age group and 13.5% in the 15 to 19 age group.

Nationally, whilst the population in the 5 to 9 age group is projected to fall over the same period, the population in the 10 to 14 and 15 to 19 age groups are expected to grow at a similar rate to Birmingham.

The high rate of growth in the population of those aged 15-19 years old in Birmingham over the next 10 years should be considered when planning services to ensure that these young people are supported to enter adulthood with the best chance of success.

University/Higher education population and young adults aged 18-25

Key Statistics

The population of those aged 18-25 years old in Birmingham in 2018 was estimated to be 161,285 with the split between males and females close to 50% each.

The Birmingham resident population of the same age group who were registered with a GP was 151,761 in July 2018. The registered population is almost 10,000 less than the ONS estimated population for the same age range in 2018 suggesting that there might be significant numbers in this age group who are not registering with a GP. This is supported by research showing that there is resistance by students to registering with a GP when at university which could prevent students accessing the health services they need.

The 2016 ONS population projections are forecasting that the size of the Birmingham population will decline to approximately 157,000 by 2023 before starting to grow again. The age 19 population in 2019 was over 5,000 larger than the age 18 population reflecting the large annual influx of students to Birmingham.

Universities

There are five higher education intuitions within Birmingham: The University of Birmingham, Birmingham City University, Aston University, University College Birmingham and Newman University. In 2017/18 there were 81,880 students enrolled on courses at these institutions.[43]

A comprehensive review of student health on a national level [44] examined student health in three main areas: looking at the general health needs of students as a group, needs of students with pre-existing conditions and how services can be best configured to meet their needs. Risky health behaviours such as drinking, smoking and recreational drug use are issues for young people. However, it has been noted that all three are on the decrease for adolescents. Encouraging healthy sleep behaviours among students is a known challenge. An American study estimated that 27% of students had at least one sleep disorder. Eating patterns may suffer as students leave home to live in temporary accommodation. A student eating habits survey in 2015 reported 30% going occasionally hungry instead of buying food, 22% saying they do not have a healthy diet because it is too expensive, and 56% found buying fresh food a financial challenge. A National Union of Students Survey reported that 20% of students said they had a mental health problem. A survey by Birmingham City University of new undergraduates found 91% of the new arrivals reported periods of stress or anxiety. Three quarters said they worry about how they look and 45% per cent said they had been concerned about their mental health. [45]

---

[43] HESA
[44] An overview of research on key issues in student health
[45] Staying well at uni

There is very little in the way of systematic UK research on the health needs of students and their use of services, although there is a growing interest in the topic and the development of several position and policy papers.[46]

Nationally, the Higher Education Initial Participation Rate (HEIPR) in 2017/18 was 28.6% for those aged 18 years old, 11.7% for those aged 19 and 3.2% for those aged 20 (The HEIPR is an estimate of the likelihood of a young person participating in Higher Education by age 30, based on current participation rates. It is not a measure of participation by particular entry cohorts).[47] This measure is not available at a more local level. National data shows that children from more deprived backgrounds were less likely to go to university after finishing school. It might therefore be expected that a lower proportion of the children growing up in more deprived areas of Birmingham would go to University.

Across the UK in 2018, 20.7% of 18-year-old students resident in England, and from low "higher education participation neighbourhoods", entered higher education, compared to 11.2% in 2006. The entry rate of state school students in England who, while aged 15 were in receipt of free school meals, has increased from 9.2% in 2006 to 17.3% in 2018. [48]

Young Adults Receiving Benefits

In September 2019 there were 8,700 claimants of employment related benefits aged between 18 and 24 in Birmingham. This was an increase of 19.8% against the previous year but the rate is much lower than it was at its peak during the recession caused by the 'credit crunch' in 2009 and can partly be explained by expansion of the Universal Credit service.[49] The claimant rate in Birmingham in 2018 was 4.8% and above the England rate of 2.8%.[50] With the strong evidence in the links between health and work it is therefore of concern for the health of Birmingham citizens that a higher proportion of this age group are claiming employment related benefits.

---

[46] Association for Young People's Health (2017) An overview of research on key issues in student health. London: AYPH

[47] https://www.gov.uk/government/statistics/participation-rates-in-higher-education-2006-to-2018

[48] Higher education in numbers: Universities UK

[49] Department for Work And Pensions. West Midlands Group State of the Group Report October 2019

[50] Based on claimant data in June 2018 and ONS mid year population estimates 2018 from https://www.nomisweb.co.uk/

Diversity and Inclusion

In 2017/18 58.5% of students at Birmingham universities were female. However, this varies by university between 47.6% at Aston University and 77.2% at Newman University. Birmingham has a diverse student population in terms of ethnicity with 40.7% of students from BAME groups. Again, this varies by University with 64.9% BAME students at Aston University and 25.4% BAME students at the University of Birmingham. Nearly 11% of students at Birmingham universities in 2017/18 were known to have a disability.[51]

It is estimated that in 2019 nearly 6,000 adults aged 18-24 in Birmingham have a moderate disability and a further 1,000 have a serious physical disability, representing 4.1% and 0.8% of the age group 18-24 population respectively.[52]

Young people aged between 18-25 years who have Autism Spectrum Disorder (ASD) and attention deficit hyperactivity disorder (ADHD) are being helped to move into employment through joint working by Forward Thinking Birmingham and a third sector organisation. The scheme offers bespoke training and multidisciplinary meetings to help identify young people who would benefit.

It is estimated that in 2019, there were 1,396 adults age 18-24 with autism in Birmingham, representing 1% of the age group population.[53] The number of adults with autism in Birmingham is projected to increase by 8% between 2019 and 2030, which is consistent with ONS population projections of 6%. However, this is based on the Adult Psychiatric Morbidity Survey from 2007 and will be an underestimate. The Birmingham SEND JSNA [54] records 9% of primary age pupils and 11% secondary age pupils have autism and the overall prevalence in children in Birmingham is 19.5%. These children do not stop have autism, so more accurate methods of measuring prevalence are needed to be able provide the right services.

National evidence shows that care leavers consistently experience some of the worst health, social, educational and employment outcomes in our society. They are known to have the following health and wellbeing needs for care. The term 'care leavers' refers to a person aged 25 or under, who has been in care of a local authority for at least 13 weeks since the age of 14. At age 18, a looked after child is no longer in care, but the local authority still has a responsibility to them as a care leaver until age 21, or up to age 25 if they are in full time education. Furthermore, care leavers are more likely to have poor mental health, have poor dental health, experience homelessness, not succeed academically, live in poverty, and be more commonly represented in the criminal justice system. Additionally, nearly half of female care leavers are mothers by the age of 24.[55] In the year ending 31 March 2018 there were 679 care leavers aged 19-21 who had been in care at Birmingham Local Authority.[56]

---

[51] HESA
[52] Institute of Public Care: Projecting Adult Needs and Service Information (PANSI)
[53] Institute of Public Care :- Projecting Adult Needs and Service Information (PANSI)
[54] Children and Young People with Special Educational Needs and/or Disability in Birmingham Joint Strategic Needs Assessment 2018-19
[55] Fallon, D., Broadhurst, K., & Ross, E. (2015). Preventing unplanned pregnancy and improving preparation for parenthood for care-experienced young people. London: Coram.
[56] Children looked after in England including adoption: 2017 to 2018 Dept. for Education

There is no routinely collected data on sexual orientation, gender identity or faith on this age group.

Unhealthy Behaviours

Substance Misuse

Substance and alcohol misuse are key issues for young adults. Alcohol use in adolescents and young adults is associated with long term health problems including risks to brain development and long-term memory, mental health disorders and social problems[57] and increased risks contracting sexually transmitted infections (STIs)[58]. Cannabis can impact on cognitive impairment including and is associated with mental health issues.[59]

Nationally there has been an upward trend since 2011/12 in class A drug use amongst those aged 16-24 years old, driven mainly by an increase in powder cocaine and ecstasy use.

The Government's 2017 Drug Strategy (Home Office, 2017) stated that specialist interventions should prevent young people's drug and alcohol use from escalating, reduce the harm young people can cause to themselves or others, and prevent them from becoming drug or alcohol-dependent adults.[60]

Birmingham has 13,295 people who are alcohol dependent. These statistics have not been made available by age groups. As of November 2018, the rate per 100 of adult population who are alcohol dependent was 1.58 in Birmingham compared to 1.35 nationally.[61]

Change Grow Live (CGL, the drug and alcohol service in the city) has reported that between 70 and 81 persons aged 16-24 were in treatment services at any one time in 2018/19, which equates to between 1.3% and 1.7% of all persons of all persons engaged with treatment. There is a known issue with engagement with treatment in the transition phase from young people support services to adult support services, which is being explored between Public Health and Commissioning teams in Birmingham.

As of March 2019, Birmingham had an estimated 10,525 people using opiates and/or crack. These statistics have not been made available by age groups. The rate of use per 1,000 of the population for opiates is 11.9 for Birmingham – compared to 7.3 nationally. Crack cocaine rate of use per 1,000 of the population for Birmingham was 9.2, compared to 5.1 nationally.[62]

There were 26 drug related deaths aged under 26 in Birmingham between 2015 to 2018. The majority of these (16) were in the 20 to 24 age bracket and the majority (16) were male. There were approximately 1,500 admissions for alcohol specific conditions in Birmingham for ages 16 to 24 in the 5 years to 2016/17 and 500 admissions for substance misuse.

---

[57] Health matters: harmful drinking and alcohol dependence
[58] Boden JM(1), Fergusson DM, Horwood LJ. Alcohol and STI risk: evidence from a New Zealand longitudinal birth cohort. Drug Alcohol Depend. 2011 Jan 15;113(2-3):200-6. doi: 10.1016/j.drugalcdep.2010.08.005. Epub 2010 Sep 16.
[59] Meier, M. H. et al (2012). Persistent cannabis users show neuropsychological decline from childhood to midlife. Proceedings of the National Academy of Sciences, 109(40), E2657–E2664. doi: 10.1073/pnas.1206820109
[60] Home Office. (2010). Drug strategy 2010. Reducing demand, restricting supply, building recovery: supporting people to live a drug free life. London: HM Government.
[61] PHE Alcohol Dependence Prevalence in England 11th November 2018
[62] PHE Opiate & Crack Cocaine use: Prevalence by Local Area 25th March 2019

NICE guidance recommends developing a local strategy to reduce substance misuse among vulnerable and disadvantaged under-25s.[63]

Sexual and Reproductive Health Issues
National statistics show that the highest rates of new sexually transmitted infections (STIs) are in young people aged 15-24. The consequences of poor sexual health can have long-term health impacts, such as infertility and cervical cancer. There are well evidenced inequalities in sexual health: women, gay men, young people and people from BAME groups are disproportionately affected by poor sexual health.

When interpreting the sexual and reproductive health statistics the focus is on the number of infections detected and terminations of pregnancy. So in some ways a high rate of diagnosed infections can reflect that a service is doing well reaching the people most in need of support but it can also reflect an increased rate of infection in the local community because of a lack of prevention work and access to condoms and contraception. Similarly termination of pregnancy is a blunt metric as within this there are terminations due to unplanned pregnancy which may reflect a lack of access to contraception as well as terminations because of detection of an abnormality in the pregnancy which may increase if maternity services improve screening and support to women. Sexual health indicators for Birmingham and core cites can be seen in table 16.

Table 16: Sexual health indicators

	England	Birmingham	Bristol	Leeds	Liverpool	Manchester	Newcastle Upon Tyne	Nottingham	Sheffield
Chlamydia Detection Rate 15-24 per 100,000 2018	1,975	1,816	1,961	3,385	2,557	2,046	1,872	1,928	1,609
Under 25s repeat abortions 2017	26.7%	31.6%	24.3%	26.6%	30.2%	26.9%	22.3%	19.7%	24.4%
HIV Diagnoses Rate 15+ per 100,000 2016/18	42.5	41.0	9.4	13.2	11.8	25.3	7.6	25.7	5.6

Source: PHE Fingertips Sexual and Reproductive Health Profiles

In 2011 the government published *You're Welcome* - quality criteria for young people friendly health services.[64] These standards are largely in line with the NICE

---

[63] NICE. (2007). Substance misuse interventions for vulnerable under 25s (PH4). Manchester: National Institute for Health and Care Excellence.
[64] Department of Health. (2011). You're welcome - quality criteria for young people friendly health services. London: Department of Health

guidance on contraceptive services for the under-25s[65]. More recent guidance about the development of Integrated Sexual Health Services has been published by the Department of Health and Social Care and Public Health England in 2018.[66]
STI testing and treatment (or 'seamless' referral to a more relevant service) and opportunistic chlamydia screening should be offered to young people. Free contraception, condoms, pregnancy testing and emergency hormonal contraception should be made available.

Educational attainment

Attainment of Level 3 equates to achievement of 2 or more A-levels or equivalent qualifications. The percentage of 19-year olds qualified to Level 3 in Birmingham with an Education Health Care Plan (EHCP) in 2016/17 was 11.6% compared to 13.1% for England. In 2015/16 the percentage was 14.4% and higher than the England average. Achievement rates for learners with learning difficulties and disabilities (LLDD) aged between 19 and 25 are lower than for other learners. The achievement gap between LLDD and other learners aged between 19-25 years old did not close between 2014-2017 [67].

Mental Health of Young Adults

Loneliness and social isolation

Loneliness and social isolation are harmful to our health: research shows that lacking social connections is as damaging to our health as smoking 15 cigarettes a day [68] Social networks and friendships not only have an impact on reducing the risk of mortality or developing certain diseases, but they also help individuals to recover when they do fall ill (Marmot, 2010).[69]

The Loneliness Experiment[70] in 2018 is the biggest survey of its kind with over 55,000 people aged 16+ years taking part to explore attitudes and personal experiences of loneliness. The survey found that nationally those aged 16-24 years old experience loneliness more often and more intensely than any other age group. 40% of respondents aged 16-24 reported feeling lonely often or very often.

Some of the key results were:

- People who feel lonely have more 'online only' Facebook friends.
- People said that dating is the least helpful solution suggested by others.
- 41% of people think loneliness can sometimes be a positive experience.
- Only a third believes that loneliness is about being on your own.

---

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216350/dh_127632.pdf
[65] NICE. (2014b). Contraceptive services for under 25s (PH51). London: National Institute for Health and Care Excellence
[66] Public Health England and Department of Health and Social Care. Integrated Sexual Health Services: A suggested national service specification. 2018
[67] Children and Young People with Special Educational Needs and/or Disability in Birmingham. Joint Strategic Needs Assessment 2018-19
[68] Holt-Lunstad J, TB, Layton JB. 2010. Social relationships and mortality risk: a meta-analytic review. *PLoS Medicine* 7 (7)
[69] https://www.campaigntoendloneliness.org/threat-to-health/
[70] https://www.bbc.co.uk/mediacentre/latestnews/2018/loneliest-age-group-radio-4

In contrast, ONS analysis of the Community Life Survey[71] found that on 9.8% of responded aged 16-24 reported feeling often lonely. Protective factors against loneliness included:

- Those reporting no long-term illness or disability were much more likely to say that they "hardly ever or never" felt lonely (44.8%) than those with a long-term illness or disability (19.3%).
- Those living in a household with other adults were more likely to say that they "hardly ever or never" felt lonely than those living in single-adult households (over 40% compared with 18.2%, respectively).

Suicide and Self-Harm

The rate of self-harm hospital admissions 20-24yr olds in Birmingham (281.2/100,000) is lower than the West Midlands (344.9/100,000) and England (406.0/100,000) rates in 2017/18. The rate in Birmingham for this age group has steadily fallen since 2011/12 [72]

Suicide is the single biggest killer of men aged under 45 in the UK and contributes significantly to years of life lost in Birmingham due to premature mortality. In the period 2015 – 17 there were 22 suicides in Birmingham by people in the 18 to 24 age group (approximately 11% of suicides by Birmingham residents in this period) [73].

Eating Disorders

Eating disorders are mental health disorders that are characterised by an attitude towards food that causes people to change their eating habits and behaviour. Eating disorders disproportionately affect adolescents and young adults. Although not considered common, over 1.25 million people in the UK are estimated to be affected by eating disorders, with around 25% of those affected by an eating disorder being male[74], and are most common in teenagers and young women. Eating disorders can have severe psychological, physical and social consequences. Children and young people with eating disorders often have other mental health problems (e.g. anxiety or depression) which also need to be treated in order to get the best outcomes. Early detection and treatment reduce the risks to physical health and improves recovery.

Service Models

Forward Thinking Birmingham (FTB) is the provider of mental health services for people up to the age of 25 in Birmingham. This is done through a partnership of four organisations that have come together to support children, young people and families in Birmingham, also working with several organisations in the voluntary and community sector. FTB have a dedicated Community Eating Disorder team, which provides a range of specialist evidence-based treatment and support options.

---

[71] https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/childrensandyoungpeoplesexperiencesofloneliness/2018

[72] 'Public Health England. Public Health Profiles. [11/12/2019] https://fingertips.phe.org.uk © Crown copyright [2019]'

[73] Birmingham Public Health

[74] BEAT Eating Disorder website

Birmingham City Council provides a Special Education Needs Assessment and Review Service (SENAR). This has responsibility for the Education Health and Care plans (EHCP) assessment process in the city. EHCPs address the health and social care needs of the child or young person as well as their educational needs and can be in force from the ages of 0-25.

Birmingham City Council's Adult Social Care Directorate (BCCASCD) is responsible for the social care for people from the age of 18 and over. In January 2018 there were 502 service users aged between 18-25 years old in receipt of services. The majority of these individuals were classified in the Learning Disability (LD) client group. Young people with LD transfer from Forward Thinking Birmingham (FTB) to BCHCFT at 19 years.

The Birmingham Children's Trust has an '18+ Care Leavers Service' which helps young people make the move from living in care to enjoying independent life as an adult.

Aston University has a health centre on campus that provides opticians and dentistry services. Students are encouraged to register at a nearby city centre GP practice that specialises in student health. The University also has an Enabling Team to support disabled students.

Birmingham University has its own Medical Practice and University Dental and Implant Centre; as well as a mental health advisory service.

Birmingham City University provides comprehensive health care services in conjunction with a large Birmingham NHS GP practice; providing medical consulting rooms on their campuses. They also have a disability support team.

Service Data

There is limited data reported publicly on services for young adults, this is an area where improvement could help better understand this age group.
In January 2018 there were 502 Adult Social Care service users aged between 18-25 years in receipt of services. The majority of these were classified in the Learning Disability (LD) client group.[75]
Birmingham has one of the lowest proportions of supported working age adults with a learning disability in paid employment in the country with less than 1% in employment during 2017/18.[76]
Future Analysis

The presence of five universities and the overall population trend suggests that there will be no reduction in the proportion of young adults in Birmingham. ONS population projection estimates indicates that there are currently approximately 140,000 persons aged 18-24 in Birmingham. This will remain relatively static until 2025, rising to 153,000 in 2030, and then 157,300 by 2035.[77]

---

[75] Children and Young People with Special Educational Needs and/or Disability in Birmingham; Joint Strategic Needs Assessment 2018-19
[76] ASCOF online at https://digital.nhs.uk/data-and-information/publications/clinical-indicators/adult-social-care-outcomes-framework-ascof/current
[77] https://www.pansi.org.uk/index.php?pageNo=383&areaID=8640&loc=8640

Young People Facing Additional Challenges

We recognise that there are many groups of children and young people who experience additional challenges. Many of the children and young people are represented in more than one group and in some cases this intersectionality can compound children and young people's disadvantage and the inequalities that result.

In this year's JSNA we have included some specific additional content on some of these groups:

- Disabled children and young people
- Lesbian, gay, bisexual and trans young people
- Migrant and Refugee children and young people
- Gypsy and Traveller children and young people
- Children in Care
- Children affected by Adverse Childhood Experiences
- Children's safeguarding
- Children in contact with the justice system

In the 2020/21 JSNA we plan to expand this section to include young people from specific ethnic minority and faith communities.

Disabled Children and Young People

The Equality Act 2010 defines a disability as 'a physical or mental impairment which has a long-term and substantial adverse effect on their ability to carry out normal day-to-day activities'. In Birmingham we are committed to helping children and young people (CYP) to function to the best of their ability and live fulfilling lives. Unfortunately, CYP who have a disability are more likely to experience inequalities. These include;

- more likely to live in poverty,
- to have fewer educational qualifications
- to be unemployed
- experience delays in receiving timely, effective and appropriate healthcare
- have poorer health outcomes
- experience prejudice and abuse.[78]

Key elements of a primary preventive approach for disabilities in CYP include:

- reducing socio-economic disadvantage, exposure to smoking and exposure to environmental hazards
- improving material environments and immunisation uptake
- safe alcohol consumption in pregnancy
- adequate dietary intake of key nutrients. [79]

Key Statistics Summary

It is estimated that the cost or raising a disabled child is up to three times more expensive than that of raising a non-disabled child.[80] In 2011 there were 19,598 CYP (aged 0-24 years) in the city with a long-term health problem or disability which limits daily activity.[81] The prevalence of disability in Birmingham is higher than the national average. The Family Resources Survey 2016/17 reported that 8% of children (0-19) were disabled and were more likely to be affected by learning or social/behavioural impairments.

Cerebral Palsy affects 1 in 500 births per year in the UK. We estimate 35 children to be affected per year in Birmingham (based on all births in the city). In Birmingham, there are an estimated 560 blind and partially sighted children aged 0-16 and 350 blind and partially sighted young people aged 17-25.[82]

There are 1,526 children (0-19) in Birmingham who were permanently deaf in 2017/18. Approximately half of these children were born with hearing loss while the other half lose their hearing during childhood.[83]

Birmingham children with learning difficulties known to schools numbered over 12,900 in 2018 (a rate of 61 per 1,000 pupils; almost twice the rate for England).[84]

---

[78] PHE The determinants of health inequities experienced by children with learning disabilities
[79] PHE Public Health Matters: Supporting children and young people with disabilities in London
[80] Counting the Costs 2012 survey: Contact a Family
[81] ONS, 2011 UK Census
[82] RNIB
[83] Action of Hearing Loss Facts and Figures
[84] Department for Education, Special Educational Needs Statistics, 2018

Children known to schools with autism numbered 4,150 (19.5 per 1,000, England 13.7 per 1,000).[85]

Service Model and Service Data

Birmingham has a local offer for CYP with Special Education Needs and Disability (SEND) with services offered by the council, Birmingham Children's Trust and the NHS.[86]   The total number of Birmingham CYP aged 0-25 years with an Education, Health and Care Plan (EHCP) at January 2018, was 9,023 (includes early years and post-16 EHCPs as well as children attending school). Trend analysis for EHCPs show the numbers of CYP with an EHCP have been increasing over the last 10 years.[87] Birmingham Children's Trust provide a disabled children's social care service which includes home support, direct payments and short break fostering.

Birmingham Community Healthcare NHS Trust provides specialist services for children with disabilities and their families. These include children with complex needs and the West Midlands Rehabilitation Centre which offers a wheelchair service, specialist orthotics and a prosthetics and amputee rehabilitation service, as well as supporting children who have cerebral palsy.

Forward Thinking Birmingham is a mental health partnership for 0-25 year olds in the city which has a learning disability (LD) team that works with approximately 300 young people up to the age of 19 years with a moderate / severe LD. GPs in England offer LD health check scheme for adults and young people. GPs located within Birmingham had a total of 571 patients aged between 14-18 years recorded on the LD register in 2018. This is just over 1% of the population in this age group.

Pre-school and school age children in Birmingham, including those attending special schools, are supported by the council's Birmingham Sensory Support Service for sight and hearing impairments.

---

[85] Department for Education, Special Education Needs Statistics, 2018
[86] https://www.birmingham.gov.uk/info/50034/birminghams_local_offer_send
[87] Children and Young People with Special Educational Needs and/or Disability in Birmingham Joint Strategic Needs Assessment 2018-19

Lesbian, Gay, Bisexual and Trans Young People

There is strong international and UK evidence that lesbian, gay, bisexual and trans [88] children and young people face significant health inequalities including:

- Increased risk of suicide and self-harm
- Increased depression and anxiety
- Increased rates of smoking
- Increased rates of teenage conception

The evidence base suggests that there are also inequalities within the LGBT population and bisexual and trans people experience worse health inequalities than their lesbian and gay counterparts, and LGBT people who are from ethnic minorities or disabled also experiences higher levels of inequalities, but all four groups face significantly worse health than their heterosexual and cis-gender counterparts.

Key local statistics

Public Health England published a national estimate on lesbian, gay and bisexual populations, at a national level it is estimated that between 2-5% of the population identify with a non-heterosexual sexual orientation. However, the PHE report highlights that young people are more likely to identify with non-heterosexual identities than older age groups. However this estimate is based on the GP survey which excluded under 17 years.

There are no national estimates on the trans population in England as it isn't asked in the census, and there isn't any research that's been done that covers enough people to be statistically significant. The best estimate is that around 1% of the population might identify as trans, including people who identify as non-binary.[89] If we applied this estimate in Birmingham (and assume that the 1% figure is equally represented across all age groups), then there are an estimated 1,400 trans people aged 16-24 in Birmingham.

Although there has been NHS guidance on collecting data on sexual orientation there is very little Birmingham data on the health of this group.

Service model and data

Birmingham has a dedicated centre called Birmingham LGBT (BLGBT)[90] which is a local charity providing support, information and advice to the local lesbian, gay, bisexual and trans community, and those who identify under a variety of other sexual orientations and genders. This includes some specific provision for LGBT+ young people:

- Sexual health services
- Wellbeing support service
- Counselling and psychotherapy

---

[88] The word trans is an 'umbrella' term for all people who cross traditional gender boundaries – whether that is permanently or periodically
[89] https://www.stonewall.org.uk/truth-about-trans#trans-people-britain
[90] https://blgbt.org/

The Council Youth Service is going through a period of transformation and it will be important to consider the needs of LGBT+ youth as part of this process. There is potential for more coherent approach across other Council led services to explicitly consider the needs of LGBT+ children and young people and LGBT+ parents, for example in children's centres and through youth offending and children in care services.

There is some existing provision in this area via OutCentral, which is a youth group for young people age 13-19, who are LGBT+ or, may be questioning their sexuality. Young people take part in a range of activities including trips out and social activities.[91]

Further approaches could be modelled on existing practice in groups such as Umbrella Health Sexual Health Service & Support who make specific provision for LGBT groups within their services[92] delivered through the BLGBT. Umbrella and the BLGBT also are actively involved in recruitment to the PrEP Impact Trial.[93] PrEP (Pre-exposure Prophylaxis) is a precautionary drug to limit the risk of contracting HIV / AIDs during unprotected sex, and as such would address a health inequality that impacts in reference to men who have sex with men.[94]

Schools are required to have bullying and harassment policies which include addressing homophobic, biphobic and transphobic bullying. There is potential to audit the approaches across Birmingham to share good practice and learning in this space and this may form part of the developing work for a Birmingham Thrive in Education Framework. This could be modelled on existing practice in Brighton and Hove.[95]

Across the NHS and other large employers within the city there is a commitment to mandatory equality and diversity training which includes awareness of LGBT inclusion issues. Although there is mandatory training there is potential for a more consistent approach to targeted LGBT awareness training such as intersectionality and health inequalities.[96]

Key Data Analysis

There is insufficient routine data collection on sexual orientation and gender identity in young people's service data to identify whether there are different inequalities affecting children and young people in Birmingham from the national and international evidence.

There is a growing body of best practice work to support LGBT children and young people, this includes:

---

[91] https://blgbt.org/directory/927-2/
[92] https://umbrellahealth.co.uk/our-services/lgbt-services
[93] https://umbrellahealth.co.uk/hiv-and-aids/prep-impact-trial
[94] https://umbrellahealth.co.uk/hiv-and-aids/prep-impact-trial
[95] https://www.theproudtrust.org/resources/research-and-guidance-by-other-organisations/trans-inclusion-schools-toolkit/
[96] https://www.stonewall.org.uk/system/files/accenture_-_engaging_the_majority_to_create_an_lgbt_inclusive_workplace.pdf

- Preventing Suicide: [LGB youth and trans youth](#)
- [Promising Practice model and RCGP LGBT Care guidelines](#)
- [Improving Health and Wellbeing of Gay and Bisexual Men and other Men who Have Sex with Men](#)
- [Improving the Health and Wellbeing of Lesbian and Bisexual Women and other Women who have sex with women](#)

The published evidence would suggest that LGBT children and young people will experience significant health inequalities that may underpin the wider inequalities in the city.

Migrant and Refugee Children and young people

Most migrants to the UK come to work or study and are young and healthy. However, there are vulnerable groups of migrants who have increased health needs associated with their experiences before, during and after migration.[97]

Children and young migrants can face particular challenges to their wellbeing, education and life chances depending on the circumstances of their migration; for example their country of origin, and whether they are unaccompanied asylum seekers (UASC), economic migrants, children of refugees, victims of trafficking, reunified children or economic migrants. They may face language barriers, poverty, social isolation, racial bullying, instability in housing and immigration status and barriers to both health care and education. While many of these challenges also affect adult migrants, children may be particularly unsettled by migration and may experience emotional, behavioural or physical symptoms and poor mental health as a result. This will particularly apply to vulnerable migrants and those arriving in the UK unaccompanied.

As well as poorer health among migrants, high levels of migration into an area can impact on existing communities by increasing demand for health care and services such as housing, social care, schools and employment. This can lead to increased social tension and create potentially additional stressors due to discrimination and harassment.

Key Data Summary
At the 2011 Census, 22.2% of the Birmingham overall population had been born overseas. Although established and new migrant communities are found citywide, the largest concentrations are in inner-city areas and wards to the west of the city. After English, the most common languages are Urdu, Punjabi, Bengali, Pakistani Pahari, Polish and Somali. In some wards, almost 40% of residents have a main language other than English. For children and young people, especially new arrivals, their limited communication skills can restrict their participation and attainment at school as well as creating challenges around social integration and service utilisation. Although the decennial census is very detailed, it is quickly out of date given the rapidly changing profile of migrants coming to the city.

There were 21,432 overseas migrants aged less than 18 years between 2014 and 2017 who were newly registered with GPs in the city, representing 25% of all migrants. The leading countries of origin for young migrants were from are Romania (18%), Italy (10%), Pakistan (6%), Spain (5%) and India (4%).[98]

The EU countries, especially from EU8 (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia) and EU2 (Bulgaria and Romania) had a notable increase in migrant children in 2015, accounting for almost 28% of all migrants under 18, though numbers have fallen since, potentially reflecting uncertainty around future rights to reside following the 2016 referendum (figure 14).

---

[97] https://www.gov.uk/guidance/vulnerable-migrants-migrant-health-guide
[98] NHS Digital "Exeter" GP registration data

Figure 14: % Migrants aged under-18 years registering with a GP for the first time from EU2 and EU8 countries
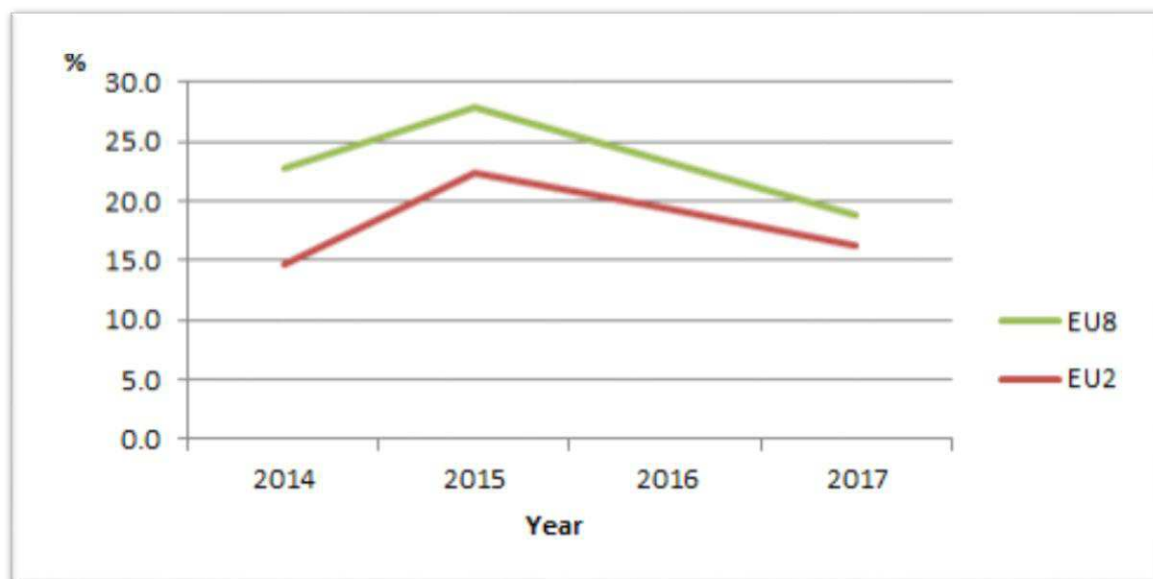
Source: NHS Digital "Exeter" GP Registration Data

Health, wellbeing and mental health is different for certain indicators in Birmingham when compared to England, whether this is for the better or worse, as is detailed throughout this document. Any such inequalities may be exacerbated in those wards with higher migrant populations, who appear to have poorer health outcomes against many health indicators such as lower life expectancy particularly among males, higher A&E attendances for children aged 0-4 and low birth weights.

Service Model and Service Data
Birmingham has two Asylum Seeker Initial Accommodation (IA) centres. There are approximately 370 beds for adults and families and asylum seekers are accommodated for up to 3 weeks (although it can be longer) before they are moved into 'dispersal accommodation' in Birmingham and across the rest of the region. While in the IA people are able to access universal health services, but they are not expected to register with a GP until they are in a more settled location, so separate health services are provided to deal with minor health issues, manage any long-term issues, and refer on to hospital if that is needed.

The Migrant and Refugee Centre is a charity working in Birmingham providing free welfare and benefits advice and support as well as co-hosting some specific health support services such as latent TB screening for new arrivals.

Gypsy and Traveller Children and Young People

Gypsies and Travelers (GT) are people dedicated to living a travelling existence, or who come from a travelling background and see travelling as an important part of their ethnic or cultural identity. This includes groups such as:
- Romany Gypsies
- Irish, Scottish and Welsh Gypsies and Travellers
- New Travellers or New Age Travelers
- Bargees and other people living in boats
- Fairground and circus families, known as travelling showmen. [99]

Birmingham had a total of 408 GT recorded in the 2011 Census with 164 children and young people aged 0-24.[100] GTs have a much younger age group compared to the general population with 40% of their population aged under 20 years old. The Department of Health completes an annual caravan count and as of January 2019 Birmingham had 22 caravans (17 on unauthorised land).[101] Birmingham had 37 Irish Travellers and 1,042 Roma/Gypsy children attending local schools in 2019,[102] 0.53% of all Birmingham school children.

Nationally GTs have poorer health, worse educational outcomes and a high level of infant mortality compared to other ethnic groups. They also face high levels of hostility and discrimination, including bullying in schools.[103] Evidence shows that accommodation is one of the major overriding factors influencing GT health.[104] Whilst the GT face significantly poorer health when compared to the general population, their children and young people face health issues such as:
- Higher infant and maternal mortality rates [105]
- Low child immunisation levels
- Higher child accident rates
- Bronchitis (even after smoking is taken into account), asthma, chest pain and diabetes in comparison to the general population
- Poor registration with general practice.

Service Model and Service Data
There is a lack of specific data on the service outcomes for gypsy and traveller children and young people.

Birmingham and Solihull CCG inequalities strategy (2018-2021)[106] aims to improve GT access to primary care as this is implemented there should be improved data on this group of children and young people.

---

[99] Gypsies and Travellers - race discrimination: Citizen's Advice
[100] 2011 Census: NOMIS
[101] https://www.gov.uk/government/statistics/traveller-caravan-count-january-2019
[102] https://www.gov.uk/government/statistics/schools-pupils-and-their-characteristics-january-2019
[103] https://www.parliament.uk/business/committees/committees-a-z/commons-select/women-and-equalities-committee/news-parliament-2015/gypsy-roma-and-traveller-communities-inquiry-launch-16-17/
[104] https://www.sheffield.ac.uk/polopoly_fs/1.43713!/file/GT-report-summary.pdf
[105] https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/360/full-report.html

Birmingham City Council has completed a housing needs assessment to assist GT populations to access housing services but there remain systemic data gaps from service providers.

Models to tackle barriers in accessing primary care services suggest the need for health promotion among GT groups and allowing GPs to apply for "enhanced service" statuses when treating GT populations. National models[107] show that GT patients require longer appointment times and a walk-in service which is inclusive and is not seen to single out GT groups. The Department of Health and Social Care [108] advocate collaborative working with local level population and service information serves as a good starting point to engage with the GT community. This includes setting up a community voice, employing specialist health visitors and undertaking peer review sessions to explore the unmet health needs and determinants influencing the GT groups.

---

[106] https://www.birminghamandsolihullccg.nhs.uk/publications/strategic/44-equality-objectives-health-inequalities-strategy-2018-2021/file
[107] http://www.gypsy-traveller.org/wp-content/uploads/2015/03/FFT_Inclusion-of-Gypsy-Traveller-health-needs-in-JSNA_FINAL.pdfhttp://www.gypsy-traveller.org/wp-content/uploads/2015/03/FFT_Inclusion-of-Gypsy-Traveller-health-needs-in-JSNA_FINAL.pdf
[108] http://www.gypsy-traveller.org/wp-content/uploads/2015/03/FFT_Inclusion-of-Gypsy-Traveller-health-needs-in-JSNA_FINAL.pdf

Children in Care

Children in Care (CIC) are defined as "a child who has been in the care of a local authority for more than 24 hours".[109] It has been recognised that those in this situation encounter many inequalities including:

- An inability to form or secure relationships
- Behavioural issues
- Lower educational attainment
- Poor mental and physical health[110]
- There is also a tendency to go missing from care placements.

Each local authority has a set of measures that central government use to measure their performance and success. We can compare each authority and identify areas with the most need nationally.

Key Data Summary

At the end of 2018 1,922 children age 0-17 years in Birmingham were in care. This gives Birmingham a rate of 67 per 10,000 population compared to the England rate of 64 per 10,000. [111] Although significantly higher than the national rate, Birmingham is second lowest out of the core cities; with Liverpool the highest at 127 per 10,000. The Birmingham number is higher than the previous year of 1,815 but trend information suggests it has fluctuated since 2012.

7.5% of CIC in Birmingham at the end of 2018 were unaccompanied asylum-seeking children (UASC) compared to an England average of 5.9%. Whilst this had been relatively consistent in Birmingham since 2014; nationally this has increased tenfold.

Service Model and Service Data

Birmingham now has a new Children's Trust that provide information and advice for families, young people and children [112]. Ofsted have in recent years regularly assessed Birmingham children's social care and the last report in 2018 showed improvements but highlighted specific areas where they expected change by their return in 3 years.

The first annual report from the Trust highlights that:[113]

- 83% of referrals for CIC received a decision within 24 hours of a referral being made
- All of assessments are completed within the required 45 working days

---

[109] Children Act 1989
[110] Bazaalgette, Rahilly and Trevelyan, 2015: Luke et al, 2014
[111] https://www.go.uk/government/publications/children-looked-after-return-2017-to2018-guide
[112] http://www.birminghamchildrenstrust.co.uk/ .
[113] www.birminghamchildrenstrust.co.uk

Furthermore, 68% of children (under 16 years) who have been looked after for 2.5 years or more, have been in the same placement (or placed for adoption) continuously for 2 years or more.

Table 17 gives a breakdown of the percentage of CIC with special educational needs (SEND) for Birmingham, England and Core Cities comparators showing Birmingham has a lower prevalence than England.

Table 17: Percentage of CIC with SEND

Core City Comparators	CIC with SEND 2017/18
England	56.3%
Birmingham	55.9%
Bristol	58.2%
Leeds	52.5%
Liverpool	47.7%
Manchester	53.4%
Newcastle Upon Tyne	48.3%
Nottingham	57.4%
Sheffield	60.7%

Source: Department of Education

Children and young people affected by Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) refer to traumatic events experienced before the age of eighteen. These include:

- parental abandonment through separation or divorce
- a parent with a mental health condition
- being the victim of abuse (physical, sexual and/or emotional)
- being the victim of neglect (physical and emotional)
- a member of the household being in prison
- growing up in a household in which there are adults experiencing alcohol and drug use problems
- domestic violence

A growing body of UK and international research is revealing the extent to which these experiences are associated with the development of a wide range of harmful behaviours including smoking, harmful alcohol use, drug use, risky sexual behaviour, violence and crime. These experiences can disrupt neurodevelopment and are linked to early onset and increased risk of diseases such as diabetes, mental illness, cancer and cardiovascular disease and ultimately to premature death.

Key Data Summary

While there is no routinely collected data on the distribution of defined ACES in childhood, commissioned surveys[114] [115] suggest, that almost half (47%) of Adults (aged 18-69) had at least one of these experiences in childhood. In Birmingham this could potentially equate to almost 350,000 people. Estimates suggest that around 9% have had four or more adverse experiences which equates to around 67,000 people. Single experiences have an adverse impact on a child's future health and wellbeing, but multiple experiences have a cumulative impact with increased risk of harmful behaviors, illness and premature mortality.

There is insufficient data to quantify how many of Birmingham's 289,000 children experience adverse events. While previous research estimates could place this at almost 50%, the real picture in Birmingham could be much higher given the relative deprivation in the City which is associated with many parental risk factors such as substance misuse and imprisonment. Awareness, early identification, prevention and support will be crucial to reducing the scale and impact of ACEs on the City's future adults

Service Model and Service Data

The Birmingham Health and Wellbeing Board developed the 'ACEs Birmingham' approach as a response to the strength of evidence of a negative life course impact that untreated adverse childhood experiences can have for individuals. The aim of the 'ACEs Birmingham' approach is to introduce routine enquiry of adverse

---

[114] ACEs in Blackburn with Darwin Council –with Liverpool John Moores University 2014 https://www.blackburn.gov.uk/Pages/aces.aspx
[115] Bellis MA, Hughes K, Leckenby N, Perkins C, Lowey H. National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviours in England. BMC medicine. 2014 Dec;12(1):72.

childhood experiences into frontline specialist practice, in services supporting adults, children and young people, and/or families. 'ACEs Birmingham' offers a set of guiding principles and a preventative framework approach to help local stakeholders to recognise the importance and benefits of aligning strategic direction to reduce the impact of adverse experiences in childhood on individuals and communities. The collective aim is to avoid the consequences of these experiences and to be able to promote recovery.

1) The opportunities for Tertiary Prevention occur where the impact of past adverse experiences in childhood on current ill health and wellbeing results in disturbance of physical or emotional health. This often results in the need for complex or specialist assistance to resolve that disturbance. There is strong evidence that using routine enquiry for the adverse experiences opens therapeutic opportunities for swifter and more significant recovery from emotional distress, health harming behaviours, and destructive relationships.

2) The opportunities for Secondary Prevention arise when disturbances in physical or emotional health are identified early in their development. A response at that point will reduce the impact of any recent adverse experiences in childhood on current health and wellbeing. The intention is to limit the impact on relationships, attachment, and future potential which, if established, would require more complex or specialist assistance later.

 3) Primary prevention identifies the opportunities to avoid the adverse experience in the first place as well as addressing the socio-economic influences of health and wellbeing. Taking the opportunities for tertiary and secondary prevention will reduce the likelihood that these adults will repeat the traumas of their childhood on their children. This reduces the likelihood of harm to future children.

Children's safeguarding

From 1st April 2019 the Birmingham Safeguarding Children Partnership (BSCP) replaced the Local Safeguarding Children Board. The Partnership, whose core members are Birmingham Children's Trust, Birmingham City Council, Birmingham and Solihull CCG and West Midlands Police, share equal responsibility for developing and leading the new partnership arrangements. The board will be prioritising and promoting the alignment of an approach to contextual safeguarding.[116]

Within Birmingham's children's services population there are groups of children who are more vulnerable than their peers, these include:

- Children for who there are concerns about their development and wellbeing
- Children who are at risk of being subject to abuse
- Children who have been subject to abuse including sexual exploitation
- Children who go missing from their home or from a care placement
- Unaccompanied asylum seeking children
- Privately fostered children
- Children at risk of Forced Marriage
- Children at risk of Female Genital Mutilation (FGM)

Key statistics summary

A child in need is one who has been referred to children's social care services and who has been assessed, to be in need of social care services.

The number of children identified as 'in need' aged under 18 in Birmingham at any point during the year ending 31st March 2019 was 15,600, a rate of 541 per 10,000 (England, 594 per 10,000) and 719 statistical neighbours. [117]

A child protection plan is a plan drawn up by the local authority and sets out how a child can be kept safe, how things can be made better for the family and what support they will need.

The rate of children who were the subject of a child protection plan at 31 March 2019 in Birmingham was 44.7 per 10,000 children (this equates to 1,289 children). This compares to a national rate of 43.7. In 2015 the rate in the city was very similar, at 45.4. [118]

Although private foster families are obliged to register with a Local Authority, it is argued that the real number may be 10 times that are registered.

---

[116] Birmingham Children's Trust Business Plan 2018-2023 - 2019/20 (Year 2) Update
[117] National Statistics: Characteristics of children in need: 2018 to 2019
[118] Department for Education: Characteristics of children in need: 2018 to 2019

The Birmingham Community Safety Partnership Strategic Assessment 2019 reports on offences such as child sexual exploitation (CSE), forced marriages and female genital mutilation.

For Birmingham, there were 243 crimes that were allocated to CSE in the strategic period (Oct '18 - Sept '19), an increase on the 207 seen the previous year.
The National Society of Prevention of Cruelty to Children (NSPCC) estimate the numbers reporting sexual abuse (of which CSE is a part) by an adult or a peer to be 16.5% of 11-17 year olds [119]– this would represent approximately 17,250 children in the city, based on 2018 populations.
Significant under reporting of the issue is recognised. This is felt to be due to issues of shame, perceived or actual threats to the young person or their family, or to the young person's failure to recognise that they are being exploited.

Forced marriage (FM) involves the use of violence, threats of violence, deception or any other form of coercion or in the case of people with learning difficulties cannot consent for the purpose of forcing a person into marriage or into leaving the UK with the intention of forcing that person to marry. In the city there were 19 crimes reported for the offence of FM in 2019, according to the strategic assessment. This was two less than the previous year.
The National Forced Marriage Unit, which gives advice and support through a help line and email, has seen a national 20% increase in numbers over the last 7 years [120] 75% of cases were female, 63% under 25 years old and 43.6% had a focus country of Pakistan (next higher country Bangladesh at 6%).

FGM also known as female circumcision or cutting, is a collective term for procedures which include the partial or total removal of the external female genital organs, or injury to the female genital organs, for cultural or other non-therapeutic reasons.
There were only 3 offences reported in Birmingham for 2019.
However, figures from a City University study [121]estimate a prevalence of 6.7 per 1000 girls aged 0-14 years old may have affected. This equates to almost 800 girls based on 2018 populations.

Service model

The BSCP recognises that the right people need to be involved so have worked collaboratively with a wide range of partners across the city to identify the organisations and agencies which need to be involved to safeguard and promote the welfare of Birmingham's children.

Birmingham Children's Trust recognise that the needs of young people, and the risks that many face in our community, require new and different approaches from public services to meet need and manage risk. Criminal and sexual exploitation and gangs

---

[119] Sexual Abuse: A public health challenge. NCPCC 2011
[120] Forced Marriage Unit Statistics 2018 Home Office 2019
[121] Prevalence of Female Genital Mutilation in England and Wales: National and local estimates: City research Online 2015.

are significant risks to our young people that require new and different service solutions. Police, schools and third sector organisations will be key stakeholders and partners in this work. Work is advanced to develop a new multi-agency response to the Contextual Safeguarding risks young people in the city face. Here Contextual Safeguarding is used as an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse.

When CSE concerns are reported, Birmingham Social Workers complete the Child Exploitation Regional Screening Tool. In January 2019 there were 67 open CSE episodes with the Children's Trust; 92% being female. These were only high and medium risk episodes; the figure would be much higher if low risks case were included. A more complete, annual picture of these reported concerns will be included in future JSNAs. [122]

Birmingham Against Female Genital Mutilation seeks to lead and co-ordinate multi-agency activity to prevent the practice of FGM by improving education, awareness and prevention work on FGM and supporting agencies to improve the identification and protection of girls at risk to enable relevant safeguarding referrals to be made. Birmingham assessment tool [123].

Headline analysis

Although the rates of children in need and children on protection plans are similar to the national figures; given the fact that the city has a young and diverse population profile, the number of children involved is large. When examining the cohorts of vulnerable children (for instance those experiencing sexual exploitation, FGM and forced marriages) there is an unclear picture as to the numbers involved. Increasing take up of various screening tools should bring more of these children to the attention of the organisations charged with supporting them.

---

[122] Report from Birmingham Children's Trust to the Children's Social Care Overview & Scrutiny Committee 13 March 2019
[123] Birmingham Health FGM Risk Assessment Tool

Children in contact with the justice system

Birmingham City Council and its partners have been developing a public health approach to violent crime, which we believe will deliver results in the medium and long term. At the core of this approach is the understanding that these events can be prevented, and that this involves working closely with communities to address the upstream causes of violence. The approach goes further and work must also be undertaken to stop people at risk of worsening violent behaviour from being drawn further into that lifestyle, as well as rehabilitating people who have established violent behaviour. We are reviewing lessons learnt from other areas (such as Scotland) to inform our approach and ensure we can make a difference in Birmingham. We have also taken immediate action in parallel to our longer term plans, and have therefore recently restructured our Community Safety Partnership arrangements. To address the worrying trend, the Community Safety Partnership has: -

- introduced specialist mentoring programmes for young people identified at risk of violent crime; and
- co-ordinated joint action around high risk locations, for example, joint patrol strategies, and crime prevention messaging to vulnerable groups.

First Time Entrants to Youth Justice System

Children and young people at risk of offending or within the youth justice system often have more unmet health needs than other children; particularly mental health needs
In 2018 the rate of Birmingham 10-17 year olds entering the youth justice system either by conviction or caution was 377 per 100,000 (significantly above the England average of 238) and 5th highest out of the core cities.
The rate of Birmingham 10-17 year olds entering the youth justice system has fallen over the last eight years, with the gap between the city and England slowly narrowing in recent years (figure 15).

Figure 15 First time entrants to the youth justice system
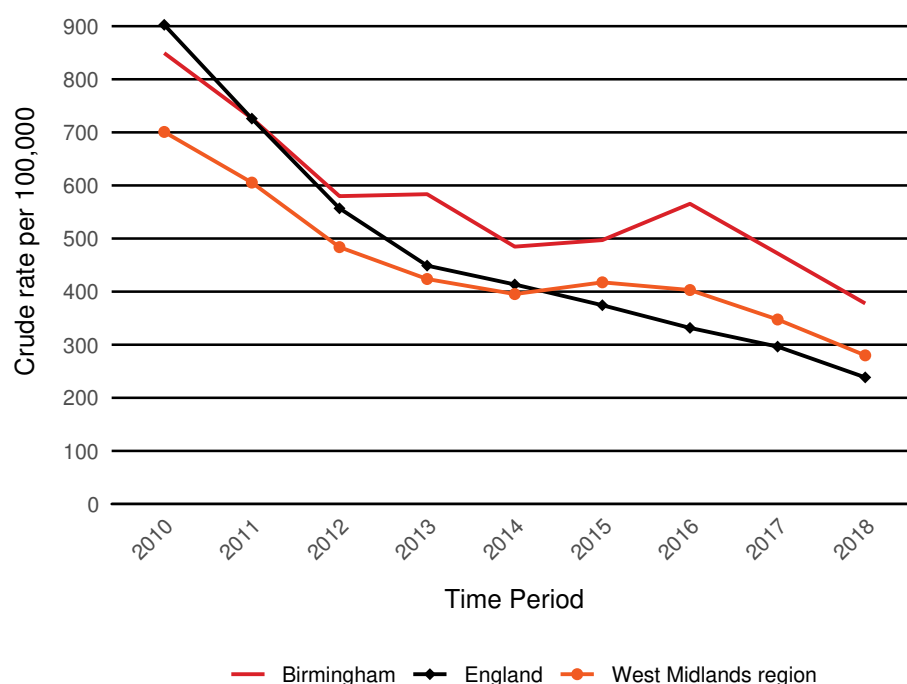
Source: Public Health England

Youth violence

Youth violence is not usually seen in isolation; those that commit violence offences tend to also display other problems such as truancy, dropping out of school and substance abuse and have experienced adverse childhood experiences. Youth violence can be seen from two perspectives: those that commit violent crime and those who are victims.

For offenders that were aged between 10-25 years, there were 691 detected offences (17% of all detected offences for this age group) for violence with injury, with 29% being domestic violence related. For youth violence, there were 10 locations around the city where 4 or more offences had occurred. Almost half of the offences (314, 45%) occurred on a Friday, Saturday or Sunday (Birmingham Community Safety Partnership Strategic Assessment 2019)

From looking at the victim data for Birmingham, where a victim is aged 25 and under, the largest proportion of offences can be classed as violence without injury. However the second category was violence with injury – assault occasion ABH accounted for 1724 offences.

Knife Crime

The number of knife crime offences have increased over a 3 year period from 2016 in Birmingham. [124] For victims of knife offences, those aged 18-25 accounted for the highest proportion, with 212 offences for this age category being 'robbery - personal property'; with offence location being public footpath being the majority for victims aged 10 – 17 years old.

The knife crime offences that occurred the most over the 3 year period are Robbery Personal Property (44%), Wounding with Intent GBH (26%), Malicious wounding (6%), ABH (6%), and Robbery Business Property (6%). Between March 2016 and March 2019, investigations completed with no suspect being identified represented 54% of offences. In 9% of offences a suspect was charged or summoned.

A pilot study of youth engagement in combating knife crime sought to understand the views of young people living in Birmingham where the incidents of knife crime are high. For reasons given, notions of self-defence and personal protection were the main explanations for weapon carrying. [125]

The victim profile for knife crime is

- 74% of the victims were aged 18 and over, with 23% aged 17 and under
- 37% of those 18 and over were aged between 18 and 24
- 85% of victims were male and 13% were female
- 50% of victims were White – North European, 31% were Asian, 10% were Unknown and 9% were Black

Amongst offenders who committed knife crime

- 91% of offenders ages are unknown (of those known, 4% were aged 25+, 3% aged 10-17 and 2% aged 18-24)
- 95% of the offenders were male, 5% were female
- 43% were Black, 33% of offenders were White – North European, and 17% were Asian

Gangs

The county lines offending model involves gangs and organised criminal networks moving drugs into one or more areas in the UK using dedicated mobile phone lines. Offenders remain highly adaptable in their operating methods and practices, including the recruitment and exploitation of vulnerable people; including juveniles. The second greatest number of county lines originated from West Midlands Police Force area; with Birmingham New Street station identified as a major hub for transporting drugs and people

---

[124] Violence Performance 2016-2019 report. Birmingham Community Safety Partnership.
[125] A study conducted in partnership between West Midlands Police, Centre for Critical Inquiry into Society and Culture (CCISC) Aston University and Legacy West Midlands (April 2017)

The National Referral Mechanism (NRM) is a process set up by the Government to identify and support victims of trafficking and exploitation in the UK. NRM highlighted the majority of referrals associated with the county lines business model in 2018 were between 15 and 17 years old. Children at risk had a profile of being in poverty, exposed to family breakdown and intervention by social services, had a looked after status, went missing frequently, had behavioural and developmental disorders and had been excluded from mainstream school. Offenders also target children who have previous involvement in criminality, including other drugs offending.[126]

The Birmingham Children's Trust Criminal Exploitation Panel reported in January 2019, 254 children under 18s were related to gang members as a child or sibling. Furthermore, 69 children under 18s were gang members (not including children and the periphery or at risk of gang affiliation). The National Crime Agency estimate that there are 60 drugs lines running out of Birmingham. [127]

The Home Office is funding a new West Midlands Violence Reduction Unit to deliver focused and strengthened multiagency partnership approach to a shared agenda. The work of the partnership will be grounded in public health principles – an understanding that violence causes ill health; that violence is preventable and not inevitable and that the causes, and the 'causes of the causes' of violence can be addressed. The proposal is to build on an understanding of violence, identify 'what works' and scale those things up, and to innovate and create the evidence of what works where it doesn't already exist. The Unit will do this through collaboration and coproduction and with communities and young people at the heart of the endeavour. The regional strategy includes six strands which implement the public health approach and have been adapted from best practice internationally.

---

[126] County lines drug supply, vulnerability and harm, 2018: National Crime Agency
[127] Report from Birmingham Children's Trust to the Children's Social Care Overview & Scrutiny Committee 13 March 2019

Appendix 1

Table 18 Live births and fertility rates in by ward in Birmingham 2017

Ward Name	Live Births 2017	GFR 2017
Heartlands	281	89.6
Sparkhill	368	84.9
Sparkbrook & Balsall Heath East Ward	519	84.1
Bordesley Green	248	84.0
Alum Rock	508	81.8
Birchfield	247	80.9
Aston	400	78.8
Lozells	203	78.2
King's Norton South	210	78.0
Small Heath	386	77.3
Ward End	243	76.2
Pype Hayes	159	73.8
Garretts Green	160	72.0
Yardley West & Stechford	220	71.8
Shard End	168	70.5
Bordesley & Highgate	287	70.4
Bromford & Hodge Hill	341	70.1
Billesley	294	70.0
Tyseley & Hay Mills	203	69.6
Newtown	218	68.8
Perry Common	175	68.4
Acocks Green	389	68.2
Handsworth	195	67.6
Erdington	273	65.4
Glebe Farm & Tile Cross	374	65.2
Sutton Reddicap	121	65.0
Longbridge & West Heath	261	64.9
Rubery & Rednal	129	64.9
Oscott	247	63.4
Allens Cross	132	63.2
Frankley Great Park	175	63.1
Druids Heath & Monyhull	136	62.8
South Yardley	100	62.2
Bartley Green	315	61.9
Hall Green North	339	61.4
Sutton Roughley	119	60.8
Balsall Heath West	183	60.4
Sutton Wylde Green	87	60.0
Northfield	135	59.7
Stockland Green	348	59.4
Highter's Heath	123	58.9
Perry Barr	270	58.5
King's Norton North	135	57.8

Gravelly Hill	113	57.5
Holyhead	182	57.4
Hall Green South	106	57.1
Yardley East	105	57.1
Quinton	233	56.4
Brandwood & King's Heath	237	56.1
Stirchley	118	55.9
North Edgbaston	353	55.6
Sheldon	226	55.4
Weoley & Selly Oak	269	55.0
Kingstanding	251	54.4
Soho & Jewellery Quarter	404	53.8
Castle Vale	113	53.2
Sutton Mere Green	74	52.4
Moseley	270	52.0
Sutton Vesey	187	51.5
Sutton Walmley & Minworth	146	50.4
Sutton Four Oaks	86	49.3
Sutton Trinity	70	48.9
Harborne	303	48.7
Handsworth Wood	209	47.4
Nechells	248	36.3
Bournville & Cotteridge	166	34.1
Ladywood	260	30.7
Edgbaston	121	19.1
Bournbrook & Selly Park	129	15.5
Grand Total	**15,403**	**59.3**

Source: ONS Births, local analysis.

	Agenda Item: 12
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**17 March 2020**
TITLE:	**PRE-CONCEPTION CONVERSATION**
Organisation	**Public Health, Birmingham City Council**
Presenting Officer	**Marion Gibbon. Acting Assistant Director, Public Health**

Report Type:	**Presentation**

1.	**Purpose:**
	The purpose of this paper is to inform you of the intention to initiate some work on pre-conception for the city of Birmingham.

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

3.	**Recommendation**
3.1	That the board agrees to the initiation of a piece of work focusing on pre-conception particularly amongst seldom heard communities.

007584/2020

4.	Report Body

4.1	Context

4.1.1 Nationally the rate of infant mortality has been declining steadily since the 2001/03 period. This has not been the trend in Birmingham where the infant mortality rate has not been consistently decreasing. In the period 2014-16 it rose to 7.9 per 1,000 and the period 2016 -18 it decreased to 369 per 1,000. This is not a significant difference however; the rate is consistently above that of England.

4.1.2 The number of infants who die between 28 days and less than one year. Infant mortality is an indicator of the general health of an entire population. It is felt that there should be a focus on pre-conception in order to improve infant mortality. Work has been undertaken on implementing, 'just one question' in relation to whether a woman is intending to get pregnant in the proceeding year. This then is able to be used as a stimulus for a conversation that focuses on possible interventions that could be undertaken.

5.	Compliance Issues

5.1	*HWBB Forum Responsibility and Board Update*

5.1.1 An annual update brief to be provided to the Health and Wellbeing Board on progress to ensure steady progress and any issue or risks highlighted that may hinder required outputs and outcomes.

5.1.2 An annual progress delivery Report will be presented on activities of the Forum to the Health and Wellbeing Board and Full Council, at their request, on the progress regarding infant mortality in Birmingham.

5.2	*Management Responsibility*
	Marion Gibbon, Interim Assistant Director of Public health

6.	Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**	
Challenges arising from the sensitive nature of this initiative	Medium	Medium	Ensuring that the system is agreeable to a focus on pre-conception in order to improve infant mortality in Birmingham	
Capacity within the public health team	Medium	Medium	Ensure that pre-conception remains priority within the team and that capacity is sourced quickly upon staff turnover.	

Appendices
None

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

Dr Marion Gibbon, Interim Assistant Director of Public Health with involvement from Karen Saunders, Public Health England.

	Agenda Item: 13
Report to:	Birmingham Health & Wellbeing Board
Date:	17 March 2020
TITLE:	BIRMINGHAM FORWARD STEPS – PROGRESS REPORT
Organisation	Birmingham Community Healthcare NHS FT
Presenting Officer	Richard Kirby, Chief Executive

Report Type:	Presentation

1.	Purpose:

1.1 The paper provides a brief progress report on the work of the Birmingham Forward Steps service – the universal service provision for children aged 0-5 years and their families.

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

3.	Recommendation

3.1 The Health & Wellbeing Board is recommended to note the progress report from the Birmingham Forward Steps service.

007585/2020

4.	**Report Body**

4.1   The attached report provides an overview of the purpose of the Birmingham Forward Steps service, the challenges it faces and the progress being made in addressing these.

4.2   Birmingham Forward Steps provides universal health and wellbeing services for children aged 0-5 years and their families. The service aims to support children to achieve the best possible start in life delivering the national child health programme and a range of supporting services and activities for children and their families. The service aims to be community-based and family-centred.

4.3   The service faces a series of challenges in seeking to deliver a safe and effective early years service to the city including:

- the wide range of needs of children in the city;
- health visitor staffing levels and workload pressures;
- establishing the fully integrated service model on which Birmingham Forward Steps is based.

4.4   The service is responding to these challenges through a range of actions taken with BFS partners, Clinical Commissioning Group input and support from Public Health and Children's commissioning at the Council. Key areas include:

- a programme of recruitment and training for 60 new health visitors by March 2021;
- a focus on the children most at risk in the short-term;
- an agreed improvement trajectory for the five nationally mandated visits;
- progress towards the fully integrated universal service model.

5.	**Compliance Issues**
5.1	*HWBB Forum Responsibility and Board Update*

Birmingham Community Healthcare has responsibility for delivering the Birmingham Forward Steps service as lead provider commissioned by the Council. There is a fortnightly oversight group involving all stakeholders to ensure progress with our improvement plan.

5.2	*Management Responsibility*

Chris Holt, Chief Operating Officer, BCHC
Marcia Perry, Director of Nursing & Therapies, BCHC

6.	Risk Analysis		

Risks relating to the successful delivery of the Birmingham Forward Steps service are included within the Corporate Risk Register and Board Assurance Framework for BCHC.

Identified Risk	Likelihood	Impact	Actions to Manage Risk
#	#	#	#

Appendices
Birmingham Forward Steps Progress Report

Birmingham Forward Steps

Progress Report

Health & Wellbeing Board, March 2020

007585/2020

Background

- This progress report provides a short update for the Birmingham Health & Wellbeing Board on the delivery of Birmingham Forward Steps – the universal and targeted early years partnership for the city.

- Birmingham Forward Steps provides universal health and wellbeing services for children aged 0-5 years and their families. The service aims to support children to achieve the best possible start in life delivering the national Healthy Child Programme and a range of supporting services and activities for children and their families. The service aims to be community-based and family-centred.

- Birmingham Forward Steps aims to serve the c. 86,000 children aged 0-5 years in the city (7.6% of the population).

- The service is commissioned by Birmingham City Council as part of the Public Health Programme and Early Years Offer. The current contract commenced in January 2018 for 5 years plus the option to extend for a further 2.

- The service is provided by a partnership of BCHC, Barnardo's, Spurgeons, The Springfield Project and St Paul's Community Development Project. The service brings together the NHS health visiting service with Children's Centres and a range of family support and early years worker provision. We also work with Homestart, KIDS, Thrive and Early Years Alliance to deliver our services.

- The service is delivered in 10 Birmingham districts and operates on a local authority resident (rather than a GP registrant) basis. It includes c. 20 children's centres plus staff working from health centres and primary care bases. c. 500 staff work across the 10 districts.

- The service has an annual budget of c. £33m

The Wider BFS Offer

- Birmingham's BFS Children's Centres are delivering a range of preventative and early intervention services to children and families in the city. The BFS Children's Centre staffing model and service provision offers a consistent service to the children and families across the city targeted to the areas of highest deprivation and the most vulnerable children and families.

- Our Children's Centres offer:

  - Parenting Programmes
  - HENRY programme and other healthy lifestyle support
  - Language through play groups and 1-1 services
  - Parental emotional wellbeing groups and 1-1 support
  - Ante-natal and breastfeeding support in groups and 1-1
  - Freedom Programme and 1-1 support around domestic violence

  - Volunteering opportunities and support
  - Employment and training support for parents
  - Targeted family support
  - Targeted stay and play provision
  - Specific services based on local need (i.e. English classes)
  - An action plan to increase the take up of EEE provision

- KIDS - providing group support to children with special needs and their parents/ carers including a range of workshops, advice, support and guidance.

- HomeStart - providing long term family support through their intensive volunteer support packages.

- Early Years Alliance (EYA) - supporting community-run stay and play groups across the city with advice and support around quality play provision, accessing funding, infrastructure development, partnership working, responding to families with needs, signposting etc..

- Thrive Together Birmingham - work with EYA to engage specifically with faith-based organisations.

Challenges

- Birmingham Forward Steps faces a series of challenges. The service was established as a new model of care bringing together a range of services to deliver an innovative and integrated model. Whilst this vision remains the right one, getting it working well in practice has proved more challenging.

- As the 2018 Director of Public Health's report for Birmingham set out, Birmingham is a young and diverse city: one in four children in the city live in poverty, many face poor housing conditions, childhood obesity is higher and immunisation rates are lower than the national average.

- Health visitor recruitment is a national challenge exacerbated by local pressures. At January 2019 the city has 162 WTE health visitors in post out of an establishment of 227 WTE. Caseloads are 443 compared to a fully-established plan of c. 350 and contain a high proportion of children at high risk (Universal Partnership Plus and Universal Partnership). Three districts face particular pressure: Northfield, Ladywood and Yardley.

- In September 2018, Children's services at BCHC were rated "Inadequate" by the Care Quality Commission largely as a result of pressures facing health visiting. In July 2019 the CQC imposed Section 31 conditions on the service including weekly reporting although these were revised in September 2019 to monthly reporting as a result of the response from the service. The service has been recently re-inspected in February 2020 and the CQC's assessment is awaited.

- Data quality and reporting issues have presented challenges that have had to be addressed in order to track progress on some key metrics e.g. breast feeding.

- The staffing pressures facing the service have slowed down the full delivery of the integrated service model across health visiting, children's services and family support and early years services.

Progress

- **Recruitment.** The service is on track to deliver additional health visitors resulting in c. 210 WTE health visitors by March 2021 in three phases: 20 newly qualified health visitors graduated in February 2020; 20 trainees commenced in November 2019; a further 20 trainees commenced in February 2020.

- **Council Employees.** Working closely with the Council and our partners we have resolved the long-standing issue of the transfer of c. 100 BFS staff from the Council to the partnership.

- **Managing Risk.** The service is prioritising the highest risk children using a team-level prioritisation matrix In January we delivered the standard we had set for UPP children with 96% of visits completed for this group. Our next priority is UP (Medium) children and we delivered 86% of their checks in January.

- **Caseload Reviews.** As a next step we are reviewing caseloads within the most pressured districts to identify scope for partners in the system to help support health visiting teams to manage risk.

- **Service improvement.** The service has an improvement trajectory with which, if successful will see us meet standards for the five mandated visits by the end of 2020. In January we were on track with 4 of the 5 visits. The full partnership is supporting this improvement – commencing early years and outreach workers accredited to support the 2 ½ year check pathway from February 2020.

- **Engagement and leadership.** We have commenced a leadership development programme for BFS districts and teams and continue to engage fully with our health visitors.

Improving Outcomes

- There are a number of positive outcomes that BFS are in the process of delivering:
  - consistent city-wide delivery of early years services to support every child to achieve the best start in life, reducing the risk of fragmented care within Early Years.
  - improved delivery of the Universal health and development reviews (Healthy Child Programme)
  - wider engagement and take up of the Healthy Start scheme.
  - encouraging engagement and measuring effectiveness of the service on the first 2 years.

- A number of measures have been prioritised to support measuring the successful delivery of the BFS model. Measuring progress of individuals from entry into the service and up till the point they are ready for school:
  - Early Help Assessment (EHA)
  - Ages & Stages Questionnaire (ASQ) Early Education Entitlement (EEE)
  - Number of completed year 1 and 2 reviews completed by BFS Partners

- We continue to focus on making sure we are keeping children safe, and that they are able to access our services.

Best Care
Healthy Communities

Page 244 of 588

Oversight

- There are a set of organisational and system wide arrangements in place to ensure continued progress with improvement.

- Within BCHC, a monthly Children's Improvement Group drives progress reporting to the Quality & Safety Committee and every other month to the Trust Board.

- BCHC leads programme board to develop the integrated BFS service model and ensure delivery of our commitments to commissioners.

- At system level:
  - there is a fortnightly CCG-chaired group overseeing progress that includes Public Health and Council children's commissioning input;
  - contract meetings between BCHC and the Council continue to ensure progress with improvement;
  - the CCG has led quarterly more senior review meeting that have provided assurance of progress and an opportunity for partners to support improvement.

Next Steps

We have a clear view of the next steps we need to take to continue to ensure that we can provide a safe and effective early years service to children and their families. This includes the action set out here.

1. Continue to provide short-term support to our teams to minimise the risk to children especially in the three districts most under pressure.

2. Ensure that we see through successfully our plans for health visitor recruitment and retention to reduce workload and caseload pressures by March 2021.

3. Ensure we deliver successfully the agreed improvement trajectory for the five mandated visits resulting in significant improvement by the end of 2020.

4. Build on existing work to improve pathways for some of the most vulnerable children including children in migrant and refugee families, children in families facing homelessness and children with safeguarding.

5. Progress with a further range of indicators of child health including Early Help Assessments completed where appropriate, use of Ages & Stages questionnaire to track progress and ensuring access to Early Education Entitlement for children for whom this is appropriate.

6. Continue with our work to fully deliver the integrated service model for health visiting, children's centre and family support services as originally designed. As partners, we remain committed to the original, integrated community-facing model and 2020 will be a key years in its development in practice.

	Agenda Item: 14
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**17 March 2020**
TITLE:	**SUPPORT TO VULNERABLE FAMILIES IN TEMPORARY ACCOMMODATION**
Organisation	**Birmingham City Council**
Presenting Officer	**Saba Rai: Service Lead Health/Housing and Homelessness** **Gary Messenger: Head of Service – Housing Options & PRS**

Report Type:	**Presentation**

1.	**Purpose:**
1.1	To share information about the services commissioned by Birmingham City Council to support vulnerable families in temporary accommodation.

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

3.	**Recommendation**
	To note the contents of the report for information.

007586/2020

4. Report Body

4.1 Context

4.1.1 The Birmingham Homeless Prevention Strategy 2017+ recognises that the causes of homelessness are a complex interaction between a person or family's individual circumstances and several social and structural factors, that are often outside of their control.

4.1.2 For many people, homelessness is not just a housing issue and is closely linked with complex and chaotic life-experiences including mental health problems, drug and alcohol dependencies, adverse experiences in childhood, being a victim of or witnessing domestic abuse, of being in care or of having been in contact with the criminal justice system.

4.1.3 The Homeless Prevention Strategy reframed the national St Basils Positive Pathway framework for young people into a system wide framework for preventing homelessness across Birmingham. It signalled a shift away from a crisis response, to proactively preventing homelessness in all its forms throughout a person or family's journey.
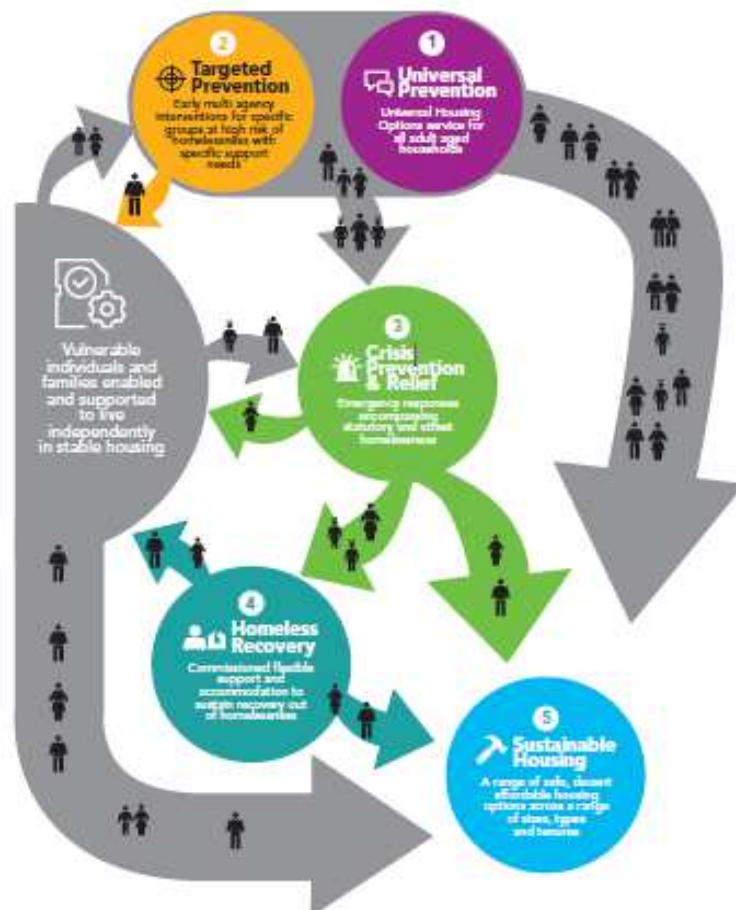
4.2   Current Circumstance

4.2.1   Birmingham has a high level of families who are homeless and/ or in temporary accommodation. Evidence suggests that temporary accommodation impacts social bonding, school performance in children as well as being linked to disadvantage in future generations. Access to employment is a key mechanism for preventing homelessness, yet, poor financial management and a failure to maximise household income continue to limit people's ability to access and sustain housing. Many of these families need additional support to enable them to break this cycle and live independently, where they can sustain stable housing.

4.2.2   Every month the council receives over 600 new homeless applications with on average around three quarters of statutory homeless applicants in a family household with dependent children. In addition, Birmingham's housing, homelessness prevention recovery and support services across a range of sectors, collectively deal with over 15,000 approaches per year from a diverse range of households finding themselves at risk of losing their home or dealing with the immediate crisis of being homeless. Navigating these services for some of our most vulnerable families can be extremely challenging.

4.2.3   In response, Birmingham City council has commissioned a Families Lead Worker Support Service as part of its wider homeless prevention commissioning model. The service aims to support vulnerable adults and families with multiple complex needs by providing targeted support to aid crisis recovery and build resilience. The service is additional to any existing support that families receive within temporary accommodation. It operates from a strengths-based approach and focuses on early targeted prevention and personalised support for families in precarious housing or temporary accommodation.
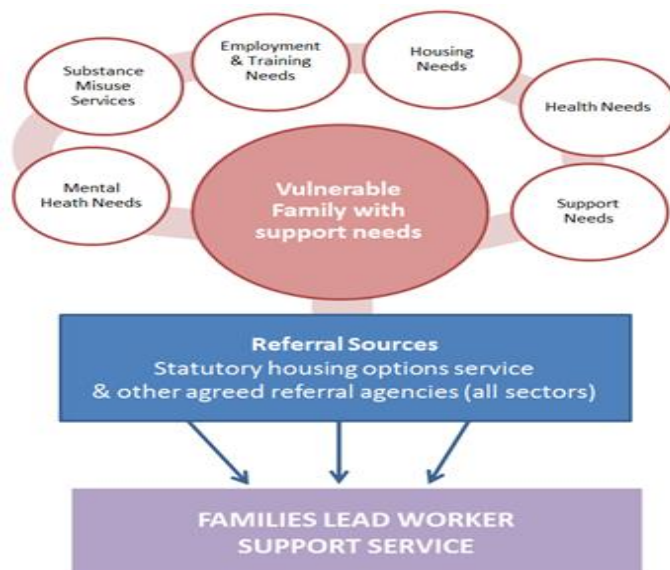
4.2.4   The service will provide initial and on-going support to vulnerable citizens through a holistic package, providing a vital link between the client and other

appropriate services (statutory and non-statutory), acting as an advocate, unblocking barriers and facilitating access into appropriate services.

4.2.5 Operating alongside the statutory housing options service, the Lead Worker Service is responsible for organising and arranging support for vulnerable families with multiple complex needs, empowering them to:

- Address and meet physical and mental health needs ranging from accessing substance misuse, to registering with a GP.
- Gaining access to employment, training and skills.
- Support with realising achievable and stable housing goals and to develop flexible pathways.
- Setting up benefit claims, utility bills, household budgeting etc for their tenancies.
- Enable clients to lead inclusive lives as part of their community, engaging with local communities and establishing positive support and social networks.
- Engage or re-engage in appropriate supportive relationships with friends, family, including dispute resolution and accredited mediation.
- Co-ordinate interventions delivered by other agencies to ensure the right support is offered at the right time, following the principles of the No Wrong Door Network.
- Preparing the family for transition out of the supported service enabling them to live independently

4.3 Next Steps / Delivery

4.3.1 Cranstoun are the commissioned provider of the vulnerable families lead worker service which mobilised in January 2020. The service will provide community based floating support to 800 families during the next 2 years. The provision of support is dependent on the needs of clients however typically, families may receive support for up to 1 year to help them to either establish and maintain independent living, improve their health and wellbeing, move on from temporary / short term living arrangements and / or access appropriate services that will best meet their needs.

4.3.2 Cranstoun will work in partnership with the full range of commissioned Vulnerable Adults Housing and Wellbeing Support Services and other agencies to meet the needs of families in temporary accommodation. They will also engage in opportunities for sharing their learning, information and encourage effective and positive partnership working between agencies and organisations.

4.3.3 As of Feb 2019, the service provider is working with the Temporary Accommodation Service to identify families with multiple complex needs and to establish appropriate referral and support pathways. Further work is planned with statutory services such as health visiting, that come into contact with vulnerable families within temporary accommodation to ensure appropriate support is provided.

5.	Compliance Issues

5.1	**HWBB Forum Responsibility and Board Update**

Progress and performance monitoring of the vulnerable families lead worker service is to Adult Social Care commissioning manager.

Progress against the wider vulnerable families commissioning model is reported to the Vulnerable Adults Board (BCC).

Progress against the homelessness prevention strategy is reported to the Homeless Partnership Board.

5.2	*Management Responsibility*

Adult Social Care (Commissioning)

6.	Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Lack of vulnerable family participation	Low	high	Referral routes and mechanisms have been established with TA and will be reviewed regularly
KPI's not met	low	high	Regular contract monitoring and reporting.

Appendices
None

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

Saba Rai, Service Lead, Health Housing and Homelessness:
Saba.Rai@birmingham.gov.uk

Gary Messenger, Head of Service, Housing Options and PRS:
Gary.Messenger@birmingham.gov.uk

	Agenda Item: 15
Report to:	Birmingham Health & Wellbeing Board
Date:	17 March 2020
TITLE:	EAST BIRMINGHAM INCLUSIVE GROWTH STRATEGY
Organisation	Birmingham City Council
Presenting Officer	Mark Gamble, Development Manager

Report Type:	Information

1.	Purpose:
	The purpose of the report is to bring the public consultation on the East Birmingham Inclusive Growth Strategy to the attention of Board Members and to invite their comments.

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

3.	Recommendation
3.1	The Board is asked to; -
	• Note the public consultation on the East Birmingham Inclusive Growth Strategy
	• Provide their comments on both the content of the Strategy and the approach to public consultation

007587/2020

4.	Report Body

4.1 Context

4.1.1 The East Birmingham and North Solihull (EBNS) area has historically faced a number of economic, social and environmental challenges including persistently high levels of unemployment; low levels of academic attainment and skills; poor transport connectivity; a shortage of employment land and a weak development market. A number of these challenges were highlighted in the independent review of Birmingham by Sir Bob Kerslake. Area based initiatives and programmes across the area have delivered positive outcomes, however persistent inequalities remain suggesting that these entrenched challenges will require a new approach.

4.1.2 The coming of HS2 and the proposed East Birmingham to Solihull extension of the Midland Metro, which will run through East Birmingham, are major opportunities for the area which can be harnessed to deliver wider positive change. The Metro will provide new connections to the two nationally significant economic hubs around the HS2 stations at Birmingham Curzon and UK Central in Solihull, and greatly improved connectivity along the route itself.

4.1.3 East Birmingham and North Solihull has been designated as an Inclusive Growth Corridor where Birmingham City Council, Solihull Metropolitan Borough Council and the West Midlands Combined Authority are working with partners to maximise the benefits of the opportunities created by HS2 and the Metro extension, address the area's significant and sustained disadvantages, deliver growth, and to develop ways of working that will ensure that this growth is inclusive.

4.1.4 The East Birmingham Board (the Board) was established in late 2018, bringing together senior officers from multiple service areas within the City Council alongside external partners including Solihull Council, the NHS, emergency services, Department of Work and Pensions, Department for Business, Energy and Industrial Strategy and the West Midlands Combined Authority. The Board is responsible for the Birmingham section of the East Birmingham/North Solihull Inclusive Growth Corridor and has two key objectives: to deliver growth; and to bring forward the key interventions to enable local residents to benefit from the jobs and opportunities created.

4.2 Current Circumstance

4.2.1 The Board has now produced an Inclusive Growth Strategy for East Birmingham (the Strategy), (attached as **Appendix 1**) which sets out; a shared vision for the regeneration of East Birmingham over the next 20 years; the Big Moves which will secure this vision; the principles which will guide the delivery of the Big Moves and supporting activities, and a summary of the next steps that will be taken in the delivery of the vision.

4.2.2 The draft Strategy is a shared statement of vision and approach, and each of the partners will commit to working in close collaboration to progress the Big Moves and wider delivery plan to address the persistent issues of poverty, deprivation and inequality which were identified by the baseline report

(**Appendix 3**)

4.3   Next Steps / Delivery

4.3.1   The publication of the draft Strategy for consultation will be the beginning of a continuous process of collaborative engagement through which local communities will shape and influence the projects emerging from the Strategy, in line with the City Council's principles of localism and community cohesion.

4.3.2   Consultation commenced on 17th February 2020 for a period of 12 weeks. The approach to consultation is set out in the engagement plan attached as **Appendix 2**.

4.3.3   The purpose of the consultation is to invite comments on the draft Strategy and to establish a stakeholder framework to guide the subsequent work which will implement the Strategy. Following consultation, the Strategy will be amended taking account of the representations received and in due course it will be brought back to the Council's Cabinet to seek approval for its adoption by the City Council.

---

5.   Compliance Issues

5.1   HWBB Forum Responsibility and Board Update

The consultation will be managed by Birmingham City council with the input of partner organisations. A report concerning the outcome of the consultation will be prepared for the Council's Cabinet and can also be brought to the HWBB if requested.

5.2   Management Responsibility

Mark Gamble, Development Manager, Inclusive Growth Directorate, Birmingham City Council

---

6.   Risk Analysis

Risks at this stage relate only to the consultation activity itself

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Failure to effectively engage with representative sample of community and stakeholders.	Medium	Medium	Please see engagement plan and supporting equalities assessment. Consultation duration is longer than usual (12 weeks)
Creation of false expectations leading to loss of goodwill.	Medium	Medium	Strategy and consultation materials/presentations has been carefully framed to minimise this risk.

Appendices
1. East Birmingham Inclusive Growth Strategy
2. Engagement Plan
3. Baseline study

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

Mark Gamble
Development Manager
Inclusive Growth Directorate
Birmingham City Council
0121 303 3988
mark.gamble@birmingham.gov.uk

East Birmingham
Inclusive Growth Strategy

February 2020

CONTENTS

FOREWORD

East Birmingham is a growing place; a place with great potential. It is home to more than 230,000 people and forms a crucial part of the city and region's economy. Major growth is coming which will deliver more than 60,000 new jobs and 10,000 homes within and near to East Birmingham over the next ten years. With the coming of HS2 and the proposed Midland Metro East Birmingham to Solihull extension, East Birmingham has a once in a lifetime opportunity for positive change.

In this Inclusive Growth Strategy, we now set out a clear vision for the future of East Birmingham as an excellent place of strong communities in which to live and work, to grow up and to grow old. To achieve this vision, the Council will work closely with partners to address health and employment inequalities, improve social mobility and make lasting improvements to residents' lives.

We will also develop East Birmingham as a centre for sustainable and low carbon technologies which will make a major contribution to achieving our target of a zero-carbon Birmingham by 2030.

The success of this strategy will be measured not just by how quickly growth is delivered, or how much East Birmingham is improved as a place, but by how effectively growth is harnessed for the benefit of the local people, and how we enable people of all backgrounds and ages to come together to realise their shared aspirations and live healthy, sustainable, and successful lives.

During the preparation of the strategy we have worked with the community and stakeholders to understand the challenges and opportunities and develop a shared vision. Today we invite you to join the conversation by giving us your views to help shape the future of East Birmingham.

Councillor Ian Ward
Leader
Birmingham City Council

Introduction
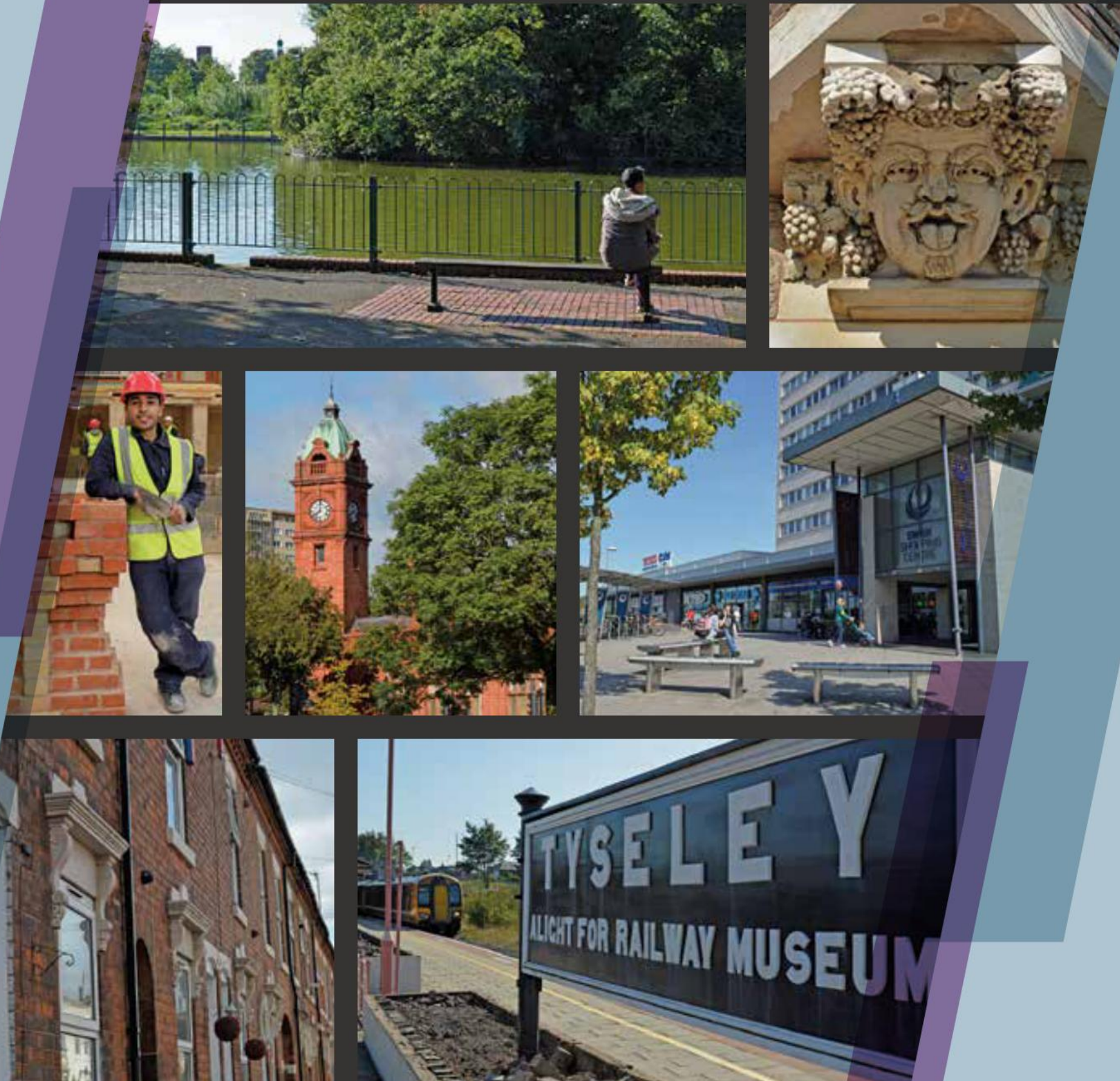
Birmingham is experiencing strong and sustained growth and it is predicted that the city's population will grow by 150,000 people by 2031. During this period, Birmingham City Council has an ambitious strategy to provide 65,400 new homes, 100,000 jobs and the infrastructure that is needed to meet the needs of the growing population. A significant part of this growth will be concentrated in the east of the city, stimulated by HS2 and enabled by improved transport links including the Metro extension to Solihull and the Sprint rapid transit route along the A45 Coventry Road corridor.

The Council is committed to reducing inequalities and building a fair, inclusive city. We will do this by making sure that the benefits of growth are shared more fairly, providing new opportunities for local people to change their lives for the better and delivering lasting improvements to living standards, education and skills, access to jobs and opportunities, health, the environment, local places and transport. This is what is meant by **Inclusive Growth**.

Inclusive Growth is defined by the West Midlands Combined Authority as follows:

A more deliberate and socially purposeful model of economic growth - measured not only by how fast or aggressive it is; but also by how well it is created and shared across the whole population and place, and by the social and environmental outcomes it realises for our people - an economy that shares the values of its citizens.

East Birmingham and neighbouring North Solihull has been designated as an Inclusive Growth Corridor where a new partnership working approach is being pioneered, bringing together public sector organisations, businesses and the local community to deliver growth, to develop new approaches and better ways of working to ensure that this growth is inclusive.

The need for this strategy
In 2017 a baseline study was undertaken to explore the best way forward for the East Birmingham and North Solihull Inclusive Growth Corridor, to tackle the long-standing problems facing the area and make the most of the social, environmental and economic opportunities provided by the coming of HS2, the Metro East Birmingham to Solihull extension and the jobs growth that is expected at key employment sites.

The study concluded that a new approach is required that brings together a focus on places (including improving transport connections, stimulating local growth and involving local people and businesses in shaping this growth), with a focus on people including partnership working to improve the way that the public sector works, both for local people and with local people.

In East Birmingham this work will be led by the East Birmingham Board which brings together the Council with key partners including the NHS, West Midlands Police and Birmingham Children's Trust. The Board will work closely with the West Midlands Combined Authority and Solihull Council's Solihull Together partnership which is responsible for delivering inclusive growth in the North Solihull area.

PLAN 1 East Birmingham and North Solihull
Inclusive Growth Corridor context

Key

▬▬	Birmingham and Solihull boundary
▮	East Birmingham/North Solihull corridor
▬▬	Motorway
▬▬	Major road
••••••	Rail line

NORTH

© Copyright Geoperspectives, supplied by Bluesky International Ltd.
© Crown Copyright and database right 2019. Licence No.100021326.
You are not permitted to copy, sub-licence, distribute or sell any of this data to third parties in any form.
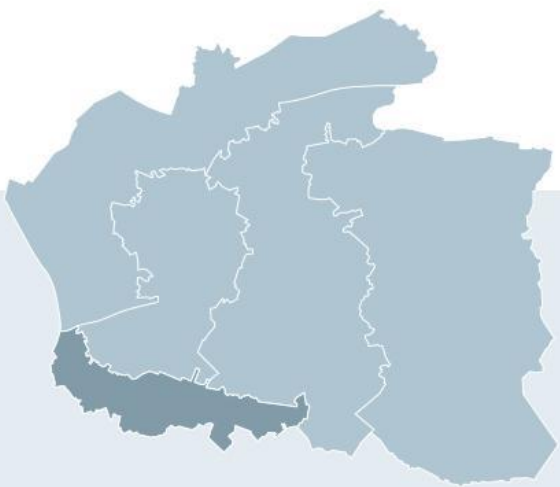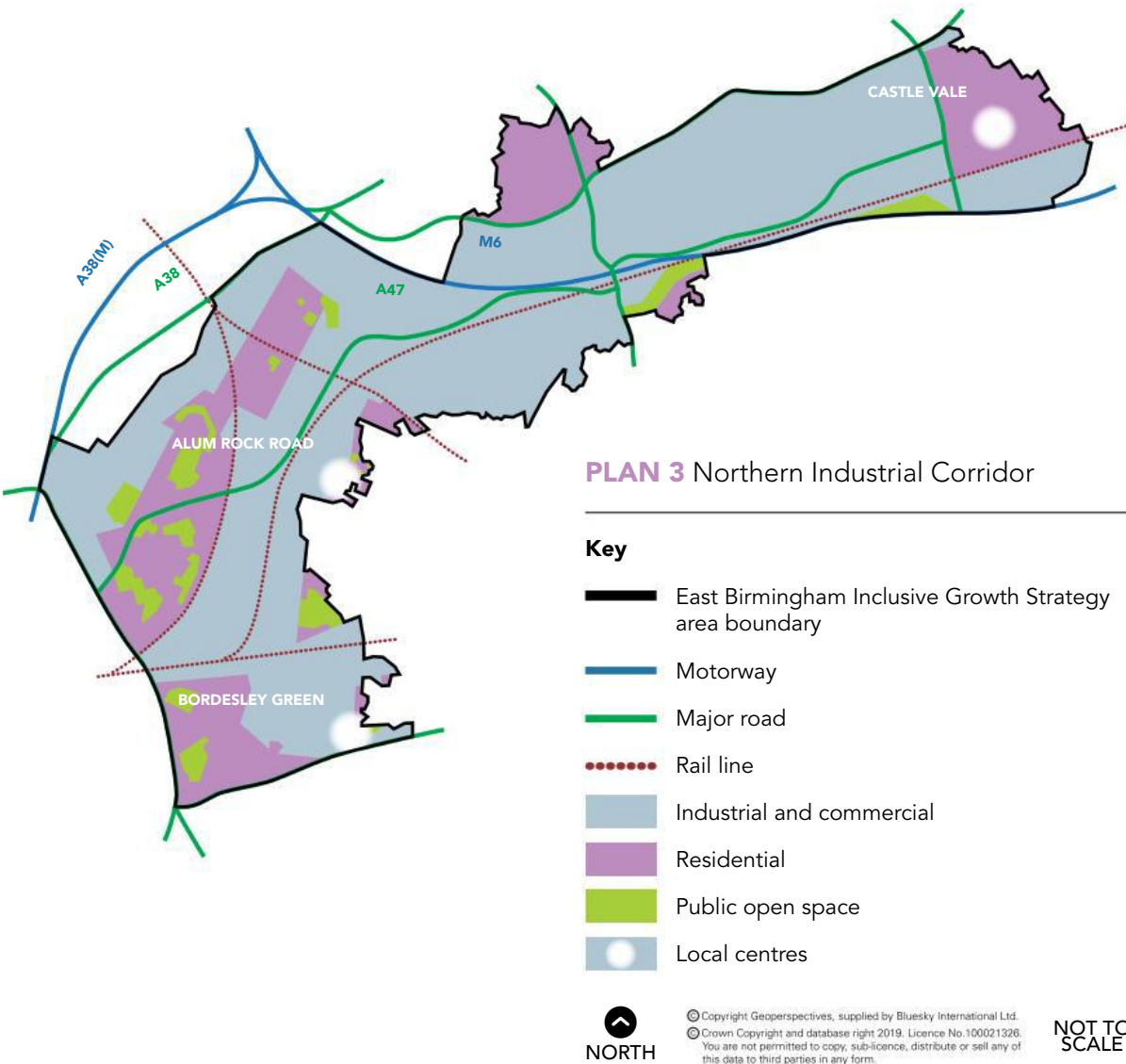
NOT TO SCALE

Each year the organisations which make up the Board spend several hundred million pounds in East Birmingham and, although a huge amount is achieved, there are some persistent problems which have not been fully addressed by our current ways of working. Over time this has led to people in East Birmingham being left behind some other parts of the city in key areas including health, job prospects and earnings, creating significant inequalities which must now be addressed.

All of the Board partners have therefore committed to work together and with the local community to bring about the major changes which are needed to ensure that these challenges are tackled effectively and that the maximum value for local people is achieved for every pound that is spent. This strategy builds on the insights provided by the baseline study to set out how this commitment will be achieved in East Birmingham using innovative new principles and ways of working.

The role of the community

The publication of this draft document for consultation is the beginning of a continuous process of engagement through which residents of East Birmingham will be empowered not only to shape and influence the strategy and decide how it is to be delivered, but also to play a leading role in that delivery.

This approach will follow the city council's principles of Localism:

Our overall aim is to move from focusing on the city council and its structures to a citizen focused approach, working with neighbourhoods to make things work better from the point of view of local residents.

To help the communities of East Birmingham achieve their aspirations we will support local groups and organisations by:

• Supporting Ward Forums to create Ward Plans setting out their priorities and aspirations.

• Providing information and advice.

• Helping communities to develop their capacity.

Purpose

The East Birmingham Inclusive Growth Strategy has been prepared by the East Birmingham Board to guide the delivery of inclusive growth in East Birmingham over the next 20 years.

To do this it sets out:

• A **Vision** for the regeneration of East Birmingham.

• The **Objectives** which we will seek to deliver.

• Five **Big Moves** - the major changes which are needed to deliver these objectives.

• A strong set of **Principles** to guide all of the work which is needed to achieve the vision.

• **Next Steps** giving an overview of the work which will deliver the strategy.

The strategy is informed by and sits alongside other strategies and publications including the Birmingham Development Plan, Bordesley Green Area Action Plan and the Birmingham and Solihull Sustainability and Transformation Partnership (STP) Strategy.

To help the communities of East Birmingham achieve their aspirations we will support local groups and organisations

About East Birmingham

East Birmingham is made up of vibrant, dynamic and unique places with bustling shopping streets and attractive parks and green spaces.

It is a young place where a third of residents are under 16 years old - one of the highest proportions of children in the country. It is a welcoming place where people of many different nationalities have made their homes, bringing with them diverse cultures, faiths and languages. However, it is also a place with significant long-term challenges, where people are more likely than most people elsewhere in the region to struggle with issues such as poor health, poverty and getting around.

For the purposes of this strategy, East Birmingham is defined as everything from the M6 and A38 corridor in the north, to the A45 Coventry Road in the south, and from Birmingham city centre in the west to the boundary with Solihull in the east. The area covers around a quarter of Birmingham, affecting all or part of 20 local council wards and 4 parliamentary constituencies, and with a population in excess of 230,000 people, by itself it is larger than many British towns and cities.

The plan shows the 5 areas which will be used here to describe the places that make up East Birmingham:

• Northern Industrial Corridor.

• Southern Industrial Area.

• Inner East Birmingham.

• Mid East Birmingham.

• Outer East Birmingham

East Birmingham is made up of vibrant, dynamic and unique places

PLAN 2 East Birmingham Inclusive Growth Strategy sub areas

Key

■ East Birmingham Inclusive Growth Strategy

■ Birmingham/Solihull boundary

✈ Birmingham Airport

NORTH

© Copyright Geoperspectives, supplied by Bluesky International Ltd.
© Crown Copyright and database right 2019. Licence No.100021326. You are not permitted to copy, sub-licence, distribute or sell any of this data to third parties in any form.

NOT TO SCALE

BIRMINGHAM

SOLIHULL

NORTHERN INDUSTRIAL CORRIDOR

INNER EAST BIRMINGHAM

MID EAST BIRMINGHAM

OUTER EAST BIRMINGHAM

SOUTHERN INDUSTRIAL AREA

Area 1: Northern Industrial Corridor

Running east-west along the route of the River Tame, this area is mainly industrial in nature. It includes major road connections including the A38, M6 motorway and A47 Heartlands Spine Road.

The corridor includes key employment locations including Star City, the Fort Shopping Park, Fort Dunlop and Jaguar Land Rover's Castle Bromwich site and the residential areas of Nechells and Castle Vale.

The area features an ethnically diverse population, and many different languages other than English are spoken. In some parts of the area there are issues with overcrowding, however the regenerated Castle Vale offers both good quality housing and public spaces.

Poor air quality is a significant problem across this area, mainly arising from major roads around the city centre, and along the M6 corridor.

PLAN 3 Northern Industrial Corridor

Key

▬▬	East Birmingham Inclusive Growth Strategy area boundary
▬▬	Motorway
▬▬	Major road
••••••	Rail line
▮	Industrial and commercial
▮	Residential
▮	Public open space
◯	Local centres

NORTH

© Copyright Geoperspectives, supplied by Bluesky International Ltd.
© Crown Copyright and database right 2019. Licence No.100021326. You are not permitted to copy, sub-licence, distribute or sell any of this data to third parties in any form.

NOT TO SCALE

Area 2: Southern Industrial Area

In the southern part of East Birmingham, there is another significant industrial area alongside the A45, Birmingham-Solihull railway line and the Grand Union canal. Focused historically on the Tyseley Locomotive Works (now a heritage railway museum), the area is now home to the Tyseley Energy Park and many light manufacturing firms which benefit from the area's good road and rail transport links.

There are small pockets of houses within this area, especially to its eastern edge, and the densely populated area of Sparkbrook lies close by to the south.

Despite the road and rail connections into the city centre, public transport in this area does not offer good connections to many other parts of Birmingham.

PLAN 4 Southern Industrial Area

Key

▬▬	East Birmingham Inclusive Growth Strategy area boundary	▮	Industrial and commercial
▬▬	Motorway	▮	Residential
▬▬	Major road	▮	Public open space
••••••	Rail line	◯	Local centres

NORTH

© Copyright Geoperspectives, supplied by Bluesky International Ltd.
© Crown Copyright and database right 2019. Licence No.100021326. You are not permitted to copy, sub-licence, distribute or sell any of this data to third parties in any form.

NOT TO SCALE

Area 3: Inner East Birmingham

Covering the areas of Small Heath, Bordesley Green and Alum Rock, this area is very densely populated. Most residents living in terraced housing, built in the late 19th and early 20th century, and face higher levels of poverty and deprivation than elsewhere in East Birmingham.

The population is predominantly Asian and British Asian and includes many people born overseas. This part of East Birmingham is a particularly young area, with a greater proportion of young people and children than anywhere else in the country.

There are large retail centres at Coventry Road in Small Heath, Alum Rock Road and Bordesley Green, which cater for the needs of the local communities. Alum Rock Road also has an important role as a specialist retail destination for South Asian goods including jewellery, clothes and textiles, attracting shoppers from around the country.

PLAN 5 Inner East Birmingham

Key

▬	East Birmingham Inclusive Growth Strategy area boundary		Industrial and commercial
▬	Motorway		Residential
▬	Major road		Public open space
•••••	Rail line		Local centres

NORTH

© Copyright Geoperspectives, supplied by Bluesky International Ltd.
© Crown Copyright and database right 2019. Licence No. 100021326.
You are not permitted to copy, sub-licence, distribute or sell any of this data to third parties in any form.

NOT TO SCALE

Area 4: Mid East Birmingham

Including Washwood Heath, Stechford and Yardley; the character of this area is 20th century inter-war housing and leafy tree-lined streets. The housing is a mixture of council and owner occupied, with a limited amount of 19th century larger housing to the west, particularly in Stechford and parts of Washwood Heath.

The Cole Valley creates a green core which runs through this area from north to south, past Heartlands Hospital at the centre of the area.

Mid East Birmingham has many desirable neighbourhoods, however, there are some parts in the centre and south of the area which have become more deprived over recent years.

PLAN 6 Mid East Birmingham

Key

▬	East Birmingham Inclusive Growth Strategy area boundary		Residential
▬	Motorway		Public open space
▬	Major road		Local centres
•••••	Rail line		Heartlands Hospital and Tamarind Centre
	Industrial and commercial		

NORTH

© Copyright Geoperspectives, supplied by Bluesky International Ltd.
© Crown Copyright and database right 2019. Licence No. 100021326.
You are not permitted to copy, sub-licence, distribute or sell any of this data to third parties in any form.

NOT TO SCALE

Area 5: Outer East Birmingham

Taking in Hodge Hill, Shard End, Lea Hall, Garretts Green and Sheldon, outer East Birmingham is a residential area featuring a mixture of mainly 20th century inter-war and post-war housing. It is a green area, with the Cole Valley cutting through east-west and is home to a large number of parks and open spaces. There are also large industrial areas near Lea Hall, Tile Cross and Garretts Green.

This area has the largest population of older people, with one in eight residents being over 65, many of whom who live alone.

Rates of car ownership are the highest in Outer East Birmingham, however public transport connections with the wider city are inadequate, particularly those running north-south, and it can take a long time to reach places of employment and education.
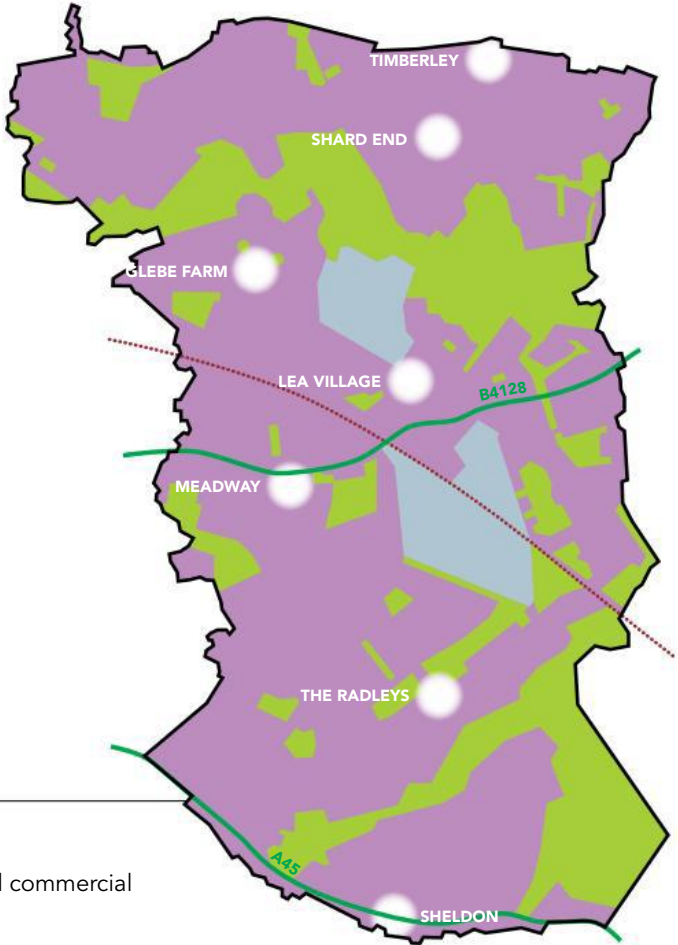
PLAN 7 Outer East Birmingham

Key

─── East Birmingham Inclusive Growth Strategy area boundary

─── Motorway

─── Major road

••••••• Rail line

TIMBERLEY
SHARD END
GLEBE FARM
LEA VILLAGE
B4128
MEADWAY
THE RADLEYS
A45
SHELDON

Industrial and commercial

Residential

Public open space

Local centres

NORTH

NOT TO SCALE

© Copyright Geoperspectives, supplied by Bluesky International Ltd.
© Crown Copyright and database right 2019. Licence No.100021326.
You are not permitted to copy, sub-licence, distribute or sell any of this data to third parties in any form.

Challenges
Much of East Birmingham falls within the top 20% most deprived areas in England according to Government statistics. This means that income, unemployment, health, education, housing, crime and the living environment are poorer than elsewhere in the country. Many of these problems are common across the West Midlands, however they are generally worse in East Birmingham than they are across the rest of the region.

All of these key challenges need to be addressed to improve the lives of residents and to help East Birmingham realise its full potential. However, these issues are linked together and improvements in one area will also have benefits elsewhere.

Health
Compared with many other parts of the city, people in East Birmingham have shorter lives and are far more likely to experience poor health. The number of people living with, or dying early from, long term health conditions like diabetes, respiratory problems and heart disease is much higher in East Birmingham than in other areas. Rates of mental health problems are also high, ranging from depression and anxiety through to schizophrenia and bipolar disorder.

Many health problems have a significant impact on local residents' quality of life and on their ability to secure and maintain employment which creates a spiral of problems. The high rate of health problems also puts pressure on local health services, meaning that the quality of services is affected. For example, many providers find it hard to see everyone who comes for help. Combined with wider issues seen nationally and across Birmingham and Solihull, such as our ageing society, these factors are increasing pressure on services and the health and social care system as a whole.

Because of these pressures it can also be hard to attract and retain health professionals in East Birmingham. Many of the local GPs are approaching retirement age and in many cases are running practices on their own. Recruitment to key roles in community services such as health visiting and district nursing is also a challenge.

Some health services in East Birmingham operate out of poor-quality buildings. This limits the help that can be provided and makes it hard for people with mobility problems to use them.

In those areas of East Birmingham where the population is very diverse it can be difficult to provide services in all the local community languages and in ways which meet everybody's needs.

> *Key challenges need to be addressed to improve the lives of residents and to help East Birmingham*

ECONOMIC INACTIVITY 2011 CENSUS

35% EAST BIRMINGHAM

31% BIRMINGHAM

23% ENGLAND
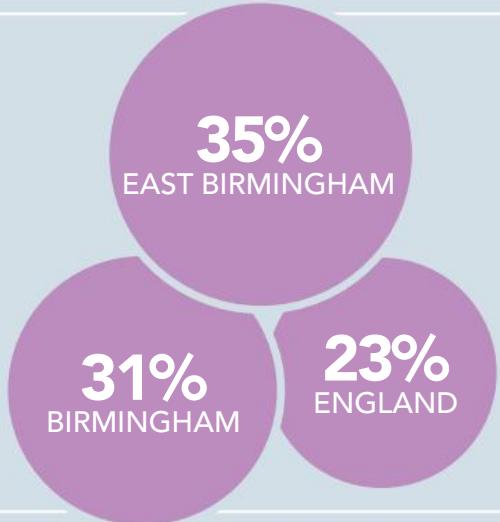
WORKING AGE RESIDENTS NOT EMPLOYED OR SEEKING WORK

PEOPLE LIVING IN AREAS OF VERY HIGH DEPRIVATION ARE...

3X MORE LIKELY TO...

BE ADMITTED FOR PREVENTABLE CONDITIONS

DIE PREMATURELY FROM PREVENTABLE CONDITIONS

BE IN CONTACT WITH MENTAL HEALTH SERVICES

HAVE A LONG TERM CONDITION

LIFE EXPECTANCY

85.1 YEARS SUTTON FOUR OAKS WARD

74.9 YEARS HEARTLANDS WARD
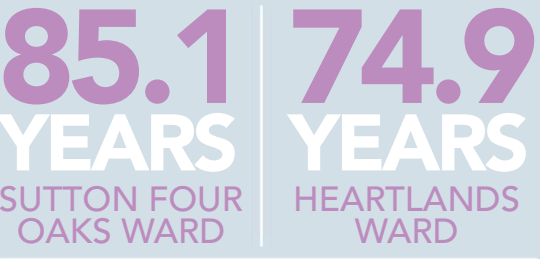
Skills and education
Schools and nursery performance and OFSTED ratings are significantly lower in East Birmingham than the national average. Children's performance at different stages of their education varies across the area, but in general children in East Birmingham leave school with fewer qualifications than average and are less likely to go on to college or another type of further education.

Adults in East Birmingham typically have fewer qualifications than average with 36% of people having no qualifications, compared with 28% for Birmingham and 23% nationally. This can make it more difficult for them to find employment, and to move on to higher-paying jobs. Language skills are also an issue for many people, and in some parts of the area more than one in ten people does not speak English well.

There are some areas in the East of Birmingham where there are not enough local secondary school places for the number of children that live there. This means that some pupils are travelling out of the area to attend a school. Whilst an expansion programme is in progress in the area, a number of secondary school sites do not have room to expand on site and so alternative options will need to be found to create the additional places that are needed.

Congestion and air quality
Traffic is a significant problem in East Birmingham. The road network is overloaded with private cars and as a result travelling around the area can be a slow and frustrating experience. One effect of this congestion is that levels of air pollution are high, particularly in inner East Birmingham and around main roads.

Poor air quality has serious health impacts, including lung cancer and heart disease, and it is estimated that up to 900 deaths per year are linked to man-made pollution. The City Council is taking steps to address this, including the adoption of a Clean Air Zone that covers the city centre.

Traffic and congestion are worsened by the fact that public transport in the area is generally not as good as in other parts of the city: train stations are hard to reach and services are irregular, buses are often delayed due to traffic, and the busy roads can discourage cycling. As a result, people living in East Birmingham often find it hard to get to some of the places important to day-to-day life, making it more difficult to find a job, attend college, or get to a doctor.

Economy
Many people and families in East Birmingham struggle to manage with low incomes. As a result, more than one in three children in the area is living in poverty.

One of the reasons for this is that more than twice as many people in the area are unemployed than the national average. Compared with the rest of the country there are many more children and young people in East Birmingham, and also a higher proportion of people who are long-term sick or disabled. As a result, a larger proportion of people are out of work or only work part-time because they need to care for family members. This type of unemployment is particularly high amongst women. Unemployment is also high amongst young people, with almost twice the national average of people between the ages of 16 and 24 out of work.

Another issue is that many of the jobs on offer in the area are in manufacturing and unskilled labour roles; in some cases with poor pay and unfavourable terms and conditions. This means that people who are out of work can sometimes be discouraged from taking jobs. Although there are some opportunities for better paid work within East Birmingham and in the surrounding areas, local people can find it difficult to access them due to congestion and poor public transport links.

AREA	1	2	3	4	5	EB Av.
Population	23,300	11,700	61,900	68,300	73,000	238,000
% Under 16	29.9	28.7	31.7	28.7	24.2	28.2
% Over 65	9.3	9.3	7.3	11.2	15.0	11.1
% Households without English as a main language	17.5	18.6	22.1	7.4	2.3	13.58
% Unemployed	14.4	11.5	13.0	10.9	9.4	11.2
% Economically inactive (working age, out of work and not looking for a job)	35.8	40.6	46.1	33.7	27.8	35.2
% Households with no car or van	52.7	47.8	42.1	37.4	35.4	43.0
% Ethnicity:						
White	38.0	23.2	10.4	47.5	77.7	41.2
Asian/Asian British	27.5	58.7	73.0	38.5	12.0	42.0
Black/Black British	24.3	9.6	10.2	7.9	5.0	11.4
Born overseas	30.0	38.1	41.6	23.7	10.5	28.8
Overcrowded households	17.3	18.0	19.8	12.1	9.4	15.3
Lone pensioners	10.7	9.8	7.8	12.0	14.0	10.9

TABLE 1 Key demographics (from 2011 Census and ONS 2017 population estimate).

Poor air quality has serious health impacts...

the City Council is taking steps to address this

The opportunity

East Birmingham has never been in a stronger position to transform itself. Its location in between Birmingham city centre and Birmingham Airport means that it already has excellent national and international transport connections and is well positioned to benefit from the major growth planned around the new HS2 stations at Curzon in Birmingham city centre and The Hub in Solihull. There are also a number of forthcoming projects which will deliver new homes, jobs and transport links. However, the biggest opportunity is to unlock the full potential of East Birmingham's most important resource: its people.

Investing in the community
There is a vast amount of potential in East Birmingham, which is home to many talented and hard-working people. By helping them to overcome the challenges which are mentioned above people in East Birmingham can be enabled to achieve this potential, to have an active role in their community and in the growth of Birmingham's economy, to have more of a say in the decisions which affect them, and become healthier, happier and more financially secure.

In addition to helping individuals, tackling these issues also benefits wider society by reducing the strain on public services, meaning better services can be provided for those who need them. For example, it is widely accepted that people in employment are generally healthier and therefore make fewer demands on the health services.

The Council is encouraging and supporting communities to work together to achieve shared goals through the Ward Planning process. This is an opportunity for people in East Birmingham to develop strong relationships with each other and with their local Councillors, and to come together to make positive change. This approach will be developed further by the 'Pioneer Places' where new ideas for neighbourhood working will be trialled and learning will be shared across the whole of the city.

There are also many existing charitable, religious and community groups in East Birmingham who provide a wide range of community functions and services. Many of these groups are making major contributions to peoples' health, happiness and quality of life. Supporting these groups to do even more, and helping communities to form new groups, is a key priority.

The children of East Birmingham are the future of East Birmingham, and there is a major opportunity to change lives for the better by helping them to have the best possible start in life. This starts in pregnancy. A healthy pregnancy can have a positive impact on a baby's growth and development, reducing the likelihood of future health problems such as chronic disease. The first 1001 days of a baby's life are also critical. The earliest experiences shape a baby's brain development and have a lifelong impact on that baby's mental and emotional health. International studies demonstrate that when a baby's development falls behind during these first years of life, it is more likely to fall even further behind as time goes on.

There is evidence that children who have stressful and traumatic lives are much more likely to suffer with a range of problems in later life including crime, drug abuse, poor health and mental illnesses. On the other hand, a good education is a key contributing factor that supports children's development and their ability to lead an active healthy life as they grow into young adults.

Many of the problems which hold people back are much easier to deal with if they are caught early. By focussing on supporting people at the right time, and in the right way, better outcomes can be achieved, helping people to become healthier, happier, resilient and more financially secure.

An important part of this approach relates to the way that children are readied to take part in adult life: helping children to understand the options available to them when they finish school and providing positive examples of potential career pathways can encourage them to have greater aspirations and to be motivated to achieve them.

> *There is a vast amount of potential in East Birmingham, which is home to many talented and hard-working people*

Major transport improvements

Over coming years East Birmingham's transport system will undergo big changes which will transform the way that it works, tackling problems which have existed for many years and delivering a much cleaner, more sustainable, and more efficient network that works better for everybody.

In January 2020 the Council published a Transport Plan which explains what will be done between now and 2031 to create this new public transport system. Changing the way that people move around Birmingham will reduce congestion, improve air quality and encourage people into healthier travel habits such as walking and cycling.

Improvements to the transport system will make it easier for people to get around, helping them to access job opportunities in the area around East Birmingham

There are already plans for major improvements to transport in East Birmingham, including:

• A new Midland Metro tram route running from the city centre through East Birmingham to Solihull and the Airport, providing a new direct and reliable connection to both HS2 stations and to Birmingham city centre.

New clean and safe cycling and walking routes will be provided, helping people to adopt healthy, active travel habits

• A SPRINT rapid bus transit route will be created along the A45 Coventry Road. Sprint will have a dedicated lane, allowing it to cut through congestion and provide a fast and reliable service.

• Improvements to the rail network providing more frequent train services from existing stations as well as the new stations near The Fort and Castle Vale on the Water Orton line.

• Improvements to main roads and junctions, including the Iron Lane junction improvements in Stechford.

• A wide range of improvements to bus routes including bus priority measures to reduce delays in areas with heavy traffic.

• Extensive improvements to cycle and walking routes across the area including new segregated cycle lanes and secure bike parking facilities.

East Birmingham's transport system will undergo big changes

PLAN 8 Transport improvements

Key

▬▬▬	East Birmingham Inclusive Growth Strategy area boundary
••••••	Rail line
✈	Birmingham Airport
••••••	HS2 route
•●●•	Proposed rail stations
•●●•	Proposed Metro extension/stops
••••••	Proposed Sprint route
▬▬▬	On-road cycle routes
••••••	Proposed on-road cycle routes
▬▬▬	Off-road cycle routes
••••••	Proposed off-road cycle routes
▬▬▬	Canal

NORTH

© Copyright Geoperspectives, supplied by Bluesky International Ltd.
© Crown Copyright and database right 2019. Licence No.100021326. You are not permitted to copy, sub-licence, distribute or sell any of this data to third parties in any form.

NOT TO SCALE

New homes and jobs
The Birmingham Development Plan sets out an ambitious programme of development to meet the needs of the city's growing population. In East Birmingham this growth is concentrated at Bordesley Park and the Eastern Triangle which is the area around Meadway, Shard End and Stechford where 1,000 new houses are proposed. The Bordesley Park Area Action Plan sets out a vision for an area of over 580 hectares in inner East Birmingham including proposals for 750 homes and up to 3000 jobs, the strengthening of the local economy and by seeking to improve connectivity and the environment in a sustainable way.

The City Council is taking a leading role in making this housing growth happen through the award-winning Birmingham Municipal Housing Trust (BMHT) which has plans to build 1,000 high-quality affordable homes in the area over the next ten years. Key BMHT schemes include Yardley Brook where 298 units are planned, and sites at Bromford and the former Poolway shopping centre at Meadway.

In the near future East Birmingham's jobs market will benefit from a number of significant developments both within the area and nearby:

- At Peddimore near Castle Vale, 6,500 jobs will be created as part of the development of a 71 hectare site for business and manufacturing uses.

- 36,000 jobs will be created by new developments in the city centre including the transformation of the Curzon area in the vicinity of the new HS2 station.

- The development of the former LDV and Alstom sites at Washwood Heath to create the HS2 Rolling Stock Maintenance Depot, HS2 Network Control Centre and a range of other employment uses is expected to create 2,000 jobs.

- HS2 will also facilitate major growth at UK Central in Solihull, near Birmingham Airport, the NEC and the new HS2 station including up to 5,000 new homes and supporting 70,000 new and existing jobs.

- The development of the Wheels site within the Bordesley Park Area Action Plan area for employment and industrial uses creating up to 3000 jobs.

- The Council is committed to revitalising local centres across the city and has published proposals in the Urban Centres Framework for a number of major centres including Meadway, Bordesley Green, Coventry Road, Alum Rock Road and Stechford.

HS2 is a once in a lifetime opportunity for East Birmingham

HS2 will pass through East Birmingham on its way between stations at Birmingham Curzon and UK Central in Solihull. The new stations will be surrounded by new jobs and development.

In Birmingham city centre the HS2 Curzon Station will sit at the centre of the 141-hectare Curzon Growth Area and adjacent to the city's Knowledge Hub where Innovation Birmingham, Birmingham City University and Aston University are delivering major expansion plans. To the south of the station is the city's digital and media district in Digbeth with its vibrant mix of businesses and cultural spaces, the growth of which will further enhance the city's historical reputation as a place for innovation and enterprise.

The UK Central Hub in Solihull is one of the UK's most strategically important development areas and a driver of regional and national economic growth. The 140-hectare Arden Cross development site will be home to the new HS2 Interchange Station which will be on the doorstep of Birmingham Airport and within easy reach of Birmingham Business Park, Jaguar Land Rover and the NEC.

Within East Birmingham itself HS2 will create major opportunities for jobs and training including up to 500 new jobs at the HS2 maintenance depot and control centre in Washwood Heath. There will also be supply chain opportunities for local businesses.

The Bordesley Park Area Action Plan will guide the growth and regeneration of the area to the east of the city centre, which includes parts of Washwood Heath, Bordesley Green, Bordesley Village and Small Heath, over the period to 2031.

HS2 is a once in a lifetime opportunity for East Birmingham

PLAN 9 Major growth area proposals

Key

— East Birmingham Inclusive Growth Strategy area boundary

✈ Birmingham Airport

Birmingham Development Plan Growth Area

Urban centre

Washwood Heath

HS2 depot

Wheels site

Housing development

Housing regeneration

NORTH

© Copyright Geoperspectives, supplied by Bluesky International Ltd.
© Crown Copyright and database right 2019. Licence No.100021326. You are not permitted to copy, sub-licence, distribute or sell any of this data to third parties in any form.

NOT TO SCALE

Clean energy and climate change

The Council has declared a climate emergency and set the ambition for the city to become carbon neutral by 2030. Moving to zero carbon will bring many opportunities, including better health and wellbeing, better jobs, and better places to live. A partnership Climate Change Taskforce has been assembled to decide how the whole city can make the required changes to the way that people live, work, and travel in order for Birmingham to lead the way in tackling climate change.

East Birmingham is the home of Tyseley Energy Park where excellent work is already underway to develop new sustainable technologies, including ways of generating clean energy. This has the potential for significant expansion and will play a key role as the city develops a new waste and recycling strategy. There is an opportunity for this growth sector to be one of the 'industries of the future' which will attract future investment to East Birmingham, creating skills and employment opportunities for local people.

Tyseley is at the forefront of clean energy and sustainable technologies

At Tyseley Energy Park (TEP) important progress is being made to develop green technologies.

TEP is home to a waste wood biomass power plant which provides power for Webster and Horsfalls' manufacturing operation.

The next step will be the development of the UK's first low and zero carbon refuelling station which will include a range of fuels that will reduce emissions including hydrogen, Compressed Natural Gas, Commercial Scale Electric Chargers and Biodiesel.

In the future there are plans to build an energy from waste facility that will be capable of generating renewable heat, electricity and biomethane that can be used across the city.

The Commonwealth Games

In 2022 Birmingham is set to host the Commonwealth Games. In preparation for the Games the city is investing in extensive improvements to its sporting venues and facilities.

The main focus for the Commonwealth Games will be in the north of the City where improvements are on site which will transform the local centre, road network and railway station The Athlete's Village is currently under construction. This temporary accommodation for athletes will be converted after the games to provide 1,400 new homes. However, the benefits are not limited to Perry Barr, and the entire city will benefit from the vast investment that the Commonwealth games will bring to Birmingham, including job opportunities and significant improvements to the city's transport system.

The Council has declared a climate emergency and set the ambition for the city to become carbon neutral by 2030

Vision

The East Birmingham Board has proposed the following overall vision and objectives for the future of East Birmingham.

The Council and its partners will make use of the unique opportunities and potential of East Birmingham to create a clean, safe, prosperous and well-connected place where citizens from all backgrounds have access to excellent housing, education, healthcare, green spaces and employment opportunities. Local communities will work together as part of the team to achieve their aspirations and will share a strong sense of ownership and pride in their area. The main role of East Birmingham within the wider city region will be as a desirable yet affordable residential area with excellent amenities which is particularly suitable for families with children, and as a centre for low carbon and sustainable industries.

Objectives
The strategy seeks to improve all aspects of the lives of people in East Birmingham. The objectives of the strategy are divided into the following key themes:

Equality
We want East Birmingham to be a fair place where people (regardless of their background, age, ability, and needs) respect one another, have high aspirations, equal access to opportunities, and can achieve what they want to achieve.

We aim to:
- Improve people's overall quality of life (including education, health, and crime levels).
- Improve fairness in employment, including supporting those who have not had a job for long time into secure work.
- Improve fairness in education.

Education and learning
We want people in East Birmingham to benefit from the best start in life and to be able to obtain the knowledge, skills, and qualifications that will help them achieve their potential and succeed in secure and sustainable employment.

We aim to:
- Increase the number of children that are school ready.
- Increase the number of children meeting their developmental goals and improve children's academic performance.
- Increase the number of people with qualifications.
- Increase the number of young people in employment, education, or training.

Health and wellbeing
We want East Birmingham to be a place where people enjoy longer, healthier lives and feel part of resilient and independent communities that take care of each other.

We aim to:
- Support people to live longer and lead independent, healthy lives.
- Improve people's health and wellbeing (including mental health).
- Reduce infant mortality.
- Support and enable families to give children the best start in life.
- Provide accurate information advice and guidance to enable residents to more easily understand the health system and how it can meet their health and wellbeing needs.

Affordable, safe and connected places
We want East Birmingham to be a desirable and affordable place where people want to live, work, learn, and spend time in, and where people can get to where they need to go safely and easily.

We aim to:
- Improve living standards.
- Reduce overcrowding and homelessness.
- Reduce crime.
- Improve how people can get around (including buses, trains, cycling, and walking).

Economy
We want East Birmingham to be flourishing place where people are able to contribute to and take advantage of the benefits and opportunities provided by a thriving local economy.

We aim to:
- Increase the number of people in employment (including increasing the number of people with higher-skilled and sustainable jobs).
- Reduce the employment gap for people with ill health and/or disability.
- Support more local businesses to provide safe, healthy and financially secure jobs.
- Promote a healthy food economy across East Birmingham.
- Reduce the number of working people who are in poverty.

Power, influence and participation
We want people in East Birmingham to be empowered, able to exercise their rights and responsibilities, and able to influence decision-making that affects them and their communities.

We aim to:
- Increase people's satisfaction with their quality of life in their neighbourhood.
- Give people more power to make decisions on public-sector spending in their local areas.
- Support communities to do more things for themselves.
- Support people of every age, sexual orientation, gender identity, faith, disability and ethnicity to participate and feel able to be an active part of their local community.

The environment
The work undertaken to achieve our vision for East Birmingham will be shaped by our responsibility to protect and enhance our environment to ensure the benefits of inclusive growth can be enjoyed by current and future generations.

We aim to:
- Improve air quality.
- Improve the natural environment and neighbourhoods, (including parks and green spaces).
- Increase the number of people using sustainable methods of transport.

Approach
To achieve the vision for East Birmingham we will work in partnership to bring forward five Big Moves - the key changes that are needed to deliver inclusive growth - and adopt new ways of working, following the principles set out in this strategy. This new approach will require significant changes to the way that we plan, deliver and evaluate services, connect with our communities, and work with our partners.

Social, economic, and environmental challenges are often linked - for example, transport improvements can deliver economic growth, better wellbeing, more jobs, and improve the quality of the environment. However, in order to secure the full benefits, and to ensure that they are shared fairly, a joined-up approach is needed that brings together the partners and community to work together as a team.

Guided by the proposed principles below, as well as the responses we receive to public consultation on this document, the East Birmingham Board will work to ensure that all of our activities are joined-up, including the delivery of the Big Moves, and that we are maximising the social, environmental, health and economic benefits of growth. The lessons that are learned in East Birmingham, and the successes that we achieve, will be used to guide the delivery of inclusive growth elsewhere in the city and region.

Our first priority will be building upon things that are already having positive impacts on people, accelerating our existing plans for improvement and ensuring that East Birmingham is at the front of the queue whenever there are opportunities for investment and innovation.

Big moves
The Big Moves are the five major changes that need to happen for the Vision to be achieved. The delivery of the Big Moves will require all of the East Birmingham Board partners and the community to work together; and in some cases will require the support of Government.

The Big Moves are not the only activities which are needed to deliver the Vision, but they are the most important.

Improved local services
Good quality local services are critical to the wellbeing of all communities and are particularly important in areas like East Birmingham where educational attainment levels are lower, health is poorer and social problems are more commonplace.

Improving the performance of the health service, social care services, and education are essential to achieving the Vision. To achieve this, we will work together to consider how each of the services can provide better outcomes and a better overall experience to those who use it, focussing on people rather than processes.

We will also prioritise East Birmingham for the improvement of existing services and as the place to develop new and innovative approaches in collaboration with the local community. This will include working together to tackle local issues and to target interventions wherever there is a particular need.

For our health services we will seek to:

• Work with local communities, providing them with tools and information to make healthier choices and manage their health problems.

• Improve access to health services, helping local people to access the right service at the right time.

• Understand the reasons why people die early in East Birmingham and develop services which can help.

• Invest in local voluntary and community sector services and create a network of link workers to help local people find out about what support and activities are available to them locally.

• Have a greater emphasis on the promotion of health and wellbeing.

• Maximise efficiency in how we use public resources.

• Bring together local primary care services (such as GPs, community pharmacies and dentists) with community services like district nursing, social work and mental health support to better plan and co-ordinate help for those who need it.

• Continuously improve the quality of care. Raise the qualtiy of health services by making improvements to premises and supporting those services which have been rated as inadequate to improve.

• Work with the providers of day care, residential care and nursing homes to ensure that services are of a good quality and meet the needs of local residents.

• Support those who take on formal or informal carers' roles for friends and families to remain well.

The City Council will ensure that children in East Birmingham have access to excellent schools and early years provision by:

• Working with the Birmingham Education Partnership, Multi-Academy Trusts and Regional Schools Commissioner to improve underperforming schools and academies.

• Continuing to invest in the improvement of school buildings and bring forward proposals for the redevelopment of schools, where capital funding allows.

• Supporting the expansion of high-performing schools and encouraging the creation of new school provision if required.

• Supporting schools to promote inclusivity, enabling pupils with additional or special educational needs to access their local school.

• Helping schools to work together and share best practice through School Collaborative Working Pilots and by pairing high-performing institutions with those that are struggling to share successful approaches.

• Supporting the provision of out of school early years provision including childcare, play groups and activities for young children.

• Working with early years health and wellbeing providers, maternity providers and NHS partners to ensure all children have the best start in life.

We will also explore opportunities to make the best use of our land and buildings in East Birmingham to deliver our services more efficiently and to support community and voluntary activities wherever possible. In some places it may be possible to create multi-agency hubs - buildings where several different services are available in the same place. Through this exercise we will also work with communities to seek productive new uses for any building or land which is no longer needed.

Business, employment and skills

Improved transport links will help residents in East Birmingham to benefit from new and existing employment opportunities including those in the city centre and at UK Central. We will focus our energy on making sure that local people know about these jobs and the support that is available to help them to get them. We want residents in East Birmingham to have every opportunity to get better paid jobs and fulfilling careers.

Support to get a job and access training is available but it isn't always easy for local residents to find out what it is and where to get it, or to know what the best route is to achieve their career goals.

We want to change this by making sure that the offer to residents is clear and that city and region-wide programmes have a clear focus and targeted offer for East Birmingham. To support this we will work to:

- Clearly set out what employment and training opportunities are available to people in East Birmingham.

- Communicate this offer to local people through community venues, community organisations, social media, etc.

- Work with employers, training and employment support providers to develop clear pathways for local people into good jobs.

- Target our resources in areas of East Birmingham with particularly low levels of employment and also on young unemployed people who are most likely to benefit.

We know that we can deliver targeted support to certain areas and people who need it now but there is much more that could be done with additional funding. We will work to explore opportunities to secure additional funding for East Birmingham to accelerate and expand the employment and training offer in East Birmingham.

Local businesses have a key role to play in the economy and can also contribute to helping people to live healthy lives. We will support the growth and vitality of local businesses by:

- Encouraging larger businesses in the area to build positive relationships with smaller businesses. This includes developing local supply chains and sharing learning and best practice.

- Supporting the growth of green technology and green energy businesses, building on the projects that are underway at Tyseley Energy Centre.

- Helping businesses to recruit people with appropriate skills and experience.

- Expanding our existing range of business support services which includes grants, loans, advice and training. At present we are not able to offer grants to shops and retail businesses. We will work to change this to ensure that we can do more to support more businesses in East Birmingham.

- Developing the ability of businesses to support the health and wellbeing of their employees using the Thrive at Work framework.

- Working with the food industry including training providers, food suppliers, processers and retailers to build a healthy food economy. This will both strengthen local businesses and increase access to fresh, healthy food.

- Develop the role of Heartlands Hospital as an anchor employer for the community of East Birmingham.

We want residents... to have every opportunity to get better paid jobs and fulfilling careers

Local places and green spaces

Local centres, shopping parades, parks and other green spaces have a strong influence on peoples' quality of life. They are the places that people come together for shopping, work, sports and leisure, and to access local services. Strengthening, improving and unlocking the potential of these places is needed to support growth and to provide a better environment for local people.

We will do this by working together with local communities to build on the existing strengths of each place, identifying opportunities for improvement, and finding solutions to local issues and problems. This will help to make these places safer, cleaner and easier to use, support the growth of local shops and businesses, help people to live healthier lives and support local community activities and cohesion.

For local shopping centres this will mean:

• Addressing transport issues such as public transport, walking and cycling routes, and car parking.

• Improving cleanliness, air quality and the quality of the environment.

• Improving the quality and availability of facilities for community and voluntary groups.

• Reducing the number of empty shop units, making sure that there are good quality spaces for local business, and identifying opportunities for new development.

• Working with the food sellers and hot food takeaways to provide more healthy choices.

• Improving access to local services such as libraries, doctors' surgeries and leisure centres.

• Seeking ways to preserve, enhance and celebrate local culture such as historic buildings and public art.

The Council's Urban Centres Framework already sets out major plans for the improvement of some of East Birmingham's most important local centres at Alum Rock Road, Bordesley Green, Coventry Road, Meadway and Stechford. We will work with the community to deliver these plans and to ensure that the maximum benefits are realised as quickly as possible. We will also encourage communities to make use of the Urban Centres Toolkit to take the lead in improving their local centre.

West Midlands Police have identified two Impact Areas in East Birmingham at Bordesley Green and Sparkbrook and Sparkhill where there will be a particular focus on tackling crime and delivering long-term improvements in safety. We will work together to support these impact areas, and to address the wider causes and impacts of crime across East Birmingham.

We will explore opportunities to improve parks, green spaces including the Cole Valley corridor, and the canal network and find ways to encourage more residents to use these places as part of an active lifestyle. There will be a key role for the local community to help identify what changes and improvements are needed, and to get involved and play a greater role in looking after their local green spaces in order to ensure that the benefits are lasting.

The Council and our partners are working to bring forward work to transform our parks and green spaces. This work, known as the Future Parks Accelerator programme, has a chosen focus on Ward End and Washwood Heath as one of 4 city pilot areas. This activity will be the first step in the development of a 25-year plan for the future of the natural environment in East Birmingham. The natural environment plan will be used alongside this strategy to provide clear steps forward to improve the quality of green spaces and neighbourhoods. We will make sure that new developments fit in with this plan by making a positive contribution to the quality of local places, providing good quality green spaces and creating healthy living environments.

PLAN 10 Local centres and green spaces

Key

▬ East Birmingham Inclusive Growth Strategy area boundary

✈ Birmingham Airport

◼ Green space

◼ Local centre

◼ Allotments

◼ Golf course

NORTH

© Copyright Geoperspectives, supplied by Bluesky International Ltd.
© Crown Copyright and database right 2019. Licence No.100021326. You are not permitted to copy, sub-licence, distribute or sell any of this data to third parties in any form.

NOT TO SCALE

We will explore opportunities to improve parks and green spaces

CASTLE VALE

TIMBERLEY

WARD END · FOX AND GOOSE · SHARD END

ALUM ROCK ROAD · PELHAM · GLEBE FARM

STECHFORD · LEA VILLAGE

BORDESLEY GREEN · MEADWAY

GREEN LANE

COVENTRY ROAD

YEW TREE · THE RADLEYS

HAY MILLS · THE SWAN

SHELDON
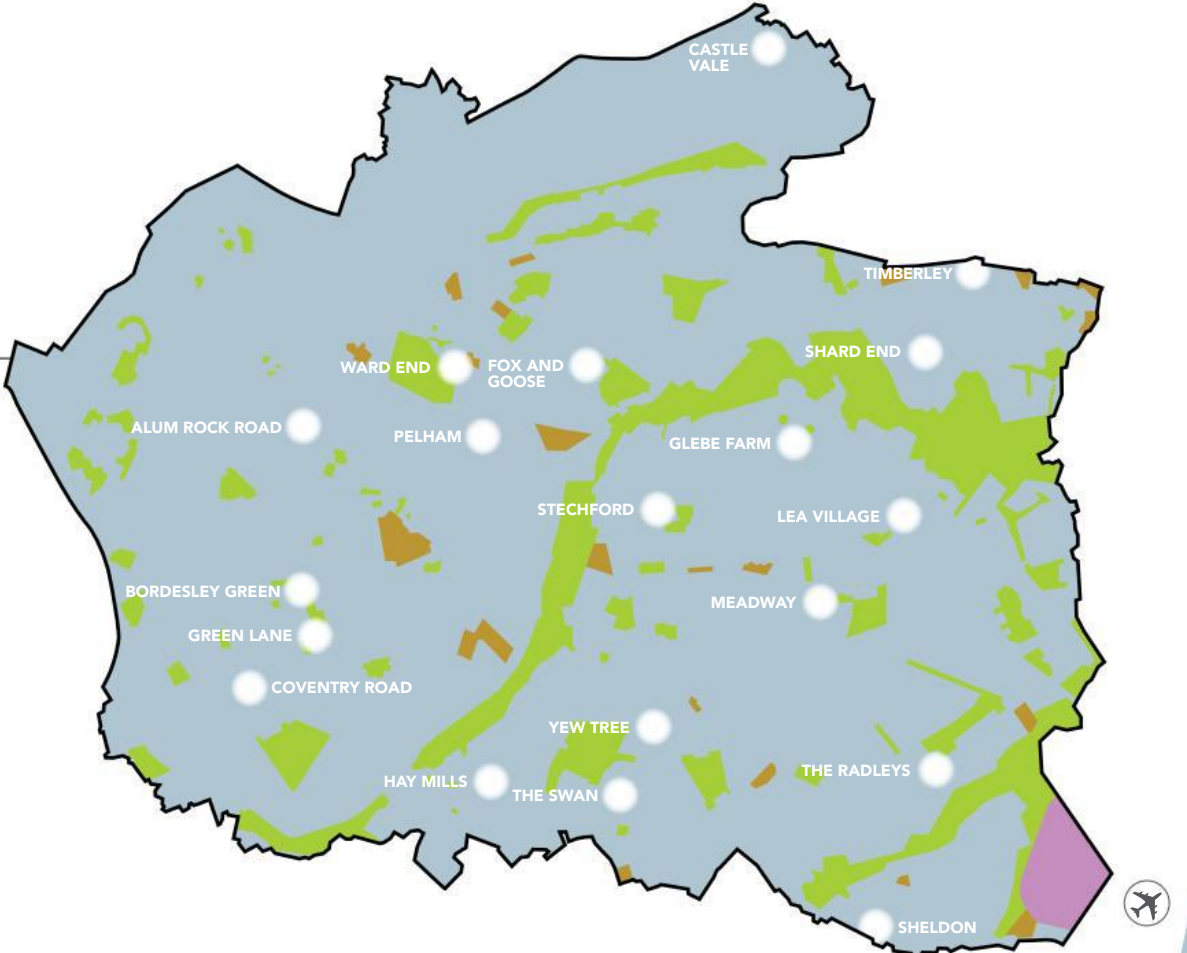
Midland Metro East Birmingham to Solihull extension

The planned extension of the Midland Metro route through East Birmingham will provide a new connection to key destinations including Birmingham city centre, Birmingham Airport and the new job opportunities around UK Central, Birmingham Business Park in Solihull and the two new HS2 Stations. The route will pass through key locations in East Birmingham including Bordesley Park, Heartlands Hospital and the Meadway redevelopment.

The delivery of the Metro is a crucial part of the excellent public transport system that is needed to help transform the way that people move around East Birmingham. Along with improvements to bus, rail, cycling and walking routes, and the forthcoming Sprint rapid transit route along the A45, the new Metro service will provide a fast and reliable connection, allowing local people to access employment, education and amenities. This improved access will also help bring people into the area, stimulating growth and regeneration along the route corridor.

The construction of the new Metro line will be a major infrastructure project which will create jobs, apprenticeships and training opportunities. There will also be opportunities for local businesses to supply the materials and services needed.

In order to make sure that East Birmingham gets the most out of the Metro project we will:

• Work together to bring forward the East Birmingham to Solihull Midland Metro extension as soon as possible. This will include the development of a strong Business Case to Government setting out both the transportation benefits and the strong contribution the Metro will make to the delivery of inclusive growth in East Birmingham.

• Design the Metro route, stops and services to work efficiently alongside other transport improvements to best meet the needs of local people.

• Ensure that the social value benefits of Metro will be maximised - including apprenticeships, training, links with schools and colleges and supply chain opportunities.

Heavy rail network

There are three railway lines running through East Birmingham, providing connections to the city centre and onward to regional and national destinations. HS2 will also pass through the area, running alongside the existing Water Orton line near the M6, with two new stations planned close by at Birmingham Curzon and Interchange Station in Solihull.

Despite these excellent opportunities, rail travel in East Birmingham is less popular and more difficult to use than in other parts of the city due to the difficulty of getting to a station, and the comparatively long waiting times between trains. Improvements are therefore needed to get the best out of East Birmingham's railway network.

There are major plans to improve East Birmingham's railways over the lifetime of the strategy. HS2 will provide a new connection between Birmingham and Birmingham International, freeing space on existing train lines and allowing the operation of more frequent services. In addition Midlands Connect will make the case for new services across the wider region; dramatically increasing capacity through the Midlands Rail Hub scheme.

This will support capacity improvements required on the Water Orton Corridor to facilitate the creation of new stations at Fort Parkway and Castle Vale/Castle Bromwich which are included in West Midlands Rail Executive's (WMRE) Rail Investment Strategy.

We will work with HS2 Ltd., Midlands Connect and West Midlands Rail Executive to support the delivery of these plans and to ensure that East Birmingham benefits fully from them. We will help local people to access employment and training opportunities linked to railway projects. We will also bring forward proposals to maximise the value of the existing rail network, including improving the public transport, cycling and walking routes to stations.

Principles

The Big Moves are the key changes that are needed to reach our vision for East Birmingham. However, we will also need to bring forward a wide range of other projects and initiatives to ensure that we are improving every aspect of life in East Birmingham.

The following principles will be used to guide this work:

Prioritising East Birmingham: we will make sure planned projects happen sooner and quicker wherever possible and that East Birmingham is considered first for new ideas (such as improvements to services and pilot schemes). We will also work together and with the community to work out how investment in East Birmingham can make a positive difference to local people.

Investing in the environment: learning from positive examples such as the Tyseley Environmental Enterprise District, we will seek to prioritise the development of sustainable and low-carbon technologies which will contribute to reducing the impact of climate change, supporting the Council's target of a carbon neutral Birmingham by 2030 and improving air quality and biodiversity. We will ensure that growth does not come at the expense of the environment, and we will always consider the effect on the environment and climate when we make decisions.

Joined-up working: we will find new and better ways of working together to make sure we are delivering high-quality services to the people who need them. This means working together to solve problems, make decisions, share learning, resources, and responsibility, and achieve positive outcomes for our communities. By working together and combining our efforts, we can better meet the needs of people and deliver better services for less money.

Empowering communities: we will find and make the most of opportunities to support compassionate and connected communities to do things for themselves and will build trust with citizens through genuine and meaningful engagement and collaboration. By supporting people to get involved in decision-making and working together to learn from the knowledge and experiences of our communities, we can respond better to the needs and aspirations of local people, make sure they can shape their own lives, support them to protect themselves against challenges, and make better use of resources.

Transparency: we will share data and information freely whenever possible and regularly publish progress reports which will provide an update on the Big Moves, wider program of activities and our progress against our objectives.

Working locally: we will work more closely with local people and places to get to know, understand, and connect with them and build long-term and trusting relationships to make sure efforts are focussed on what really matters to our communities. This will involve listening to and working with people to understand local issues, making the most of the strengths of our people and places, learning from what is and isn't working well, and developing shared and unique solutions that will help tackle local problems.

Prevention and early intervention: prevention is about being proactive, recognising the potential needs of people, and acting before problems arise. Early intervention is about identifying problems early and intervening quickly to stop things becoming worse. This way of working addresses people's needs early on and helps to protect their health and wellbeing. By doing so as well as focussing on the strengths of individuals and their communities, we can empower them to do things for themselves and respond better to life's challenges, encourage them to have high aspirations, and enable them to achievetheir goals. Partners will work closely together and seek to focus resources on prevention and early intervention approaches that can have lasting benefits throughout a person's life.

Putting technology to work: digital technology is changing the way people live. We will make sure that East Birmingham is able to take advantage of the benefits of new technology by finding practical opportunities for innovation and the development of commercial and employment opportunities. We will make the most out of new opportunities in digital connectivity to make sure people can take advantage of the economic, social, and physical benefits provided.

Joined-up transport: a joined-up transport network that's reliable, works well, and meets the needs of residents, businesses, and visitors has the potential to significantly increase economic growth and unlock the potential of East Birmingham by attracting opportunities for investment and regeneration. Improving transport, in line with local priorities and needs, will enable people to get to where they need and want to go (regardless of where they live, their accessibility needs, or their economic circumstances), will connect more people with more opportunities, and will improve the quality of life for local people by encouraging healthier active forms of travel such as walking and cycling.

We will...ensure that we are improving every aspect of life in East Birmingham

The purpose of this draft strategy is to start a discussion with the community of East Birmingham. During this initial consultation we will engage with local people, Councillors, businesses and community organisations and create lasting links that will shape the way that the strategy is delivered. Following this initial engagement, we will update the strategy taking on board the views and comments we have received and formally adopt it.

Following the adoption of the strategy we will work to develop a detailed plan of action which will bring together the Big Moves and all of the other activities and projects that are needed to deliver our shared vision. We will use the action plan to make sure that we are working in a joined-up way in line with the principles we have set out above, and that the maximum benefits are acheived.

The following table summarises some of the work which will make up the action plan, including the next steps we will take and some of the longer-term goals we will be working towards such as the Metro extension, HS2 and improvements to the railways. Many of the things in this list are either already in progress, or can be brought forward quickly, and will be delivering benefits while we are working to develop and fund our longer-term proposals.

Project/ Programme	Description	Timescale to deliver	Funding status	Primary objective theme
Health and wellbeing improvement programme	To begin our programme of improvements to health and wellbeing we will: Engage local people to: • Understand more about their health and wellbeing concerns, aspirations and expectations of health and social care services. • Co-design information to support them to use the right health service at the right time to remain healthy and independent for as long as possible. • Understand their requirements and preferences for information to enable them to make healthy choices and prevent and manage long term health conditions. • Increase uptake of screening, immunisations and vaccinations. • Increase participation in physical activity. • Build local voluntary and community sector activity to support local people within their local neighbourhoods. Ensure that East Birmingham has the resources it needs to deliver high quality health and social care services by: • Creating a single workforce plan for the area which creates opportunities for local people where appropriate and sets out clearly our plans for local GP recruitment and retention. • Creating an estates strategy which informs capital investment to ensure that physical standards are improved and makes the best use of the space available to us.	0-5 years	To be identified	Health and wellbeing

Continued »

Project/ Programme	Description	Timescale to deliver	Funding status	Primary objective theme
	• Creating a digital plan to ensure that local services have access to IT systems which enable their work and interface to enable information sharing. • Addressing safety and quality issues within services. • Providing safe facilities and social settings for physical activity. Improve local health and social care services by: • Implementing Primary Care Networks to bring together GP practices into groupings to deliver enhanced primary care services to 30-50,000 patients. • Reviewing urgent care services such as walk-in centres and recommissioning as appropriate. • Increasing the range of health services available locally by moving some services/activities out of Heartlands Hospital and into a community setting. • Creating multi-disciplinary teams which bring together health and social care services to deliver joined up services to local people who are struggling to live independently due to problems like frailty, dementia, mental health problems or diabetes. • Improving local maternity and early childhood health services. • Creating an infrastructure of social prescribing link workers and neighbourhood network schemes to connect local people back to help and support in their local communities where this will meet their needs more effectively than formal health and social care services. Next Steps Following on from these initial activities we will continue to work together in partnership and with the local community to find ways to offer better services which meet local needs.	5-10 years	To be identified	
Skills review and investment plan	To start improving skills and employment support we will focus on the following areas: Engagement • Map the employment and training offer in East Birmingham to clarify the support available. • Develop an East Birmingham communication campaign, working with local stakeholders and using local social media channels to flood the area with information on the support and job opportunities available and how to access them. • Hold 'Opportunity Roadshows' in community venues, showcasing employment support, training and job opportunities. Employment Support • Set up an East Birmingham Taskforce, bringing together key stakeholders to clarify and co-ordinate support for local people. • Deliver employment support and other local employment, training and skills programmes through the Connecting Communities projects in Washwood Heath and Shard End.	0-2 years	Funded	Economy Education and learning
	Careers/Information Advice and Guidance • Deliver targeted information, advice and guidance about real jobs in East Birmingham, profiling local employers and showcasing support and training available to secure the opportunities. • Develop and share career profiles relating to opportunities with major employers and developments, for example HS2 and the NHS.	0-2 years	Funded	

Continued »

Project/Programme	Description	Timescale to deliver	Funding status	Primary objective theme
	Vocational Skills • Work with the NHS to develop and pilot accessible training and employment support pathways into opportunities for East Birmingham residents, particularly at Heartlands Hospital. • Work with HS2 Ltd contractors to develop accessible training and employment support pathways into opportunities for East Birmingham residents. Employer Engagement • Develop a co-ordinated approach to employer engagement to connect local people with local job opportunities with an initial focus on building relationships with medium sized companies based in East Birmingham. • Target SMEs based in East Birmingham to promote the WMCA levy transfer scheme and make best use of public sector levy funding generally, including Council funding. • Secure support from local businesses to provide mentoring opportunities through Mayor's Mentors partners. In Work Support • Through employer engagement activity, promote support available to upskill existing staff through long and short courses and apprenticeships. • Pilot activity with the NHS to support local people into work and continue their development in work and to upskill staff to open up entry level opportunities. Next Steps In the longer term we will: • Continue to work together to explore opportunities to secure additional funding for East Birmingham to accelerate and expand the employment and training offer. • Evaluate the impact of our engagement activity and so that we can review and improve our approach. • Share the lessons learned from the delivery of the Connecting Communities project to raise awareness of what works in East Birmingham. • Expand careers information about local job opportunities working with local employers. • Expand sector-based approach to vocational skills into other sectors with accessible job opportunities for East Birmingham residents. • Continue to engage with local employers with a particular focus on building long term relationships to open up pathways into employment and to upskill existing staff.	2-5 years	Funded Funded Funded Funding to be identified	
Schools and early years improvement programme	We will improve the quality and availability of schools and early years provision by: • Focussing Council investment to maximise high-performing school places and schools, improve school buildings and redevelop schools where required. • Minimising days lost through education as a result of maintenance issues by directing investment to priority works and ensure a safe, warm and dry environment for our children. • Providing free early year entitlements for two, three and four-year-olds, for eligible parents. • Securing sufficient childcare for working parents. • Providing information, advice and assistance to young people and parents. • Providing information, advice and training to childcare providers. • Ensuring young people and parents are aware of the requirement for young people to participate in education, employment or training to their 18th birthday and beyond. • Promoting participation of vulnerable young people not in education, employment or training (NEET) and identifying and working with young people who are 'Not Known'.	0-5 years	Funding to be identified	Education and learning

Continued

Project/Programme	Description	Timescale to deliver	Funding status	Primary objective theme
	• Securing sufficient suitable education provision for pupils requiring Special Education Needs (SEND), disabilities or specialist provision. • Supporting education providers to ensure that they have enough appropriate space for their needs. • Consulting children and young people with SEND or disabilities, and their parents, when reviewing local SEND and social care provision. • Working with the Regional Schools Commissioner to tackle underperforming schools and academies. • Extending 'collaborative working pilots' to help schools to work together and share best practice.			
Expand business support	The partners will develop options to expanding business support provision in East Birmingham, with the aim of supporting key business sectors such as small and medium businesses and new start-ups and supporting healthy high streets and local centres. In the longer term we will explore how support could be offered to types of business such as retail which are not eligible under our current funding arrangements.	0-2 years 0-5 years	Funding to be identified Funding to be identified	Economy

Local places and green spaces	We will work with local communities, businesses and other stakeholders to improve the quality of the environment, tackle problems and meet local needs.
	
	As part of this work we will work to bring forward plans for the improvement of the major local centres at Alum Rock, Bordesley, Coventry Road in Small Heath, Meadway and Stechford which are identified in the Council's Urban Centres Framework and Local Cycling and Walking Infrastructure Plan. Guided by conversations with the community we will also find ways to support and improve smaller shopping centres and other important places across the area. This work will be carried out in co-ordination with improvements to the transport system.
	
	We will take a similar approach to the area's many green spaces. Working in a joined-up way with the community we will improve the safety, quality, and appeal of local green spaces. This approach will build on the lessons learned through the Ward End Park Future Parks Accelerator where the Council, the Active Wellbeing Society and Sport England will be working together to improve Ward End Park and to find ways to get local people involved to develop skills and experience.
	
	Supporting these projects will be activities which will improve cleanliness and the quality of environment. These will include:
	• Area-based projects focusing on the improvement of specific priority areas, working with the community to deliver lasting change.
	• Making proactive use of the Council's enforcement powers including:
	  - Allocating a dedicated Planning Enforcement Officer to target neglected buildings and untidy land.
	  - Expanding the use of litter patrols in local centres.
	  - Working with shops and businesses to ensure that commercial waste is disposed of properly.
	• Awareness and education projects to reduce fly tipping and littering and to help and support communities care for their local places.
		Ongoing
		
		Ongoing
		
		Ongoing
			Funding to be identified
			
			Part funded
			
			Funding to be identified
				Affodable, safe and connected places
				
				Economy

Continued

Project/Programme	Description	Timescale to deliver	Funding status	Primary objective theme
Transport improvements	Major changes and improvements are planned which will transform the City's transport system. In East Birmingham we will ensure that this work is brought forward in the best way to support all aspects of the strategy and to maximise the benefits that are delivered, including improvements to air quality.			Affordable, safe and connected places
	Walking and Cycling • We will work to secure funding and deliver proposed walking and cycling routes (as set out in the Council's Local Cycling and Walking Infrastructure Plan) as quickly as possible and with the involvement of the local community. Projects will include: - Coventry Road cycle route. - Tame Valley green route (Bromford). - Improvements to the accessibility of Ward End Park and Grand Union Canal in Small Heath. • We will encourage cycling by supporting cycle hubs, community cycling groups and other projects such as 'Big Birmingham Bikes' and 'Bike Banks' for families. • We will prioritise the improvement of safe walking and cycling links to railway stations and public transport corridors.	0-5 years	Part funded	
	Public Transport A range of major improvements are planned to public transport, including:			
	Bus Services Bus services will be improved by increasing frequency, improving reliability and improving cross-city connections by giving buses priority over other traffic. In East Birmingham we will ensure that these improvements take into account the needs of local people, including those who work outside normal hours at major employment sites (for example Birmingham Airport) and focussing on north-south routes.	0-5 years	Part funded	
	A45 Sprint The A45 Sprint route will soon provide a fast and reliable new service from Birmingham to Solihull and Birmingham Airport along the A45 Coventry Road, including the provision of bus priority measures.	Opening 2022	Funded	
	Midland Metro East Birmingham to Solihull Extension The planned Midland Metro East Birmingham to Solihull route is a crucial part of the changes which are needed to the area's transport infrastructure. We will work with the Government to secure the funding that is needed, and with the local community to ensure that the design of the route will work alongside other transport improvements to best meet local needs.	5-10 years	Part funded	
	Rail Improvements The partners will work together to maximise the value of the rail network in East Birmingham. This will include increased service frequencies following the opening of HS2, and improvements to the quality and accessibility of the existing stations, for example, new step-free access and cycle parking at Stechford railway station.	0-5 years	Part funded	
	We will also work to secure funding to bring forward the major plans for improvements set out in the West Midlands Rail Executive's (WMRE) Corridor Priorities for the Birmingham East Tamworth-Nuneaton Corridor, and Wolverhampton to Coventry Corridor, as included in WMRE's West Midlands Rail Investment Strategy (WMRIS). In particular the opening of new local stations along the Birmingham East Tamworth-Nuneaton Corridor at Fort Parkway and Castle Vale/Castle Bromwich, which would be enabled by delivery of the Midlands Rail Hub (MRH), as the MRH is needed to provide the necessary step change in infrastructure capacity to allow new rail services calling at those stations to connect with central Birmingham.	10-15 years	Funding to be identified	

Continued »

Project/Programme	Description	Timescale to deliver	Funding status	Primary objective theme
	Highway Improvements Several major highway improvement projects are planned or currently underway:			
	Iron Lane At Iron Lane work is underway to implement two new gyratory arrangements to increase junction capacity and reduce congestion at the junction of Iron Lane, Flaxley Road and Station Road. This will include dedicated pedestrian/cycle crossing facilities, improved bus stops and new street lighting to improve public safety and security.	Completing 2020	Funded	
	Bromford Gyratory The planned Bromford Gyratory improvements include the delivery of two 'at grade' roundabouts to provide increased capacity for all modes by improving journey time reliability, reducing existing congestion and supporting sustainable transport. Improvements will support the delivery of HS2 by playing a vital role in relieving congestion on the Birmingham Motorway Box, offering an alternative route into and out of Birmingham.	0-5 years	Funding to be identified	
	Brays Road safety scheme Safety measures will shortly be installed following discussions with local residents. The scheme will include the Installation of Vehicle Activated Signs, the introduction of road markings, provision of in-line uncontrolled pedestrian dropped crossings and the upgrading of the existing zebra crossing.	Start on site February 2020	Funded	
	Brownfield Road safety scheme Work is underway to design improvements to Brownfield Road to improve safety following a number of recent collisions. The scheme is likely to include traffic calming measures including the narrowing of the junction and building up of the mini-roundabouts.	0-3 years	Funding to be identified	
	HS2 Road safety fund HS2 has made £2.6m for road safety schemes in Birmingham the vicinity of the HS2 route to be delivered in the next five years. The next step will be to carry out a survey to identify high risk roads where safety improvements are needed. We will then work to ensure that schemes are designed and delivered as quickly as possible.	0-5 years	Funded	
	Green Travel Districts The purpose of Green Travel Districts is to help people to reduce their use of private cars, achieving economic, social and health benefits. The planned Green Travel Districts for Small Heath, Tyseley and Castle Vale will include projects such as car clubs, bike hire and freight consolidation which will work alongside Sprint and other planned transport improvements to reduce congestion and improve air quality.	0-5 years	Funded	
Housing and development	The Birmingham Development plan sets out an ambitious programme of growth and development including major proposals in and around East Birmingham. The Council will work with partners to ensure that this growth is delivered in a way that secures the maximum benefit for the people of East Birmingham. Some key elements of this work will include:			Affordable, safe and connected places Economy
	• Peddimore, near Castle Vale, which will create a major new location for business and manufacturing uses, creating 6,500 jobs.	Start 2020	Funded	
	• The extensive development which is planned around the Curzon HS2 stations in the city centre and UK Central in Solihull.	Ongoing	Funded	
	• The development of the HS2 Network Control Centre, Rolling Stock Maintenance Depot and neighbouring employment uses at Washwood Heath which expected to create 2,000 jobs.	0-10 years	Funded	
	• The major growth and regeneration planned for the Bordesley Park area including the development of the Wheels site for employment and industrial uses.	0-15 years	Part funded	

Continued »

Project/ Programme	Description	Timescale to deliver	Funding status	Primary objective theme
	• Proposed improvements to local centres including Meadway, Bordesley Green, Coventry Road, Alum Rock Road and Stechford.	0-10 years	Part funded	
	• New affordable homes delivered via the Council's Birmingham Municipal Housing Trust including major sites at Meadway and Yardley Brook in the Eastern Triangle growth area.	0-5 years	Funded	
Climate change and green technologies	It is essential that East Birmingham contributes fully to tackling climate change and making the city carbon neutral by 2030. We will work with the Birmingham Climate Change Taskforce and local business to establish East Birmingham as a focus for innovation and the new jobs and businesses opportunities which will be emerging from the green and low carbon technology agenda. Existing examples include the innovative work underway at Tyseley Energy Park and Jaguar Land Rover's electric vehicle manufacturing at its Castle Bromwich plant.	0-5 years	Funding to be identified	Economy Environment Affordable, safe and connected places
	New projects will be developed to put low carbon technologies to work in East Birmingham, including trials of hydrogen-powered vehicles and electric charging. We will also work with partners to create training and employment opportunities for local people in the green technology sector.	0-5 years	Funding to be identified	
Localism, community development and engagement	Beginning with the engagement and consultation on this draft document we will: • Work with Ward Councillors, the community and partners including Neighbourhood Networks to build positive relationships with and between all elements of the community so that local people can fully contribute to and influence the work that is happening in their area. • Contact local community voluntary organisations to discuss how we can help them to achieve their goals and how they can contribute to the objectives of the strategy. • Support and encourage Ward Plans, Neighbourhood Plans and other community-driven initiatives. • Work with Universities and national organisations to support innovative research projects which will help to develop new tools and approaches to the delivery of Inclusive Growth.	Ongoing	Funded	Power, influence and participation
Social value and community wealth building	We will encourage businesses to support the objectives of this strategy and we will invest in East Birmingham not just by the money we spend, but by how we spend it. We will help businesses that work in Birmingham and the West Midlands understand how to bid for our contracts; by promoting large projects such as HS2, the Commonwealth Games and the Midland Metro at events where businesses can speak to each other and understand more about future plans; by advertising our opportunities locally on FindItInBirmingham.com and by ensuring our contractors do the same. This way, more local businesses get the chance to win work and spend is recycled locally. We will then work with our contractors and partners to ensure they provide good quality training and employment opportunities for local people, especially for those who may have found it challenging to get into work. We will also look for these companies to play their part in reducing waste and tackling climate change as well as pay a real living wage to those working on our contracts.	Ongoing	Funded	Health and wellbeing Economy

Contact

Planning and Development
Inclusive Growth Directorate
Birmingham City Council

Click:

E-mail:
planningandregenerationenquiries@birmingham.gov.uk

Web:
birmingham.gov.uk/ebigs

Call:

Telephone:
(0121) 303 3988

Visit:

Office:
1 Lancaster Circus
Birmingham
B4 7DJ

Post:
PO Box 28
Birmingham
B1 1TU

The City Council will communicate this document in a suitable way to all audiences. In addition to the online and printed documents, requests for the document in alternative formats will be considered on a case by case basis including large print, another language and typetalk.

Plans contained within this document are based upon Ordnance Survey material with the permission of Ordnance Survey on behalf of the Controller of Her Majesty's Stationery Office.

© Crown Copyright. Unauthorised reproduction infringes Crown Copyright and may lead to prosecution or civil proceedings.
Birmingham City Council. Licence number 100021326, 2020.

East Birmingham has never been in a stronger position to transform itself

East Birmingham
Inclusive Growth Strategy

east birmingham growth strategy

East Birmingham
Inclusive Growth Strategy

Birmingham
City Council

<u>Appendix 3:</u>

<u>East Birmingham Growth Strategy</u>

<u>Engagement Plan</u>

<u>Part 1: Introduction</u>

The City Council seeks to engage local communities, businesses and stakeholders of East Birmingham on the draft East Birmingham Inclusive Growth Strategy. In addition, the City Council wishes to create avenues of engagement which will guide the delivery of the Strategy through consultation, collaboration and co-design.

This document sets out the strategy the City Council will adopt for this engagement including the identification of the key stakeholders and the methods the City Council will adopt for consulting with these groups.

007587/2020

Part 2: Context

East Birmingham is an area which is faced with a number of complex and inter-related issues, some of which are specific to particular sections of the community. As such it is crucial that the approach of the City Council and its partners is informed by the people who are best placed to understand these issues: the residents, businesses and regular visitors to the area.

The Birmingham City Council Plan 2018-2022 (2019 Update) states that the Council will take a collaborative approach to achieving its priority outcomes and in particular that:

"We will foster local influence and involvement to ensure that local people have a voice in how their area is run."

(Birmingham City Council Plan 2018-2022 (2019 Update) Outcome 4, Priority 6)

The East Birmingham Inclusive Growth Strategy (EBIGS) will not contain statutory planning policies, but nevertheless the starting point for the consultation will be the approach which is used for engagement on planning policy documents, drawing on the general principles set out in the Birmingham Statement of Community Involvement (2020), in particular:

- Consultation should involve key partners, including the community.
- Consultation should begin at the very start of the preparation of a document as part of the 'pre-production work' whereby information, issues and evidence are gathered to help in the preparation of the document.
- Comments made should be acknowledged in the preparation of the document and the final document should be produced considering the comments made during the consultation process.
- Documents should be published for a six-week consultation period, being made widely available in public places, online and advertised in newspapers.
- Adopted documents should be widely available to the general public, in public places and available online, and those who asked to be notified of the adoption of the document should be written to.

<u>Part 3- Engagement Strategy</u>

The draft East Birmingham Inclusive Growth Strategy has been prepared for consultation by the East Birmingham Board - a partnership board which includes the City Council and key public sector partners. The aim of this initial stage of the consultation is:

- To publicise the draft Inclusive Growth Strategy and baseline evidence.
- To gather further evidence, including specific feedback on equalities issues.
- To establish links with stakeholders and community groups to facilitate future consultation, with a particular focus on hard to reach groups.
- To encourage community buy-in and ownership of the East Birmingham Inclusive Growth Strategy from the outset.

Consultation Timescale
The consultation will take place over a period of 12 weeks from 17th February 2020. This period has been extended beyond the usual 6-week in order to maximise opportunities to engage with the community and stakeholder organisations.

Consultation Methods
- Face-to-face engagement
- Electronic engagement
- Paper based engagement.

Further details of the methods of engagement within these categories can be found at the end of this report.

Consultation Materials
The preparation of the consultation materials has been informed by discussion with individuals and organisations including:

- Council officers.
- Councillors including the ward members for all affected wards and the relevant Cabinet Members.
- Representatives from the East Birmingham Board, which includes the Children's Trust, the West Midlands Combined Authority, the Department for Work and Pensions (DWP), University Hospitals Birmingham NHS Trust, Public Health England, Birmingham and Solihull Clinical Commissioning Group, West Midlands Police (WMP), Solihull Metropolitan Borough Council, Transport for West Midlands and the Homes and Community Agency.
- The Members of Parliament for the Birmingham Erdington, Birmingham Hodge Hill, Birmingham Ladywood and Birmingham Yardley constituencies.
- The Council's Neighbourhood Network lead partners for the affected constituencies.
- HS2.Ltd

The consultation materials will consist of:
- The East Birmingham Inclusive Growth Strategy
- Leaflets summarising the East Birmingham Inclusive Growth Strategy and seeking comments

Responses will be accepted through the following means:

- In person via meetings with stakeholders
- E-mail
- Online via a web-based consultation site (using the Council's Be Heard platform)
- Post
- Telephone

The consultation materials have been tailored to the demographic profile of the East Birmingham area. In particular consideration has been given to:

- Consultees with limited or no English language*
- Consultees with limited literacy**

As a result, the following measures have been identified to address these issues:

- The consultation materials feature simple and straightforward language, over and above the City Council's usual plain language approach.
- Consultees, in particular community leaders and educators, will be asked to explain the consultation matters to those who are unable to access the information themselves for reasons of language or literacy, and seek to assist them in submitting responses.

Distribution and Publicity

A consultation database has been produced based on existing resources including the Birmingham Development Plan and Bordesley Area Action Plan consultation databases, expanded using nominations from the groups and individuals listed above, the City Council's Neighbourhood Networks, and direct research which has sought to identify all relevant stakeholders and community groups. It is proposed to distribute the consultation materials to the listed individuals and organisations in a combination of electronic and paper formats. Copies will also be made available in public facilities including local libraries, neighbourhood offices and schools.

The consultation materials are designed to be further circulated within the community following initial distribution, and the database will be further expanded for future use based on responses to this initial consultation. In addition to the distribution of the leaflets, the consultation will be signposted by the City Council's website and opportunities will be sought to publicise the consultation using social media. The specific steps which will be taken to engage with various categories of stakeholder are set out in Appendix 1 to this document.

Next Steps

Following the conclusion of the consultation exercise the responses will be anonymised, summarised and reported to the East Birmingham Board. The responses will inform the preparation of revised drafts of the East Birmingham Growth Strategy and this will be reflected in the document and future consultations. The consultation summary will also be published on the Council's website and made available to interested parties on request.

* Up to 5% of the population of Birmingham are estimated to speak English "not well, or not at all". This is likely to be significantly higher in parts of the East Birmingham area which are very ethnically diverse. Source: Office for National Statistics, *Language in England and Wales: 2011*, 2011
**Inhabitants of multi-cultural inner city areas are significantly more likely to have poor literacy than the national average. Source: *2011 Skills for Life Survey*, Department for Business, Innovation and Skills, 2011

East Birmingham Engagement Plan – Overview

The table below provides a broad overview of the format the strategy will take. In terms of community engagement, the key points for each of the three types of engagement: Face-to-Face, Electronic and Paper-Based highlighted in the following tables.

```
                        ┌────────────────────────────────┐
                        │   East Birmingham Strategy      │
                        │   Paper and Electronic Copies   │
                        └────────────────────────────────┘
                           /                        \
        ┌──────────────────────────────┐    ┌──────────────────────────────┐
        │  INTERNAL USE AND PARTNERS    │    │  EXTERNAL (WIDER COMMUNITY)   │
        └──────────────────────────────┘    └──────────────────────────────┘
```

FACE-TO-FACE	PAPER BASED	ELECTRONIC	FACE-TO-FACE	PAPER BASED	ELECTRONIC
Board Meetings to propose ideas and discuss strategy. Meetings with partners and key organisations to discuss strategy. EBIGS Launch Event (held at a community organisation). Ideas Workshops with various groups.	Briefing Note on Strategy was sent out before formal consultation period for departments and partner organisations to provide ideas and feedback. Paper copies handed out at Board Meetings. Copy of full EBIGS (either paper-based or electronic) sent to all interested parties.	Briefing Note on Strategy was sent out before formal consultation period for departments and partner organisations to provide ideas and feedback. Briefing note sent out by email. Electronic copy of strategy sent out.	Community Engagement Walk Arounds. Meetings with selected organisations. Engagement Sessions held at different community organisations. Engagement sessions held at different public locations.	Paper copies of strategy available. Information leaflets highlighting key points of the strategy. Press coverage.	Be Heard (BCC online consultation). Posts about the strategy on Social Media platforms. EBIGS page on Birmingham City Council website. Articles published electronically by local newspapers and magazines.

Stakeholder	Role in Area	Type of Engagement	Timescale	Responsibility for Delivering This Engagement
MPs	4 MPs cover the area, with 1 MP representing each constituency • Erdington • Hodge Hill • Ladywood • Yardley	• Briefings will be offered to each MP. • Copy of draft Strategy sent for their comments. • Invitation to launch of EBIGS. • Opportunity for regular updates going forward.	Both before and during the community engagement, with opportunities for regular updates if desired.	BCC Inclusive Growth East Birmingham Team (hereafter referred to as EB Team) to lead this.
Local Councillors	26 Local Councillors cover 20 Wards • 6 wards have x2 local councillors • 14 wards have x1 local councillor	• Sent briefing paper covering key points of the Strategy. • Councillor Briefing Session (held at Council Offices) for all councillors. • Opportunity for one-to-one meetings with all councillors. • Invitation to launch of EBIGS. • Opportunity for regular updates as strategy moves forward.	Both before and during the community engagement, with opportunities for regular updates.	EB Team to lead this.
Neighbourhood Network Partners	4x Neighbourhood Network Partner Organisation. Each organisation covers	• Individual meetings between EB Team and each of the 4	Meetings with the 4 Neighbourhood Network Partners were held while strategy was in	EB Team to lead this.

	one of the 4 constituencies in East Birmingham.	Neighbourhood Network partners. • Partners to be provided with a copy of the Strategy notes to comment on. • Ongoing engagement and feedback with the groups.	development. Ongoing engagement after the strategy has been released and throughout the public engagement period.	
Community Organisations and Groups	These range in size from larger community organisations (including places of worship) with a team of paid staff to very small informal groups where all the members are voluntary. These smaller groups may also not have their own premises, but instead may operate within a private house or a venue owned by a larger community organisation.	• Meetings with larger organisations to discuss the Strategy. • EBIGS Launch Event for community organisations – held at a venue in East Birmingham. • Scope for community organisations to organise engagement activities for their clients/local networks.	Meetings with larger organisations during the community engagement process. Smaller organisations to be engaged via email, phone and at community engagement events, during the engagement process. Ideas gained from these organisations to be reflected, where possible, in the final version of the EBIGS.	EB Team to lead this. Engagement sessions involving some of the smaller organisations to be led by larger community partners.
Cross-section of Wider Community	Especially focusing on general public who have not been contacted through another group.	• Engaged through events held at community organisations. • Series of events held throughout East	At some events prior to formal start of the community engagement process.	EB Team to lead this. Community groups may also lead some engagement sessions to

		Birmingham – at publicly accessible locations such as shopping centres, local hospital etc. • Social media. • Birmingham Be Heard website.	Throughout the community engagement process.	reach their clients in a familiar and comfortable setting.
Local Businesses (larger)	Larger local businesses categorised as having over 300 employees.	• Meetings with larger local businesses to discuss EBIGS.	Where possible to be engaged individually throughout the community engagement process.	EB Team to lead this.
Local Businesses (SMEs and micro-businesses)	Smaller local businesses of less than 200 employees. These comprise the majority of employers in East Birmingham.	• Meeting with smaller local businesses (selected businesses in each of 20 wards) • Engagement Walk Arounds in local areas (covering different parts of East Birmingham). • Wider community engagement in local areas.	Throughout community engagement process.	EB Team to lead this. Community groups/representatives may also help to consult during consultation events held at their venues and links within the local community.
NHS	This covers all parts of the NHS including: • NHS Birmingham and Solihull Clinical Commissioning Group	• NHS Birmingham and Solihull Clinical Commissioning Group (CCG) is part of the EB Board.	NHS input has already shaped the strategy via previous Board and working group meetings.	EB Team to lead this. Community groups/representatives may also help to consult during consultation events held at their venues.

	• University Hospitals Birmingham NHS Foundation Trust • Primary Care Networks • GP surgeries • Clinics • Hospitals • Extra Care Providers and any other linked care providers.	• Meetings will be held with other NHS partners to discuss the Strategy. • Updates to all GP surgeries and clinics about the project. • Visits to selected care homes and selected venues – where people are unable to attend wider community engagement activities.	Meetings will be held with key organisations to discuss EBIGS. Engagement throughout wider community engagement process.	
National Government Services	National Government Departments	• Representatives of some Departments (DWP and BEIS) have been part of the EBIGS Board • Opportunity for ongoing updates.	Copy of strategy sent with invitation for comments.	EB Team to lead this.
Public Services (Police, Fire Ambulance)	Statutory public services, including: • Police • Fire • Ambulance	• Some services have been part of the Board (WMP) • Meetings with service providers where this is possible. • Opportunity for ongoing updates.	Representatives of some organisations have been part of the EBIGS Board. Engagement throughout wider community engagement process.	EB Team to lead this.
Support Services	Services that offer community support/advocacy	• Meetings with service providers where this is possible.	Meetings held with certain organisations to discuss strategy.	EB Team to lead this.

		- Launch event for community organisations. - Visits as part of Engagement Walk Arounds	Engagement throughout wider community engagement process.	
Utilities	Key utility services including: - Power - Water - Electricity - Gas - Telecommunications	- Notify about the Strategy as part of the consultation process. - Meetings with specific service providers if required	Copy of Strategy sent to affected organisations in advance. Engagement throughout wider community engagement process.	EB Team to lead this.
Residents Associations	'Active' Residents Associations operating in the area.	- Notify about the Strategy as part of engagement process – largely via email, letter or phone call. - Invite representatives to wider Community Engagement events.	Engagement throughout wider community engagement process.	EB Team to lead this. Community groups may also help to consult during consultation events held at their venues and within their local community. .
Schools, Colleges and Educational Facilities	All public and private run educational establishments including: - Nursery - Primary - Secondary	Notify about the Strategy as part of engagement process.	Contact throughout Community Engagement process.	EB Team to lead this. Could also be scope for organisations to discuss the EBIGS with their students.

	• Colleges and other further education establishments.			

Face-to-Face Engagement					
Method Of Engagement	**Description Of Activity**	**Produced By**	**Delivered by**	**Main Benefits**	**Proposed Outcome**
Drop-in events and workshops – held at different locations within East Birmingham.	Events held at locations around East Birmingham, such as local community venues, retail centres, GP surgeries. Stands at local events.	Birmingham City Council and Partners	Birmingham City Council	These provide opportunities to discuss the strategy and suggestions going forward in a local, familiar and relaxed environment. Can cover a wide variety of locations. Reach a wider cross-spectrum of the community, including some hard-to-reach groups.	To publicise and discuss the East Birmingham Inclusive Growth Strategy. Gain the ideas and opinions of a wide variety of people. To compare the opinions and ideas of people in different locations across East Birmingham – to see if there are common themes and issues that are specific to particular locations.
Meetings with local community groups	Informal events/meetings with local groups, ideally at their own venues, such as places of worship, community centres and community cafes.	Birmingham City Council	Birmingham City Council / Community Volunteers	To meet with different groups at their own venues or the venues they use. Excellent way to meet with a large number of people across different areas of East Birmingham. Can speak with people individually or as a group, in a place they feel comfortable and often passionate about; which helps build trust.	To publicise and discuss the EBIGS. Gain the ideas and opinions of a wide variety of people. To compare the opinions and ideas of people in different locations across East Birmingham – to see if there are common themes and issues that are specific to particular locations and to specific groups.

Engagement Walk Arounds	Very similar to 'Drop In' events, but rather than being fixed to one location, the idea is to walk around.	Birmingham City Council	Birmingham City Council / Community Volunteers	Excellent way to meet with a larger number of diverse people within a geographic area. Also offers an excellent opportunity to access a range of locations such as shops, places of work (reception areas), train stations.	Gaining a more in-depth consultation than traditional 'drop in' events provide. By entering a wide variety of venues, people can be engaged with, who may otherwise not be able to attend a static 'drop in' event. This also allows gaining of opinion/ideas and understanding patterns for different types of businesses/venues/workplaces in different areas. The people consulted can then be encouraged to speak with their customers/employees/congregation to participate in the consultation, creating a type of 'net' effect.
Meeting with local councillors (and Ward Forums)	Meet with local council representatives from all 20 wards in the East Birmingham area.	Birmingham City Council	Birmingham City Council	Councillors have an in-depth understanding of their local ward and will have helpful information and contacts. They also have strong local networks that can be accessed (which may not be easily achievable otherwise). To help build-up trust within the local community network	For councillors to promote this community engagement to their local network (residents, local leaders, groups, businesses). To reach a greater number of people, especially accessing more hard-to-reach groups (such as vulnerable people who may attend their advice surgeries).

Electronic Engagement					
Method Of Engagement	**Description Of Activity**	**Produced By**	**Delivered By**	**Main Benefits**	**Proposed Outcome**
Birmingham 'Be Heard' online consultation	Online survey via the Birmingham City Council website – that will allow people to learn about the strategy and voice their opinion/suggestions.	Birmingham City Council/ Partners	Birmingham City Council	A fast and cost-effective way to engage with a large number of people, across a wide area. The template and structure for this already exists, so it will be easy and cost-effective to produce. An often used and trusted method of consultation. Being internet-based, anyone with an internet connection, can provide their feedback. Can reach people who live outside the East Birmingham area; who may have helpful opinions/information. A link to Be Heard' can easily be provided from other publicity. As the responses are anonymous if desired and	Hope to receive a wide variety of responses from people within East Birmingham and from outside the area – who may have equally helpful information and ideas. Reaching a larger audience than face-to-face consultation should provide a greater number of responses. Can potentially see if perceptions of the area (by people who live/work outside it) are different from people within East Birmingham.

				there is no face-to-face interaction, responses may be more honest and people may feel more comfortable to provide suggestions. People can also complete the form in their own time and in the comfort of their own home.	
Social media posts	Posts about the Growth Strategy and engagement can be made from Birmingham City Council's Facebook and Twitter pages.	Birmingham City Council/ Partners	Birmingham City Council/ Partners / Wider Community	These pages already exist and have a large following – for instance Birmingham City Council's main Twitter feed has 153,000 followers. Cost effective and takes minimal effort to add these posts. Links to a dedicated webpage and Be Heard, can also easily be added. Reach an audience who do not traditionally attend 'drop in sessions' or access paper based materials. Provide regular and fluid updates at regular intervals and that can be changed quickly should	Further publicise the strategy and community engagement. Gain feedback from (people, organisations, groups, businesses) both within and outside East Birmingham. Gain responses from audiences who do not traditionally attend 'drop in sessions' or access paper-based materials. With post sharing, a 'net' effect can be created, where posts created by Birmingham City Council and Partner Organisations are shared by other organisations/community, who in turn share these posts and so on. The reach here can be very great indeed.

				circumstances/events change. Posts can be shared/linked by other organisations and members of the community. Potentially use targeted content aimed towards residents with EB postcodes.	
East Birmingham Inclusive Growth Strategy webpage	A dedicated webpage on the Birmingham City Council website, with important information about the Strategy, an electronic copy of it and information/links to the community engagement. The webpage will show an electronic version of the consultation materials.	Birmingham City Council	Birmingham City Council	A webpage on a trusted website of a well-known organisation. Minimal cost to produce but can host a large volume of information and links to various documents/Be Heard page. Easy to provide the address or electronic links to this webpage from our other publicity (with address posted on paper-based publicity and clickable link on electronic publicity).	To receive responses from a wide variety of people, who would not otherwise be easily contacted.
Content created by local media	Online articles and other publicity created by local and	Local and community media (with	Local and community media	Content created without the time and resources of	To gain a greater reach for the community engagement.

	community media – discussing the strategy and consultation.	information from Birmingham City Council)		Birmingham City Council required. Content can be reached by a large number of people, who will find it by coincidence rather than searching for it.	

Paper-Based Engagement

Method Of Engagement	Description Of Activity	Produced By	Delivered by	Main Benefits	Proposed Outcome
Paper copies of The East Birmingham Growth Strategy	Though people will be encouraged to access electronic copies of the Growth Strategy, paper copies will be available, at specific locations in East Birmingham (e.g. Libraries, Neighbourhood Offices, Schools) and at' Birmingham City Council offices at Lancaster Circus.	Birmingham City Council	Birmingham City Council	Having paper copies will make the Strategy accessible to more people in the community – including people who do not have access to a computer/internet.	All members of the local community to have easy access to the Strategy – so they have the opportunity to provide their feedback.
Consultation Leaflets and Posters (including graphics for events)	Leaflets highlighting the key themes of the strategy – and events during the community engagement process. Pull-up banners for events.	Birmingham City Council	Birmingham City Council	Further highlights and publicises the key points and objectives of the strategy. Promotes engagement events in East Birmingham. Provides the community with clear and quickly-absorbed information.	Further promotes both the Strategy and the community engagement process/events. With greater awareness in the local community, it is hoped that more people will engage and provide their views for the Strategy.

Part 3: Engagement Methodology

East Birmingham – North Solihull (EBNS)

Stage 1: Baseline

007587/2020

	Name	Position	Signature	Date
Prepared by	Andrew Clarke Richard Pestell Cathy Hall Francesca Rowson Dan Griffith Neil Bateman	Senior Associate Director Senior Associate Senior Planner Senior Associate Transport Planner	*A.Clarke*	04/07/17
Reviewed by	Andrew Clarke	Senior Associate	*A.Clarke*	04/07/17
Approved by	Keith Mitchell	Chairman	*Keith Mitchell*	04/07/17

For and on behalf of Peter Brett Associates LLP

THIS REPORT IS FORMATTED FOR DOUBLE-SIDED PRINTING

Contents

Executive summary

This baseline report looks at East Birmingham North Solihull (EBNS). Our objective is to identify the nature of the underlying social, economic and policy conditions in the area so that later vision and strategy work can make well-informed choices - changing life in EBNS for the better.

We approached the work from a predominantly economic perspective, and have set out findings under the topic areas set out below.

We have looked at the future opportunity. The economic geography of the UK will change as a result of HS2. East Birmingham North Solihull (EBNS) is on the eastern side of the West Midlands conurbation, and will benefit from being within easy reach of two HS2 stations – one within its boundaries at the UK Central Hub in Solihull, and one very nearby at Curzon Street in central Birmingham. Jobs growth in and around the area is expected at a series of strategic employment sites. Critically, these new jobs are accompanied by major investments in local connectivity, including a Metro extension, new bus rapid transit services, new railway stations on the classic rail network, and higher local rail service frequencies. The economic fundamentals are therefore falling into place, making ENBS a place of great potential.

This report puts this opportunity in its historic, geographical and demographic context. To properly capitalise on its potential, evidence demonstrates that EBNS needs to innovate to respond to economic change, and create opportunities for its young, growing, diverse, but relatively deprived population.

We have looked at jobs in EBNS. EBNS is a strategically important industrial area for the West Midlands conurbation, but evidence suggests that employment concentrated in traditionally low paying sectors.

Educational performance is strongly indicative of future deprivation, making early years, school and FE provision an important dimension of future success in the area. Educational attainment in EBNS underperforms against comparator areas at Early Years, Key Stage 1, Key Stage 2, and GCSE. This underperformance feeds through into subsequent educational stages, with the result that EBNS has relatively low levels of higher education participation amongst 18 and 19 year olds. However, this state of affairs can be changed: evidence from London suggests that big cities can improve performance over time. Whilst circumstances are very different, London has achieved very significant improvements in schools' performance in the last 17 years.

Evidence around skills and labour market participation suggests that skills levels are a major factor in attracting investment and generating growth. However, EBNS workers are less skilled than average. Labour market participation is also worse than average, and these effects vary by gender and ethnicity. Long term and youth unemployment is more prevalent than average. Looking at the evidence around the public sector response to these difficulties, there is evidence that the combination of multiple actors, strategic overload and short term is funding is unhelpful in getting solutions in place.

Poor health and wellbeing (H&W) can be simultaneously both a cause and effect of social and economic problems. Evidence suggests that health and wellbeing will improve as the economy improves over the longer term, but we cannot ignore the importance of the 'here-and-now': prevention and early intervention on lifestyle-related conditions will remain very important. Long term sickness and disability in EBNS is around 50% higher than the English average, with the biggest single reason for claiming sickness-related benefits being mental and behavioural disorders. Evidence also suggests that child mental health in EBNS is amongst the worst in Birmingham. However, interventions can help deal with these problems, and start to break down the resulting cycle of inter-generational disadvantage that these problems create. Obesity and air pollution are also major problems for EBNS. Evidence suggests that a multi-disciplinary H&W theme group could be useful in attacking these problems.

We looked at the evidence around **crime and anti-social behaviour.** Reported instances of anti-social behaviour in EBNS are lower than the English average, but violent/sexual offences, burglary, criminal damage and vehicle crime are higher. Reported drug crime is at the English average rate, but some evidence suggests that these crimes may be under-reported.

Work is looking at how public sector agencies might **join up the public estate** to create public services which are both more efficient to deliver, and more effective. Work is still emerging, but there is evidence to show that opportunities exist to co-locate services in EBNS using innovative new configurations of the public estate. Evidence suggests that joint working will be needed to realise these benefits.

The future will see the creation of several very high quality **connectivity** corridors through the EBNS area, generating very useful labour market effects which better connect workers to job nodes. However, not everywhere is better connected as a result of investment, and new bus routes could be useful. Evidence also suggests that further 'last mile' walking and cycling work could improve local connectivity to rail, metro and sprint investments, as well as creating health and wellbeing benefits. Park and ride at Metro stops and improved train stations could also be helpful in attracting growth on the public transport system.

We looked at the evidence around **accelerating place investment.** The economic modernisation sought in EBNS depends fundamentally on the market's ability to reconfigure built assets on housing and employment sites in response to economic and social change. Getting markets working efficiently will be critical, because public investment alone cannot work at the speed and scale necessary to make the changes desired. Viability evidence presented here suggests that transport investment can help by raising currently low development values – so creating market-viable development opportunities. Retail is struggling in parts of EBNS, and evidence suggests that EBNS needs an updated approach to retail centres, perhaps integrated with housing change.

This report has pulled together evidence on **the delivery of physical change.** EBNS could use best practice from London, where local authorities and the GLA put together brownfield land opportunities and new transport investment to create 'Opportunity Areas'. Opportunity Areas focus public investment and private developer interest, and are then used to marshal management attention, planning, infrastructure and funding around these points. Evidence suggests that three new EBNS 'Opportunity Areas' (at Bordesley Park, Stechford/Eastern Triangle and Chelmsley Wood) could be investigated, and help EBNS to make the step change it needs. (UK Central is effectively already an Opportunity Area). Evidence suggests that it could be very useful to assemble a cross-sector 'growth coalition' for the area to create innovative solutions for EBNS.

Evidence suggests that there is scope for an innovative approach to the **evaluation of change** in EBNS, and an opportunity to pilot the use new datasets to track delivery and change.

Standing back, the evidence shows that EBNS is a place of very significant untapped potential. The fundamental drivers around jobs growth and connectivity suggest that the future is bright. Consistent progress on education, skills, and health and wellbeing, together with work to accerate place investment, could see the benefits from transport investment maximised.

A new growth trajectory for the area is the prize, creating very real benefits for the current and future residents of the area.

Introduction

Introduction

This report is the baseline study which looks at the East Birmingham North Solihull area (which we call 'EBNS' for short). This report was written by PBA, with OCSI. We have also had specialist inputs from URBED and Housing Futures Ltd.

This is the first stage of a five-part process. Stage 2 will look at the development strategy and vision, Stage 3 will look at viability, Stage 4 at implementation strategy, and Stage 5 at funding models.

With this baseline, we are trying to avoid the creation of an indiscriminate and formulaic statistical dragnet. Our purpose is not to describe every aspect of life in EBNS. Instead, our objective is to identify the nature of the underlying social, economic and policy conditions in order that later vision and strategy work might make better informed decisions that will change the area for the better. We also hope that the information contained here will

- **Inform private sector investors** about the context for their investment plans, and in particular show how the public sector might respond to growth opportunities by assisting labour and land markets
- **Inform the network of public sector investors** about the broader context of change, possibly helping the development of infrastructure business cases, HCA strategy, and West Midlands Combined Authority investment choices;
- **Encourage engagement at an early stage with the development of a cross-stakeholder growth agenda**; and
- **Provide the first step in the creation of a long-term evaluation framework**.

Whilst we have attempted to cast the net wide, we have inevitably had to make choices about what has been included and what has been excluded from this baseline. Different teams may have made different choices. We are relaxed about this. We hope the subsequent stages of work can add to the baseline for what is going to be a long term and complex attempt to put East Birmingham and North Solihull on a new growth pathway that will see a revolution in opportunities for local residents.

About the evidence we are presenting in this baseline study

In this baseline study, we have presented a number of different types of evidence. Maps and data tables make up the bulk of the evidence. It is important to understand our approach. Many of the maps presented in this report will look similar to the example to the right. The areas shaded on the maps are the buildings contained within each Lower Layer Super Output Area (LSOA). LSOAs are neighbourhoods of approximately 1,500 people. The maps can be used to compare performance of LSOAs in EBNS on a particular indicator relative to England as a whole.

The colours of the map show how the LSOAs rank on a particular indicator compared with other areas across England. Each LSOA in England has been ranked from highest to lowest on each of the indicators and then grouped into 10 bands (deciles) with an equal number of LSOAs in each decile.

LSOAs ranked in the worst 10% of areas in England on an indicator are ranked in decile 1 and shaded dark blue (shown in the area highlighted with the red circle on the example map on the right). Areas ranked in the best or least worst 10% of areas are ranked in decile 10 and shaded yellow (e.g. the area highlighted with the green circle on the example map on the right). The colours circled in orange in the key are the deciles between the lowest 10% and the highest 10%. Note that the colour scheme convention adopted in this report is to use the dark blue colour for indicators showing a worse outcome regardless of whether a worse outcome is denoted by a higher or lower value: for example for pupil attainment measures areas are ranked in the dark blue decile if they have a low value, whereas for unemployment figures areas are ranked in the dark blue decile if they display a high value. For more neutral indicators, e.g. population aged 0-15, the dark blue decile is assigned to areas with a higher value on this indicator. All streets and buildings in each LSOA are shaded, including non-residential properties. Where non-residential properties are shaded, the colour they are assigned relates to the levels in the surrounding residential area that falls within the same LSOA neighbourhood.

Many maps also show a coloured wash, indicating a typical walktime to a public transport connection (typically Metro, Sprint, or rail). This wash should not be confused with the LSOA data.

Many of the tables in this report will look similar to the example on the right. These tables are frequently independent of the maps. In tables, white text on a dark blue background denotes the poorest performing value (this can be the highest or lowest value, depending on the data set). The EBNS is always highlighted in red, as shown in the example table on the right.

We use the most up-to-date data available at the time of writing. Some data is from the 2011 Census and so is growing old, and this needs bearing in mind. There is no way around this problem, because in some instances only the Census gives us data at the spatial scale we need.

In some instances we have included peer-reviewed academic work, policy literature and the results of interviews with those working on the ground. Inevitably, some of the interviews include assertions and opinions: in our view, these still count as important evidence, and have been included where we think it likely that they will be useful during the vision and strategy development process. Interviews were undertaken on Chatham House rules, so interviewees will not be named. We have provided a list of written sources as an appendix.

Example mapping
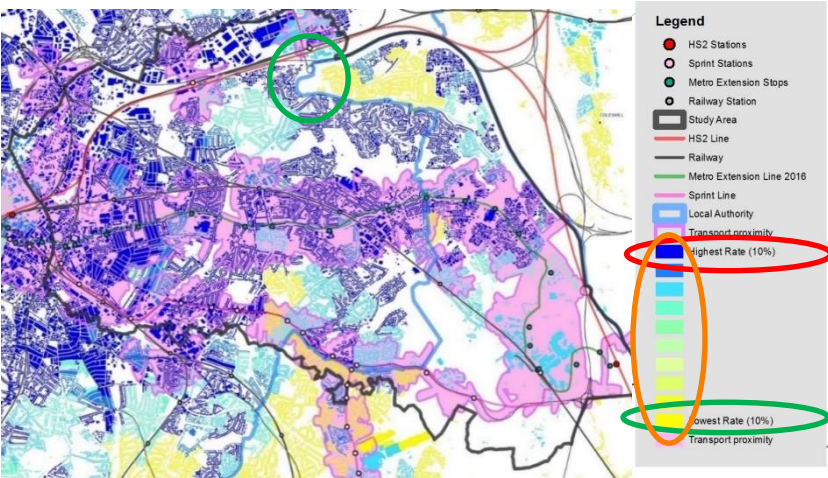
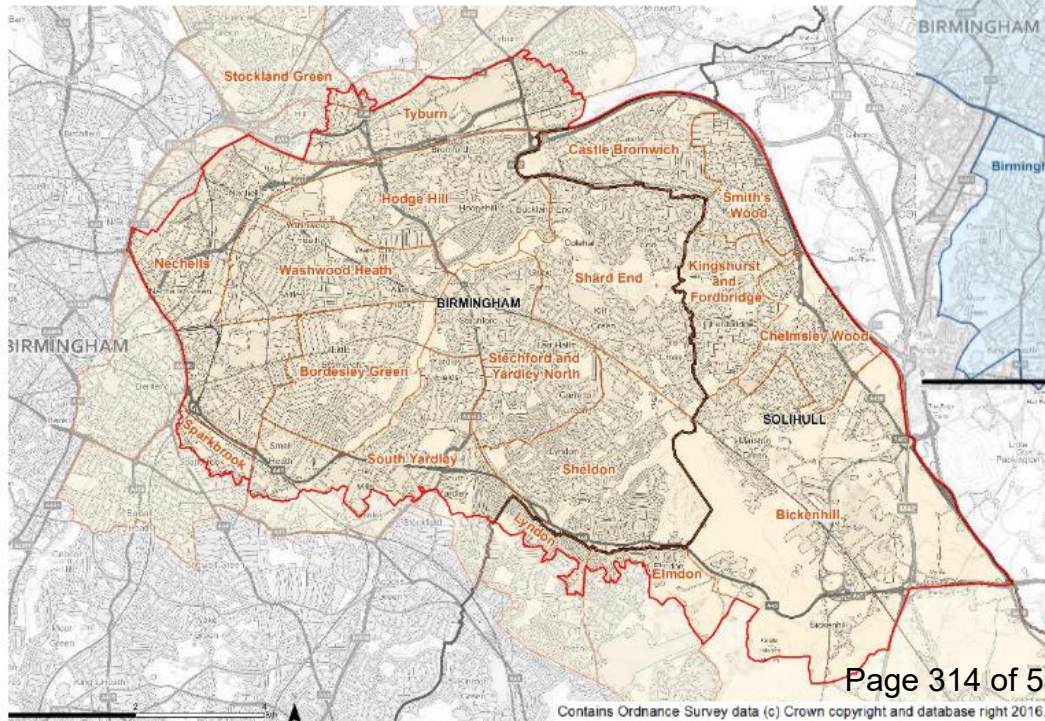| Area	Population aged 0-15 (as % of total population)
EBNS study area	**26.7%**
Birmingham	22.9%
Solihull	19.1%
WMCA constit LAs	21.3%
England	19.1%

The EBNS study area includes seven parliamentary constituencies and 19 local government wards. It extends from the UK Central HS2 site in the east to the City ring road (A4540) in the west, and from Castle Vale in the north and A45 in the south, covering 7,586 Ha and nearly 300,000 people

The EBNS study area geography has been created for this study and provided to us by the client group.

The study team recommended a modest expansion in the area in order to encompass geographical walk-time catchments around new transport proposals in the area; the SPRINT route to the south, and the potential new stations on the rail line to the north, which may be released by the Camp Hill Chords improvements. We will talk about these transport proposals in detail later in the report.

EBNS parliamentary constituencies and study area

Contains Ordnance Survey data (c) Crown copyright and database right 2016.
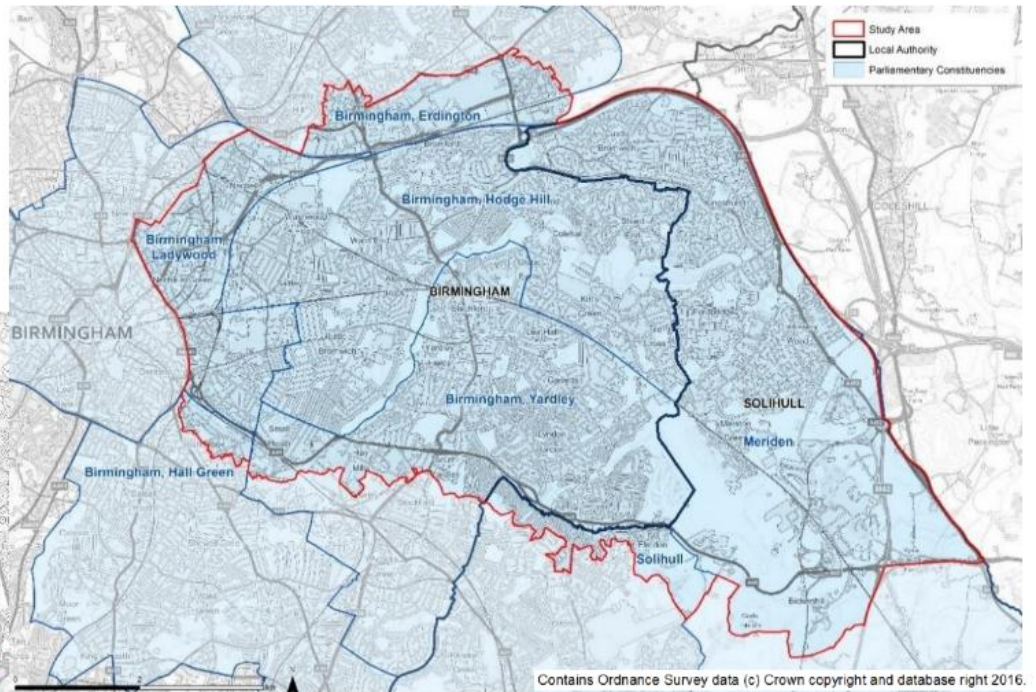
Source: BCC and SMBC

The boundary has been based around Lower Layer Super Output Areas where possible to allow for collection of data.

The administrative boundaries of Birmingham City Council and Solihull Metropolitan Borough Council meet within the study area.

EBNS ward map and study area

Contains Ordnance Survey data (c) Crown copyright and database right 2016.

Source: BCC and SMBC

The future opportunity

Key issues

- The UK's new economic geography will favour East Birmingham & North Solihull

- Jobs growth is in the pipeline

- Transport investment is in the pipeline

The economic geography of the UK is changing. EBNS can benefit

The UK is at a moment of change – and EBNS capitalise on this. New infrastructure will create new, more integrated economic patterns and the EBNS area can take advantage of changes beyond its borders. EBNS is ideally placed to capitalise, being on the eastern side of the West Midlands conurbation, with easy access to strategic connections.

The first phase of HS2 (expected in 2026 in Solihull and Birmingham), will create new configurations of labour and product markets, as well as creating agglomeration benefits (Gibbons 2010). Birmingham's HS2 stations will provide quicker links into central London than many stations in London Zone 5 and 6. Such new connections have been shown to have a real effect on growth patterns, and can be expected to do so again (Chen & Hall 2011).

Major development is expected around Curzon Street and the HS2 Interchange Station at UK Central. Alongside this, Birmingham Airport has major expansion plans. On completion of these plans, the Airport would be of European significance, creating a major transport node for the West Midlands. At the same time, car manufacturing is undergoing a renaissance, a UK Industrial Strategy has been launched, and the Combined Authority may be able to provide additional strategic focus on EBNS.

Current economic configurations (UK): growth predominantly centred around local cities

The emerging new geographies (2030): West Midlands and South-east region merge
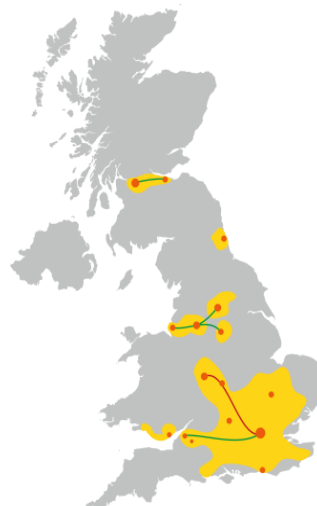
The completion of the HS2 "Y" and beyond 2040: the West Midlands with fast links to the northern and southern economies and the creation of a 'mega-region'
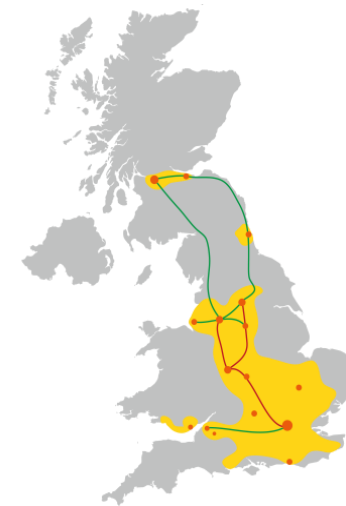
Source: Alan Baxter Associates in Independent Transport Commission (2015) *Connectivity and Cities*

EBNS' future jobs market is expected to be transformed by major planned investments in and around the area

National Exhibition Centre and Birmingham City Council (BCC) have prepared a high level masterplan for the NEC site responding to known current market demand for leisure related land-uses and forecast demand based on research and the ambition of UKC for the M42 corridor. The opening of Resorts World in October 2015 represents the first step in realising the masterplan vision.

Birmingham Airport is seeking to increase capacity within the existing assets and seeking alternative options for future growth. Subject to planning approval and business case, new airport facilities at the HS2 Interchange Station could create a unique multi-modal interchange co-locating high speed rail with air, road, bus, rapid transit and other transport modes. Uniquely, this option builds on top of HS2 and would create the potential to enhance the scale of office, industrial retail/leisure and hotel uses within the Hub. This could also include the provision of a combined Airport/HS2 Terminal to fully maximise the connectivity between air and rail and the economic benefits this would bring.

Jaguar Land Rover (JLR) at Lode Lane Solihull and Castle Bromwich Birmingham. JLR's ambitions for Lode Lane (Solihull) are to significantly enhance manufacturing capability, including the construction of a new Logistics Operation Centre. The phased longer term proposals set out would be subject to future business cases and planning approval. At the Castle Bromwich site (Birmingham), plans were announced in September 2016 to transfer production of the Jaguar XE model will transfer over from Solihull to Castle Bromwich in a move which will 'future proof' the site.

Arden Cross Consortium (the HS2 station site) is being delivered by a consortium of four landowners. At the heart of the development is the HS2 Interchange Station. Masterplanning is underway for over 266,000 sq m of commercial space suitable for national and international occupiers, 2,000 new homes and complementary retail and leisure amenities.

Washwood Heath (circa 64 ha) is mainly the sites of the former Alstom (and before that Metro-Cammell) train works to the west of Common Lane and the former LDV vans plant to the east of Common Lane. All of the land at Washwood Heath was included in the HS2 Bill (and the HS2 Safeguarding area) both for permanent rail infrastructure and the construction process. The site will become a strategic employment site. 40 ha will be retained for HS2 use in two parts. Firstly, the HS2 Rolling Stock Maintenance Depot (RSMD) will serve both phases 1 and 2 of HS2. The RSMD will be an operational and maintenance hub for HS2 incorporating activities which will include all light and heavy maintenance requirements. The RSMD will operate 24 hours a day, 365 days a year and will employ up to 500 people when at capacity, starting around 2026. Secondly, the HS2 Network Integrated Control Centre (NICC), will employ 140 people and will manage train control and communications for the entire network starting around 2026. Once the phase 1 construction period is complete, 24 ha of land will be available for development (although 4 ha may be released early). The site will be used for employment, but will need to go back through the planning system. On the 24 ha outside HS2 use, up to 3,000 jobs could be accommodated, assuming a typical employment density (40% plot ratio and B2 industrial/B8 warehousing blend), and around 3,640 jobs on the site overall, including HS2 jobs.

Birmingham city centre is expected to grow, with the many of these jobs can be directly linked to the new development opportunities available in and around Curzon Street (36,000 jobs) immediately to the west of the EBNS area.

Birmingham Business Park is an established employment centre in multiple ownership, with Blackrock controlling a significant element. It consists of 60 hectares of land and currently accommodates circa 177,000 sq m of office space. Planning permissions exist for a further 14,100 sq m of office development.
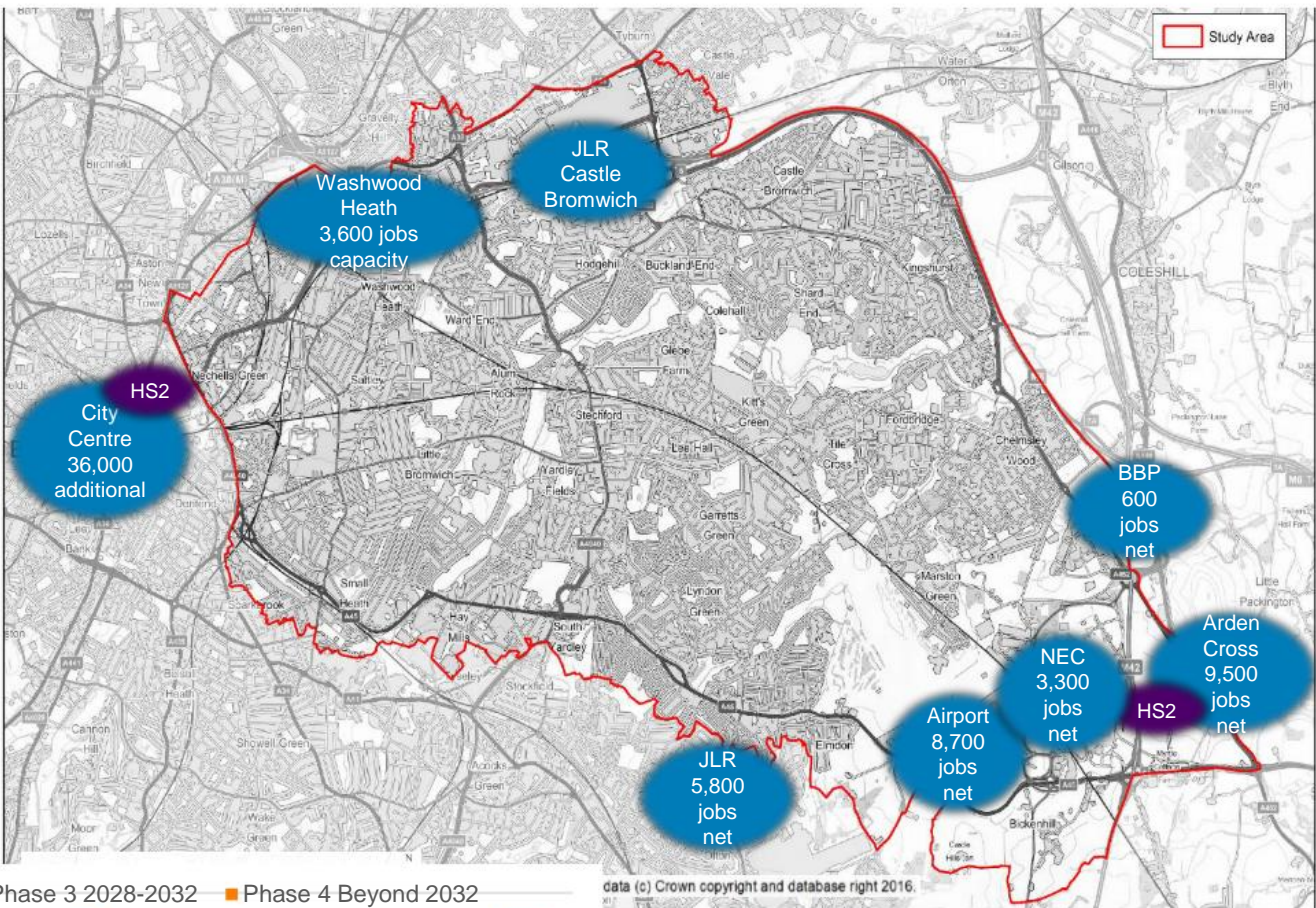
Page 317 of 588

Jobs growth is located at key sites within and surrounding EBNS

EBNS study area and job opportunities (UK Central jobs shown are draft)

We have taken the economic opportunities listed on the previous page and set them out geographically.
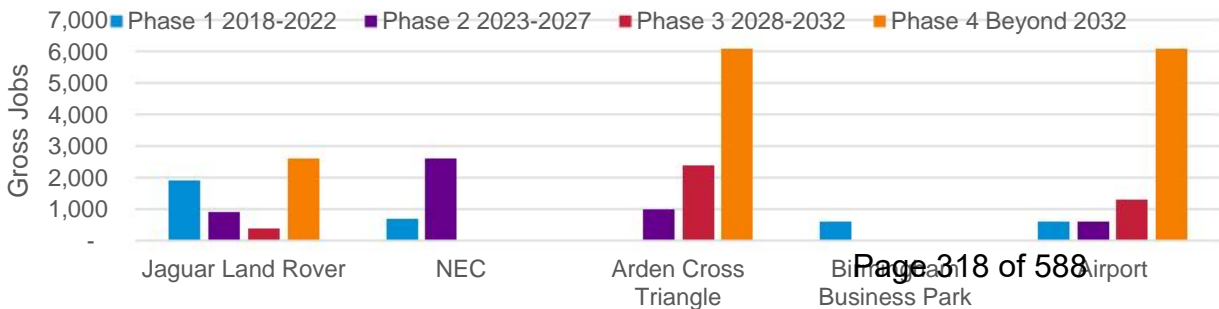
To the west of EBNS is Birmingham city centre, which has been growing rapidly over the last two decades, and will be further boosted by the arrival of HS2 at Curzon Street; to the north is potential expansion at JLR Castle Bromwich and on the Washwood Health site; and to the east is UK Central, which will see a new HS2 station on a green field site, major expansion at Birmingham Airport, new opportunities at the National Exhibition Centre in Birmingham, and planned expansion at JLR plants at Lode Lane.

The map shows how the key sites surround the EBNS area. The UK Central jobs numbers are Full Time Equivalent workplace based net new jobs for Solihull, allowing for displacement effects. No allowance has been made for deadweight or local multiplier effects. **Numbers quoted are draft**, and are subject to change as work develops. Detailed labour market analysis in ongoing to determine the ability of the local labour market to meet the demand profile.

Source: Amion for UK Central

Net additional jobs, UK Central, draft projections excluding multiplier effects

Legend: Phase 1 2018-2022 | Phase 2 2023-2027 | Phase 3 2028-2032 | Phase 4 Beyond 2032

Categories: Jaguar Land Rover, NEC, Arden Cross Triangle, Birmingham Business Park, Airport

Major investments in connectivity - including investment in Metro, a new bus rapid transit route, more services on 'classic' heavy rail lines and new stations - will create a new accessibility to job opportunities

Study Area

JLR Castle Bromwich

Washwood Heath 3600 jobs capacity

New stations at the Fort and Castle Vale and improved frequencies on Birmingham-Tamworth line

HS 2

City Centre 36,000 additional

Improved frequencies on WCML

Metro (tram) extension

BBP 600 jobs net

Sprint Bus Rapid Transit

Arden Cross 9,500 jobs net

NEC 3,300 jobs net

HS2

Airport 8,700 jobs net

JLR 5,800 jobs net

Contains Ordnance Survey data © Crown copyright and database right 2016.

15

The historic, geographical and demographic context

Key issues

- Future growth needs innovation and change
- EBNS has a growing, young, but relatively deprived population
- EBNS has diverse local communities

Why is this issue important? A brief review of the literature and local context

History matters to economic outcomes. Prof James Simmie uses economic history to explain the present, and provide a guide to the future. The economic future of places rests to a certain extent on its historic economic "path" (Simmie 2008). According to Simmie, places become path dependent because

- there are (originally) profits to be made – which leads to firms and consumers being locked into repetitive patterns of production and consumption, and this limits the opportunity for new products and services to make it to the market.

- technological (and capital) lock-in occurs, tying an area to existing technologies. This is accompanied by institutional inertia, which includes Governmental, organisational or cultural systems that lag behind economic change.

Simmie's work suggests that the challenge is to create a new growth path. As Simmie says, areas "must be able to escape their past to create new economic futures. Continual growth is never guaranteed. There is a continual need for constant change and innovation". Different elements of the EBNS area might be at different points of the cycle. EBNS has experienced "path decay" in the past. It must avoid "path decay" in future. A new path must be found.

Demography matters to economic outcomes. Other things being equal, rising populations tend to bring rises in economic output, but the profile of the population has an important influence on income per head. This is because economic behaviour and needs vary at different stages of life: young people require investment in health and education, prime-age adults supply labour and savings, and the elderly require health care and retirement income (Prskawetz 2007).

Geography matters to economic outcomes. Academics have made much of ideas such as the 'end of geography' and the 'death of distance': developments in the technologies of transport and communication have meant that capital and firms are no longer tied to place (Reich, 1991). We follow geographers' counter-arguments in suggesting that place remains very important: "every component in the production chain, every firm, every economic activity is, quite literally, 'grounded' in specific locations. Such grounding is both physical in the form of sunk costs and less tangible in the form of localised social relationships". (Dicken 1998). In short, places do still matter.

Industrialisation: the west EBNS area (east of the city centre) was well positioned for light industry and warehousing overspill from the city centre through the 19th century. Large swathes of land further east were subject to housing development for more affluent car-owning workers through 1930s-50s.

EBNS locks in to manufacturing model: it works well. By 1961, household incomes in the West Midlands (county) were 13% above the national average, exceeding London and the South East.

EBNS path decay? The automotive industry and supply chain struggles with overseas competition through 1960s and 1970s, and fails to reinvest. Wages fall in relative terms. Land and development markets begin to struggle, and skills do not keep pace with change

Source: Simmie et al (2008) *History matters: Path dependence and innovation in British city-regions*

Path dependence: a rough view of where EBNS is now
- Income, education, health statistics suggest long term weak performance: path decay?
- Manufacturing industry is possibly in two places: path dependence and path creation.
- EBNS is possibly on the brink of a new path creation phase. JLR's growth is revolutionising prospects for automotive, with step change investments in electric vehicles in prospect; airport growth could create major change in logistics industries and wider catalytic impacts; HS2 impacts in central Birmingham; growth at the NEC; and possible growth at the Arden Cross site (the location of the HS2 station). A truly international transport hub is being created, with co-located strengths in advanced engineering.
- The challenge at EBNS is getting the path creation phase to work as rapidly as possible, and ensure that this change brings maximum benefit to the residents of the EBNS area

The majority of the urban form in EBNS was the result of expansion between WWI and WWII, housing a well paid manufacturing workforce. Post war expansion was focused in North Solihull. Some areas have changed little since then

East Birmingham

The economy and personality of Birmingham are very different from other industrial or mercantile cities, such as Liverpool or Bristol.

Birmingham was once one of the most innovative cities in the world. The city focused on small-scale specialised companies with highly-skilled and well-paid workforces and had an entrepreneurial municipal leadership inherited from Victorian times.

Until 1920, Birmingham was fairly compact; however, between the wars Birmingham built 50,000 council houses and allowed 65,000 private homes to be built. Cottrills Lane in Alum Rock was the first scheme to be completed after WWI.

North Solihull

The urban character of North Solihull is defined by the housing areas and landscape features. The majority of Chelmsley Wood, Smith's Wood and Fordbridge were built during the 1960s to a Radburn layout with backs of properties and high fences fronting onto the road and housing blocks geometrically arranged around parking courtyards, drying spaces or small green areas. The area contains a large number of high rise blocks. Densities are generally within the range of 35 – 45 units per hectare.

Kingshurst has a contrasting character including pre-1950s development of semi-detached and detached units, early 1950s housing, later housing comprising a mix of flats, terraces and maisonettes arranged around cul-de-sacs and courts and 1970s – 80s development fronting Babb's Mill Park.

Chelmsley Wood Town Centre has dual carriageways on three sides and major roundabouts at key gateways, which act as barriers between the shopping centre, the residential neighbourhoods and the green spaces of the River Cole Valley.

The expansion of EBNS since 1938 at Kitts Green

Date: 1938
Source: National Library of Scotland

Date: 1952
Source: National Library of Scotland

Date: 2017
Source: Ordnance Survey

North Solihull

19

The EBNS population lives at higher densities towards the west of the study area. Population trends from 2001 show a pattern of rapid growth

The EBNS area's population has risen by almost 11% since 2001 - a faster rate than all comparator areas with the exception of Birmingham. During this time the population has gone from approximately 269,151 to 298,600, an increase of almost 30,000 people. Between 2010 and 2015 the area has seen population growing at 4.8%, a faster rate than all comparators including Birmingham.

Population over time	2001	2015	% growth 2001-15	% growth 2010-15
EBNS area	269,151	298,600	10.9%	4.8%
Birmingham	984,640	1,111,307	12.9%	4.7%
Solihull	199,578	210,445	5.4%	2.0%
WMCA constit LAs	2,568,003	2,833,557	10.3%	4.5%
England	49,440,225	54,501,221	10.2%	3.5%

The average population density across EBNS is 39 persons per hectare. Compared to all LSOAs in England, the population density in some parts of EBNS (including Washwood Heath & Bordesley Green) is in the highest 10%. This is not surprising due to the urban nature of the area. However, EBNS is not as densely populated as other English comparators.

Area	Population density (persons per hectare)
EBNS study area	39.02
London: Tower Hamlets	138.03
Leeds Harehills	52.65
Liverpool: Everton	52.59
Manchester: East	40.86

Population – Index, 2001 = 1
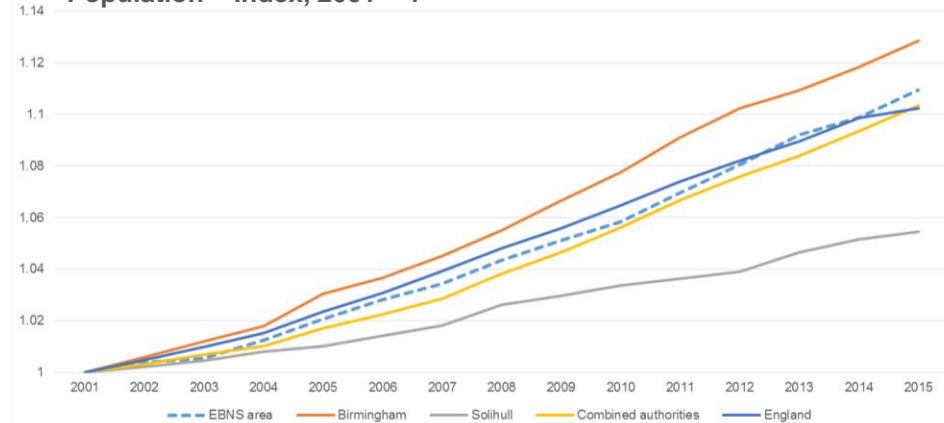
Legend: EBNS area, Birmingham, Solihull, Combined authorities, England

Dataset: Mid Year Estimates (MYE) of population Date: 2001-2015 Source: Office for National Statistics (ONS)

Population density: ranked by LSOA

Dataset: Mid Year Estimates (MYE) of population, Date: 2014, Source: Office for National Statistics (ONS)
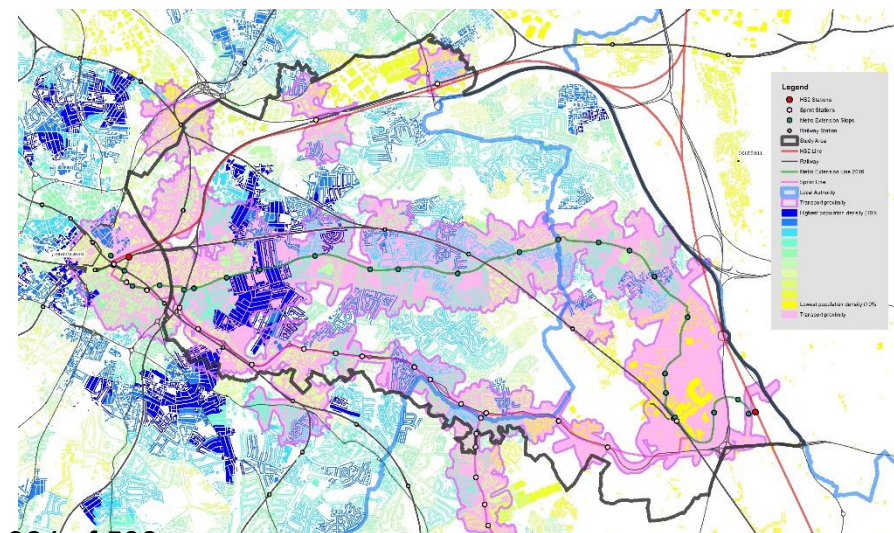
EBNS has a younger than average population, with more than one in four people in EBNS aged 15 or under. The western area has the highest proportion of young people, and parts of Castle Bromwich and Sheldon the lowest

The EBNS area has a young population compared to the England average. This is shown in the chart's wider base, with a higher proportion of people in each of the five year age/gender bands up to the age of 35 than the national average. By contrast, the narrower top of the chart indicates the study area has significantly lower proportion of people aged 55 and over than the national average.

Proportion of 0 to 15 year olds: ranked by LSOA
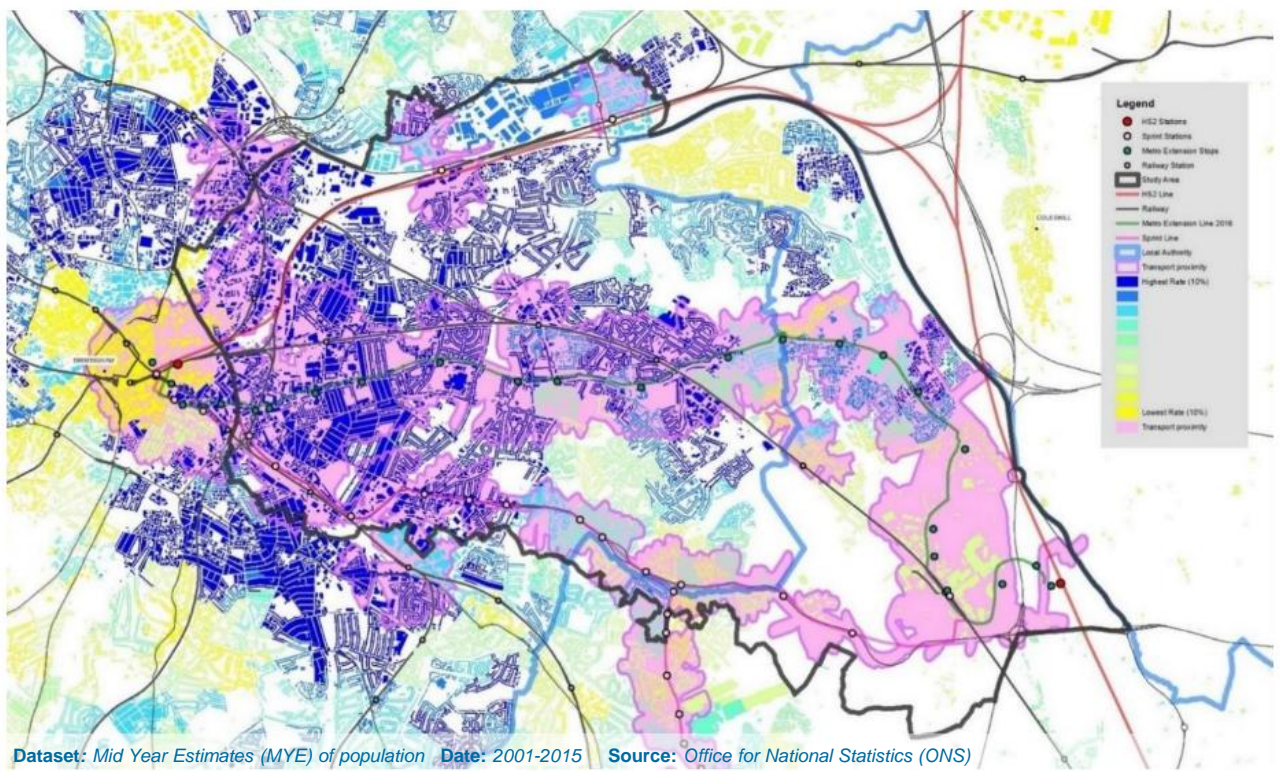
Dataset: Mid Year Estimates (MYE) of population **Date:** *2001-2015* **Source:** *Office for National Statistics (ONS)*

EBNS population age profile (% in each age category)

	Women	Men
85pl	2.2	1.2
80 to 84	2.1	1.6
75 to 79	2.7	2.3
70 to 74	3.1	2.8
65 to 69	3.7	3.7
60 to 64	3.9	3.9
55 to 59	4.5	4.8
50 to 54	5.7	5.6
45 to 49	6.2	6.3
40 to 44	6.2	6.1
35 to 39	6.5	6.2
30 to 34	7.0	6.9
25 to 29	7.6	7.1
20 to 24	7.0	7.3
15 to 19	7.2	8.0
10 to 14	7.5	8.2
5 to 9	8.2	9.0
0 to 4	8.5	9.2

England values / EBNS Area

The younger population is not evenly distributed across EBNS. The western area of EBNS, near to the city centre, and around Stechford, has the highest proportion of 0–15 year olds, whereas Castle Bromwich is in the lowest decile of 0-15 year olds.

This is shown through the map above, which represents relative proportion of residents in the 0-15 year age category across the study area. The shading is coloured into deciles with blue shading the highest 10% and yellow the lowest 10%.

Area	Population aged 0-15 (as % of total population)
EBNS study area	**26.7%**
Birmingham	22.9%
Solihull	19.1%
WMCA constit LAs	21.3%
England	19.1%

This young population has been increasing over time. Between 2001 and 2015 there was an increase in people aged under 15, whereas Birmingham and Solihull on the whole has seen a decrease

Percentage change in population for selected age bands, 2001-2015

■ Aged 0-15 ■ Aged 16-64 ■ Aged 65+
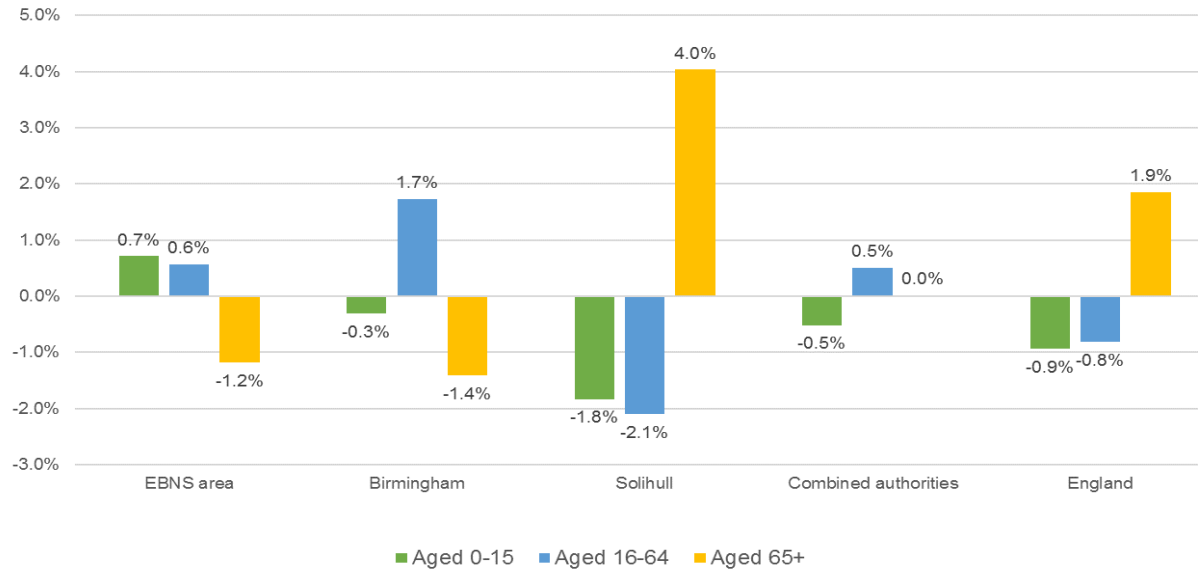
The EBNS area has experienced an increase in the proportion of 0-15 year olds between 2001 and 2015, from 26.1% to 26.8%.

There has also been a decline in the proportion of people of pensionable age between 2001 and 2015.

This trend contrasts sharply with the national average which has seen the proportion of people aged 0-15 fall, while the proportion aged 65 grow over the same period.

Change in the 16 to 64 age group has been positive. This is consistent with the pattern in Birmingham and across the combined authorities, but contrasts with Solihull and England as a whole.

% of people within each age band for 2001 and 2015

	2001						2015					
	Age 0-15		Aged 16-64		Aged 65+		Age 0-15		Aged 16-64		Aged 65+	
EBNS Area	**26.1%**	**70,219**	**59.9%**	**161,297**	**14.0%**	**37,637**	**26.8%**	**79,949**	**60.5%**	**180,520**	**12.8%**	**38,131**
Birmingham	23.2%	228,534	62.4%	614,169	14.4%	141,926	22.9%	254,085	64.1%	712,208	13.0%	144,985
Solihull	20.9%	41,774	62.2%	124,138	16.9%	33,667	19.1%	40,153	60.1%	126,404	20.9%	43,889
WMCA constit LAs	21.8%	560,337	62.6%	1,607,425	15.6%	400,237	21.3%	603,096	63.1%	1,788,630	15.6%	441,798
England	20.0%	9,907,391	64.1%	31,698,752	15.8%	7,834,148	19.1%	10,399,494	63.3%	34,488,260	17.7%	9,662,523

22

EBNS has seen a 4.6% growth in working age population from 2010 to 2015

From 2001 to 2015, there has been **continued population growth in EBNS,** and an 11.9% increase in working age population from 2001. In the five years between 2010 and 2015 population growth was higher in East Birmingham (and Birmingham) than all the other comparator areas.

Working age Population over time	2001	2015	Total % growth 2001-15	% growth between 2010-15
EBNS area	**161,297**	**180,520**	**11.9%**	**4.6%**
Birmingham	614,169	712,208	16.0%	4.6%
Solihull	124,138	126,404	1.8%	-1.3%
WMCA constit LAs	1,607,425	1,788,630	11.3%	3.7%
England	31,698,752	34,488,260	8.8%	1.1%

23

Dataset: Source: *Business Register and Employment Survey (BRES)*

Most of the EBNS area is in the top 20% most deprived areas in England

The map to the right shows the Index of Multiple Deprivation (IMD) 2015. The IMD is a relative measure of deprivation for small areas. The overall IMD combines together indicators under seven different domains of deprivation: Income; Employment; Education; Health; Crime; Barriers to Housing and Services and Living Environment. A high score indicates that an area is experiencing high levels of deprivation.

In the map, the areas shaded dark blue are among the 10% most deprived in England on the IMD 2015, while areas shaded yellow are among the 10% least deprived.

There is widespread deprivation across the EBNS area, except for parts of Castle Bromwich, Sheldon and Hodge Hill. The most deprived areas are located towards the west, with a central band of deprivation running through the area, along the proposed metro route and the area surrounding (but not including) Castle Bromwich.

Index of Multiple Deprivation 2015 score: ranked by LSOA
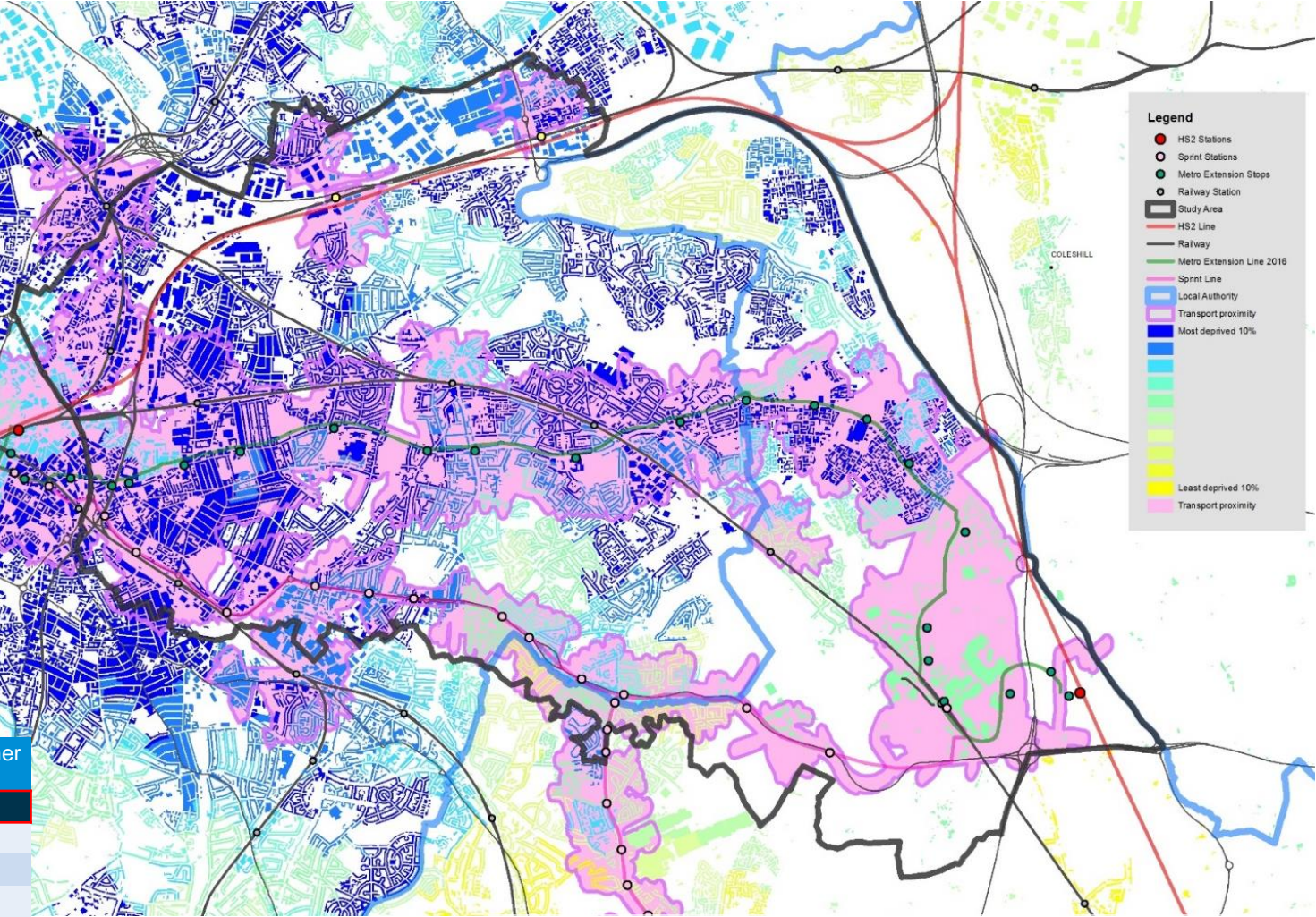
Dataset: *The Index of Multiple Deprivation (IMD)* **Date:** *2015* **Source:** *Communities and Local Government*

Area	IMD 2015 Deprivation score (higher = more deprived)
EBNS area	**44.78**
Birmingham	37.72
Solihull	17.76
WMCA constit LAs	31.6
England	21.69

24

More than one in three children in the EBNS area are living in poverty

Children in poverty: ranked by LSOA

The children in poverty measure shows proportion of children (aged 0-15) in families in receipt of out of work benefits, or in receipt of tax credits where their reported income is less than 60% of the median income. Out of work means-tested benefits include: Income-Based Jobseekers Allowance, incapacity benefits and Income Support.

The Birmingham Child Poverty Commission is supervising a response to these issues.

Area	% of children (aged 0-15) in poverty
EBNS area	36.1%
Birmingham	32.9%
Solihull	16.9%
WMCA constit LAs	29.2%
England	20.1%

Relative deprivation has been increasing in areas along the planned Metro line extension, particularly towards inner Birmingham and within Solihull

The Index of Multiple Deprivation measures all LSOAs in England on an index of measures. We can look at changes in an area's rank to understand how each area has performed relating to others. Because change is relative to other areas, the data does not necessary indicate that there has been an *absolute* change in deprivation.

The map on the right depicts the change in the rank of deprivation in LSOAs in the EBNS area between IMD 2010 and IMD 2015. Areas shaded yellow show little or almost no change (changing rank less than 1000 places). Areas shaded blue became relatively more deprived and those shaded yellow became relatively less deprived.

There have been some slight changes in deprivation across the area, with scattered areas moving up and down in ranking from 2010 and becoming less and more deprived, with a concentration of increased deprivation in the East of the EBNS area and some dramatic changes in rank (positive and negative) in the west of the area.

Increase in Index of Multiple Deprivation 2010 to 2015: ranked by LSOA
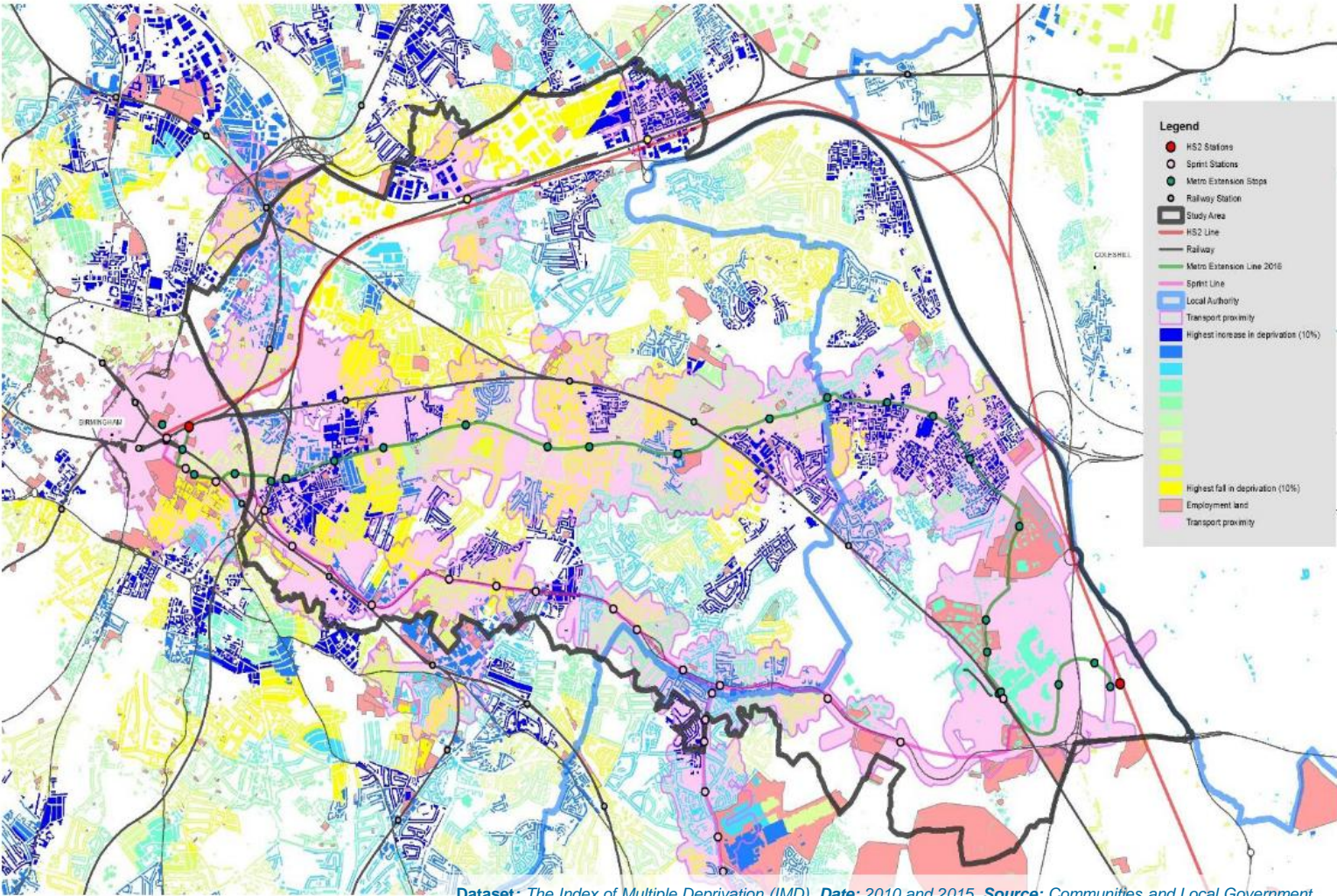
Dataset: *The Index of Multiple Deprivation (IMD)* **Date:** *2010 and 2015* **Source:** *Communities and Local Government*

We have used Mosaic social profiling to better understanding the EBNS area

We have used Mosaic, a social profiling model by Experian, to provide an understanding of the social profile of the EBNS area.

Mosaic works by segmenting the population into 15 groups which describe an individual's consumer behaviour.

The diagram shows the west as dominated by the 'Urban cohesion' socio-economic group (yellow). This groups is often multicultural and tends to have a high sense of community. The group is frequently found in city suburbs, and characterised by settled extended families and 3-bed home ownership.

'Family basics' (orange) and 'Aspiring homemakers' (turquoise) populate the centre and south of the study area. These groups are often young families with children, with few resources and often in low cost rented accommodation (Family basics) or younger families in full time employment (Aspiring home makers), often on starter salaries and working in mid-level professions positions. Those in 'Prestige positions' (dark purple) are dominant in the north of the study area (Castle Bromwich), as well as some eastern areas.

'Modest traditions' (pink) and 'Municipal challenge' (red) are also prevalent throughout the study area. Those of 'Modest traditions' are often homeowners, of a mature age, in affordable housing, on modest incomes with grownup children. Those in 'Municipal challenge' are often social renters, in low cost housing and challenged neighbourhoods with few employment options and low incomes. This group is commonly found to the east (Chelmsley Wood & Fordbridge) and north (Buckland & Shard End) of the study area.

EBNS Mosaic social profiling
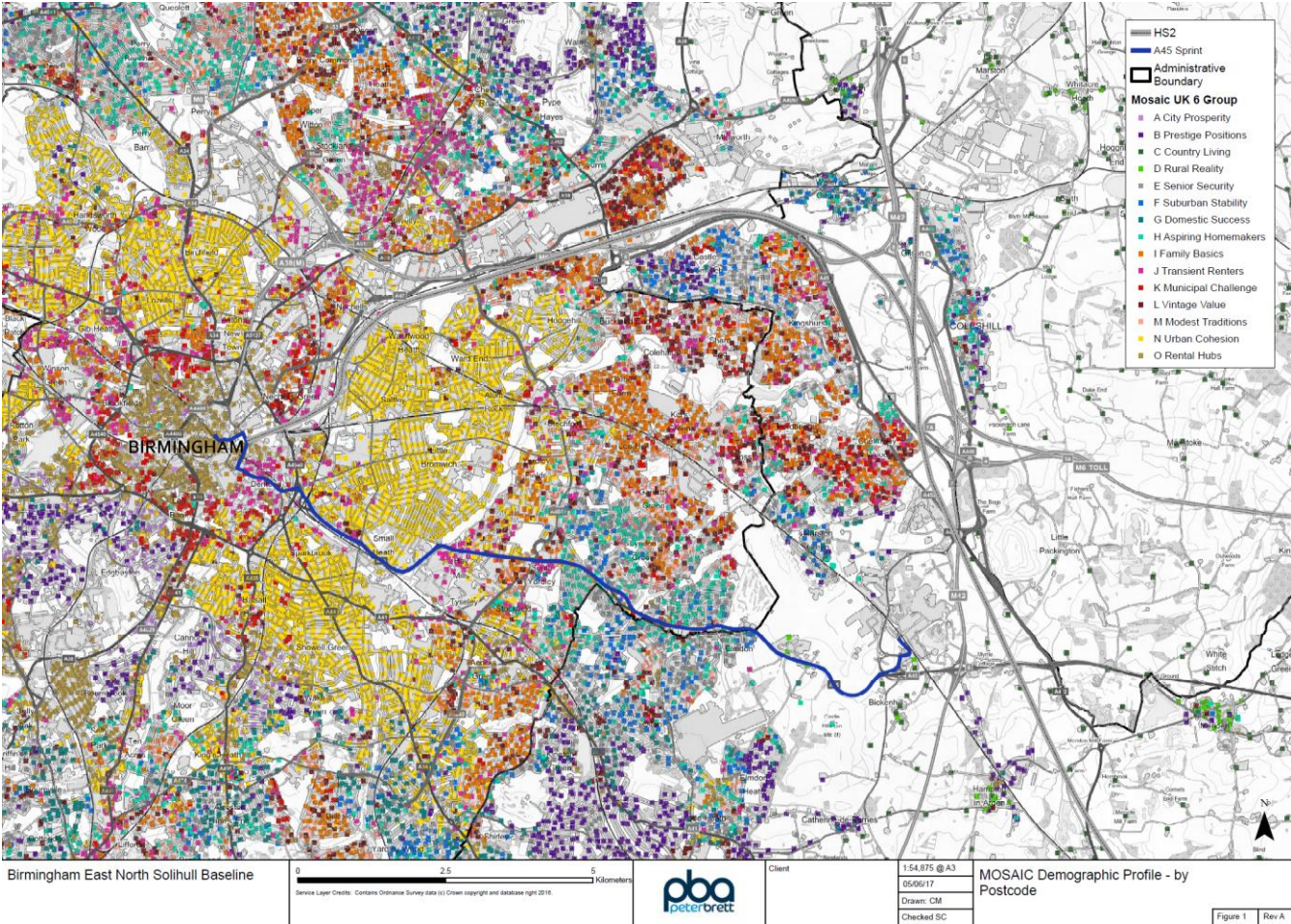
Dataset: Mosaic Date: 2017 Source: Experian

EBNS is predominantly urban in nature, with the River Cole, River Tame and River Rea running through the area. Towards the west, the area has a small amount of greenbelt and is the gateway to rural Solihull

The River Cole Valley, including Kingshurst Brook, Low Brook, Hatchford Brook and Westley Brook, forms a dominant landscape feature throughout EBNS. There is a green buffer along the valley containing grassland, pockets of ancient woodland, country parks and nature reserves.

Two other rivers flow through EBNS – The River Rea and River Tame. Flood mapping shows that the land surrounding the rivers Rea, Tame, Cole and the Brooks could be affected by flooding in the absence of flood defences. The plan to the right shows that some of the adjacent land is affected by flood zone 2 (with up to 0.1 percent / 1 in 1000 chance of a flood occurring each year) and flood zone 3 (a 1 per cent / 1 in 100 or greater chance of happening each year).

The whole Birmingham City Council area is covered by an Air Quality Management Area, whereas this is not in place within the Solihull section of EBNS. The Government has recently consulted on Clean Air Zones, where targeted action is taken to improve air quality. Birmingham Council is in the process of considering how a Clean Air Zone in Birmingham would work.

A green belt on the eastern parts of the study area separates residential areas from the more rural areas of Solihull. Parts of the green belt may be released to accommodate the forthcoming HS2 station, which is to be located on the triangle of land to the east of the NEC.

Map of environmental constraints
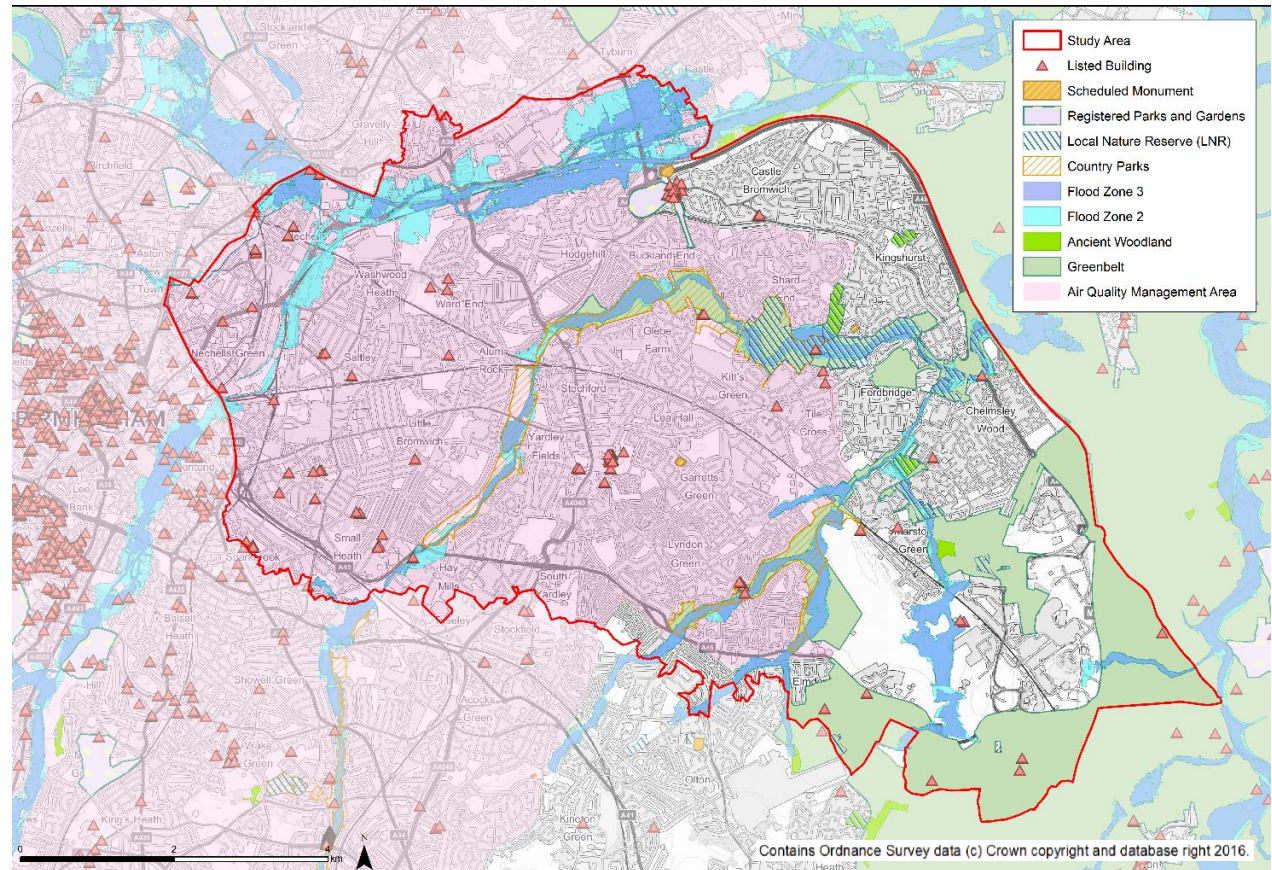
Dataset: Environmental Constraints Date: 2017 Source: PBA

Jobs in EBNS

Key issues

- EBNS is a strategically important industrial area

- Employment is concentrated in traditionally low paying sectors

The EBNS area sits between two of the most significant employment areas in the West Midlands, and is clearly a strategically important industrial area for the city and wider area in itself

To the west of EBNS, there is Birmingham city centre. To the east there is UK Central, including the Airport, NEC, Birmingham Business Park, JLR and the Arden Cross site (the future location of the HS2 station). Continued growth and major improvements in connectivity have the potential for considerable employment growth.

The city centre is still in the process of regeneration and is seven years through the transformational 20 year 'Big City Plan'. The city centre benefits from a strong pipeline of new commercial and residential space and renewed interest from businesses and households. The recently approved Birmingham Development Plan makes positive provision for this regeneration to extend beyond the existing city centre. Large areas of former industrial land to the east of the city centre are now allocated for mixed use redevelopment through the plan or through the Bordesley Park Area Action Plans (AAPs).

The investment in HS2 at both UK Central (to the east of EBNS) and Curzon Street (in the city centre) will lead to a step change in market attractiveness and connectivity for the strategic employment areas. In Curzon Street, new jobs are anticipated to be spread across office, professional services, back of office, digital/ creative, and retail. This is based on the broad areas in the masterplan, and further work is being undertaken to identify the employment requirements.

The market attractiveness in EBNS could be supported through the proposed Metro and SPRINT routes which will provide direct connections between HS2 and the major new employment areas. It is on this basis that the employment land baseline in this section starts on an area wide basis, then focuses in on the existing situation along these routes.

Across Birmingham and Solihull, office-based sectors employ more people than industrial sectors (around 62% of jobs are in office settings). However, industrial uses take nearly three times more land.

The number of people currently employed across Birmingham City Council and Solihull Metropolitan Borough Council within the employment land use classes (B1, B2 or B8) is estimated at around 250,000. To produce these estimates we have started from official statistics (from ONS / BRES) that show employment by sector. We then translated sectors into land uses, using a method commonly used in Employment Land Reviews.

Of these people most are employed in offices (B1); 155,000 people work in jobs we expect to be accommodated in office space. 80% of these are in Birmingham and 20% in Solihull. The balance, some 95,000 people, work in either warehouses or factories, mostly (80%) in Birmingham.

Area	Estimated no. people working in office floorspace	Estimated no. people working in factory-type floorspace	Total (estimated no. people)
Birmingham	125,000	75,000	200,000
Solihull	30,000	20,000	50,000
Total	155,000	95,000	250,000

Warehouse and industrial space is land hungry. Even though there are more people working in office jobs, in terms of land and floor space, warehouse or industrial space takes disproportionality more space than offices. This is because warehouse and industrial firms employ fewer people per square metre of floorspace than offices. Across Birmingham and Solihull, we estimate there is around 2.5 million square metres of office space but 7 million square metres of industrial space (source: VOA 2012)

30

EBNS has a large number of office based jobs (21,000). But when we look at EBNS' share of the total number of jobs in Birmingham and Solihull, we see that the area is better understood as a strategically important location of industrial and warehousing jobs – but that relatively few of these *existing* industrial and warehousing jobs are located near Metro and Sprint corridors

The table shows the share of total warehousing, industrial and office jobs accommodated in EBNS – and shows that EBNS is a strategically important industrial area. We estimate that around a quarter of all industrial and warehousing employment in the two Council areas is found within our study area. Of the 55,000 industrial jobs in Birmingham and Solihull 15,000 are within EBNS. 10,000 of the approximate 40,000 warehousing jobs are within our study area.

But while industrial employment (and hence industrial floorspace) is very significant in the study area, the table also shows that the main *current* reservoirs of employment and warehousing land are located slightly away from the two routes, and so may be less affected by the labour market improvements generated by transport investment: the share of industrial jobs within walking distance of the Metro and Sprint lines are relatively modest, and suggests that neither the Metro nor Sprint routes will service large reservoirs of *today's* office stock or office jobs *within the EBNS boundary*. The BRES data we have used shows that there are only around 2,500 industrial jobs and a further 2,500 warehouse jobs along the Metro corridors. For the Sprint route we estimate there are only 2,500 industrial and 2,500 warehouse jobs within an easy walktime along the route.

The reason why so few jobs are located within an easy walk of the routes is because the main industrial area within EBNS is along the A47 corridor – which is located away from the Metro or Sprint route.

However, the two routes still link the smaller, local industrial sites providing employment opportunities in close proximity to where people live. The proposed metro route links the older industrial areas at

Bordesley Green along with the newer, purpose built estate at Garretts Green. The Kitts Green estates are just on the edge of Metro Route area. The sprint route links the estates around Tysley in the west with the more dispersed industrial and warehousing space stretching along Coventry Road. Without these industrial areas local residents would need to travel further for work.

|	Birmingham & Solihull	EBNS	Metro isochrones	SPRINT isochrones
Industrial based jobs	55,000	15,000	2,500	2,500
Industrial jobs % of Birmingham and Solihull total		27%	5%	5%
Warehousing based jobs	40,000	10,000	2,500	2,500
Warehousing jobs % of Birmingham and Solihull total		25%	6%	6%
Office based jobs	185,000	21,000	8,500	3,000
Office based jobs % of Birmingham and Solihull total		11%	5%	2%

Of the jobs based within EBNS, the highest proportion are associated with motor trades, closely followed by hospitality and transport/storage

Here we look at employment by industry of those who work in EBNS, irrespective of whether they are residents or otherwise. EBNS has a relatively high proportion of jobs in retail/motor trades (27%) (driven by Jaguar Land Rover) and transport and storage 10.2% (Birmingham Airport) relative to England as a whole (with 16% and 4.7% respectively). By contrast, there are less than half as many jobs locally in public service or business administration industries (which typically require high level qualifications) than the national average.

The sectors where the EBNS area has the biggest gap in relation to comparator areas are public administration, business administration and professional, scientific and technical roles. In the latter sector the difference is particularly stark, with the EBNS area having less than half the national proportion of jobs in professional occupations, at 4.2% to England's 8.8%.

This is shown in the table to the right, where jobs in the EBNS area and comparators are broken down by broad industry group. Instead of combined groups, all categories are provided, allowing for a more in-depth look at the unique features of employment in the EBNS area. It is also shown graphically below.

Proportion of jobs per industry group
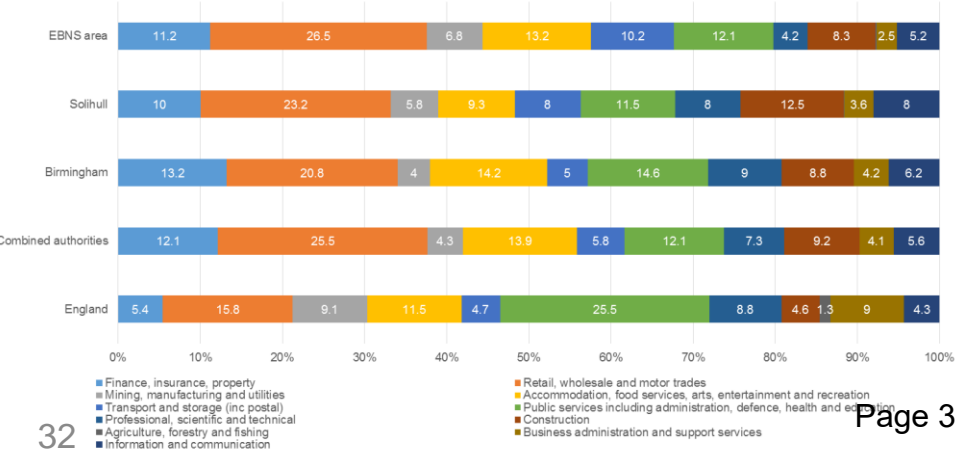
Proportion of jobs per industry group				
	EBNS area (%)	Birmingham (%)	Solihull (%)	Combined Authority (%)	England (%)
Accommodation and food services (hospitality)	11.8	13.6	8	12.6	7
Transport and storage (inc postal)	10.2	5	8	5.8	4.7
Retail	8	8.2	9.8	9	9.9
Wholesale	6	4.6	2.7	5.2	4.1
Arts, entertainment, recreation and other services	1.4	0.6	1.3	1.3	4.5
Health	1.8	4.6	3.1	3.4	12.5
Education	7.7	5	5.3	4.7	9
Jobs in professional, scientific and technical	4.2	9	8	7.3	8.8
Jobs in motor trades	12.5	8	10.7	11.3	1.8
Jobs in financial and insurance	9.7	11.4	8	10.4	3.5
Jobs in construction	8.3	8.8	12.5	9.2	4.6
Jobs in manufacturing	2.5	1.6	1.3	2	8
Jobs in mining, quarrying and utilities	4.3	2.4	4.5	2.3	1.1
Jobs in agriculture, forestry and fishing	0.1	0	0.1	0	1.3
Jobs in property	1.5	1.8	2	1.7	1.9
Jobs in business administration and support services	2.5	4.2	3.6	4.1	9
Jobs in information and communication	5.2	6.2	8	5.6	4.3
Jobs in public administration and defence	2.6	5	3.1	4	4

Proportion of jobs per industry group

Dataset: *Jobs by broad industry group (based on the 2007 revision of the Standard Industrial Classification (SIC)) from the Business Register and Employment Survey (BRES) of approximately 80,000 businesses and weighted to represent all sectors of the UK economy. Based on actual jobs within each area, not resident population.*

Date: *2019*

Source: *BRES*

There are far fewer registered business per head in the EBNS area. However, the area is closing the gap on regional and national comparators

Number of registered businesses

As shown by chart and table, **EBNS has fewer VAT registered businesses per 1,000 population than England and the local authority areas of which it is part**. However, this gap is closing, particularly driven by a sharp increase in business registrations per head in EBNS in 2010/11.

Area	VAT registered local businesses per 10,000 working age population
EBNS study area	436.9
Birmingham LA	515.6
Solihull LA	725.1
Combined authorities	523.9
England	721.9
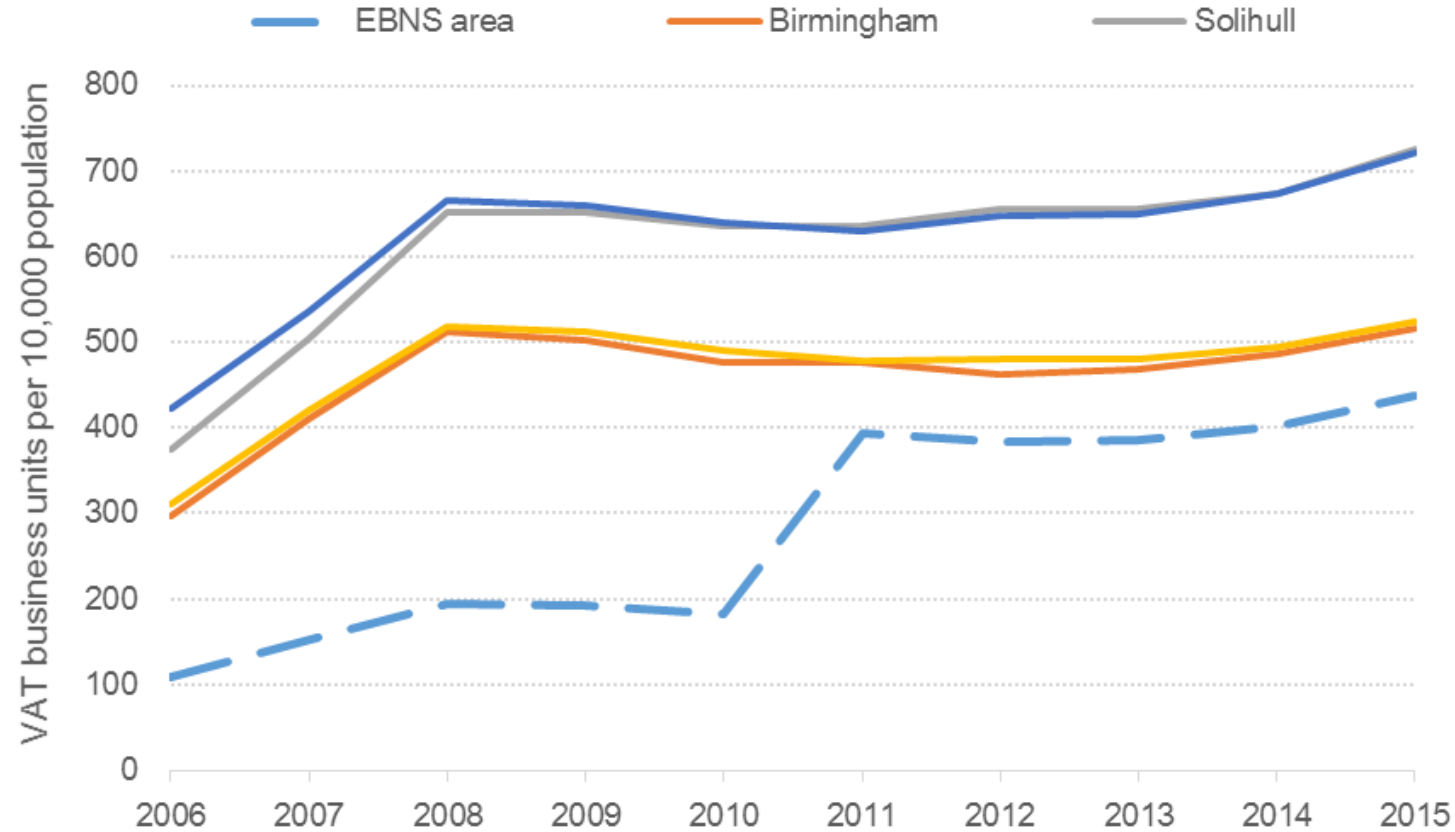
Dataset: *Shows the number of VAT based local business units per 10,000 working age population. The count of VAT registered local business units taken from the Inter-Departmental Business Register (IDBR), which is the comprehensive list of UK businesses. It provides the main sampling frame for surveys of businesses carried out by the ONS and by other government departments. It is also a key data source for analyses of business activity.*
Date: *2015*
Source: *Office for National Statistics (ONS)*

EBNS has a higher proportion of larger businesses than average, with that employment concentrated in traditionally lower paid sectors

The chart below shows the proportion of all local businesses by number of employees. The table shows business units by sector and is ranked in order of the largest employing sectors within the EBNS area. It shows that wholesale and retail trade, manufacturing, education and human health and social work activities are the largest employers in the study area.

Proportion of businesses by size

Legend: ■ EBNS area ■ Birmingham ■ Solihull ■ Combined authority ■ England

employees	EBNS area	Birmingham	Solihull	Combined authority	England
0 to 4 employees	62	66	71	66	70
5 to 9 employees	16	15	12	15	14
10 to 19 employees	10	9.2	7.6	9.1	7.9
20+ employees	12	10	9.3	10	8.2

% of all local business units (y-axis: 0–80)
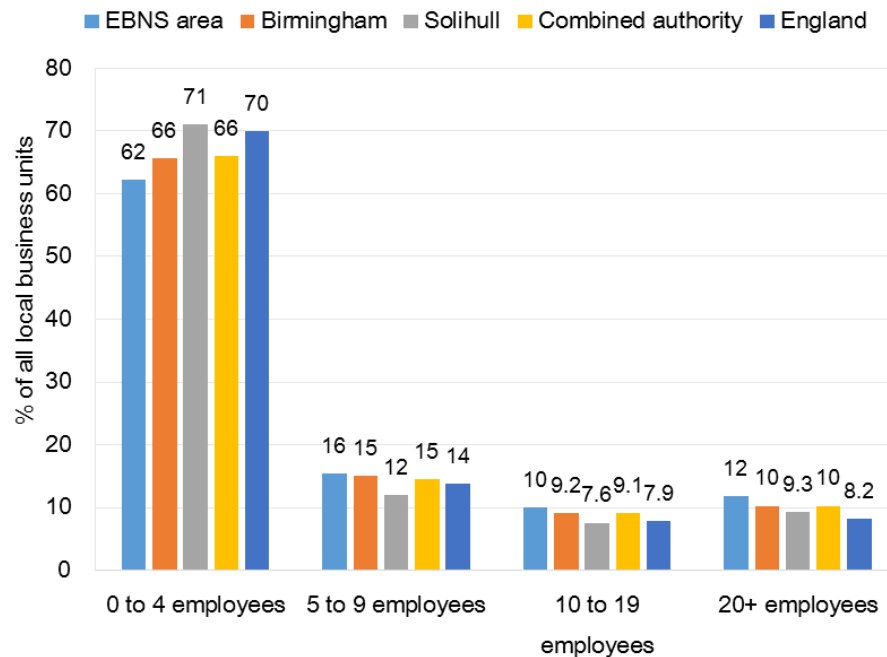
Businesses units by sector (% of all businesses in the area)	EBNS area	Birmingham	Solihull	Combined authority	England
Wholesale and retail trade; repair of motor vehicles and motor cycles	18.1	15.7	15.6	17.0	15.9
Manufacturing	11.7	9.2	10.0	11.7	8.8
Education	9.2	12.1	10.4	10.8	9.9
Human health and social work activities	9.2	12.1	10.4	13.5	9.9
Transport and storage	8.1	5.7	4.5	5.7	5.0
Construction	6.9	6.1	7.8	7.1	7.7
Accommodation and food service activities	6.7	6.3	4.8	5.4	5.6
Administrative and support service activities	6.5	5.3	5.3	5.0	4.9
Public administration and defence; compulsory social security	4.0	4.8	4.9	5.0	5.9
Other	3.9	4.6	4.3	4.4	5.0
Professional, scientific and technical activities	3.5	5.6	7.1	5.9	6.7
Financial and insurance activities	3.5	4.0	5.1	3.7	4.4
Information and communication	2.3	3.0	4.4	2.8	4.1
Real estate activities	1.3	1.5	1.6	1.4	1.5
Water supply; sewerage, waste management and remediation activities	0.8	0.6	0.8	0.8	0.7
Electricity, gas, steam and air conditioning supply	0.5	0.5	1.5	0.7	0.6
Agriculture, forestry and fishing	0.1	0.1	0.2	0.1	0.8
Mining and quarrying	0.0	0.0	0.0	0.0	0.2

Some labour market evidence sends conflicting messages. Solihull and Birmingham have a higher rate of businesses with job vacancies than the national average – but the proportion of 'hard to fill' vacancies is lower

This chart shows employer-reported job vacancies for Solihull and Birmingham authorities and comparator areas (England and West Midlands local authority averages). Both Solihull and Birmingham are above the national and regional averages for businesses with vacancies as well as for average number of vacancies. This suggests that job prospects in the wider area surrounding the ESBN area are relatively strong – leading to questions why the rates of labour participation are not higher in EBNS. The evidence suggests that employers might not be finding the right skill set in EBNS workers.

By contrast, the table below shows that there are fewer 'hard to fill' vacancies in businesses in Solihull and Birmingham than the national average. The evidence does to provide a very clear picture

Employer reported vacancies: % with at least one vacancy and av. vacancies per establishment

Bar values: Solihull 23.1% (3.2), Birmingham 22.1% (3.5), West Midlands LAs 21.3% (2.8), England 19.7% (2.6)

Legend: ■ % of employers with at least one vacancy ● Average vacancies per establishment with vacancies
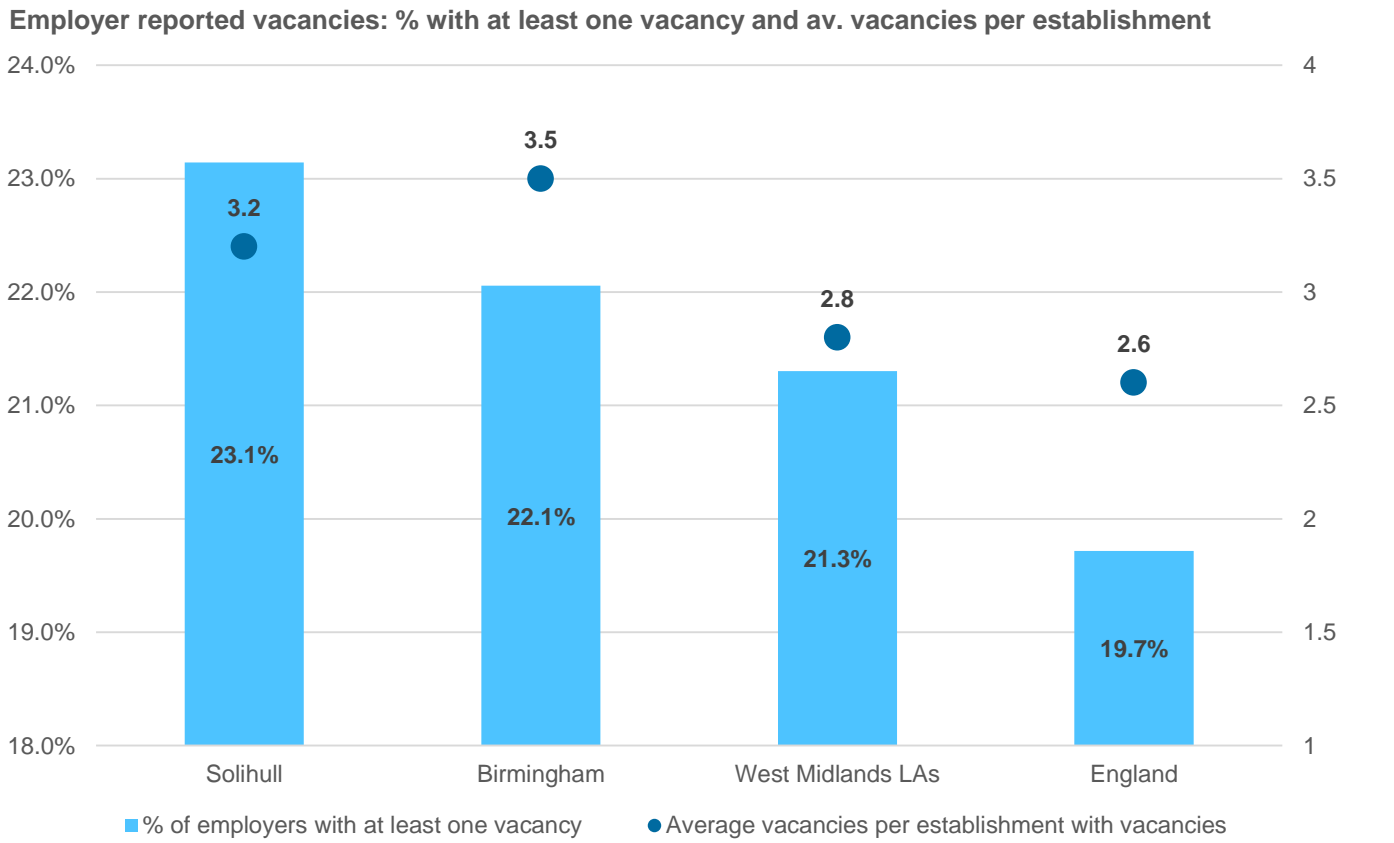
Total vacancies and hard to fill vacancies

Summary of vacancies	Solihull		Birmingham		Combined authorities		England	
Total vacancies	4,096		16,425		36,411		797,440	
Hard-to-fill vacancies	898	21.9%	3,866	23.5%	11807	32.4%	262,337	32.9%

Dataset: *This data is derived from the UK Commission for Employment and Skills (UKCES) Employer Skills Survey, a modelled survey of 91,000 employers,* **Date:** *2015,* **Source:** *UK Commission for Employment and Skills (UKCES)*

Early years, school and FE provision

Key issues

- Schools underperform, but there are differences in outcomes within the area

- HE involvement is relatively low

- Providing young people with better insights into job opportunities could be important

- Big cities can make dramatic improvements in educational outcomes over time

Why is this issue important? A brief review of the literature and local context

Schools' performance has very significant long term economic implications. People entering the school system now will enter the labour market between 2033 and 2035 and leave the labour market around 2075. Improving underperforming schools would represent a major long term economic development strategy in itself.

Evaluation evidence collated for OFSTED (2013) finds that "there is now little doubt that early education for low income and ethnic minority children can contribute importantly to combating educational disadvantages if certain criteria are met". The work indicates that the design of programmes and the approach to pedagogy and curriculum is crucial to success. The review quotes European Union research that "low intensive, low dose, late starting, mono-systemic approaches are less effective overall. A didactic or academic approach in a negative socio-emotional climate may do more harm than good. Early starting, intensive, multi-systemic approaches that include centre-based education and the involvement of trained professionals as a core activity are superior, with impressive long term results and very favourable cost benefit ratios. It is now clear that investing in accessible, high quality, early starting and intensive care and education provisions for young children is socially and economically very profitable" (EACEA 2009, 38). The OFSTED researchers find, though, that the problem is that many targeted early education programmes do not meet the criteria of quality and efficiency and many programmes are often temporary projects and vulnerable to economic trends.

School performance is strongly indicative of future deprivation. Labour Force Survey evidence suggests that the low skilled are at considerably increased risk of deprivation (ODPM). Work by the Treasury has placed skills as the most important determinant of productivity levels (and consequent earning ability). Low levels of basic skills in numeracy and literacy have very negative consequences for national productivity and for the affected individuals.

A culture of learning is something that is required across the range of skills. However, the Leitch Review a decade ago (Leitch 2006) found that this impacts disproportionately on those at the bottom end of the skills market who are disengaged from education at an early age and are trapped in inter-generational cycles of low attainment and low aspiration. The Leitch Review stresses that actions should therefore be targeted at this group of workers. As it is about embedding a culture of learning, some activity should also be directed before disengagement gets too deep. A possible action here may be a greater emphasis on non-cognitive skills. Inter-personal skills, for example, are highly valued by employers but not formally recognized. Carneiro, Crawford and Goodman found that social skills are important because they impact on achievement at schools and also directly on labour market performance. Further they found that there was a greater potential for mobility between quartile bands in social rather than cognitive skills.

Soft skills and a flexible culture of lifelong learning will be critical to create long term economic resilience. Professor Arturo Bris states "that 60% of the jobs for the next generation do not yet exist, and that 1 job in 5 will disappear in the next 5 years." (Bris 2016). The ability to adjust to change will be vital.

EBNS has a young population: there are approximately 98,000 people aged under 19 in EBNS

In Birmingham, birth rates are declining after sustained increase since 2010. Secondary school places are still in excess of demand.

**In Solihull, following a period of steady increase up to 2015, birth rates have been gradually declining.**

There are 131 state schools and nurseries across the EBNS area. EBNS has 86 primary and 28 secondary schools, across two authorities, and under a range of management systems.

In North Solihull there are no state owned nurseries. There are a total of eight state owned nurseries in EBNS, which are all located in East Birmingham.

There are also nine 'all through' schools in EBNS, most of which provide tailored facilities for 5-16 year olds.

Area	EBNS area	Birmingham	Solihull
No. of nursery age	21,120	68,763	9,767
Nursery as % of total pop.	7%	6.3%	4.7%
No. of primary age	35,866	113,213	17,779
Primary as % of total pop.	12.0%	10.3%	8.6%
No. of secondary age	36,700	103,376	18,061
Secondary as % of total pop.	12.3%	9.4%	8.7%

Distribution of schools in EBNS
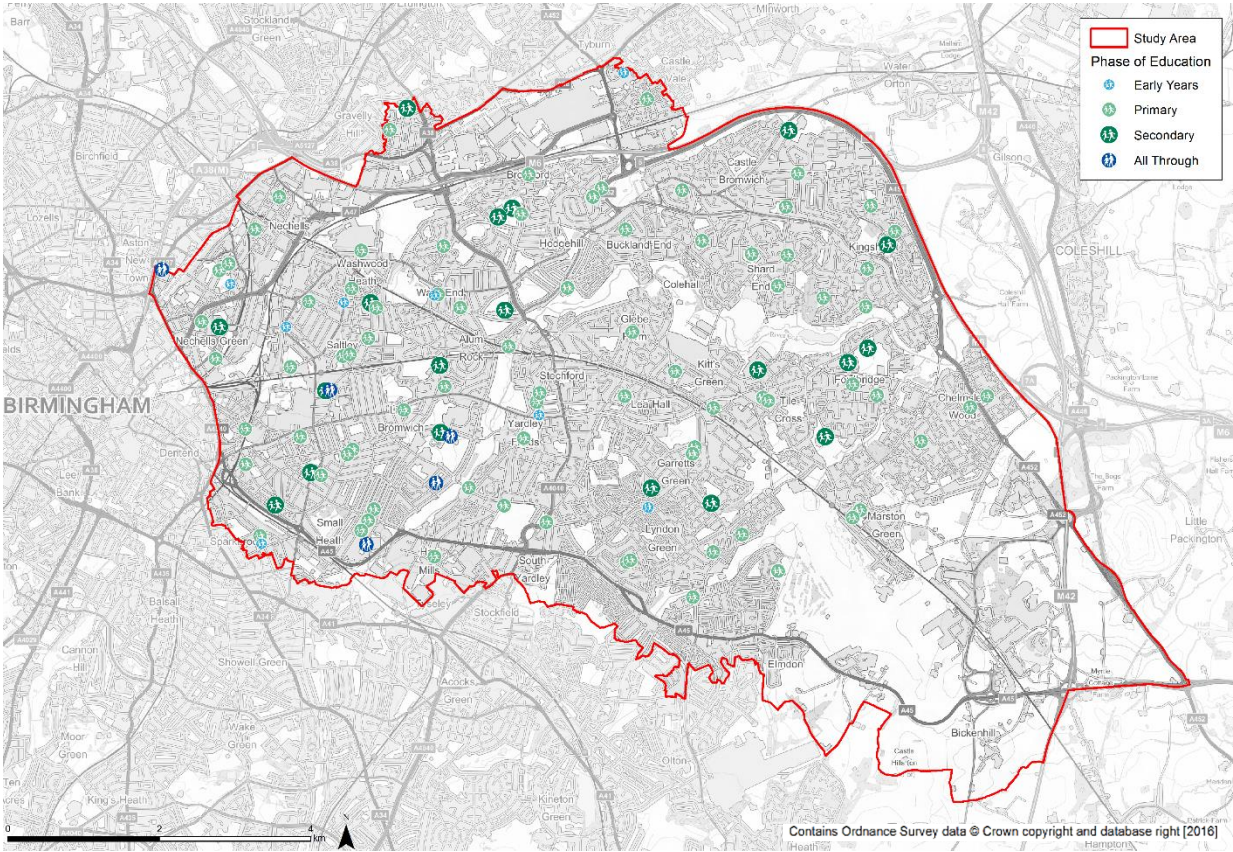
Dataset: *Location of Early Years, Primary, and Secondary facilities in EBNS*
Date: *2017*
Source: *BBC and SMBC*

39

Pupils in the EBNS area are less likely to meet their early years learning goals than those in the wider region and England

Data provided by BCC and SMBC shows that generally the proportion of children achieving a good level of development in EBNS is below the national average.
In East Birmingham, only 61% of early years pupil achieve a good level of development, compared to 64% in the City and 69% nationwide.
North Solihull is only just below the national average at 67%. However, when compared to the rest of Solihull this proportion is low, as the whole of Solihull sits at 72%.

Early years foundation stage (proportion of children achieving a good level of development) in EBNS
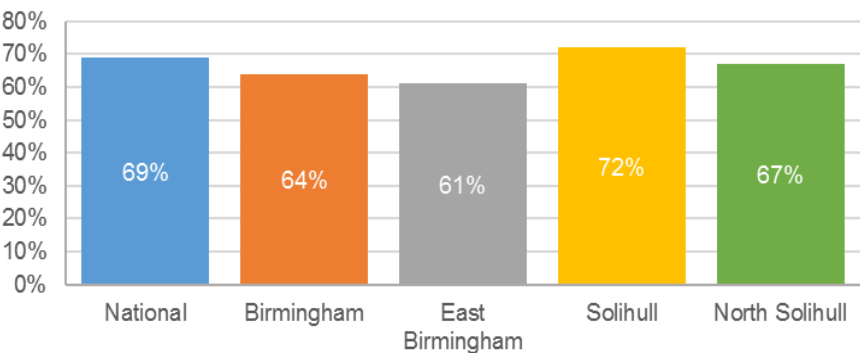
The map shows in yellow the areas considered to be within the top 10% of the UK for EYFS average score per pupil. Overall, EBNS has a lower EYFS score than the individual local authorities or England.
The highest early years score in North Solihull is between Smith's Wood and Castle Bromwich, with a small area towards the north of Bickenhill. There are small pockets of Washwood Heath which are considered within the UK top 10% of EYFS scores.

Distribution of Early Years Foundation Stage scores
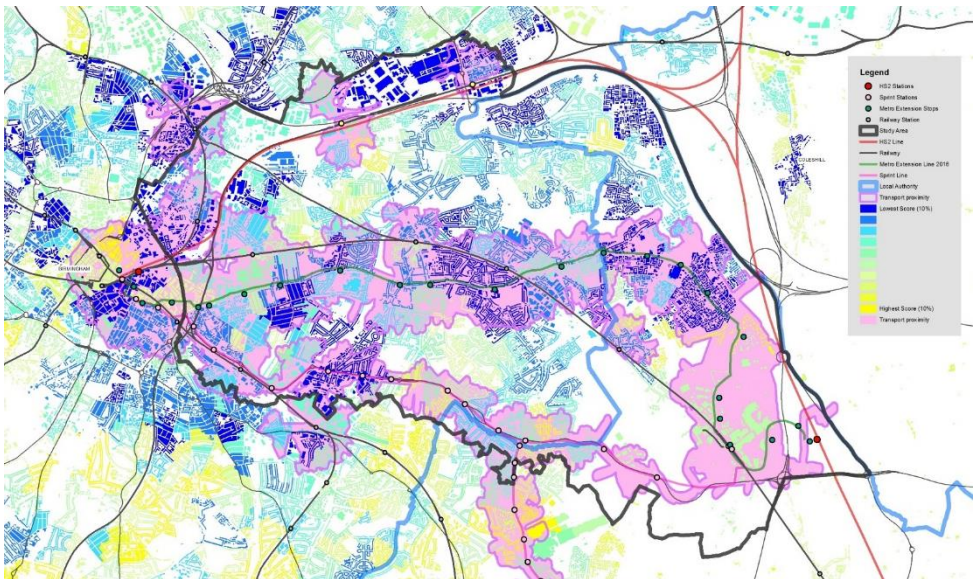
Dataset: *Average Point Score per pupil at the Early Years Foundation stage (an assessment of pupils in foundation year at school (aged 4 to 5).There are 7 areas of learning covering 17 early learning goals (ELGs). A child is scored 1 for emerging, 2 for expected, and 3 for exceeded. Therefore the minimum score is 17 points and the maximum possible score is 51 points.*
Date: *2013/14*
Source: *Department for Education (DfE)*

Area	Early Years Foundation Stage (EYFS) average point score
EBNS study area	32.0
Birmingham LA	33.3
Solihull LA	34.5
WMCA constit LAs	33.0
England	33.9

In the Birmingham part of EBNS, there is a 66% take up of Early Education Entitlement for eligible 2 year olds and 88% for 3-4 year olds. This is lower than the Birmingham city wide take up

Information from BCC has shown that the take up of early years education in the East Birmingham part of EBNS is lower than the city-wide take up.
The graphs shows the two year old Early Education Entitlement (EEE), revealing the proportion of children that are eligible for EEE, and the percentage of those that are eligible that are accessing EEE. There are certain wards which match the city-wide take up, but most are lower. Take-up is at its lowest in Bordesley Green, where only 61% of those that are eligible are accessing EEE. For the take up of EEE at 3-4 year old level Bordesley Green and Shard End show the lowest take up at 83%.

The information displayed for North Solihull cannot be directly compared with that for East Birmingham. However, it does show the different take up of early education amongst 2-4 years olds.
In North Solihull, Smith's Wood has the lowest take up of early years education, at 39% for two year olds, and only 17% for 3-4 year olds.

The EYFSP summarises and describes pupils' attainment at the end of the EYFS.

The purpose of the assessment is to gain insight into levels of children's development and their readiness for the next phase of their education

The EYFSP gives: the pupil's attainment in relation to the 17 early learning goals (ELG) descriptors; and. a short narrative describing the pupil's 3 characteristics of effective learning

"Good Level of Development" is a standard way of measuring performance. A child achieves GLD if they achieve "expected level" in:
- the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and;
- the early learning goals in the specific areas of mathematics and literacy.
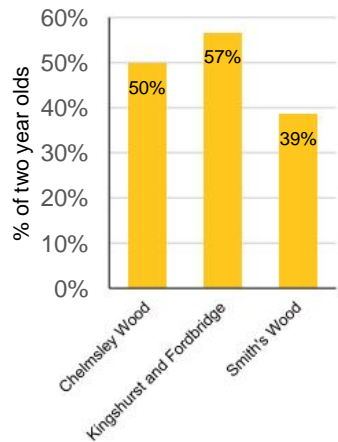
Two year old Early Education take-up (North Solihull wards)
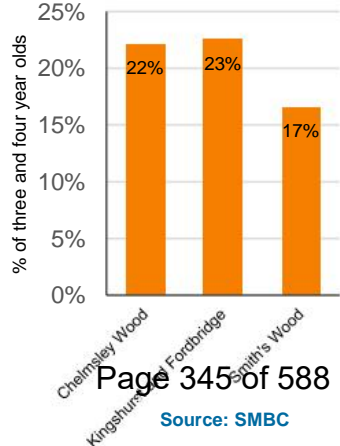
Two year old Early Education Entitlement (East Birmingham wards)
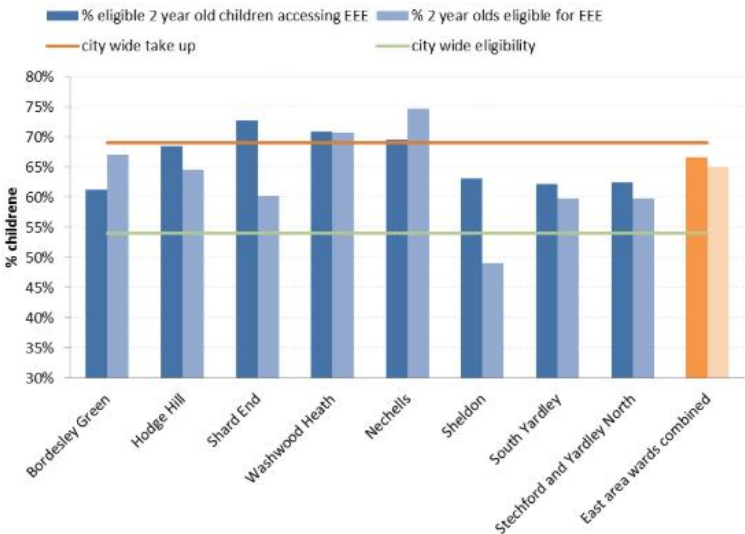
Three and four year old Early Education take-up (North Solihull wards)

Source: SMBC

Three and four year old Early Education Entitlement (East Birmingham wards)

Source: BCC

41
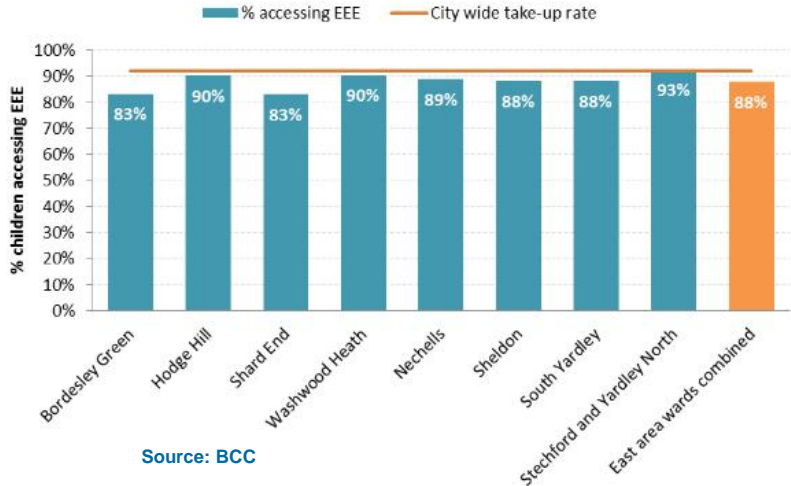
Key Stage 1 results are also slightly lower than the England average. The LSOAs ranked with the lowest scores roughly align with the proposed route of the metro line

As shown by the table below, the EBNS area scores the lowest on average point score at Key Stage 1 compared to regional and national comparators.

The map shown the results of the Key Stage 1 examinations, revealing that Castle Bromwich is one of the best performing areas in EBNS.

Following a similar pattern to the unemployment data described previously, there are large clusters of the EBNS area, particularly in the east and south east, which are within the lowest 10% of England's LSOAs.

Area	Key stage 1 pupils average point score
EBNS study area	15.5
Birmingham LA	15.6
Solihull LA	16.7
WMCA constit LAs	15.7
England	15.9

Key Stage 1 examination results
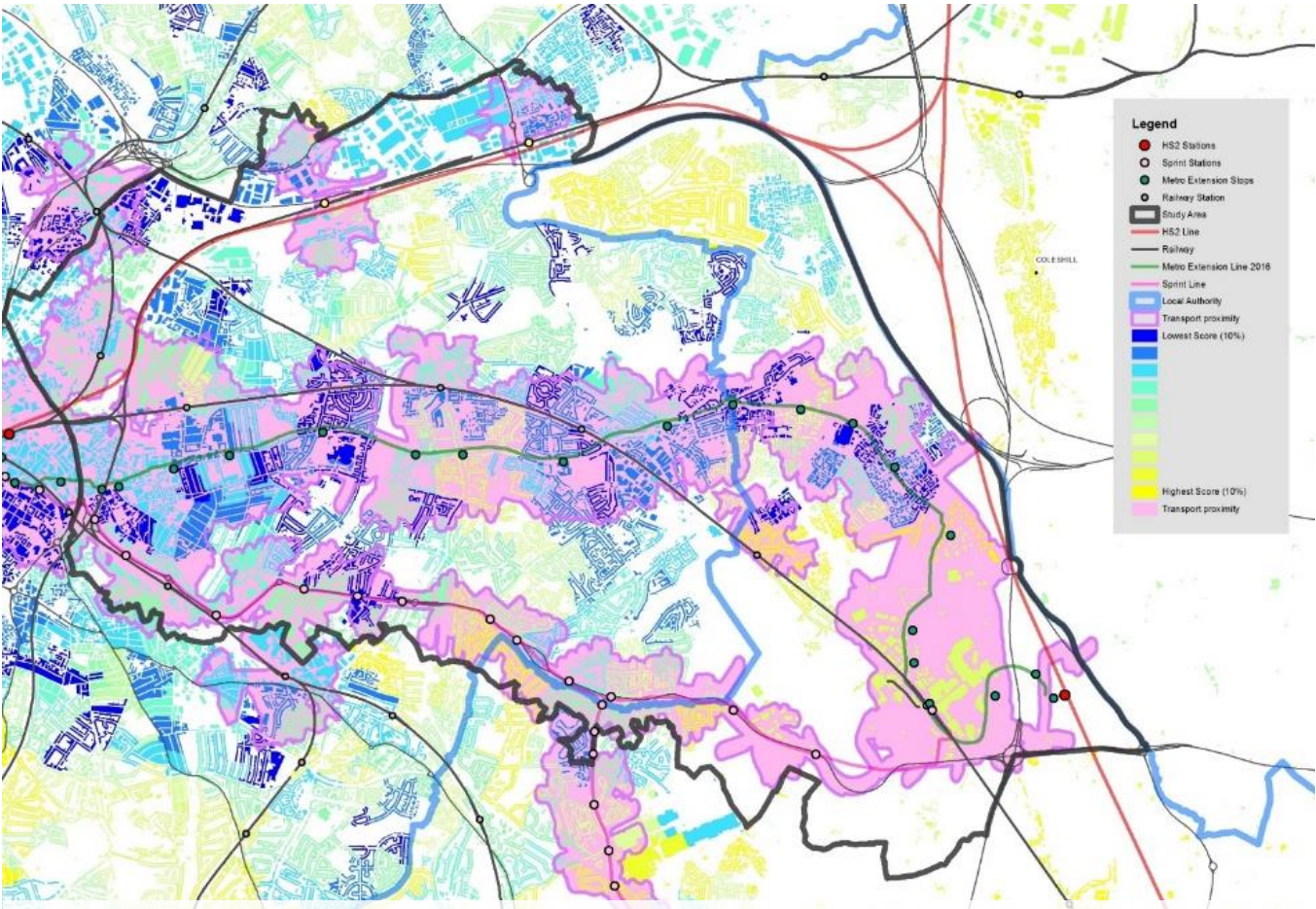
Dataset: Average Point Score per pupil for pupils sitting Key Stage 1 (KS1) examination assessments. KS1 is the National Curriculum standard test for seven year olds. This is made up from the Reading, Writing, Mathematics and Science point scores.
Date: 2013/14
Source: Department for Education (DfE)

42

Key Stage 2 pupils are less likely to achieve the expected levels of development than elsewhere. This is more widespread than in KS1 and affects pockets of the EBNS area

Within North Solihull, the poor areas of attainment are clustered near Kingshurst and Fordbridge, and in East Birmingham it is nearer the City.

Overall Solihull LA has a high level of attainment at KS2. The EBNS area has a low level of attainment in KS2 reading, writing and maths, at only 71.5% against a national average of 78%.

In East Birmingham, when the different subjects are broken down, the gap between the expected standard and what is achieved for reading is 13%.

Area	Pupils achieving Key Stage 2, Level 4 in Reading, Writing and Maths (2013/14)
EBNS study area	71.5%
Birmingham LA	75.0%
Solihull LA	80.0%
WMCA constit LAs	76.3%
England	78.0%

Key Stage 2 examination results
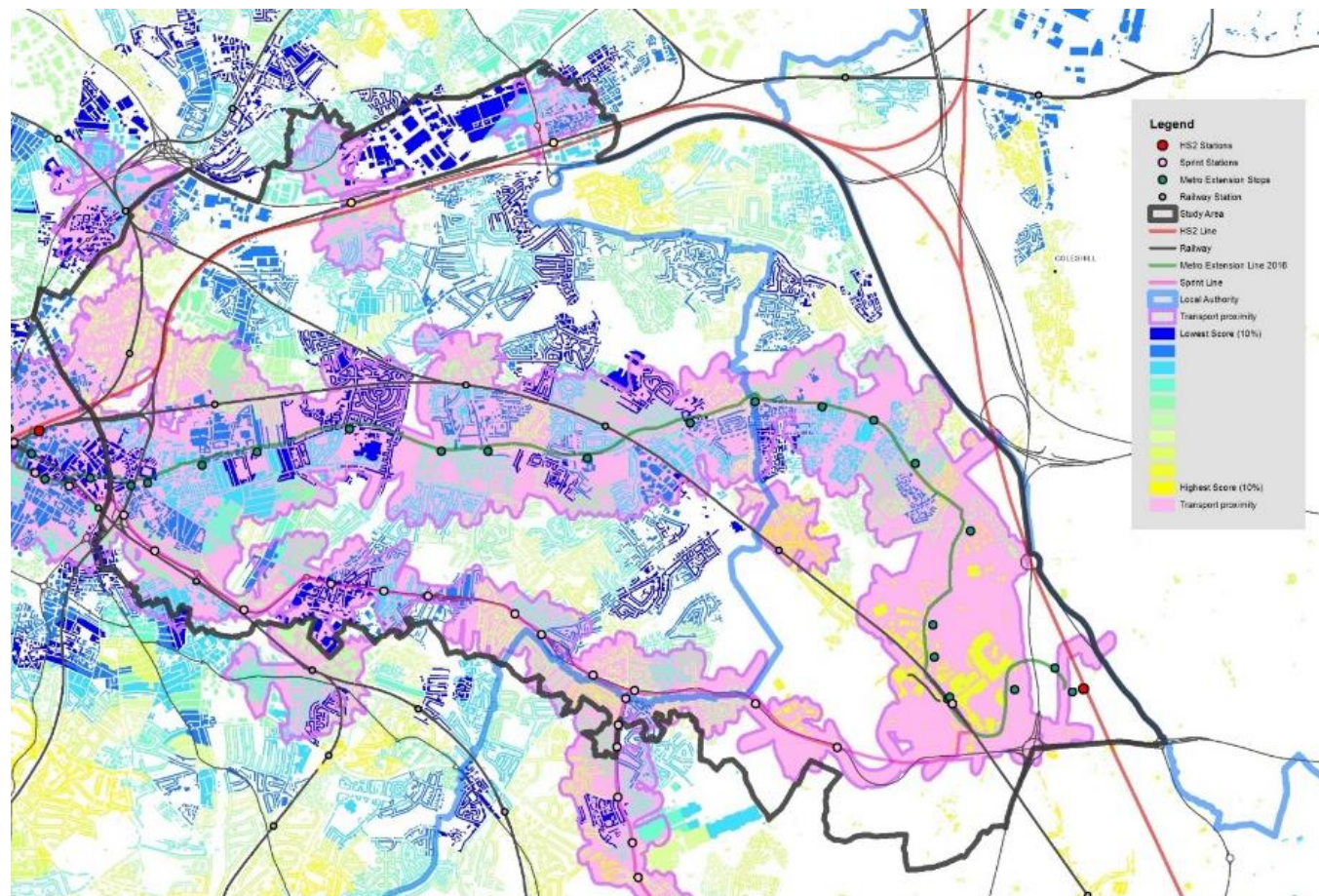
Dataset: *The proportion of pupils achieving level 4 in Reading, Writing and Mathematics at Key Stage 2 (KS2). Level 4 is the expected level for most 11 year olds.*
Date: *2013/14*
Source: *Department for Education (DfE)*

43

GCSE results are lower in the EBNS area on average than across England. The areas which are ranked within the lowest 10% of English SOAs include part of Castle Bromwich, Smith's Wood, Kingshurst, Fordbridge, Shard End and Shelton

It is clear from the table below that the GCSE score per pupil in EBNS is significantly lower than elsewhere.

Solihull LA has a higher GCSE average point score per pupil than the national average, showing that the rest of the LA does not face the same issues as North Solihull.

At GCSE level, the worst performing areas are in the very east of Birmingham and the north west of North Solihull.

Key Stage 4 examination results

Area	GCSE average point score per pupil
EBNS study area	318.6
Birmingham LA	356.2
Solihull LA	399.3
WMCA constit LAs	353.1
England	368.0
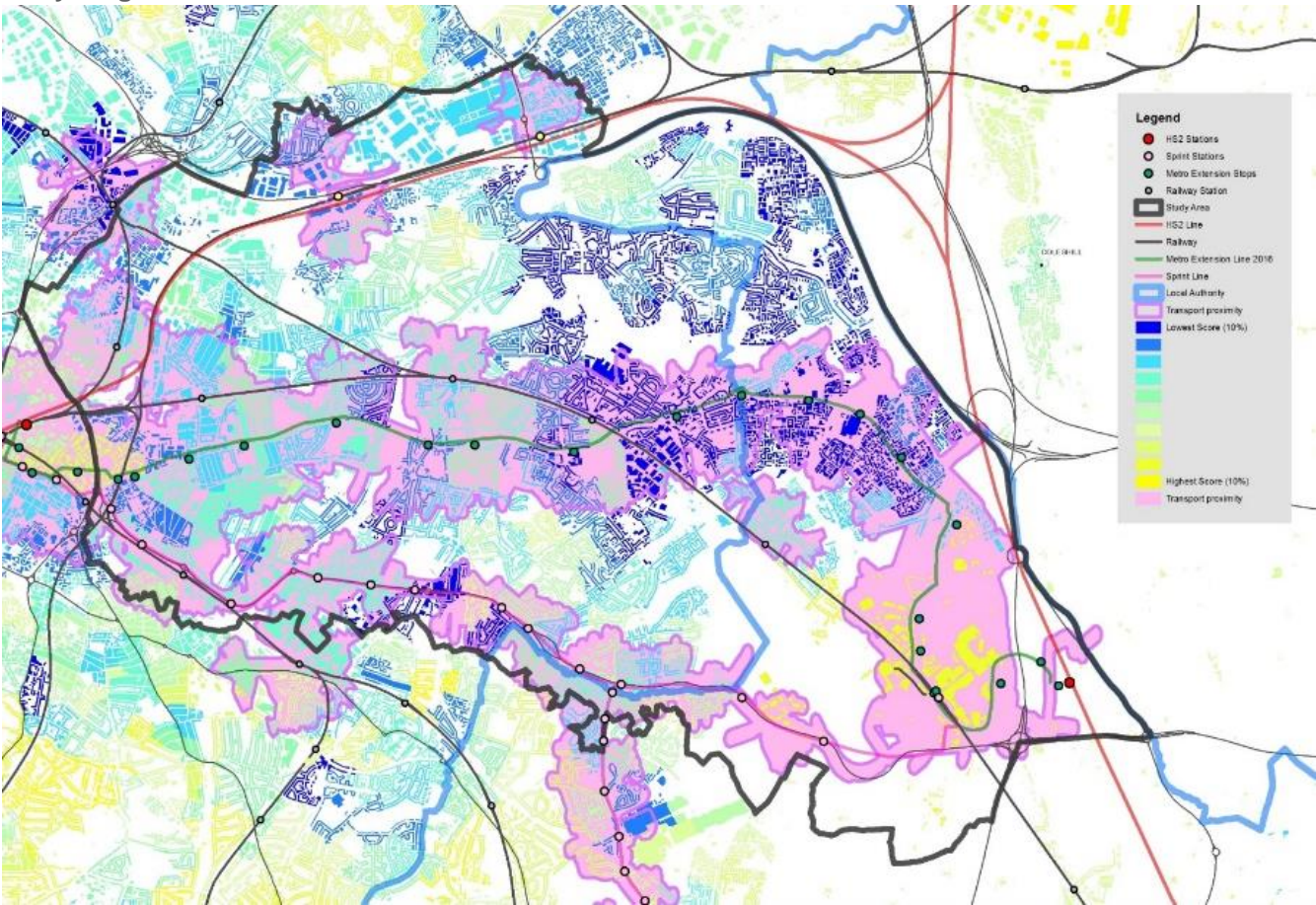
Dataset: *Average Point Score per pupil for pupils sitting Key Stage 4 (GCSEs) exams. Average Point Score is a measure of the average attainment of pupils across all subjects for pupils resident in the local area. At Key Stage 4, Average Point Score is made up of all GCSE examinations sat, with a point score of 58 awarded to those receiving and A*, 52 for those with an A, 46=B, 40=C, 34=D, 28=E, 22=F, 16=G. These scores are added up for all pupils and all subjects and divided by the number of pupils in the area.*

Date: 2013/14

Source: *Department for Education (DfE)*

GCSE results (A*-C) in the EBNS were improving at a faster rate than the national average between 2005 and 2013, but EBNS saw a larger fall between 2012 and 2014 than across the comparator areas

The table below shows that Birmingham, Solihull and England all experienced a decline in the proportion of pupils achieving a GCSE grade between 2011/12-2013/14. The decline in the EBNS area was much more significant than that for England and Solihull, but in line with that for Birmingham.

The dip in the EBNS data in 2010 is an anomaly; it was caused by one of the schools not using an English qualification that officially counted within the performance tables.

Area	Change in % gaining GCSE grades A*-C between 2011/12 and 2013/14
EBNS study area	-6.9
Birmingham LA	-6.4
Solihull LA	-3.5
WMCA constit LAs	-6.5
England	-3.2

A-C GCSE grades by location 2004/05-2013/14

Legend: EBNS area — Birmingham — Solihull — Combined authority — England

Y-axis: Pupils achieving 5+ A*-C including English and Maths

X-axis: 2005-06, 2006-07, 2007-08, 2008-09, 2009-10, 2010-11, 2011-12, 2012-13, 2013-14
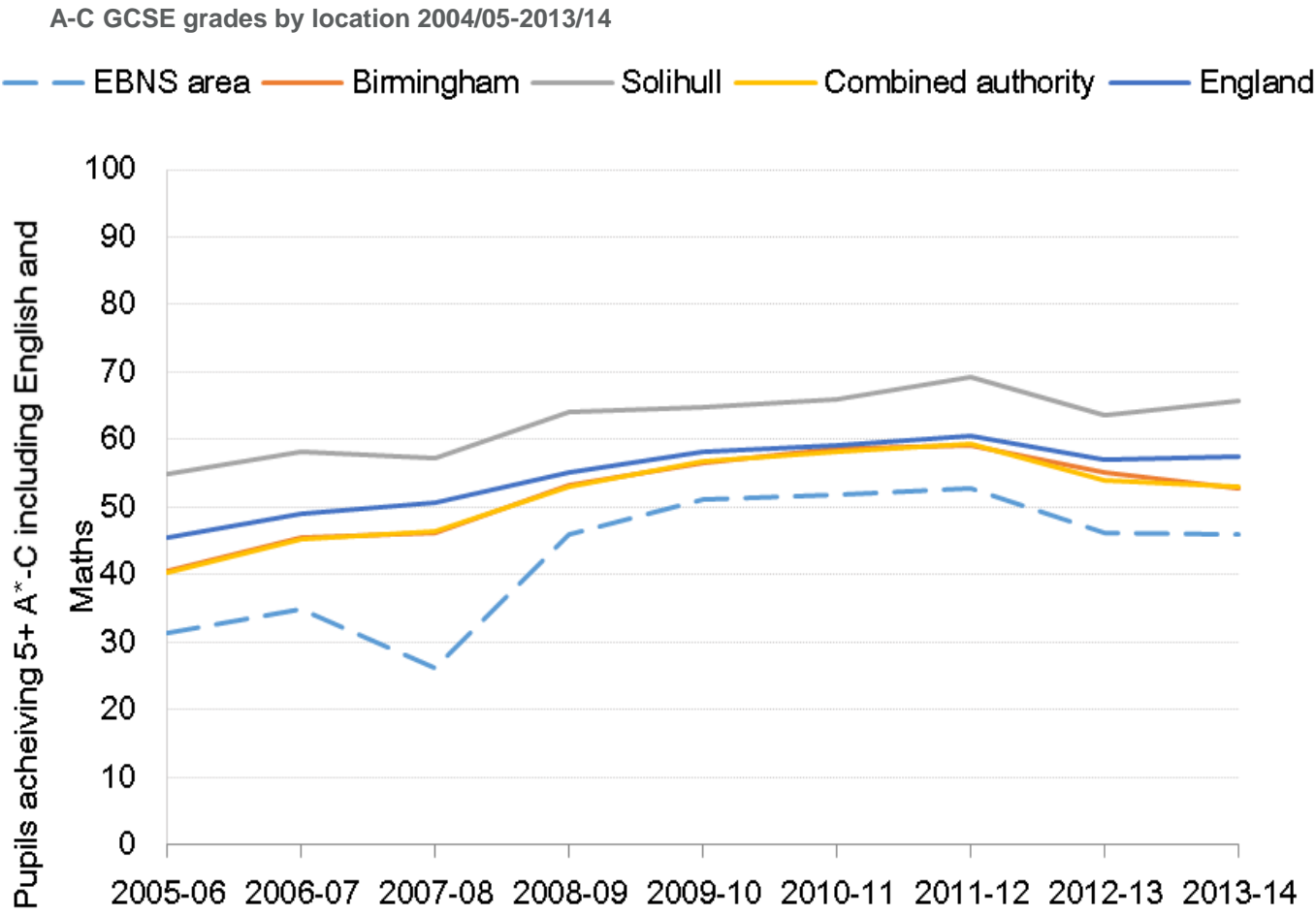
Dataset: *Pupils achieving % GCSE grades A*-C by location of pupil residence*
Date: *2004/05 to 2013/14*
Source: *Department for Education (DfE)*

Data suggest that there are different 'trajectories of success' by areas within EBNS. Bordesley Green educational outcomes improve from early years, Key Stage 2 and Key Stage 4 (GCSE). In Chelmsley Wood, early years pupils begin disadvantaged, improve during primary stages, but slip back at GCSE

Bordesley Green Early Years

Bordesley Green Key Stage 2

Bordesley Green Key Stage 4 (GCSE)

Chelmsley Wood Early Years

Chelmsley Wood Key Stage 2

Chelmsley Wood Key Stage 4 (GCSE)

Legend
- HS2 Stations
- Sprint Stations
- Metro Extension Stops
- Railway Station
- Study Area
- HS2 Line
- Railway
- Metro Extension Line 2016
- Sprint Line
- Local Authority
- Transport proximity
- Lowest Score (10%)
- Highest Score (10%)
- Transport proximity
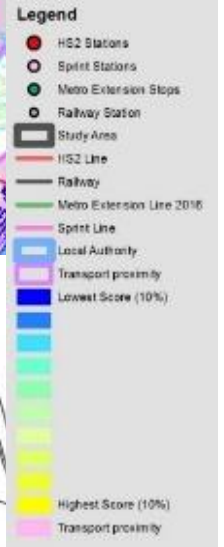
The data suggests that there is an encouraging picture of improvement in Bordesley Green, where pupils start with relative disadvantages but gradually catch up, and perform relatively well at GCSE. Performance in Chelmsley Wood improves, but then falls back at GCSE. More detailed work would be needed on underlying reasons, but we understand that, in Bordesley Green, English is sometimes not spoken at home, and childcare take-up is low. Improvements are made through the primary sector, and through some strong secondaries and 'through schools'. In contrast, some of the stronger performing secondary schools and a pro-education home culture might not be in place to the same extent in parts of North Solihull.

46

According to the most recent Ofsted ratings, 71% of schools and nurseries in EBNS are rated Good or Outstanding, compared to 89% in England

The most recent Ofsted data shows that there is a significant proportion of schools and nurseries in EBNS rated as requires Improvement or Inadequate. There are 29% of these schools in EBNS compared to 11% in England.

All of the Inadequate schools are located within East Birmingham. The map to the right shows that the schools rated poorly by Ofsted cluster within Small Heath and near Lea Hall.

Generally, the Good schools are evenly distributed throughout EBNS. There is a significant cluster of Outstanding facilities in Nechells Green. All nurseries in EBNS are considered Good or Outstanding. This is compared to 75% of primary and 54% of secondary schools.

Ofsted rating in EBNS

Bar chart comparing EBNS and England:
- Outstanding: EBNS 20%, England 21%
- Good: EBNS 51%, England 68%
- Requires improvement: EBNS 20%, England 9%
- Inadequate: EBNS 9%, England 2%
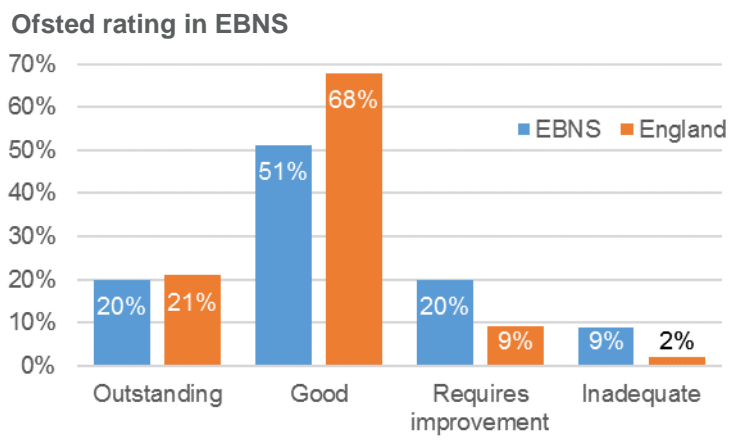
Location of schools and their Ofsted rating in EBNS

Legend:
- Study Area
- Ofsted Rating
  - Outstanding
  - Good
  - Inadequate
  - Requires Improvements
  - No Ofsted Report Published

Contains Ordnance Survey data © Crown copyright and database right [2016]
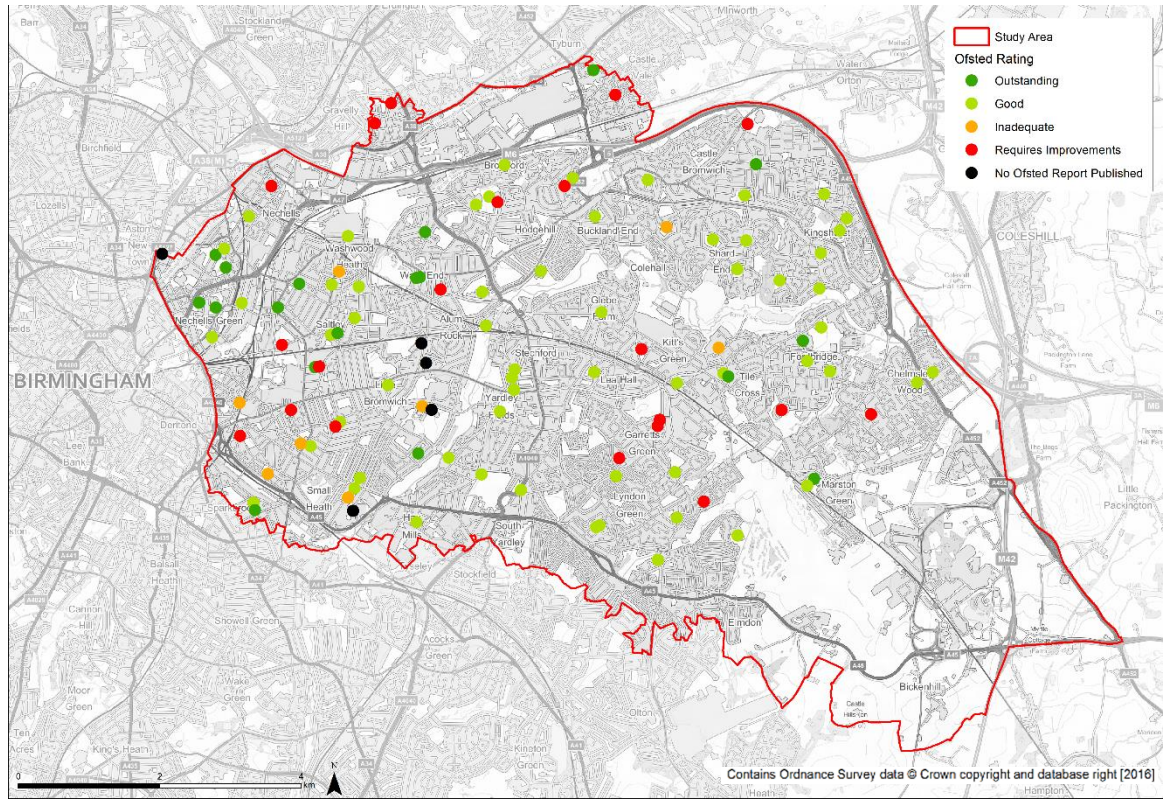
Dataset: The most recent Ofsted ratings for EBNS schools and nurseries
Date: *2017*
Source: *Ofsted*

47

In EBNS, there appears to be no clear relationship between area deprivation as ranked on the Index of Multiple Deprivation and OFSTED ratings

The map shows the Index of Multiple Deprivation with the Ofsted ratings of schools and nurseries in EBNS.

Not all poorly rated schools are in deprived areas. For example, Park Hall Academy in Castle Bromwich was rated 'requires improvement', but it is not located within one of the significantly deprived areas.

Furthermore, some of the highest rated facilities are within highly deprived areas, for example, the schools in Nechells.

School Ofsted ratings and the IMD
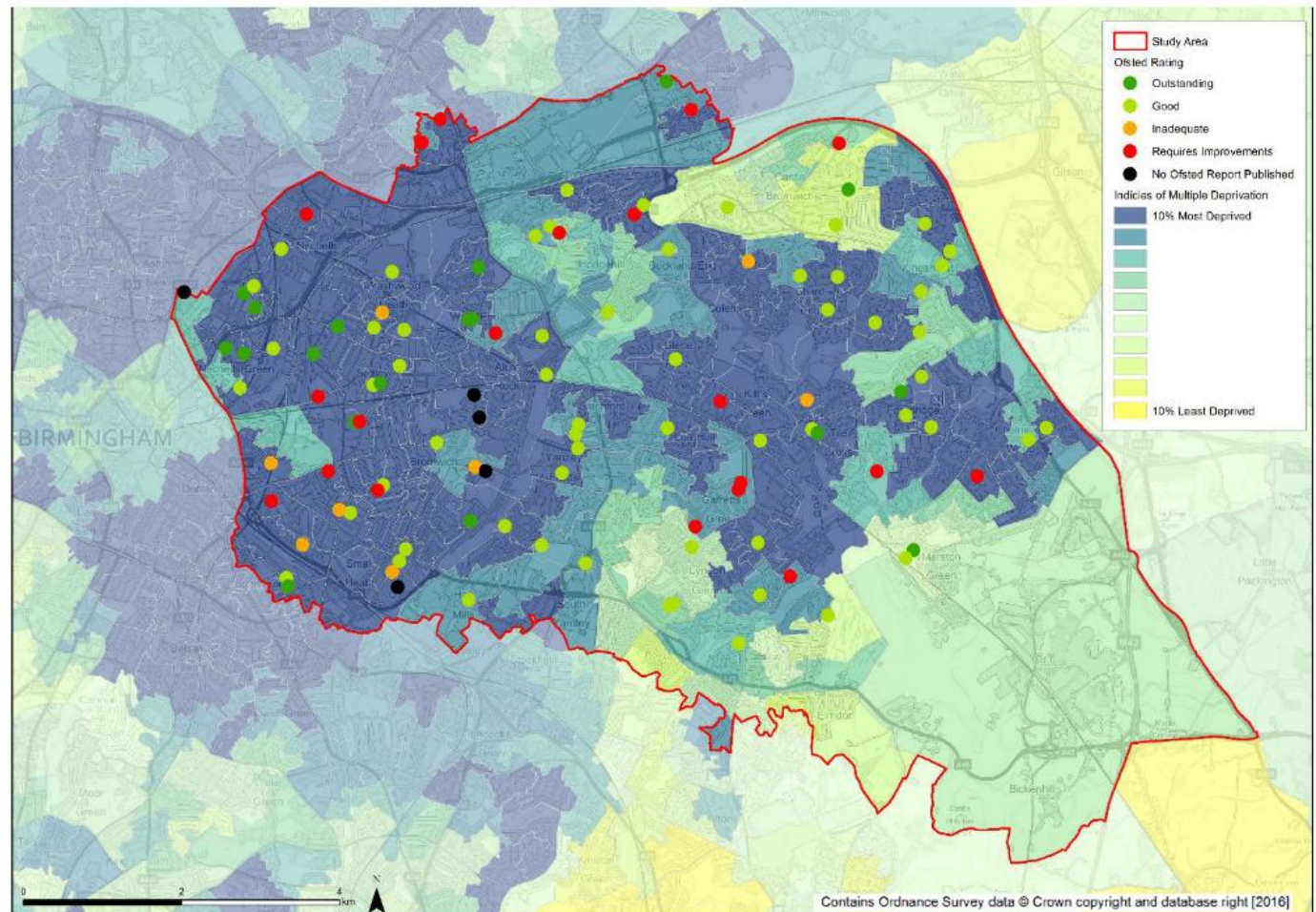
Dataset: The most recent Ofsted ratings for EBNS schools and nurseries, overlaid with the rank of the Index of Multiple Deprivation
Date: *2017*
Source: *Ofsted and IMD*

There are a range of schools with sixth forms and sixth form colleges, but these are unevenly dispersed throughout EBNS

There are eight schools and colleges providing sixth form facilities in North Solihull, and in East Birmingham there are seven.

The map shows that there are no sixth form facilities in the centre of EBNS. In North Solihull the facilities tend to cluster between Fordbridge and Lea Hall, with near to no provision in the rest of the area.

Location of secondary schools and colleges with sixth form facilities

Secondary Schools with Sixth Forms
01. Bordesley Green Girls School and Sixth Form
02. Braidwood Trust School for the Deaf
03. CTC Kingshurst Academy
04. Grace Academy Solihull
05. Hallmoor School
06. Hodge Hill Girls School
07. Hodge Hill Sports and Enterprise College
08. John Henry Newman Catholic College
09. Park Hall Academy
10. Saltley Academy
11. Small Heath Upper School
12. Smith's Wood Sports College
13. The International School
14. Washwood Heath Academy
15. Waverley School
16. WMG Academy

Dataset: Location of secondary schools and colleges with sixth form facilities in EBNS
Date: 2017
Source: BCC and SMBC

49

Contains Ordnance Survey data © Crown copyright and database right [2016], Use Types and Vacant Previous Use within Primary Shopping Areas - Resurvey 2015-16 (Birmingham centres), Solihull Retail Study Health Check Appendices (2011)

London has achieved significant improvements in schools performance in the last 17 years.   Can EBNS learn from this experience and do the same?

London schools have improved significantly since 2000, at a faster rate than anywhere else in the country.

Some explanations suggest that improvements in KS4/GCSE results are best ascribed to changes in primary school attainment from year 2000 onwards (IFS/Institute for Education 2014). Later research by an IFS/LSE team (2015) suggests that the "London effect" for poor children began in the mid-1990s – well before many of the high-profile policies in secondary schools previously credited with London's success, such as the London Challenge, Teach First, and the growth of academies. This research suggests that improved performance largely reflects gradual improvements in school quality over time. Improvements in primary schools played a major role in explaining later improvements in secondary schools.

Other research disagrees (Centre for London, CBFT 2014). These researchers suggest that four key school improvement interventions *did* provide the impetus for improvement - London Challenge, Teach First, the academies programme and improved support from local authorities was responsible for the change, and identifies common features that link together all of these interventions:

* a focus on data and data literacy

* a culture of accountability

* the creation of a more professional working culture

* a collective sense of possibility and highly effective practitioner led professional development.

* effective leadership at every level of the system.

Whatever the underlying cause of change, Birmingham could look at how to replicate these changes. There is clearly no certain relationship between deprived areas and poor educational outcomes. Social Mobility and Child Poverty Commission (2014) reported on the relationship between

disadvantage and education provision: "Some schools seem to have learnt the secret of how to alleviate the impact of background on life chances. They have found a way of overcoming the barriers that impede social mobility. At a time when social mobility is stalling and child poverty is rising, there is an urgent need to share the lessons so that every school can crack that code."

The key findings of the report were that the wide variation in results between schools with similar intakes shows that there is a lot of scope to raise performance. Secondly, some schools will need to shift their focus towards core academic subjects and raising attainment across the whole ability range to avoid falling in national league tables and - most importantly - to improve social mobility for their pupils. Thirdly, some teachers' expectations of students from disadvantaged backgrounds are too low and getting the best teachers to teach in the worst schools requires stronger incentives, including higher pay. And finally, schools could

> A) use the Pupil Premium strategically to improve social mobility
> B) build a high expectations, inclusive culture
> C) incessantly focus on the quality of teaching
> D) tailor strategies to engage parents
> E) prepare students for all aspects of life - not just for exams

Change in proportion of pupils eligible for FSM achieving five or more GCSEs at A*–C including English and maths (or equivalent), across London local authorities, 2002–12
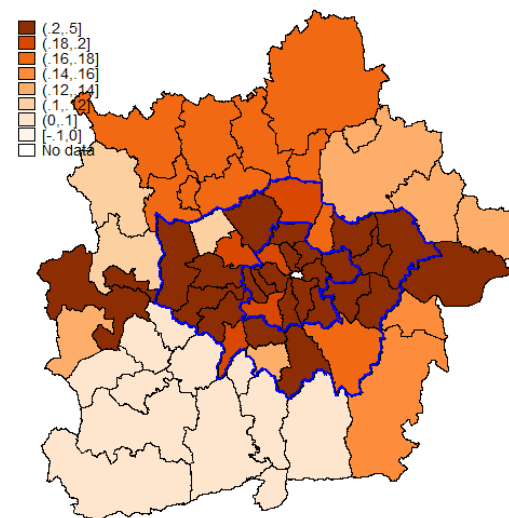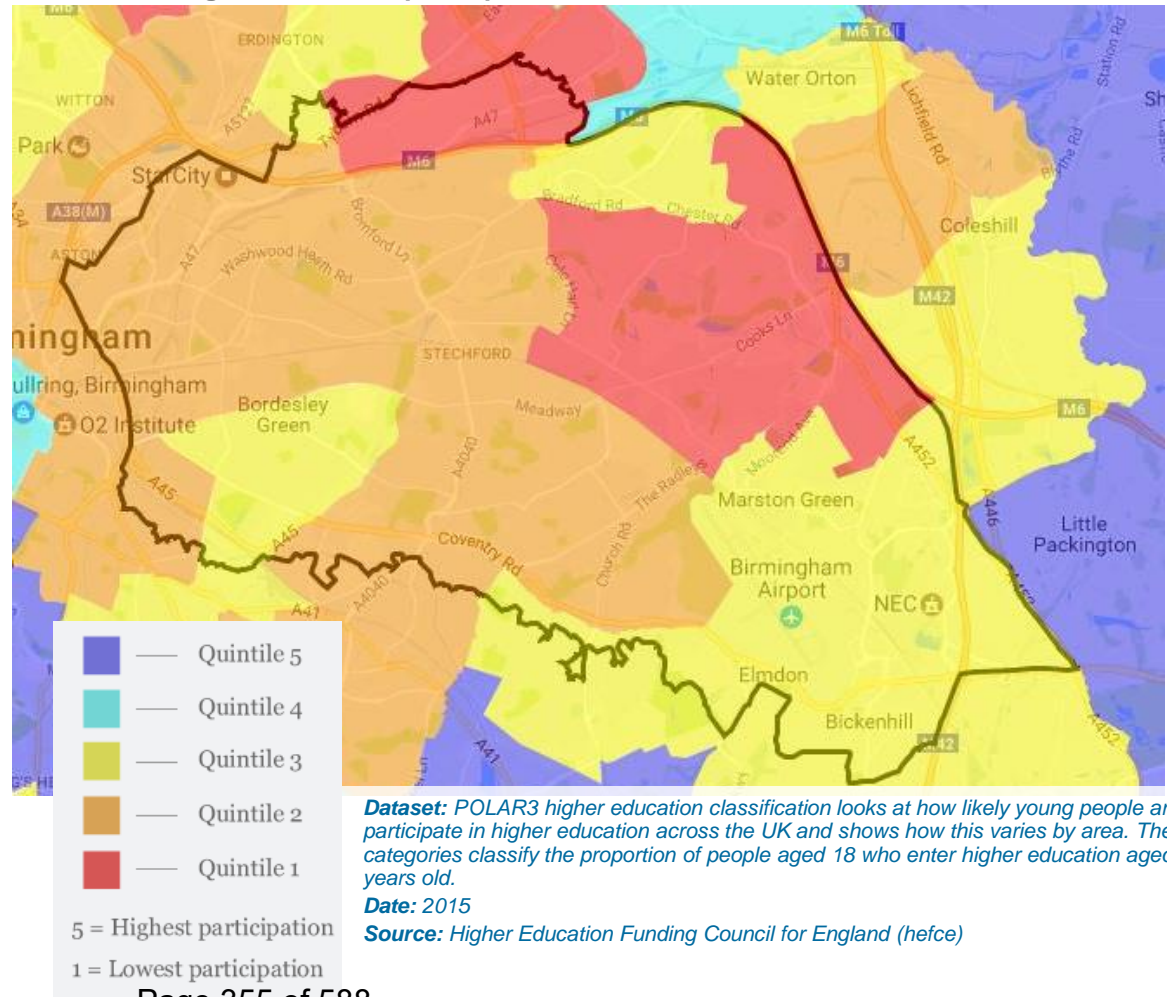
The EBNS area has low levels of higher education participation amongst 18 and 19 year olds

HE (Higher Education) refers to courses for which the level of instruction is above that of level 3 of National Qualifications Framework - mainly people studying for degrees.
Some areas have reasonable access rates (southern parts of Bordesley Green and Castle Bromwich) but there are pockets of very poor rates of access, particularly around Chelmsley Wood.

Area	HE participation (%)	POLAR3 Quintile
Acock's Green (B)	23.2	2
Hodge Hill (B)	25.1	2
Nechells (B)	26.0	2
Shard End (B)	11.0	1
Sheldon (B)	23.1	2
Small Heath (B)	30.0	3
Washwood Heath (B)	23.0	2
Yardley (B)	26.3	2
Bickenhill (S)	31.4	3
Castle Bromwich (S)	33.1	3
Chelmsley Wood (S)	11.1	1
Fordbridge (S)	11.2	1
Kingshurst (S)	12.4	1
Smith's Wood (S)	10.7	1

POLAR3 Higher Education participation

Quintile 5
Quintile 4
Quintile 3
Quintile 2
Quintile 1

5 = Highest participation
1 = Lowest participation

Dataset: POLAR3 higher education classification looks at how likely young people are to participate in higher education across the UK and shows how this varies by area. The categories classify the proportion of people aged 18 who enter higher education aged 18 or 19 years old.
Date: 2015
Source: Higher Education Funding Council for England (hefce)

51

There are two Further Education (FE) providers in the study area (South & City College at Bordesley Green, and Solihull College Woodlands Campus). FE provision is hard to reach on public transport for some people

Location of further education facilities in EBNS, and current transport isochrones (isochrone centred on both facilities)

The only FE facilities in EBNS are located at Bordesley Green (South & City College) and Smith's Wood (Solihull College). As was shown with sixth form provision, FE facilities are non existent in the centre of EBNS.

The map shows the location of these FE facilities and the 10, 20, and 30 minute public transport isochrones for accessing them. This shows that people living in the north area of EBNS (Tyburn) and to the west of the airport (Sheldon), would have to travel for longer than 30 minutes to reach these FE facilities.

It is interesting to note that Tyburn and Sheldon both have significant levels of NEETs, at 7.4% and 5.4% respectively.
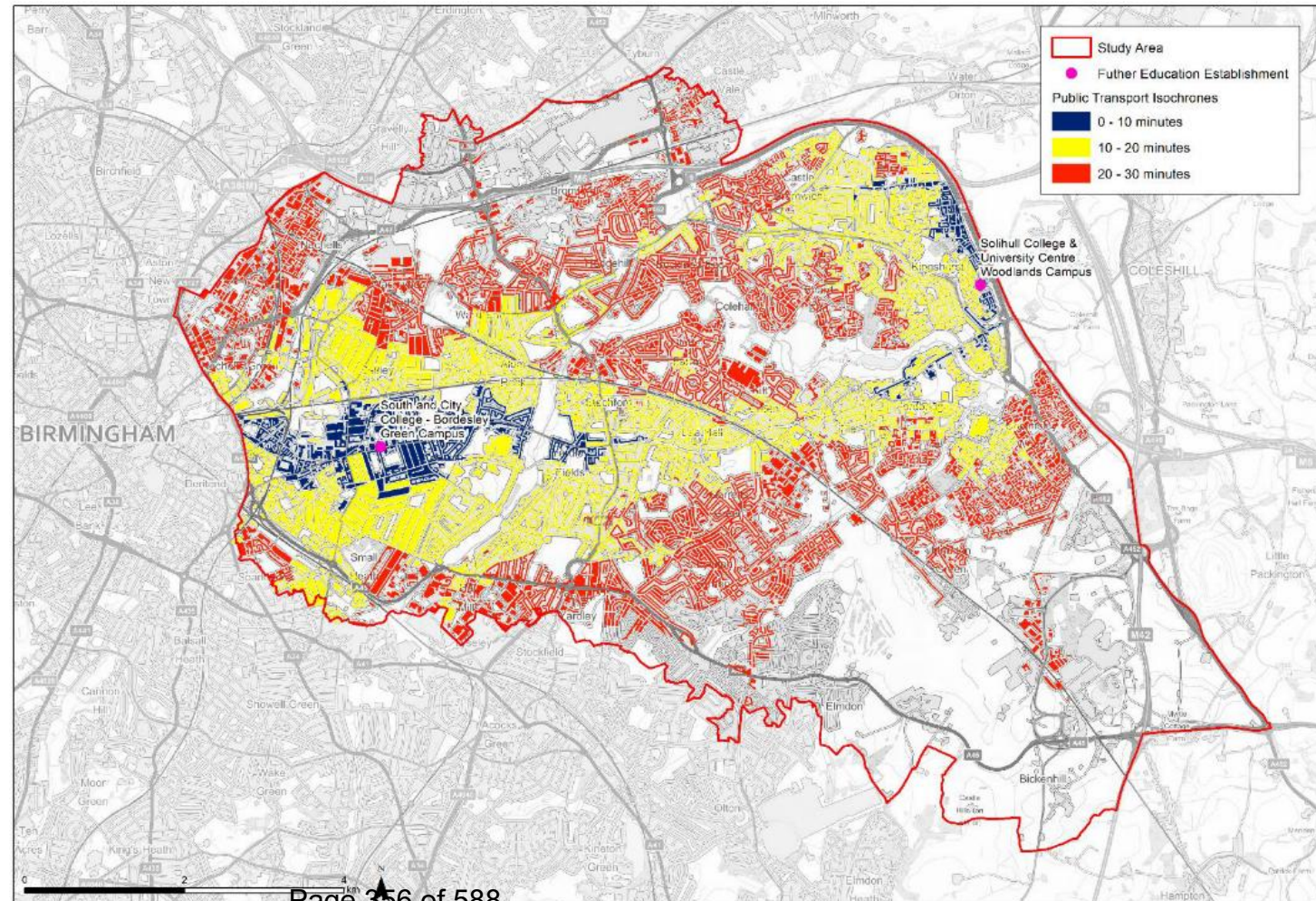
Dataset: *Location of FE facilities and existing public transport isochrones in EBNS*
Date: *2017*
Source: *BCC and SMBC*

52

Research elsewhere highlights the importance of clear 'lines of sight' from school to the workplace via high quality careers provision with employer engagement

London Councils have pulled together London Ambitions: Shaping a successful careers offer for all young Londoners (2015). The document was written by Dr Deirdre Hughes OBE, University of Warwick, Institute of Education Research. It states that "parents, employers, schools, colleges, training providers, universities and career development specialists - all will need to work together to keep up-to-date with and communicate effectively on fast changing education and labour markets."

The document sets out seven evidence-based recommendations to establish a coherent framework for young people, and these might provide a good starting point for work in Birmingham, Solihull and the West Midlands. Those recommendations are as follows.

1. Every young person should have access to impartial, independent and personalised careers education, information, advice and face-to-face guidance in their local community.

2. Every young person should have completed at least 100 hours experience of the world of work, in some form, by the time they reach the age of 16. This may include career insights from industry experts, work tasters, coaching, mentoring, enterprise activities, part-time work, and other relevant activities.

3. Every secondary school and college should have in place an explicit publicised careers policy, reviewed by the governing body at least every three years. All schools and colleges should also report annually on delivery of the careers policy and curriculum.

4. Every good institution will have a governor with oversight for ensuring the organisation supports all students to relate their learning to careers and the world of work from an early age.

5. Every secondary school and college should have up-to-date, user-friendly labour market intelligence/information (LMI) readily accessible by young people, teachers and parents/carers.

6. The quality of careers provision should be strengthened by developing 'careers clusters' to share resources in improving awareness of the labour market and supporting school and college leaders in a whole-school approach to plan and deliver careers provision.

7. An 'Ambitions Portal' should enable more schools and colleges to easily find high-quality careers provision designed to support career development.

100 hours experience in the world of work
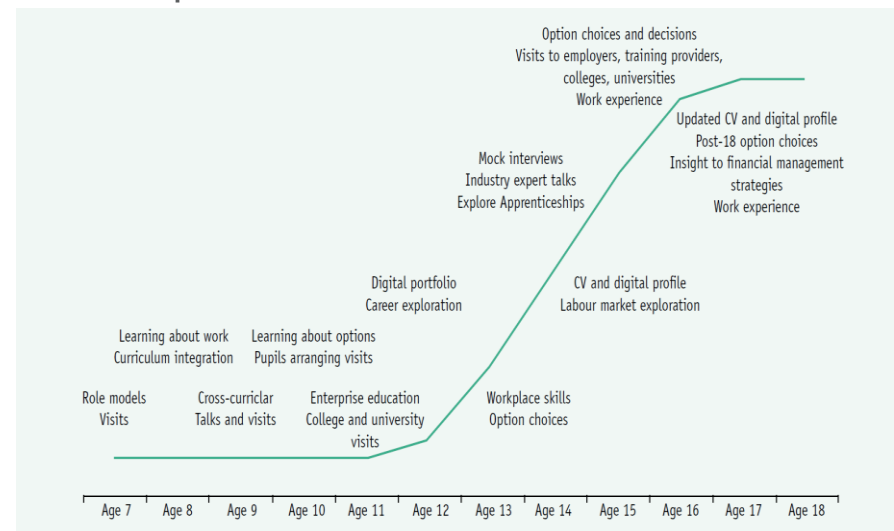
Source: London Councils (2015) *London Ambitions*

Further education (FE) is undergoing a number of changes, in EBNS and across the sub-region. A virtual 'Institute of Technology' is being set up and the National College for High Speed Rail is opening on the EBNS boundary

Nationally, further education is being challenged to simplify and streamline its provision. The Independent Panel on Technical Education, headed by Lord Sainsbury, reported in April 2016. It looked at the post-16 skills system and advised Government on measures which could improve technical education in England.

The Independent Panel found that the system is over-complex, with a confusing array of courses and qualifications that are insufficiently linked to the world of work and the needs of employers. The panel found that individuals need access to a national system of technical qualifications which is easy to understand, has credibility with employers and remains stable over time but that "our current system fails on all these counts". The panel stated that "individuals and employers must navigate a confusing and ever-changing multitude of qualifications: currently over 13,000 are available to 16-18 year olds. Many of these qualifications hold little value in the eyes of individuals and are not understood or sought by employers, but too many people do not realise this until it is too late."

The Government accepted the Panel's recommendations and in July 2016 published a Post-16 Skills Plan setting out its vision for the reformed system.   FE "Area Reviews" have been undertaken nationwide to examine the local issues, with Birmingham and Solihull being the first area to be reviewed. The Government expects the area reviews to "enable a transition towards fewer, larger, more resilient and efficient providers, and more effective collaboration across institution types."

The Birmingham and Solihull Area Review has found no evidence of service duplication. Seven colleges (three sixth-form colleges and four general further education colleges) participated in the Birmingham and Solihull review, of which one (South & City College Birmingham) has facilities located within the study area (Bordesley Green Campus). The Area Review found that Birmingham and Solihull's colleges "have distinct recruitment areas and there is little significant duplication in their offer." (19)

The Area Reviews made a series of recommendations. Alongside recommendations relating to the financial sustainability of provision, the Area Review stated that:

• Colleges should develop specialisms, particularly at levels 4 (which is

equivalent to BTEC) and Level 5 (awarded after two years of full time study). Specialisms will provide learners and employers with improved access to training, and address skills gaps and skills shortages, including in LEP identified priority sector areas. In EBNS, relevant specialisms could be around meeting the needs of HS2 (aligning to Washwood Heath opportunities), engineering (aligning to JLR), and construction (given high levels of infrastructure spending in the pipeline).

• Colleges should grow apprenticeships, in particular through the commitments made by each of the four general FE colleges to establish an apprenticeships company to improve employer engagement and increase their market share.

• Colleges should co-operate on a plan for a new Institute of Technology. This investment now forming part of the Government's recently launched (Jan 2017) Industrial Strategy, has at its heart the objective of significantly increasing the number of apprenticeships available in the city. The Area Review also anticipated that this Institute would have a role in delivering the more sector-specialist approach discussed above.

Since the Area Review process closed, a partnership of four colleges and four universities has collaborated on plans for the Institute of Technology (IoT). The IoT will be a virtual organisation, rather than have a physical presence: the £170m IoT national budget will be shared across 10-12 applicants, and be shared across three years – suggesting that there is insufficient funding for a new campus, although this approach could change by the time the application submitted (DfE has 'spring 2017' as a deadline). Advanced robotics will be purchased as part of the scheme, although choices about which existing campus or campuses will get this equipment have yet to be made by the partnership. A full business case will be developed over summer 2017, with successful applications announced in autumn 2017. The new virtual institution will go live 1 Sept 2018, assuming that the application is successful.

Additionally, the National College for High Speed Rail is scheduled to open in 2018. It is located a few hundred metres of the western boundary of the study area. Its offer will include civil engineering and command, and control & communications.

Skills and labour market participation

Key issues:

- EBNS workers are less skilled than average

- Labour market participation effects vary by gender and ethnicity

- Long term and youth unemployment higher than average

- Evidence suggests that the combination of multiple actors, strategic overload and short term funding is unhelpful in getting solutions

Why is this issue important? A brief review of the literature and local context

In the section above on education, we showed evidence which suggested that there were current weaknesses in performance in this area.

Evidence collated in this section suggests that historical underperformance in education has fed through into skills levels for those of working age.

Underperformance in skills has far-reaching effects. Skills levels are likely to be critical to the short, medium and long term performance of the EBNS economy. There is evidence that improving skills attracts investment and growth: the skills of the workforce and technical expertise in a region are the most important drivers of knowledge-based industry business location choices (DfT, undated). In OECD countries a 1% increase in the number of graduates adds 1.1% to GDP growth (BIS, 2012).

Skills are also an important determinant (some studies place it as *the* most important determinant) of employers' willingness to invest in a location. Improvements in skills levels would assist in attracting and retaining the high quality employers that will be central to its prosperity in future (DfT undated).

UK-wide, strong demand is projected for skilled workers, who need not be graduates: evidence shows that the UK faces a chronic shortage of people with technician-level skills. In engineering and technology alone, Engineering UK data shows an annual shortfall of 29,000 people with level 3 skills and a shortfall of 40,000 people with skills at level 4. Among 16-24 year olds, England and Northern Ireland together now rank in the bottom four OECD countries for literacy and numeracy – key prerequisites for access to intermediate and higher level skills training. By 2020, "the UK is set to fall to 28th out of 33 OECD countries in terms of developing intermediate skills, and the size of the post-secondary technical education sector in England is extremely small by international standards. This adversely affects our productivity, where we lag behind competitors like Germany and France by as much as 36 percentage points" (2016, Independent Panel on Technical Education).

A culture of lifelong learning will also be critical to create long term economic resilience. Over the longer-term, Andy Haldane (Bank of England Chief Economist) suggests that we may be on the cusp of a fourth industrial revolution. Automation of routine administrative, clerical and production tasks may affect major swathes of the labour market. 15 million jobs may be at risk within the UK. If these trends do materialise, workers in higher skilled jobs will tend to be insulated, as well as those within jobs that demand high levels of creativity, caring and emotional intelligence. A rapid response to economic change will require a high quality skills response.

Over a third of all EBNS residents have no qualifications – far exceeding the English average of 23%

This chart and table show the proportion of the study area and comparators by highest qualification achieved.

Well over a third of the EBNS area population – 36.7% - has no academic, vocational or professional qualifications. This is a far higher figure than for all comparator areas, particularly in relation to the national average of 22.5%. EBNS also has a higher proportion of people with qualifications at level 1 (equivalent of 1 GCSE pass).

Put together, the "no and low" qualification residents make up 53% of the population, compared to 36% in England as a whole.

By contrast the area has a lower proportion of people with level 3 (equivalent of 2+ A-levels) or degree qualifications than each of the compactor areas.
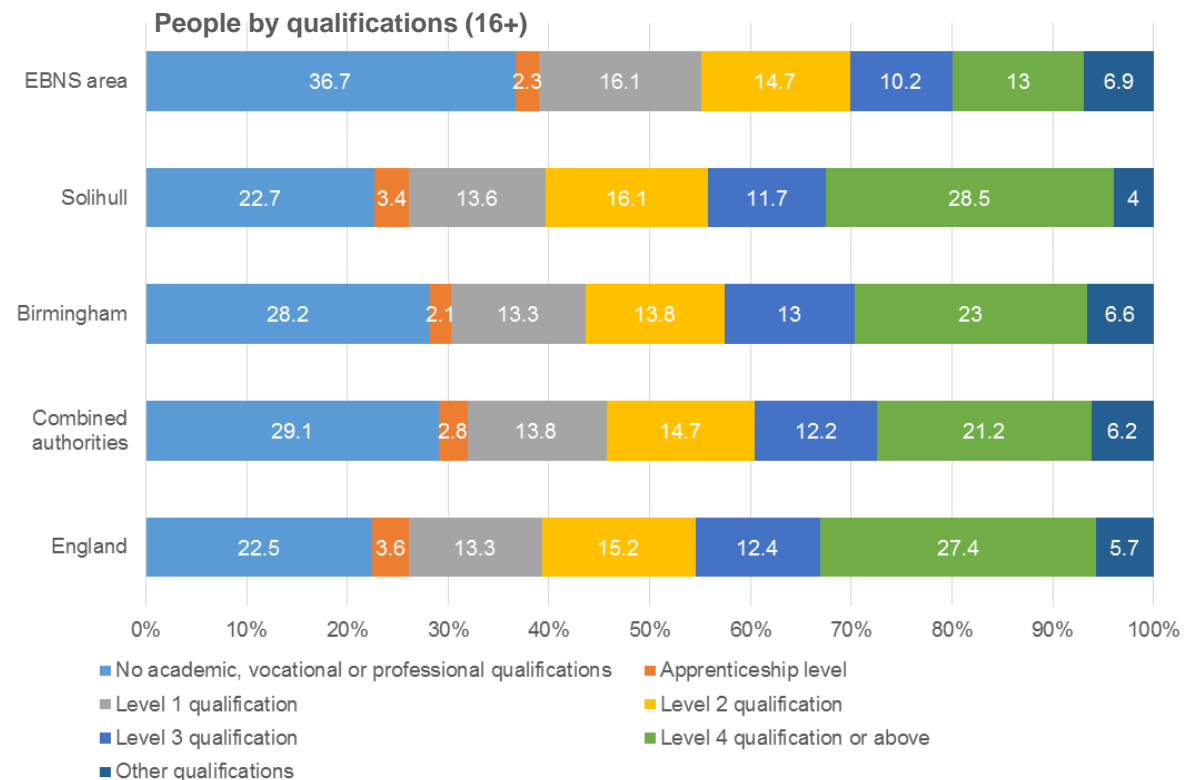
Dataset: *People by qualifications (16+)*
Date: *2011*
Source: *Census 2011*

People by qualifications (16+)

Legend:
- No academic, vocational or professional qualifications
- Apprenticeship level
- Level 1 qualification
- Level 2 qualification
- Level 3 qualification
- Level 4 qualification or above
- Other qualifications

	No academic, vocational or professional qualifications	Apprenticeship level	Level 1 qualification	Level 2 qualification	Level 3 qualification	Level 4 qualification or above	'Other qualifications'
EBNS area	36.7	2.3	16.1	14.7	10.2	13	6.9
Birmingham	28.2	2.1	13.3	13.8	13	23	6.6
Solihull	22.7	3.4	13.6	16.1	11.7	28.5	4
WMCA constit LAs	29.1	2.8	13.8	14.7	12.2	21.2	6.2
England	22.5	3.6	13.3	15.2	12.4	27.4	5.7

In terms of spatial distribution, a lack of qualifications is widespread across the EBNS area. Most areas are in the bottom 10% of LSOAs on this measure

Adults with no qualifications

As shown in the map, many adults with no qualifications in EBNS are within walktimes of new and improving transport infrastructure. There are pockets of more skilled people in the area (for example, in parts of Castle Bromwich, Hodge Hill and Sheldon). These areas tend to be more distant from upgraded PT facilities.
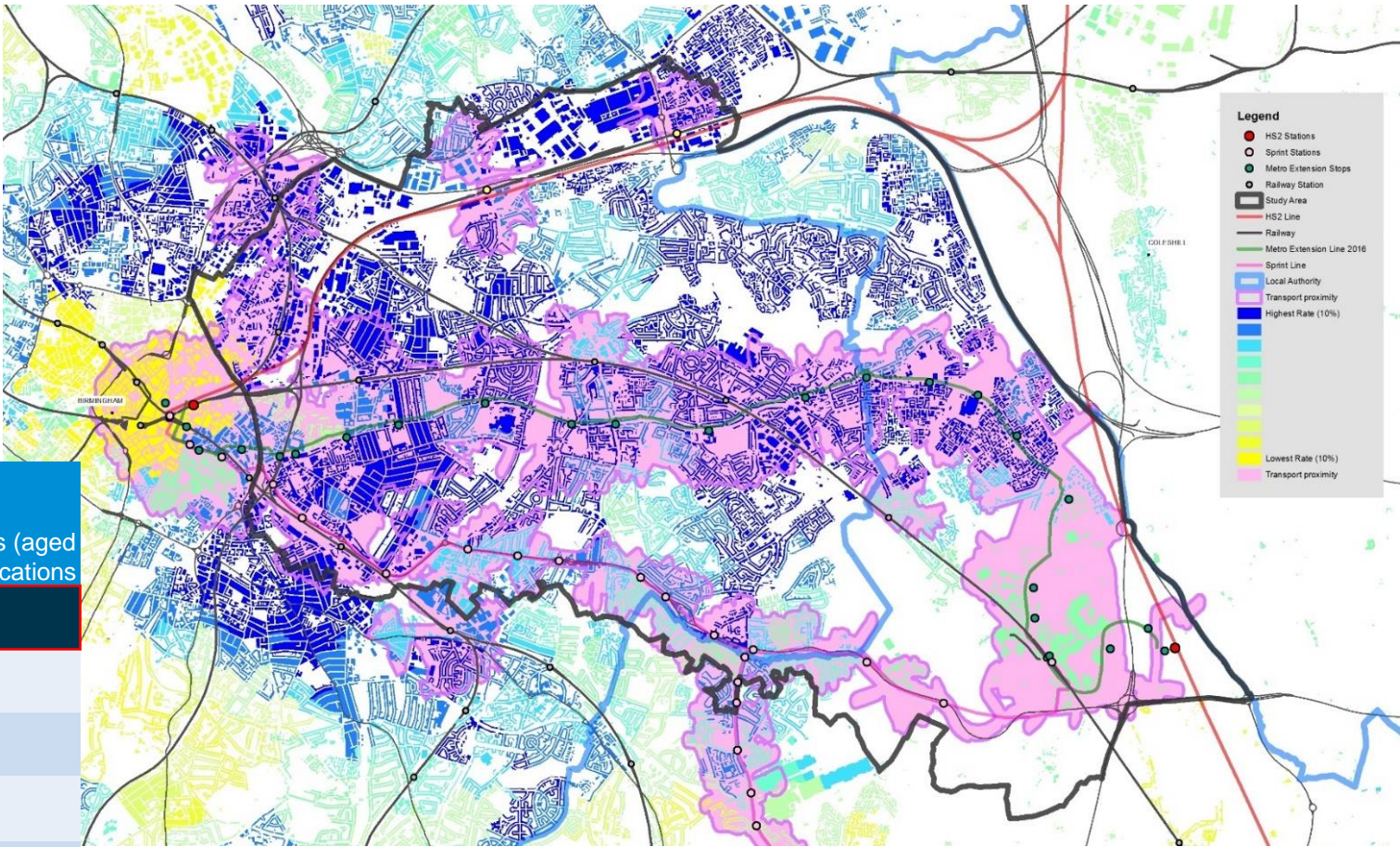
Area	Proportion of adults (aged 16+) with no qualifications
EBNS area	36.7%
Birmingham	28.2%
Solihull	22.7%
WMCA constit LAs	29.1%
England	22.5%

Dataset: *People with no qualifications. This data is derived from the Census 2011 self-reported questions on qualification levels*
Date: *2011*
Source: *Census 2011*

58

Historic educational underperformance in EBNS is likely to be one reason why EBNS has a relatively unskilled workforce. People in the EBNS area are half as likely to hold degree level qualifications as the national average

Adults with Level 4 qualifications

The chart and table show the significant deficiency of adults holding degree level qualifications in EBNS. As shown by the table below, EBNS falls well below comparators on this measure. The map shows that a significant proportion of areas are in the bottom 10% of LSOAs of this measure.

Dataset: *People with level 4/5 qualifications (degree level or higher). This data is derived from the Census 2011 self-reported questions on qualification levels*
Date: *2011*
Source: *Census 2011*
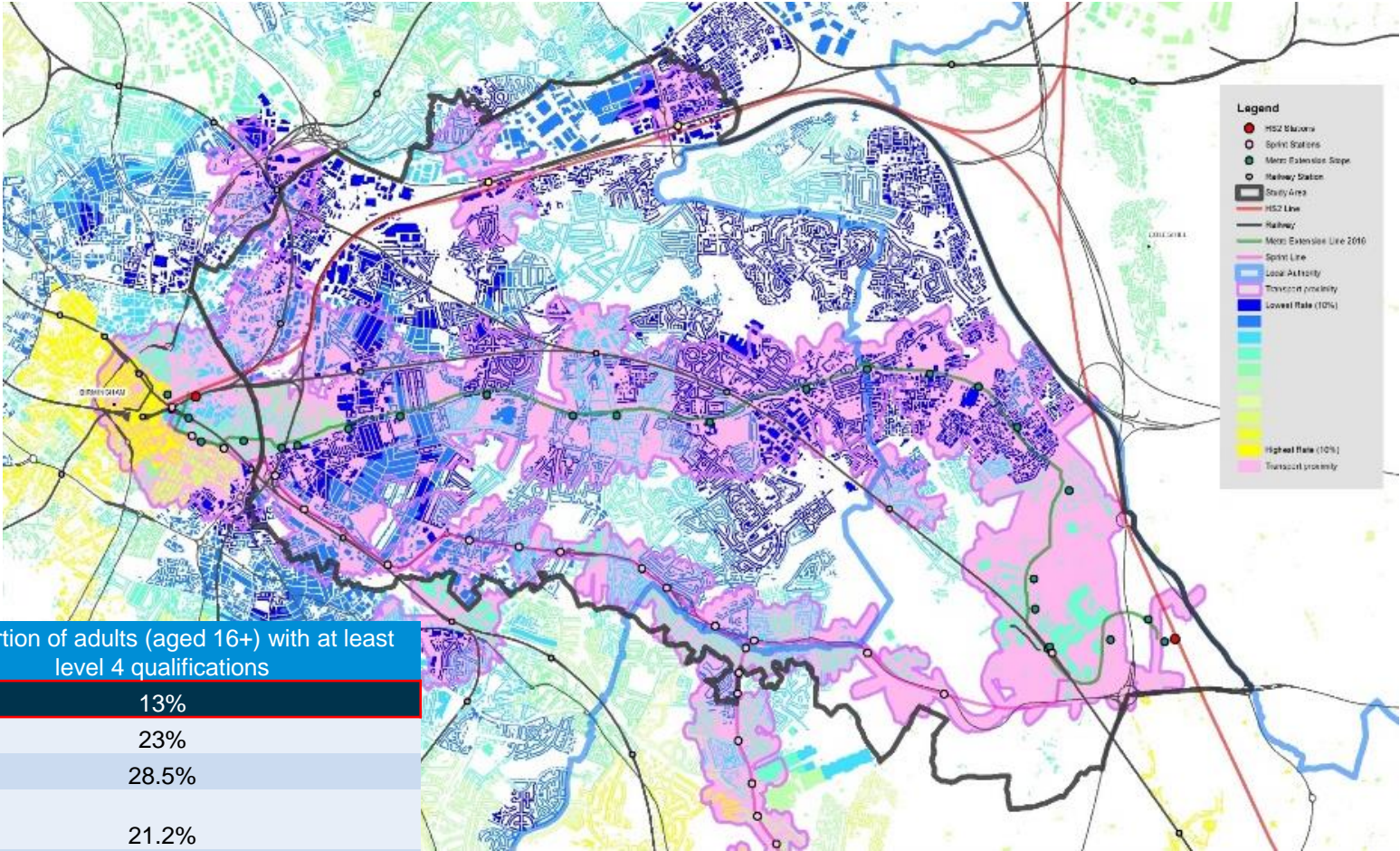
Area	Proportion of adults (aged 16+) with at least level 4 qualifications
EBNS area	13%
Birmingham	23%
Solihull	28.5%
Combined authorities	21.2%
England	27.4%

59

The lower skills of EBNS residents has also translated into the labour market occupational profile. EBNS residents are less likely to be in professional roles and more likely to be in elementary occupations than across comparator areas

The occupation profile mirrors the skills profile with a lower proportion of people living locally employed in occupations requiring higher qualifications (managerial, professional and technical) and a higher proportion in low skill occupations including process plant machine operatives and elementary occupations.

Dataset: *Shows the proportion of people in employment (aged 16-74) by occupation group. An individual's occupation group is determined by their response to the occupation questions in the 2011 Census.*
Date: *2011*
Source: *Census 2011*

Legend:
- Skilled trades occupations
- Sales and customer service occupations
- Professional occupations
- Process, plant and machine operatives
- Managers, directors and senior officials
- Elementary occupations
- Caring, leisure and other service occupations
- Associate professional and technical occupations
- Administrative and secretarial occupations
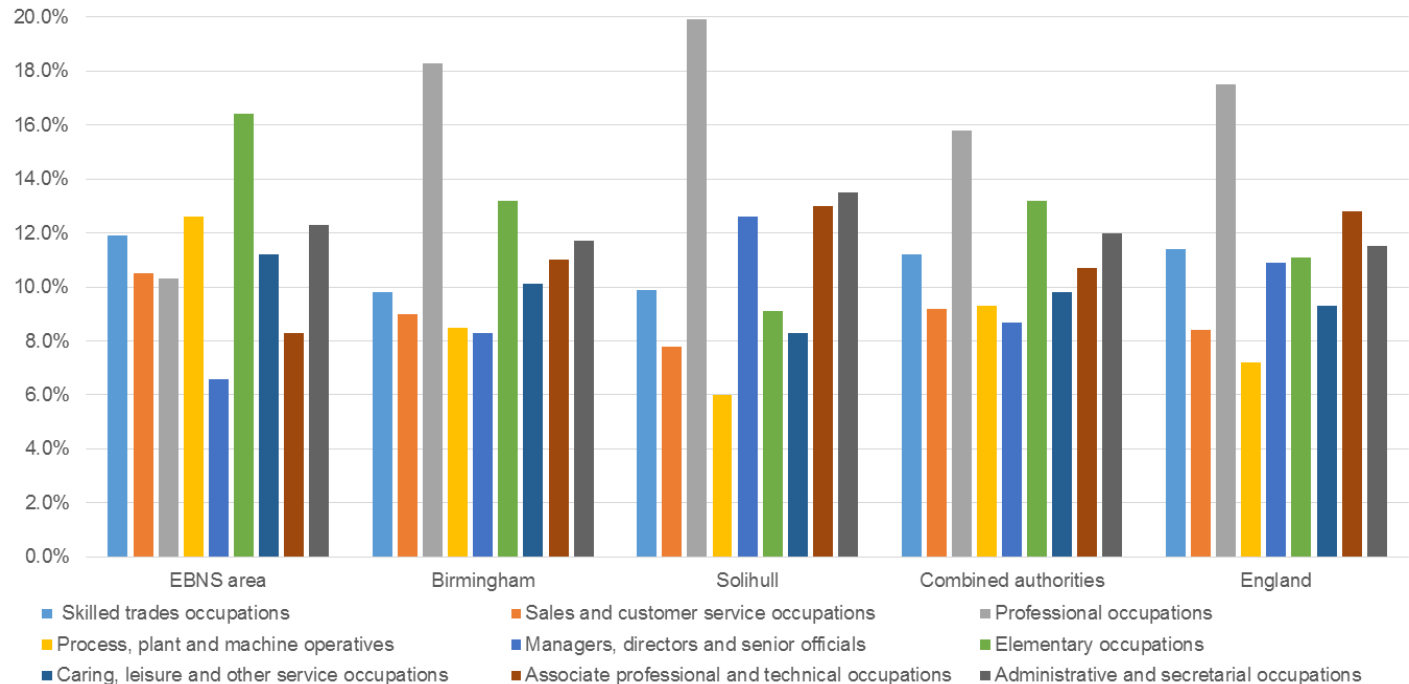
	Managers, directors & senior officials		Professional		Associate professional & technical		Administrative & secretarial		Skilled trades		Caring, leisure & other service		Sales & customer service		Process, plant & machine operatives		Elementary	
EBNS area	6.6%	6,762	10.3%	10,587	8.3%	8,499	12.3%	12,675	11.9%	12,221	11.2%	11,580	10.5%	10,759	12.6%	12,923	16.4%	16,930
Birmingham	8.3%	35,160	18.3%	77,424	11.0%	46,762	11.7%	49,752	9.8%	41,640	10.1%	42,626	9.0%	38,152	8.5%	36,206	13.2%	55,969
Solihull	12.6%	12,312	19.9%	19,446	13.0%	12,723	13.5%	13,260	9.9%	9,681	8.3%	8,093	7.8%	7,649	6.0%	5,895	9.1%	8,882
WMCA constit LAs	8.7%	99,522	15.8%	181,583	10.7%	123,152	12.0%	137,995	11.2%	128,567	9.8%	112,628	9.2%	105,009	9.3%	107,004	13.2%	150,914
England	10.9%	2,734,900	17.5%	4,400,375	12.8%	3,219,067	11.5%	2,883,230	11.4%	2,858,680	9.3%	2,348,650	8.4%	2,117,477	7.2%	1,808,024	11.1%	2,792,318

60

Economic impact work has been carried out as part of the UK Central Hub Growth and Infrastructure Plan, and provides an early indication of skills demands

Further work is being carried out, so these projections come with significant caveats, but current projections suggest that the labour demand for gross jobs (ie, existing jobs plus new jobs) at UK Central sites will require skilled workers. The largest single skills category is Level 4 (degree level) and above, at 31% of gross jobs. Even so, there will be some demand for those with low and no qualifications: 30% of occupations will be open to those with no qualifications and level 1 qualifications.

Labour demand skills profile at the UK Central sites (% gross jobs)

- Apprenticeships and other qualifications, 8%
- No qualifications, 13%
- Level 1 qualifications, 17%
- Level 2 qualifications, 17%
- Level 3 qualifications, 14%
- Level 4 qualifications and above, 31%
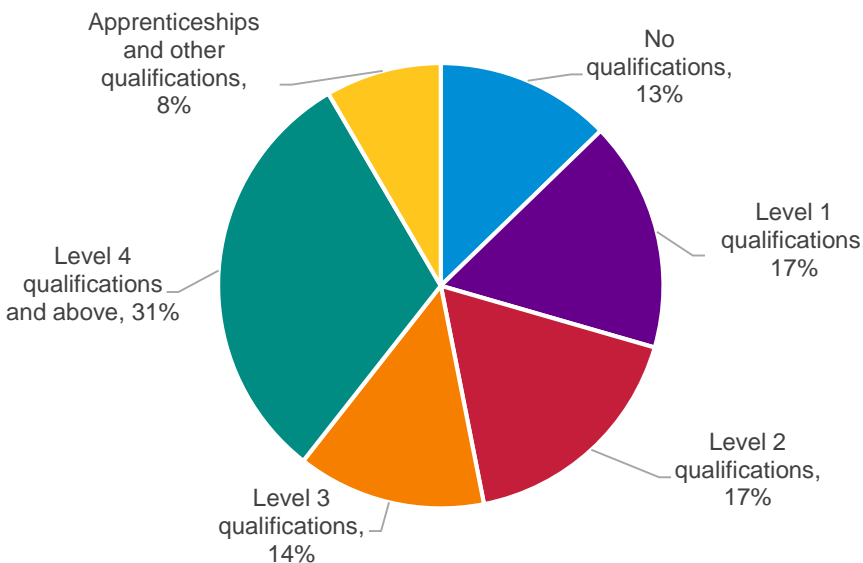
Source: Amion for the UK Central Growth and Infrastructure Plan (2017)

Labour demand occupational profile at the UK Central sites (% gross jobs)
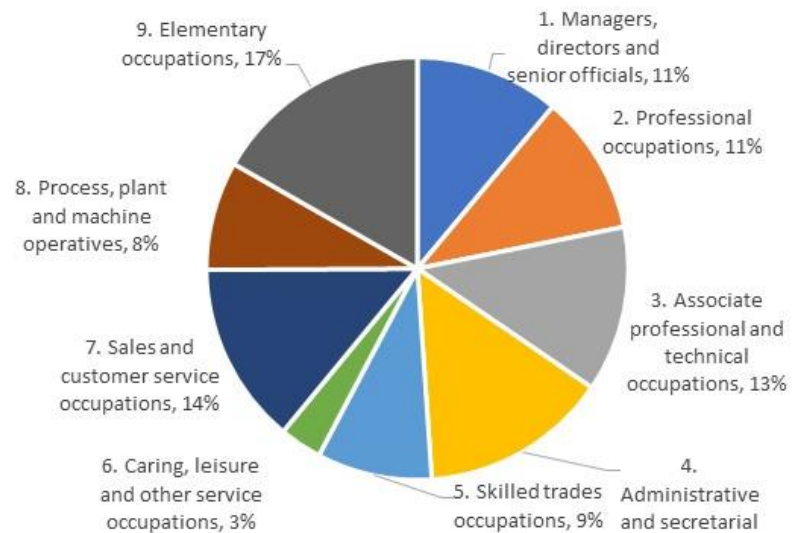
- 9. Elementary occupations, 17%
- 1. Managers, directors and senior officials, 11%
- 2. Professional occupations, 11%
- 8. Process, plant and machine operatives, 8%
- 3. Associate professional and technical occupations, 13%
- 7. Sales and customer service occupations, 14%
- 6. Caring, leisure and other service occupations, 3%
- 5. Skilled trades occupations, 9%
- 4. Administrative and secretarial

Source: Amion for the UK Central Growth and Infrastructure Plan (2017)

61

Unemployment is highest in the west of the EBNS area closer to inner city Birmingham

The map displays the rank of LSOAs in EBNS, based on the proportion of people claiming JSA and UC.

The table shows that Washwood Heath has 6% of people on JSA (Job Seekers Allowance) and UC (Universal Credit)- the highest in EBNS. In general relatively high levels of JSA & UC claimant rates are seen right across EBNS. The table shows that areas with lower levels of claimants are found in parts of Bickenhill and Castle Bromwich.

Area	JSA/Universal Credit claimants	
	N of claimants	% of claimants aged16-64 in each area
Acock's Green (B)	765	3.9
Hodge Hill (B)	715	4.2
Nechells (B)	1,284	5.0
Shard End (B)	825	5.3
Sheldon (B)	475	3.6
Small Heath (B)	1,141	5.0
Washwood Heath (B)	1,320	6.0
Yardley (B)	670	4.4
Bickenhill (S)	180	2.0
Castle Bromwich (S)	105	1.5
Chelmsley Wood (S)	390	5.9
Fordbridge (S)	285	5.5
Kingshurst (S)	190	3.9
Smith's Wood (S)	315	4.9
EBNS Total	8,660	4.8

Proportion of people (aged 16-64) claiming JSA or UC: ranked by LSOA
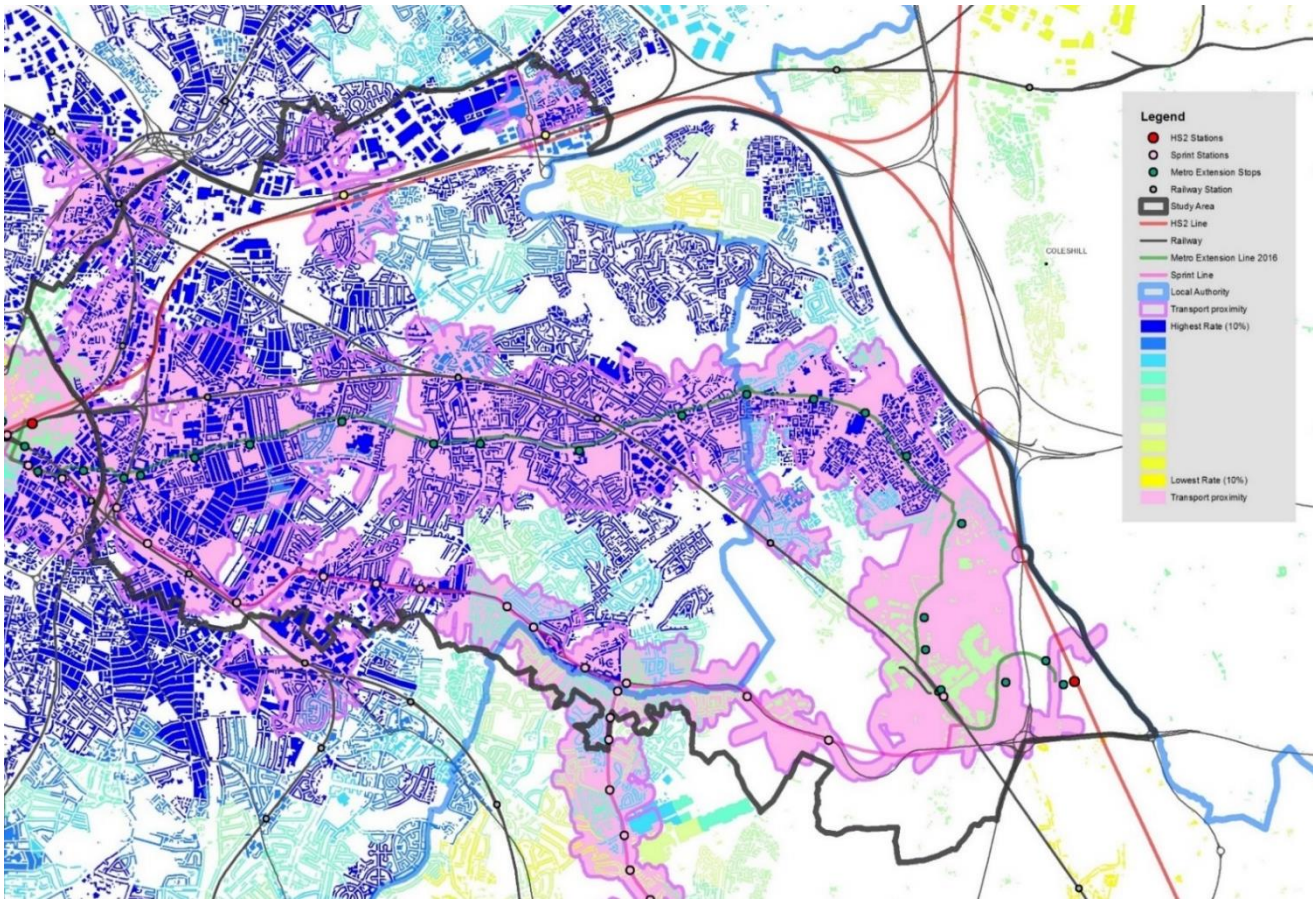
Dataset: *Proportion people aged 16-64 claiming Jobseekers Allowance or Universal Credit for out of work reasons*
Date: *December 2016*
Source: *Department for Work and Pensions (DWP)*

The EBNS area has had a consistently higher unemployment claimant rate than comparator areas over the last fifteen years

With regard to claimant count unemployment, the EBNS area shows a similar trend to the national and regional comparators with a sharp rise during the recession, followed by a steady fall from 2011. The rate has been broadly steady since late 2015.

Note that changes to unemployment claimant levels are affected by changes to benefit eligibility criteria and sanction policy as well as changes to labour market conditions. The unemployment benefits measure also does not capture all people who are unemployed as only captures those who are claiming benefits and who are not subject to benefit sanctions.

The International Labour Organisation (ILO) definition of unemployment gives a broader picture, but this data is not available at this spatial scale.

Area	JSA and Universal Credit claimants aged 16-64 (Dec-16)
EBNS study area	4.8%
Birmingham LA	4.2%
Solihull LA	1.8%
WMCA constit LAs	3.4%
England	1.8%

Proportion of people (aged 16-64) claiming JSA and UC: ranked by LSOA

Legend: EBNS area, Birmingham, Solihull, Combined authority, England

Dataset: *Shows the proportion of people aged 16 – 64 claiming Jobseekers Allowance or Universal Credit for out of work reasons.*
Date: *December 2016*
Source: *Department for Work and Pensions (DWP)*

63

Page 367 of 588

The EBNS area has a low employment rate relative to comparators, with just over half the population aged 16-74 in employment

Both economic activity and employment rates are shown in the table to the right.

- Economic activity rates are defined as those working full-time, part-time, the self-employed, full-time students (working) and those who are unemployed but looking for work.
- Employment rates show the percentage of the total working age population which is both economically active and in work.

The EBNS area has a lower total rate of economic activity than comparator areas, at just 62% of the population relative to a national average of 69.9%. Subtracting the unemployed from the economically active total gives us a basic employment rate for the EBNS area, which again is significantly lower than comparator areas. The employment rate for the EBNS area is just 53.5% relative to a national average of 65.5%.

Proportion of the economically active compared to the employment rate
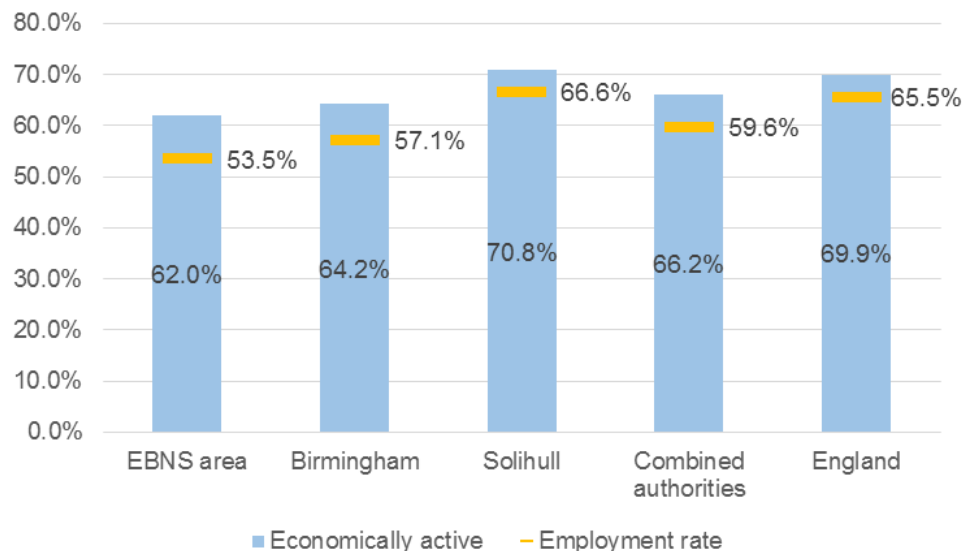
	Total population (age 16-74)	Total economically active		Economically active: unemployed		Employment rate	
EBNS area	196,612	62.0%	121,904	8.5%	16,737	53.5%	105,167
Birmingham	760,252	64.2%	488,221	7.1%	54,114	57.1%	434,107
Solihull	148,360	70.8%	105,108	4.2%	6,304	66.6%	98,804
WMCA constit LAs	1,958,674	66.2%	1,296,464	6.5%	128,196	59.6%	1,168,268
England	38,881,374	69.9%	27,183,134	4.4%	1,702,847	65.6%	25,480,287

Dataset: *Economic activity data is based on self-reported responses to the 2011 census*
Date: *2011*
Source: *Census 2011*

There are big differences in labour market participation by ethnicity and gender which are hidden by the average. Asian groups have the lowest rate of employment in EBNS, but the highest rate of all groups in Solihull

Employment rates are based on 2011 census data for all those aged 16 – 74. The older age group has been used to capture economic activity generated by an older aged working population.

The gender gap in overall employment rates is particularly wide across the EBNS area, with males, with a difference of 13.2 percentage points between the rates of men and women, relative to a national difference of 8.7 percentage points.

Employment rates by gender	EBNS area	Birmingham	Solihull	Combined authorities	England
Males	60.1%	61.9%	70.6%	64.0%	69.9%
Females	46.9%	52.4%	62.7%	55.4%	61.2%
Difference	13.2%	9.5%	7.9%	8.6%	8.7%

There is some degree of ethnic variation in terms of average employment rates, with employment rates in EBNS lower for people of Asian ethnic groups than across other ethnic groups. **Employment rates for all ethnic groups are lower across the EBNS area than equivalent ethnic groups across England as a whole, but have noticeably strong performances in Solihull, where Asian, black and other ethnicities having higher rates than whites**.

Employment rates by ethnicity	EBNS area	Birmingham	Solihull	Combined authorities	England
White	51.2%	54.1%	58.2%	54.5%	59.3%
Asian	41.4%	45.7%	66.7%	50.1%	55.9%
Black	47.8%	50.7%	62.8%	52.1%	56.8%
Mixed	44.7%	49.1%	58.1%	49.6%	57.5%
Other	42.4%	41.1%	64.2%	45.6%	50.5%

65

Page 369 of 588

Dataset: *Employment by gender data is based on self-reported responses to the 2011 census and includes self-employed, full-time students those working full-time, part-time, the (working) aged 16 – 74.*
Date: *2011*
Source: *Census 2011*

Employment rates by gender
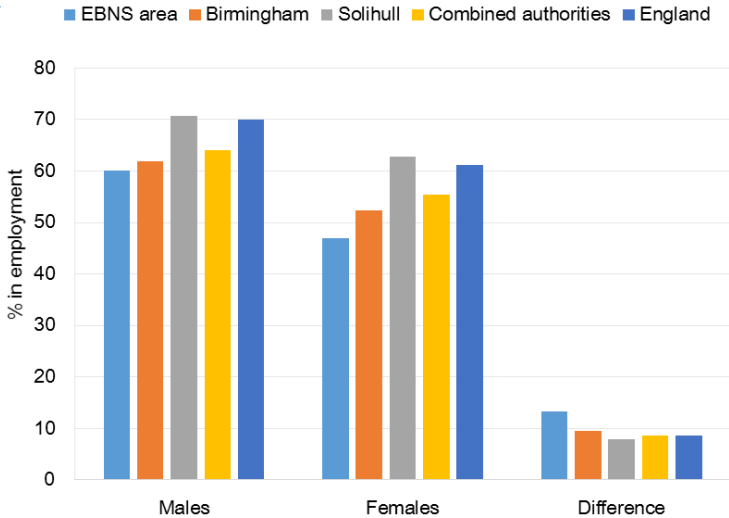
Dataset: *Employment by ethnicity data is based on self-reported responses to the 2011 census and includes those working full-time, part-time, the self-employed, full-time students (working) aged 16 – 74.*
Date: *2011*
Source: *Census 2011*

Employment rates by ethnicity
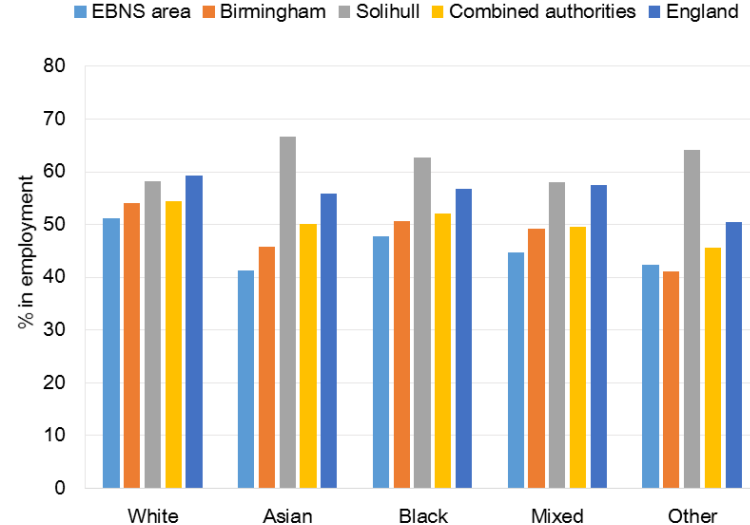
Youth unemployment is more than double the national average across the EBNS area

The table to the right shows the % of people aged 16-24 claiming JSA/UC – so 5.1% of 18-24 year olds in EBNS claim JSA/UC. Within EBNS, this age group are more likely to be claiming JSA or UC than the comparator areas. The map shows that LSOAs within the west and centre of EBNS are within the worst performing 10%.There are stronger performing areas in parts of Castle Bromwich, Hodge Hill and Yardley.

However, it is worth noting that the data set is based on those claiming JSA and UC. It therefore does not take into account those who are unable to work for other reasons.

The table below shows that the Fordbridge area has the highest concentration of youth unemployment, followed by Smith's Wood and Chelmsley Wood.

Area	JSA/Universal Credit	
	No. of claimants	Claimants as % of all aged 16-64
Acock's Green (B)	150	4.1
Hodge Hill (B)	180	4.8
Nechells (B)	257	2.5
Shard End (B)	170	5.5
Sheldon (B)	105	4.3
Small Heath (B)	295	5.1
Washwood Heath (B)	315	5.8
Yardley (B)	155	4.8
Bickenhill (S)	50	3.5
Castle Bromwich (S)	35	2.9
Chelmsley Wood (S)	90	6.8
Fordbridge (S)	85	8.2
Kingshurst (S)	55	5.8
Smith's Wood (S)	90	6.9
EBNS Total	2,032	5.1

% of people aged 16-24 claiming benefits

Area	% of people aged 16-24 claiming JSA/Universal Credit	Area	% of people aged 16-24 claiming JSA/Universal Credit
EBNS study area	5.1%	Birmingham LA	3.8%
WMCA constit LAs	3.5%	Solihull LA	2.9%
England	2.1%		

Proportion of people aged 16-24 claiming benefits
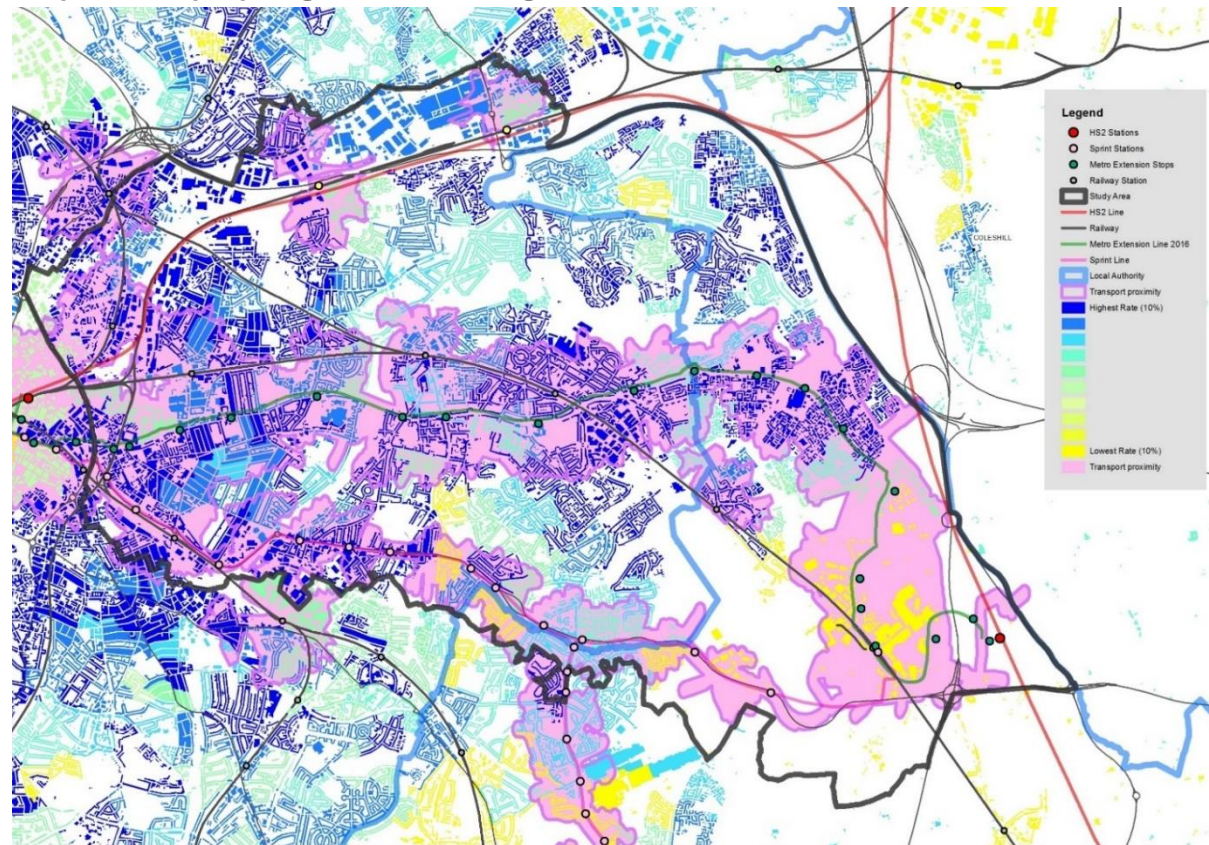
Dataset: *Proportion of people aged 16-24 claiming Jobseekers Allowance or Universal Credit for out of work reasons*
Date: *December 2016*
Source: *Department for Work and Pensions (DWP)*

At EBNS scale, NEET levels for 16-24 year olds are hard to track accurately. We have used data on NEETS aged 16-18 data as a proxy

The 2013 Birmingham Commission on Youth Unemployment dealt head-on with the complexities around the terms used to define youth unemployment, pointing out that 'a confusing range of terms are used in discussions on youth unemployment' (BCC, 2013, 13).

The term 'NEET' covers all young people Not in Employment, Education or Training. It seeks to identify those effectively dropping out of the labour market and becoming economically inactive. But not all unemployed 16-24 year-olds are NEET and not all people who are NEET are unemployed. Nationally, the Office for National Statistics states that around half, or 43%, of all young people in the UK who were NEET were looking for and available for work, and therefore classified as unemployed. (Guardian, 24 Nov 2016). The remainder were either not looking for work or not available for work and therefore classified as economically inactive. That category includes the long-term sick and those caring for children or other relatives.

The Commission stated that 'at local level, keeping track of the numbers in each case is difficult.' Local authorities track the number of 16- to- 18-year-olds who are NEET, but they do not track the number of young people over the age of 18 who are NEET. There are also wide seasonal variations, and there is a substantial group of 'not known' individuals, who may or may not be active in the labour market (either in the formal or informal market).

The map shown to the right looks at the local authority 16-18 NEET data only. It cannot be compared to national NEET data, which looks at the different age range of 16-24. Both the Solihull and Birmingham data is derived from the respective local authorities, and may be an under-estimate because it excludes the category of 'not known' where no data is available. These are a complex group: whilst some might be genuinely NEET, many could be working but chose not to inform LAs as it is not compulsory for them to do so. Others are difficult to contact because they do not want the LA to know their circumstances, whilst others have health problems. The Solihull 'not known' category is modest at 1.7%.

With those caveats, the data remains useful insofar as it identifies geographically where the major problems are located.

Proportion of those age 16-18 who are NEETs by ward in EBNS (number shown excludes those classified as Not Known; January 2017)

Contains Ordnance Survey data © Crown copyright and database right [2016], North Solihull, data is 16-18. NEET figure based on January 2017, Birmingham data obtained on 18.05/17. NEET by percentage by ward - 16-18
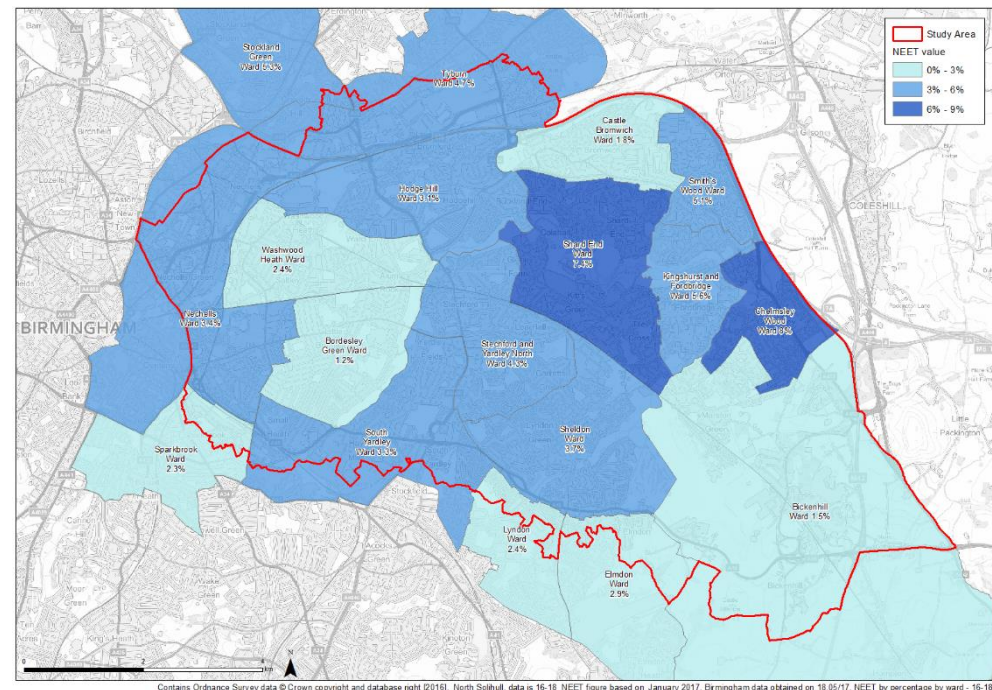
Dataset: Proportion of NEETs as a percentage of the ward population aged 16-18 (EET: engaged in education, employment and training)

Date: 2017

Source: BCC and SMBC

Long-term unemployment is also widespread, with most of the area in the worst performing 10% of English LSOAs

The map shows that within EBNS the LSOAs within the worst performing 10% are clustered at the west and centre of the area. The table below shows that Washwood Heath has the most significant proportion of people claiming benefits for over 12 months. All other areas experience much lower levels of long term unemployment.

Castle Bromwich is once again the area with the lowest levels of unemployment – which may be due, in part, to the demographic profile of the area, which sees a higher concentration of old people than the rest of EBNS.

Area	People aged 16-64 claiming benefits for over 12 months	
	No. of claimants	% of claimants aged 18-24 in each area
Acock's Green (B)	220	1.1
Hodge Hill (B)	195	1.2
Nechells (B)	345	1.3
Shard End (B)	285	1.8
Sheldon (B)	140	1.0
Small Heath (B)	325	1.4
Washwood Heath (B)	480	2.2
Yardley (B)	205	1.3
Bickenhill (S)	50	0.6
Castle Bromwich (S)	15	0.2
Chelmsley Wood (S)	100	1.5
Fordbridge (S)	50	1.0
Kingshurst (S)	50	1.0
Smith's Wood (S)	80	1.2

Proportion of people aged 16-64 claiming benefits for over 12 months
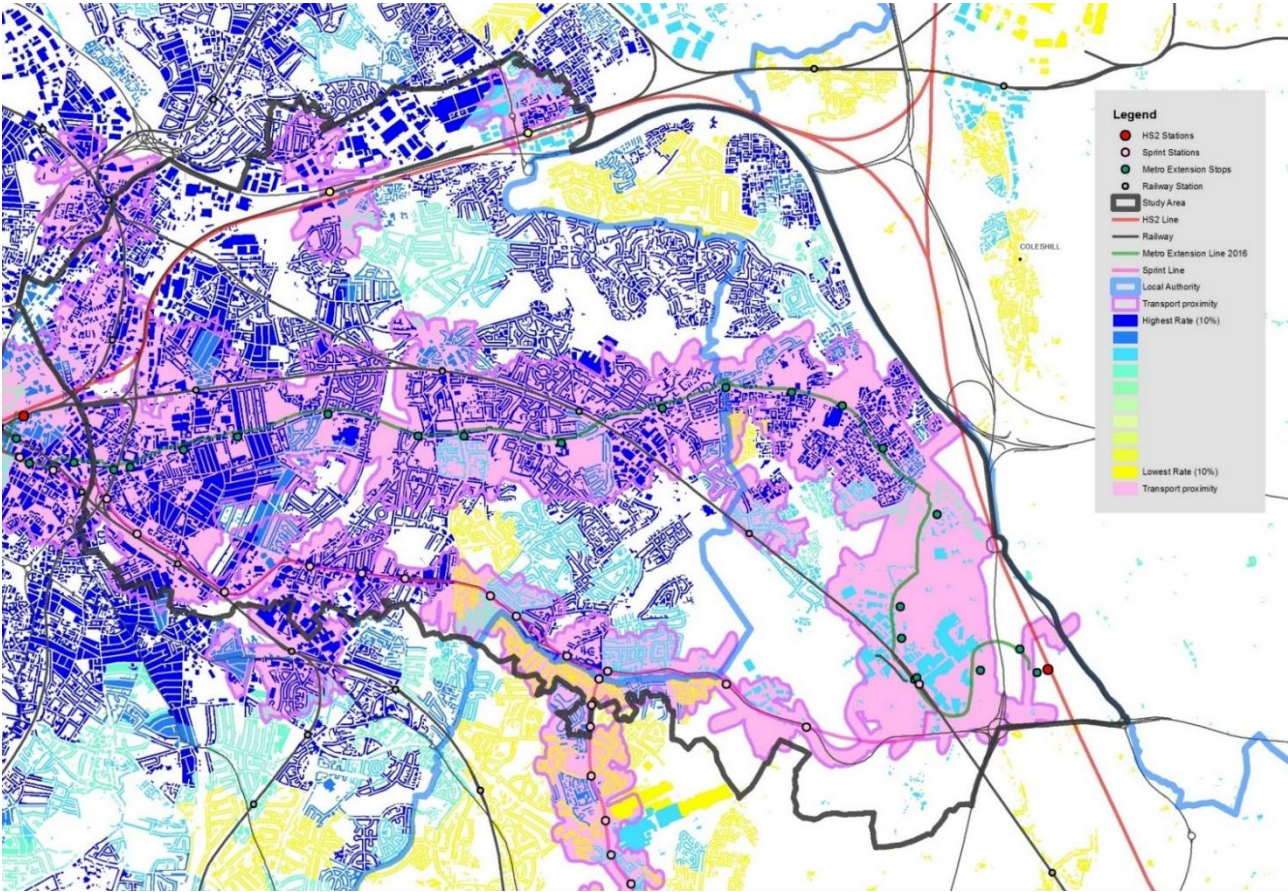
Dataset: *Proportion of people claiming Jobseekers Allowance for over 12 months*
Date: *December 2016*
Source: *Department for Work and Pensions (DWP)*

Note on data: *Please note that Universal Credit claimants are not included in these counts as figures are not yet published on the number of Universal Credit claimants claiming for more than 12 months*

68

Under-employment also appears to be a problem. EBNS residents who are in employment are 25% more likely to be working part time than the national average

People who live in the EBNS area and have a job are more likely to work part time than those in comparator areas. In all, over a third of the EBNS population in employment (34.2%) work part-time, compared with a national average of 29%. Full-time employment is likely to be better paid than part-time employment indicating a greater risk of people in low income occupations.

By contrast there is a notably small population working 49 hours or longer per week at just 7.7% compared to the national average of 13.3%. This likely reflects the occupation mix of the area, for example a lack of professional and managerial roles which are more likely to involve long working hours.

Hours worked by those in employment aged 16-74
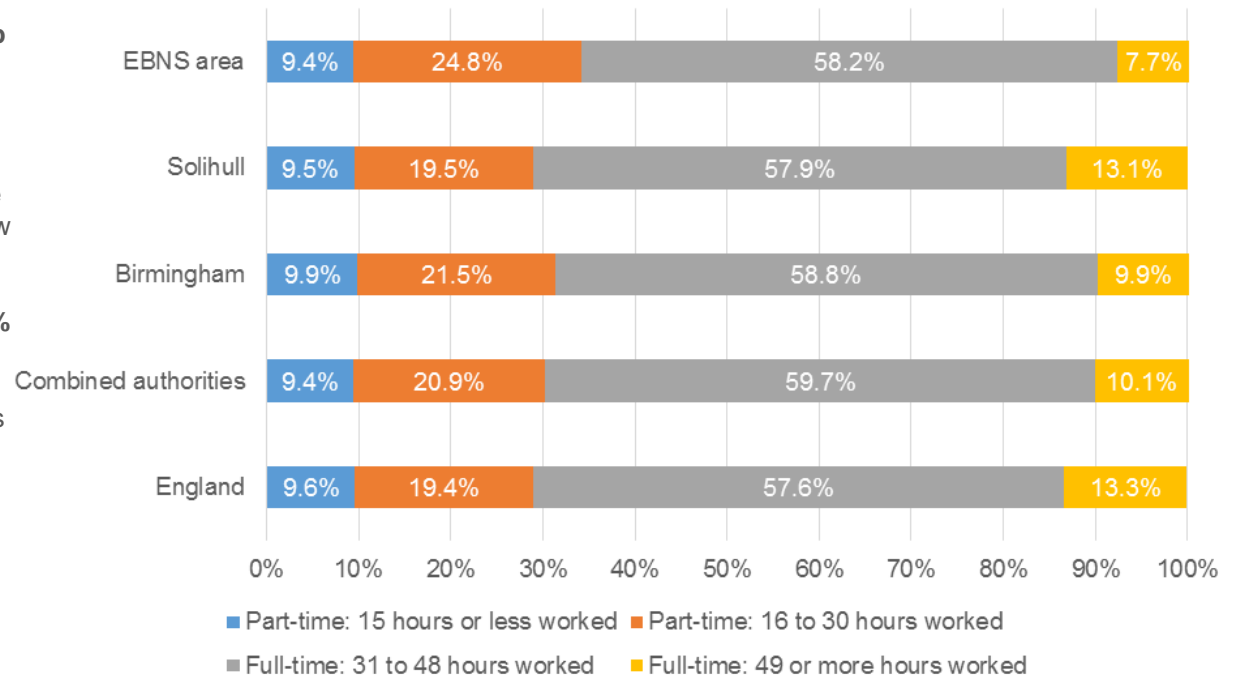
Weekly hours, as % of all working people	Part-time: 15 hours or less worked		Part-time: 16 to 30 hours worked		Full-time: 31 to 48 hours worked		Full-time: 49 or more hours worked	
EBNS area	9.4%	9,632	24.8%	25,478	58.2%	59,899	7.7%	7,927
Birmingham	9.9%	41,824	21.5%	90,924	58.8%	249,030	9.9%	41,913
Solihull	9.5%	9,338	19.5%	19,110	57.9%	56,677	13.1%	12,816
WMCA constit LAs	9.4%	107,222	20.9%	239,339	59.7%	684,565	10.1%	115,248
England	9.6%	2,418,518	19.4%	4,888,565	57.6%	14,502,713	13.3%	3,352,925

Some places have responded to weak labour markets with higher levels of 'defensive' self employment. That has not happened in EBNS: self-employment is lower in the EBNS area than the England average

The figures in the map and table are based on responses to the 2011 Census economic activity questions. The distinction between employee and self-employed is determined by the response to the question "Do (did) you work as an employee or are (were) you self-employed?" It relates to the person's main job in the week before Census or, if not working in the week before Census, their last main job. EBNS has a substantially lower proportion of self-employed people when compared with England and the LAs. One issue to understand, though, is that we have needed to use Census data in order to use mapping at this spatial scale   The Census was taken in 2011, and this issue has been quite fast moving as in recent years, some employers have preferred to register employees as self employed. As datasets are updated, we may see change in this issue.

Proportion of people aged 16-74 who are self-employed
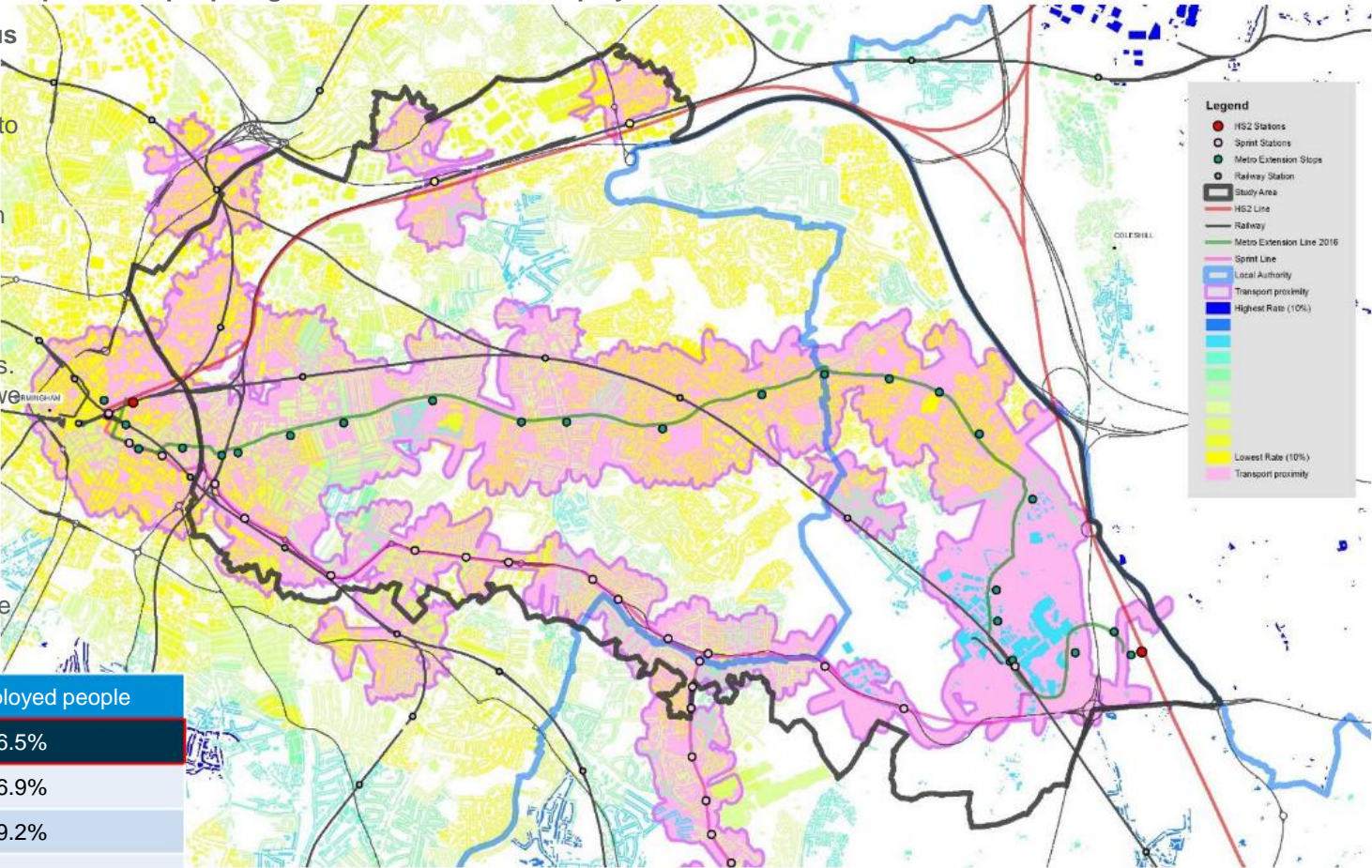
Area	Self-employed people
EBNS study area	6.5%
Birmingham LA	6.9%
Solihull LA	9.2%
WMCA constit LAs	7.0%
England	9.8%

Dataset: *Shows the proportion of adults aged 16-74 who are in self-employed.*
Date: *2011*
Source: *Census 2011*

We looked at the reasons why people in EBNS have a higher level of economic inactivity. People in the EBNS area are more than twice as likely to be out of work due to home and family commitments than the national average, and over 50% more likely to be long term sick or disabled

With the exception of those that have retired, the largest economically inactive group in the EBNS area are people who are looking after home or family, as 8.7% of the labour force are out of work due to this. This is likely to reflect the age profile of the area (with more children than the national average) and is likely to drive the relatively low employment rates among women.

When compared to England and the individual authorities, EBNS also has the highest proportion of people out of work due to long-term sickness or disability.

Dataset: *Economic inactivity data is based on self-reported responses to the 2011 census, of those aged 16-74*
Date: *2011*
Source: *Census 2011*

Proportion of those who are economically inactive

	Longterm sick or disabled	Looking after home or family	Student (including fulltime students)	Retired	Other
EBNS area	6.3%	8.7%	7.2%	11.4%	4.5%
Birmingham	5.3%	6.4%	9.7%	10.7%	3.7%
Solihull	3.3%	3.7%	4.4%	16.2%	1.5%
Combined authorities	5.0%	5.5%	7.5%	12.8%	3.0%
England	4.0%	4.4%	5.8%	13.7%	2.2%

■ Longterm sick or disabled ■ Looking after home or family ■ Student (including fulltime students) ■ Retired ■ Other

Economically inactive	Total economically inactive		Long-term sick or disabled		Looking after home or family		Student (including fulltime students)		Retired		Other	
EBNS area	38.0%	74,708	6.3%	12,338	8.7%	17,089	7.2%	14,129	11.4%	22,362	4.5%	8,790
Birmingham	35.8%	272,031	5.3%	39,917	6.4%	48,771	9.7%	74,102	10.7%	81,213	3.7%	28,028
Solihull	29.2%	43,252	3.3%	4,949	3.7%	5,506	4.4%	6,496	16.2%	24,019	1.5%	2,282
West Midland LAs	33.8%	662,210	5.0%	97,831	5.5%	108,239	7.5%	146,761	12.8%	250,851	3.0%	58,528
England	30.1%	11,698,240	4.0%	1,574,134	4.4%	1,695,134	5.8%	2,255,831	13.7%	5,320,691	2.2%	852,450

Strategies are in place to raise skills. This is a complex and crowded field

At GBSLEP level, the Skills for Growth Plan was published in June 2013. It sets out 46 actions – some of which will now have been delivered - across five key themes to be delivered over a five year period. The key themes are:

- inspired leadership by utilising the Employment and Skills Board (ESB)
- Creating a dynamic partnership between business and skills providers
- Creating a demand orientated local skills system by identifying and articulating local business needs and targeting activity on the area's key growth sectors
- Increasing aspiration and opportunity amongst young people and adults by linking pupils and learners with real-world work opportunities
- Supporting a thriving FE and HE ecosystem by working with the area's Further and Higher Education providers to support a world-leading reputation for educational excellence, and to develop an environment where students and graduates will want to study, live and work.

At Birmingham level, the Birmingham Skills Investment Plan (2016-26) lists 19 deliverables under 5 themes – representing a large and complex agenda which might need further prioritisation. The document was not intended to look at specific sub-areas within the city, so the precise response needed to deal with issues in EBNS is not apparent from the document, and, generally speaking, the document does not attach roles and responsibilities for delivery of its objectives to different institutions. However, the document makes the point that *"one of the consistent messages from employers, their representatives and wider stakeholders is that the skills landscape in the city remains too complex, opaque and difficult to navigate. People are confused by the array of organisations and messages they receive. The myriad of initiatives and organisations involved in supporting the functioning of the labour market needs to be simplified and better coordinated."*

Further action planning on operationalising and prioritising this strategy is taking place elsewhere. The strategy states that it is BCC's role to improve "the strategic leadership for skills and training in the city, combining employers, the council and providers developing a common and shared analysis of the challenges, priorities, and actions ensuring the needs of the city are reflected in the policies of the new Combined Authority and the Local Enterprise Partnership". We understand that the refreshed Birmingham Employment and Skills Board will take this function.

The Combined Authority is also sponsoring a joint programme on skills development under the themes of

- Ignite: covering themes such as careers information guidance, and workplace-based activity with clients including creating clear 'lines of sight' to the workplace.
- Accelerate: Building on the skills of people in work to develop higher level skills
- Retune: Develop skills of those who are unemployed or underemployed or in employment where demand is decreasing

On behalf of the CA, the West Midlands Productivity and Skills Commission is currently very active. Looking at the issues right across the sub-region, the Commission has the following objectives.

- To gather evidence and understand the full extent of the productivity and skills challenge across the three LEP geography of the West Midlands,
- To understand the component causes of the productivity and skills challenge and the inter-relationships between them, including where differences exist between key sectors and industries
- To make recommendations as to how these causes can be addressed at pace, taking a whole system approach,
- To provide guidance and recommendations on the implementation of plans to be approved by the Combined Authority Board,
- To propose monitoring systems to review the effectiveness of the work,
- To ensure that skills needs are future proofed, forward looking and cognisant of technology changes.

A launch of the Commission took place in April 2017. At the time of writing, a call for evidence is underway, which has the objective of setting out a way forward that will bring "lasting and meaningful change". Future strategy work for EBNS could usefully take account of the Commission's findings.

The Department for Work and Pensions (DWP) has an important role in commissioning support for getting people into work. That provision is run through a number of routes

DWP's labour market access programmes aim to increase employment by upskilling job-seekers. This support is delivering skills through a number of mechanisms, as follows.

- **Adult Skills Budget funded through Skills Funding Agency**. This is colleges' mainstream funding, but a portion is allocated to 19+ age groups, and those on unemployment benefits. This is the main funding stream for provision to DWP clients. DWP does not contribute budget directly, but can support access by supporting travel expenses, work clothing, books and course materials to assist to access. These providers do not work to specific geographic areas, meaning that there is no data collected on the level of spend available through these budgets to clients resident within the EBNS area (or, indeed, any other area). DWP state that attempts are made to commission services and geographically target services, so that clients do not have to travel far, but accept that provision can be patchy.

- **Intermediate level provision** is funded through the local authority (with Birmingham Adult Education Service acting as a college but using SFA funding) lottery funding, community budget funding, and charitable organisations. For JSA claimants, this provision acts as a supplement to SFA funded provision, and Job Centres Plus staff are able to signpost clients to these services. No DWP contract is in place for these services, and so DWP have no control over quality levels, instead relying on feedback from Work Coaches and attendees about quality. No DWP resource in in place to evaluate quality of this provision.

- **DWP Flexible Support Fund** –Evaluation of CSP found that "discretionary funding can play an important role in helping partnerships to provide services to address local needs". This is a flexible budget which District Managers can use to fund local gaps in provision. (In this case, the DWP 'district' covers Birmingham and Solihull). Budgets are not yet set for this financial year, but last year the Flexible Support Fund

had roughly £1m budget, which could be expanded to £2-3m over coming year across the District. Funding is allowed following a process of understanding local needs in individual job centres. ESOL has attracted significant funding in the past. There is existing Skills Funding Agency supported ESOL provision run through South and City College provision (Bordesley Green campus in EBNS). This is for provision around "Entry Level 2" English levels – for 26 weeks. For people who haven't gone up a level within 26 weeks, DWP is investigating providing ESOL job clubs where jobs are sought which do not require English proficiency. DWP is also looking to commission a course for people with mild to moderate mental health issues, and a history of drug and alcohol misuse.

DWP provision has an important interaction with the benefits system. DWP provision is undergoing significant structural change. The Work Programme – delivered nationally for the last five to six years - finishes on 31 March 2017. From the end of March, DWP will be changing: customers will stay with DWP for 2 years, and, if still unemployed, transfer onto the Work and Health Programme. The bulk – roughly 80% - of Work and Health Programme provision is aimed at dealing with health and disability issues, and is currently being contracted. Funding is limited for long term unemployed clients without health or disability problems at around 20% of the budget. This decision has apparently been taken for financial reasons, with ESA payments being higher than JSA, and ESA clients absorbing additional health-related spend. There will be other programmes coming on to deal with LT unemployed, direct through DWP.

Universal Credit reforms are close to being implemented. By the end of 2016, DWP will have completed a full roll out of UC.

73

Birmingham City Council also has a role in employment and skills provision. BCC is running provision aligned to DWP provision, which is intended to plug gaps, and targets particular key local issues

Birmingham City Council has an important role through the delivery of the Youth Employment Initiative (YEI) project in Birmingham and Solihull - Youth Promise Plus (YPP). Birmingham City Council are the accountable body for YPP. DWP are the Managing Authority for all ESF in the UK, including YEI. This provision is aligned to mainstream DWP/SFA provision, projects like Talent Match and incorporates the Destination Work project and provides intensive personalised support for NEET young people aged 15-29.

NEET individuals have an intervention worker who work in conjunction with work coaches in Job Centres and through more informal environments such as community centres. Intervention workers get smaller caseloads than the typical 300 clients managed by Job Centres Plus caseworkers, and are therefore able to provide higher levels of support. Other elements of the YEI include working around careers - Birmingham Careers Service are an internal delivery partner for Youth Promise Plus.

A large amount of money needs to be spent very rapidly under this programme (£50m revenue by July 2018). This is contracted into the North,

South, East, West Birmingham and Solihull areas plus specialised contracts for young people with particular barriers – such as disability and mental health issues, those at risk of offending and homeless. Localities provision is delivered in quadrants of the City plus Solihull and is not congruent with the EBNS area. Delivery is based on original needs assessment, but estimates from BCC staff are that of the £50.4m for YPP, East Birmingham will get around 29%, or £14.6m, of the available funding. (For these purposes, East Birmingham is defined by the constituency boundaries of Hodge Hill, Hall Green and Yardley). 11% will go to Solihull. From East Birmingham, the target is that 4,870 people will receive support.

One of the generic problems in service provision – across all service providers - is the stop/start nature of funding, making the creation of a long-term, high quality employability service difficult to achieve. Current funding-focused provision is hard to deliver in a consistent and efficient way, with time being taken in project set up and shut-down, and relatively little time spent in consistent service delivery to end users.

What does the evidence suggest is needed to reduce unemployment and improve skills? 1) Evidence around pro-work social norms

There is no question that problems around un- and under-employment in EBNS appear quite intractable. Successive rounds of regeneration funding and skills provision have not been successful in driving unemployment rates down to levels equal to the sub-regional or national average rate.

We explored some of the possible solutions with officers. Whilst not a package of statistics, this nonetheless provides a useful evidence base on how progress could be made.

Evidence from provider interviewees we have worked with in the course of this study suggests that some clients are unwilling to undertake the disruption of giving up benefits in exchange for a short –term and possibly insecure job, and so can become habituated to a culture of worklessness. DWP staff have suggested that jobcentre delivery and allied programmes to reduce long-term unemployed have not had the degree of impact on the pattern of unemployment and worklessness as might have been hoped. For example, after two years on the DWP funded Work Programme, 62% of people in Birmingham and Solihull are still not in work (although this is a slightly better performance that the national statistic performance of 65%).

Although it is hard to point to evidence on social norms and values, we have repeatedly heard evidence that, in some places, we need to create and reinforce an intergenerational culture of aspiration and being in work. This evidence from EBNS is supported by peer-reviewed evidence from elsewhere, which supports the suggestion that micro-cultures within peer groups and small geographical areas can affect behaviour. Dasgupta and Putnam have pointed out that social networks can prevent markets from functioning properly, and as a result can hold people back. For example, research has shown that unemployed people tend to have segregated social networks – unemployed men in particular tend to mix primarily with other unemployed men. Equally, though, this research does show how valuable social networks can be when put to good use: research shows that local labour markets are defined for low-wage workers by word-of-mouth recruitment. It is argued that the job-finding process is a social one.

Programmes have been target on these issues in the past. Between 2014 and March 2017, in specific jobcentres in Birmingham and Solihull (including Washwood Heath, Erdington, Solihull and Chelmsley Wood Jobcentres) "Destination Work", a personalised coach mentor programme for 16-24 year olds, has also existed. This was commissioned through Birmingham City

Council and funded through central government Cabinet office via a repackaging of Youth Contract resources. The personal support model adopted within this approach has had a positive effect for many individuals with a total of 2,433 young people being engaged and supported across the area of whom 888 have progressed into paid employment. However, even here there have been limits on impact with higher than expected drop out and non-engagement rates between DWP referrals and actual entry to the programme, and lower volumes of sustained jobs being achieved than originally hoped. In addition specifically in the East Birmingham area there was a pause in Destination Work delivery due to financial difficulties encountered by, and ultimately the closure of, one of the commissioned providers.

Best practice on breaking these 'micro-cultures' of worklessness is informing the creation of new programmes. West Midlands CA is bidding for DWP money for the Innovation Support Pilot which is based on the US experience through the Jobs Plus model which looks at long term unemployment in localities. Shard End in EBNS is in the top three areas within the CA area (alongside Kingstanding and Lozells East Handsworth). We understand that, currently, Kingstanding is seen as a priority, based on a basket of indices, meaning that it will likely be the priority location for delivery. (It may be that Shard End is targeted if other WMCLA constituent areas are not adopted). The programme will see a 'saturation model' put in place, targeting everyone, for upskilling and job search. Delivery will be commissioned and a Voluntary Sector organisation is likely to be selected. Community level delivery will take place through informal settings such as barbers shops, churches, mosques, and schools.

DWP staff state that the forthcoming Universal Credit (UC) reforms may have a role in creating new pro-work cultures. Forthcoming reforms to the benefit system mean that clients no longer 'sign on', and instead remain on UC until their wages are at a level sufficient to extinguish UC support. UC can more easily deal with flexible working and part time employment because it is linked to HMRC, allowing benefits to be automatically adjusted in line with paid hours. Birmingham and Solihull DWP staff are also looking at how the legalities of sanctioning might work, particularly around refusals of available jobs after long and expensive courses have been provided (eg HGV Cat2 driving courses take around 18 weeks and cost around £2000).

75

What does the evidence suggest is needed to reduce unemployment and improve skills? 2) The evidence around skills and employment support delivery settings

DWP staff suggest that developing a fine grained understanding of issues in particular areas is critical to an effective approach. Fixing persistent worklessness in East Birmingham and North Solihull is unlikely to come through major providers delivering big programmes. Evaluations of City Strategy Pathfinder initiatives undertaken from 2008, which found that 'the experience has demonstrated, irrefutably, is that more locally informed and based interventions are able to connect with, and gain the trust of, individuals who may (or may not) be on workless benefits, which allow them to engage with and explore the range of assistance and options available to them in a way in which, in general, local arms of national agencies have found it difficult to do hitherto."

There are a number of initiatives under way which take this broad approach.

- DWP are commissioning District Jobs and Skills Plans in Q2 2017, and individual job centre input around the intricacies of local conditions is likely to be central to successful District Jobs and Skills Plans.

- At the moment, in North Solihull there are six locations outside Job Centres for providing skills and employment support for those seeking work. There are ten within East Birmingham.

DWP are attempting to respond to this evidence base, with attempts under way to deliver support through schools, mosques, churches and community groups, particularly through the Flexible Support Fund. Erdington Works is one example of good practice in this respect, and saw community level exercises run with businesses and community/residents groups to better understand how to intervene effectively in labour markets. As part of this process, links to local employers are being better developed. in Sparkhill, for example, there is work with the Asian Business Forum, allowing people with ESOL needs straightforward access to jobs. Job Centre staff frequently know the main business people and community leaders, and are able to invite those leaders in to show what DWP could do and how they could work together. Again at Sparkhill, one of the work coaches arranged for a meeting with the

mosque, publicising services at Friday prayers.

Wider public estate moves around the streamlining of the health and education estate work well with this evidence. Evidence collated during the course of this study shows that NHS providers are keen about the opportunities to deliver employment support through the health estate, and employability provision would work very well with moves to create health and education community service hubs.

Distribution of skills and employment support locations in EBNS
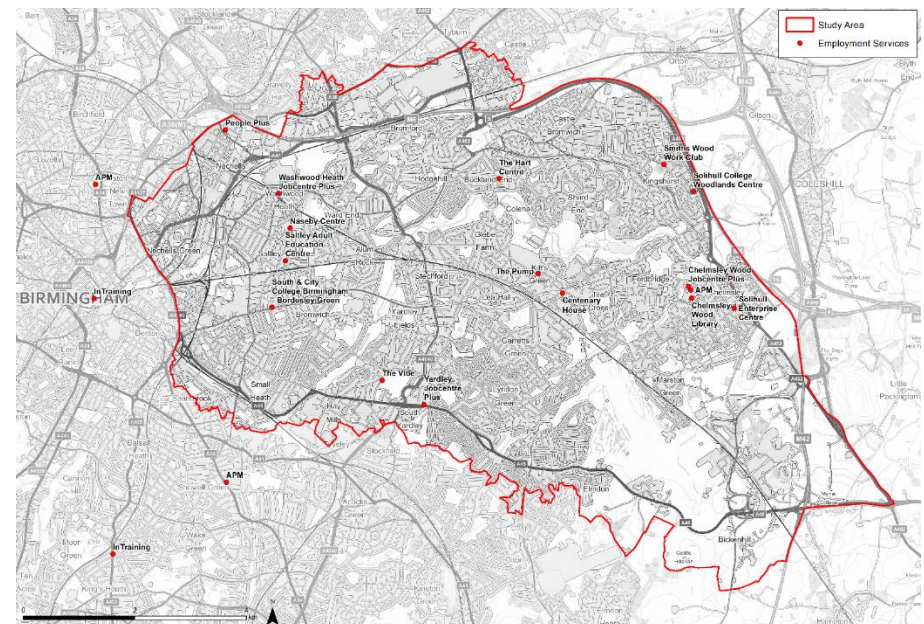
Source: BCC

What does the evidence suggest is needed to reduce unemployment and improve skills? 3) The evidence around service complexity and the need for better employer relationships

There is evidence that the skills and employability programmes suffer from significant organisational complexity and overlapping responsibilities: the Birmingham Skills Investment Plan and the role of GBSLEP in sub-regional skills strategy add layers of complexity. Officers reported that there is a lack of clarity about how the Skills Investment Plan and GBSLEP provision is influencing the DWP agenda. DWP staff note that there have been historical attempts to undertake provision mapping (by searching for gaps and duplications in the geography and content of provision) but little has been successfully resolved as a result of these exercises. We understand that the Learning and Work Institute undertook a "fragmentation analysis" elsewhere in the Midlands, and found significant overlaps in different programmes and different agencies, and also big gaps in provision.

There is evidence on the need to streamline and refocus SFA, Intermediate, and Flexible Support Fund provision, both in EBNS and beyond. There are numerous schemes and providers, operating over different areas and with different specialisms. Evaluations are infrequent, and service quality is not tracked systematically. Some structural reforms are starting to deal with these issues: for example, quality is likely to be driven up through the start-up of a new system of payment by results for providers. This is a major structural shift which comes as part of the Dynamic Commissioning System which has been recently launched by DWP.

There is evidence that new models of provision are creating new partnership and service delivery opportunities: for example, the DWP Work and Health Programme (which is currently being commissioned to replace Work Programme, and will for the most part focus on the needs of those with disabilities) has seen design input from LAs, especially around looking at what is needed for people in health issues. This has never happened previously. This relationship is developing and needs time to play out; it adds complexity but DWP staff believe the costs are entirely worthwhile. There are working groups setting these up but is currently on a standstill whilst ITTs are out.

Officers interviewed in the course of this study have stated that relationships with employers could be made more coherent, with clearer lines of communication between national and local Government staff, LEP staff, DWP, and employers. Relationships are frequently complex and fractured, without clear 'owners'. Whilst DWP staff work at the airport and NEC Job Point, creating strong relationships with those employers, DWP staff state that their main relationship with JLR is through the Council and national DWP relationship managers. However, there is little clear "line of sight" for jobseekers through to JLR jobs, although there may be good reasons for this (DWP provision only works to Level 2 skills, typically lower than required by JLR).

When effective, evidence suggests that relationships with employers can be very effective: for example, John Lewis in Birmingham and Solihull stores provide DWP clients with work experience for four weeks. At the two-week point, they have specific work coach to the end of the work experience, resulting in a very successful 58% going into work. Similarly, Tesco works with Job Centre Plus by providing a programme (tailored to an employer) whereby candidates obtain work experience in-store, and are then guaranteed a job interview.

There may also be a role for ensuring that employers' responsibilities are clarified. For example, LGV training for Blue Arrow and John Lewis Partnership costs around £2000 per person, and it may be reasonable to investigate how these costs can be at least partially recouped.

This report does not substitute for future vision and strategy – but the evidence we have collected suggests a number of lines of future investigation

This work is not intended to substitute for a vision and strategy for EBNS. However, the evidence points to a number of possible lines of investigation for future work. There is scope to make innovative solutions in EBNS, if this innovation is delivered in a properly controlled and evaluated way.

- **The evidence suggests that partners need more clarity around who does what, when, where, and with whom.** Information on spend and an evaluation mechanism could be built in. Work on how the interface between education and the workplace might be better managed would also be helpful. Ideally, there would be more control around detailed actions planning, roles, responsibilities and timeframes to address worklessness which are not in the Skills Investment Plan. The work could, possibly, be part of a refined DWP District Plan. These could broaden out from their focus on DWP provision, driving it wider to encompass wider Local Authority and even private sector provision.

- **It could be important to avoid further duplication and fracturing of responsibilities.** The Birmingham Employment and Skills Board and the Solihull Employment and Skills Board report into the LEP's Employment and Skills Board (chaired by Andrew Cleaves, Principal and Chief Executive of Birmingham Metropolitan College). Work from the Combined Authority Productivity and Skills Commission will need to be incorporated (the Commission will be publishing a strategy after the closure of this baselining project).

- **Longer term funding** would overcome the efficiencies associated with stop-go project-based delivery. Evidence suggests we should see employability and skills delivery as a service, rather than a set of projects.

- **A focus on particular sub-groups.** There are some perceptions that though YEI and YPP could be considered to be already dealing with this issue, EBNS might work to focus this provision down to particular gender, age and ethnicity groups, perhaps through a more fine-grained, sensitive and ethnographic approach to research.

- **Evidence suggests that public sector employers – notably Heartlands Hospital - could take a more innovative approach to developing local skills and links to local job seekers.** Some good practice appears to be available through the HS2 Education and STEM ambassadors, and the South & City College Bordesley Green Campus has established links with the High Speed Rail College.

- **A geographically tailored focus on getting Work Coaches out of job centres and into more informal community settings where support is more effective.** Issues appear to be highly distinctive between, say, Chelmsley Wood and Alum Rock, and so solutions will vary widely.

- **A focus on One Public Estate efficiencies.** This study has shown that there are real opportunities to work along wider One Public Estate Initiatives in health and education.

- **A focus on keeping people in work and an innovative approach to new policy.** Given the 'payment by results' model of funding which is being adopted by DWP, it may be that the importance of supporting individuals to sustain and progress in employment will become a greater imperative. Incentive payments focused on staying in work might have a role and evaluation findings from earlier programmes could be reviewed on this issue. If incentive payments are effective in building a culture of working in individuals and communities, such approaches have the benefit of short-circuiting a great deal of complexity around commissioning provision, and would be assisted when Universal Credit arrives in full, because more flexibility under UC would be available.

- **A focus on correcting anomalies in provision.** For example, traineeships do not get travel payments, but apprenticeships do. EBNS may be able to address this inequality for individuals within the area.

Officers suggest that one of the biggest prizes for the future could be around changing young peoples' attitudes to work, and transmitting a positive and realistic sense of the opportunities available. The seeds of a future programme could already be in place, which could work well at a time of public sector austerity

Although it is hard to point to hard evidence on social norms and values, we have shown above that there is good evidence to suggest that, in some places, we need to reinforce a positive intergenerational culture of working and aspiration. One of the biggest single prizes for delivery in the area could be to set in place long term measures to deliver a pro-work cultural shift in hard-to-help families. Detailed and sensitive thinking would need to be carried out, but a distinctive EBNS approach might evolve here which specifically targeted young people, and aimed to provide clear, aspirational but entirely realistic "lines of sight" to employment opportunities in the area. There could be a role for a reinforced careers service here.

Evidence suggests that there are possibly the starts of such a programme in place. This approach was adopted as part of work undertaken through the North Solihull Partnership, and Birmingham already has a Charter of Social Responsibility which is signed by any contractor with works over the value of £1m – committing them to activities such as schools liaison, the provision of work experience for young people, school site visits, and so on. BCC is in the process of contracting £15m through Balfour Beatty for school construction, and will be adopting this approach. (Chalet-style outside classrooms will be constructed at schools, with the involvement of children).

This approach could be up scaled to deal with the billions of pounds-worth of contracts likely to be commissioned for the public sector in EBNS over the next decade, alongside private sector investment (see BCC's contribution to House of Lords Infrastructure and Employment Sub-Committee, Oral and written evidence, 2014). Each successful contractor could be asked to start a schools programme, which would attempt to inculcate an optimistic but realistic sense of the possible future job opportunities, alongside developing the soft skills that employers say they need. A significant merit of this approach is that it might cost relatively little public sector funding, aside from employer relationship building, some contracting and procurement support to enforce delivery, and some programme support through a revitalised careers service. (There are limitations in Careers Service funding, meaning that young people from families with little experience of wider labour markets get relatively little exposure to the career choices which might be available. Some of this role might be picked up via schools - Careers Service funding is limited, whilst schools have statutory responsibilities). The Public Services (Social Value) Act of 2012 backs this approach and requires public authorities 'to have regard to economic, social and environmental well-being in connection with public services contracts'. The legislation does not define 'well-being' but official guidance encourages commissioners of public service contracts to meet the wider social, economic and environmental needs of the community, as well as the best price.

Improved relationships between schools and the private sector could be developed through mechanisms other than a pure contractor relationship. Nationally, a number of large employers – such as JLR and Microsoft – have established schools programmes which could be extended further. There are also opportunities such as those available through University Technical Colleges (UTCs) which could be further examined. This work could aim to be highly ambitious, and create a genuinely revolutionised relationship between schools, HE and employers.

Careful scoping and evaluation would be needed. But because of the relatively light load on public sector resources that this approach creates, this approach might work neatly with a continued time of public sector austerity.

79

Health and wellbeing

Key issues:

- Prevention and early intervention on lifestyle related conditions remains important

- Long term sickness is higher than average, with mental and behavioural disorder being a significant problem

- Adverse childhood experiences and child poverty create long term problems

- Obesity and poor air quality are major issues

- Interdisciplinary solutions could get traction

81

A brief review of the literature and local context

Whilst health and wellbeing is a very wide topic, in this baseline report we focus that remit on the issues which are likely to have the most direct relationship to the current and future economic success of the East Birmingham North Solihull areas. We see those issues as being those which have a particular impact on the capability of individuals to participate in the labour market, and make a full economic contribution without barriers being placed in their way by ill-health. In this section, we look at the evidence regarding the prevalence and causes of health and wellbeing problems, what is currently being done, and what the evidence suggests might be done in future.

Attempts to look at the underlying causes of health and wellbeing problems are complicated by the fact that poor health can simultaneously be both a cause and effect of social and economic problems. Studies have distinguished between the primary indicators of public health, and proxy indicators.

Primary indicators are predominantly linked to the wider and social determinants, including access to employment, and education, a good working environment, access to housing and healthcare services.

Secondary, or proxy indicators include the ones that we often consider to be primary, including mental health, heart disease, respiratory disease, alcohol related hospital admissions, and preventable premature mortality rates. It could be argued that these indicators are indeed primary ones. However, they are predominantly preventable, and are linked firmly to the wider determinants. We know that people in more affluent wards and districts in Birmingham live on average 10 years longer than those in the most deprived areas (figure 2). We also know that they have a better quality of life for longer.

Given that causes and effects of poor health are so embedded in one another, it can be unhelpful to look for a single underlying 'root problem': such a problem is elusive. Instead, we must start somewhere, and the most productive way forward would appear to be trying to identify both the primary *and* proxy manifestations of poor health, and tailoring action to deal with each, in the expectation that, over time, health and wellbeing is improved. Because other parts of this baseline are looking specifically at dealing with unemployment, poor skills and consequent poverty, this section will concentrate on the main proxy indicators of public health.

Life expectancy rate at birth (2007/09) Birmingham mean: 79

Within only **eight stops** you can shave nine years off the average life expectancy of a citizen.

Data source: Birmingham Electoral Ward Profiles (August 2011) Birmingham Public Health Information Team http://bit.ly/phitwp0811

82

Economic and community influences on health and wellbeing are critical. But the evidence suggests that fixing the long term cannot overshadow dealing with the 'here-and-now'

There is good evidence to show that the majority of ill health - including mental ill-health and chronic illness - is preventable and is related to wider determinants. The Barton and Grant (2006) model shows that lifestyle decisions, community networks, and the built environment are some of the biggest drivers for health and wellbeing outcomes. Areas of high deprivation and those people lower down the social gradient are far more likely to have poor health and wellbeing outcomes. We know that people who live in areas of high deprivation make poorer lifestyle and behaviour choices and take risks associated with poorer health outcomes, including substance misuse, drinking to harmful and hazardous levels, and smoking.

We also know that families without a working member are more likely to suffer persistent low income and poverty. There is also evidence of a correlation between lower parental income and poor health in children (Griggs & Walker 2008).

The 2010 Marmot Review on Health Inequalities sums the issue up as follows.

"People with higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. This link between social conditions and health is not a footnote to the 'real' concerns with health – health care and unhealthy behaviours – it should become the main focus. In other words, we need to tackle the wider determinants of health. There needs to be a fundamental shift away from a focus on health care and unhealthy behaviours, and a refocus on social conditions."

The built environment contains the very material determinants of health, including housing, neighbourhood conditions and transport routes, all of which shape the social, economic and environmental conditions for which good health is dependent (GCPH 2013) and Improving the health of the working age population is critically important for everyone, in order to secure both higher economic growth and increased social justice (Waddell 2006).

Evidence (from Marmot and other academic papers) suggests that health and wellbeing can be expected to improve as the economic and social success of the area is improved.

However, EBNS needs to make progress for the health of its inhabitants in the here and now. This structural economic change is a long term process, so addressing *current* health issues with a degree of urgency is also justified.

The Barton and Grant model shows that economic and community influences on health and wellbeing are important
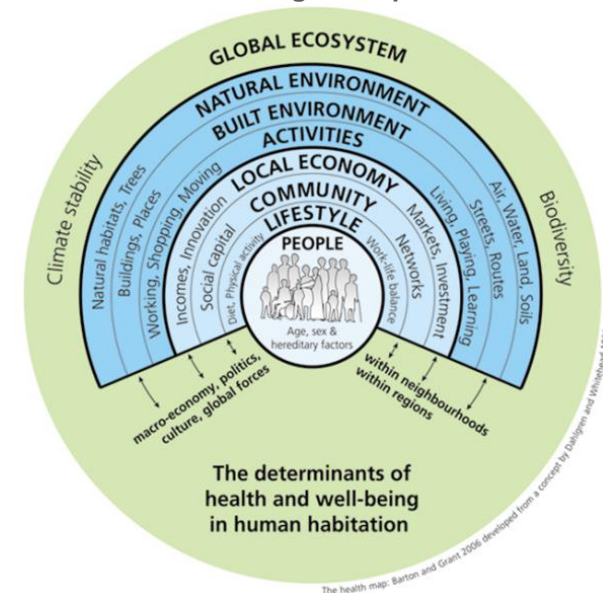
Source: Barton, H. and Grant, M. (2006) A health map for the local human habitat

To deal with the 'here and now' issues, continued prevention and early intervention on lifestyle related conditions will be important

There are 13 wards over four districts in Birmingham, and five wards in Solihull, that make up the East Birmingham and North Solihull footprint. We find similar health and wellbeing concerns:

- Child poverty
- Infant mortality
- Preventable deaths under the age of 75
- Premature death from coronary heart disease
- Premature death from respiratory disease
- Premature death from cardiovascular disease
- Premature death from cancers
- Significantly high levels of diabetes
- Significantly high levels of obesity
- Significantly high levels of mental health
- Communicable disease deaths

We have taken Bordesley Green as a case study. The chart shows that Bordesley (and Birmingham) life expectancy is around two years under the English average. The life expectancy change over time does not follow the English or Birmingham rate of change, indicating that there are clear health and wellbeing issues that are not being addressed. The precise reasons for this would need detailed separate study.

Bordesley Life Expectancy against Birmingham and English averages

Bordesley Green Ward Life Expectancy 2001 - 2013 on a 3 year Rolling Average
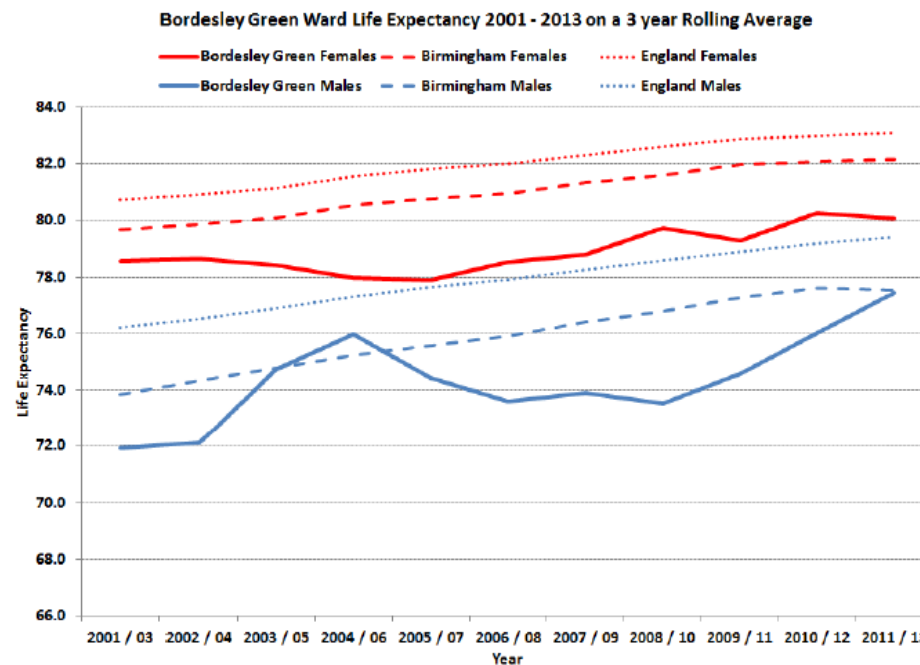
Evidence put together by BCC shows that the many health and wellbeing issues are underpinned by wider and social determinants, and that many premature deaths are preventable

.

The spine chart (right) is a graphical interpretation of the position of Bordesley Green district according to important health indicators. The chart portrays Bordesley Green's value (shown by a coloured circle) against the spread of values for all Birmingham districts (the grey horizontal bars) compared to a benchmark of either the England or Birmingham average (the central black line). The circle for Bordesley Green is coloured red for those indicators where the Bordesley Green value is significantly worse than the benchmark, green for indicators where it is significantly better than the benchmark and amber where it is similar to the benchmark. In addition, some indicators are coloured light or dark blue. These are indicators where a value judgement cannot be made about whether a high value is good or bad. For example a high diabetes prevalence may indicate poor levels of health in the case of high numbers of people with diabetes; alternatively, it could indicate good performance in primary care if GPs are good at identifying and recording cases of diabetes.

- If you live in Bordesley Green your life expectancy is below the England and the Birmingham average
- Mental health, dementia, and depression prevalence are all significantly higher than the England average
- 100% of Bordesley Green's population fall within the most deprived 20% of areas in England.
- During 2011/13 Bordesley Green ward's under 75 death rate was 32.1% higher than the rate for England (Birmingham was 23% higher than England)
- Infant Mortality is one area of concern: the district rate was 12.9 per 1,000 live births in 2011/13, this compares to an England rate of 4.0 and a Birmingham rate of 7.4
- There were 248 homeless registrations between 2012-2014 in Bordesley.
- The average age of death for a homeless person is 43-47 years of age.
- Over 70% of people using homelessness services report having experience of mental distress.

Bordesley Green Ward Health Indicators Spine Chart – Birmingham Public Health 2015

	Indicator	Bordesley Green Number	Bordesley Green Stat	B'ham Avg	Eng Avg	Ward Range
1	% of Children in "Poverty" 2012	3830	29.4	29.9	19.2	
2	Adults with learning dis. in stable accommodation 2013/14	44	53.0	51.2	73.5	
3	Violent Crime Admissions 2010-14	121	98.5	78.1	57.6	
4	Low Birth Weight 2013	63	8.1	10.0	2.9	
5	Excess weight 4-5 year olds 2013/14	186	24.6	23.2	22.5	
5	Excess weight 10-11 year olds 2013/14	290	42.5	38.8	33.5	
6	Injuries due to falls 65+ Persons 2013/14	62	2380.4	2931.1	2011.0	
7	Infant Mortality 2011-13	n/a	12.9	7.4	4.0	
8	Mortality from all causes U75 2011-13	217	132.1	123.2	100.0	
8	CVD Deaths U75 2011-13	45	134.2	129.5	100.0	
8	Cancer deaths preventable U75 2011-13	33	60.5	116.8	100.0	
8	Respiratory disease deaths preventable U75 2011-13	n/a	86.4	132.8	100.0	
8	Communicable disease deaths 2011-13	43	160.3	111.8	100.0	
8	Diseases of the liver deaths preventable (U75) 2011-13	n/a	161.3	126.1	100.0	
9	Hip fractures 65+ admissions 2013/14	66	510.2	617.8	568.1	
9	Alcohol related admissions 2013/14 (narrow)	147	701.2	711.5	829.4	
10	Diabetes Prevalence 2013/14 (QOF)	1473	6.5	8.1	6.2	
10	Mental Health Prevalence 2013/14 (QOF)	330	1.2	1.1	0.9	
10	Dementia Prevalence 2013/14 (QOF)	237	0.8	0.5	0.6	
10	Depression Prevalence 2013/14 (QOF)	1604	7.5	6.0	6.5	

Key:

- Significantly better than England average
- Not significantly different from England average
- Significantly worse than England average
- No significance can be calculated
- Significantly lower than the England average*
- Significantly higher than the England average*

Worst district | England average | Best district

85
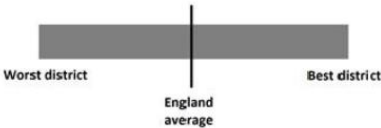
Health and wellbeing problems affect the life chances of individuals affected. Aside from the equity issues raised, health and wellbeing issues have a serious impact on the economic activity rate: long term sickness and disability in EBNS is around 50% higher than the English average

Proportion of adults aged 16-74 who are economically inactive and have a long term sickness or disability

This pattern can also be seen in higher proportions of people out of the labour market due to permanent sickness or disability than across England and neighbouring areas.

The data shows the proportion of adults aged 16-74 who are economically inactive and have a long term sickness or disability. Economic activity relates to whether or not a person was working or looking for work in the week before Census.

The table below demonstrates that rates of economic inactivity due to long term sickness or disability are around 50% higher than the England average.
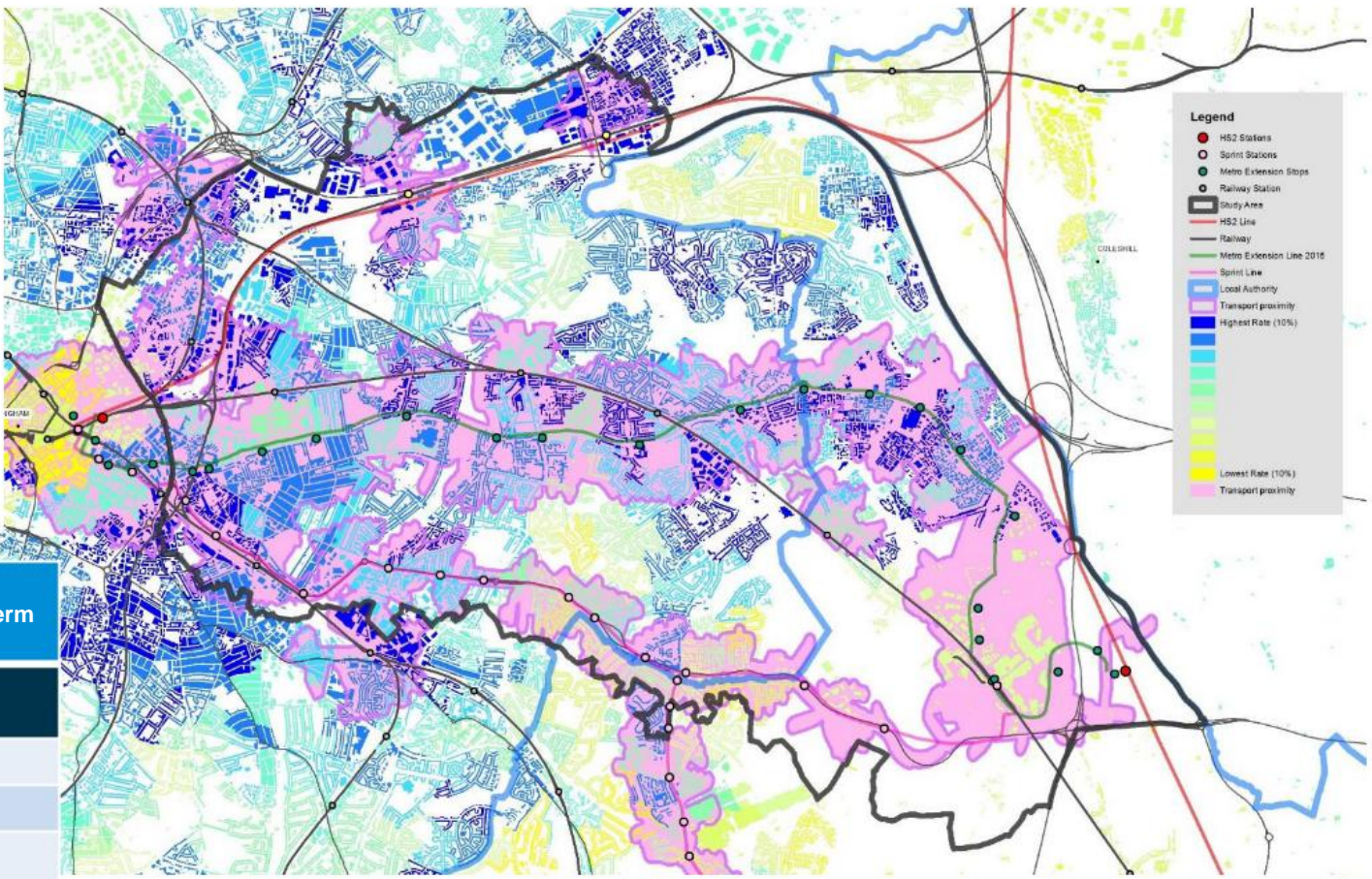
Area	Economically inactive: Long-term sick or disabled
EBNS study area	6.3%
Birmingham LA	5.3%
Solihull LA	3.3%
WMCA constit LAs	5.0%
England	4.0%

Dataset: *Proportion of adults aged 16-74 who are economically inactive and have a long term sickness or disability.*
Date: *2011*
Source: *Census 2011*

People who are economically inactive due to sickness and disability translate into high rates of Employment Support Allowance claims in the EBNS area

The dataset shows the proportion of people who are out of work and receiving benefits relating to poor health: Incapacity Benefit (IB) / Employment Support Allowance (ESA). IB and ESA are workless benefits payable to people who are out of work and have been assessed as being incapable of work due to illness or disability and who meet the appropriate contribution conditions. ESA replaced IB and Income Support paid on the grounds of incapacity for new claims from October 2008.

A number of areas in EBNS are in the highest decile of IB/ESA claiming rates in the country. However, there are pockets of very low claimant rates around Castle Bromwich and parts of Hodge Hill, Sheldon and Stechford.
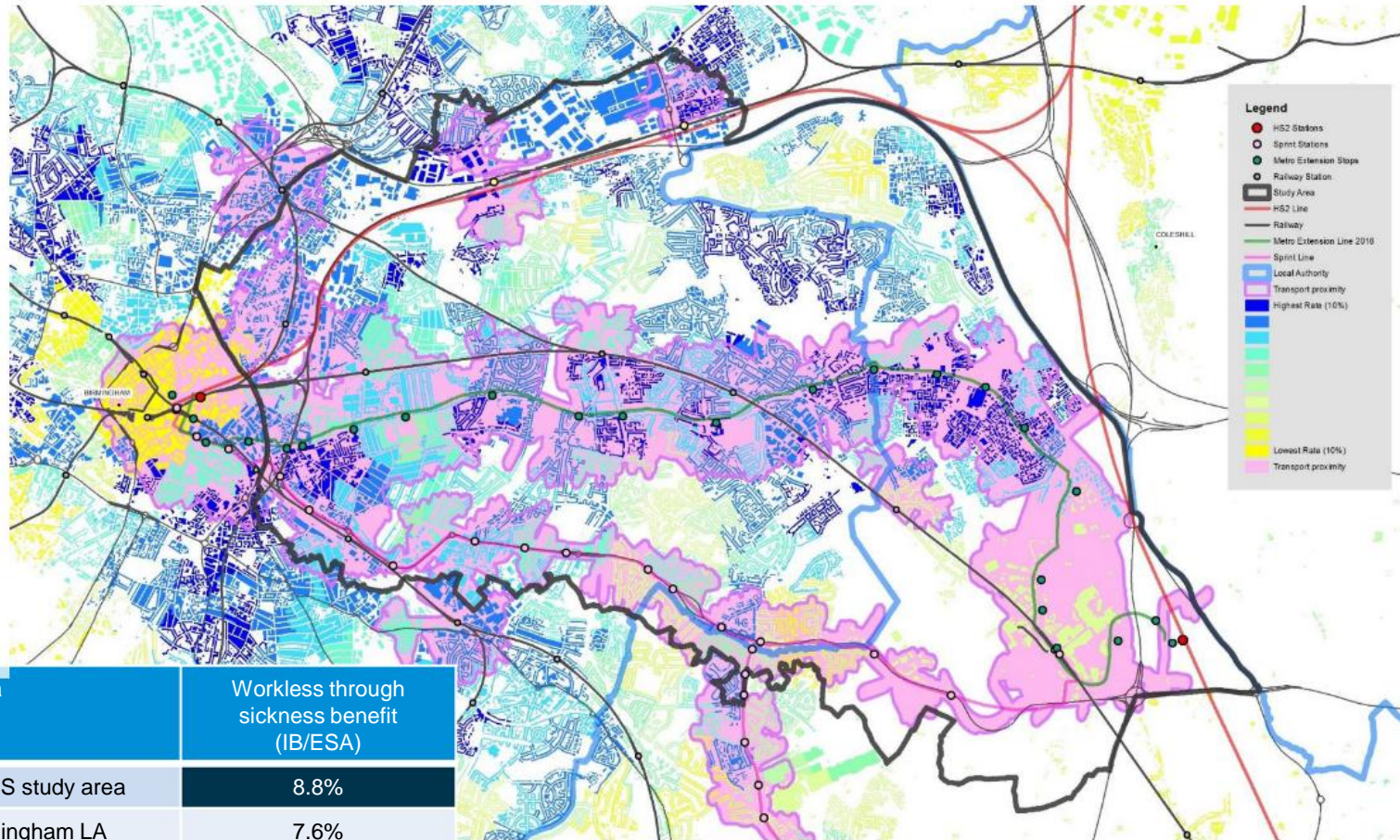
Area	Workless through sickness benefit (IB/ESA)
EBNS study area	8.8%
Birmingham LA	7.6%
Solihull LA	5.0%
WMCA constit LAs	7.2%
England	6.0%

Dataset: Proportion of people who are out of work and receiving benefits relating to poor health: Incapacity Benefit (IB) / Employment Support Allowance (ESA). **Date:** May-16
Source: Department for Work and Pensions (DWP)

Mental and behavioural disorder is by far the biggest reason why people are claiming ESA/IB in ENBS. That category is three times larger than the next largest category, which is musculo-skeletal disorders

Data in the table to the right sets out the reasons why people in Birmingham and Solihull are claiming ESA. Approximately half of all people receiving ESA/IB in Birmingham and Solihull are claiming for mental health reasons. Data shows that that proportion rises to around 63% of all claimants for those aged 25-34. In general the proportion of all claimants with a mental or behavioural disorder falls with increasing age. Mental health difficulties range from patients with a diagnosis of depression and/or anxiety disorder to schizophrenia, bipolar affective disorder and other psychoses. Note that mental health difficulties are a national issues, rather than one particularly confined to EBNS. The next largest reason why ESA/IB was being claimed related to diseases of the musculoskeletal system and connective tissue.

The table below shows that this means that with more than 4% of the working age population are economically inactive due to mental/behavioural disorders. We can see the geographical distribution of mental health difficulties across EBNS in the map below.

Birmingham and Solihull: reasons for ESA claims

Diseases of the circulatory system 4%

Injury, poisoning and certain other consequences of external causes 5%

Diseases of the nervous system 5%

Symptoms, signs and abnormal clinical and laboratory – not classified 9%

Diseases of the musculoskeletal system and connective tissue 14%

Mental and behavioural disorders 49%

Area	% of the working age population economically inactive due to mental/ behavioural disorders (receiving IB/ESA)
EBNS study area	4.3%
Birmingham LA	3.9%
Solihull LA	2.5%
WMCA constit LAs	3.5%
England	2.9%

Dataset: *Shows the proportion of people receiving out of work benefits due to poor mental health (IB-ESA for mental health reasons). The figures for the number and proportion of people with mental health issues are based on the claimants of Incapacity Benefit who are claiming due to mental health related conditions. Incapacity Benefit is payable to persons unable to work due to illness or disability.*
Date: *May-16*
Source: *Department for Work and Pensions (DWP)*

88

Page 392 of 588

Table 1: ESA/IB claimants by age Birmingham & Solihull			*Source: DWP/NOMIS/BCC*		
Age	Birmingham & Solihull - Mental & behavioural disorder	Birmingham & Solihull - All claimants	Those with a mental & behavioural disorder as % of all claimants		
			Birmingham & Solihull	Core Cities	Great Britain
Under 18	50	110	45%	55%	52%
18-24	2,830	4,880	58%	62%	61%
25-34	6,480	10,230	63%	66%	64%
35-44	7,200	12,300	59%	61%	58%
45-49	4,290	8,300	52%	55%	51%
50-54	4,220	9,310	45%	49%	44%
55-59	3,630	9,430	38%	41%	37%
60+	2,460	7,460	33%	35%	30%
Total	31,160	62,030	50%	52%	49%

The 2017 West-Midlands Combined Authority Action Plan to drive better mental health in the West Midlands (entitled *Thrive)* finds that the cost of mental ill health in the West Midlands is around £12.6b per annum – approximately £100m pa in EBNS

Thrive finds that *"People with mental ill health get a raw deal…the cost of mental ill health to the West Midlands is estimated to be £12.6 billion per year. We now have the knowledge and understanding to address this, to make better use of public and private resources to achieve better results for people. So the moral and the economic case for acting is unanswerable".*

Norman Lamb – West Midlands Combined Authority (2017)

A very rough pro-rata of these findings by population suggests that the costs of mental ill health in EBNS is around £100m per annum. *Thrive* has a number of themes for action.

- Theme 1: Supporting people into work, and supporting them whilst in work (via IPS model)
- Theme 2: Providing safe and stable places to live, including a *housing first* model.
- Theme 3: Mental Health and Criminal Justice, including developing a programme that more effectively supports people with mental ill health as they prepare to leave prison and settle back in the community.
- Theme 4: Developing approaches to health and care; very similar to the aspirations of Forward Thinking Birmingham – improving accessibility and outcomes.
- Theme 5: Getting the community involved, including a large public health programme to get 500,000 people across the West Midlands in Mental Health First Aid.

Evidence from officers suggests that there is a growing understanding of the costs and benefits of dealing with the link between poor mental health outcomes, ACEs and deprivation, and breaking the intergenerational cycle of deprivation. For example, officers state that the CCG can ensure that contracts and facilities reflect the social determinants of health and are not merely outlets for medical/clinical intervention. GPs are reporting that more and more patients are presenting with a social problem and not necessarily a medical one, although the physical manifestations of the issue could have outwardly clinical symptoms, including anxiety, depression and hypertension.

There may be an opportunity to consolidate new and emerging recommendations, strategies, services and facilities into real outcomes for EBNS.

89

Birmingham performs badly on child mental health compared to the national average, suggesting that mental health problems will persist into the future. Within Birmingham, evidence suggests that EBNS is likely to perform amongst the worst

Each year a survey of a sample of Children and Young People is undertaken in Birmingham schools. Statistical breaks which allow us to focus on EBNS are not available, but even so, Wilkes (2014) finds that there are some striking differences in these patterns revealed in the survey when compared with the national norms. Of those that completed the survey it was found that:

- 8% of 11-15s have emotional problems compared to the national average 5%.
- 14% of 11-15s have conduct disorders compared to the national average 11%. Although there appears to be a decrease in trend, it still has been consistently higher than the national average
- 13% of 11-15s have poor attention and concentration, compared to 11% national average.
- 4% of 11-15s have poor peer relationships compared to the national average 1%.
- 9% of 11-15s poor pro-social skills compared to the national average 2%.

Solihull uses a different method for collecting emotional wellbeing data from children & young people than Birmingham so it is difficult to make direct comparisons. However, the findings of the Health Related Behaviour Questionnaire (from secondary school pupils aged 12 to 15 surveyed in Solihull in 2016) are available. The first figure is the North Solihull schools data, and the figure in brackets shows the overall Solihull percentage for comparison. The North Solihull cohort responded more negatively than the Solihull average. Only statistically significant findings are listed.

- NS 27% (38% Solihull average) of pupils responded that they enjoy 'most' or 'all' of their lessons at school
- NS 21% (15% Solihull average) of pupils had a med-low self esteem score (9 or less)
- NS 37% (46% Solihull average) of pupils had a high self esteem score (15 or more)

An attempt to use national and local research to assist in predicting where the communities of greatest need resulted in a local Mental Health Index. It scored the factors identified in the published research to have an impact upon children's emotional health. It was then used to identify communities with a more or less of these factors and therefore an influence on the likelihood for the children to develop emotional distress or mental illness. Whilst data was not collected for North Solihull, the work indicates that the East Birmingham area is likely to contain some of the most acute child mental health needs.

11-15 year old Mental Health comparison against national averages
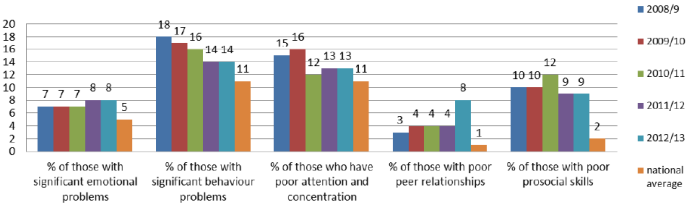
Source: Dr Dennis Wilkes for BCC (2014) Children & Young People's Mental Health Drivers & Responses
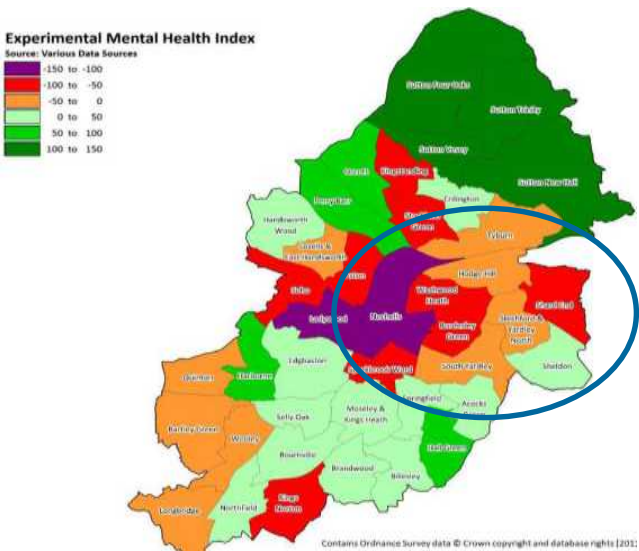
Source: Dr Dennis Wilkes for BCC (2014) Children & Young People's Mental Health Drivers & Responses

Further evidence is emerging on the long term effects of a poor childhood. Chronic early stress in childhood, termed Adverse Childhood Experiences (ACEs) damage long-term life chances and create less productive members of society

In 2015, Public Health Wales reported recent evidence that demonstrates that chronic traumatic stress in early life alters how a child's brain develops and can fundamentally alter nervous, hormonal and immunological system development. The report stated that "Children who experience stressful and poor quality childhoods are more likely to adopt health-harming behaviours during adolescence which can themselves lead to mental health illnesses and diseases such as cancer, heart disease and diabetes later in life. Adverse Childhood Experiences are not just a concern for health. Experiencing ACEs means individuals are more likely to perform poorly in school, more likely to be involved in crime and ultimately less likely to be a productive member of society."

However despite significant investment, the report found that the overall impact of these programmes on preventing ACEs is often unclear. The report stated that in order to effectively reduce ACEs and improve individuals' life course prospects, a number of issues should be addressed. The report is worth quoting in detail.

- *"Firstly, improved awareness is needed of the importance of early life experiences on the long-term health, social and economic prospects of children. Information should be available to a wide range of professionals (health, education, social, criminal justice and others) on ACEs, their consequences and how they can be prevented. Information should also be disseminated to the public and especially those planning or having children.*

- *[…] a better understanding is needed of specifically what support every individual should and ultimately does receive. Support must conform to established and emerging evidence of what works in the prevention of ACEs and the successful development of resilience in children.*

- *Finally, some families (often but not exclusively in deprived communities) require enhanced support in parenting and child development…what is actually delivered, how well needs are met and how well interventions match the evidence for ACE prevention is sometimes unclear. ACEs may*

be prevented through enhanced public and professional awareness, evidence-informed universal service specifications, effective pathways into additional support, monitoring of intervention coverage and content and, routine audit of fidelity to intervention specifications. While Public Health may have a leadership role in these developments they require partnerships and investment from healthcare services, local authorities and more widely across the whole public sector."

Infographics relating to Adverse Childhood Experiences (ACEs) offer a picture of the impact of poor child development and family dysfunction.
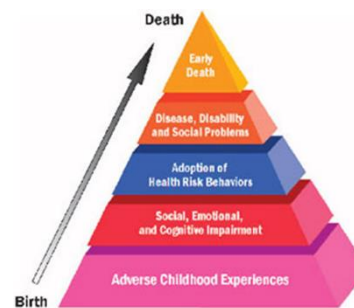
The first ACE image (left) offers an overview of ACEs and their impact across the life-course, ultimately leading to premature mortality. The second ACE infographic (bottom left) shows the impact of ACEs on children can manifest as outcomes as an adult. However, from an asset based perspective, the third ACE infographic (bottom right) shows the outcomes that can be achieved if we intervene at an early age, or better still, prevent ACEs.
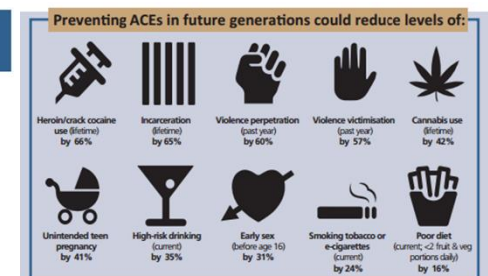
Source: 2015 Public Health Wales NHS Trust

Page 395 of 588

There is evidence to suggest that family intervention and counselling can help break the inter-generational cycle of deprivation

Dr Dennis Wilkes' work for Public Health Birmingham notes that the work of Field, Munro, Allen, and Marmot has been developing the case for earlier intervention to prevent or diminish the development of child and family dysfunction. The objective would be to try to break the inter-generational cycle of deprivation. Wilkes reports that Allen in particular called for action to set up a culture of early interventions to develop a virtuous spiral out of recurrent difficulties.

The evidence for this case was developed in more detail by a Birmingham Task & Finish Group in 2013 and was integrated into the Birmingham Child Poverty Strategy. The Group identified there were two groups of early interventions. Reactive Early Interventions, namely interventions delivered early in the development of a child's or family struggle thereby preventing escalation of need for specialist assistance, and Programmed Early Interventions which are delivered early in the child and family's life with the aim of reducing the likelihood of difficulties arising in the first place and enhancing the child's development to improve the likelihood of achieving their full potential.

The Task and Finish Group supported the commissioning of services that strengthen family functioning and build resilience through evidence-based interventions such as Functional Family Therapy, Family Group Conferencing and Solution Focussed Therapy. The approaches aim to change family interaction and family relationships, and through this, individual problem behaviour.

Established challenging behaviours or conduct disorders in young people were identified as requiring attention through the use of evidence-based interventions that tackle challenging behaviour in children such as specific Cognitive Behaviour Therapy Programmes related to Aggression Reduction Therapy and Multi-Systemic Therapy. In response to the mental health needs of young people, it was proposed that the systematic use of Cognitive Behaviour Therapy by health professionals is increased and available early at the point of identified need for teenagers with anxiety, depression or psychological issues. Selective Programmed Early Intervention is the rationale of the Right Service, Right Time framework adopted locally by the Birmingham Safeguarding Children Board. In Birmingham there are programmes which have been shown to have a positive impact upon children and families before entrenched problems have arisen, namely Family Nurse Partnership, Triple P, Safe Care, Incredible Years and Promoting Alternative Thinking Strategies.

We understand from BCC officers that an update report has gone to Scrutiny and Overview which tracks progress on this issue.

92

Obesity and sedentary lifestyles are generating major long-term health costs

The maps below show the prevalence of overweight and obesity at yr. 0 (when children start primary school) and year 6 (when children leave primary school). Child data is presented because good quality data can be collected for children. There is a strong relationship between the prevalence of obesity in children and adults. There is a distinct increase in overweight and obesity between these years. We see similar patterns of deprivation, child poverty, fuel poverty, high levels of diabetes, poor mental health and premature mortality in areas of higher overweight and obesity.

Being overweight or obese is inextricably linked to social determinants, food environment and physical activity environment (as well as biology). We therefore have control over the major causes and is effectively a preventable issue. Being overweight is linked to being sedentary. Research shows that those people who are physically active have better life expectancy, better quality of life, better mental health and less prevalence of lifestyle related disease and musculo-skeletal issues (mental health and musculo-skeletal issues being the two biggest causes of ESA and IB claims). Public Health Intelligence currently has physical activity data at local authority level, and so we are unable to present data specifically at sub-local authority level. However, 51% of adults in Birmingham are achieving at least 150 minutes of physical activity per week which is significantly lower than the England average (57%) (Source: Active People Survey, Sport England).

Birmingham ward map of excess weight by Reception and Year 6 (May 2015)

93
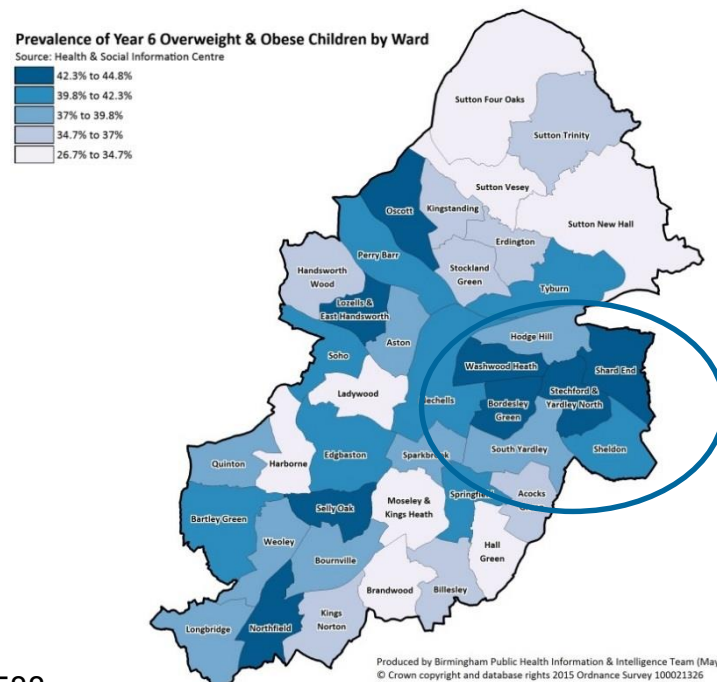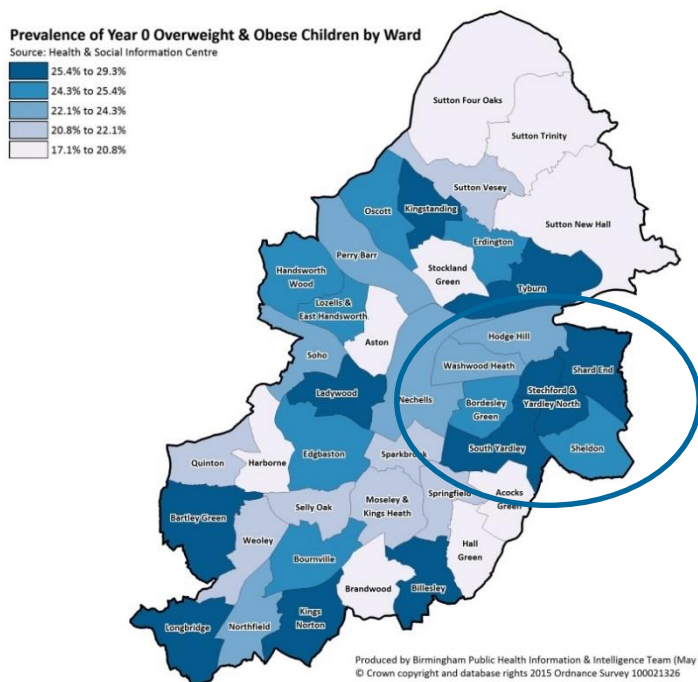
Is EBNS an 'obesogenic environment?'

The term 'obesogenic environment' refers to the role environmental factors may play in determining both nutrition and physical activity. Environmental factors may operate by determining the availability and consumption of different foodstuffs and the levels of physical activity undertaken by populations.

There is considerable literature on the relationship between the prevalence of hot food takeaways and diet. However, causality has not been satisfactorily proven. A literature review for the Government Office for Science (2007) found that environmental influences on diet may involve access to foods for home consumption from supermarkets, or access to takeaways and restaurants. **However, similar findings are not consistently observed elsewhere, and a recent high-quality study in the UK found no effect of the introduction of a supermarket in a deprived area.**

Other research shows that the number of takeaways in an area has an impact on obesity. Whilst there is debate on the extent of the importance of the issues (for example, whether the number of takeaways are cause of poor health, or a symptom), University of Cambridge research (2014) found that people are exposed to, on average, 32 different takeaway options each day. Cambridge study, published in the BMJ, looked at the eating habits and weight of nearly 5,500 people who took part in a lifestyle study in 2011, and compared the results to information on the number of takeaway outlets in their area. Researchers estimated grams of daily takeaway consumption based on intake of burgers, pizza, fried chicken and chips. The group of people who were most exposed to fast food options consumed on average 5.7 grams more takeaway food than the least exposed group (Independent, 2014).

Planning policy is seeking to control the number of takeaways. Birmingham City Council has limited the number of takeaway outlets to no more than 10% of units in any shopping area. Part of the justification for this policy is around town centre vitality, but part is around combating obesity (Cllr Steve Bedser, Birmingham Post, 28 March 2014). Solihull has a similar policy (P18) which 'seeks to manage the concentration of hot food takeaways, particularly around schools, which may increase the propensity to consume unhealthy food."

The map shows the most recently published data on the proportion of A5 uses (hot food take-aways) in EBNS centres. For Birmingham centres the map provides a snapshot of the proportion of A5 uses in 2016 and for Solihull centres the data is from 2011. The three centres with the highest proportion of A5 uses are Glebe Farm, Pelham and Timberley (Castle Bromwich Bradford Road). Nine out of 25 centres in the EBNS study area are considered to have a high proportion of A5 uses with 25% of units or more in A5 use. The centres with the lowest amount of A5 uses include Alum Rock (Saltley), Swan (Yardley) and Meadway at 8%, 7% and 4% respectively.

Obesity drivers
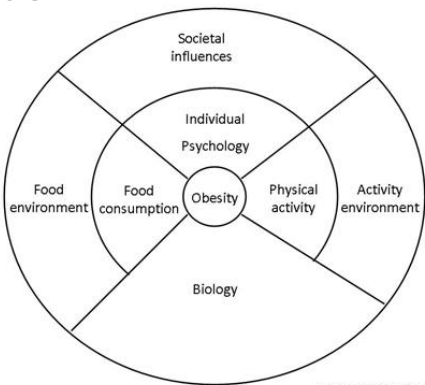
Source: Foresight systems map, 2007

Proportion of A5 Hot Food Takeaway uses in EBNS centres (%)
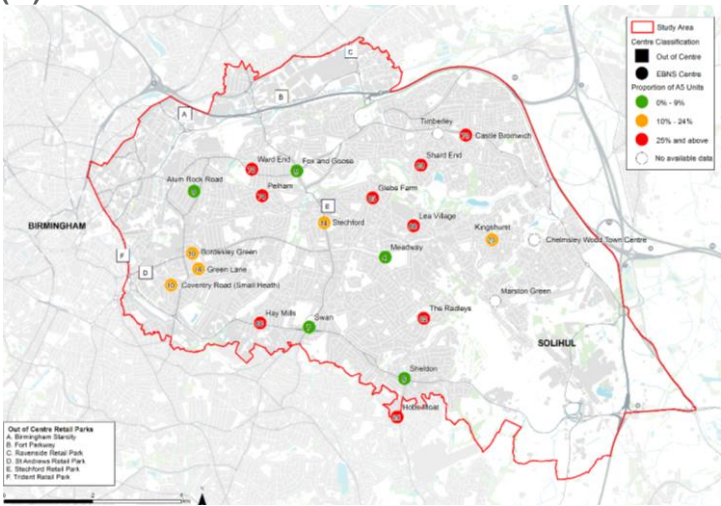
Dataset: *Table 3: Policy 4 - Percentage of Class A5 Uses Statistics 2016[1]*
Date: *2016[1] and 2011[2]*
Source: *Shopping & Local Centres Supplementary Planning Document (SPD) Monitoring Report 2016[1] and Solihull Retail Study Health Check Appendices 2011[2]*

Cross-disciplinary working with walking and cycling strategies could help both physical and mental wellbeing. The 'last mile' strategy is critical for the success of public transport strategies, and could have onward health benefits

A large number of studies have examined the association between environmental characteristics and physical activity. However, relatively few have analysed body mass or obesity as outcomes. The Government Office for Science literature review finds that the general picture from these projects is that residents of highly walkable neighbourhoods are more active and have slightly lower body weights than their counterparts in less walkable neighbourhoods, as do those living in areas with high land-use mix. The only UK study reviewed found that perceptions of social nuisances in the local neighbourhood increased the risks of obesity, while good access to leisure centres and living in a suburban environment reduced the risks. These effects remained after adjustment for self-reported participation in walking, sports and overall physical activity.

The Birmingham Cycle Revolution plans a cycle route through EBNS – via Castle Vale, the Fort and JLR (see the Connectivity section). Later visioning and strategy work may choose to consider whether these initiatives need expanding, particularly by providing walking and cycling connections to Metro and Sprint, with cycle parking facilities at stops.

Evidence collated for the connectivity section of this report suggested that cycling and walking strategies could be further developed.

Evidence from other cities (source: CIHT (2016) A Transport Journey to a Healthier Life

Bristol City Council's transport and public health professionals are co-located in the same team and have a shared agenda to promote active travel and preventative approaches to health and wellbeing. Initiatives include the introduction of 20mph zones in the city and a Traffic Choices website. This uses simple language to show the effectiveness different types of road safety interventions can have on improving community involvement in local transport decision-making.

Gloucestershire NHS has published an Active Planning Toolkit that includes a scorecard to help determine the level of collaboration between public health, planning and transport planning on plans and policies.

In Birmingham, it is likely that air pollution is second only to tobacco smoke in causing premature death (deaths before the age of 75)

The JSNA Air Quality chapter reports at a city level, rather than particular areas of the urban area (such as EBNS), and finds that across Birmingham overall, based on current mortality, air pollution causes almost 900 premature deaths a year.

Air pollution has overtaken poor sanitation and a lack of drinking water to become the main environmental cause of premature death in the world and in Europe it is the single greatest environmental risk to health (JSNA Air Quality Chapter quotes OECD 2014, European Environment Agency 2015, and House of Commons. 2016).

Evidence from the JSNA shows that most air pollution in urban areas comes from road transport, followed by industrial processes and some background levels caused by natural sources. The evidence states that private cars are predicted to continue to be the major source of air pollution in the city, with an projected increase in the number of trips increasing the number of trips made Monday-Friday from 3.3 million daily trips currently to 4 million trips by 2031. The JSNA states that, given that at present the majority of trips are made by private car, changes are required to mitigate the impact this might have on worsening air pollution despite efforts in place currently to reduce it.

The JSNA states that evidence suggests air pollution tends to be worse in areas where the population is more vulnerable to its effect; in Birmingham there is a steep socio-economic gradient, with approximately 75% of people in the most deprived areas being exposed to levels just below the EU threshold and none in the least deprived. This is important given that people living in poorer areas are already exposed to other risk factors that negatively impact cardiovascular and respiratory health . Also, because it is known that:

- For every 10μg/m3 increase in PM2.5 is associated with a 6% increase in all-cause mortality
- For every 10μg/m3 increase in NOx is associated with a 2.5% increase in all-cause mortality.

We understand that DEFRA will release national air quality data updates over the next few months. This will help provide a consistent EBNS picture.

Average NO2 by LSOA. Note this shows data Birmingham only
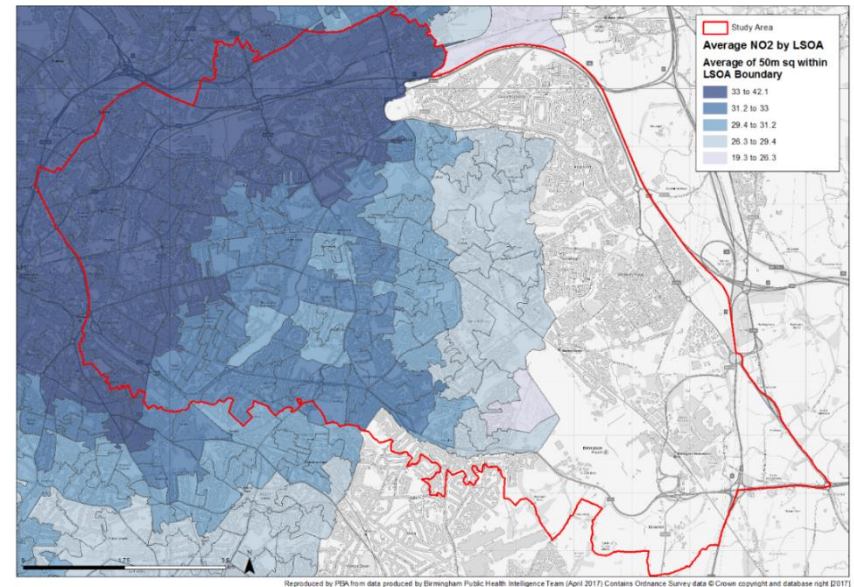
Average NO2 (wider area) covering Birmingham and Solihull

Page 400 of 588

96
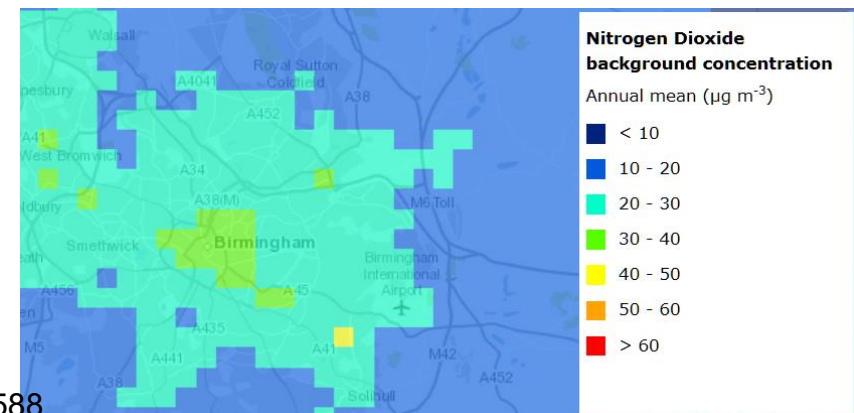
The evidence suggests that a multidisciplinary health and wellbeing theme group could be useful

Evidence from officers suggests that EBNS needs to approach health and wellbeing differently in future.

Evidence from officers suggests that a multidisciplinary health and wellbeing theme group would be welcomed as part of the EBNS development methodology. This is currently lacking. Officers state that EBNS needs multidisciplinary approaches, cross cutting themes, and a dedicated commitment to working with, and across the services that represent the wider determinants.

Evidence from officers suggests that the remit and deliverables of this group would need careful framing, and with tracking and outcome evaluation to help ensure that progress was understood, and success reinforced.

Whilst the remit of the group would need further work, the evidence in front of us suggests that there are a number of key issues which could be addressed.

- Child poverty and deprivation issues are a major driver of poor health outcomes, and need a continued focus.
- There are plainly serious difficulties with child and adult mental health, which represent a very serious long term social and economic cost to the area. Emerging approaches from Government and the West Midlands Combined Authority target this issue, and there are important implications for primary care and DWP alongside Birmingham and Solihull Councils.
- There is a need to break the inter-generational issues associated with the social and wider determinants; to 'design in' opportunities to move people up the social gradient, and also reduce inequality; and to create routine access and uptake of healthcare services.
- The role of exercise through extended walking and cycling strategies (which would form part of the critical 'last mile' approach to a public transport strategy) is also important to both physical and mental wellbeing strategies.
- The 'classic' public health issues also need continuing attention.
- A consolidated index which looks at health issues across EBNS would help further focus intervention.

Crime and anti-social behaviour

Key issues:

- Many important crime rates are higher than average

Reported instances of anti-social behaviour are lower than England, but violent/sexual offences, burglary, criminal damage and vehicle crime are higher. Reported drug crime is at the English average rate

The map shows reported levels of various types of crime in EBNS per 1,000 residents. The dark blue shows the LSOAs that rank within the highest 10% of areas in terms of crime levels. The dark blue areas are very prominent in Birmingham city centre. With drugs crime, the maps show that there are pockets of dark blue which extend eastward from the city centre into EBNS, along main roads, following the route of the Metro extension.

Typically, the northern area of EBNS is within the areas ranked lowest in terms of crime per 1000 residents.

Area	Anti-social behaviour	Violent/ sexual offences	Burglary	Criminal damage	Vehicle crime	Drug crime
EBNS area	20.0	17.9	16.1	9.2	9.6	1.8
Birmingham	21.0	17.5	18.6	7.9	9.8	1.8
Solihull	13.5	10.7	15.3	6.2	9.5	1.4
WMCA constit LAs	17.9	15.6	17.5	7.4	8.6	1.5
England	26.3	16.8	13.8	7.8	5.6	1.8

Drugs crime offences
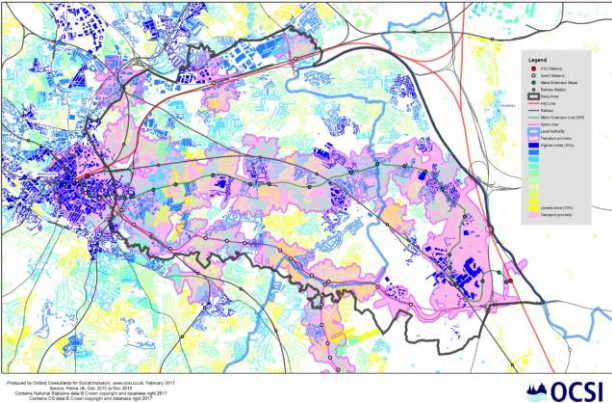
Anti-social behaviour
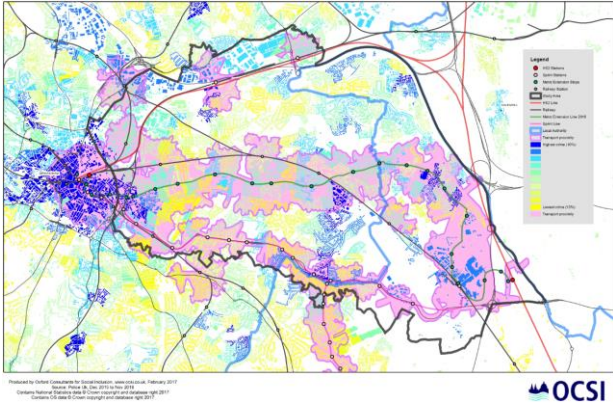
Violent crime and sexual offences
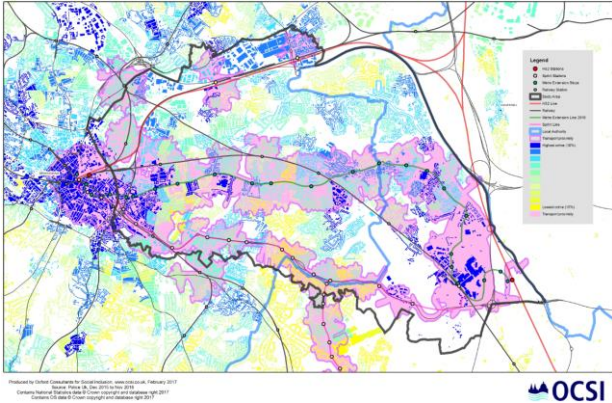
Date: Dec-2015 to Nov-2016, Source: Police UK (Police recorded crime figures)

Evidence suggests that drug use and dealing is a significant problem in the area – and that crimes might be being under-reported

A survey of constituents was undertaken by Liam Byrne MP's office in December 2016. It covered a range of issues. 700 responses were received. One question asked constituents whether drug use or dealing was a problem in their area. Residents were asked to rank the seriousness of the issue on a scale of 1 to 5, with a response of 5 indicating that the problem was severe. Constituents report that drug dealing is a highly visible problem across the areas surveyed.

We also understand that constituency casework for Liam Byrne MP (Hodge Hill) suggests that there could be a substantial under-reporting of crime in the area.

Question: are drugs a problem in your area? (area detail) (EBNS area-wide; 1 is low, 5 is high)
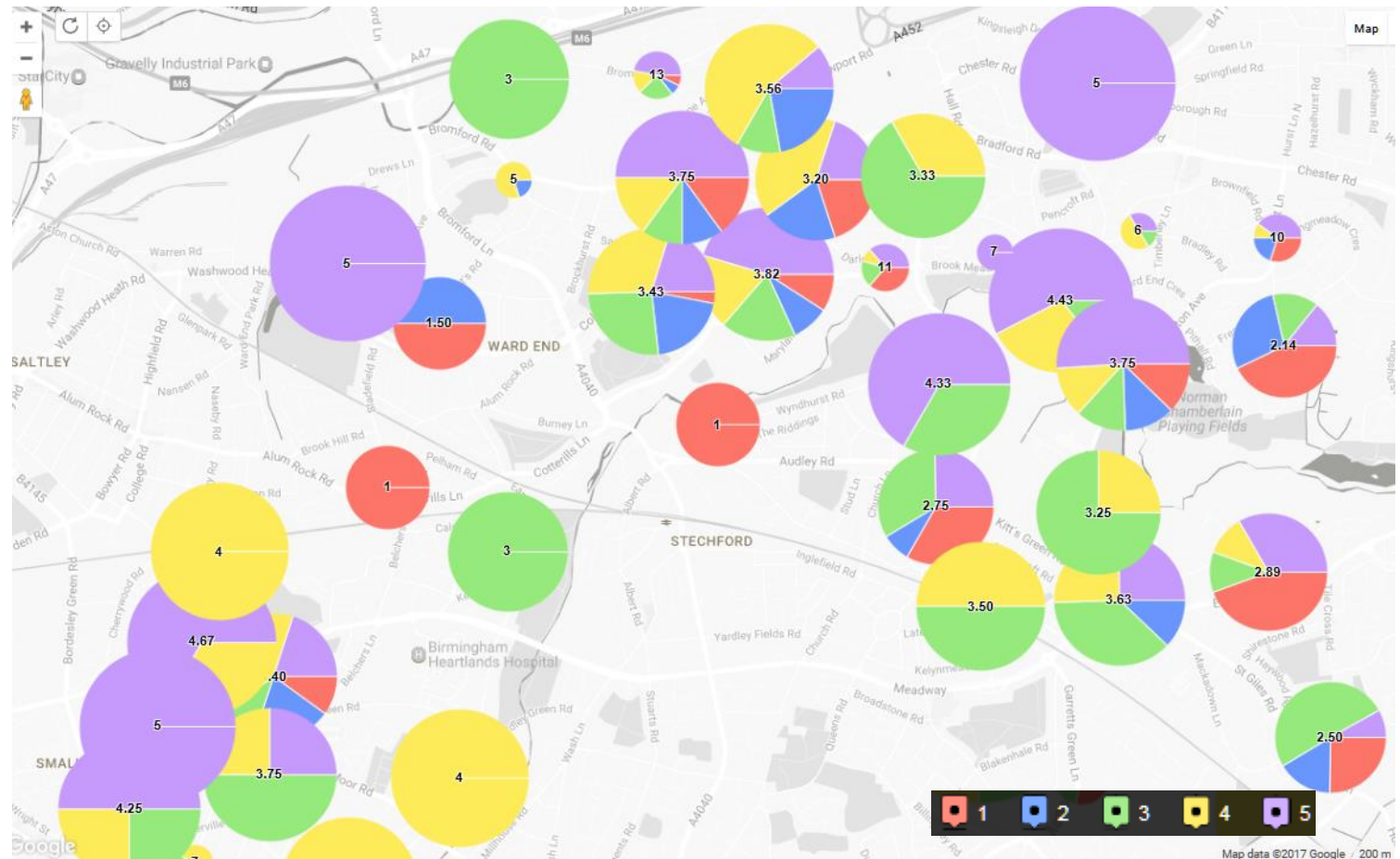
Source: Office of the Rt Hon Liam Byrne MP

Joining up the public estate

Key issues:

- Significant opportunities exist for innovative service delivery

Estate Reconfiguration and Rationalisation is being pursued by the NHS as part of the Sustainability and Transformation Plan. Some possible early wins are emerging

The Birmingham & Solihull NHS Sustainability and Transformation Plan (STP) has three strategic aims.

- Creating efficient organisations and infrastructure
- Transformed primary, social and community care
- Fit for future health, care and wellbeing services

STP Wide Estate Reconfiguration and Rationalisation sits under the first strategic aim of creating efficient organisations and infrastructure. The objective is to create an estate footprint that is fit for future purpose, and flexible enough to adapt to and support changes in clinical service models, without the need for additional significant capital investment. This will be achieved by:

- Initial disposal of unused, poor condition, and/or surplus estate to fund estate change programme
- Reducing the known areas of estate void (e.g. in LIFT buildings) and implementation of other innovative opportunities to repurpose existing buildings enabling the delivery of high quality place based clinical services within the natural communities
- Ongoing oversight of estate utilisation across Birmingham and Solihull and planned use on a footprint-wide basis to realise additional benefits and optimised estates utilization.

The interdependencies across the system and across the service change projects set out in the STP are complex. There are considerable organisational complexities: the Birmingham and Solihull area has six NHS providers – Birmingham Women's and Children's Hospital (BWCH); Heart England Foundation Trust (HEFT) University Hospitals Birmingham UHB, Royal Orthopaedic (ROH); and two community level providers are Birmingham Community Healthcare (BCHC) Birmingham and Solihull Mental Health Trust (BSMHT) along with 228 Primary Care providers. The STP faces significant risks to a joint estates strategy that encompasses the whole governance environment and there may be difficulties obtaining the head leases or freeholds required to make the necessary changes to estates.

Even so, the opportunity is considerable. Across the full BSol area, the estates currently comprises circa 650 buildings with 1000+ property interests. The quality of estates is variable across the footprint, a large number of poor quality buildings in Birmingham, and overstretched buildings in Solihull. The STP states that there is a clear need and opportunity to address poor quality and sub-optimal estate through a planned programme of rationalisation An initial baseline for Estates has been completed, and work continues to establish a full asset baseline and condition report for all buildings. Some progress has been made towards identifying initial quick win opportunities that will increase utilisation of modern LIFT buildings providing the potential to enhance primary care and integrated services, and enabling disposal of unused, poor condition, or surplus estate.

Surplus estate can be disposed of – possibly creating regeneration and development opportunities – alongside a capital receipt. (However, GP surgeries are frequently run from individually owned premises, meaning that no capital receipt will be available to the NHS). The future direction of NHS estates is to run health provision through corporately owned premises, and this approach allows new health provision to be co-located with other community facilities including leisure centres and schools, perhaps alongside wider quasi-health provision designed to reduce loads on clinical staff.

It is critical to ensure that the estates strategy aligns to the clinical commissioning strategy

The broad direction of clinical commissioning is that provision will increasingly be delivered through community based care, with Service Hubs delivering specialised services, in order to support local hospitals.   However, there are limited capital budgets, so there is relatively little scope for new physical provision: it will broadly be a case of delivering care through existing buildings and estates, rather than sparking a major new-build programme. There is a significant amount of Department for Health, Cabinet Office, and Treasury interest in improving the relationship between clinical strategies and estate strategies, with this agenda being reinforced through Sustainability and Transformation Plans and their likely successors.   However, there is at the moment a shortage of information available regarding the capacity and condition of the estate, which is currently being filled.

Officers state that the primary care estate is in a period of change and realignment. Through the Birmingham CrossCity ACE Schemes and the national direction of new care models, providers are recognising the advantages of the way that is primary care provision works together at scale to deliver services.   This has resulted in a cultural shift in provision as partnerships merge and federated models evolve.

There is evidence of health providers beginning to work more effectively with other health-related providers. For example, BITA pathways and the Disability Resource Centre (charities) and DWP advisors are using space at Washwood Heath and Hodge Hill.

There are 134 NHS-commissioned buildings in the EBNS area. These cover a range of functions including Primary Care (61), Community Healthcare (51), Mental Health facilities (21) and one major acute hospital. At the time of writing, the review of the NHS estate is only around 75% complete in the EBNS area, and data needs to be reviewed and checked, but early findings shows some of the premises which might need consolidation and updating.

Analysis carried out by the STP Estates Workstream has picked up some early wins. Work shows that in Washwood Heath, £1.2m pa is being paid for rents for empty space. At Kitts Green, opportunities to run primary care provision alongside other public sector developments are being explored

Cabinet Office funding is being sought for feasibility studies to look at fixing overcapacity and quality issues in two places in EBNS: Saltley/Washwood Heath and Kitts Green.

In **Washwood Heath**, plans exist for a number of GP practices in poor quality premises to be run out of good quality under-utilised buildings, alongside other services. There are two under-used premises which can be used to run these services which are already costing the NHS money for void space. The first is at Saltley Heath (where empty space is costing c.£300k pa in rents to NHS Property Services) and the second is at Washwood Heath (where 30% of space is empty, incurring costs of c.£900k pa in rents to Community Health Partnerships).   A hypothetical solution is being reviewed which could see provider level services (including urgent care centre, mental health centre) being run out of Washwood Heath LIFT building, whilst GPs could be run from Saltley health centre. The objective would be to run wellbeing services from these buildings alongside healthcare. The objective would be to intercept patients needing "social

prescriptions" rather than medical prescription, so reducing GP workloads by offering touchdown space for services from DWP, housing and employment outreach. This physical provision would work in tandem with 'triage' systems currently being developed, including new artificially intelligent call handling systems currently under development.

At **Kitts Green**, Cabinet Office funding is also being sought to reconfigure the provision of NHS services. A number of GPs practices have been identified as requiring transfer to new premises.

NHS Estates providers intend to review joint working opportunities across the public sector.

Early analysis at Washwood Heath and Kitts Green can be extrapolated to indicate the level of investment needed within that natural community, and across EBNS

The data in the table to the right shows some of the early analysis that has been carried out on community facilities in Washwood Heath and Kitts Green. In the area tested, the data shows that the majority of buildings are unacceptable from a physical and functional perspective.

The second graphic shows the number of patients affected in Washwood Heath and Kitts Green by an estate which does not achieve a suitable utilisation of functional quality. The graphic breaks NHS community provision in Washwood Heath and Kitts Green into three categories – underutilised, overcrowded and fully utilised. Within those categories it looks at the levels of required investment, and shows the likely next steps ('consolidate with poor quality estate' – suggesting that this good quality space which has capacity to accommodate patients from poorer quality sites; 'needs investment'; and 'do nothing').

The analysis shows that 29,000 patients are served from buildings which are classed as highly underutilised yet are of good quality, and that around 50,000 people are served by buildings that are of poor quality and so need investment.

Number of Primary and Community Facilities in Target Area

	Physical Condition - Score	Functional Suitability - Score	Space Utilisation - Score
Acceptable	10	11	8
Unacceptable	14	13	16
	24	24	24
		Overcrowded	5
		Underutilised	11

Sum of patient activity by space utilisation – score
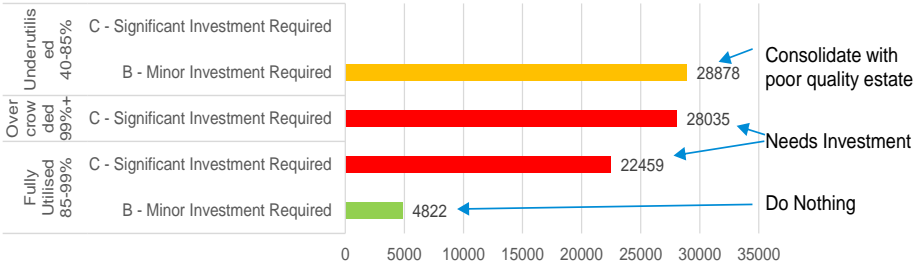
There are other initiatives in the area that may create opportunities to consolidate the NHS estate

Early evidence collated for the Birmingham and Solihull STP suggests that there are **similar opportunities available in the Bordesley Green area**, where premises can be used more efficiently, and also provide facilities which can divert demand away from A&E provision at Heartlands Hospital. The Bordesley Green AAP discusses far reaching change in the area, including new schools and community provision, which could provide new opportunities for co-located provision. These plans are at a relatively early stage, and will require continued monitoring by the CCG and stakeholders.

Regeneration masterplanning is also under way at Kingshurst, where North Solihull Partnership are currently working on the early stages of a masterplan which looks at replacing a 1950s/60 retail centre, creating further possible opportunities.

Elsewhere in this report, we have set out the possibilities at Chelmsley Wood, and there are also opportunities emerging at **Washwood Heath.**

In Birmingham, the LEA is considering releasing a series of school and playing field sites near to unsuitable primary care buildings. Early work suggests that these opportunities are available at

*   Green Lane playing field
*   Brocklehurst Playing Field and the Beaufort school site (although local NHS estate has capacity, which should be used before new buildings created)
*   Hallmoor School site

A major investment is expected at Heartlands. A total budget of £220m capital is available, which will pay for three phases of delivery.

1) A new 'Planned Care' Building (£150m) will centralise outpatients into new building

2) Urgent Care Centre and combined A&E

3) Administration functions all being combined into one facility.

This may allow possible A&E patients to be diverted away from A&E

provision, into primary care. The objective is to have the Heartlands work complete by 2025. These three projects free up space for two further onsite plans which currently have yet to obtain planning permission and allocated budget. The first project is onsite intermediation care centre intended to care for people too well to be in hospital, but not well enough to be at home; and the second project is expected to be approximately 50-100 homes. (No decision has been made about tenure or type of these homes).

There are opportunities to realign primary care provision at

*   **Bordesley Green**
*   **Kingshurst Parade regeneration site**
*   **Chelmsley Wood**

We investigated whether there were opportunities to bring together these opportunities with DWP sites. Within the East Birmingham and North Solihull study area, DWP Job Centre Plus are located at Washwood Heath, Yardley, and Chelmsley Wood. There is also provision funded by BCC, SMBC and voluntary providers. However, there appear to be no major opportunities to bring DWP estates provision into a wider review of public sector provision in East Birmingham. After 20 years, the private finance initiative contract that covers many DWP offices is nearing an end: it will expire at the end of March 2018. In advance of this end date, the DWP estate has recently been reviewed and rationalisation has been carried out. New leases have recently been signed, meaning that fundamental provision is unlikely to change within the lease period. There is some flexibility within the lease contract, but it will be limited.

We understand, however, that there may be opportunities to deploy DWP or DWP-funded provision into community hubs or other non-traditional locations (such as health centres and schools).

More opportunities are likely to emerge as the review of NHS estates proceeds.

We can match education's list of possible estates opportunities to look at how education, NHS and wider regeneration opportunities could be joined up. New schools provision could also be included in the One Public Estate approach
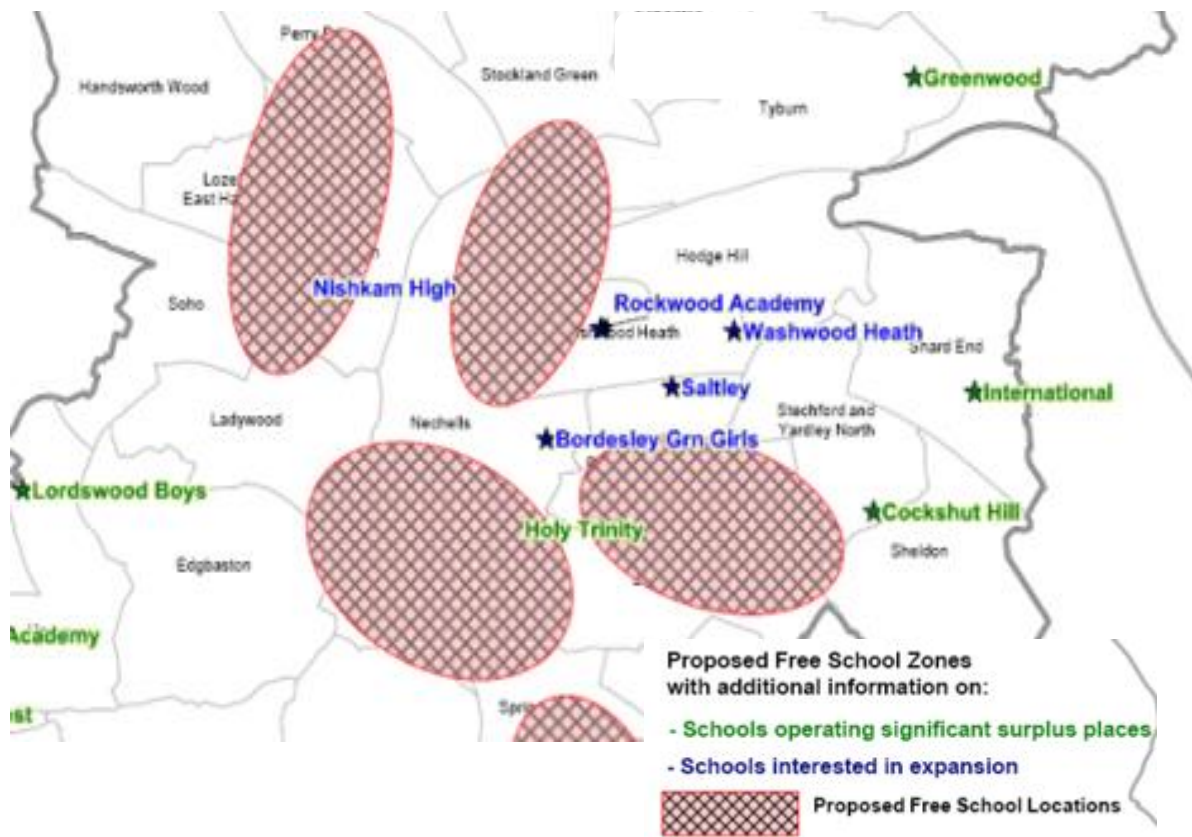
NHS estates regeneration strategies are not yet complete, but work is ongoing which looks at identifying which surgeries are moving, relocating, having an unsustainably small list size, or being disposed of. We stress that this review process is not complete – but it gives an initial outline of where the NHS estate will be changing, and so shows where some of the early opportunities to join up provision might lie.

Meanwhile, BCC Education have also set out new secondary requirements to 2019. High level estimates suggests that there is a requirement for

• 5 x 6-8FE New Schools to 2019 : optimum location is shown on the map to the right

• Up to 20FE provided within existing schools to complement to 2019

• Potential bulge expansions in years 8 and 9 as cohorts move through.

Evidence suggests that if these workstreams were put together, we might be able to identify valuable co-location opportunities. With skilful design, new schools could accommodate health, community, sports, and adult learning provision. Cross-silo working parties are likely to be needed to look at the opportunities. Opportunities will need to be revisited as the work proceeds.

Proposed school expansions and free school locations, also showing schools with surplus places

Proposed Free School Zones with additional information on:
- Schools operating significant surplus places
- Schools interested in expansion

Proposed Free School Locations

Source: BCC

Connectivity

Key issues:

- The future will see several high quality transport corridors through the EBNS area, bringing useful labour market effects

- Further 'last mile' walking and cycling could improve connectivity to new investment and create health and wellbeing benefits

- Not everywhere is better connected - new bus routes could be useful

- Further innovations could be explored – perhaps including park and ride at Metro stops and upgraded train stations

What does the evidence say about the economic impact of connectivity?

Transport creates productivity improvements from better connections to labour and product markets, and through agglomeration economies.

- In the labour market, the transport system is a key factor in making labour accessible to firms. The effective labour market for any company is extended by good transport, which enables companies to be within reach of a larger labour pool within any given commuting time.

- In product markets, transport allows customers to be reached at lower cost. The transport investments networks being contemplated for EBNS are unlikely to have strong product market effects, because trains, buses and metro links are unlikely to be used to deliver goods to customers (although there could be effects on moving business people to client locations).

- Agglomeration economies occur when individuals and firms benefit from being near to others. Being close to other individuals and firm creates 'knowledge spillovers'. Agglomeration effects are likely to arise from EBNS transport investment, but they are likely to arise in central Birmingham and the UK Central area rather than within the immediate EBNS area.

We say more about the effects of transport investment on site development viability and health and wellbeing in a later section of this report.

The area's road infrastructure is highly congested. Road capacity is going to need to move from cars to public transport

The area's road infrastructure is highly congested, with Birmingham having an average "A" road speed of just 18.6 mph which affects both bus and car travel times. This is illustrated in the average peak road speed map to the right.

The strategy document *Movement for Growth - The West Midlands Strategic Transport Plan* (WMCA) reports that travel demand is forecast to increase by 22% over the next twenty years, due to increased population and higher employment levels. Combined with a long term trend for longer journeys, particularly for work, gives a 34% forecast increase in the number of car kilometres travelled. The *Birmingham Connected* White Paper (2014) states that 'currently many people feel that they have no real alternative to driving their car.'

BCC is addressing this issue by looking at transport space allocation, which looks at the allocation of road space between competing uses, with a greater emphasis on the functions of place and people.

The West Midlands Combined Authority's HS2 Connectivity Programme aims to ensure the benefits from HS2 are spread as far as possible across the region, enabling existing businesses to expand and providing opportunities for new businesses. The Connectivity Programme 'puts the public transport user first and will deliver the connectivity that people and businesses require allowing them to travel across the city and the wider area in high quality vehicles, feeling safe and secure and at busy times faster than they could by car'. (2015,6)

Average road speed 08:00 - 09:00 (2015-16)
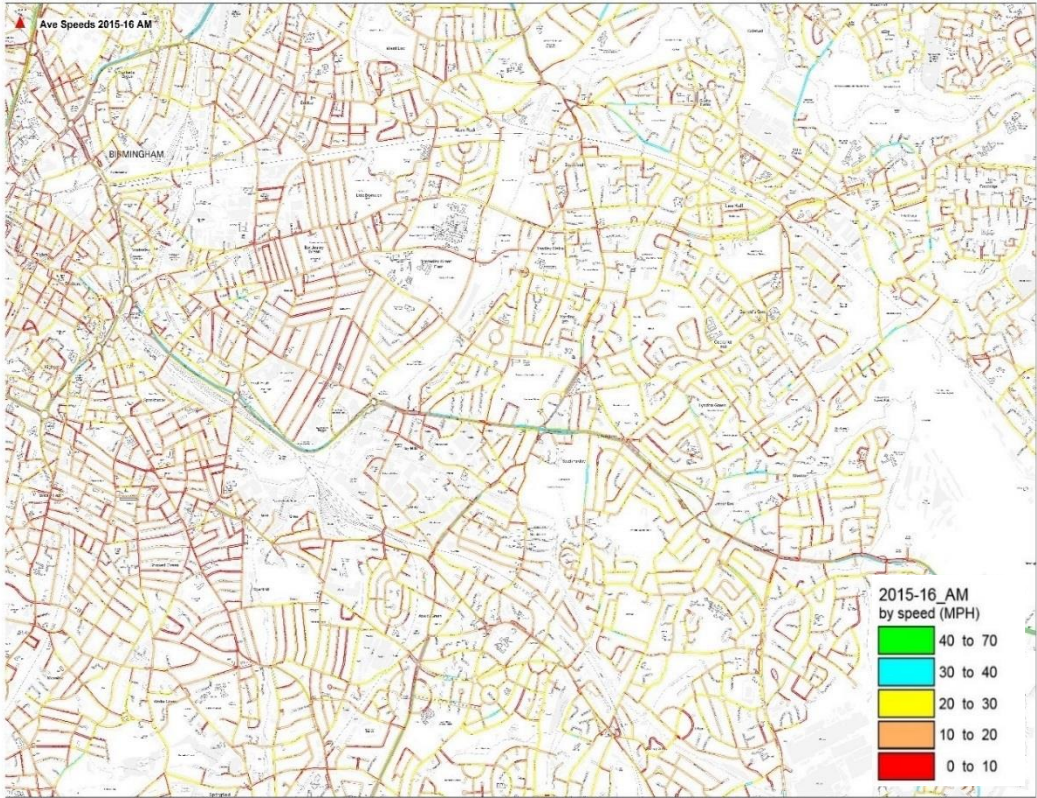
Dataset: *Shows the average road speed between 8-9am in 2015/16.*
Date: *2015/16*
Source: *PBA*

Area	Average A Road speed
Birmingham LA	18.6
Solihull LA	29.9
Combined authorities	20.4
England	25.2

There are very few gaps in the bus service: most places are within 6 minutes walk of a bus stop

The map shows the areas within 6 minutes walk of a direct bus to Birmingham city centre. It can be seen that most areas can access the city centre. However, many areas are reliant on services which stop frequently and take convoluted routes in order to serve the areas.

Areas with a bus within 6 minute walk of a bus to the city centre

Contains Ordnance Survey data © Crown copyright and database right [2016]
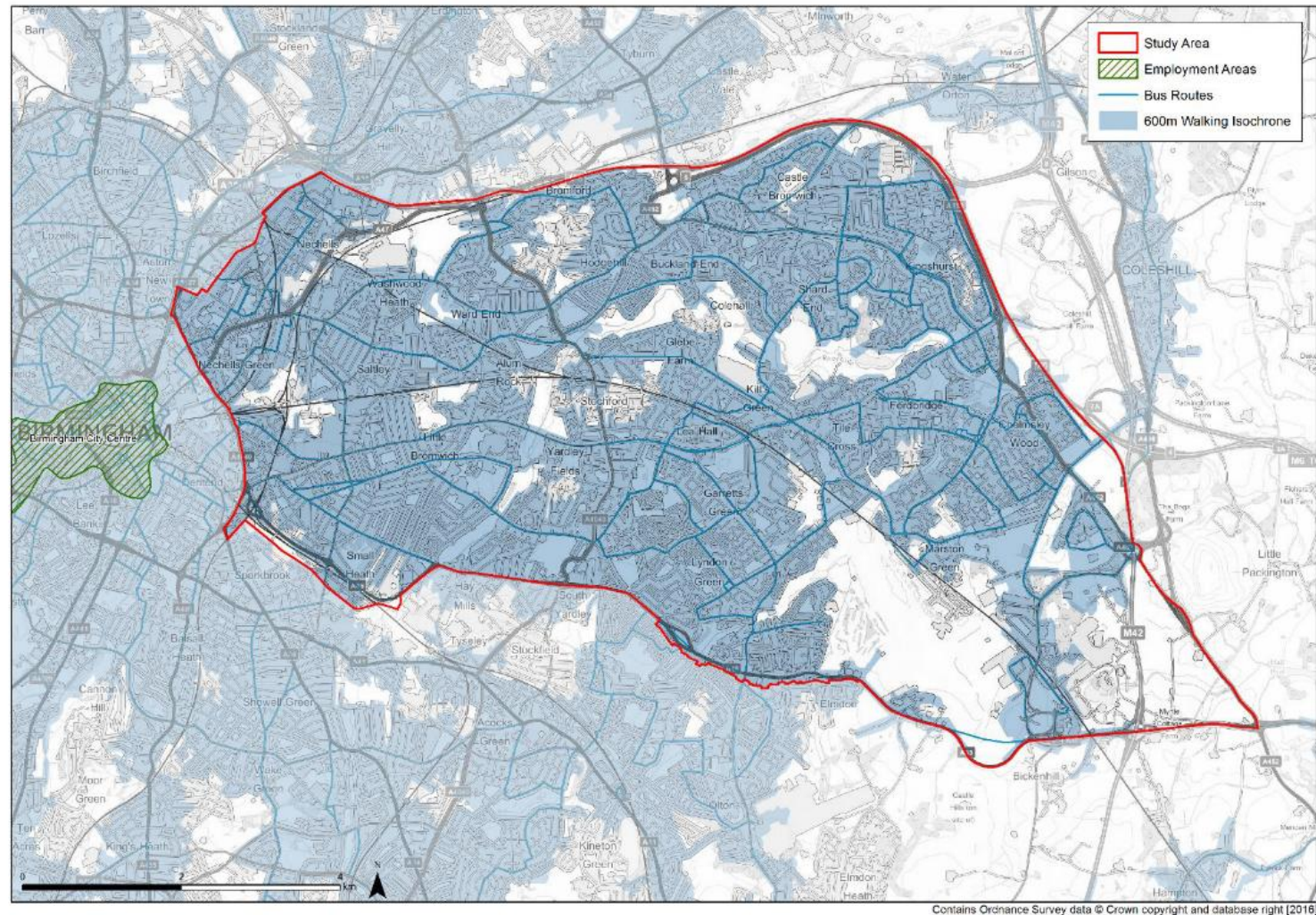
Dataset: *Shows the areas in EBNS within a 6 minute walk of a bus to the city centre.*
Date: *2015/16*
Source: *PBA*

East/west 'radial' routes into the city centre are slow (Chelmsley Wood to city centre is 46 mins), but at least they are direct. Routes to other job locations frequently require changes of service, which further lengthens journey times and reduces passenger willingness to use public transport

The map illustrates that the journey time of public transport users travelling into the city centre varies widely within the EBNS area, with some journeys taking nearly an hour, and relying on interchange between services or between bus and train.

There are numerous direct services into Birmingham city centre from across EBNS, but peak period journey times are high. For example, travel from Chelmsley Wood to the city centre takes 46 minutes, for a journey of 8 miles. This is no faster than an average person on a bicycle could achieve (10mph).

Whilst measures such as SWIFT cards allowing use of bus, metro or rail and some real time information are in place, the level of service frequency is limited in some areas to two buses per hour, and linkages between infrequent services stand as a considerable barrier both in terms of journey time, but also in respect of public perception of service reliability.

The result of the above factors is that the network is broad but often limited, and therefore less attractive as a commuting journey for public transport users who will want a reliable and simple journey as far as possible for regular journeys such as to work.

Travel time to Birmingham city centre
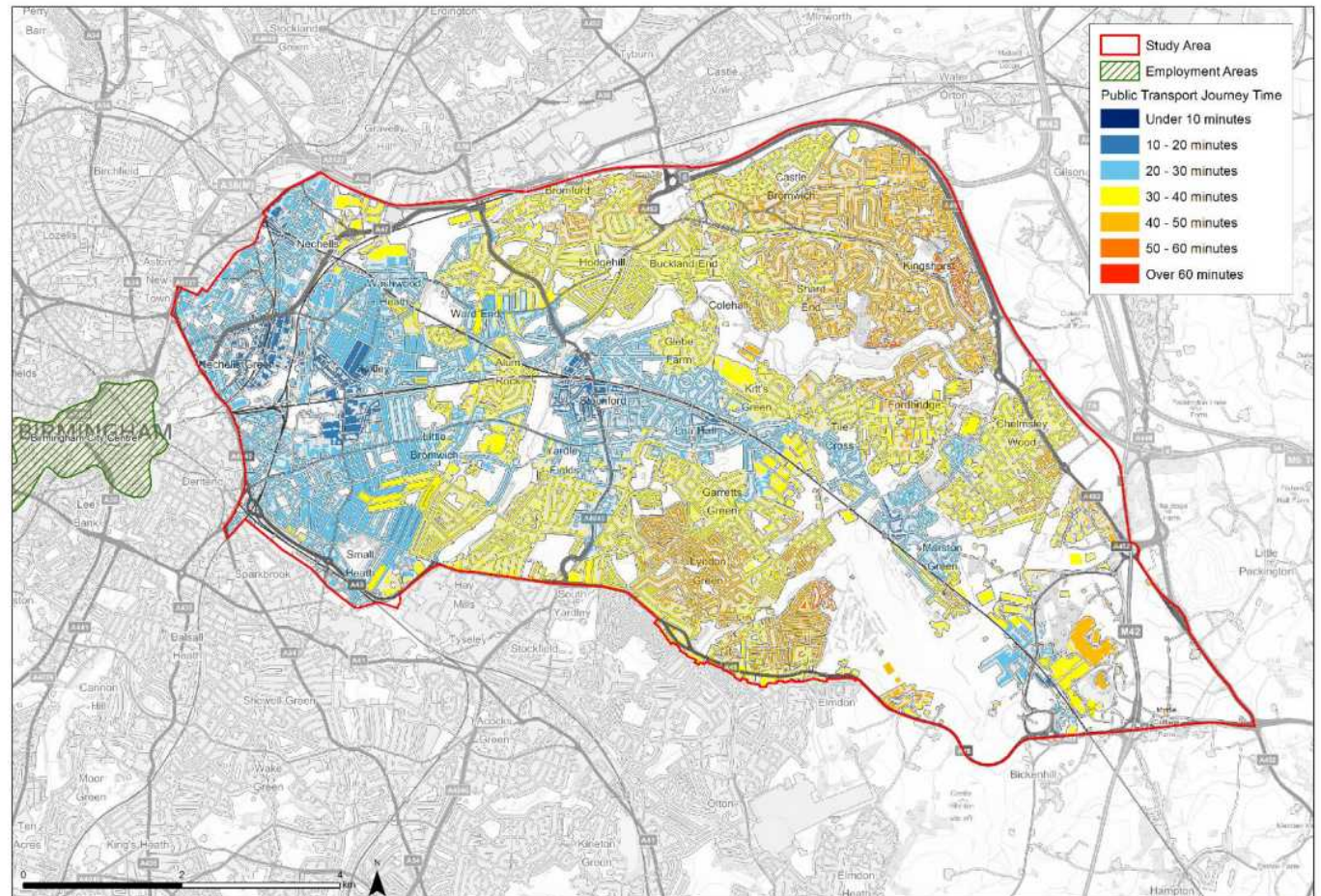
Dataset: *Shows the public transport travel time to the city centre from areas in EBNS*
Date: *2015/16*
Source: *PBA*

115

Non-radial (north/south) public transport journeys are frequently complex, often a result of pinch points on the system. Interchanges between bus routes increase journey times and reduce passenger willingness to use services

The map shows the bus network map with major service corridors in dark blue and minor routes in light blue, demonstrating the point that main routes are radial and coverage is filled in with less direct minor services across most of the area.

Changes of service (for example, from one bus route to another) are frequently necessary if a non-radial journey is taken. However, changing services substantially reduces passenger willingness to make these journeys. Morris et al note in their paper on Transport Interchange for the Association for European Transport (2006)

"Journeys which involve interchange represent the area of travel by public transport where the greatest number of barriers exist that prohibit service contemplation and use. Public transport users perceive interchange in terms of how they make choices and trade-offs in travel cost and time, and the influence particular interchange attributes may have over these travel choices (SECRU, 2001). The significance of a high quality interchange environment in achieving an integrated public transport system conducive to the development of 'seamless' public transport journeys is therefore paramount. "

Bus network plan (National Express)
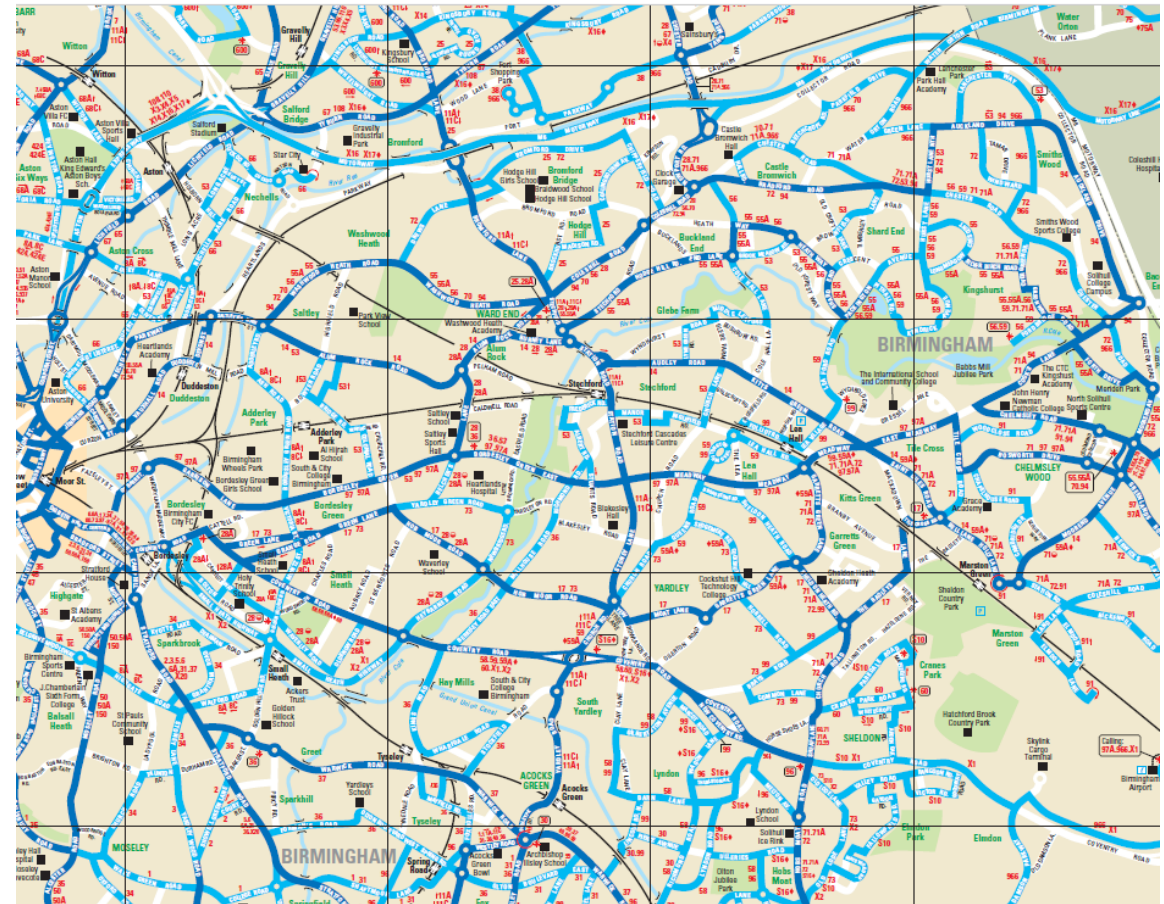
Dataset: *Shows the local bus network serving EBNS*
Date: *2015/16*
Source: *National Express*

Page 420 of 588

116

A heavy rail network is in place, but is dominated by long distance services on the West Coast Mainline rather than local stopping services

The existing rail network is focused on serving Birmingham city centre. The only services which serve stations in EBNS are Virgin West Coast, London Midland, Cross Country and Arriva Trains Wales. The dashed red line on the map is the proposed HS2 route. Therefore at present the EBNS area remains poorly connected with regards to rail transportation.

Adderley Park station, for example, is only 5 minutes to New Street station – but only has one direct service per hour. There is a similar – though not quite so poor - situation for Stechford (two direct services hourly), Lea Hall (two direct services hourly) and Marston Green (three direct services hourly).

The Birmingham-Tamworth line, which runs along the northern boundary of the study area, currently has no stops within the study area.

Rail network

Service configurations on the existing rail network undermines the use of the facilities for local people, but this is not shown by traditional accessibility assessments. We have therefore used PTAL to better illustrate this point

PTAL (Public Transport Accessibility Level) is a measure of connectivity by public transport, which has been used in various planning processes in London for many years. For any selected place, PTAL suggests how well the place is connected to public transport services. It does not cover trips by car. PTAL values range from zero to six, where the highest value represents the best connectivity. A location will have a higher PTAL if:

• It is at a short walking distance to the nearest stations or stops

• Waiting times at the nearest stations or stops are short

• More services pass at the nearest stations or stops

• There are major rail stations nearby.

PTAL scoring provides a useful way to understand the number of transport options and the quality of those options in an area, irrespective of if they go to a desired destination for a particular individual. In that sense it is a measurement of the area connectivity in general rather than specific terms, and provides us with an overview of the level of confidence that people within an area are likely to have in public transport local to them and the opportunities it provides.

The map illustrates that large areas are within the "very poor" (blue) or "poor" (light blue) bands of PTAL scores with isolated pockets of moderate (green) to good (yellow) network quality where rail stations are collocated with bus services.

As Birmingham does not have an underground network in addition to other modes, it is impossible for a score of 6 (best) to be achieved, and scores consequently range between 1 (very poor), and 5 (very good).

Current PTAL score – network quality (blue is worst network quality, orange/red are best)
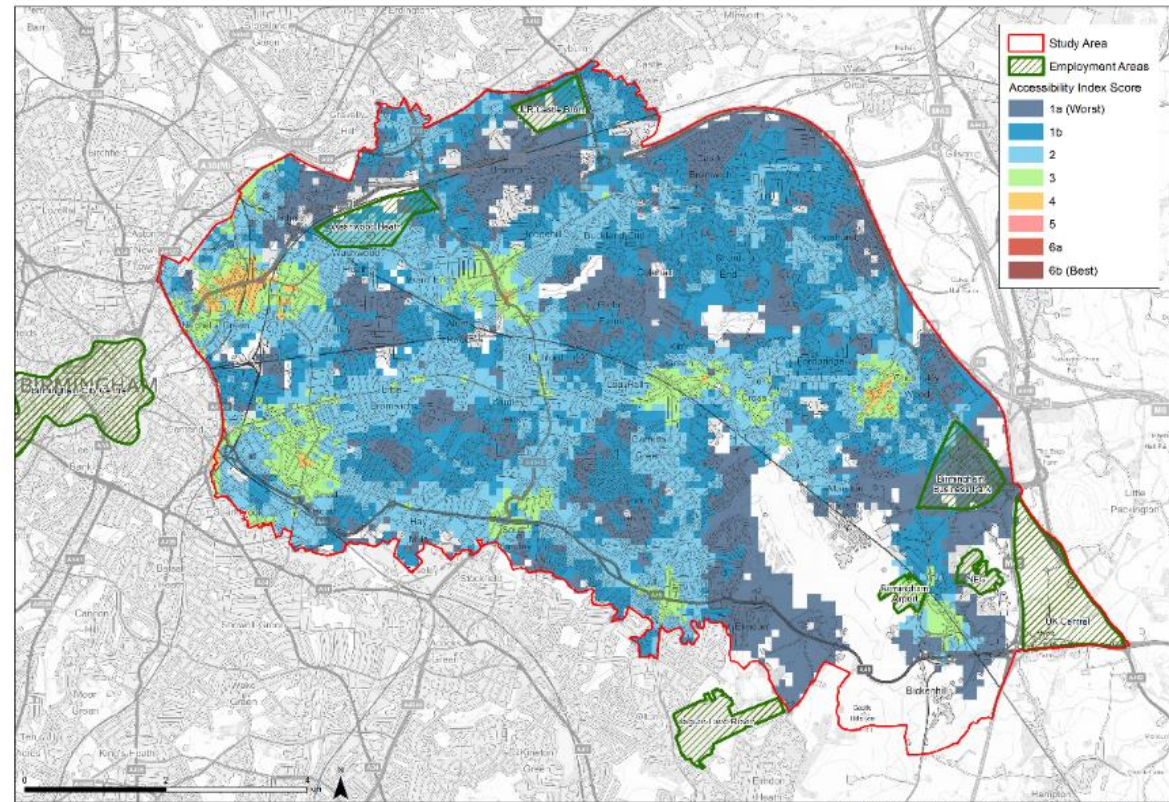
Dataset: *Shows the PTAL distribution in EBNS before planned improvements to the public transport network.*
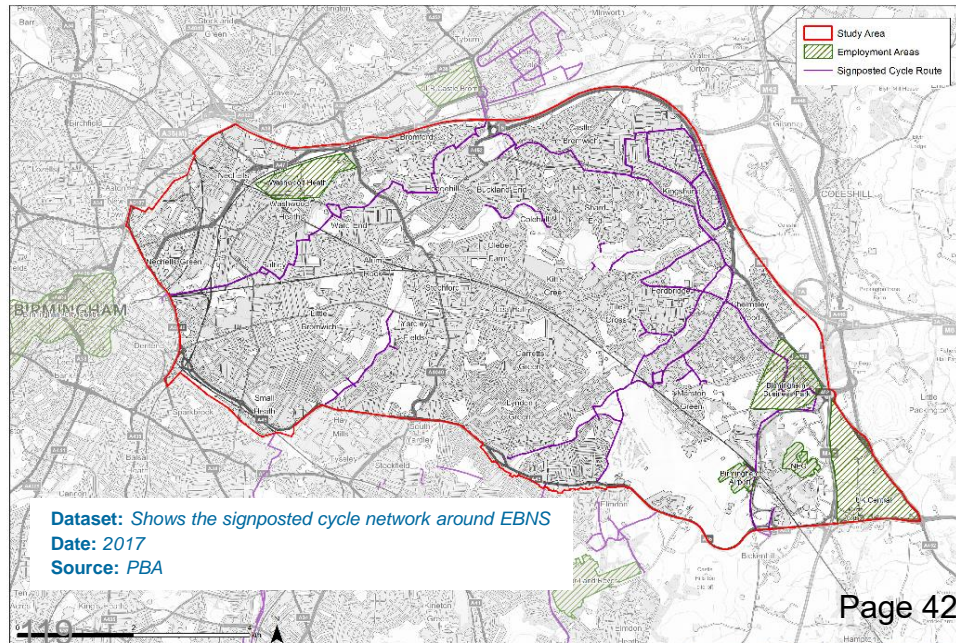**Date:** *2015/16*
Source: *PBA*

The Birmingham Cycle Revolution project is aiming to make cycling an everyday way to travel. In EBNS, cycling improvements are planned. But for now, cycle routes within and through the study area are relatively fragmented and underdeveloped

As the map shows, there are a number of cycling routes signposted throughout the EBNS area. A cycling route is present along the River Cole, but the connections to employment locations appear poor, and the issues with travel westwards into the city centre due to poor accesses onto the road network make it less attractive than cycling along other routes.

The relatively poor cycling environment may contribute to Birmingham being ranked 48th of 63 UK cities by the Centre for Cities for number of people choosing to commute to work via cycling (Centre for Cities, accessed 2017.

Later visioning and strategy work may choose to consider whether these initiatives need expanding, particularly by providing walking and cycling connections to Metro and Sprint, with cycle parking facilities at stops.

Existing signposted cycle routes

Dataset: *Shows the signposted cycle network around EBNS*
Date: *2017*
Source: *PBA*

BCC's Birmingham Cycle Revolution project is aiming to make cycling an everyday way to travel in Birmingham over the next 20 years. The aim is to ensure that 5% of all trips in the city are made by bike by 2023 and to double this to 10% by 2033.

An existing programme of improvements is currently being delivered elsewhere in Birmingham. Starting in July 2017, works will begin to deliver physically separated cycling routes from the City Centre to Selly Oak. For EBNS, Coventry Road (A45) may be suitable for similar treatment in future, but officers note that it can be difficult to insert dedicated cycling road space in some areas.

New cycle routes are planned for EBNS. These include a route from the River Cole to Castle Bromwich via Chester Road, and a route through Sheldon Country Park to the Grand Union Canal in South Yardley. There are also identified needs for a route under the WCML viaduct at Stechford and a need for a bridge over the Grand Union Canal at the Ackers, Small Heath.

A new BCC cycling and walking strategy is currently under development. New Government guidance has been produced, and the expectation is that BCC will use this guidance (and the accompanying Route Selection Tool) to develop cycling plans. These tools will pick up current major commuter flows in the city, but might not successfully pick up links to *future* public transport schemes, so the methodologies used will need to be kept under review if new projects are to reinforce Metro, Sprint and rail investment.

Severance negatively impacts connectivity in EBNS and creates pinch points, particularly for north/south journeys – which also affects local access to new transport infrastructure

The River Cole, the M6 and railway lines create barriers to accessing public transport routes. These lines of severance are shown in red in the map.

Major pinch points are found at
- Saltley Viaduct
- Bromford Gyratory
- Aston Church Road
- Chester Road

Walking routes to current and future public transport infrastructure as part of longer journeys are affected by severance limiting route options and perceptions of safety in some locations. These lines of severance will also affect access to proposed new transport infrastructure.

Generally, improvements to walking infrastructure would make these lines of severance less prominent, through new and improved pedestrian crossings. Furthermore, improved wayfinding facilities, such as lighting and signage would be welcomed on off-road routes such as Elmdon Park.

.

Lines of severance
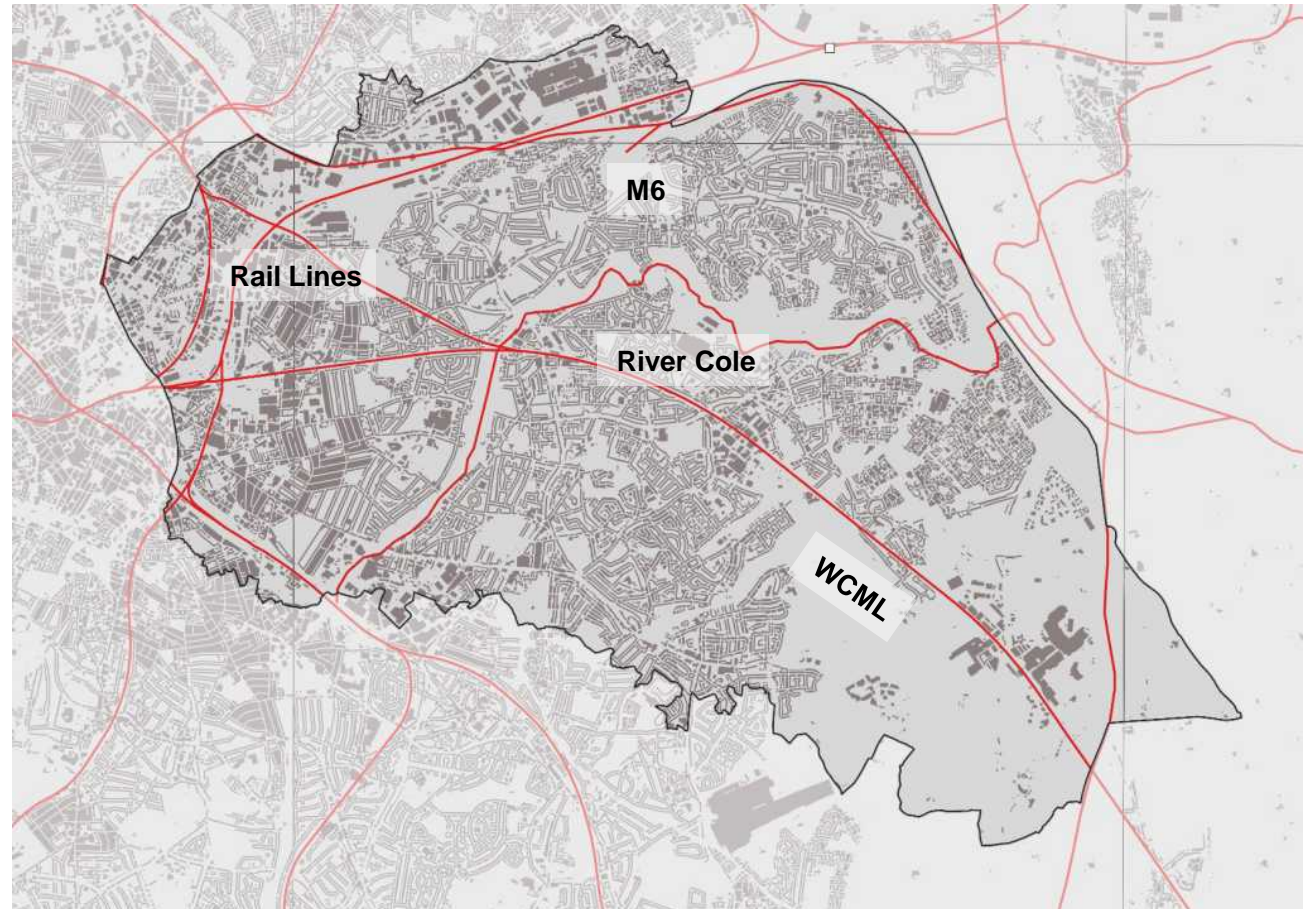
Dataset: *Shows the lines of severance in EBNS*
Date: *2017*
Source: *PBA*

The EBNS area has low levels of car ownership compared to other areas, suggesting that local people are more dependant on public transport provision than other areas. This creates an opportunity for future delivery of public transport improvements

The low levels of car ownership reflect the lower levels of economic activity and unemployment and consequently reduced average incomes present in the EBNS area when compared to surrounding areas such as Solihull and parts of Birmingham city centre.

Research states that:

"Transport can be a major barrier to accessing employment opportunities. People who are unemployed are less likely to own a car and to be reliant on public transport. Therefore, the connectivity provided by the public transport network and the cost of using it will be a major influence on a person's ability to access a job."

People are more likely to use buses and less likely to use trains to travel to work than comparator areas – likely because rail does not penetrate the area effectively

Households with no car or van (by decile)
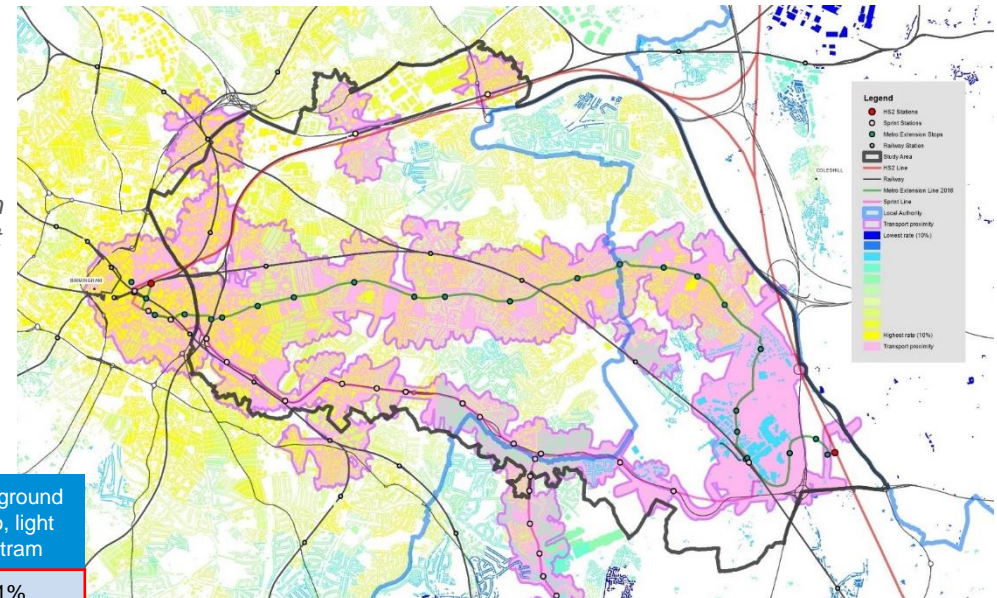
Dataset: *The proportion of households who do not have access to a car or van.*
Date: *2011*
Source: *Census 2011*

Dataset: *The proportion of the usual resident population aged 16-74 travelling to work by underground, metro, light rail, tram, train, bus, minibus or coach. Based on the Census 2011 means of travel to work question. The means of travel to work is that used for the longest part, by distance, of the usual journey to work.*
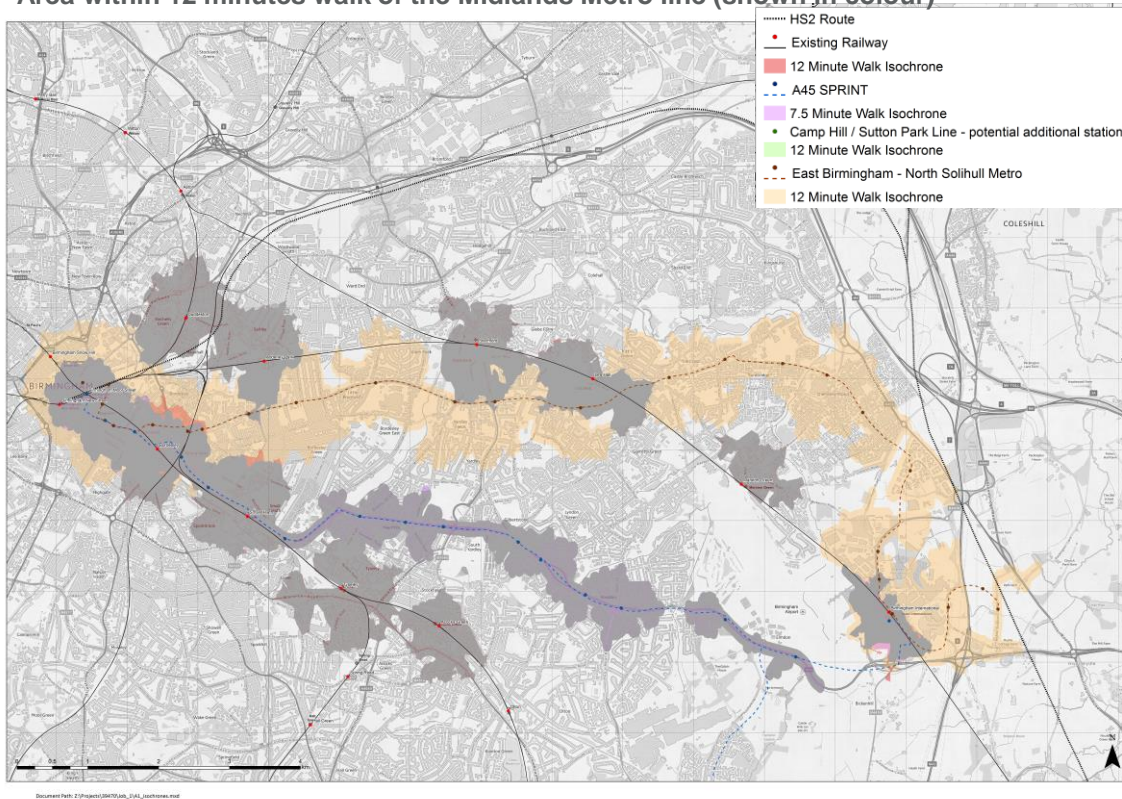**Date:** *2011*
Source: *Census 2011*

Area	Households with no car
EBNS study area	38.1%
Birmingham LA	35.8%
Solihull LA	19.7%
WMCA constit LAs	31.5%
England	25.8%

Area	Bus, minibus or coach	Train	Underground metro, light rail, tram
EBNS study area	10%	1.2%	0.1%
Birmingham LA	9.6%	2.6%	0.2%
Solihull LA	5.4%	3.6%	0.1%
WMCA constit LAs	7.6%	2.1%	0.3%
England	4.9%	3.5%	2.6%

121

An extensive transport investment programme is planned. Plans exist for a Metro extension through the core of the EBNS area, linking Birmingham city centre to the Airport, Birmingham International Station/ NEC and HS2. The extension will reduce travel time from Stechford to the city centre by 50 % / Airport by 60%

Area within 12 minutes walk of the Midlands Metro line (shown in colour)

Legend:
- HS2 Route
- Existing Railway
- 12 Minute Walk Isochrone
- A45 SPRINT
- 7.5 Minute Walk Isochrone
- Camp Hill / Sutton Park Line - potential additional stations
- 12 Minute Walk Isochrone
- East Birmingham - North Solihull Metro
- 12 Minute Walk Isochrone

Dataset: *The map shows the area within a 12 minutes walk of the Midlands Metro Line*
Date: *2017*
Source: *PBA*

Midland Metro Alliance is a team of planning, design and construction specialists responsible for building a number of new tram extensions over the coming decade on behalf of the West Midlands Combined Authority. With regard to the East Birmingham-Solihull Line they state:

"The extension of the Midland Metro from Digbeth to East Birmingham-Solihull will play a key role in delivering the full potential for growth and jobs of HS2 and provide transformational benefits to areas of economic and social deprivation by giving people access to jobs and services, linked to the Greater Birmingham and Solihull Local Enterprise Partnership (GBSLEP) training and skills agenda.

*The 16km extension will link growing residential areas and key destinations such as: Heartlands Hospital with existing and new growth areas including Curzon HS2, Birmingham city centre office and retail districts, Paradise Circus/Arena Central developments and Brindley Place/Five Ways/Edgbaston to the west, and the NEC/Airport and UK Central to the east. (*Midlands Metro Alliance, 2017)"

Approximately 31,000 people within the EBNS area live within 12 minutes walk of a stop along the proposed Midlands Metro extension to Birmingham Airport. The maximum journey time saving for passengers is approximately 15 minutes (for people in Stechford) compared to existing bus services running in the area (97A).

122

Plans exist for a SPRINT bus rapid transit system through the south of the EBNS area. This will incorporate limited stops to cut journey times, and link Birmingham to the Airport and Birmingham International Station

SPRINT is a rapid bus transit system. A route is proposed along the A45 to connect Birmingham city centre and Birmingham International Airport/ NEC; this improves the options to travel by public transport in the southern extents of the EBNS, decreasing travel times to the airport and providing greater reliability and frequency along this route including to JLR (Lode Lane) and Solihull

The A45 Birmingham to Airport Sprint transport scheme is promoted by Transport for West Midlands in partnership with Birmingham City and Solihull Metropolitan Borough Councils. Research suggests that bus users are willing to walk around 7.5 minutes to stops – suggesting an effective market of approximately 28,900 people who live within this walktime (600m) of stops, and improve links between Birmingham Airport, the NEC, Solihull and east Birmingham and the Enterprise Zone sites and wider transport links in the city centre (including HS2 when constructed).

Area within 7.5 minutes walk of the SPRINT Routes
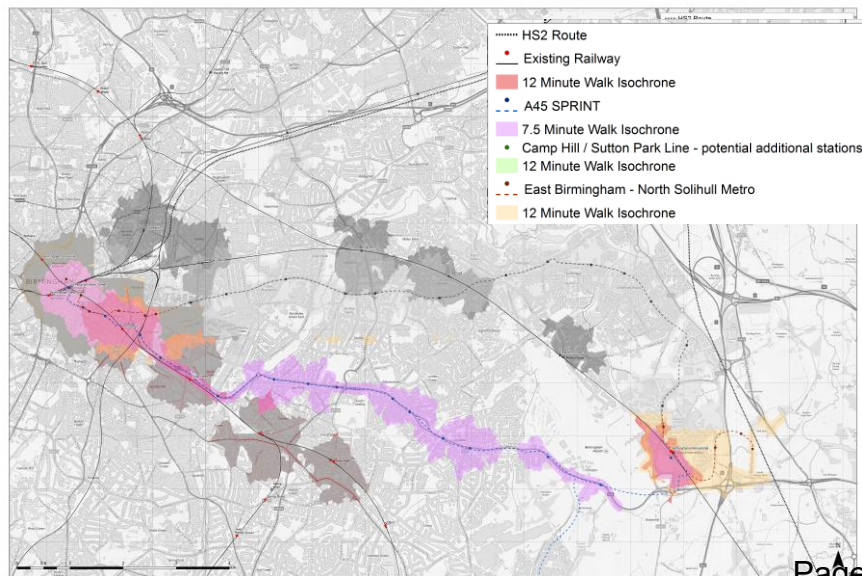
Birmingham to Airport and Solihull

123
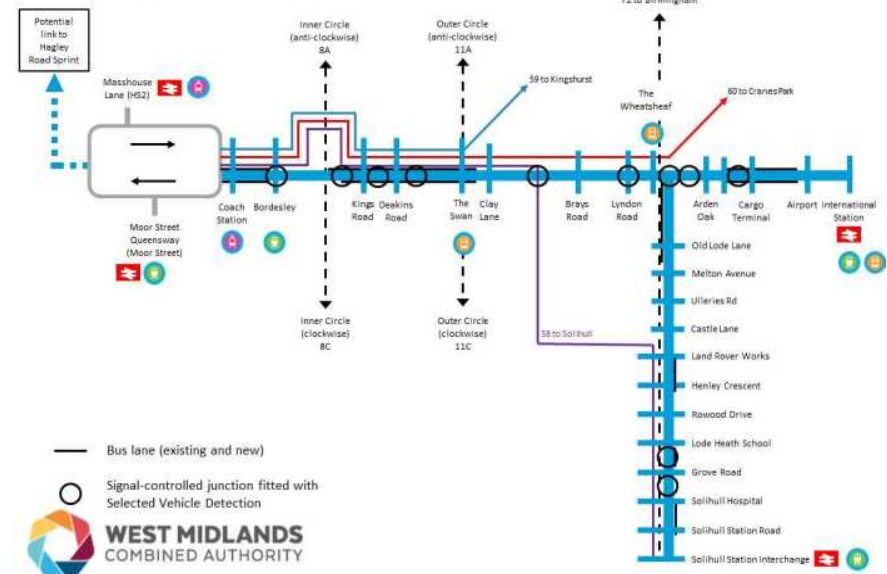
Plans exist to improve rail service frequencies. As part of the HS2 connectivity package, there will be 50% increase in stopping train services at stations between the city centre and Birmingham International rail station

HS2 will release capacity on the classic rail network. The restoration of the Inter City service to a standard 30 minute pattern releases additional capacity, facilitates more cross-Birmingham links to the Black Country (including both inter city London services continuing beyond Birmingham doubling the service frequency to Sandwell & Dudley and Wolverhampton), retains a half hourly fast (60 minute) London service from Coventry calling at Milton Keynes (doubling service frequency from West Mids) and, alternately, at Rugby or Watford.

The stations which serve the EBNS area will experience a 50% increase in stopping train services. Specifically stopping train services at Adderley Park, Lea Hall and Stechford will increase by 100%, and Marston Green and Birmingham International increase by 33%.

Overall there is expected to be a very slight (1-2 minute) slowing in journey time for Inter city services between New St and International, which enables the service frequency to increase as follows:

- New St and International 9 passenger trains per hour to 12 trains per hour

- New St and Coventry 7 passenger trains per hour to 8 trains

There will also be improvements to journeys to Northampton/ Rugby and Coventry.

As with other public transport network enhancements the improvements will require promotion and public information to maximise the benefits to EBNS residents. In particular, those who do not currently use the rail network may be unaware of current frequencies or available destinations, and publicity at stations will not reach such potential users who may be more able to connect to employment opportunities as a result.
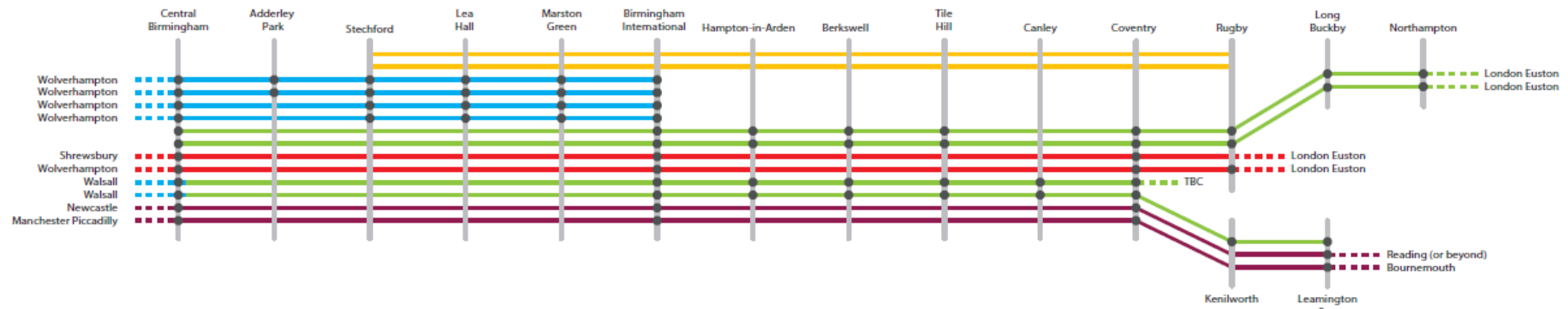
Plans exist for new rail stations in the north of the EBNS area. Transport for West Midlands is looking to open stations at The Fort and Castle Vale as part of the Birmingham-Tamworth line improvements

New stations at the Fort and Castle Vale are due to be open by 2020. These increase accessibility to the city centre by rail from the north, as well as linking to JLR Castle Vale and the proposed HS2 depot at Washwood Heath. The stations have a funding allocation through the devolution deal and the Combined Authority.

At the moment, the Water Orton corridor shown takes longer distance services to Stansted, Nottingham and Derby. West Mids authorities are seeking dedicated local rails services which connect Birmingham to Derby, and possibly Nuneaton. However, accommodating these services requires the delivery of a series of accompanying projects. These are being proposed by Network Rail on behalf of Midlands Connect, and form part of the 'Midlands Rail hub' concept. Midlands Connect is currently developing a Strategic Outline Case (SOC) for the following proposals.

- Two new platforms at Moor St Station
- Provision of sidings at Snow Hill (to create capacity at Moor St)
- Providing access to Moor St Station and sidings via the Bordesley Chords project (also known as the Camp Hill Chords)
- Track remodelling at Water Orton

The map shows the areas within 12 minutes walk of the proposed stations, which contains approximately 2,300 people.

The station concepts are currently undergoing the business case development.

Integration of ticketing and networks to enable easy interchange between the available modes will be required to spread the benefits of the improved services as widely as possible.

Further proposals post 2026 see the extension of services to Sutton on the 'Sutton Park line'.

Area within 12 minutes walk of the proposed stations (shown in colour)
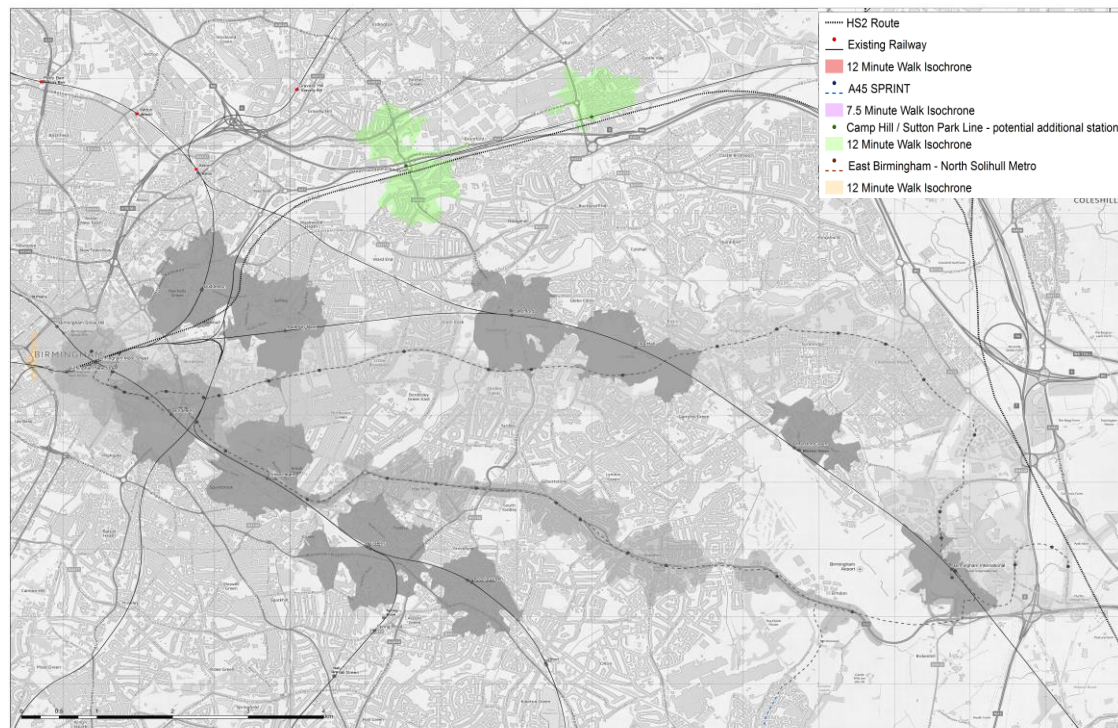
**Dataset:** *The map shows the area within a 12 minutes walk of the proposed rail stations*
**Date:** *2017*
Source: *PBA*

125

Road improvements are planned in EBNS by Birmingham City Council

At **Iron Lane and Bromford Gyratory**, work is planned to address some of the key pinch points within the study area. This will benefit journeys by private car, key orbital bus route 11 and, at Iron Lane, pedestrians/ cyclists.

Iron Lane improvements
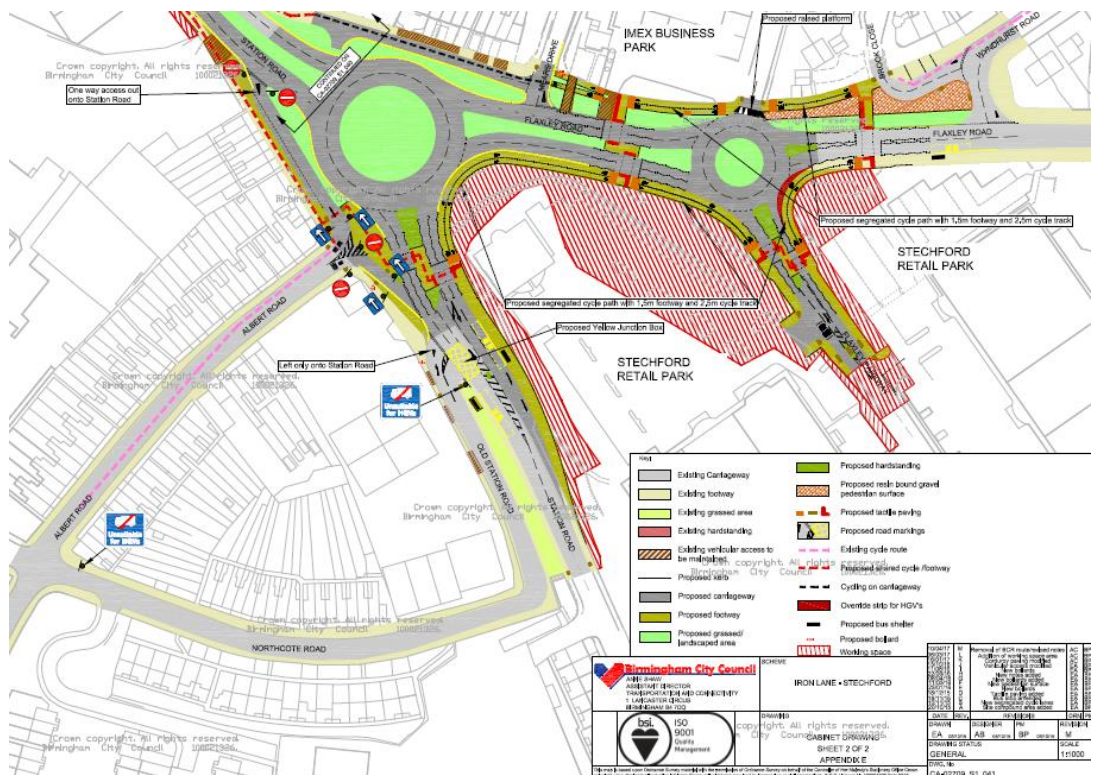
Bromford Gyratory improvements
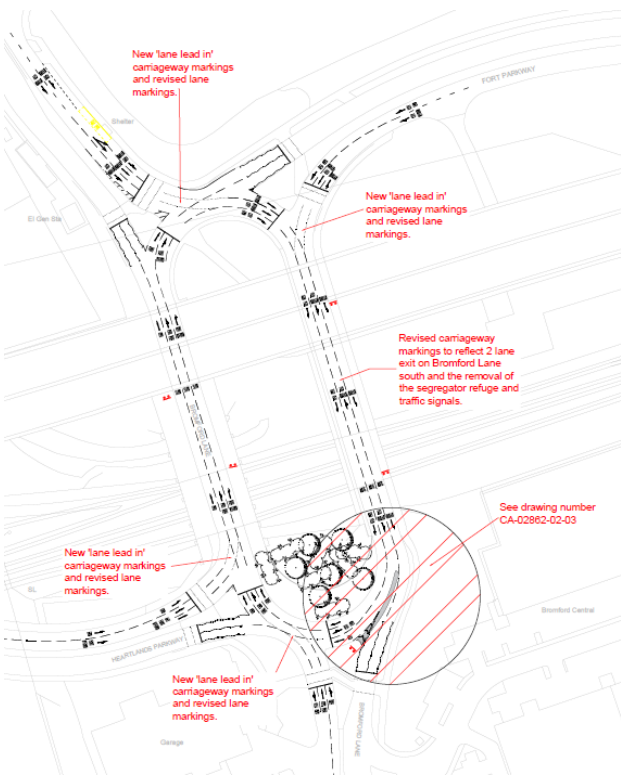
Overall access to jobs is improved by investment. As a result of the overall transport improvements, the working age population within 20 minutes of access to one or more of the key job locations (NEC, Airport, City Centre, JLR Lode Lane, JLR Castle Vale and Washwood Heath) will increase by around 6,000 (a 7% increase) and the number of JSA and ESA claimants within 20 minutes will increase by around 800 claimants (a roughly 10% increase). We have included detailed work as an appendix

Working Age Population

Minutes	Current	Future	Change
0-10	6,103	6,231	128
10-20	73,718	79,728	6,010
20-30	198,699	196,428	-2,271
30-40	14,155	10,288	-3,867
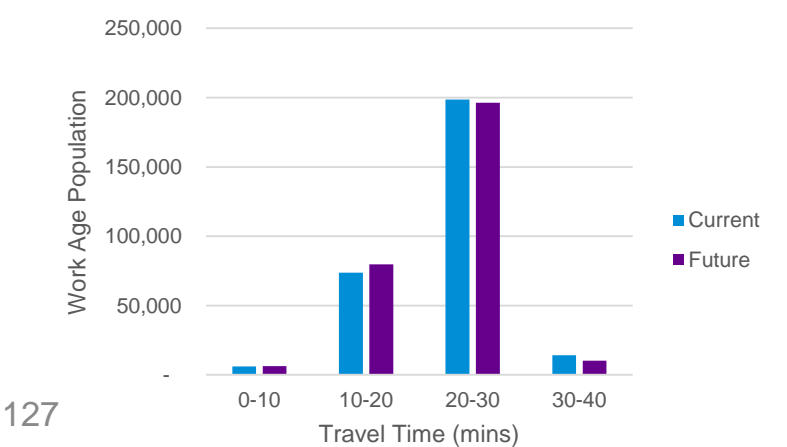
JSA/ESA Claimants

	Minutes	JSA claimants	ESA claimants
Current	0-20	2,526	5,867
	20-40	8,133	19,798
Future	0-20	2,766	6,484
	20-40	7,894	19,180
Change	0-20	109%	111%
	20-40	97%	97%

As a result of the overall transport improvements (SPRINT routes to the airport and Solihull, East Birmingham Metro line, Sutton Line improvements and improvements to train frequency at Lea Hall/Adderley Park/Stechford) enable improved access to jobs, the following cumulative benefits can be determined:

- The number of work age population within 20 minutes of access to jobs will increase by around 6,000; a 7% increase over the current situation.
- The number of JSA and ESA claimants within 20 minutes of access to jobs will increase by around 10% over the current situation.

127

We now examine the evidence on labour market impacts for specific employment sites. Birmingham Business Park has been taken as a case study, and shows how transport infrastructure significantly expands local labour market opportunities. (We have looked at other sites in the Appendices)

After the investment package, twice as many people of working age can access Birmingham Business Park within 40 minutes, and six times as many within 20 minutes. Nearly 100% of the EBNS working population will be within 40 minutes compared to a current 70%.

New public transport travel time to Birmingham Business Park following the planned infrastructure improvements
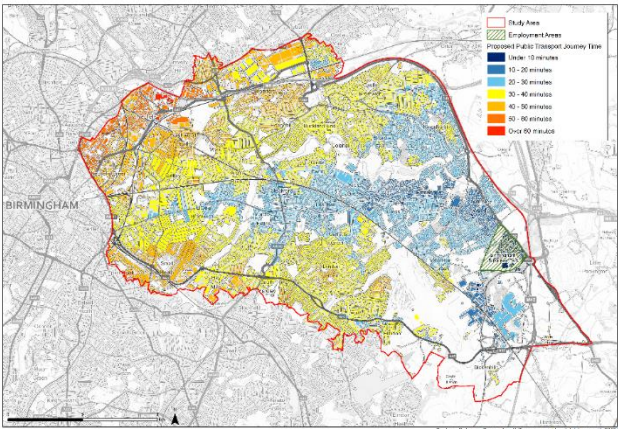

This map shows travel time by all modes of public transport (assuming up to 6 minutes walk to access it) to Birmingham Business Park following the planned package of new transport infrastructure (Metro, SPRINT) and rail infrastructure improvements (where improved service frequencies feed through into improved average journey times). The shortest journey times to BBP are shown in blue, suggesting that, generally speaking, those areas most geographically proximate to BBP have the best access times.

Change in Public transport travel time to Birmingham Business Park following planned infrastructure improvements
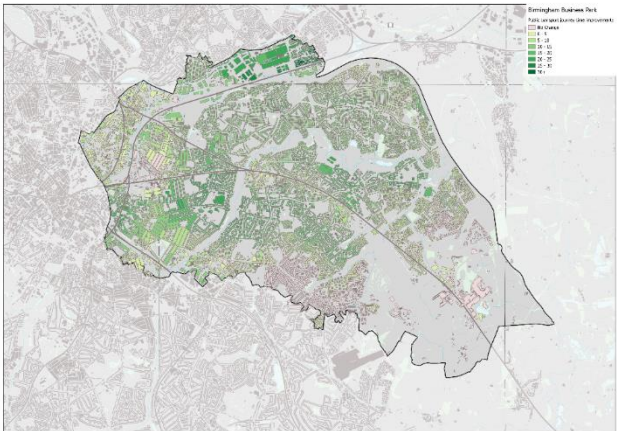
The *change* in travel time is shown in the map above.

Those areas which experience the biggest improvements are shown on the map in light purple and include places which are more distant from BBP including Tyburn and Nechells. Sheldon and Shard End also see significant improvements. In particular, Nechells, with a population of 33,957, has areas with a decrease in journey time from 50 minutes to around 30 minutes.

Overall impact on people of working age (16-64)
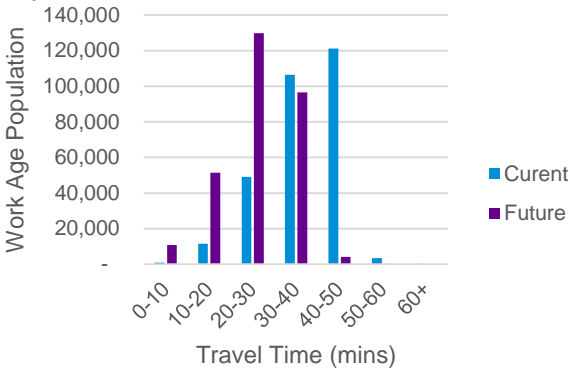
| Working Age Population			
	Current	Future	Change
0-20 mins	12,511	62,203	497%
20-40 mins	155,506	226,366	146%
40+ mins	124,658	4,106	3%

The graph and summary table above show the overall impact on labour catchments at BBP. The increase in people within 20 mins commute is quite dramatic, at 497%. The scale of this shift is explained by the very limited current available public transport to BBP. Metro has a stop in BBP, which immediately creates a major impact itself, whilst Metro connections to other modes (rail, bus) also creates a positive ripple effect across the area

Transport connectivity (as measured by PTAL) will improve significantly after the programme of planned public investment

We examined the PTAL improvements resulting from the development of SPRINT routes to the airport and Solihull, East Birmingham Metro line, Sutton Line improvements and improvements to train frequency at Lea Hall/ Adderley Park/ Stechford.

The before and after assessment using PTAL provides an illustration of how the general transport network is forecast to strengthen as a result.
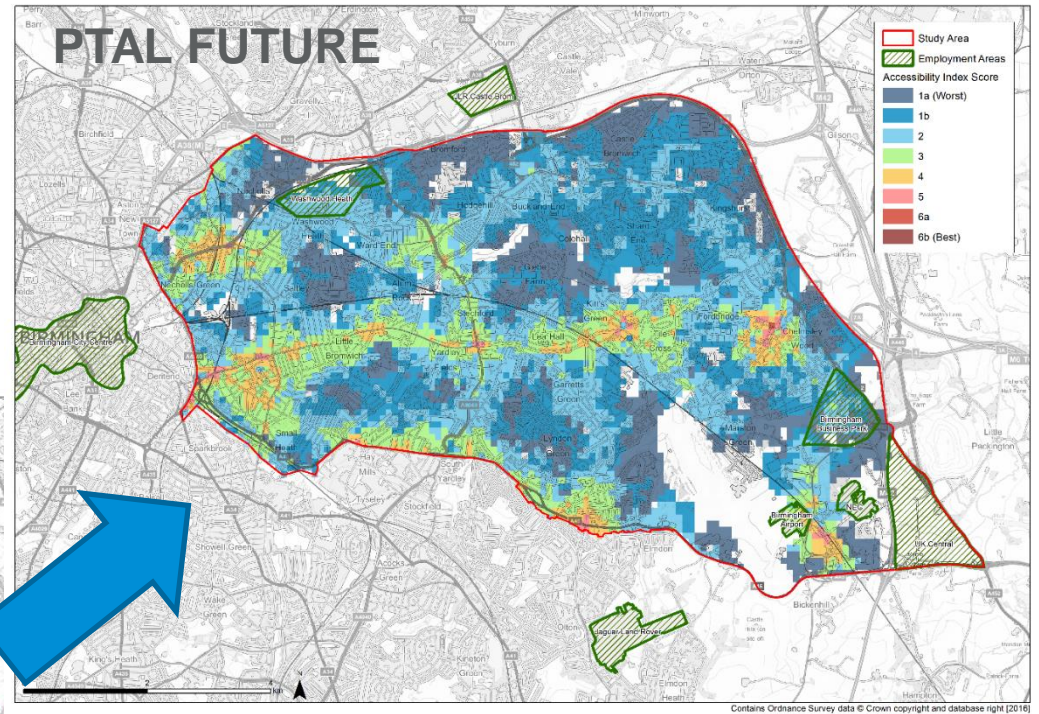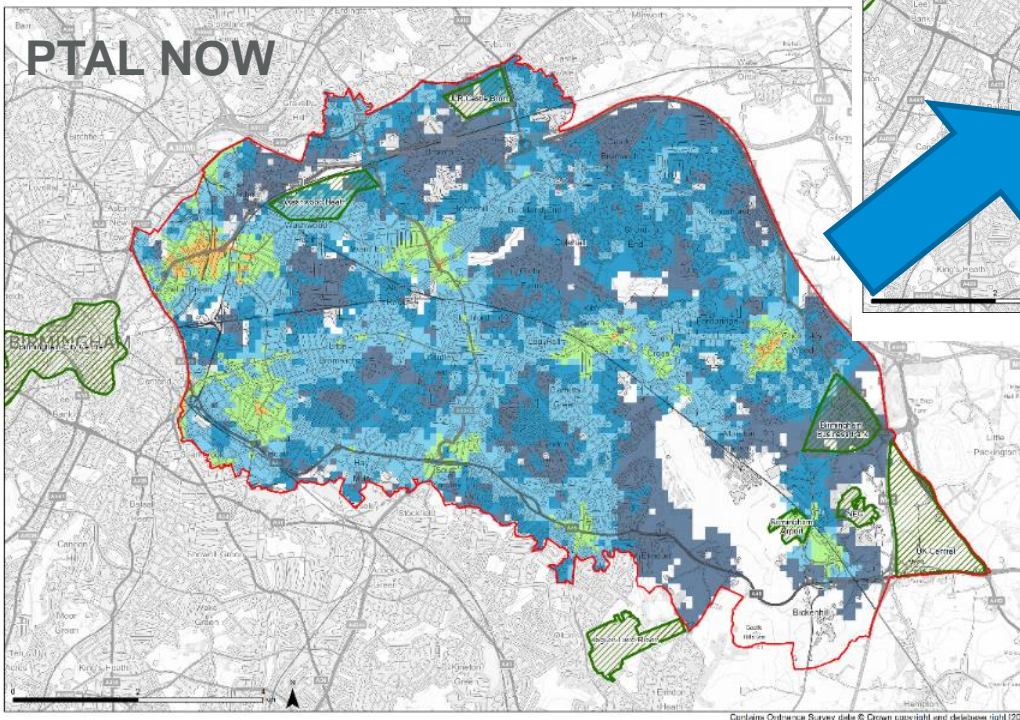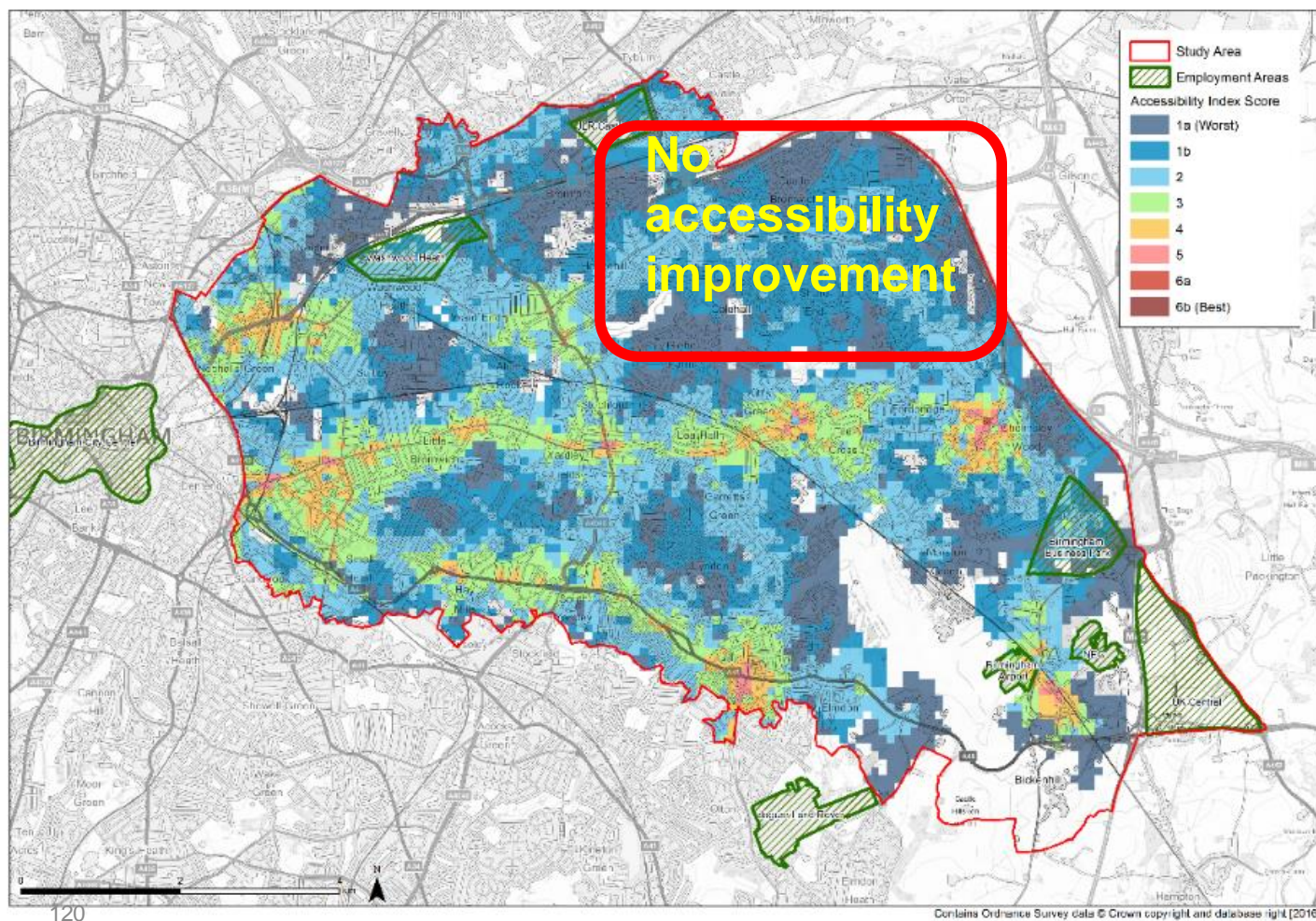
The evidence shows that, even after connectivity investment, the northern part of the EBNS area still has poor accessibility to jobs by bus (other than those jobs in the city centre). Its projected PTAL score shows limited improvement

The PTAL score and accessibility of the Castle Bromwich residential area, particularly to Birmingham Airport/ NEC/ UK Central and JLR sites, does not substantially improve as a result of the rail, metro and SPRINT schemes proposed.

It may be necessary to improve services in these areas in order to help ensure an equitable level of jobs access across EBNS.

No accessibility improvement

Study Area
Employment Areas
Accessibility Index Score
1a (Worst)
1b
2
3
4
5
6a
6b (Best)

Contains Ordnance Survey data © Crown copyright and database right [2016]

120

The evidence suggests that further improvements are likely to be required to enhance provision in northern parts of the study area. New bus routes could be considered. There may also be scope to create park & ride facilities around Metro or rail stations, creating more general benefits

In improving public transport services, it is beneficial to provide destinations at either end of the service to try and maximise the capacity of each bus and minimise the amount of "dead-running" (i.e. empty buses); this maximises the efficiency of any new service and provides the greatest opportunity to sustain viable public transport.

The evidence suggests that one potential option, particularly once the next extension of Jaguar Land Rover Castle Vale is operational, would be to provide a service operating between Jaguar Land Rover Castle Vale and Birmingham International Rail station and/or Jaguar Land Rover at Lode Lane. It may be possible to link this to the proposed rail station at Castle Vale to provide further destinations accessible by public transport to use as part of a longer journey and reduce car use.

Additional services to Peddimore and Langley could be considered. We understand that the devolution deal contained a Sprint route linking UKC to Water Orton via North Solihull.

The frequency of this bus service could be linked to shift patterns at Jaguar Land Rover Castle Vale and Birmingham International, and as these are often out of the core hours, it may be possible to use existing fleet vehicles to operate this service. Opportunities to extend or improve speeds of existing services, such as those operating between Solihull and Birmingham International could also be explored. As noted previously, journey time is a key factor, and so a limited stopping service to concentrate key locations may be required. Use of bus priority on key sections of highway may also provide benefits to all bus users by advantaging them over private cars in congested areas. **There may also be scope for improving bus links to the airport, perhaps run in partnership with employers.**

An investigation for the scope for Park and Ride facilities near metro or rail could also be useful. (TfWM are currently looking at the issue). We understand that similar facilities on Metro in the Black Country have proved popular, and could run in line with revisions in parking standards in central Birmingham.

New bus route possibilities

The "last mile strategy" is important to overall effectiveness of public transport interventions, and has important health benefits. Evidence suggest that it may be helpful to explore cycling facilities to Metro stations and Sprint stops

Public transport journeys often also include an element of walking: in London, for example, over two-thirds of all public transport trips involve walking for five minutes or more and half of all walking is done as part of public transport trips. (Mindell, JS et al, 2011) Walking and cycling provides health benefits to people using the public transport network, and is explored further in this report in the section on public health. It may be useful to explore how walking and cycling facilities (such as cycle sheds) might integrate with metro and sprint investments, to widen the effective catchment of the infrastructure.

BCC is currently rolling out a programme of 20mph limits at various locations across the city. There are opportunities to explore how this could be rolled out in EBNS.

Wayfinding and information available at potential employment and transport opportunities will be important to maximise the integration of the transport network within the EBNS area and thereby the economic and social benefits of the transport improvement programme for the area.

Image: BCC

Accelerating place investment

Key issues:

- Housing development viability is poor, slowing the delivery of change

- Transport is part of the viability solution and creates opportunities

- Retail is struggling in some places, and could be reconfigured

Why is this issue important? A brief review of the literature and local context

Economic modernisation depends fundamentally on the market's ability to reconfigure built assets on housing and employment sites in response to economic and social change. If making these changes to the built environment cannot be made profitable for an entrepreneur, then an area's economy will suffer very serious negative effects over time: it creates a shortage of locations in which modernising investment can take place.

Evidence shows that positive impacts from transport policies have been lost in the past because of poor integration with land use and regeneration policies. Evidence suggests that supporting economic and planning policy is necessary to capture benefits from transport investment. A transport project can potentially promote local and regional economic development if an economy has growth potential and if suitable reinforcing policies are designed and implemented (Berechman, 2001). For example, poor integration with land use and regeneration policies has meant that the regeneration effects of the Sheffield Supertram have been minimal (Lawless 2001).

Considerable work has been done by BCC and SMBC on Local Plan allocations, and AAPs. We are not trying to replicate this. Instead, we are pulling together the review of baseline information for transport accessibility, retail, local employment, and housing to understand what opportunities could be create in EBNS.

The Birmingham Development Plan (BDP) sees two growth areas in EBNS: Bordesley Park and the Eastern Triangle. At Bordesley Park plans exist for 750 new homes and up to 3,000 new jobs

The BDP sets out an approach for East Birmingham. The Bordesley Park AAP Pre-submission Report (BCC, 2017) provides more detail, and looks specifically at an area of around 580 ha to the immediate east of the City Centre, including parts of Washwood Heath, Bordesley Green, Bordesley Village and Small Heath. The AAP promotes significant transport investment, including the extension of the Metro through the area and the construction of the Bordesley Chords.

- **In the AAP, options were explored for the Wheels site**. The preferred option sees the site redeveloped for new employment uses. The rationale given is that there is a shortage of employment space in the city, and that the site is contaminated, and so would need extensive remediation and level changes before it could be used for residential.

- **The AAP's Cherrywood Road preferred option** seeks the creation of a new residential neighbourhood.

- **The AAP's Adderley Park preferred option seeks mixed uses**, with some heavier industries and bad neighbour uses relocated and an exploration of relocation options for the currently constrained Adderley Primary School.

- The AAP's **Alum Rock Road option** includes gateway expansion and enhancements, and improved use of space at St. Saviour's School, and commercial premises.

- **Small Heath's linear local centre runs for 1 mile from Cattell Road to Small Heath Park**. The AAP finds that "within the centre, opportunities for change are limited [but] the area at the western edge (Cattell Road) does have the potential for improvement". One of the options explored considered local centre consolidation – returning some retail uses at the extreme east of the centre to residential use. This option was rejected in favour of an approach which encourages investment and the creation of a 'gateway' including new development to define the western end of the centre
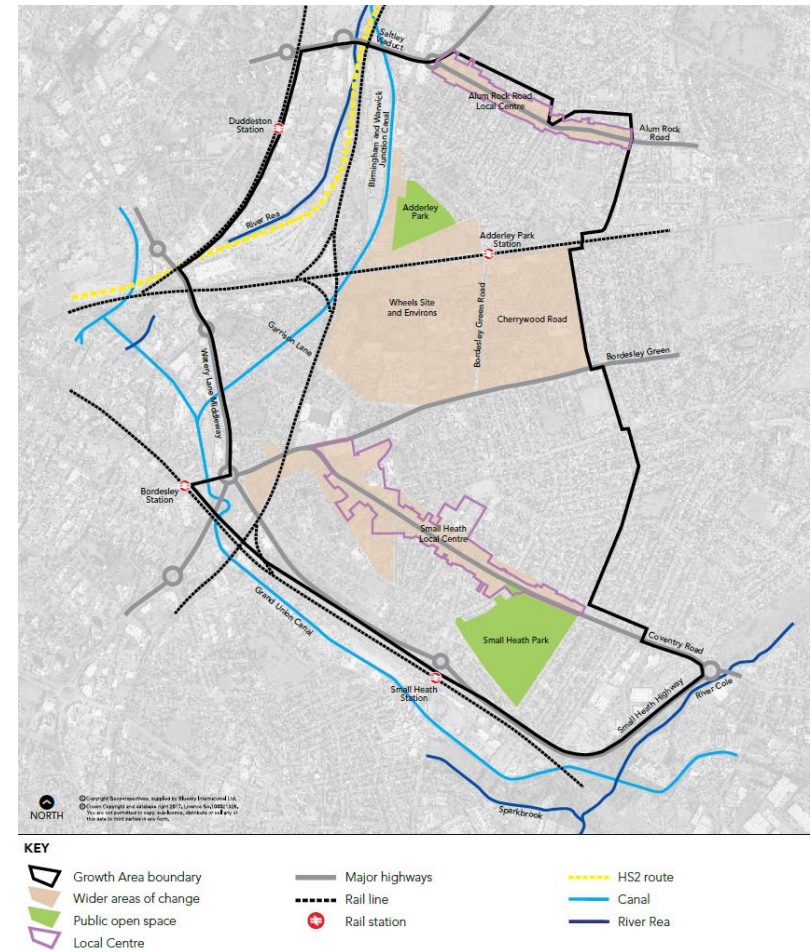
Source: Birmingham Development Plan (adopted 2017)

135

The Birmingham Development plan proposes an Eastern Triangle (covering Stechford, Meadway and Shard End) will deliver regeneration and around 1000 new homes

The Birmingham Development Plan proposes that the Eastern Triangle will deliver regeneration and growth for around 1000 new homes. The potential for the redevelopment of further unsuitable housing stock as well as the more efficient and effective use of existing land and buildings where practical and particularly at locations that are close to local centres, accessible by public transport and on or close to main transport corridors will be explored.

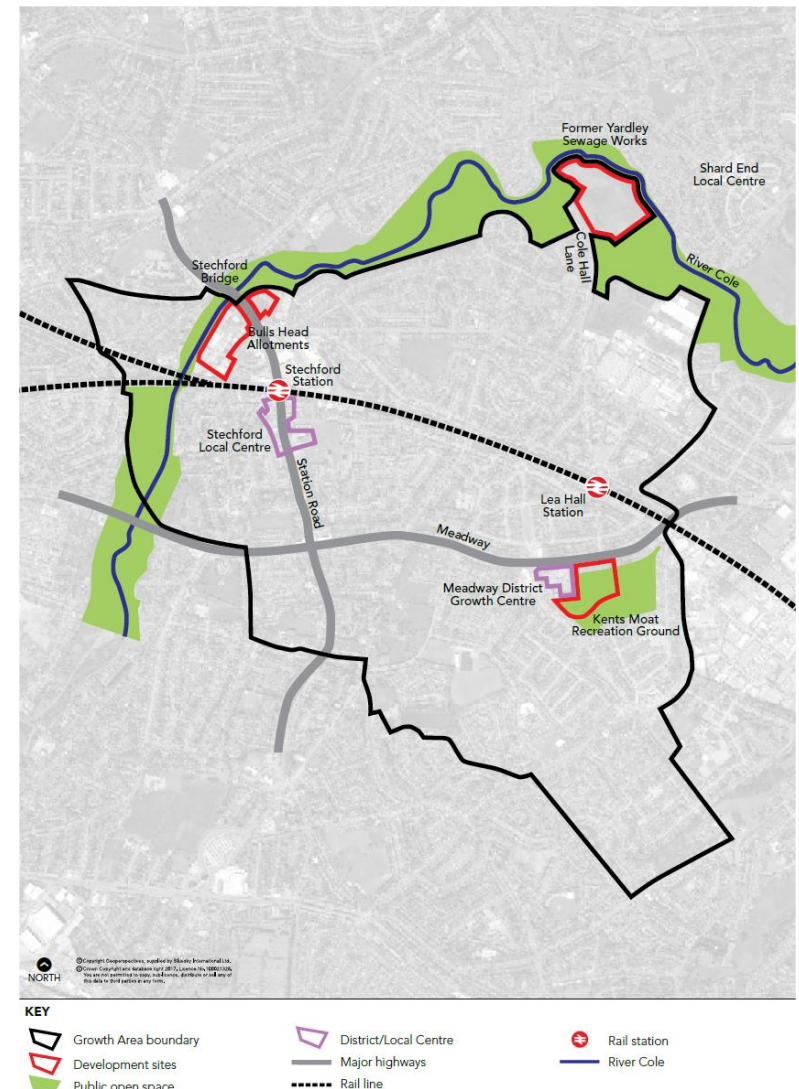**At Stechford this will include:**

- The promotion of new residential development, and the growth and improvement of Stechford Local Centre to meet the retail, service and community needs, and potential to consider the future of other sites for housing or associated development including under-used allotments at Burney Lane and Francis Road.

- Improved accessibility by all means of transport including enhanced pedestrian and cycle linkages and connectivity to Stechford rail station and the local centre.

- Environmental improvements, including enhanced access to the River Cole Valley.

At the Meadway this will include:

- Redevelopment of the former Meadway flats site which will deliver the reconfiguration and enhancement of the adjoining Kent's Moat Recreation Ground and Poolway Shopping Centre (already under way).

- Improvements to Lea Hall rail station, including improvements to parking, interchange and the pedestrian and cycle links from the station to the centre and adjoining residential areas.

At Shard End this will include:

- The removal from the Green Belt of part of the former Yardley Sewage Works site and development of up to 350 new homes.

- Enhancement of the Cole Valley

KEY

Symbol		Symbol		Symbol	
	Growth Area boundary		District/Local Centre		Rail station
	Development sites		Major highways		River Cole
	Public open space		Rail line		

Page 440 of 588 Source: Birmingham Development Plan (adopted 2017)

In Solihull, the draft local plan looks specifically at two areas which sit either partially or wholly within EBNS: UK Central and the North Solihull regeneration area

The Draft Local Plan (December 2016) deals specifically with the North Solihull area within the EBNS study area. In North Solihull, the plan states that

"the regeneration programme will continue to have made a real difference to people's lives where there will be an increased choice in the housing stock through widening the housing mix, size, type and tenure, and improved quality; improved opportunities and access to employment; a more highly skilled workforce and a better range of jobs. This will include better connections to employment and other opportunities beyond the area through investment in public transport. Local communities will have become healthier, safer and mixed with easier access to thriving community hubs and village centres, enhanced green space and public realm. The River Cole valley and its setting will have been protected and enhanced. Chelmsley Wood Town Centre will have become a vibrant centre with a better range and quality of retail, leisure and community facilities."

The vision for Chelmsley Wood Town Centre is that it

"will be developed and sustained as a focus of commercial activity, services and public transport. It will be shaped and managed to secure its regeneration and economic growth and to provide a focus for the local community and an identity of which it can be proud". Policy P2 states that "further limited comparison retail development is also included. New development can bring opportunities to strengthen the role of the Centre in serving the community by improving links to North Solihull and to nearby open spaces".

Policy P1 deals with the UK Central Hub Area. The area contains Birmingham Airport, the NEC, Arden Cross, Birmingham Business Park and JLR (which are each key economic assets) and seeks to support their future aspirations in a holistic, well connected way, together with the development of the HS2 Interchange Station.

The UK Central Hub has a Growth and Infrastructure Plan which specifically looks at the area. The area has a dedicated Urban Growth Company (UGC) - a special purpose delivery vehicle created specifically to realise the full economic potential of the HS2 Interchange Station and related infrastructure.
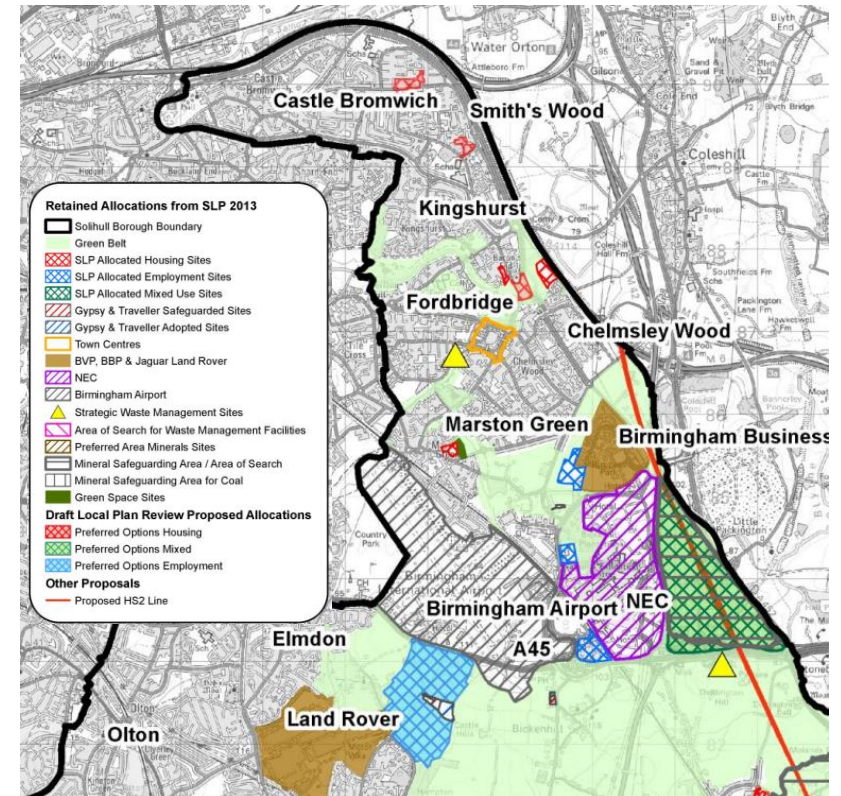
Whilst planning strategies for EBNS exist, the market has been relatively unwilling to take them up. The central problem is likely to be one of viability

Housing sales values are relatively low in EBNS. Because housing build and labour costs are relatively fixed, and land costs frequently inflexible, this means that developers have a narrow profit margin – making development relatively risky for them in parts of EBNS

Rank of LSOA on average house-price for all properties, over the last 12 months (June 15 to May 16)
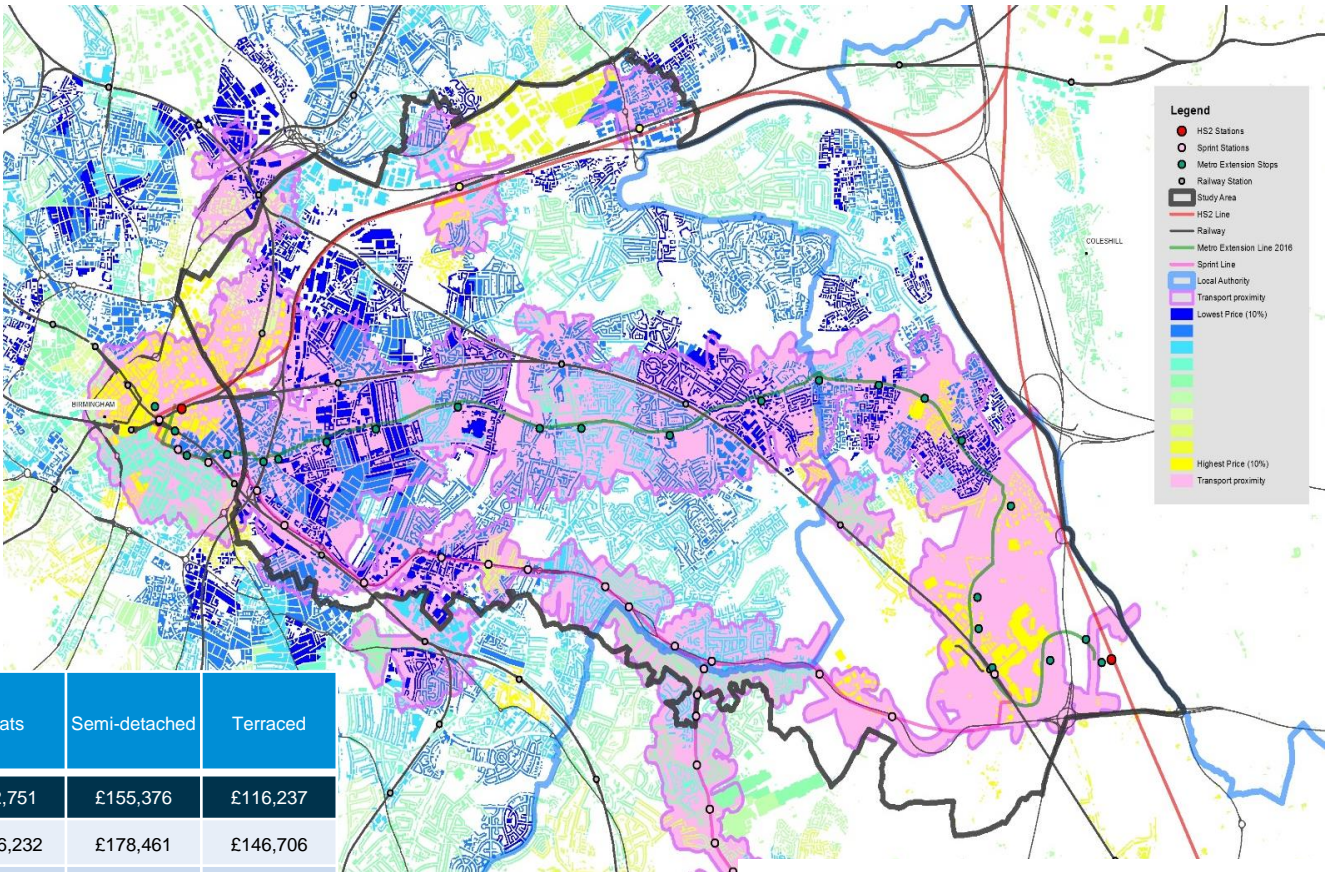
Property price by house type	All types	Detached	Flats	Semi-detached	Terraced
EBNS study area	£176,509	£236,151	£82,751	£155,376	£116,237
Birmingham LA	£206,887	£356,523	£136,232	£178,461	£146,706
Solihull LA	£311,640	£456,343	£168,283	£251,247	£187,866
WMCA constit LAs	£228,237	£396,524	£142,594	£194,321	£151,480
England	£300,314	£386,568	£269,473	£238,292	£233,163

Dataset: *Average house-price for all properties, over the last 12 months. The Land Registry collect data on all housing transactions, published by individual property and date.*
Date: *Jun-15 to May-16*
Source: *Land Registry*

138

Transport investment in EBNS could improve the viability of sites, and so be used to accelerate a positive process of market-led redevelopment

Low wages locally mean that housing sales values are low. On their own, this damages the viability of development. But, particularly in the central and western areas of the EBNS area, there is frequently an additional factor that damages development viability further. The area's ex-industrial heritage means that sites are frequently relatively expensive to develop: previous uses mean that land has to be remediated. This can be costly, and also represents a significant risk to developers, because it can be difficult to buy land in full knowledge of remediation risks. Combined with a very similar issue in employment land markets, this reduces the ability of the economy to respond to economic change and so generate productivity growth.

Transport investment can raise sales values of housing sites, so improving site viability and encouraging development activity. However, transport investment is not a magic bullet which will solve all viability problems. An LSE review on transport economic impact studies (LSE 2015) found that the quality of studies on the impact of transport on land and property is variable. In all cases there is great variability in the models employed; the data used; the variables measured and hence there are difficulties comparing results. The LSE reported the following.

- A 1% increase in accessibility as expressed in the travel time, discounted access to employment opportunities (and correlated effects), induces a roughly 0.25%-0.3% increase in residential property prices (Ahlfeldt 2011).
- Mikelbank (2001) suggested that home prices rise in response to transportation improvements that occur along shortest-path routes connecting individual homes to the region's CBD or to the local shopping centre;
- Many studies have found a positive relationship between transport

infrastructure investment and the prices of land or housing (e.g. McDonald and Osuji, 1995; Haughwout, 1997; Boarnet and Chalermpong, 2001).

- A study of US towns over two decades showed house value premiums for homes within a quarter to half mile from train stations ranging between 6.4% to 45%.
- A study of residential property values in Buffalo NY found that average property values increased by $2.31 for every foot closer the home was to a light rail station.

Rail projects tend to have a positive effect on residential property prices, although the size of the effect varies considerably depending on the type of residential unit and its proximity to provision. The LSE's work found that for evaluations showing positive effects, the degree of price appreciation ranged from extremely small to quite substantial. For example, a study which looked at the impact of light rail in Charlotte, North Carolina found effects that ranged from near zero up to around 13%, depending on:

- the type of property (for example, 'condominiums' see a greater increase than single-family properties); and
- proximity from the station (for example, single-family homes within half a mile of the station see no impact, whilst condominiums within half a mile are subject to a greater increase than those further away).

No rail effect on commercial property prices has been found. The LSE found one good quality study on rail effects on commercial prices – but it found no effect.

We have undertaken high level viability work to look at the extent to which market forces can be expected to achieve higher housing supply and area regeneration, or whether public subsidy would be required

Employment growth around the EBNS study area at the HS2 Birmingham Interchange and the continuing growth in Birmingham city centre employment, combined with increased connectivity of enhanced services to the rail stations and the planned rapid transport link between these two centres, provides an opportunity to consider whether these factors can combine to result in improvements in development viability which would allow new, more ambitious strategies to emerge.

We have undertaken high level viability work to look at the extent to which market forces can be expected to result in improvements in viability, or whether further subsidy would be required.

Large areas have been chosen for the case studies so that a "market shift" can be achieved with higher densities, higher market values and an increase in neighbourhood spending power by encouraging households on higher incomes to move in or work in the areas. In neighbourhoods of 500 to 2,500 dwellings it is considered that a 50% increase in market housing stock, and with that aimed at higher earning households, is required to achieve a "market shift" and to attract new employers. The absolute number of affordable (or sub-market) dwellings will be maintained, in part through reprovision in the same neighbourhood.

The case study areas

Three neighbourhoods have been chosen for high-level study. Each lies close to the proposed Metro link route and the existing rail services. Each has low intensity land use with relatively low market values.

- Case Study A has a mix of land uses, mainly light industrial, and covers an area of 47.7 hectares. Case study A sees an increase from 47 dwellings to 250 dwellings.

- Case Study B is predominantly residential and has an area of 37 hectares. Case study B sees an increase from 670 dwellings to 1,000 dwellings.

- Case Study C is a larger area of residential with retail zones and has an area of 99.4 hectares. Case Study C sees an increase from 2,143 dwellings to 3,000 dwellings.

Details and some important caveats are attached as an appendix.

The results of high level viability testing: one case study scenario is viable, whereas two are not. The market-viable scenario is predominantly residential. The non-viable scenarios could be made viable with £21m/ £39m subsidy, or made more viable through an increase in housing numbers to create greater value uplift

The results

Case Study A does not appear to be viable. This is due to the retention of a high proportion of employment use (in warehousing and light industrial). The value uplift potential for these land uses is low. If more housing was included, then development would be more viable.

Case Study B appears to be viable. The focus on market housing intensification and the ability to achieve the highest density increase (the ratio of original density to proposed density) generates the highest uplift effect.

Case Study C does not appear to be viable. Housing density uplift is not as great because the existing housing density is at an above average level. Furthermore, the acquisition costs of businesses such as large supermarkets are closer to the proposed value and the lost rental income during a redevelopment is significant.

HCA or similar public sector interventions would be very helpful in de-risking site development. HCA funding is available for this, as is Combined Authority funding.

A summary of the results is shown in the table.

Practical considerations

Community Infrastructure Levy has been recycled within the study areas to meet some of the infrastructure obligations (hard, soft and social). The size of the areas make this a reasonable assumption.

A method of capturing potential increased hope value is required. As schemes like these take effect then expectations of remaining owners rise. Some form of declaration (or setting a base line of Existing Use Value)

before commencement coupled with CPO powers, perhaps through a New Town, or Combined Authority Mayoral, Development Corporation, or similar, could be helpful.

Large scale redevelopment schemes involving existing housing were common in city areas for much of the last century. In more recent times these have become harder to instigate because of the uncertainties and upheaval that will impact existing residents. The gains though are substantial and, as we see a reduction in appetite for adding to housing supply on green field sites, capacity for engagement and local governance will need to be enhanced.

High level viability scenario testing results

Ratios and results	Market Housing EUV	Market Housing GDV	Ratio	Housing density before	Housing density after	Ratio	% AH before	% AH after
	£	£		dpha	dpha			
Case Study A	95,000	200,000	2.1	61	83	1.37	0%	0%
Case Study B	125,000	225,000	1.8	35	61	1.74	49%	33%
Case Study C	125,000	225,000	1.8	45	61	1.35	51%	36%
	EUV	GDV	Ratio	Project balance				
	£m	£m		£m				
Case Study A	37	227	6.1	-21				
Case Study B	61	187	3.0	4				
Case Study C	259	699	2.7	-39				
	AH	=	Affordable Housing					
	EUV	=	Existing Use Value					
	GDV	=	Gross Development Value					
	dpha	=	Dwellings per hectare					

As the land supply reduces, the North Solihull Partnership will need to reduce its activity in March 2018 – but has valuable lessons which can inform future strategy development in EBNS. A major determinant of performance was site viability: markets performed less well than hoped, meaning that targets were missed

PBA interviewed the Regeneration Director of the North Solihull Partnership as part of the baseline study.

The North Solihull Partnership started 12 years ago, with the objective of using investment in education infrastructure though the Building Schools for the Future programme alongside physical and community regeneration to deliver a step change in education and deprivation levels in North Solihull. The Partnership was comprised of four partners – Whitefriars Housing Association, Bellway, Solihull MB Council, and InPartnership (commercial developer). The strategy was intended to capitalise on the relatively low-density development of the area (given the area's Radburn estates and redundant school sites) to generate new housing opportunities.

The Partnership was set up with an innovative financial model. It intended to use the value created from the grant of planning permission on under-utilised land to help pay for wider redevelopment, alongside other public sector funding streams. The typical process was that land in council ownership was declared surplus; then sold to the North Solihull Partnership at existing use value; planning permission acquired; and then land was sold with permission, allowing the uplift in value created by permission to be recycled through the Partnership and used to deliver wider social objectives. In the case of school surplus land and playing fields, 50% of the value uplift from replacement value had to be spent on education within the LEA area. Warwick Manufacturing Group have delivered a new school, seven new schools have been provided and three refurbished. One more primary school to come in Yorkswood.

The Partnership has not achieved its objectives around housing. The Partnership has built 2,000 homes, against its original target of 8,000; it has demolished 1,000 homes, whereas the original strategy set a target of 3,000.

We understand that there are a number of reasons for this. Firstly, the uplift in housing values created on redeveloped sites has turned out to be less than expected in the original financial modelling, so depressing the uplift in land value resulting from planning permission. This has depressed the willingness of developers to bring forward new housing: second hand property in North Solihull can be bought for £100k, which puts a natural limit on the price of new stock. There was a wider housing downturn caused as a part of the financial crisis

Secondly, costs and risks were higher than projected. A particular problem has been the acquisition of owner occupied homes, frequently those acquired under right to buy. Whilst extant, AWM paid for the acquisition of existing owner occupied properties and demolition, and subsequently other grants were given through Whitefriars to create equity investment in properties to enable people to move. Further, the planning process associated with the release of school property has proved lengthy and complex, increasing risks for developers who run the cashflow risks resulting from having investment tied into sites which are running through relatively risky Section 77 planning processes. The costs and complexity associated with decanting and at times extinguishing businesses has been high.

142

(cont. from previous page)

Significant public sector investment has accompanied private sector investment. The Regeneration Director of the Partnership has estimated that there has been over £0.5b investment in the area, including £50m from HCA. In more recent years, commercial developments have only really gone ahead because the Council has stepped into developers' shoes – and have made grants to keep the property acquisition process moving.

At its peak, the North Solihull Partnership was a major management undertaking, with over 30 full time employees.

Community opposition to parts of the strategy was strong, necessitating a change in strategy. Broadly speaking, local people now accept that the housing was a "cost" of the necessary facilities. There were local suspicions that the Partnership was a vehicle for Bellway, and the evidence that schools were being re-provided did not create a broad enough constituency of support across the community. This had political implications. At commencement of the Partnership there was a political consensus that the regeneration programme would not be politicised. This consensus broke down, and the electoral profile of the area has changed. Support has increased in recent years, but has only come as a result of community facilities in village centres being delivered. In the last four years a wider approach has been taken which extends benefits to those without school age children, with the provision of specialist accommodation for over 55s, residents with learning difficulties (with extra care and dementia care buildings programmed). Significant amounts of money (£150k per annum) have been raised for local community and voluntary sector groups, which has further assuaged community opinion.

Policy flexibility has been important. Public sector policy has had to respond to more difficult economic conditions. On housing, the Council has derogated from policy which encouraged mixed tenure developments to allow sites which are 100% outright sale (and 100% affordable). There have also been adjustments to the funding model: when the OJEU selection process started there was a condition that first 700 properties built would go to Bellway, and then the rest would be market tested. After the crash, the viability of the Partnership was in question, and Bellway was provided loans to keep the partnership going; in exchange the 700 property stipulation was set aside.

It is unlikely that we would be able to directly reassemble the North Solihull Partnership to work in East Birmingham. Inpartnership has adjusted business strategy; Bellway is wary of the risk and complexity of regeneration sites, and is being successful in obtaining the volume development sites it needs elsewhere; and Whitefriars Housing Association, is unlikely to compete with Birmingham Municipal Housing Trust in the area given the financial advantages that Birmingham Council enjoys around financing costs and the treatment of stock depreciation. Nevertheless, it would not be definitive that Whitefriars/Bellway would not be interested in East Birmingham without a specific discussion surrounding the full scope of the area.

The Partnership is expected to reduce activity in March 2018. Land which is in the control of the council will be brought forward by March 18. Once the land supply is exhausted, there is limited funding to cover overheads. Regeneration work in North Solihull will continue through the Council and private sector partners.

Birmingham Municipal Housing Trust is now Birmingham City Council's preferred the social housing developer for the Birmingham administrative, area and no land transfers are made to RSLs. Birmingham are using prudential borrowing to do this rather than bank finance. It is likely that large scale housing regeneration strategies and private sector will need the very close involvement of the Municipal Housing Trust, and take account of the experience gained in North Solihull around costs, values, planning risks, the level of management commitment and the importance of policy flexibility set out above.

Innovative housing delivery methods may improve the build out rate and viability of development in EBNS. A number of initiatives could be investigated further, and BCC is developing expertise in the Private Rented Sector

Using Private Rented Sector (PRS) investment to broaden the tenure available to new occupiers could increase delivery rates. We note that BCC has experience in the PRS sector through INREACH, a company set up specifically to develop new homes for market rent within the city.

Around the country, the emerging model is one of developers finding the opportunities and working in partnership with the public sector to secure land at low value and/or agree nominal affordable housing contributions – and agree other elements including access to funding and reductions in planning risk. Some of the cost assumptions (e.g. ongoing management costs) are untested and therefore part of the role of the Councils (and HCA) could be to bring forward these sites for development as 'proof of concept' to establish new benchmark costs and values as a basis for future developments.

Using custom and self-build could broaden the appeal of the site to groups which might not find a volume housing product attractive. The argument is that custom and self-build provision would broaden the effective market for new homes, in a context where 75% of the population will not buy a new home from any volume housebuilder resulting in a small number of prospective purchasers for any particular speculative volume housebuilder standard house type range.

Igloo's written evidence submitted to Parliament (Housing and Planning Bill 2015) suggests that the three principle forms currently operating in the UK are:

- Individual Custom Build - where a small builder delivers a single home to an individual's design either on a site owned by the customer or the builder (the "Grand Design" approach)
- Custom Build Development where a Custom Build Developer secures the site and planning and offers a basic house type with scope for customisation (eg Inhabit, Fairgrove, Modcell, Urban Splash, HAB) and

- Custom Build Enabling where an enabler secures the site, planning permission, mortgages and a panel of Home Manufacturers and then delivers and markets the serviced plots (eg igloo, Cherwell).

Igloo's evidence states that

- 53% of the UK population would like to build their own home at some time in their lives (12%/7 million people in the next 12 months) but only around 10,000 succeed (IPSOS Mori).
- The available evidence suggests that Custom Build is around 3-5 times faster than market sale (Holland).
- In the UK self-build amounts to around 10% of new home production and there is virtually no Custom Build. Igloo finds that in other developed countries, on average, around half of homes are Custom Build or self-build and they build on average about double the number of homes per head of population.

However, Igloo state that *"to be viable Custom Build requires sites in excess of 100 plots. Home Manufacturers require on average a minimum of around ten to fifteen homes per site in order to recover the individual site set up costs and make a reasonable profit (they typically require a profit margin slightly above a builder (say 5%) but substantially below a developer (say 20%) because they do not have sales risk or a significant requirement for capital (as they are paid in stage payments before they have paid their suppliers)."*

There is no question that this is a currently unproven marketplace. Careful policy scoping work would need to be undertaken.

Direct action to deal with land remediation is likely to be necessary at some sites. £200m Combined Authority funding is available over five years for these tasks.

Birmingham City Council is a major player in housing development, through the Birmingham Municipal Housing Trust, which builds 25% of all new homes across the city. HCA also has funding targeted at housing sites. Any future strategies would benefit from close alignment with BMHT and HCA

The Homes and Communities Agency (HCA) has funding streams targeted at the purchase, de-risking and decontamination of housing sites. HCA will be useful partners in future regeneration efforts in East Birmingham.

Any attempts to create new growth nodes is likely to need to involve the Birmingham Municipal Housing Trust (BMHT). BMHT was set up in January 2009 as a brand name for the Council's new build programme. BMHT is part of the Council, not an arms length organisation. HRA subsidy reform made it viable for the Council to build new homes for the first time since the 1970s. The Council can bid for HCA grant in the same way as a Housing Association.

Quite independently of any long term plans for intensification around transport nodes, BCC is active in local housing development markets, focusing on financially unviable housing stock and site development opportunities. The BCC 2016 asset management model identifies 11 financially unviable tower blocks in East Birmingham - all Large Panel System blocks, in Erdington, Bromford and Ward End. There is also a small number of non traditional built low rise unviable properties in Shard End. Most of the BCC stock is financially viable. Total programmed BMHT delivery in the East 2016-20 is 1,241 units, as follows:

- Abbey Fields - 320
- Erdington Gardens - 116
- Meadway - 300
- Bromford – 200
- Yardley Brook – 250
- Small sites - 75

There are also a series of privately owned sites for potential acquisition in the East. BMHT's model requires up front working capital of £10 million, recycled through the programme as sites are built out and properties sold.

Direct delivery through BMHT means the Council is in control of the development process, meaning that:

- The Council can control timing/phasing of developments not subject to other partners' Business Plans;
- The Council can directly control rents and customer service standards;
- The Council can cross subsidize sites to achieve viability;
- The Council can control design standards and quality on new developments in detail;
- The Council can offer a range of tenures to suit local housing markets.

Over **1000** new rented homes completed since 2009

Almost **1000** homes for sale completed since 2010

317 rented homes completed 2014 - 15

321 completed 2015 - 16

BMHT schemes at Abbey Fields Erdington

145

North Solihull Partnership has made progress on regeneration schemes around North Solihull. NSP has previously delivered new centres at Chelmund's Cross (previously called Craig Croft) and Smiths Wood. Kingshurst is now being progressed. Future strategies will need alignment with NSP and its possible successors, and use its experience

North Solihull Partnership has a track record of successfully regenerating obsolete retail parades. A large element of the first phase of the programme was funded on the use of surplus playing field land, which went hand in hand with the provision of new schools and associated facilities.

At Craig Croft, the old precinct at Craig Croft had a range of facilities available to local residents but the area was becoming increasingly run down. The area has undergone regeneration and has been renamed Chelmund's Cross.

Similarly, the shopping precinct in Arran Way, Smiths Wood, was becoming increasingly out of date and run down. A brand new shopping centre has been created in a more accessible location with its own high street at Burtons Way, Smiths Wood.

The next area for regeneration is Kingshurst, **where a regen scheme by SMBC is looking at updating the local centre.** Perhaps typically of the area, Kingshurst is a 1950s/1960s inward facing centre that is now somewhat dated, a poor use of land lends itself to anti-social behaviour. In addition to shops, there are flats and community facilities such as a library. North Solihull Partnership are currently working on the early stages of a masterplan which looks at the centre itself and some adjacent sites. The question at this stage is how much of the existing centre needs to be demolished and how much should be refurbished. Reprovided sites will be a mixture of retail, community and residential; at this stage studies are looking to establish the amount of each.

The masterplan will be ready by summer 2017, although implementation timescales are unknown at this time. An understanding of the land required will come with the masterplan.

Craig Croft – before and after

Smiths Wood – before and after

146

The Partnership is leading on studies for new sites at Chester Road, and the Simon Digby Campus

North Solihull Partnership are leading on studies for new sites, using LEP funding. The partnerships is going out to tender on Chester Road study, in order to investigate the potential for development on five separate sites around a possibly reconfigured roundabout at the junction of Chester Rd and Moorend Avenue. We believe that there is clear potential for comprehensive redevelopment at Chelmsley Wood Town centre, creating the step change that the area needs

SMB and the HCA are looking at potential on the former Simon Digby Campus site. This has a local plan allocation for 200 homes. The site has constraints: it needs new access and flood alleviation, and there are possible issues around land ownership (the site is half owned by Solihull College, half Solihull Council) and noise attenuation, given that the site abuts the motorway. Mitigations using a combination of bunding and fencing are being explored.

147

We now turn to retail development opportunities. Retail is not just another economic sector – it is the 'shop window' of an area, and has a major role in creating perceptions

There is a structural shift under way in retailing. It is important to understand what this might mean for EBNS.

- **Polarisation: Most National comparison (non-food) retailers are increasingly concentrating their trading activities in a smaller network of large stores concentrated in high order centres, shopping malls and regional centres.** Since the downturn, the quality and diversity of the retail offer in the largest 'Top 100' centres has improved relative to small and medium town centres which have struggled to retain key anchor retailers. Out of centre retail parks have also become increasingly attractive to retailers since the downturn. The share of comparison retail sales conducted through town centre shops declined from 64% in 2002 to just over 40% by 2013 and out of centre superstores and retail parks have been one of the main beneficiaries (PBA 2013).

- **Digital technology: Digital technologies facilitating online sales have altered the ways in which retailers utilise physical floorspace and it is likely that new technologies will impact on the retail sector in unpredictable ways.** Retailers are increasingly utilising digital technology to drive footfall and in-store purchases. For example, providing handheld internet devices which provide customers with detailed product information and enable online customers to order a wider range of products in-store.

- **Growth of commercial leisure: Commercial leisure uses (such as cafes, bars, restaurants and cinemas) will constitute a growing share of town centre floorspace driven in part by the increase in household leisure expenditure and reduced demand for retail space in secondary centres**. As shown in the table, Experian expect that leisure spending growth will reach 1.3% in the long-term (2026-2035) which is a reversal of the historic trend of declining per capita leisure expenditure (1997-2009). Nationally, spending on food and drink typically accounts for almost half of total leisure spending (37% in 2016). There is scope for town centres to capitalise on this trend. The development of a strong commercial leisure offer can help to increase footfall (particularly outside of core retail hours) and increase visitor's dwell-time in centres.

- **Restructuring of the convenience sector: since the economic downturn major convenience (food) retailers have increased their network of small in-centre stores and invested in online shopping while discount food operators such as Aldi and Lidl have increased their market shares.** In January 2015, Tesco announced they would abandon the development of 49 'very large' stores and close 43 unprofitable stores (BBC 2015). The proportion of convenience floorspace accounted for by 'smaller stores' is forecast to increase from 37.6% in 2007 to 41.6% by 2017 (Verdict 2015). This shift has been driven by consumer behaviour; shoppers are now undertaking more regular smaller 'basket shopping' trips instead of a weekly food shop to a superstore.

- **Expenditure growth will slow: According to Experian, in the short-term, retail spending growth will slow sharply as a result of economic uncertainty related to the Brexit vote.** Convenience retail spending growth is forecast to slow from 0.0% in 2016 down to -0.9% in 2019 while comparison growth is forecast to decline from 3.3% in 2016 down to 1.0% in 2018. Leisure spending is also expected to slow quickly from 1.9% in 2016 down to 0.2% in 2018. In the long-term, retail sales growth will recover to reach 2.1% although this is well below the historic pre-recession rate of 5.1% due to the economic constraints posed by Brexit and the ongoing need for fiscal restraint.

- **Further bank closures will undermine high streets:** HSBC has shut the most outlets of any bank since the start of 2015, reducing nearly 30 per cent of its network across the country by closing 321 branches. The state-backed lenders Royal Bank of Scotland and Lloyds Banking Group shut 191 and 180 branches respectively. (FT, December 2016). The process is not played through: in February 2016, the Royal Bank of Scotland announced it would close 150 branches and cut more than 750 full-time jobs, citing a "dramatic shift" towards mobile and online banking (FT, March 2017)

These trends accentuate a growing failure of town centres and retail parades to successfully adapt to change, as:

- Some retailers are not surviving at all, whilst many need fewer shops with a bigger footplate (some need no shops),

- Major players care about their neighbouring retailers, and are able to dictate 'pick lists' on which retailers they would like to be situated next to.

Growth per capita	Annual average growth (%)				
Period	1997-2007	2008-2011	2012-2015	2016-2025	2016-2035
Total retail	5.1	-0.5	2.1	1.8	2.1
Convenience	-0.3	-3.2	-1.0	-0.1	0.1
Comparison	8.0	0.6	4.1	2.7	3.0
Leisure	-0.9	-3.3	1.7	1.2	1.3

Dataset: : *Summary of long –term retail expenditure growth*
Date: *November 2016*
Source: *Experian Retail Planner Briefing Note 14*

148

If we wish to bring a step change in the way that retail performs in EBNS, we need to think about how emerging trends can combine with changing local circumstances to create investment opportunities

We have to think in terms of what will happen to bring about a step change in the way in which the area functions. These events can be positive and/or negative: for example, investment in one town centre could improve its performance but that improvement could be at the expense of another nearby centre. This will be an important issue to balance in the study area.

With reference to the study area, investment in transport infrastructure has the potential to bring about a step change in the way in which people use the existing structure of town centres, as well as on out-of-centre provision. This applies equally to new connections as to improvement to existing connections. The key interventions are:

-New transport links i.e. the Metro and SPRINT buses

-Greater frequency of local services on existing fixed rail links

-New stations on the Birmingham – Tamworth line

In looking at the potential for these investments to improve the performance of current provision we have to think about proximity. They will have the greatest direct impacts on the retail and town centre provision that is in closest proximity of the routes and critically stations or stops.

Evidence presented here suggests that the relatively limited take-up of top-up convenience shopping in the study area is due to the lack of critical mass i.e. low density residential population with a large number of small centres providing too much space to serve their needs. A key opportunity of improved public transport will be to create key activity nodes which would be capable of supporting additional retail and town centre uses. However, proximity is key; therefore those centres closest have the potential to benefit the most.

Other factors could include developments within (or outside town centres) to improve the performance. For example, the redevelopment of Shard End local centre to include a convenience store, other shops and adjacent car parking, has improved the health of the centre. Less direct investments, for example the introduction of a major new employer in the local area also has the potential to drive change. There is the potential for higher density residential to increase demand in the study area.

149

There are two main types of retail centre in EBNS: linear town centres which are located along the main roads through the study area, and purpose-built suburban shopping parades

We have looked at the existing retail provision to understand its role and function in the study area and potentially whether it serves a wider role outside the study area, focusing on the definition of town centres as set out in the NPPF. We therefore do not look in detail at local shopping parades.

Across the EBNS area, there are a combination of town, district and local centres, shopping parades, as well as undesignated out-of-centre locations including retail parks, food stores and leisure destinations. There are 21 designated centres in the study area, ranging in size and position in the retail hierarchies for the two authorities.

There are two main types of centre: linear (and often very long) town centres which are located along the main roads through the study area; and purpose-built suburban shopping parades, which have larger units and often dedicated car parking. They range in size from 13 units (Shard End) to 275 units (Small Heath) (BCC and SMBC health checks 2016 and 2014); and their geographic spread across the study area is uneven.
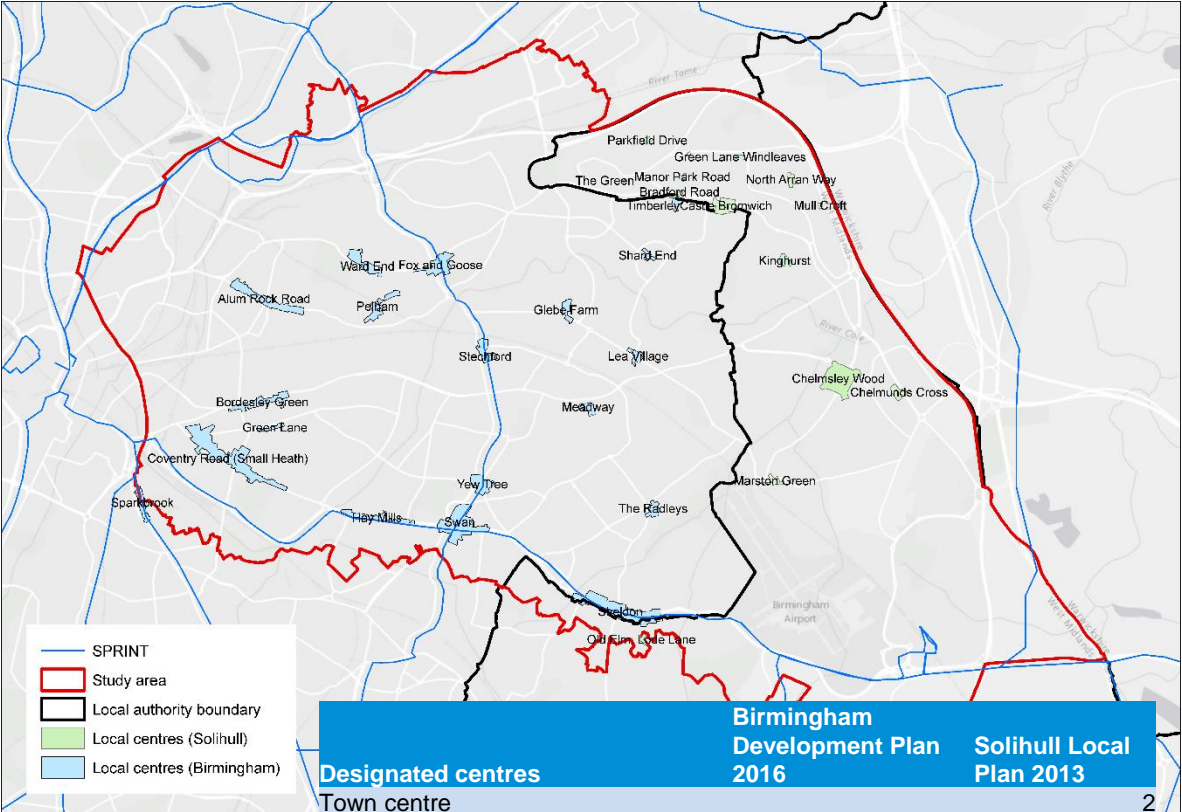
Dataset: *The type and location of retail centres in EBNS, according to the relevant local planning document*
Date: *2017*
Source: *Birmingham Development Plan 2016; Solihull Local Plan 2015*

Location of retail centres in EBNS

Designated centres	Birmingham Development Plan 2016	Solihull Local Plan 2013
Town centre		2
District centre	5	
District growth centre	1	
Large neighbourhood centre	2	
Local centre		3
Small neighbourhood centre	8	
Total	16	5

150

Most EBNS town centres cater to day-to-day residential needs, whilst Birmingham, Solihull and out-of-town centres take bigger purchases. There has been limited recent investment in town centres

The existing town centres are primarily catering to the local population in meeting day-to-day residential shopping needs. This is reflected in the latest household surveys undertaken on behalf of BCC and SMBC (Birmingham Retail Needs Assessment 2009 (Hollis Vincent) and Solihull Retail Study 2011 (DTZ)), which only record a handful of the centres as attracting significant market share beyond their home zones; the resultant turnovers of these centres is low, and largely limited to convenience goods. **The wider retail and town centre geography directly informs this, with the proximity of Birmingham city centre and also Solihull town centre serving to limit the comparison shopping function of existing provision.** This is reflected in the low market shares achieved by most of the centres in the study, even in their home zones. Typically it is only where there are larger food stores in centres that any substantial comparison market share is recorded. A substantial proportion of available spending on non-food items is made outside the study area, leaking away to these larger destinations, so too is spending in out-of-centre retail parks.

It is also clear that the level of available spending in the study area is constrained: as shown in the map, per capita retail spending levels in 2015 were greater in the western part of the study area. However, in overall terms, the average per capita retail expenditure for the study area is 20% lower than the Birmingham and Solihull average at £3,428 per annum compared to 4,226 per annum in 2015 (Experian Retail Planner MMG3).

There has been very little direct investment in the majority of these centres in recent years; but where investment has taken place, the results have been successful (Shard End and the Swan). Furthermore, there has been limited investment which could indirectly benefit the centres.

Alongside the network of allocated centres, there is a significant quantum of out-of-centre retail and leisure space in the study area. There are large out-of-centre stores outside Castle Bromwich and Small Heath. Comparison provision outside the town centres is focused on the Fort area to the north of M6 which includes four major retail and leisure parks. Other notable provision is a retail park outside Stechford district centre. In relation to commercial leisure, Star City and the cluster of uses at the NEC are the main destinations in the study area.

Retail expenditure per person (2015)

Expenditure
Total retail per person

- £2,450-2,691
- £2,691-2,931
- £2,931-3,171
- £3,171-3,411
- £3,411-3,651
- £3,651-3,892
- £3,892-4,132
- £4,132-4,372
- £4,372-4,612
- £4,612-4,852

Dataset: *Retail expenditure in EBNS*
Date: *2016*
Source: *Experian*
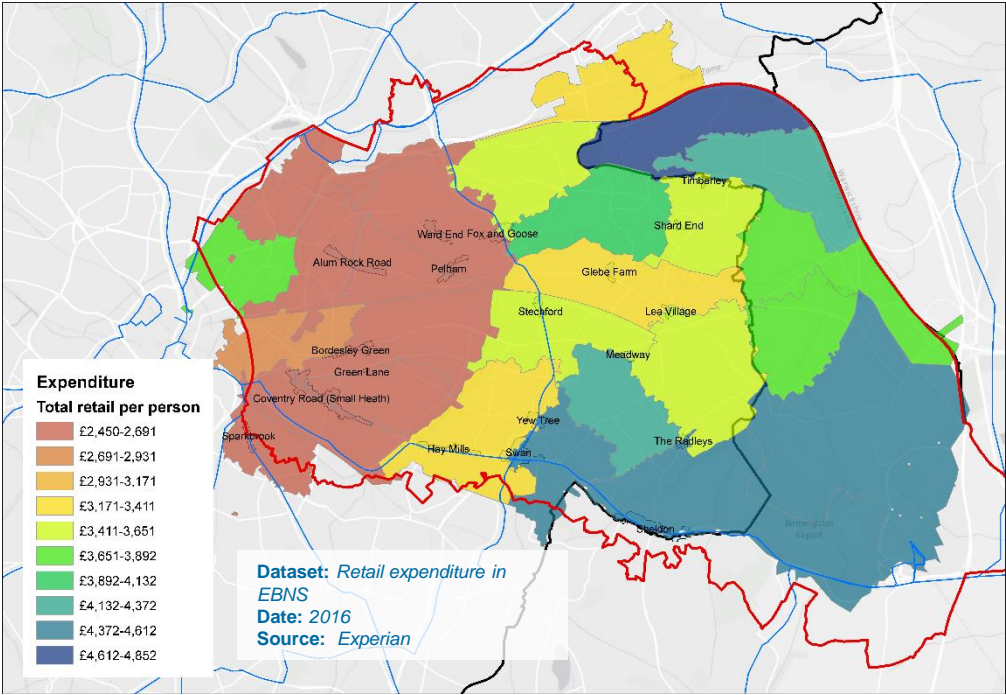
Out-of-centre convenience retailers

Out-of-centre comparison and leisure destinations in EBNS	Units	Multiples	Food & drink
Birmingham Star City	44	12	13
Fort Parkway	50	43	7
Kingsbury Road Leisure Park	2	0	0
Ravenside Retail Park	32	24	0
Trident Retail Park	5	1	3
Stechford Retail Park	13	11	1
Birmingham Airport	71	59	13
Total	217	150	37

151

There is unlikely to be a major shake-out in convenience sector retail in EBNS, but equally, there is unlikely to be much growth
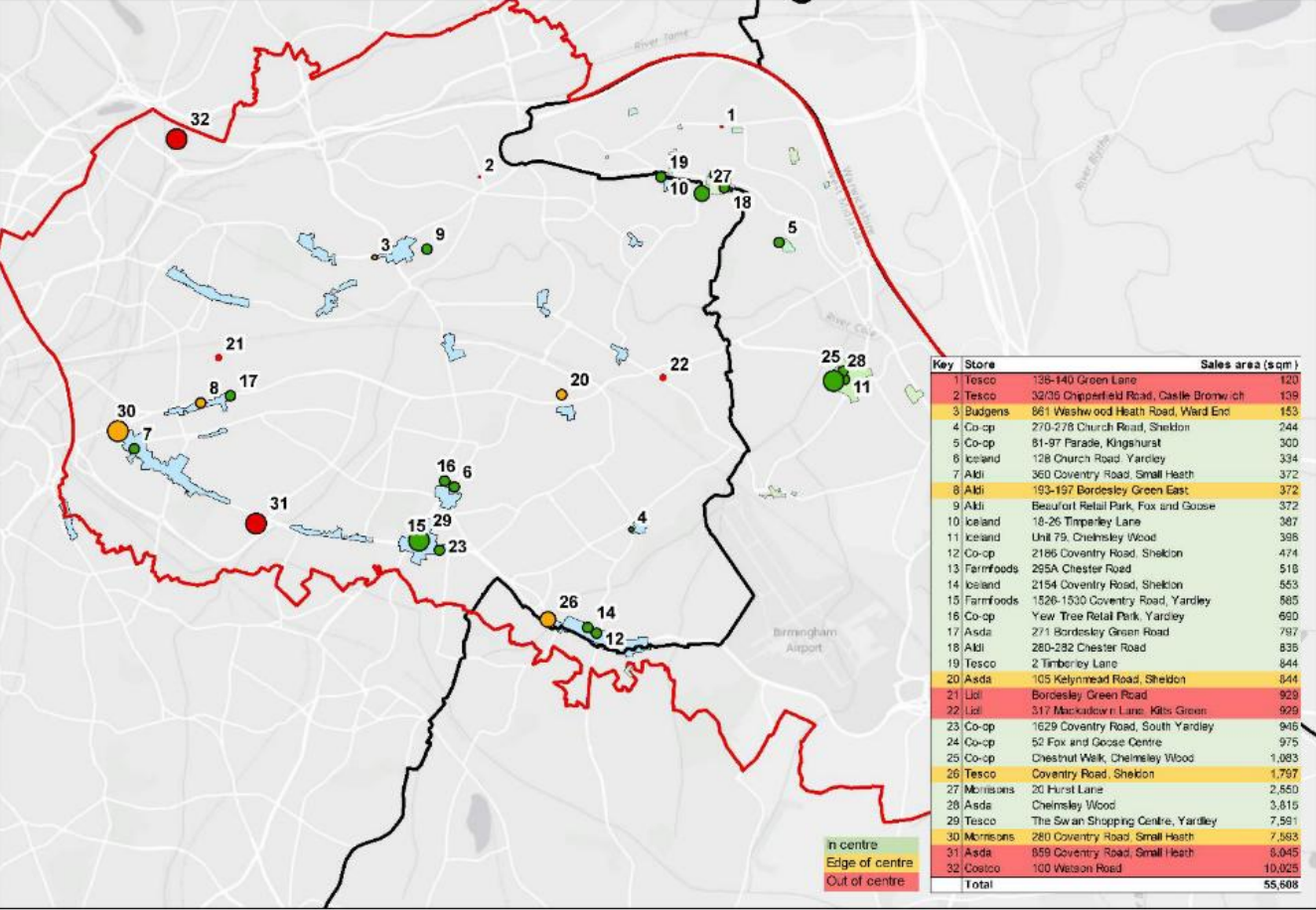
There is a well-developed network of convenience shopping provision across the study area. The majority of these are within existing town centres which is beneficial to their vitality and viability.

While there has been some restructuring in this sector, there is limited evidence of this in the study area. This is in part because of the specialist nature of independent retail provision in some centres e.g. Bordesley Green, Alum Rock/Saltley and Small Heath are tailored to local communities.

Additionally, the presence of major arterial roads running through the study area means that there are a number of large food stores with adjacent car parking, such as at Castle Bromwich and Hay Mills. In fact, running counter to the trend of more top-up shopping trips is the opening of a substantial new large-format Tesco store at the Swan. This allows the national multiples to maintain a certain level of footfall to operate these stores.

Population growth will also underpin the convenience sector. Because growth in convenience spending per head of population is now flat, it is only through population growth that significant need is generated.

National convenience operators in EBNS by location and showing in centre, edge of centre and out of centre status


Key	Store		Sales area (sqm)
1	Tesco	138-140 Green Lane	120
2	Tesco	32/35 Chippenfield Road, Castle Bromwich	139
3	Budgens	861 Washwood Heath Road, Ward End	153
4	Co-op	270-278 Church Road, Sheldon	244
5	Co-op	81-97 Parade, Kingshurst	300
6	Iceland	128 Church Road, Yardley	334
7	Aldi	360 Coventry Road, Small Heath	372
8	Aldi	193-197 Bordesley Green East	372
9	Aldi	Beaufort Retail Park, Fox and Goose	372
10	Iceland	18-26 Timperley Lane	387
11	Iceland	Unit 79, Chelmsley Wood	398
12	Co-op	2186 Coventry Road, Sheldon	474
13	Farmfoods	295A Chester Road	518
14	Iceland	2154 Coventry Road, Sheldon	553
15	Farmfoods	1526-1530 Coventry Road, Yardley	585
16	Co-op	Yew Tree Retail Park, Yardley	690
17	Asda	271 Bordesley Green Road	797
18	Aldi	280-282 Chester Road	835
19	Tesco	2 Timberley Lane	844
20	Asda	105 Kelynmead Road, Sheldon	844
21	Lidl	Bordesley Green Road	929
22	Lidl	317 Mackadown Lane, Kitts Green	929
23	Co-op	1629 Coventry Road, South Yardley	946
24	Co-op	52 Fox and Goose Centre	975
25	Co-op	Chestnut Walk, Chelmsley Wood	1,083
26	Tesco	Coventry Road, Sheldon	1,797
27	Morrisons	20 Hurst Lane	2,550
28	Asda	Chelmsley Wood	3,615
29	Tesco	The Swan Shopping Centre, Yardley	7,591
30	Morrisons	280 Coventry Road, Small Heath	7,593
31	Asda	859 Coventry Road, Small Heath	8,045
32	Costco	100 Watson Road	10,025
	Total		55,608

In centre
Edge of centre
Out of centre

Source: IGD, VOA and planning application data

152

Vacancy rates are high in some EBNS centres

The map shows the most recently published data on vacancy rates for centres in EBNS. For Birmingham centres the map provides a snapshot of the vacancy rate in 2016 and for Solihull centres the data is from 2011. The best performing centres in terms of vacancy rates are Glebe Farm, Kingshurst and Shard End. Each of these centres were fully occupied at the time the latest survey was undertaken. At the other end of the spectrum Lea Village, Meadway and Marston Green are the worst performing centres in terms of vacancy rates. Each of these centres had a vacancy rate of between 14% and 24% at the time the latest survey was undertaken.

Vacancy rates in EBNS centres (%)
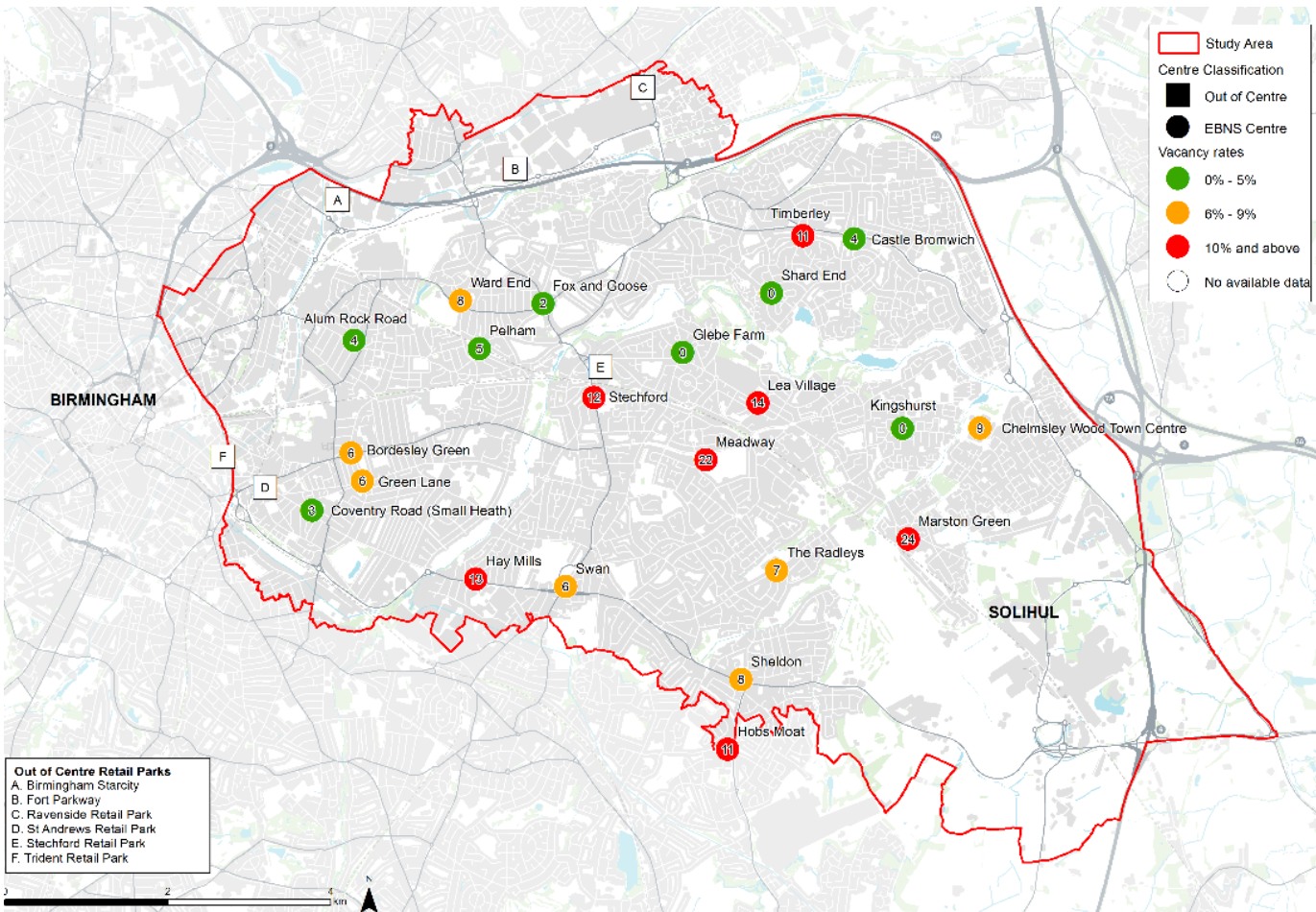
Dataset: *Use Types and Vacant Previous Use within Primary Shopping Areas - Resurvey 2015-16 [1]*
Date: *2016[1] and 2011[2]*
Source: *Use Types and Vacant Previous Use within Primary Shopping Areas Resurvey 2015-16[1] and Solihull Retail Study Health Check Appendices 2011[2]*

153

Retail rents are relatively low, and retail properties frequently spend a long time on the market

**EBNS five-year average rents (£ per sq ft)**

The map below shows the five year average rents for EBNS centres and retail parks within the study area for the years 2012-2017. According to Costar, the Fort Parkway Shopping Park has the highest rent at £53 per sq ft. Chelmsley Wood has the highest rent at £25 per sq ft. Rents levels in the EBNS study area are still significantly lower than central Birmingham, according to Costar, five year average rents for the Bullring Shopping Centre sub-market were recorded at £97 per sq ft. Compared to this, the retail locations in EBNS with the lowest rents are Kingshurst centre and Trident Retail Park at £9 per sq ft and £8 per sq ft respectively.

EBNS five-year average number of months on the market

The map below shows the average number of months that vacant retail units were on the market for EBNS centres and retail parks within the study area over the period between 2012-2017. The least amount of time available retail units properties spend on the market is an indicator of stronger operator demand for retail space. According to Costar, available retail units in Ward End were on the market for the least amount of time at 2 months on average. Again, the data shows that demand for retail floorspace in central Birmingham is much stronger than in the EBNS study area. According to Costar, available retail units in central Birmingham were on the marker for less than 1 month. Compared to this, units in Chelmsley Wood were on the market for an average of 30 months over the same period.

Dataset: *Five-year average rent per sq ft*
Date: *2017*
Source: CoStar (2017)
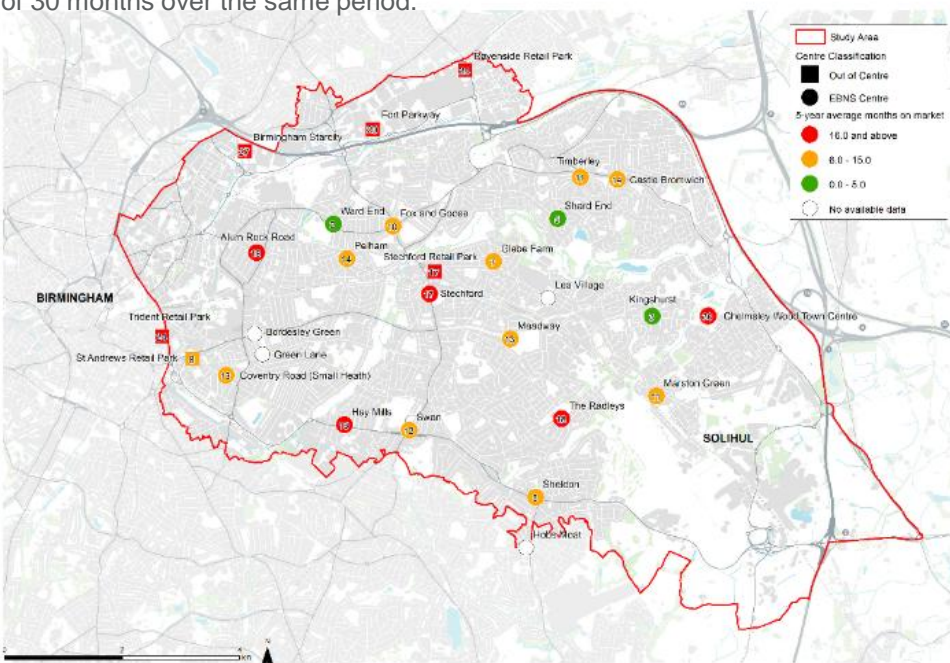
Dataset: **Five**-*year average months on market*
Date: *2017*
**Source:** CoStar (2017)

154

Overall, only a small number of EBNS retail centres are performing well

We have assessed the performance of the centres using a traffic light ranking. In doing this, we have had regard to the scale of the centres; for example, a small local centre will fulfil a very different role to a town centre. The centres are categorised as follows:

- **Green – good health**. Low vacancies, diversity of provision in terms of retail, services and other town centre uses, good quality unit stock and environmental quality. e.g. Shard End: the centre is well used and includes the range of services typical of a centre of this scale, no or limited vacancies, it has adjacent car parking and the environmental quality is high.

- **Amber – underperforming**. Poorer environmental quality, limited diversity of offer, some vacancies in better quality stock. e.g. Bordesley Green: although there is a diverse retail offer in the centre and units are relatively well-occupied, the environmental quality is poor due to traffic and the retail stock is shows limited signs of investment.

- **Red – poor health**. High and persistent vacancies, overconcentration of uses such as betting and charity shops, A5 units, poor environmental quality e.g. Kingshurst: the centre has high vacancies and its environmental quality is poor.

Most of the centres in the study area are classed as underperforming. We have only identified two as being healthy; both these centres have received large-scale investment in recent years and it is likely that it is this which has brought about this change. The majority of centres have been identified as underperforming.

Health of retail centres in EBNS
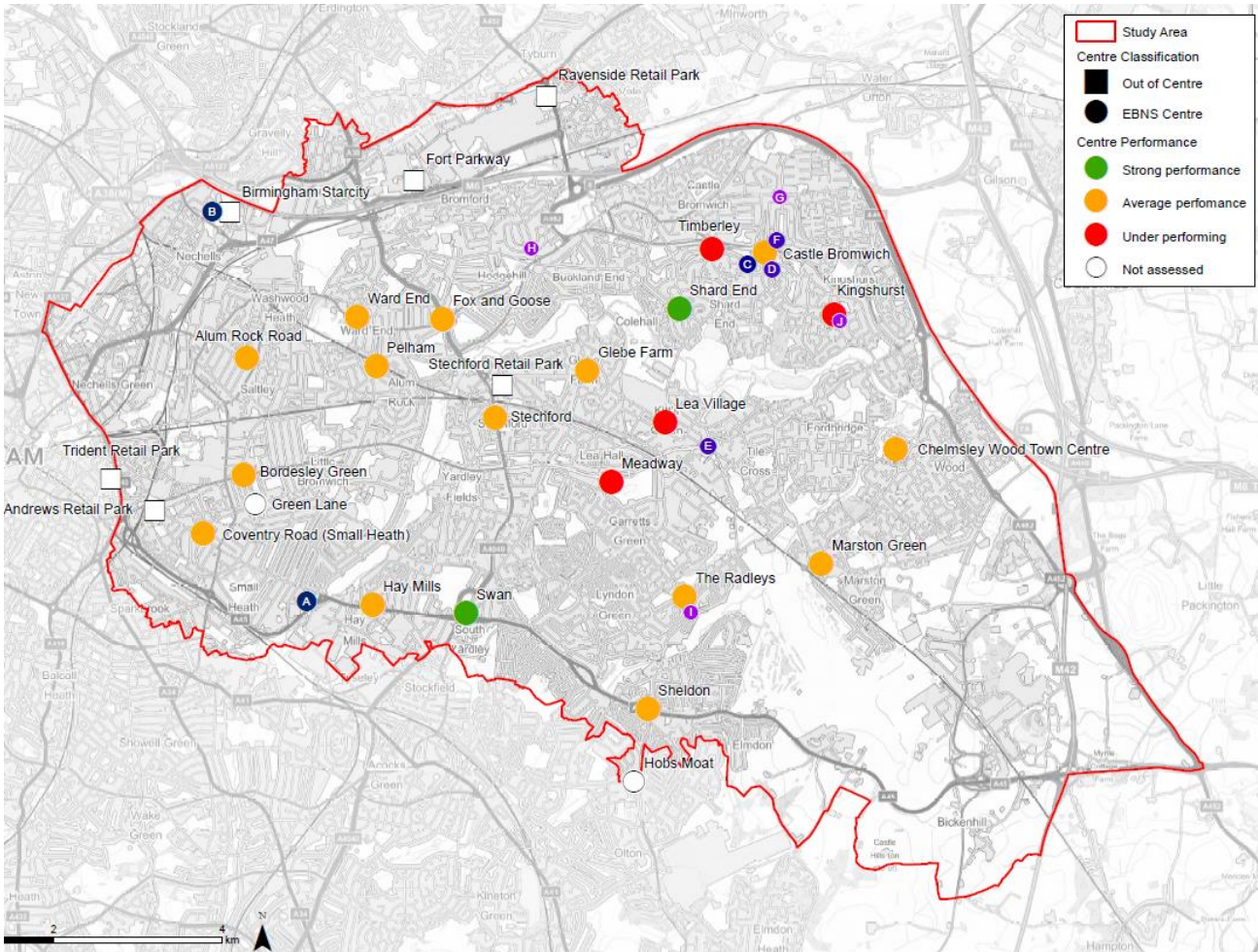
For EBNS, evidence suggests that comparison retailing at Chelmsley Wood and other smaller centres could be eroded over time due to the effects of polarisation and multi-channel retailing. Commercial leisure investment in EBNS is likely to remain muted

Polarisation is likely to undermine Chelmsley Wood and other smaller centres

Of the centres in the study area, this is particularly relevant to Chelmsley Wood. Many of the stores that would traditionally anchor a secondary centre of this type are no longer on the high street (e.g. Woolworths) and in their place there are often discount comparison retailers. This serves to reduce the role of the centre in meeting higher order comparison needs, with shoppers increasingly travelling to either Birmingham or Solihull, or to out-of-centre stores at The Fort and Stechford Retail Park. It also means that, given the scale of centres in the study area, there is a real challenge to secure major comparison retailers – which would act as key attractors and therefore drive footfall within the centres. For this reason, it is unsurprising that it is BCC that is advancing the regeneration of Meadway district centre and that the investment made by the private sector (e.g. Ellandi as owners of Chelmsley Wood) has so far been limited.

Digital technology effects are likely to be limited to the larger comparison shopping areas (Chelmsley Wood and the retail parks), but there may be a growing demand for click and collect facilities in smaller centres

Because this is most relevant in relation to comparison shopping, it is less significant for the study area at the moment. This is because comparison shopping provision is limited to a few larger destinations, whether in or out of centre (Chelmsley Wood, Stechford Retail Park, St Andrews Retail Park and Hay Mills), the direct impacts have been limited.

However, the rise of multichannel shopping presents some opportunities for the study area in terms of the form of click and collect facilities within smaller centres as a way of driving footfall.

The loss of high street banking may erode high street viability

As more people switch to internet banking and there are mergers in the banking sector, banks and building societies are reviewing their portfolios to reduce their high street presence. For many of the centres in the study area, the potential closure of banks and building societies risks a reduction footfall in the centres and also leave vacant sites that are often challenging to fill, particularly if they comprise older premises.

Commercial leisure investment in designated centres is likely to be muted: available spending power is likely to remain low for the medium term

There is currently limited leisure provision as part of the town centres within the study area. The Fort area at the northern part of the study area includes the Star City leisure complex which is one of the main commercial leisure hub. However, it is an out-of-centre destination which is likely to be made more accessible through the investment in new stations on the Birmingham to Tamworth line and Kings Heath line to the south. Similarly, while the NEC represents a further focus of leisure provision, its attraction far exceeds the local area.

In relation to designated centres, while there are some leisure facilities, these are public sector-led e.g. the new swimming pool at Stechford, there is little sign of commercial leisure investment. This is likely to be because there are not sufficient returns to attract commercial operators to invest in the area.

Given the importance of the food and beverage sector in commercial leisure consumption, the study area has very limited provision. Centres such as Bordesley Green, Alum Rock/Saltley and Small Heath all have strong restaurant offers; however that offer is a characteristic of the local population which those centres serve and is uninfluenced by recent trends to increase the range in town centres.

Plainly, as with retail expenditure levels, the viability of commercial leisure facilities is a function of the available spending; in this case it is below the average City and Borough levels (Experian). Larger scale leisure uses are successful at the NEC and in the Fort area because of their strategic accessibility i.e. because they can draw from a much wider than local catchment. This is not an attribute shared by many of the existing town centres, however, with infrastructure improvements, this could change.

156

We have looked at what the evidence suggests around possible approaches to the town centres in EBNS

We have identified three possible approaches to planning for the future of the town centres within the study area.

Business as usual with pro-investment policies – for centres that are either performing to the level expected given their current scale and function or for those centres which are remote from any major planned investment, including new transport links. An example of this is Pelham: it is performing adequately and no major investment is planned that would result in a shift in role/function.

Consolidation, modernisation and repurposing – centres that have too much space or which are close to other centres that better meet needs or have more potential for future improvement. An example of this is Glebe Farm, which although performing adequately is very close to Lea Village. Given Lea Village's accessibility will be significantly improved by the Metro, growth should be focused there and Glebe Farm allowed to contract.

Intensification with redevelopment – centres that are located at those nodes subject to connectivity improvements. Chelmsley Wood is a key opportunity given it is in a single ownership and will have a Metro stop at it; similarly the Meadway will benefit from improvements to its accessibility so combined with redevelopment, it has the capacity to play a much more significant role in the retail hierarchy. Both Marston Green and Stechford have the potential to trade more intensively if higher frequency train services into central Birmingham were introduced.

We have applied these categories to each of the EBNS centres in the table to the right.

Business as usual with pro-investment policies?	
Alum Rock/ Saltley	Performing relatively well and unlikely to be impacted by the planned investment. Protect its existing role.
Castle Bromwich	No specific interventions planned in this area. Seek to protect its existing role.
Fox and Goose	No specific interventions planned in the area and recent investment from opening of the new Tesco store.
Pelham	No specific interventions planned in this area. Seek to protect its existing role.
Shard End	Subject to recent redevelopment.
Swan	Subject to recent redevelopment.

Consolidation, modernisation and repurposing?	
Bordesley Green	Truncated along the main road – consider tightening the boundaries
Glebe Farm	In close proximity to other provision – consider managing contraction.
Hay Mills	Truncated along the main road – consider tightening the boundaries
Kingshurst	Consider deallocating and redeveloping
Sheldon	Truncated along the main road – consider tightening the boundaries
Small Heath	Truncated along the main road – consider tightening the boundaries
The Radleys	Consider tightening the boundaries to reduce size and number of A5 uses
Timberley	Severed by main road and close to provision at Castle Bromwich – consider tightening boundaries
Ward End	Consider tightening boundaries at the periphery.

Intensification with redevelopment?	
Chelmsley Wood	In single ownership and to have a Metro stop in close proximity
Lea Village	To have a Metro stop in close proximity
Marston Green	Greater frequency rail links could increase footfall
Meadway	Subject to major regeneration plans and in close proximity to a Metro stop
Stechford	Greater frequency rail links could increase footfall

A range of policy responses could accompany these local approaches. All would be intended to accerate investment in, and modernisation of, retail centres

In planning for retail and town centre uses in the EBNS area, there are a range of policy options available to secure these objectives of protecting, consolidating or intensifying existing town centres. So while there are adopted town centre hierarchies in place for both Birmingham and Solihull, their adoption does not take account of the potential changes that could be secured with the improved transport links in the area. The Councils could consider exploring the following options.

- **Local Development Orders** – explore the use of LDOs to shape change and accelerate its delivery. This could include promoting intensification in existing centres but equally it could be focused on managing the contraction of others.

- **Permitted development and repurposing** – making local businesses aware of the options available to them without the need for planning permission and taking a positive stance on prior approval applications. The widening of legislation to allow greater flexibility was introduced by Government in part to allow the less fit-for-purpose stock to 'fall out' of the market. This includes allowing retail to residential conversions (A1 to C3) and retail premises to convert restaurants (A1 to A3 conversions). District centres and retail parades could be repurposed, to be centres of living, working and leisure. A diversified range of town centre users will be required, with retail floorspace being proactively reassigned to residential, community, employment and other uses.

- **Compulsory purchase** – fragmented ownership is often the main barrier to delivering change in town centres. BCC is already exploring this route with Meadway, where a CPO has been made to allow regeneration of the centre, and BCC has used CPO powers in the past to facilitate regeneration of the Shard End and Swan centres. The benefit of single ownership is it allows greater curation of the retail offer and reduces the risk of there being a 'race to the bottom' in order to simply secure a tenant - which can lead to the overconcentration of A5 uses, betting shops and charity shops in many of the centres in the study area.

- **Reviewing the retail hierarchy and town centre boundaries** – considering de-designating some smaller centres in the context of the overall network of centres and tightening the definition of the core of the centres and allowing the peripheral parts to fall away. In order to look at the study area as whole, it would be worth the two authorities undertaking a co-ordinated review.

- **Car parking strategy reviews and traffic calming** – a careful review of parking (which ensured it did not damage trade) could be considered. Traffic calming could improve some centres' poor environmental quality.

158

Delivering physical change

Key issues
- Triggering market regeneration processes
- Focusing public and private investment
- Delivering and managing change
- Creating a cross-sector 'growth coalition'

Clear and consistent leadership has been long identified by various academic studies of regional and city growth as being critical to growth, through its effects on de-risking both public and private investment. Prof Michael Parkinson's conclusions over a decade ago bear re-reading. He states that "a key characteristic of successful cities is their strategic capacity to exploit their assets," and that leadership needs strategy, stating that "Manchester in particular has a very robust strategy". The Treasury (2011) states that the past decade has seen increasing recognition of the need for coordination and strategic decision-making across areas.

Evidence also shows that good leadership is essential to secure quality outcomes from transport investment. Work for the Independent Transport Commission suggests that successful outcomes from a programme of high speed rail implementation depend on the presence of a number of success factors which are dependent on high level political and officer commitment at the right scale, depth, and breadth. These are

- Common purpose – shared vision between partners
- Connectivity – integrating different modes, and connecting labour markets
- Commitment – programme spanning more than a generation and lasting several economic and political cycles
- Collaboration – to work across disciplines, boundaries and interests in order to compete in bigger markets
- Communication – to create lasting relationships
- Control – possibly taking the role of master developer, and controlling delivery through regulation and participation.

The right sub-regional governance structures are important. The spatial scale over which decisions are made matters to growth. Research at European level (Cheshire & Magrini, 2005) shows that where the level of decision-making is a good fit with an area's economic footprint, this associated with better economic performance.

Evidence suggests that the public sector might usefully sponsor a pro-active and innovative policy development and delivery process. NESTA work (2008) suggests that policymakers should think in terms of an "AC/DC model". Absorptive capacity (AC) allows a place to identify, value and assimilate new knowledge. Absorptive capacity is made up of three elements - a) the capacity to access networks of knowledge and innovation; b) the capacity to anchor external knowledge from people, institutions and firms; and c) the capacity to diffuse new innovation and knowledge in the wider economy. Development capacity (DC) allows a place to either create or exploit new knowledge.

The changing political and economic context for local authorities is tending to force the public sector to adopt a more entrepreneurial development role, using and adding to its own assets. Continued public sector funding austerity compels local authorities to be increasingly ambitious in the way that they raise revenue. A number of solutions arise from possible development in EBNS, and arise from the possibilities generated through increased Council Tax receipts (driven by underlying household growth) and Business Rates in order to continue to serve the area and its residents. Authorities could commission a review of public sector property to develop an understanding of the scale and potential of the public sector property portfolio in the EBNS area, with particular focus on the potential to a more entrepreneurial approach to the development of land around future infrastructure assets. We anticipate that such an exercise would show how better use of assets would deliver more housing in total, more affordable housing, new public sector services and a financial return to local authorities.

The evidence suggests that there is major untapped potential in EBNS. New jobs and infrastructure can create structural change – but we need to trigger the process of regeneration so that self-sustaining market processes can take change forward

This is a baseline report, and does not attempt to anticipate future stages of vision and strategy work.

The evidence suggests that a step change in performance is possible for the EBNS area: the combination of real economic opportunities arising from new labour demand, and planned connectivity improvements, will create the conditions for this change.

However, our reading of the evidence suggests that delivering this scale of change could require quite an extensive and far-reaching review of existing strategy and policy. EBNS will need to challenge accepted ways of working across a range of delivery 'silos', new delivery structures, and create a new set of ideas about what is possible in the area.

Getting change to happen requires us to have a basic starting idea of how the broad process of change might be successfully delivered. At the risk of drifting into territory that will need to be mapped out by the vision and strategy, our view – informed by a reading of the history of regeneration policies in this area and elsewhere – is that spreading the 'jam' too thinly would be a mistake: it will do very little to fundamentally change market perceptions of investment in EBNS. This is critical given that market perceptions will be critical if we are to trigger long term change in an age of austerity.

We are likely to need to pursue a 'tipping point' approach to regeneration. Private development markets will need to work harder and faster. The public sector needs to assist this process by providing de-risked, decontaminated sites which demonstrate that new marketplaces exist. Once the demonstrator sites have changed market perceptions the market will be ready for bigger challenges.

We wish to see a set of mutually reinforcing processes in which success breeds success, in a form of chain reaction. This means that, somewhat counter-intuitively, we suggest that we may need to avoid a "worst first" approach, and instead show development markets that it is possible to make a success of development in EBNS. Once the demonstrator growth sites have changed market perceptions the market will be ready for bigger challenges, growing values out of these stronger areas. (We are acutely aware, however, that one of the weaknesses with the traditional approach to evidence bases in planning - around, for example, employment land and retail assessments - is that it can work to roll forward past trends).

The question, then, is where to start in triggering off these processes of change. We need to create a process which can identify specific places where we might start the process.

EBNS could use best practice from London. London puts together brownfield land opportunities and new transport investment to create 'Opportunity Areas' focusing public investment and private developer interest

The evidence suggests that EBNS needs a mechanism to help de-risk investment by driving out information and building a shared understanding of delivery between public and private sectors about investment opportunities in the area.

We have looked at what the evidence from other areas tells us about possible approaches to this issue. In London, a very complex planning situation is simplified by the creation of London Plan "Opportunity Areas" and "Intensification Areas".

The Opportunity Areas are not simply the largest London development sites. Critically, they are large brownfield sites which are to be reinforced by improved transport investment, and so will provide a valuable supply of land to accommodate growth. They are derived from an integrated land use and infrastructure investment strategic which is able to operate in a mutually reinforcing fashion.
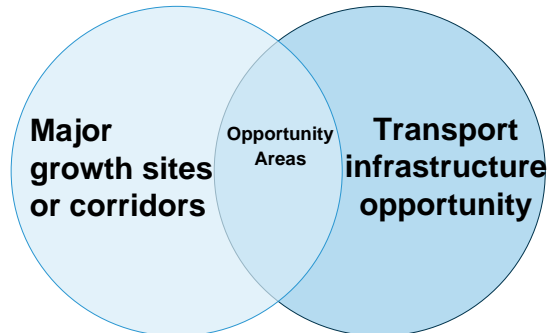
Intensification areas are typically built-up areas with good existing or potential public transport accessibility which can support redevelopment at higher densities. They have significant capacity for new jobs and homes but at a level below that which can be achieved in the opportunity areas.

Each Opportunity Area is masterplanned (with the creation of an Opportunity Area Planning Framework) which is then delivery tested with a Development Infrastructure Funding Study (DIFS) which looks at infrastructure requirements, costs and funding, and sets these against development viability and build-out trajectory. This de-risks development, both for public and private sector investors. Effectively, EBNS has already seen this approach in action at the UK Central site in Solihull.
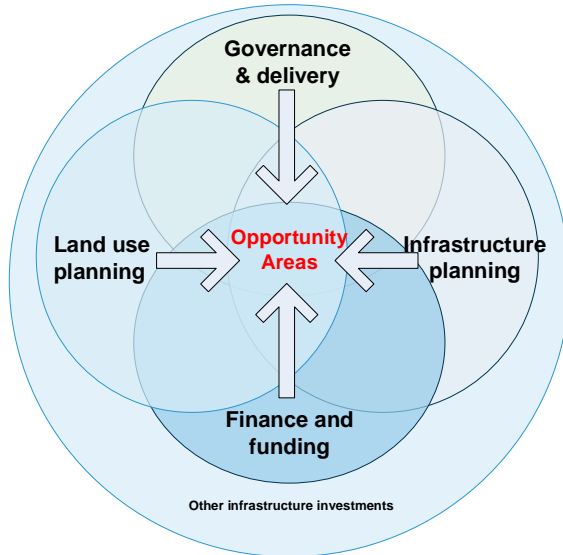
At some point, a similar approach could be taken in EBNS. It is likely that EBNS will need to identify a list of sites which have both significant development potential strategic importance, plus a good relationship to transport investment (or at least, spare transport infrastructure capacity). These sites could then become the focus of concerted efforts to get the sites moving. In order for growth to ripple out from the Opportunity Areas, each authority will need to understand what complementary planning and connectivity is required to link these to the wider areas. The EBNS will need to take responsibility for driving value and connectivity to surrounding areas.

Having arrived at an agreed list of Opportunity Areas, EBNS will need to build up a package of governance, land use and infrastructure planning, and funding and financing support at each Opportunity Area. The objective must be to create development momentum at the sites. This may require land assembly, land remediation, new policy, and/or assistance with the relocation of some of the existing uses, particularly industrial activities.

**The elements which create the London Opportunity Areas**

Major growth sites or corridors — Opportunity Areas — Transport infrastructure opportunity

Brigading policy, management and funds around Opportunity Areas

Governance & delivery — Land use planning — Opportunity Areas — Infrastructure planning — Finance and funding — Other infrastructure investments

Putting together an analysis of the factors above and London experience with Opportunity areas suggests that we could arrive at three new 'Opportunity Areas' that could help EBNS to make the step change it needs. (UK Central is effectively already an Opportunity Area)

We have set out the possible Opportunity Areas on the map. We advance these concepts tentatively, in the knowledge that a spatial strategy is not a substitute for the land use planning process. The intention here is only to set out some possible high level direction of growth. This has been undertaken in advance of any consultation.

UK Central is effectively already an Opportunity Area - it has a high level masterplan, a delivery team, an infrastructure study, an understanding of viability and a market profile.
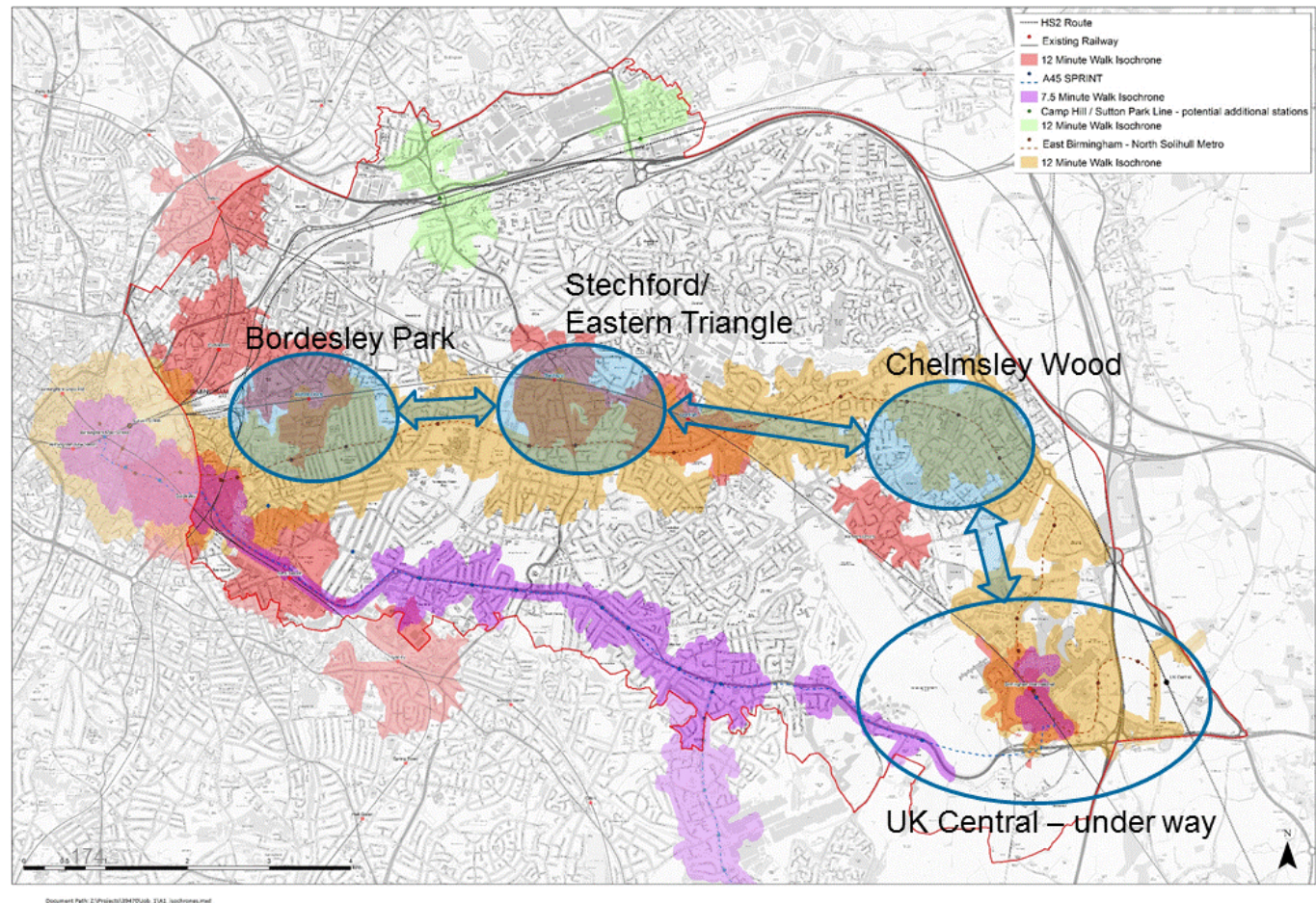
Bordesley Park and Wheels 'Opportunity Area': the area sits between the to-be-improved connections at Adderley Park station, and the new metro line. It will be very well connected to central Birmingham

This area is located between a much improved train frequencies at Adderley Park station and the new metro line - suggesting that it could become a super-connected zone which could form one of the new Opportunity Areas for EBNS.

The 16ha Wheels site forms part of the Bordesley Park AAP. Land at the Wheels site has now been designated as Core Employment Land and is a part of the city's growth strategy to deliver industrial land and job opportunities. The plan sees promotion of new industrial and employment opportunities including the comprehensive and coordinated development of the Wheels site to deliver up to 1 million sq ft of floor space and up to 3,000 jobs and training opportunities. The introduction of metro will also be the opportunity for new development and mixed uses on the Bordesley Green frontage. Consideration will need to be given to ways in which the impact of the nearby transport infrastructure is maximised.

The Adderley Park area has roughly 7.5ha which the AAP sees currently as being mixed use. The right mix at the site is likely to flex with changing circumstances. Over time, and given the proximity of transport infrastructure, it is possible that this area could move towards predominantly housing use. If it did, it would add around 500 homes, and the Cherrywood Road housing already in the AAP will further reinforce this change.
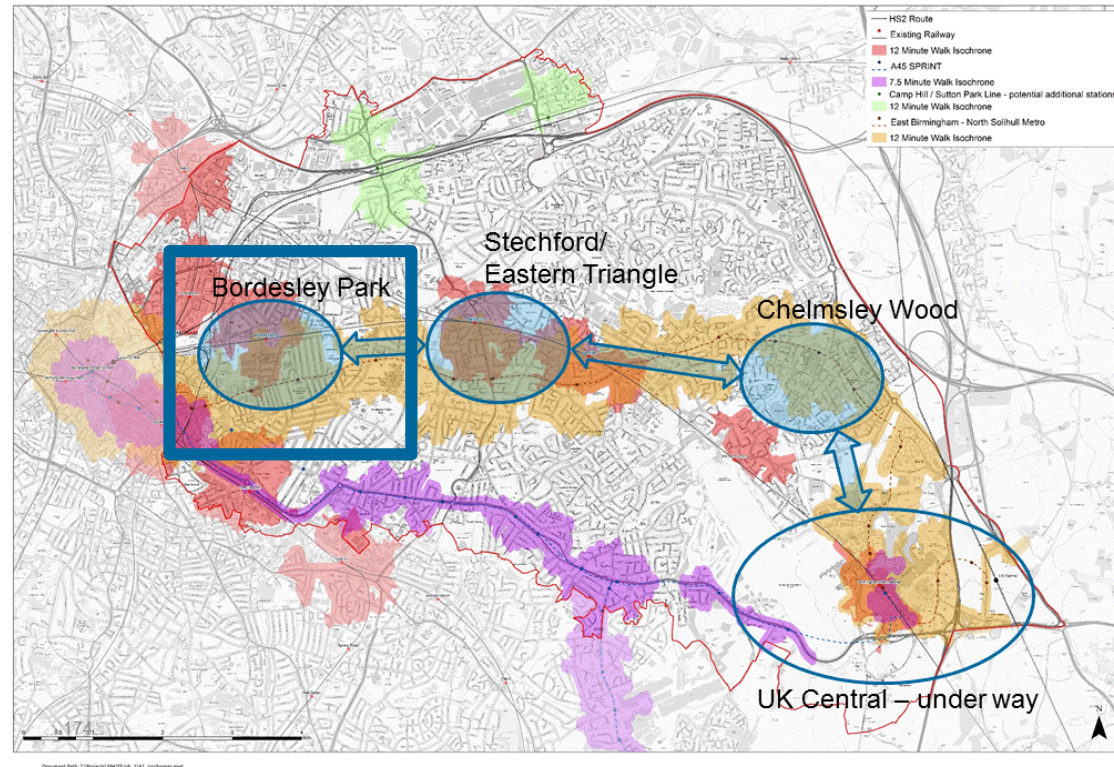
Stechford, Meadway and Shard End 'Opportunity Area' can develop out of the existing Birmingham Development Plan position

Stechford, Meadway and Shard End 'Opportunity Area': the Birmingham Development Plan already sees useful reconfiguration around Stechford, with 1000 new dwellings at Stechford, Meadway and Shard End. Evidence suggests that BCC stick to this plan – but perhaps elevate the visibility of this development using the Opportunity Area label.

Opportunities to reshape the market's view of what is possible in the area should be intensively sought out. For example, there is a significant opportunity for a high quality development at the ex-sewage treatment plant site in the area.

It may be that over time, retail park viability erodes in favour of housing uses. This process is under way already in parts of the country. The balance is not likely to tip in this area for a number of years, but if it does, the retail land near Stechford station would provide highly sustainable links into Birmingham and out to the airport along the classic rail line, if redeveloped for housing.
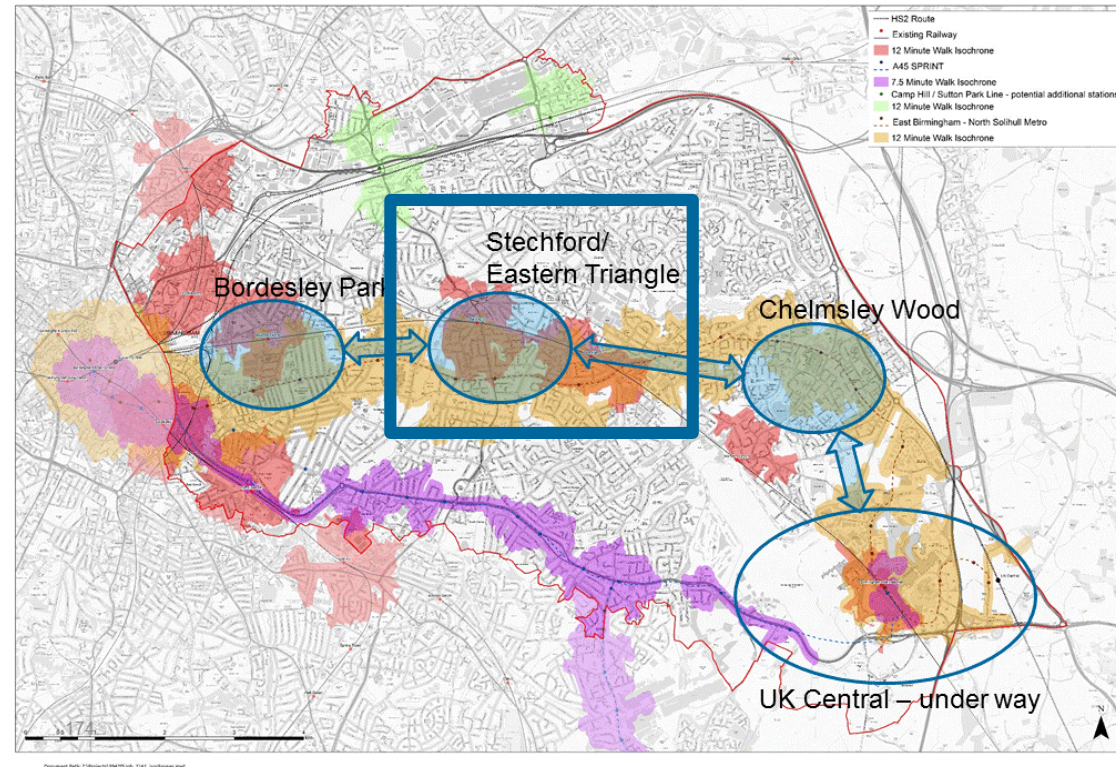
A radical approach at Chelmsley Wood could be possible

Evidence suggests there is scope for a radical approach to Chelmsley Wood Town centre. The 2005 North Solihull SPG suggests a refurbishment is necessary, but a dozen years on we suggest that a fully comprehensive approach would create the step change that is needed for the area.

- **There is potential to assemble a site large enough to create its own value zone**, if a comprehensive redevelopment was possible, boosting values by close co-location with the adjacent new Metro infrastructure which will run along Chelmsley Road and integrate with the existing bus station.

- **Stronger links to Meriden Park and Kingshurst Brook** (a tributary to the River Cole) could use good quality environments to further drive values and thus development viability.

- **The existing retail provision could be redeveloped.** The retail offer is tired and inward looking, with a number of vacancies. Retail in its current form is likely to continue to suffer from processes of retail polarisation and the "two way road" effect of metro services opening up better access to Birmingham town centre. (That being said, the retail site is currently a strong performer in the Ellandi portfolio).

- **There is possibility to rationalise the Chelmsley Road / Moorend Road roundabout to create a larger development footprint**, and reconfigure parking at the site.

- **There is potential to rationalise or relocate the Police Station and Royal Mail building**: police have recently closed singles accommodation and gym provision at the site, and are open to new ideas about service configurations in the area. Whilst Royal Mail operations could be relocated, we understand that there is telecoms masts and infrastructure within the building which would be costly to relocate.

We understand that Ellandi are interested in exploring redevelopment and refurbishment options and are in touch with the North Solihull Partnership.
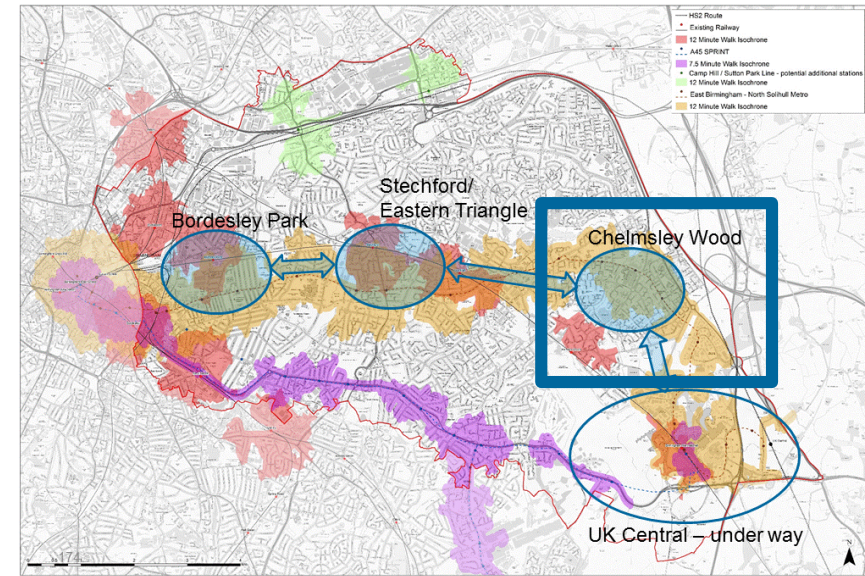
Chelmsley Wood town centre retail

Route of the new metro at Chelmsley Wood town centre

With the loss of the Regional Development Agencies, is there 'a gap in the market' for a project delivery organisation?

Planning has become increasingly concerned with questions of 'how' development can be delivered, and 'when' - rather than just 'what' development is desired and 'where'. With this shift comes a focus on the *means* of securing development rather than simply the ends, and an increasing focus on delivery issues. This shift could be encouraged, with a particular focus on delivery in East Birmingham.

This is not especially new: for example, the Killian Pretty review of 2008 sought to deliver a more "a positive and proactive approach to shaping, considering, determining and delivering development proposals." However, the implications of this change should not be underestimated. Major projects are likely to need pro-active involvement from planning authorities could be actively viewed as projects in themselves – not as an application that will materialise at some point in future.

An EBNS Board has been set up to co-ordinate action on the area. However, this could need reinforcement. We are agnostic about delivery mechanisms, and further study would be needed to look into this issue, but note that Manchester City Council has been very successful in hooking together the political and executive impetus to get change in place. In London, and more recently in Teeside, Mayoral Development Corporations are being used to create a single minded delivery authority with a focused set of roles and responsibilities. Whether or not such a body (or others) were investigated in EBNS, we note that both Solihull and Birmingham are experienced in using Limited Liability Partnership delivery vehicles (at Iknield Port and Argent in central Birmingham, and with the North Solihull Partnership). These LLPs might have a role in the delivery of some

Opportunity Areas – perhaps particularly at the Wheels site.

In Solihull, major investment at UK Central is being co-ordinated by the Urban Growth Company (UGC). Research was undertaken about how this process could be most effectively managed. Between May to October 2015 work was undertaken to determine the most appropriate delivery vehicle. These included:

- Option 1 Do nothing – continue operating within the current structure

- Option 2 Enhanced as is – improving the current governance arrangements

- Option 3 UKC Urban Growth Company – Arms length

- Option 4 Urban Growth Company – Independent

- Option 5 Urban Development Corporation

Out of the 6 options available, Option 3 enabled the Council to provide a dedicated focus through a highly skilled Board under the direction of an Independent chair for delivering major infrastructure. The UGC would seek to develop alliances with key partners that would ensure a co-ordinated and sequenced approach to the delivery of infrastructure. The UGC Proposition would also mean that the Council would retain its planning powers and the UGC would work closely with the Council to being forward and manage planning applications.

Can local authorities' planning departments fill the gap in project delivery?

No matter what decision about management structures is taken at EBNS (if any) the authorities involved in planning will need to

- play an active role in enabling development and planning infrastructure, or running applications more carefully to ensure that what is needed is provided when it is needed.

- get an understanding of what needs to happen; and seek to understand, and then bring about the right response. That could mean a highly proactive approach, working alongside public sector investors and developers to ask questions like: how do we fix the barriers to positive change? What do we do next? When? Who is responsible? What is the right planning role?

- Understand how to solve real-life issues on the critical path. The issues on the critical path are those which directly impact the planned project completion date. Management intervention and funding could be focused on these issues.

Should an active project management approach be adopted, this could include each "project" comprising the following.

- A project sponsor. This needs to be a senior officer who has the experience and line management authority to break through internal organisational silos.

- A clearly defined project manager. This individual would be held responsible for project progress and delivery.

- A clearly defined project team and project management structures.

- Excellent links between the project team and developers/investors. We are not suggesting that any development should be waved through. But the public interest is not necessarily inimical to the private interests of the developers. The local authorities need to operate as a joint delivery partner alongside the developer in assisting delivery.

An active public sector land strategy and CPO strategy could also be pursued, to ensure that the public sector captured more of the land value uplift created by investments in remediation, planning re-designation and connectivity investment. Public sector land can be identified, but very fine grained work is needed to convert this view into deliverable opportunities

Local authority owned land: Birmingham and Solihull ownerships, including details of property which is registered to Birmingham City Council within the Solihull boundary (leasehold and freehold titles)
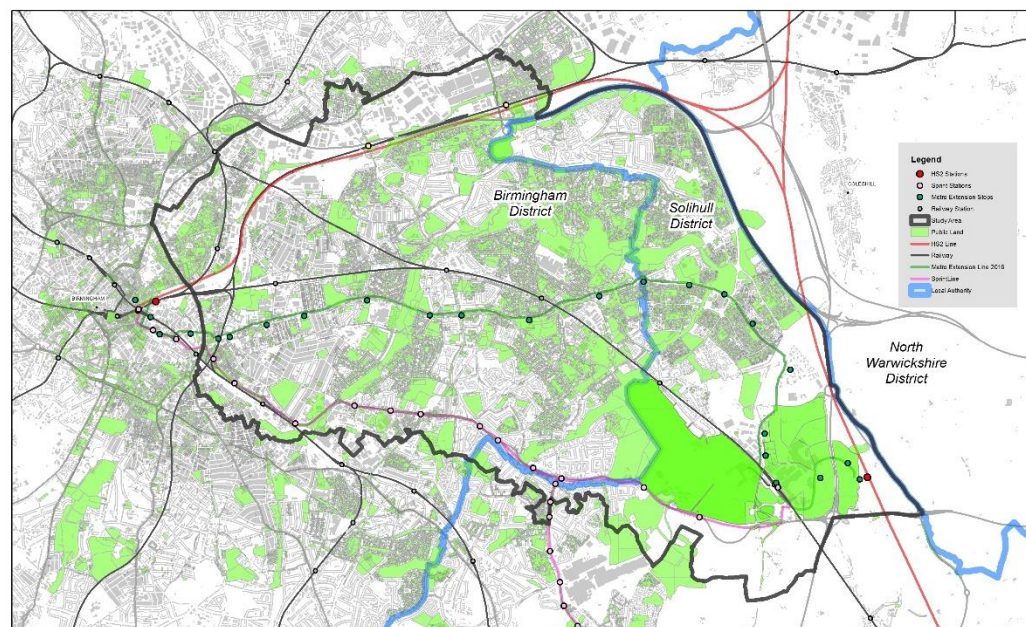
Produced by Oxford Consultants for Social Inclusion, www.ocsi.co.uk, January 2017
Contains National Statistics data © Crown copyright and database right 2017
Contains OS data © Crown copyright and database right 2017

Can some of the management burden be shared in an approach which builds 'collective intelligence' for EBNS? Can major employers take more of a role? Can we create a joint 'growth coalition' for EBNS?

The Kerslake Review (2014) found that governance structures in Birmingham needed improvement. It stated that "regeneration must take place beyond the physical transformation of the city centre. There is a particularly urgent challenge in central and east Birmingham." The review went on to advise that "the council should facilitate the creation of a new independent Birmingham leadership group. The group should approve the new long-term City Plan and be used to hold all involved in delivery of the plan to account." Kerslake points out that "other local authorities, such as Leeds have used their civic leadership role to develop a shared narrative and priorities for their city's future. They have used this to help agree shared strategic objectives across the city and to form the partnerships that are needed to deliver them".

Adapting this idea to EBNS, the EBNS area could build a new policy network which involves communities, local Government, local businesses, utilities, academia, and consultancies. NESTA points out that new ideas and new working cultures very rarely arrive as a result of an individual or organisation operating alone. Instead, they most frequently arrive following communicating with others with different experiences and professional qualifications. NESTA states that 'In an age of "combinatorial" innovation – where major breakthroughs are likely to involve knowledge from different fields, and joint working between thinkers, doers and communicators - being good at collective intelligence will be a crucial determinant of success for businesses, for governments, and for countries. Understanding more about how collective intelligence happens, and devising and implementing effective tools for fostering it should be a major project for the UK in the next decade'. This evidence suggests that success in EBNS might require the creation of a network that includes local Government, private businesses, utilities, academia, and consultancies in the creation of a "growth coalition" for the EBNS area.

Elsewhere, innovative methods of research have been adopted to stimulate this growth coalition. One example is the adoption of innovation X-prizes (which see a 'bounty' offered for solutions to a particular problem, such as the Wolfson Prize or the Wimbledon Innovation Prize). Skilfully delivered, such a process could also raise the profile of the EBNS area as an innovative, creative area.

We heard strong views from local councillors that it would be absolutely critical to ensure that the local people were involved in both strategy development and policy delivery in future.

This 'collective intelligence' approach suggests that the development of EBNS is not the sole responsibility of officers at the local authority. Instead, this 'collective intelligence' approach would see a more interactive process where officers would facilitate a series of conversations which are set up to find opportunities. A process of policy co-design, which builds in the ideas of a broad base of users from the very beginning of the planning process, and then involved in the evolving thinking as the plan is shaped. This can distinguished from the usual plan design process where a draft (but relatively finalised) plan is presented for public consultation. (This process of co-design can be seen as a somewhat less ambitious version of what is known as 'co-production', in which service users take responsibility for both design and delivery of policies. In practical terms, we cannot see users or communities being made responsible for the delivery).

Defining co-production (with co-design marked)

		Responsibility for design of services		
		Professionals as sole service planner	Professionals and service users/ community as co-planners	No professional input into service planning
Responsibility for delivery of services	Professionals as sole service deliverers	Traditional professional service provision	Professional service provision but users/communities involved in planning and design	Professionals as sole service deliverers
	Professionals and users/communities as co-deliverers	User co-delivery of professionally designed services	Full co-production	User/community delivery of services with little formal/ professional
	Users/communities as sole deliverers	User/community delivery of professionally planned services	User/community delivery of co-planned or co-designed services	Self-organised community provision

Source: NESTA (2013)

Evaluating change

Key issues

- There is scope for an innovative evaluation approach

- There is a major opportunity to pilot new datasets which track delivery and change

EBNS could adopt an innovative evaluation framework, using new data sources to track outcomes for both places and (anonymised) individuals

We have been asked to identify how we might use baseline data collated to evaluate the success of that vision and strategy over time. More broadly, we have been asked to comment on how councils and local agencies can use high quality monitoring information to constantly improve planning and strategy delivery.

For this process of evaluation and delivery monitoring to be a success, we will need to work around two principles. We should:

- 1.Set out up-front the specific impacts that the development is seeking to deliver
- 2.Identify the impacts of development on place, and the impacts of development on people.

We deal with each in turn.

1. Setting out up-front the specific impacts that the development is seeking to deliver

BCC and North Solihull have an opportunity to set out a robust and rigorous approach to evaluation, by starting from the 'development impacts' they are seeking to deliver. This avoids the crude 'data mining' approach taken by many programme and project evaluations, where a long-list of indicators is assessed after the event, and those indicators showing positive change are cherry-picked as evidence of success.

It is not our role in this baselining study to specify the 'development impacts': those should tie back to the main elements of the agreed vision which will be developed at stages subsequent to this baseline stage. However, given the likely main thrusts of the future strategy and vision, we suggest that the development impacts should perhaps cover the following areas:

- 1. Employment, and specifically youth employment
- 2. Jobs and employment mix, including occupational status
- 3. Incomes
- 4. Skill levels, including school attainment
- 5. Business mix
- 6. Site viability, as measured through proxy data on house prices.

We might be tempted to include an overall measure of the local area such as the Index of Multiple Deprivation (IMD), the governments' standard measure of deprivation at local area level. We might expect that successful development and associated projects should lead to improved ranking on the IMD. However, this should be avoided; we do not know whether the IMD will be updated at appropriate times for the evaluation; and if it is updated, we do not know that it will be produced in a consistent manner, and we do not know that changes in the local area would be captured by changes in the IMD ranking.

2. Identifying the impacts of development on place, and the impacts of development on people

The data in this baseline study is based on area averages, such as the average unemployment rates across the study area and neighbourhoods. Analysis of these area averages over time can help show the impacts on place, but to understand the impacts on individual people requires analysing individual data. For example, a successful local employment initiative may result in significant numbers entering the workplace. But the average (un)employment rate may remain static (and not show any positive change) if these people are then able to afford to move to a more desirable area and are replaced by a new group of workless people. Similarly, changes in area averages may be due to other factors, beyond the control of any local development.

The lack of available and appropriate individual-level data is a major barrier here. However, there is significant interest in making better use of data held by central government. Alongside better accessibility and use of data on individual services and outcomes, there is growing recognition of data science for more efficient and more effective services.

We see a major opportunity here for BCC and NS to work with national agencies to pilot a robust approach to evaluation of major development projects such as the EBNS

Much of this work goes beyond the neighbourhood data available from open data, and enables analysis of individual outcomes that can be aggregated up to provide a view for service commissioners and providers. This data is richer than simple statistics published at neighbourhood level, and allows:

- Comparison of changes over time between the study place and a control group of similar areas;

- Comparison of changes over time between people in the study area, and a control group of similar people. For example, changes over time for 'in-movers' and 'out-movers' to and from the study area can be compared against 'remainers';

- Disentangling 'place' and 'people' outcomes. One example is the Ministry of Justice DataLab, which provides organisations working to reduce re-offending with aggregate statistics on the percentage of their clients who return to jail, benchmarked against a control group. The delivery organisation and MoJ benefit from better information on the effectiveness of re-offending reduction interventions, while no individual or sensitive data is released or shared. DWP and other agencies are exploring similar approaches, while ONS makes much of its underlying microdata (although not Census) available to researchers and public sector through the Virtual Microdata Lab.

We see a major opportunity here for BCC and NS to work with national agencies to pilot a robust approach to evaluation of major development projects such as the EBNS. The precise details of the evaluation will need to be penned-in during future stages of the EBNS project alongside the vison and strategy. However, at this stage we can sketch the broad canvas.

- *1.Impacts of development on place* should be assessed based on the area-based data published by national agencies, or held by local agencies. For each of the six issues highlighted above, the first column in the table below sets out the primary area-level datasets for the EBNS area that we suggest should form the basis of any such place-based

evaluation. This list will need reviewing over the course of the development, as the availability of data is likely to change (for example the implementation of Universal Credit, and any subsequent changes to the benefit system, may impact the availability and comparability of data).

- *2.Impacts of development on individual people* should be assessed through accessing data held by national and local agencies, in a similar way to the MoJ Justice DataLab example above. The third column in the table below highlights individual-level data that are currently held by government agencies; many can be analysed by public sector bodies under strictly controlled access. The table below outlines current access to data held by government agencies.

Issue	Current source of area-level data for EBNS	Potential source of individual-level data
Employment, and specifically youth employment	Jobseeker's Allowance and Universal Credit data. Employment data (Census).	HMRC data, based on PAYE and self-assessment returns. DWP data underpinning unemployment benefit, universal credit etc
Jobs and employment mix, including occupational status	Employment and jobs by industry (Census, BRES) and occupation (Census).	HMRC data, based on PAYE and self-assessment returns
Incomes	Experimental income estimates based on PAYE data. Children living in poverty (HMRC). Modelled estimates.	HMRC data, based on PAYE and self-assessment returns
Skill levels, including school attainment	Key Stage data by school, and by pupil residence (DfE). Access/ entry to FE and HE. Qualifications (Census).	DfE, based on school census. Local authority data on FE attendance. UCAS / HESA data on HE entry, local data on FE entry
Business mix	VAT-registered businesses (ONS). Industry sectors (ONS).	Companies House and HMRC, based on formation data, VAT returns, self-assessment returns
Site viability	House prices, land availability	Land Registry, individual property transactions

173

Accessing data held by government agencies

The following datasets could be used by future evaluators.

• Office for National Statistics (ONS). The ONS Virtual Microdata Laboratory (VML) provides access for approved researchers to the microdata underpinning published statistics. Access is granted under secure and controlled conditions only, to projects for social good, and no sensitive data may be removed. BCC and BS researchers, or their contractors, may access this data.

• DfE. Individual record data from the DfE National Pupil Database and School Census is available under strictly controlled circumstances, and for approved projects.

• HESA. Individual record data from HESA on university applications is available under strictly controlled circumstances, and for approved projects.

• DWP. There is significant interest in a DWP DataLab. Although there is no publicly available DataLab access to DWP datasets, however our understanding is that this is in development.

• HMRC. The HMRC DataLab allows approved researchers to access anonymised HMRC data in a government accredited secure environment. See https://www.gov.uk/government/organisations/hm-revenue-customs/about/research for details.

As well as looking at 'hard' data outcomes, any future evaluation could look at management and leadership. The Kerslake Review worked to the principles of the Local Government Association's (LGA) peer challenge model. These principles could provide a useful framework for the evaluation of any future governance and leadership in East Birmingham itself, as well as the wider city. The dimensions are

a. effective political and managerial leadership, working as a constructive partnership;

b. a good understanding of the local context which informs a shared long-term vision and a clear set of priorities understood by the workforce and other partners;

c. effective governance and decision-making arrangements that respond to challenges and manage performance, change, transformation and disinvestment;

d. capacity and resources focused in the right areas in order to deliver the agreed priorities, supported by relevant organisational and workforce development; and,

e. a financial plan in place to ensure its long term viability and evidence it is being implemented successfully.

Appendix 1 – Viability testing method

Appendix 1: About the method used in high level viability testing, and the caveats attached

The methodology used

For each case study, we have estimated the breakdown of land usage by type and area, and have assessed existing use values from recent market data including Land Registry Price Paid Date. Areas within the case studies for intensification will require acquisition where currently in private ownership.

Then a proposed scheme of intensified land use and higher value market housing has been assessed using uplifts in values reflecting values obtained for new housing, offices and retail in the more economically vibrant parts of the region but not using the highest value areas such as Birmingham city centre commercial or Solihull prime residential. The costs of transition are assessed including acquisition, compensation and demolition costs, and associated infrastructure obligations that will arise for the net additions in market housing.

New residual land values have been calculated, and allowing for administration and financing costs, if the new land use receipts exceed all the transition costs then the scheme is considered viable.

We have not cut the number of affordable homes in each scenario. The number of affordable homes has stayed the same as today. The percentage of affordable housing falls in the scenarios, but because the numbers of homes produced has risen, this allows us to keep the absolute number of the same (though product type may shift).

Significant sensitivities and caveats

The viability of regeneration with intensified land use is most sensitive to:

- The change in market values that can be achieved especially for market housing
- The degree of increase in density of land use, again particularly in respect of market housing
- And to a lesser extent the balance of tenures (or the proportion of land ownership in the public sector) before and after development. A high private market ownership at the beginning leads to high acquisition and compensation costs, whereas a high market provision in the proposed scheme leads to higher receipts and improved viability.

Other sensitivities exist within the underlying calculations, such as the cost of financing, but the above three factors have by far the most significant effect on viability. This is further reinforced given evidence presented in this study on lessons learnt from the North Solihull Partnership's work.

Many rough estimates have been made in this high-level assessment. A more detailed study may show gains, for example acquisition costs of a commercial lease will be much less if the lease term is about to end.

Finally, there is evidence that regeneration of this nature will enhance the values of neighbouring stock, and dwellings and buildings that are within the study area but physically untouched. This "unearned" value uplift can be considerable and warrants a study of mechanisms to recycle these gains into the scheme (see Transport for London study on Land Value Capture, Feb 2017). No assumptions about these indirect gains have been incorporated into this high-level viability assessment.

Appendix 1: Viability case study summaries

Case Study A

Land use	Existing Estimate	Proposed		hectares	Density Existing Dwellings	Dpha	Proposed Dwellings	Dpha
Domestic buildings	0.4							
Domestic gardens	0.4							
Housing sub-total		0.8		3.0	47	61	250	83
					Floor space (sm) Existing	Plot ratio	Proposed	Plot ratio
Retail	-		-		-	-	-	-
Offices	0.5		8.0		5,600	1.1	100,000	1.3
Light industrial	8.9		12.0		89,000	1.0	125,000	1.0
Parking	5.1		6.0					
Commercial sub-total		14.6		26.0	94,600		225,000	
Roads and paths	4.7							
Parking where not included above	0.4							
Highways sub-total		5.1		6.0				
Education	2.3	2.3		3.9				
Leisure	17.4			2.0				
Greenspace	3.6							
Allotments	-							
Water	-							
Amenity total		21.0		4.8				
Other	4.0	4.0		2.0				
Total	47.7	47.7		47.7				

Version 2.0   Page 1

Case Study C

Land use	Existing Estimate	Proposed		hectares	Density Existing Dwellings	Dpha	Proposed Dwellings	Dpha
Domestic buildings	10.1							
Domestic gardens	37.3							
Housing sub-total		47.4		49.1	2,143	45	3,000	61
					Floor space (sm) Existing	Plot ratio	Proposed	Plot ratio
Retail	3.1		3.8		30,800	1.0	40,000	1.1
Offices	1.2		2.0		60,800	5.2	90,000	4.5
Light industrial	-		-		-	-	-	-
Parking	2.6		1.2					
Commercial sub-total		6.9		7.0	91,600		130,000	
Roads and paths	14.2							
Parking where not included above	0.3							
Highways sub-total		14.4		13.0				
Education	8.5	8.5		8.5				
Leisure	0.3							
Greenspace	17.8							
Allotments	-							
Water	0.2							
Amenity total		18.2		17.8				
Other	4.0	4.0		4.0				
Total	99.4	99.4		99.4				

Version 2.0   Page 1

Case Study B

Land use	Existing Estimate	Proposed		hectares	Density Existing Dwellings	Dpha	Proposed Dwellings	Dpha
Domestic buildings	4.4							
Domestic gardens	14.9							
Housing sub-total		19.3		16.5	670	35	1,000	61
					Floor space (sm) Existing	Plot ratio	Proposed	Plot ratio
Retail	0.3		0.6		3,000	1.0	6,000	1.0
Offices	0.2		0.5		4,000	2.0	10,000	2.0
Light industrial	0.8		1.6		3,100	0.4	6,000	0.4
Parking	0.5		1.3					
Commercial sub-total		1.8		4.0	10,100		22,000	
Roads and paths	6.2							
Parking where not included above	0.1							
Highways sub-total		6.3		7.0				
Education	0.2	0.2		0.2				
Leisure	0.8							
Greenspace	7.3							
Allotments	0.6							
Water	-							
Amenity total		8.7		8.5				
Other	0.8	0.8		0.8				
Total	37.0	37.0		37.0				

Version 2.0   Page 1

Appendix 2 – Selected sources

Appendix 2: selected sources

Ahlfeldt (2011) Mikelbank (2001) quoted
http://www.spatialeconomics.ac.uk/textonly/SERC/publications/download/sercdp0075.pdf

Allen G. 2011; *Early Intervention: The Next Steps*, www.

Amion (2017) for the *UK Central Growth and Infrastructure Plan*

Amion UKC-Hub Growth and Infrastructure Plan Gross jobs (01/03/2017).

Barton, H. and Grant, M. (2006) *A health map for the local human habitat* The Journal for the Royal Society for the Promotion of Health, 126 (6). pp. 252-253. ISSN 1466-4240 Available from: http://eprints.uwe.ac.uk/7863

BBC (13 February 2015) *The ghost Tesco stores* (http://www.bbc.co.uk/news/magazine-31365003)

BCC (2017) *Delivering New Homes in East Birmingham – Presentation to the East Birmingham North Solihull Board* Clive Skidmore

Birmingham City Council. (2013). *'Birmingham Cycle Revolution' – A Summary, Birmingham City Council.*

Birmingham Commission on Youth Unemployment (2013) *Final Report*

BIS (2012) Next steps for Universities, Business and Government
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/32399/12-903-following-up-wilson-business-university-collaboration-next-steps.pdf.

BPAAP: Pre-Submission Report February (2017)
https://www.birmingham.gov.uk/downloads/file/6004/bpaap_pre-submission_report_february_2017

Bris, quoted Evening Standard, 18th October 2016 *How to survive work in the 21st century.*

Centre for Cities accessed Q1 2017 http://www.centreforcities.org/city/birmingham/

Centre for London, CBFT (2014) *Lessons From London Schools: Investigating The Success*
http://www.centreforlondon.org/wp-content/uploads/2016/08/*Lessons-from-London-Schools*.pdf

Centro. (2013). *P41.Towards a World Class Integrated Transport Network. Centro*

Chen, C.-L., & Hall, P. (2011). The impacts of high-speed trains on British economic geography: a study of the UK's InterCity 125/225 and its effects. *Journal of Transport Geography,* 19, 689-704

Cheshire, P, Magrini, S (2005) *European Urban Growth: Throwing some economic light into the black box.* Paper presented at the Spatial Econometrics Workshop, Kiel Institute for the World Economy, Kiel, Germany, 8–9 April

CIHT (2016) *A Transport Journey to a Healthier Life*

Clean Air Zones https://www.birmingham.gov.uk/info/20076/pollution/1051/clean_air_zones

Dasgupta P and Serageldin (1988) *Social Capital: a Multifaceted Perspective states that "when social networks within each community block the growth of markets, their presence inhibits economic progress"* quoted Coyle (2007) p224.

DfE (2016) *Birmingham and Solihull Area Review* November (12)
https://www.gov.uk/government/publications/birmingham-and-solihull-further-education-area-review-report

DfE Birmingham and Solihull Area Review Final report November \(2016)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/572605/Birmingham_and_Solihull_report.pdf

DfT (2004) *The Importance of Transport in Business' Location Decisions (52)*

DWP (2008) *City Strategy: Final Evaluation*

DWP (2008) *City Strategy: Final Evaluation*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214569/rrep783.pdf

Early Years Foundation Stage, Key Stage 1, Key Stage 2 or Key Stage 4 at sub-Local Authority level since the Academic year (2013/14) which was published in June (2015).

Engineering UK (April 2016) *Report of the Independent Panel on Technical Education* (9)

EURYDICE (2009) *Tackling Social and Cultural Inequalities through Early Childhood Education and Care in Europe*, European Commission: Education, Audiovisual & Culture Executive Agency (EACEA).

Experian MMG3 (2016) *Living Costs and Food Survey*, National Statistics Crown Copyright 2012, Published with the permission of the Office of Public Sector Information (OPSI)

Field F Department of Health December (2010) *The Foundation Years: Preventing Poor Children Becoming Poor Adults The Report of the Independent Review on Poverty and Life Chances*

Financial Times 14 December (2016)

Financial Times 27 March (2017)

GCPH (2013) *The built environment and health*

Gibbons, Ralf Martin (2010) *The spatial decay of agglomeration economies: estimates for use in transport appraisal*

Gordon Waddell, A Kim Burton Department for Work and Pensions (2006) *Is Work Good For Your Health And Well-being?*

Graham Daniel J., Stephen Gibbons, Ralf Martin (2010) *The spatial decay of agglomeration economies: estimates for use in transport appraisal.*

Griggs/Walker Joseph Rowntree Foundation (2008) *The costs of child poverty for individuals and society*

Haldane November (2015) *Labour's Share* – a speech
http://www.bankofengland.co.uk/publications/Pages/speeches/2015/864.aspx

Hanson and Pratt (1995) *Gender, Work and Space*

HM Treasury 2011 *Unlocking Growth in Cities*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/7523/CO_Unlocking_20GrowthCities_acc.pdf

HM Treasury 2011 *Unlocking Growth in Cities*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/7523/CO_Unlocking_20GrowthCities_acc.pdf

House of Commons Briefing Paper Number 7357, 4 November (2016)
http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7357

Housing and Planning Bill (2015) RIBA
http://www.publications.parliament.uk/pa/cm201516/cmpublic/housingplanning/memo/hpb138.htm

Appendix 2: selected sources (cont)

Hughes Deidre, University of Warwick, Institute of Education Research for London Councils (2015) London Ambitions: Shaping a successful careers offer for all young Londoners

IFS/Institute for Education (2014) *Lessons from London schools for attainment gaps and social mobility* https://www.ifs.org.uk/uploads/publications/docs/london_schools_june2014.pdf

Igloo written evidence submitted to Parliament (*Housing and Planning Bill* (2015) original source: RIBA http://www.publications.parliament.uk/pa/cm201516/cmpublic/housingplanning/memo/hpb138.htm

Independent Panel on Technical Education (2016) *Report of the Independent Panel on Technical Education* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/536046/Report_of_the_Independent_Panel_on_Technical_Education.pdf

Independent Transport Commission (2014) *Ambitions and Opportunities*; ITC (2014) *Connected Cities*

Independent Transport Commission (2015) *Connectivity and Cities*

Jiwattanakulpaisarn (2008) *The Impact of Transport Infrastructure Investment on Regional Employment: An empirical investigation*

K. Morris, S. Pope, Halcrow Group Ltd. (2006). *Beyond The Infrastructure: Understanding The Further Design And Implementation Requirements Of Transport Interchanges Within* The Urban Public Transport Network. Association for European Transport

Kerslake (2014) *The way forward: an independent review of the governance and organisational capabilities of Birmingham City Council*

Lawless (2001) quoted DfT (2004) *The Importance of Transport in Business' Location Decisions*

Leitch for Treasury (2006) Leitch *Review of Skills – Prosperity for all in the Global Economy*

Llewellyn Davies, Bannister, Hall for DfT & ODPM: *Transport and City Competitiveness: A Literature Review*

LSE What Works Centre for Local Economic Growth (2015) *Evidence Review 7 – Transport*

Morris et al, (2006) *for the Association for European Transport Interchange*

Munro, (2010): *The Munro review of child protection interim report: The child's journey*; www.dera.ioe.ac.uk

NESTA (2013) *Plan I the case for innovation–led growth* https://www.nesta.org.uk/sites/default/files/plan_i.pdf

NESTA October (2008) *Innovation by Adoption – Measuring and mapping the absorptive capacity in UK nations and* regions (4)

NESTA, NEF, The Lab (2009) *The Challenge Of Co-Production How equal partnerships between professionals and the public are crucial to improving public services*

ODPM – SEU (2004) *The drivers of social exclusion - Review of the literature for the Social Exclusion Unit*

Parkinson (2006) *State of the English Cities*

Pascal and Bertram for OFSTED (2013) *The impact of early education as a strategy in countering socio-economic.*

Peter Brett Associates (2013*) Investing in the High Street: Town Centre Investment Management*

Prskawetz, Thomas Fent, Werner Barthel (2007) *The Relationship Between Demographic Growth and Economic Change*

Public Health Wales NHS Trust (2015) *Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population*

Putnam (2000) *Bowling Alone: The Collapse and Revival of American Community.* Gallie D, Gershuny J, and Vogler C (1994), '*Unemployment, the household and social networks', in Gallie D, Marsh C and Vogler C (eds.), Social Change and the Experience of Unemployment.*

Reich (1991) *The Work of Nations*

Simmie et al (2008) *History matters: Path dependence and innovation in British city-regions.*

Social Mobility and Child Poverty Commission (2014) *Cracking the code: how schools can improve social mobility.*

Steering Committee for the Workshop to Assess the Potential for Promoting Technological Advance through Government-Sponsored Prizes and Contests, National Academy of Engineering (1999) Concerning Federally Sponsored Inducement Prizes in Engineering and Science http://www.nap.edu/catalog/9724.html.

The Guardian (5 April 2017) *Is London's new cycling tsar too nice to face down the bike-haters?* https://www.theguardian.com/cities/2017/apr/05/will-norman-london-new-walking-cycling-czar-commissioner-mayor-sadiq-khan.

The Guardian (24 November 2016) *The UK rise in Neets: those not in education, employment or training* https://www.theguardian.com/society/2016/nov/24/uk-rise-neets-not-in-education-employment-or-training-brexit

Transport for London (2009). *Interchange Best Practice Guidelines. Transport for London*

Van Reenen et al (undated) *The Impact of Training On Productivity and Wages: Evidence from British Panel Data* http://www.ifs.org.uk/wps/wp0516.pdf.

Verdict (2 January 2015) *Food & Grocery UK*

West Midlands Combined Authority (2016) *Productivity and Skills Commission* https://westmidlandscombinedauthority.org.uk/media/1687/17-productivity-and-skills-commission.pdf

Which Skills Matter – Carneiro, Crawford and Goodman, *LSE Centre for Economics of Education* (2006)

Wilkes for BCC (2014) *Children & Young People's Mental Health Drivers & Responses* http://birminghampublichealth.co.uk/manager/_mods/_ckfinder/userfiles/files/1_4%20BirminghamCYP%20Mental%20Health%20Needs.pdf

Wilkes for BCC P*ublic Health Children's Health & Wellbeing Lead On behalf of the Early Intervention Task & Finish group* (Appendix One) (06 August 2013) *Early Interventions To Improve The Health & Wellbeing Of Children & Young People Of Birmingham Findings Of A Search For The Evidence Of Effectiveness And The Analysis Of Local Descriptive Epidemiological Data*

Wolf Report 2011) .http://www.education.gov.uk/schools/performance/2014/secondary_14/s3-1.html

Appendix 3 - Effects of transport investment on workers' access to jobs

The future network assessment shows how, overall, improvements in journey times affect people with different skills. There will be 2,687 (8%) more people with no qualifications within 20 minutes of one or more of the key job locations

Skill Levels (EBNS study area residents)

	Minutes	No Qualifications	Level 1 Qualifications	Level 2 Qualifications
	0-20	31,480	13,858	12,915
Current	20-40	89,197	35,857	30,371
	0-20	34,167	15,052	14,041
Future	20-40	86,509	34,663	29,245
	0-20	109%	109%	109%
Change	20-40	97%	97%	96%

The breakdown of benefits across people with limited qualifications is shown below, demonstrating that the greatest travel time improvements, around 8%, will be experienced by those with no qualifications travelling between up to 20 minutes.

Note that there a reduction in the overall number of people travelling 20-40 minutes. This is because these statistics look at the number of people within the EBNS study area only. In reality travel time distances (and the people within it) will extend beyond the study area boundary.

Change in public transport travel time for people with qualification level 2 or below (within EBNS study area)
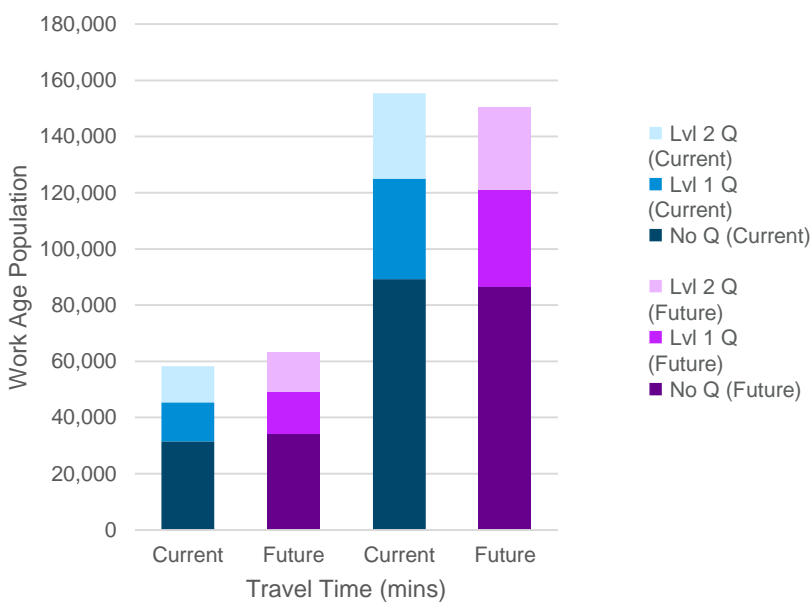
The evidence shows that, overall, improvements in journey times will have a positive impacts on people of all occupations. 1,500 more people in manual roles are within 20 minutes of a job node

There are improvements for people across the occupation groups for journey times up to 20 minutes, but journey time improvements most affect those people in manual roles over this duration with a 1,500 (8%) increase expected.

Occupation Groups (EBNS study area residents)

	Minutes	Professional			Service and Support			Manual Roles		
		Managers, Directors and Senior Officials	Professional Occupations	Associate Professional and Technical Occupations	Administrative and Secretarial Occupations	Caring, Leisure and Other Service Occupations	Sales and Customer Service Occupations	Skilled Trades Occupations	Process, Plant and Machine Operatives	Elementary Occupations
Current	0-20	2,925	4,667	3,782	5,422	4,670	4,326	5,197	5,196	6,658
	20-40	6,706	9,799	7,361	11,333	10,482	12,024	10,751	11,805	18,045
Future	0-20	3,087	4,913	4,028	5,825	5,106	4,640	5,635	5,622	7,298
	20-40	6,545	9,554	7,115	10,930	10,046	11,710	10,313	11,379	17,406
Change	0-20	106%	105%	107%	107%	109%	107%	108%	108%	110%
	20-40	98%	97%	97%	96%	96%	97%	96%	96%	96%

Change in public transport travel time to NEC, Airport and UK Central by employment group (EBNS study area residents)
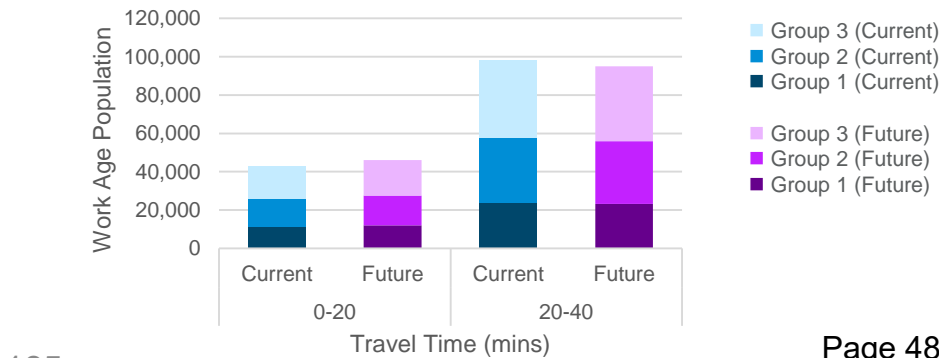
The improvements affect all occupations without significant differences in benefits to any particular group, however, the largest single affected category being those in manual professions (e.g. skilled trades, plant operatives and elementary professions). For this group, around 1,500 people currently employed and located within 20 minutes journey time would benefit; an 8% increase over the current situation.

Note that there again a reduction in the overall number of people travelling 20-40 minutes. This is because these statistics look at the number of people within the EBNS study area only. In reality travel time distances (and the people within it) will extend beyond the study area boundary.

Around 6,700 (45%) of JSA and ESA claimants will benefit from improved levels of accessibility to public transport as a result of proposed transport infrastructure improvements

JSA/ESA Claimants (EBNS study area residents)

	PTAL	JSA claimants	ESA claimants
Current	Very Poor	4,312	10,100
	Poor	4,050	9,903
	Moderate	2,190	5,462
	Good	106	199
	Very Good	1	2
Future	Very Poor	3,829	8,840
	Poor	2,628	6,379
	Moderate	3,245	8,017
	Good	907	2,300
	Very Good	51	129
Change	Very Poor	89%	88%
	Poor	65%	64%
	Moderate	148%	147%
	Good	855%	1158%
	Very Good	5651%	7198%

At present a high proportion of people claiming JSA and ESA live in areas with a poor or very poor level of PTAL accessibility.

The introduction of the Metro and SPRINT services will bring public transport connections into such areas, making considerable improvements for those worst affected.

The improvements to the public transport infrastructure not only brings better connections, but also enhanced opportunities to people who live in areas which are poorly connected at present.
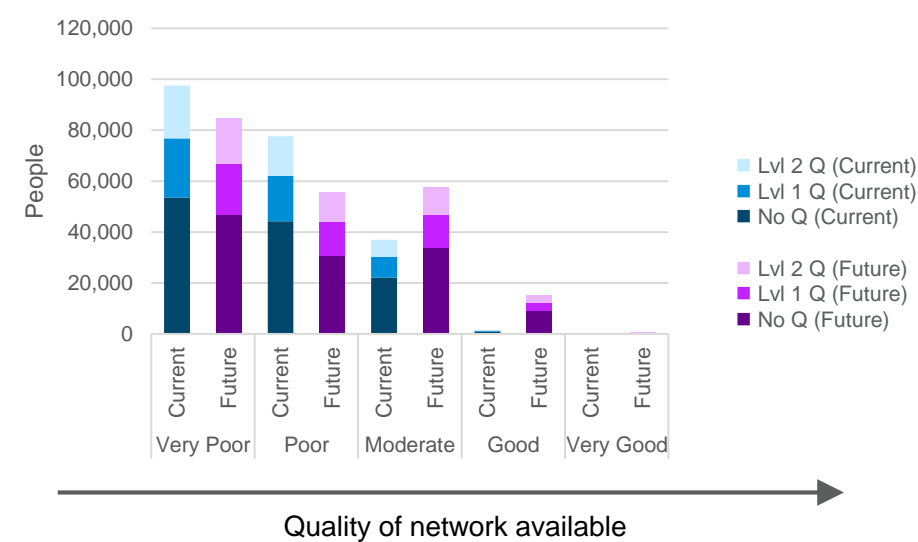
186

The evidence shows how, overall, improvements to PTAL following transport investment affect people with different skills

There are improvements for people across the skills levels, but improved PTAL (moderate and above) primarily affects those people with no qualifications, with around 20,000 people in EBNS (50%) of this group positively impacted. Although lower increases in person numbers will be experienced for those with Level 1 and 2 qualifications, the improved access to pubic transport still represents a 50% increase over the current situation.

Number of residents of EBNS affected by PTAL change - by skill levels

	PTAL	No Qualifications	Level 1 Qualifications	Level 2 Qualifications
Current	Very Poor	22,781	9,924	8,729
	Very Poor	30,694	13,418	11,982
	Poor	44,183	17,888	15,611
	Moderate	22,135	8,127	6,670
	Good	878	358	294
	Very Good	9	2	3
Future	Very Poor	22476	9652	8501
	Very Poor	24080	10449	9420
	Poor	30,893	13,032	11,550
	Moderate	33,851	12,950	10,795
	Good	8,930	3,472	2,892
	Very Good	451	163	131
Change	Very Poor	0.99	0.97	0.97
	Very Poor	78%	78%	79%
	Poor	70%	73%	74%
	Moderate	153%	159%	162%
	Good	1017%	971%	983%
	Very Good	5014%	6825%	4972%

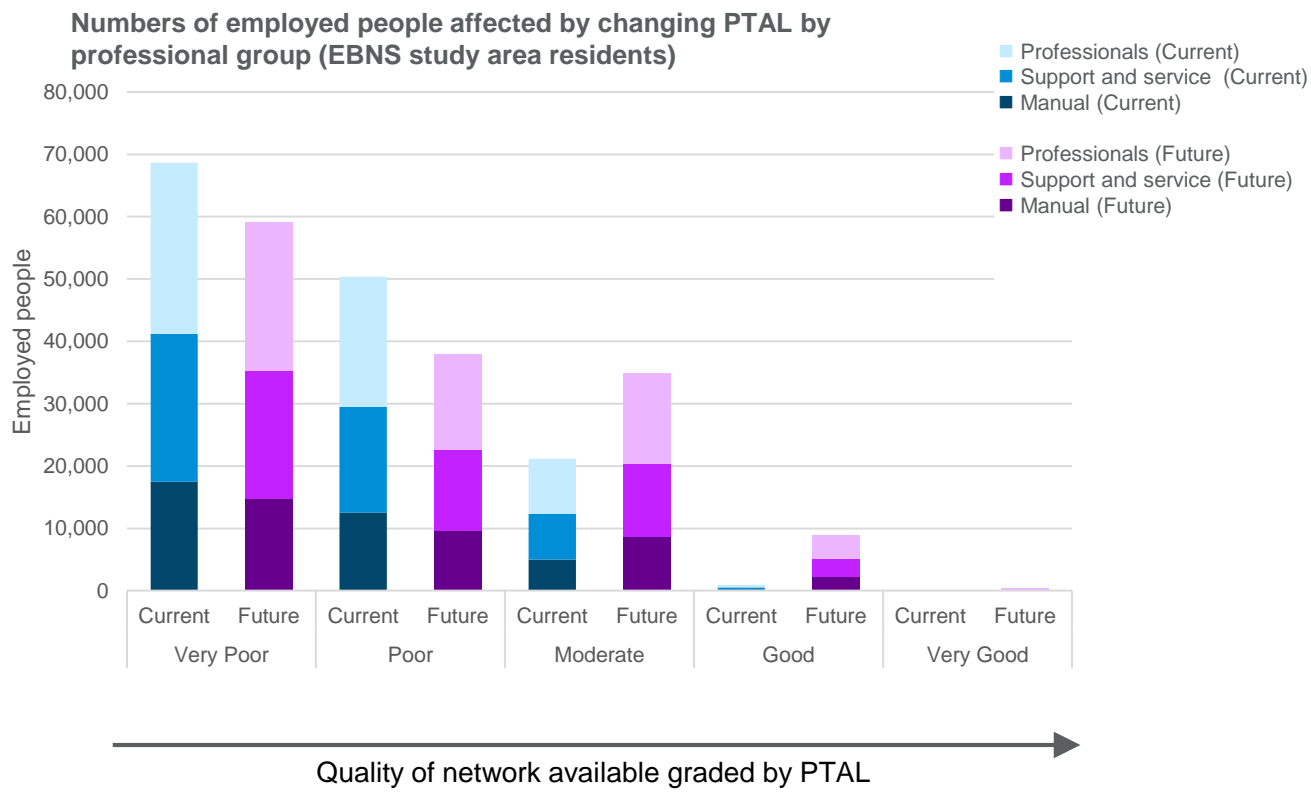**Change in public transport travel time for people with qualification level 2 or below (EBNS study area residents)**

Legend:
- Lvl 2 Q (Current)
- Lvl 1 Q (Current)
- No Q (Current)
- Lvl 2 Q (Future)
- Lvl 1 Q (Future)
- No Q (Future)

People (y-axis): 0 – 120,000

X-axis categories (Current / Future): Very Poor, Poor, Moderate, Good, Very Good

Quality of network available

The evidence also shows how, overall, improvements to PTAL affect people with different occupations. There are improvements for people across the occupations groups, but improved PTAL (moderate and above) primarily affects those people in manual roles

Improved PTAL affects those people in manual roles to the greatest extent, with around 9,200 (50%) positively impacted. Although lower increases in person numbers will be experienced for those in professional and support/service industry occupations, the improved access to public transport still represents a 50% increase over the current situation.

Numbers of employed people affected by changing PTAL by professional group (EBNS study area residents)

Legend:
- Professionals (Current)
- Support and service (Current)
- Manual (Current)
- Professionals (Future)
- Support and service (Future)
- Manual (Future)

Y-axis: Employed people (0; 10,000; 20,000; 30,000; 40,000; 50,000; 60,000; 70,000; 80,000)

X-axis categories (Current / Future): Very Poor, Poor, Moderate, Good, Very Good

Quality of network available graded by PTAL

Appendix 4 - Effects of transport investment on the labour market catchment for specific investment sites

Labour market impacts for employers at NEC, Airport and UK Central:
After the investment package, 25% more people of working age could access NEC, Airport and UK Central within 40 minutes and 18% within 20 minutes. Around 40% of the EBNS working population will be within 40 minutes of NEC, Airport and UK Central, compared to the current 30%

To keep the analysis clear, we have packaged together our analysis of the labour market impacts at NEC, the Airport, and UK Central. The geographical proximity of these sites, and the fact that they are on the same planned networks, makes this possible – although there are likely to be differences at the margin for some routings.
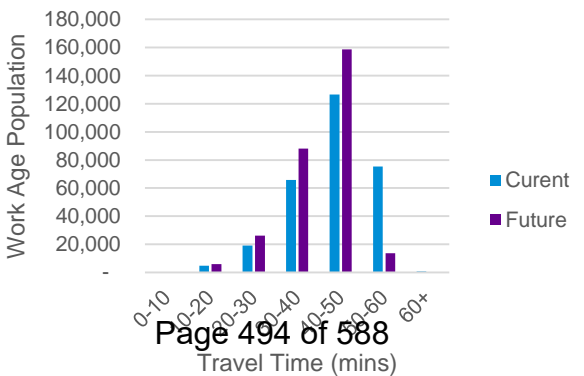
New public transport travel time to NEC, Airport and UK Central following the planned infrastructure improvements
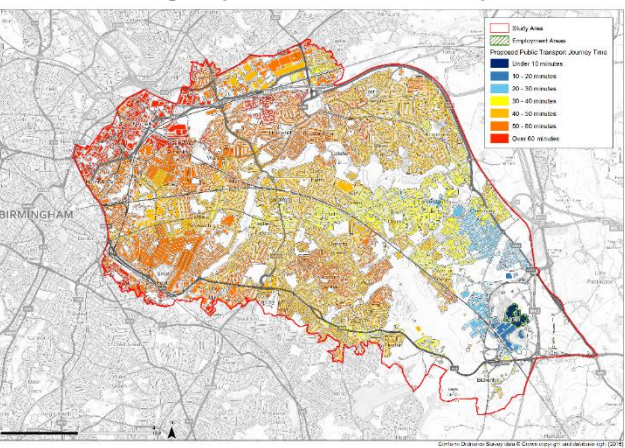

This map shows travel time by all modes of public transport (assuming up to 6 minutes walk to access it) from NEC, Airport and UK Central following the planned package of new transport infrastructure (Metro, SPRINT) and rail infrastructure improvements (where improved service frequencies feed through into improved average journey times).

190

The shortest journey times to NEC, Airport and UK Central are shown in blue, suggesting that, generally speaking, those areas most geographically proximate to NEC, Airport and UK Central have the best access times

Work Age Population

	Current	Future	Change
0-20 mins	5,014	6,148	123%
20-40 mins	85,022	114,161	134%
40+ mins	202,639	172,366	85%

Change in Public transport travel time to NEC, Airport and UK Central following planned infrastructure improvements
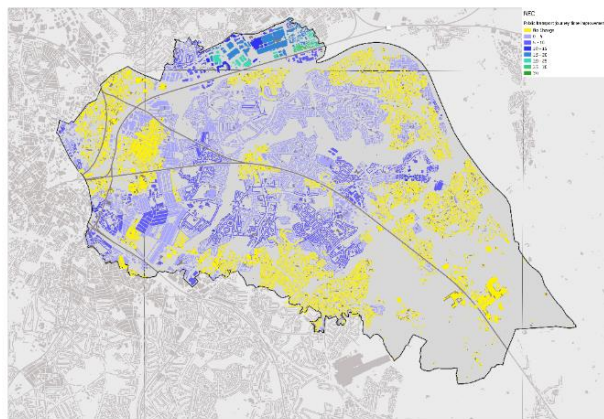
The *change* in travel time is shown in the map above. Those areas that experience the greatest improvements are shown in dark greens and blues on the map and include those areas that are more distant from NEC, Airport and UK Central, including Tyburn, South Nechells and Bordesley Green and areas within Sheldon, Shard End and Stechford and Yardley North that are located within proximity of the railway.

Labour market impacts for Jaguar Land Rover Lode Lane site: after the investment package, 5% more people of working age could access Jaguar Land Rover Lode Lane within 20 minutes, an improvement of 6,400 people. Around 140,000 (48% of the EBNS area) working population will be within 20 minutes of Jaguar Land Rover Lode Lane, compared to the current 134,000

New public transport travel time to Jaguar Land Rover Lode Lane following the planned infrastructure improvements

This map shows travel time by all modes of public transport (assuming up to 6 minutes walk to access it) from Jaguar Land Rover Lode Lane following the planned package of new transport infrastructure (Metro, SPRINT) and rail infrastructure improvements (where improved service frequencies feed through into improved average journey times).

The shortest journey times to Jaguar Land Rover Lode Lane are shown in blue, suggesting that, generally speaking, those areas most geographically proximate to Jaguar Land Rover Lode Lane have the best access times

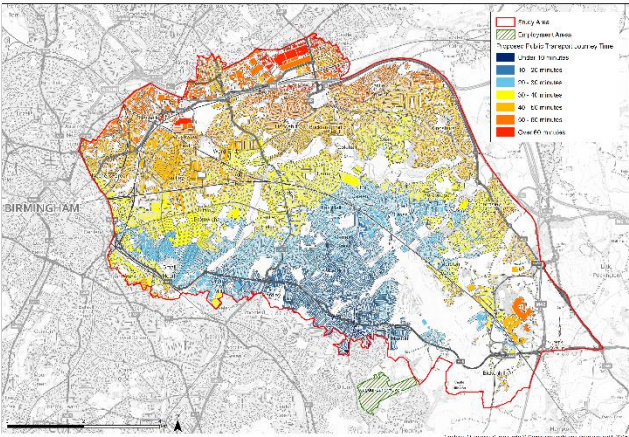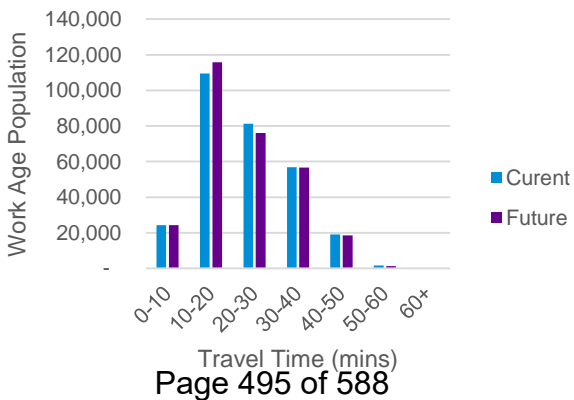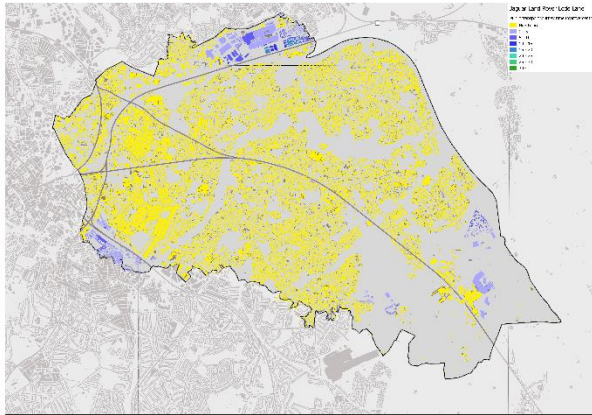| Work Age Population			
Minutes	Current	Future	Change
0-20 mins	133,760	140,172	105%
20-40 mins	138,154	132,732	96%
40+ mins	20,761	19,770	95%

Change in Public transport travel time Jaguar Land Rover Lode Lane following planned infrastructure improvements

The *change* in travel time is shown in the map above. Those areas that experience the greatest improvements are shown in dark greens and blues on the map and include those areas that are more distant from Jaguar Land Rover Lode Lane, including Tyburn, South Nechells and north Sparkbrook.

191

Labour market impacts for Jaguar Land Rover Castle Vale:

After the investment package, 3% more people of working age could access Jaguar Land Rover Castle Vale within 40 minutes, an improvement of 5,700 people. Around 217,000 (94% of the EBNS area) working population will be within 40 minutes of Jaguar Land Rover Castle Vale, compared to the current 212,000

New public transport travel time to Jaguar Land Rover Castle Vale following the planned infrastructure improvements

This map shows travel time by all modes of public transport (assuming up to 6 minutes walk to access it) from Jaguar Land Rover Castle Vale following the planned package of new transport infrastructure (Metro, SPRINT) and rail infrastructure improvements (where improved service frequencies feed through into improved average journey times).

The shortest journey times to Jaguar Land Rover Castle Vale are shown in blue, suggesting that, generally speaking, those areas most geographically proximate Jaguar Land Rover Castle Vale have the best access times

Work Age Population

Minutes	Current	Future	Change
0-20 mins	57,027	57,181	100%
20-40 mins	211,798	217,482	103%
40+ mins	23,850	18,012	76%
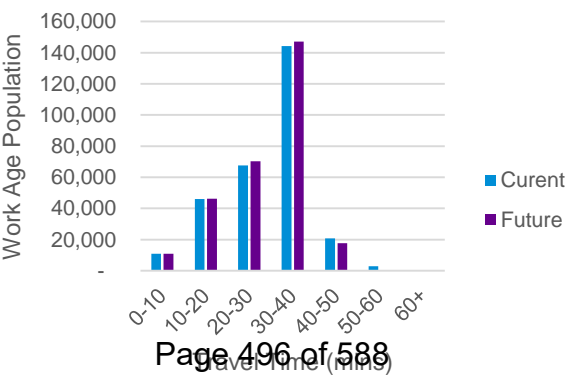
Change in Public transport travel time to Jaguar Land Rover Castle Vale following planned infrastructure improvements
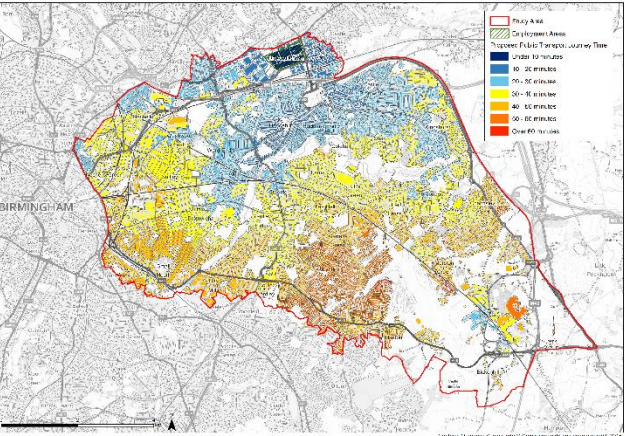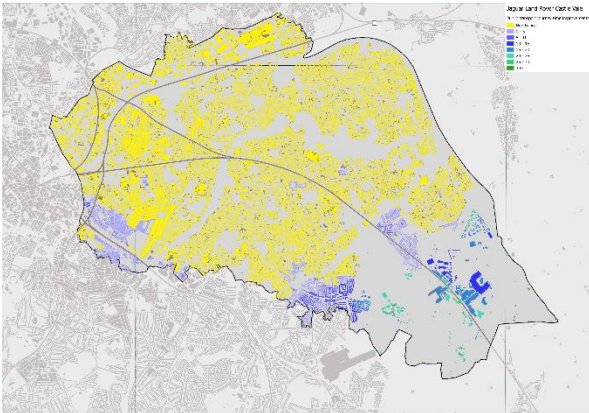

The *change* in travel time is shown in the map above. Those areas that experience the greatest improvements are shown in dark greens and blues on the map and include those areas that are more distant from Jaguar Land Rover Castle Vale, including South Nechells and north Sparkbrook, and areas within Sheldon, Lyndon and Elmdon and Bickenhill.

192

Labour market improvements for Birmingham city centre and Washwood Heath resulting from connectivity investment are more marginal, but can still be expected to create significant advantages

The above slides have set out the impacts of new transport infrastructure on labour market catchments for specific investment sites. We have looked at the size of working populations within a given commuting time of a key employment sites, and have then looked at the impacts of changes on different groups by skills, occupation and benefit claimant status (detailed information is in the appendix).

We have not presented the same data pack for Birmingham city centre and Washwood Heath. This is because the effects of change created by new transport infrastructure on the city centre appear very much more marginal on these measures – which, in turn, is due to the fact that radial routes into the city centre already exist, and the new infrastructure makes a less significant difference to journey times.

However, the new transport infrastructure can still be expected to create significant advantages. For residents of EBNS, new transport infrastructure will create more transport options into Birmingham city centre, higher frequencies, more connectivity, and better interchange opportunities. The benefits of this new network are shown in the PTAL measures which better highlight the effects of higher frequency services, rather than simple travel times. We have demonstrated the effects of new transport on PTAL elsewhere in this evidence base.

Employers in the city centre will also benefit. The ability to bring more workers into Birmingham city centre can be expected to create agglomeration impacts, which accrue from firms being able to locate near each other and so experience economies of scale, knowledge spillovers and network effects.

Birmingham Mobility Action Plan (BMAP) states that improvements in transport infrastructure are intended to create benefits resulting from improvements in CO_2, NOx, and particulate emissions, but we have not analysed those benefits in detail here.

Change in PTAL for working age population

Travel Time (mins)
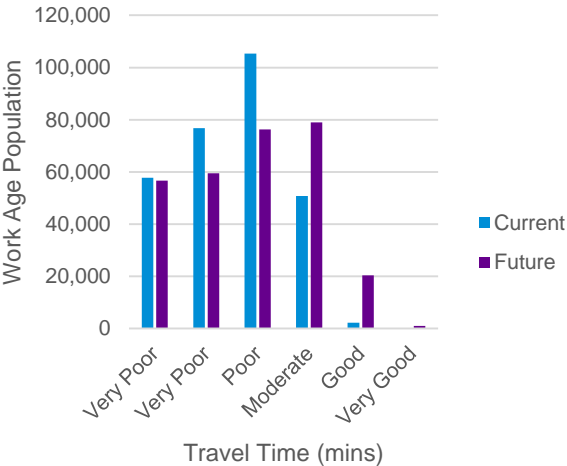
Work Age Population			
	Current	Future	Change
Very Poor	57,712	56,707	98%
Very Poor	76,711	59,461	78%
Poor	105,279	76,274	72%
Moderate	50,806	78,995	155%
Good	2,163	20,320	939%
Very Good	18	933	5179%

Peter Brett Associates LLP is a leading development and infrastructure consultancy. As an independent consulting practice of planners, economists, project managers, property professionals, engineers and scientists, we provide trusted advice to create value.

All of our work, from the engineering of landmark buildings and critical infrastructure to the spatial planning and economic evidence in support of development, is evidence based and informed by a deep understanding of what it takes to deliver construction.

UK
Ashford Birmingham Bristol Cambridge Doncaster Edinburgh Glasgow London Manchester Newcastle Northampton Oxford Plymouth Reading Southampton Taunton

International Czech Republic Germany Slovakia

Services
Transport Planning Energy and Buildings Civil Engineering
Water, Environment and Geotechnical
Planning, Development and Economics

'Triple Zero' – A draft Drug and Alcohol Strategy for Birmingham (2020 – 2030)

Birmingham Health and Wellbeing Board
17th March 2020

Chris Baggott
Service Lead, Public Health

Making a positive difference everyday to people's lives

Birmingham City Council

007590/2020

The 'Triple Zero' ambition for Birmingham

- Zero deaths due to drugs or alcohol addiction

- Zero overdoses due to drug or alcohol addiction

- Zero people living with addiction to drugs or alcohol not receiving support to manage their addiction

Making a positive difference everyday to people's lives

PAGE 2

Birmingham
City Council

Six themed work-streams

i. Prevention

ii. Early intervention

iii. Treatment, Support & Recovery

iv. Children and young people

v. Additional challenges

vi. Data and Evidence

Making a positive difference everyday to people's lives

PAGE 3

Birmingham
City Council

Consultation timeline

- Cabinet decision 17th March

- Consultation opens: 24th March

- (PCC Political sensitivity period: 30th March – 7th May)

- Consultation closes: 16th June (12 weeks)

Making a positive difference everyday to people's lives

Birmingham City Council

PAGE 4

Recommendation

- To note the consultation plan and to support the consultation once launched (dependant on the decision of Cabinet 17th March 2020)

Making a positive difference everyday to people's lives

Birmingham City Council

	Agenda Item: 17
Report to:	Birmingham Health & Wellbeing Board
Date:	17 March 2020
TITLE:	BIRMINGHAM DRUG AND ALCOHOL DRAFT STRATEGY CONSULTATION – 'TRIPLE ZERO'
Organisation	Public Health, Birmingham City Council
Presenting Officer	Chris Baggott, Public Health Service Lead

Report Type:	Presentation

1.	Purpose:
	The purpose of this paper is to inform you of the intention to initiate a consultation on the draft drug and alcohol strategy for Birmingham.

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

3.	Recommendation
3.1	To note the consultation plan and to support the consultation once launched (dependant on the decision of Cabinet 17th March 2020).

007590/2020

4.	Report Body

4.1	**Context**

4.1.1 Birmingham Public Health has been working closely with the West Midlands Police and Crime Commissioner (PCC), Council colleagues and other strategic partners to develop ambitions for the City's response to drug and alcohol misuse. This included a workshop in late November which Cllr Hamilton, Thompson and Cotton attended which agreed the triple zero ambitions.

4.1.2 The ambitious outcomes the City would like to work towards by working in partnership are:

- Zero deaths due to drugs or alcohol addiction

- Zero overdoses due to drug or alcohol addiction

- Zero people living with addiction to drugs or alcohol not receiving support to manage their addiction.

4.1.3 These three ambitions form the basis of the "Triple Zero Drug and Alcohol Strategy". A draft strategy document has been produced in partnership with the PCC, West Midlands Police, NHS, drug and alcohol service providers and other strategic partners. This strategy includes the rationale for the Triple Zero ambitions and a framework for action covering six themed workstreams:

I. Prevention
II. Early intervention
III. Treatment, Support & Recovery
IV. Children and young people
V. Additional challenges
VI. Data and Evidence

4.1.4 It is intended that the Triple Zero City Strategy will open for public consultation on 24th March 2020 to avoid the PCC political sensitivity period and run for 12 weeks to take account of this. This allows the out-going PCC an opportunity to launch the consultation with us and a space for negotiation with the incoming PCC following the elections before the end of the consultation (16th June).

4.1.5 Permission is being sought from Cabinet on 17th March for approval to consult on the draft Strategy – this consultation plan will be amended, if necessary, following the Cabinet decision.

5.	Compliance Issues

5.1	*HWBB Forum Responsibility and Board Update*

5.1.1 An update briefing will be presented to the Health and Wellbeing Board with the main themes from the consultation responses, with a revised draft of the strategy.

5.2	*Management Responsibility*
	Marion Gibbon, Interim Assistant Director of Public Health

6.	Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**	
Unintended media or public responses to the content of the strategy	Medium	Medium	Pre-prepared communications plan with FAQs	

Appendices
Draft Drug and Alcohol Strategy for Birmingham – 'Triple Zero'

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

Chris Baggott, Public Health Service Lead

DRAFT FOR CONSULTATION

Triple Zero City Strategy

Birmingham

2020-2030

Our Shared Ambition

We want Birmingham to be a city where drugs and alcohol addiction do not cause preventable deaths and damage lives through overdose and crime.

We want Birmingham to be a city where young people grow up without addiction and where adults who are living with addiction to substances can access treatment and support and regain control of their lives.

Outcomes

We have three key ambitious outcomes we want to achieve through working in partnership across the city:

- Zero deaths due to drugs or alcohol addiction
- Zero overdoses due to drug or alcohol addiction
- Zero people living with addiction to drugs or alcohol not receiving support to manage and overcome their addiction

These are deliberately ambitious as we need to keep pace and focus to drive change at scale and truly impact on the challenge of drug and alcohol addiction in the city.

Key Objectives

These three outcomes are underpinned by a series of objectives which allow us to monitor progress towards these three longer term goals:

- Reduce access to, and the affordability of, illegal drugs in Birmingham
- Reduce the proportion of young people trying illegal drugs
- Reduce the number of harmful and hazardous drinkers
- Increase the proportion of people with drug and alcohol addiction in treatment
- Explore new models of treatment, care and support to minimise the risk of overdose and death
- Improve access to Naloxone and other interventions that can improve outcomes of overdose
- Improve access to employment support for people accessing treatment and support for drug and alcohol addiction
- Improve access to healthcare services for people accessing treatment support for drug and alcohol addiction
- Work in partnership with citizens, businesses, and organisations across the city to achieve our shared ambition to achieve the triple zero targets

Context

Birmingham is a diverse, global, vibrant city with over a million citizens, however too many of our citizens lives are being damaged by addiction to alcohol or drugs.

Addiction to drugs comes in many forms and the landscape of drugs has evolved significantly over the last twenty years. The Triple Zero strategy will address a broad definition of drug addiction including novel psychoactive substances, steroid abuse, club drugs and prescription drug addiction as well as the more traditional opioid-based drug addiction models.

Alcohol addiction is often described in the context of harmful and hazardous drinking. The National Institute for Health and Care Excellence (NICE) defines harmful drinking as a pattern of alcohol consumption that causes health problems, including psychological problems such as depression, alcohol-related accidents or physical illness such as acute pancreatitis. Harmful drinkers can become alcohol dependent, which NICE defines as characterised by craving, tolerance, a preoccupation with alcohol and continued drinking despite harmful consequences.

Tackling alcohol and drug addiction and the harm that it causes needs us to work in partnership across the city. Preventing addiction requires action across the life-course to improve mental wellbeing, reduce access, reduce demand and give people other pathways to managing life challenges. Supporting those living with addiction to reduce the risk of death and overdose requires early identification, brief interventions as well as, for some, longer-term treatment and support. Enabling those living with addiction to manage and overcome their addiction and regain balance means working with educators and employers, as well as health and social care providers, to provide opportunities for individuals to achieve a healthy and productive life.

Led by Birmingham City Council in partnership with the West Midlands Police and Crime Commissioner, the Triple Zero Strategy sets out a refreshed approach to creating a healthier and safer city for all the residents of Birmingham.

Definitions

Drugs

In the UK illegal drugs are classified into three main categories, A, B and C, with class A drugs attracting the most serious punishments and crimes (Table 1). The drugs are classified as controlled by the Misuse of Drugs Act (1971) and the class is allocated based on the level of harm the drug is thought to cause. Under the Act it is illegal for individuals to possess the drug, supply it or sell it, or allow it to be used in premises they own.

Table 1: Drug Classifications

Class	Drug
A	Crack cocaine, cocaine, ecstasy (MDMA), heroin, LSD, magic mushrooms, methadone, methamphetamine (crystal meth)
B	Amphetamines, barbiturates, cannabis, codeine, ketamine, methylphenidate (Ritalin), synthetic cannabinoids, synthetic cathinones (for example mephedrone, methoxetamine)
C	Anabolic steroids, benzodiazepines (diazepam), gamma hydroxybutyrate (GHB), gamma-butyrolactone (GBL), piperazines (BZP), khat
Temporary class drugs (The government can ban new drugs for 1 year under a 'temporary banning order' while they decide how the drugs should be classified.)	Some methylphenidate substances (ethylphenidate, 3,4-dichloromethylphenidate (3,4-DCMP), methylnaphthidate (HDMP-28), isopropylphenidate (IPP or IPPD), 4-methylmethylphenidate, ethylnaphthidate, propylphenidate) and their simple derivatives

There are a range of other words used in relation to drugs and alcohol which we have included definitions of here:

Opioids is a term used to describe a group of psychoactive substances derived from the poppy plant, including opium, morphine and codeine, as well as their semi-synthetic counterparts, including heroin (World Health Organisation, 2004).

Novel Psychoactive Substances describes a group of new drugs that have been designed to replicate some of the effects of other drugs like cannabis, cocaine and ecstasy while remaining legal which is why they are sometimes called 'legal highs'. The effects of NPS vary significantly from drug to drug and, compared to more traditional drugs, we have relatively little information on them. However, there is a growing body of evidence to demonstrate the potential short and long-term harms associated with their use.

Club Drugs is a term used to describe a group of drugs that are associated with use in parties and club nights. This includes drugs like MDMA (Ecstasy), GHB, Rohypnol, Ketamine, Methamphetamine, and LSD. Club drugs carry significant health risks and can cause serious harm and death with the risk often increased through contamination with other substances.

ChemSex Drugs describes drugs that are predominantly used in association with sexual activity, the most common drug in this group is Methamphetamine, more commonly known as Crystal Meth, Tina, Glass or Yaba. Chemsex drugs carry health risks as drugs but also associated with higher sexual risk taking.

Steroids, in the context of steroid abuse, describes anabolic steroids which are often used illegally to increase muscle mass, decrease fat and enhance athletic performance. Steroids have significant health risks in both the shorter and longer term.

Prescription and over the counter drug abuse is the use of a prescription or over the counter medication in a way not intended by the prescribing doctor or dispensing pharmacist, this can be as a result of addiction or criminal activity. The most commonly abused drugs include opioids like codeine, antidepressants, ADHD medication and anti-anxiety medication.

Alcohol

Unlike most drugs in this policy alcohol is legal for adults to drink. The Chief Medical Officer recommends that adults drink no more than 14 units of alcohol a week. A unit of alcohol is about half a pint of normal strength beer or cider or a single shot, a small glass of wine is about 1.5 units.

There are two main terms used in the context of alcohol misuse:

Harmful drinking

The definition of harmful alcohol use in this guideline is that of the World Health Organisation's International Classification of Diseases, 10th Revision [The ICD-10 Classification of Mental and Behavioural Disorders] (ICD-10; WHO, 1992):

> "a pattern of psychoactive substance use that is causing damage to health. The damage may be physical (e.g. hepatitis) or mental (e.g. depressive episodes secondary to heavy alcohol intake). Harmful use commonly, but not invariably, has adverse social consequences; social consequences in themselves, however, are not sufficient to justify a diagnosis of harmful use."

Hazardous drinking

The term 'hazardous use' appeared in the draft version of ICD-10 to indicate a pattern of substance use that increases the risk of harmful consequences for the user. This is not a current diagnostic term within ICD-10. Nevertheless, it continues to be used by WHO in its public health programme (WHO, 2010a; 2010b).

Policy Context

There is significant variation in policy on drug and alcohol misuse across the world. As a global city we have developed the strategy for Birmingham drawing on policy and practice from both UK and international policy.

As a city our citizens experience the impact of drugs and alcohol misuse at an individual, family, community and city-wide level. Cities often face additional challenges in relation to organized crime and being a hub for transport and migration. Cities also face tensions between the desire for economic growth linked to the night-time economy and the interconnection between this economy and drug and alcohol misuse. There is some evidence that cities are at often at the forefront of tackling the challenges of drug and alcohol because they have the immediate responsibilities for responding to the impact of these challenges such as violence, disorder, crime and inequality.

National & International Drug Policy Overview

The Home Office Drug Strategy 2017 sets out an approach based largely on reducing demand and supply, with a mention of rehabilitation and co-operation in action to reduce overall global supply of Class A drugs.

National policy places the responsibility for the commissioning of drug treatment services as part of the recommended services commissioned through the local authority public health grant, however it is not a statutory service. Local authorities have responsibilities with regards to the NHS Constitution under the 2012 legislation to delivery drug and alcohol recovery services and are required to fund appropriate interventions as recommended by National Institute of Clinical Excellence (NICE).

NICE have published guidelines on drug treatment and also made recommendations about interventions at a system level that can influence drug misuse but these are not government policy.

The World Health Organisation (WHO) identifies the world drug problem as both a public health issue and a safety and security issue, with different countries responding with their own balance between these two domains. The WHO recommends that drug use disorders are managed within the public health system, as the evidence shows this is what works best. In certain countries the idea of including treatment of drug use disorders still meets resistance – *"partly owing to a delay in transferring science to policy and ultimately to the implementation of evidence-based clinical practices".* The WHO advocates for a life course approach to prevention on the basis that intervention in the early years has most impact.

In international terms, the UK has taken a less liberal approach to drug criminalisation[i] than some other countries although in general this is restricted to liberalisation relating to Cannabis. There are some areas where there has been significant innovation internationally, especially in relation to heroin assisted treatment such as "safer injecting facilities". In some countries drug consumption

rooms, where illicit drugs can be used under the supervision of trained staff, have been operating for the last three decades and are now found in 10 countries. The benefits of providing supervised drug consumption facilities may include improvements in safe, hygienic drug use, especially among regular clients, increased access to health and social services, and reduced public drug use and associated nuisance. There is no evidence to suggest that the availability of safer injecting facilities increases drug use or frequency of injecting. These services facilitate rather than delay treatment entry and do not result in higher rates of local drug-related crime.

National and International Alcohol Policy Overview

The WHO provides a Global Status Report on Alcohol Policy. The mechanism by which this works is through the Global Alcohol Policy Alliance. A report was produced for the World Health Assembly in 2019 to report on the implementation of the WHO's global strategy to reduce the harmful use of alcohol during the first decade of its endorsement. A conference will be held in Dublin in March 2020.

National policy on Alcohol was produced by PHE in 2018: "Alcohol: applying All Our Health". This focuses on work to reduce alcohol harm in professional practice and action that can be taken by front-line health and care professionals. It also outlines actions that can be taken by both management and strategic leaders. The primary measures of the impact of alcohol harm are found in the Public Health Outcomes Framework Indicators (alcohol-related admissions to hospital and successful completion of alcohol treatment). There is an Everday Interactions measuring impact toolkit that can be used by health care professionals and an alcohol impact pathway. NICE PH24 provides guidance on prevention of alcohol use disorders.

The context of drugs in Birmingham

The Drug market in Birmingham

The majority of organised crime groups (OCG) in the West Midlands are heavily involved in the drugs trade. In 2017, there were 84 OCGs being tracked by West Midlands Police, of these 31 were primarily involved in drug related criminality. OCGs involved in the drugs trade are likely to have an international client base; The National Crime Agency (NCA) has reported Birmingham as one of the three main exporting areas of drugs in the UK, alongside London and Liverpool. Of the 84 OCGs tracked, 27 were known to have an international footprint. Organised criminals in the West Midlands are profiting from a drug market worth approximately £188m.

One of the eight drug policy recommendations from the West Midlands Police and Crime Commissioner is to seize the money from organised criminals including across the drug market and put this towards improving drug services. Those who have previously been benefiting from the drug market will instead be paying for drug services to help those suffering with a drug addiction and to reduce the number of drug-related deaths. Between 2012 and 2017, West Midlands Police seized more than £17 million from offenders under the Proceeds of Crime Act (POCA).

Drug Misuse in Birmingham

Estimated prevalence of opiate and/or crack cocaine use in Birmingham residents (5-64 years old) has been nearly twice the national rate in recent years. In 2011/12 the rate was 15.2 per 1000 population (England 8.4). In 2016/17 Birmingham's rate decreased to 14.2 and the national has increased to 8.9 per 1,000 population.

The city's recorded number of drug users (opiate and/or crack cocaine use measured by various organizations, including drug treatment, probation, police and prison data) fluctuates over time: with cases at a peak of 10,743 (2011/12), then decreasing to 9,705 (2014/15) and rising again to 10,525 (2016/17).

We have limited local data on patterns of drug and alcohol misuse but there are national prevalence estimates from the Crime Survey for England and Wales from which we can estimate the potential burden of misuse in Birmingham (Table 2). This modelling estimates that in the last month over 8,900 adults in Birmingham have used a class A drug (this is an under estimation as this will not include hostels, students and anyone else with temporary addresses. Over the last year over 1,370 have used anabolic steroids and 43,870 used non-prescribed prescription-only painkillers. However, it is important to note that there is significant variation in use frequency e.g. only 5.9% of adults using powder cocaine in the last month were using daily compared to 25.4% of cannabis users using daily.

Table 2: Estimated number of adults using drugs based on national and regional prevalence data from the Crime Survey for England and Wales 2018/19[ii] (based on est. pop of 16-59yr of 685,603)

Data from Crime Survey for England and Wales 2018/19	Adults 16-59yrs who used drug ever in their lifetime		Adults 16-59yrs who used drug ever in the last year			Adults 16-59yrs who used drug in the last month	
	% national	Est. pop. In B'ham	% national	% West Midlands	Est. pop. In B'ham	% national	Est. Pop in B'ham
Class A							
Any cocaine	10.80%	74,045	2.90%	N/A	19,882	1.10%	7,542
Powder cocaine	10.70%	73,360	2.90%	2.10%	14,398	1.10%	7,542
Crack Cocaine	0.80%	5,485	0.10%	N/A	686	0.00%	0
Ecstasy	9.90%	67,875	1.60%	0.70%	4,799	0.30%	2,057
Hallucinogens	8.50%	58,276	0.70%	0.50%	3,428	0.10%	686
LSD	5.00%	34,280	0.40%	N/A	2,742	0.00%	0
Magic mushrooms	6.90%	47,307	0.50%	N/A	3,428	0.10%	686
Opiates	0.70%	4,799	0.10%	N/A	686	0.10%	686
Heroin	0.50%	3,428	0.10%	N/A	686	0.00%	0
Methadone	0.40%	2,742	0.10%	N/A	686	0.00%	0
Class A/B							
Any amphetamine	8.90%	61,019	0.60%	N/A	4,114	0.10%	686
Amphetamines	8.80%	60,333	0.60%	0.40%	2,742	0.10%	686
Methamphetamine	0.50%	3,428	0.00%	N/A	0	0.00%	0
Class B							
Cannabis	30.20%	207,052	7.60%	6.30%	43,193	4.00%	27,424
Ketamine	3.10%	21,254	0.80%	N/A	5,485	0.30%	2,057
Mephedrone	1.70%	11,655	0.00%	N/A	0	0.00%	0
Class B/C							
Tranquillisers	2.80%	19,197	0.40%	N/A	2,742	0.20%	1,371
Class C							
Anabolic steroids	1.10%	7,542	0.20%	N/A	1,371	0.10%	686
New psychoactive substances	2.50%	17,140	0.50%	N/A	3,428	N/A	N/A
Nitrous Oxide	N/A	N/A	2.30%	N/A	15,769	N/A	N/A
Non-prescribed prescription only painkillers	N/A	N/A	6.40%	N/A	43,879	N/A	N/A
Any Class A drug	16.00%	109,696	3.70%	2.50%	17,140	1.30%	8,913
Any drug	34.20%	234,476	9.40%	7.90%	54,163	5.00%	34,280

There is some variation in patterns of use between different age cohorts for example younger adults are more likely to be using nitrous oxide than the overall adult population (8.7% compared to 2.3%) and this may mean the true picture for Birmingham is slightly different given our larger proportion of young adults.

There is also variation in drug use patterns in different ethnic groups (Table 3), in general drug use is highest in mixed ethnicity groups and white ethnicity groups within the population. Given Birmingham's significant diversity this reinforces the need for local approaches to consider cultural identity in the provision of services and support.

Table 3: Proportion of 16 to 59-year olds reporting use of illicit drugs by ethnic group in 2018/19[iii]

	Class A Drugs			Class B Drugs		Any Drug
	Any Class A	Powder Cocaine	Ecstasy	Amphetamines	Cannabis	
ALL ADULTS AGED 16 to 59	**3.7**	**2.9**	**1.6**	**0.6**	**7.6**	**9.4**
Ethnic group						
White	4.1	3.3	1.7	0.7	8.0	9.9
Non-White	1.9	1.1	1.0	0.1	5.9	6.7
Mixed	10.5	6.2	4.7	0.6	18.5	23.4
Asian or Asian British	0.5	0.3	0.3	0.1	2.8	3.0
Black or Black British	1.1	0.6	0.6	0.0	6.7	6.8
Chinese or other	1.7	0.6	1.2	0.0	7.5	8.4

The lesbian, gay, bisexual and transgender (LGBT) community has a higher than average reported use of recreational drugs and different patterns of drug misuse. A 2011 survey highlighted that 50% of respondents had used drugs for recreational purposes.

At a national level, communities that are most deprived have nearly three times the prevalence rate than the least deprived areas for opiate and/or crack cocaine use.

Steroid abuse is most commonly associated with male body builders; however, the use has spread to female body builders as well as into the recreational gym scene[iv]. One study in South Wales found over 70% of recreational gym users reported using anabolic steroids[v]. There is also reported use alongside the street drug scene where steroids can be used to counteract some of the anorexic effects of other drug addictions.

Treatment and Support
The main national focus of treatment and support commissioning guidance is on opioid drug addiction and harmful alcohol addiction. There is limited national emphasis on treatment of club drugs, steroid abuse or NPS. This trend might be the result of individuals who tend to access treatment tend to be opiate users rather than anyone using any other type of substance, therefore the data available is likely to be opiate heavy. Provision of treatment and support services is not a statutory

requirement but is a recommended service for commissioning through the local authority public health grant.

In 2020 it is estimated that 43% of opiate users in the City are engaged in treatment services. Those opiate users in treatment and new to treatment tend to have a relatively high level of multiple complexities compared to similar areas nationally and are an ageing cohort which is generating new areas of health and social care need.

In 2020 Birmingham City Council invested £14.8m on drug and alcohol treatment and support for all ages funded by the public health grant. A single system with a matrix of partnership providers has been commissioned to deliver these services. GP and pharmacy primary care, as well as the third sector are part of the provider matrix led in 2020 by Change, Grow, Live (CGL). There are a range of service responses provided through this partnership including specific service elements focused on mental health, prison release, employment, criminal justice, blood borne viruses, domestic abuse, acute sector, child protection and homelessness.

In 2018/19 5,399 people accessed treatment, 76% of these were male and 24% female, the largest age group was aged 30-39yrs but it is important to note that 13% of clients were over 50yrs old. Over 90% of people were in treatment for opioid drug addiction, with a much smaller number being treated for alcohol addiction or alcohol and non-opioid addiction. 1,757 people were new presentations to treatment, over 60% of these were White British, 7% were Pakistani and 5% Caribbean and just under 90% were UK nationals. Although most new presentations reported no religion, 18% were of a Christian faith and 8% were Muslim. At the time of presentation 2% reported a lesbian, gay or bisexual sexual orientation and 27% of clients had at least one disability recorded.

At presentation 8% of clients reported use of prescription-only medicines or over-the-counter medicines and 8% of clients reported use of club drugs.

99% of clients had an initial wait of less than three weeks to start treatment which is in line with the national average and unplanned exit from treatment were slightly lower than the national average (17% compared to 18%).

The local service compares well to the national picture in terms of opiate treatment with 47% completing treatment in under two years and 38% of opiate users achieving abstinence at six-month review and 24% reporting significant reduction in use.

Treatment outcomes are tracked nationally through the Treatment Outcomes Profile which reviews outcomes for different drug types at six months in terms of abstinence, significantly reduced use and injecting use. Across most drug types the profile for Birmingham on abstinence at six months is not as strong as nationally, however it is more positive for significant reduction in use. A similar proportion of clients are no longer injecting at 6 months.

Successful completion of treatment by clients who do not re-present to treatment in Birmingham is slightly lower for Opiates than nationally (5.4% compared to 5.8%) but higher for Non-Opiates (37.9% compared to 34.4%).

In line with the national policy focus the current service provision has primarily an opiate user focus although there is some service provision for alcohol addiction and other forms of drug addiction.

The commissioned system has a primary focus on treatment although the nationally funded individual placement support pilot has strengthened the approach to employment support for people in treatment. The focus on prevention, early intervention and longer-term recovery is an area that needs further development in the future.

Alongside the commissioned drug and alcohol treatment services there are a range of voluntary and community sector providers including peer to peer support groups and organisations like Alcoholics Anonymous, Cocaine Anonymous and Narcotics Anonymous and charitable provision of residential rehabilitation support.

Drug overdose
Drug overdose is monitored at a national level as hospital admissions related to drug poisoning. As well as being a key issue to be addressed in themselves, poisoning admissions can be an indicator of future deaths. People who experience non-fatal overdoses are more likely to suffer a future fatal overdose.

Drug overdose is reported as a crude rate per 100,000 people. The most recent published data for 2018-19 suggests the rate in Birmingham is higher than the national average (Table 3).

Table 4: Crude rate of hospital admissions for drug poisoning (2018/19)

Indicator	Birmingham	England
Hospital admissions for drug poisoning (primary or secondary diagnosis) All persons, crude rate per 100,000	65.2	56.2

Deaths related to drug misuse
Drug related deaths in the UK are at a record high and have been increasing for the last four years. More specifically within the West Midlands, every three days someone dies from a drug poisoning; nationally over 54% of deaths involved opiates. There has been an increase in the number of overdose deaths due to the impact of fentanyl mixed with heroin in the UK drugs market. This highlights the importance of focusing on preventing these deaths and educating the public on the effects of drugs. The latest available data (2016-18)[vi] shows that the rate of deaths from drug use in Birmingham is 6.3 (per 100,000 population) and this is significantly higher than the England and West Midlands rates that are both 4.5. Birmingham has the second highest rate in the region behind Stoke-on-Trent and are the 6th lowest of the 8 Core Cities.

The context of alcohol in Birmingham

There is in general more limited data on the scale of alcohol misuse and the impact in terms of crime and health services when compared to drug misuse.

The alcohol economy in Birmingham
In our city alcohol is often part of socialising and celebration and the hospitality and recreation sector is an important and valued part of Birmingham's economy, especially the vibrant night-time economy. Across the city there are over 170 supermarkets selling alcohol, with many more shops, bars and pubs with an alcohol licence.

In England we spend on average £16.30 per week on alcoholic drinks, of this about £8.10 per week is spent on alcoholic drinks away from home[vii]. The average spend per household in the West Midlands is slightly lower at £14.60 per week, however the proportion of this spend for at home consumption is higher than the national average (53% compared to 51%). Nationally the average household spend on alcohol has fallen over the last decade, especially in relation to the spend on alcoholic drinks away from home. This has been reflected in over 11,000 pubs closing over the last decade in the UK, although in the same period employment in pubs and bars has increased by 6%[viii].

In Birmingham there are about 2.8 pubs per 10,000 people which is lower than the UK average of 5.8 pubs per 10,000. There are now about 220 fewer pubs in Birmingham than in 2001, a fall from 545 pubs in 2001 to 325 pubs in 2018. Approximately 5,000 people have jobs in Birmingham's pubs and bars, although this has fallen by 28.6% since 2001[ix]. Birmingham is also home to several breweries and distilleries which are important parts of our local economy.

In 2010, £42.1 billion was spent on alcohol in England and Wales alone. Alcohol is often heavily discounted so that it is now possible to buy a can of lager for as little as 20p or a two litre bottle of cider for £1.69[x]. The pricing of alcohol is a national issue, but it is also a local issue in terms of business responsibility as well.

Much like healthy food the approach has to balance the practicalities of business, the importance of jobs and economic growth alongside the potential health impacts and risks of harm from alcohol misuse and addiction. We have to work constructively with businesses and communities to support responsible drinking across the city.

Alcohol misuse in Birmingham
Alcohol-related harm is largely determined by the volume of alcohol consumed and the frequency of drinking occasions.

In January 2016 the Chief Medical Officer (CMO) issued revised guidance on alcohol consumption, which advises that in order to keep to a low level of risk of alcohol-related harm, adults should drink no more than 14 units of alcohol a week. The 2011-2014 Health Survey for England found that almost double the proportion of adults in

Birmingham abstain from alcohol compared to the national average (30.9% compared to 15.5%), and although the proportion of adults drinking more than 14 units of alcohol a week is lower in Birmingham than the national average it is still significant (18.9% compared to 25.7%).

Based on national prevalence rates it was estimated that there are approximately 12,667 adults in Birmingham with alcohol dependence in need of specialist treatment.

National data has highlighted there are variations in rates of harmful drinking in different ethnic groups, rates are highest in White British ethnic communities (Table 5).

Table 5: The percentage of adults nationally, by ethnic group, who drink at harmful or dependent levels (2014)

Ethnicity	% of adults drinking at harmful or dependent levels
White British	5.2%
White other	1.9%
Asian	1.0%
Mixed	3.9%
Black	3.5%

There is also variation depending on deprivation; 2.1% adults in the most deprived decile were dependant drinkers, compared to 0.9% in the least deprived.

Treatment and support for alcohol misuse
In 2017/18, Birmingham had 1,617 dependent drinkers in alcohol treatment of which males were estimated to be 13% of those estimated to be in need, compared to 18% nationally. Treatment for alcohol misuse is part of the CGL commissioned service.

Analysis by Public Health England of clients in alcohol treatment in 2018-19 reported that 64% were male and 36% female which is comparable to the national gender balance. The largest proportion of clients in treatment were aged 40-49yrs and 50-59yrs, and it is important to note that 11% of clients in treatment were aged over 60yrs.

Analysis of clients presenting new to treatment in 2018-19 in Birmingham highlights that most clients are White British (66%) followed by Indian (5%) and Pakistani (4%) ethnicities. 89% of those presenting for treatment have a UK nationality and after no religion (45%), Christianity (23%) and Islam (4%) and Sikh (3%) are the most common faiths.

3% of clients presenting new to treatment had a gay, lesbian or bisexual sexual orientation and 35% of clients had at least one disability.

100% of clients waited less than three weeks to start the first intervention for alcohol treatment. The service had a lower proportion of unplanned exits from treatment (11%) than the national average (14%).

It is important to highlight that the case load of clients in Birmingham appears to have a higher proportion of severely dependent drinkers (32% of male and 26% of female clients) compared to the national profile (18% male and 15% female), however there are a higher proportion of clients nationally where this profile is unknown.

The NICE Clinical Guidelines on treatment recommend that harmful and mildly dependent drinkers receive a three-month treatment intervention and for those with moderate and severe dependence this should be for a minimum of six months. In Birmingham the average time in treatment is 180 days compared to 186 days nationally, however only 27% of clients leave treatment before 3 months compared to 35% nationally.

There are two key measures of in-treatment success, abstinence rates at planned exit and days of drinking change between start and planned exit. Birmingham had a lower proportion of individuals achieving abstinence at exit (49%) than nationally (51%), however the service achieved a great change in number of drinking days dropping from 22.2 at entry to 9.6 at exit, compared to 20.7 and 11.5 days nationally.

Successful treatment is measured in the context of completion of treatment and the client not returning to alcohol within 6 months. Birmingham is achieving a slightly higher level of successful treatment against this indicator in 2018 (40%) than the national average (38%).

Alcohol overdose
Alcohol overdose is described in the context of admission episodes for intentional self-poisoning by and exposure to alcohol condition, it is reported as a directly standardised rate by gender of clients (Table 6). The rate of alcohol overdose is lower in Birmingham than nationally, especially for women.

Table 6: Directly standardised alcohol overdose rates for Birmingham and England (2017/18)

2017/18	Birmingham Per 100,000 adults	National rate Per 100,000 adults
Male	38.8	39.5
Female	47.7	53.0

Impact of alcohol misuse
Alcohol consumption is a contributing factor to hospital admissions and deaths from a wide range of conditions which costs the NHS about £3.5 billion per year and society £21 billion annually.

Whilst the overall drinking rates in England have decreased from 2011 to 2016 (from 34% to 31% for males and 18% to 16% of women), Birmingham's (2017/18) hospital admissions for alcohol related conditions are significantly higher than England. For male admissions it was 3,553 per 100,000 (England 3,051) and for females 1,762 (England 1,513) (Table 7).

The Birmingham rate for alcohol specific and alcohol related mortality is significantly higher than the England average and has been over recent years. The latest period 2015/17, has the alcohol specific mortality rate for Birmingham at 14.4 deaths per 100,000 population (England, 10.6 deaths). Similarly, the 2015/17 alcohol related mortality rate for Birmingham is 53.3 deaths compared to the England rate of 46.2 deaths per 100,000 population.

Table 7: Hospital admissions counts and rates for alcohol-related conditions for Birmingham, West Midlands and England

Indicator	Period	Birmingham		West Midlands	England
		Count	Rate/100,000	Rate/100,000	Rate/100,000
Admission episodes for alcohol-specific conditions - <18yrs	2016/17-18/19	140	16.2	26.1	31.6
Admission episodes for alcohol-related conditions (narrow)	2018/19	6,748	706	739	664

Drug and alcohol misuse amongst Young People and their parents in Birmingham

Birmingham has a larger proportion of children and young people than the UK average and if we are going to address drug and alcohol misuse fully we have to explicitly consider how to work with them to change the city.

Drug and alcohol misuse impacts on children and young people in many ways, either because they are themselves using alcohol or drugs, or their parents or other family members are, or because they are pawns in organised crime or victims of crime.

Although the number of young people who are using drugs and alcohol is much smaller than adults this is a highly vulnerable group. A Substance Misuse Needs Assessment for Children and Young People, was carried out in August 2018, shows:

Table 8: What About Youth (WAY) Survey 2014/15 (age 15): Birmingham results

Getting drunk in the last 4 weeks	Rates were lower in Birmingham than in England (5.9% vs 14.3%) Within Birmingham, rates were higher for girls than boys; highest for white ethnicity amongst girls and mixed ethnicity amongst boys
Ever trying cannabis	A lower proportion of Birmingham children reported ever trying cannabis (6.5%) than in England (10.5%) Within Birmingham, mixed ethnicity had the highest rates
Taking cannabis in the last month	A lower proportion of Birmingham children reported taking cannabis in the last month (2.0%) than in England (4.55). Within Birmingham, rates were highest for black boys and mixed ethnicity girls
Ever trying drugs other than cannabis	A lower proportion of Birmingham children reported ever trying drugs other than cannabis (1.4%) than in England (2.4%) Within Birmingham, rates were higher for girls; highest for white girls and black boys
Taking drugs other than cannabis in the last month	A very low proportion of Birmingham children reported taking drugs other than cannabis in the last month (0.2% vs 0.8% in England)

Young people receiving interventions for substance misuse have a range of vulnerabilities that require specialist support and intervention. Those in treatment often say they:

- are/were victims of domestic violence
- have contracted a sexually transmitted infection
- have experienced sexual exploitation

And are more likely to:

- not be in education, employment or training and
- be in contact with the youth justice systems

Table 9: Numbers affected in Birmingham: 11-15 year olds

	National Prevalence %	Estimated B'ham Prevalence (ethnicity adjusted) %	Est. number in B'ham population aged 11-15yrs N=73,252 (2016)
Ever taken drugs	23.9	26.0	19,000
Taken drugs in the last month	17.4	18.2	13,300
Taken drugs in the last month	9.7	9.8	7,200
Ever drunk alcohol	45.3	30.4	22,300
Drunk alcohol in the last week	10.3	5.7	4,200
Ever smoked	19.0	16.3	12,000
Current smokers	6.3	5.0	3,600
Regular smokers	2.7	2.0	1,500

Table 10: Number affected in Birmingham: 16-24 year olds

	National Prevalence %	Estimated numbers in Birmingham population aged 16-24 N=169,046 (2016)
Infrequent drug users (once or twice a year)	46	77,800
Frequent drug users (>once a month)	4.1	7,000
Taken NPS in the last year	1.2	2,000
Number drinking >8/6 units on heaviest drinking day	20.4	34,500

Source: Smoking, drinking and drug use among young people, 2016

Young people in treatment 2019/20
Young People's substance misuse treatment services in Birmingham offer support to anyone under 18 years who has a substance misuse problem, or who are affected by parental (or guardian) substance misuse.

This support is delivered by means of a service offering brief interventions and advice, comprehensive assessment and care planning and 1:1 structured interventions. The current contract for the service was awarded to Aquarius Action Projects in October 2019 for a period of 2 years with an option to extend for a further two years (e.g. 2 + 1 + 1) subject to available funding and satisfactory performance.

At 31st December 2019 there were:
- 350 under 18s in treatment (up 5% compared to previous rolling year)
- 56 in secure estate
- 0 over 18s in YP services
- 93% wait less than 3 weeks
- 80% had planned exits (England 82%)
- 30% drug free (England 33%)
- Main substances: cannabis (95%), alcohol (44%), nicotine (3%), cocaine (3%) and Solvent (4%)

Parental Substance Misuse

Dependent parental alcohol and drug use has an adverse impact on children, particularly regarding their physical health, psychosocial wellbeing and personal alcohol and drug use.

There is increasing evidence that adverse childhood experiences (ACEs) such as living in a household with problem alcohol use can contribute to long term harms. If a child experiences four or more risk factors during childhood they have a substantially higher risk of developing health-harming behaviours, such as smoking, heavy drinking and cannabis use.

A report by the Children's Commissioner produced in July 2018 showed:

- 30,000 children and young people aged under 18 in Birmingham are living with an adult who has reported substance misuse
- Of these, over 11,000 are living with an adult dependent on drugs or alcohol
- Of these, 2,500 are living with an adult who also has severe mental health problems and has experienced DV

The Quarter 2 Diagnostic Outcomes Monitoring Executive Summary 2019/20 shows:

- There are 1,564 adults currently accessing treatment who live with children (this represents 22.6% of all adults accessing treatment)
- 19.3% of all adults starting treatment in quarter 2 were adults living with children
- 8.9% of children were on Child Protection Plans (higher than the national average of 7%)
- 2.9% of children were looked after (national average of 2.9%)

Although a small number of pregnant women present each year for treatment for drug or alcohol misuse these are an important group and our local maternity providers have specialist midwives who are trained to work with these women and support them through pregnancy and work with treatment providers to achieve positive outcomes for bother mother and baby.

Our Framework for Action

The Framework for Action is focused on delivery through six themed workstreams that will work together to create a safer, healthier city.

The six themed workstreams are:

1. Prevention
2. Early intervention
3. Treatment, Support & Recovery
4. Children and young people
5. Additional challenges
6. Data and Evidence

Through the six workstreams there a five 'golden threads' which weave across all of the Forum frameworks for action:

Citizen First
We will put the citizen at the heart of our approach, working with citizens across the city to help co-produce a healthy, sustainable, economically viable environment that is accessible to everyone.

Regulation & Enforcement
We want to support businesses to be financially and environmentally sustainable and make the most of the everyday contact between regulation and enforcement authorities in the city and the region to support businesses to work towards our shared ambition of a city in which people enjoy alcohol responsibly and without it causing harm.

Diversity & Inclusion
We know that there are significantly different relationships with drugs and alcohol in different cultures and communities across the city and as we progress this work we want to work with these communities to find solutions and approaches that work in the context of celebrating this diversity.

Scale & Pace
Birmingham is a large city with a diverse community and it is important that we keep a focus on moving at pace and scaling to reach every part of Birmingham with our work, building on success and finding ways to scale across the whole city to ensure every citizen benefits.

Learning & Listening
We also know we need to listen and be humble in our approach, learning in true partnership with cities, in the UK and across the world, learning from research and practice-based evidence and from our citizens. We will be open and honest in our conversations about the challenges as well as the opportunities and successes.

Workstreams of Action

Through the development of the action plan that will deliver this strategy we will review the evidence and take an action-learning approach to the action plan to move at pace to address the drivers of addiction as well as support those whose lives are blighted by the impact.

The six workstreams of action will create a framework for delivering the vision and ambition of the strategy.

Prevention

Prevention requires action on multiple levels across the city to reduce the supply of drugs and saturation of alcohol as well as reducing demand. Action on prevention may include:

- Disrupt and close-down organised crime that underpins the drug trade
- Challenge the saturation of low-cost alcohol sales
- Education and awareness raising, especially with communities most at risk
- Exploring opportunities to tackle sales of steroids and nitrous oxide in the city
- Targeted social marketing and awareness work with communities at highest risk
- Medicine monitoring and support in healthcare settings to tackle prescription and over the counter medicine misuse
- Work with key settings such as workplaces, schools and universities to support organisational approaches to reducing drug and alcohol misuse

Early intervention

Early intervention is about providing support to prevent addiction forming and providing alternative ways of managing the stress and pressures that are pushing people towards misuse. Action on early intervention may include:

- Promoting access to peer support and self-care early interventions
- Increasing training and awareness among professionals working with communities most at risk
- Work with community and performance gyms to raise awareness of steroid abuse risks and impacts
- Continue to strengthen the collaboration between homelessness, mental health and substance misuse services
- Explore how to better support family and friends to enable peer early intervention and support

Treatment, Support & Recovery

Treatment aims to help people to manage their addiction, ideally with the ambition to achieve a life free of drugs or alcohol misuse, or where this is not possible to achieve a level of maintenance which enables them to actively participate in society. Action on treatment, support and recovery may include:

- Continue to support drug and alcohol treatment services in line with national commissioning guidelines and national provided funding resources
- Continue to review the models of care provided against the emerging pattern of usage
- Employment support for people accessing drug or alcohol treatment services and work with employers to encourage provision of job opportunities
- Increase connectivity between commissioned professional treatment services and community based mutual aid groups such as Alcoholics Anonymous, Cocaine Anonymous and Narcotics Anonymous
- Explore innovative models of risk minimisation in treatment such as heroin assisted treatment and safer injecting facilities

Children and Young People

The impact of drugs and alcohol on children and young people can last a lifetime and it is important that we have a specific focus on their needs and issues as well as engage them in active solutions for the city. Action on children and young people may include:

- Address youth gang violence and crime and particularly tackle organised crime's use of children and young people in drug trafficking
- Integrate drug and alcohol prevention and early intervention into other services concerned with reducing risky behaviours in children and young people such as sexual health or truancy
- Support schools to deliver high quality evidence-based education on personal resilience in all educational settings including schools, and universities
- Promote access for young people to accurate information about drugs to allow them to make informed choices
- Increased screening and referral of young people at risk of substance misuse through mainstream services working with higher risk groups
- Ensure that drug and alcohol treatment services have strong relationships with social care and safeguarding support to ensure children and young people in families where there is substance misuse are safe and protected
- Ensure that support for children and young people is closely joined up to support for adults so that young people get the support they need as they get older and transition between services.

Additional Challenges

Many individuals who are struggling with addiction face additional challenges, these include those who are homeless or have insecure housing, people living with mental health issues or people experiencing violence, coercion, abuse or involved in the criminal justice system.

In 2018/19 the drug treatment service identified 35% of new presentation clients had a mental health condition, in alcohol treatment this was higher at 40%, of these 72%

of those in drug treatment and 80% of those in alcohol treatment were receiving active mental health treatment from their GP or the Community Mental Health team. In the same cohort 17% of those with drug issues and 10% of those with alcohol issues presented with a housing problem or no fixed abode at the start of treatment.

14% of newly presenting clients for drug treatment and 18% of those presenting for alcohol treatment in 2018-19 were living with children and a further 35% in drug treatment and 25% in alcohol treatment are parents but not living with children. It is important that through our approach we consider the additional challenges of drugs and alcohol not just on individuals but also on their families, especially their children. We will make sure that children living in families and households where adults use drugs and alcohol are safe and supported.

In the same year 3% of women presenting for drug treatment, and 2% presenting for alcohol treatment, were pregnant, although this is a small number, these are a particularly high-risk group to consider.

It is important that we specifically consider the needs of these individuals in developing our approach generally and also consider where explicit intervention is needed. Action on people with additional challenges may include:
- Additional targeted training and awareness to support engagement and referral for people accessing mental health or housing services
- Specific work with the Birmingham Children's Trust to strengthen links and support for families where a parent or family member is misusing alcohol or drugs
- Specific work with Birmingham United Maternity Partnership (BUMP) to ensure interconnected pathways of care and support for mothers with addiction issues
- Specific work with the criminal justice health system to address drug and alcohol issues within custody and through probation and youth justice services

Data and Evidence
Through the work to deliver this strategy we aim to increase the understanding of the picture of drug and alcohol misuse and addiction in the city and strengthen the evidence base for what works. Action on data and evidence may include:
- Developing a more detailed local data set of indicators to track progress and impact
- Explore potential for economic indicators and metrics to look at impact of low cost alcohol
- Research into steroid, nitrous oxide, club drug and NPA to better understand patterns of use and supply chains
- Research to better understand the cultural context of alcohol and substance misuse and the inequalities within the city

Measuring Success

The triple zero has three headline objectives:

- Zero deaths due to drugs or alcohol addiction
- Zero overdoses due to drug or alcohol addiction
- Zero people living with addiction to drugs or alcohol not receiving support to manage their addiction

The baseline data for these three objectives are:

Deaths attributable to Alcohol
Deaths from alcohol misuse are measured through two nationally reported indicators (Table 11):

Alcohol-Specific Mortality - Deaths from alcohol-specific conditions, all ages, directly age-standardised rate per 100,000 population. Reported annually by Public Health England.

Alcohol-Related Mortality - Deaths from alcohol-related conditions, all ages, directly age-standardised rate per 100,000 population. This includes deaths of children where parental alcohol use was a significant contributing factor such as foetal alcohol syndrome causing infant mortality. Reported as a 3yr average rate.

Table 11: Birmingham deaths attributable to alcohol

		2016-18	2015-17	2014-16	2013-15	2012-14
Alcohol-Specific Mortality	*Persons*	15.0	14.4	14.3	14.2	13.9
	Males	22.3	21.7	21.9	21.6	21.2
	Females	8.1	7.7	7.3	7.2	6.9
		2018	**2017**	**2016**	**2015**	**2014**
Alcohol-Related Mortality	*Persons*	57.4	53.2	53.0	51.9	59.2
	Males	83.1	79.2	79.8	77.5	92.0
	Females	35.2	31.4	30.1	30.4	30.9

Drugs attributable to Drug misuse
Deaths from drug misuse are measured through one nationally reported indicator (Table 12):

Deaths in drug treatment, mortality ratio - The indicator is calculated as a three-year rolling average expressed per 100,000 population and is published by Office of National Statistics (ONS). ONS data is based on the current National Statistics definition of deaths related to drug poisoning by both legal and illegal drugs and includes accidents, suicides and assaults involving drug poisoning, as well as deaths from drug misuse and drug dependence. From these a smaller number of cases are selected that satisfy a definition of drug misuse deaths (a) deaths where the underlying cause is drug abuse or drug dependence or (b) deaths where the

underlying cause is drug poisoning and where any of the substances controlled under the Misuse of Drugs Act (1971) are involved.

Table 12: Birmingham deaths attributable to drugs

		2014/15 - 16/17	2013/14 - 15/16
Deaths in drug treatment	*Count*	122	102
	Mortality Ratio/100,000	0.77	0.70

Overdose

For alcohol we are using the following indicators as metrics to measure impact:

Admission episodes for intentional self-poisoning by and exposure to alcohol
Admissions to hospital where the secondary diagnoses is an alcohol-attributable intentional self-poisoning by and exposure to alcohol code on the hospital record system. It is reported each financial year as sex-specific annual average rates calculated per 100,000 population (Table 13).

Table 13: Admission episodes for alcohol poisoning and exposure in Birmingham

		2017-18	2016-17	2015-16	2015-14	2014-13
Admission episodes for intentional self-poisoning by and exposure to alcohol	*Persons*	43.2	49.0	53.7	50.9	49.8
	Males	38.8	47.5	46.7	46.9	47.7
	Females	47.7	50.7	60.7	54.8	51.8

Admission episodes with a primary diagnosis of poisoning by drug misuse
Admissions to hospital where the primary diagnosis is poisoning by drug misuse as coded on the hospital record system. It is reported each financial year as annual average sex specific rates calculated per 100,000 population (Table 14).

Table 14: Admission episodes with a primary diagnosis of drug misuse poisoning in Birmingham

		2017-18	2016-17	2015-16	2015-14	2014-13
Admission episodes with primary diagnosis of poisoning by drug misuse	*Persons*	37	26	28	27	23
	Males	40	31	32	33	26
	Females	34	21	24	22	21

People Not Receiving Treatment/Support

Alcohol

For alcohol we are using the following indicators as metrics to measure the proportion of people not accessing treatment and support for alcohol (Table 15):

Number in treatment at specialist alcohol misuse services – Total number of individuals who received treatment at a specialist alcohol misuse service. Reported annually in financial years.

Proportion of people waiting more than 3 weeks for alcohol treatment - Proportion of first alcohol treatment interventions where the person waited over 3 weeks to commence treatment. Reported annually in financial years.

Proportion of dependent drinkers not in treatment - The estimated proportion of alcohol dependent adults in the given year who were not in contact with alcohol treatment services in that year. Reported annually in financial years.

Table 15: Number in alcohol treatment indicators for Birmingham

	2017/18	2016/17	2015/16	2014/15
Number in treatment at specialist misuse services (persons)	1413	1,895	1,824	2,105
Proportion waiting more than 3 wks for alcohol treatment (persons)	1.0%	1.4%	5.8%	10.5%
Proportion of dependent drinkers not in treatment (%)	N/A	81.1%	82.3%	79.3%

Drugs

For drugs we are using the following indicators as metrics to measure the proportion of people not accessing treatment and support for opioid drugs (Table 16):

Proportion of opioid users not in treatment – The estimated proportion of the local opiate users in the given year who were not in contact with drug treatment services for an opiate problem in that year. Reported for adults aged 15-64yrs, annually in financial years.

Proportion of people waiting more than 3 weeks for opioid drug treatment - Proportion of first opioid drug treatment interventions where the person waited over 3 weeks to commence treatment. Reported annually in financial years and this measure has evolved in the way this is reported due to providers recording this incorrectly in the past.

Table 16: Number in drug treatment indicators for Birmingham

		2016/17	2015/16	2014/15
Proportion of opioid users not in treatment (persons)	Count	3,159	3,325	3,228
	%	38.4%	40.4%	39.2%
Proportion waiting more than 3 wks for opioid drug treatment (persons)	Count	13	52	112
	%	0.4%	1.7%	3.7%

We will develop a further matrix of proxy metrics based on local service data which will enable us to monitor the implementation and impact of the strategy.

Governance

The Triple Zero Strategy will be overseen by the Health and Wellbeing Board, as a statutory committee of Cabinet.

The Framework for Action workstreams will be delivered through the Creating a City Without Inequality Forum, which reports to the Health and Wellbeing Board, under the leadership of the Cabinet Member for Inequalities and Community Cohesion.

References

[i] https://www.release.org.uk/sites/default/files/pdf/publications/A%20Quiet%20Revolution%20-%20Decriminalisation%20Across%20the%20Globe.pdf

[ii] Crime Survey for England and Wales 2018/19 https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2018-to-2019-csew

[iii] Crime Survey for England and Wales 2018/19 https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2018-to-2019-csew

[iv] Molero Y, Gripenberg J, Bakshi AS. Effectiveness and implementation of a community-based prevention programme targeting anabolic androgenic steroid use in gyms: study protocol of a quasi-experimental control group study. BMC Sports Sci Med Rehabil. 2016;8:36. Published 2016 Nov 17. doi:10.1186/s13102-016-0062-9

[v] Baker JS et al. 2006. Steroid and prescription medicine abuse in the health and fitness community: A regional study. Eur J Intern Med. 2006 Nov;17(7):479-84.

[vi]
https://fingertips.phe.org.uk/search/drug#page/3/gid/1/pat/6/par/E12000005/ati/102/are/E08000025/iid/92432/age/1/sex/4

[vii] ONS. 2019. Family spending in the UK: April 2017 to March 2018.
https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/expenditure/bulletins/familyspendingintheuk/financialyearending2018#households-alcohol-drinking-habits-have-changed-over-the-last-10-years

[viii] ONS. 2018. Economies of ale: small pubs close as chains focus on big bars.
https://www.ons.gov.uk/businessindustryandtrade/business/activitysizeandlocation/articles/economiesofalesmallpubscloseaschainsfocusonbigbars/2018-11-26

[ix] ONS. 2018. Economies of ale: small pubs close as chains focus on big bars.
https://www.ons.gov.uk/businessindustryandtrade/business/activitysizeandlocation/articles/economiesofalesmallpubscloseaschainsfocusonbigbars/2018-11-26

[x] UK Government. 2012. The Government's Alcohol Strategy. P6.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf

Item 18

	Agenda Item: 18
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**17 March 2020**
TITLE:	**HEALTH AND WELLBEING FORUM UPDATES**
Organisation	**Birmingham City Council**
Presenting Officer	**Stacey Gunther, Service Lead, Public Health**

Report Type:	**Information**

1.	**Purpose:**

1.1 This update report details recent, current and future work related to:

- Creating a Healthy Food City
- Creating a Physically Active City Forum
- Creating a City without Inequality Forum
- Health Protection Forum

1.2 The Creating a Mentally Healthy City Forum has submitted a presentation report to the January 2020 Board and is outside the scope of this report.

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

3.	**Recommendation**

3.1 It is recommended that the board note the contents of the report.

007591/2020

4.	Report Body

4.1	**Background**

4.1.1   The Birmingham Health and Wellbeing Board has five thematic forums. The forums oversee the development and delivery of shared action to drive city-wide improvement. The forums are: Creating a Mentally Healthy City, Creating a Healthy Food City, Creating an Active City, Creating a City Without Inequality, and the Health Protection Forum.

4.1.2   At each Birmingham Health and Wellbeing Board meeting a presentation will be given from 1 of the thematic forums for discussion. The other forums will provide written update reports. The themes will be present on a rota basis, with each theme presenting at least annually.

4.1.3   This report is formed of 4 written updates. Further detail specific to each Forum can be found in **Appendices 1-4.**

5.	Compliance Issues

5.1	**HWBB Forum Responsibility and Board Update**

5.1.1   Regular updates will be reported to the Health and Wellbeing Board via a joint update report in this format, with each forum providing a presentation item rather than an information item update at least annually.

5.1.2   Action logs of the forums shall be recorded and reviewed at every forum to ensure actions are delivered.

5.2	**Management Responsibility**

Stacey Gunther, Service Lead, Public Health
Kyle Stott, Service Lead, Public Health
Mo Phillips, Service Lead, Public Health
Monika Rozanski, Service Lead, Public Health
Chris Baggott, Service Lead, Public Health
Marion Gibbon, Interim Assistant Director, Public Health
Elizabeth Griffiths, Acting Assistant Director, Public Health
Dr Justin Varney, Director of Public Health

6.	Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Partners not delivering on the assigned actions required to enable the forums work.	Medium	Medium	Robust monitoring and regular update reports via the relevant forum

2

Appendices
Appendix 1 - Creating a Healthy Food City Appendix 2 - Creating a Physically Active City Forum Appendix 3 - Creating a City without Inequality Forum Appendix 4 - Health Protection Forum

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

Stacey Gunther, Service Lead, Public Health
Mel Coton, Senior Officer, Public Health
Monika Rozanski, Service Lead, Public Health
Chris Baggott, Service Lead, Public Health
Marion Gibbon, Interim Assistant Director, Public Health
Elizabeth Griffiths, Acting Assistant Director, Public Health

Appendix 1 – Creating a Healthy Food City Forum Highlight Report

1.1 Context

The 'Creating a Healthy Food City' forum brings partners from across the city to work together to apply a whole system approach to understanding the food landscape of the city and improving the food behaviours at a population level across Birmingham by ensuring that a joint action plan is developed and delivered.

The forum's draft ambition and vision is of a city where every citizen can eat an affordable healthy diet, enjoys occasional treats, and knows that the food they eat is ethical and environmentally sustainable.

We want Birmingham to be a city where the food economy is vibrant and reflects the diversity of our communities and is financially successful and sustainable contributing to a circular economy for food which reduces waste and maximises the local assets of the city and west midlands region.

The forum meets every two months, with an additional extended forum convening once every six months.

A Linked In group has been created to continue conversations and collaboration outside of meetings. It is also a place for members of other health and wellbeing forums to link across different agendas.
CHFC Linked In group: https://www.linkedin.com/groups/13744273/

1.2 Current Circumstance

The second meeting of the forum was held in January 2020 and chaired by Councillor Paulette Hamilton – Cabinet Member for Health and Social Care.

The following project updates were provided to the forum:
• BINDI partnership
• Childhood Obesity Trailblazer
• Birmingham Food Conversation Update

    o Food Survey report outcome
    o Seldom Heard Food Conversations
    o Fizz Free February

A first draft of the Birmingham Food Strategy is in progress. Its objectives are:

• Improve the access to affordable, safe, healthy sustainable food across Birmingham in every community for every citizen;
• Develop a financially and environmentally sustainable food system in the city;
• Reduce the inequalities in food access and nutritional intake across the city;

007591/2020

- Work in partnership with citizens, businesses, and organisations across the city to achieve our shared ambition to create a healthy food city in Birmingham

Forum members took part in a workshop to share thoughts and ideas around the eight themes of the strategy:

1. Food Production
2. Food Transformation
3. Food Logistics/Supply Chains
4. Food Retail – Home
5. Food Retail – Out of Home
6. Recycling & Waste
7. Food beliefs & behaviours
8. Data and Evidence

Volunteers are needed from partner organisations to sit on subgroups. To date there has been limited response from forum members.

The Birmingham Food Conversation is going well – there are currently 372 responses to the food survey. Public Health would welcome assistance from forum members in sharing the link and promoting the survey.

1.3 Next Steps and Delivery

Consolidate food strategy workshop

Continue to discuss and explore the eight strategy themes.

Report progress on Childhood Obesity Trailblazer and International Food Partnerships

Complete second draft of strategy and workshop at the extended food forum in April.

Organise extended food forum for April.

Appendices

Appendix 2 – Creating a Physically Active City Forum Highlight Report

1.1 Context

The 'Creating a Physically Active City' forum brings partners from across the city to work together to increase physical activity at a population level by developing and delivering a joint action plan.

The forum's ambition and vision is of thriving cohesive communities where citizens, of every ability, at every age lead active lives where the majority of short daily trips are made on foot, bicycle or public transport, and citizens engaging with each other and the city through active lives.

The forum meets every two months, with an additional extended forum convening once every six months.

A Linked In group has been created to continue conversations and collaboration outside of meetings. It is also a place for members of other health and wellbeing forums to link across different agendas.
CPAC Linked In group: https://www.linkedin.com/groups/13734676/

1.2 Current Circumstance

The planned meeting in December 2019 had to be cancelled due to Purdah, and so the second meeting of the forum was held in February 2020 and chaired by Councillor Waseem Zaffar – Cabinet Member for Transport and Environment. The Terms of Reference were agreed and requests for membership suggestions made.

It was agreed the forum would focus on one key change – reducing journeys by car under one mile. This links into 'Big Move 3' of the draft Birmingham Transport Plan – Prioritising Active Travel in Local Neighbourhoods.

The forum plans to approach car journeys across three themes:

- Journeys to school
- Journeys to work
- Journeys to local amenities

The following project updates were provided to the forum:

- Partnerships for Healthy Cities – Bloomberg
- Seldom Heard Physical Activity Conversations
- Future Parks Accelerator – Naturally Birmingham
- School Streets

The 'Trajectory to a Car Free City' scoping work was presented to the forum alongside the draft Birmingham transport Plan. It was well received and generated a lot of discussion.

007591/2020

Forum members were informed of the 'Fizz Free Feb' campaign and asked to support and share. A group photo was taken to promote the campaign.

1.3   Next Steps and Delivery

- The development of a workshop to facilitate discussions and identify actions towards reducing car journeys under one mile from 25% to single figures. Clear aims and objectives to be agreed.

- Seldom Heard Physical Activity Conversations: Public Health to feed initial findings from focus group reports into the Birmingham Transport Plan Consultation.

- Seldom Heard Physical Activity Conversations: Public Health to share initial findings with forum in April 2020.

- Next forum meeting is scheduled for 22nd April 2020

Appendices

Appendix 3 - Creating a City without Inequality Forum Highlight Report

1.1 Context

The Creating a City without Inequality forum's aim is for all citizens of Birmingham to live a healthy and fulfilling life by ensuring equality of opportunity and by improving the health and wellbeing of those most at risk of experiencing health inequalities.

The CCwI forum will develop a strategic commitment and a whole system approach across Birmingham to tackle the drivers of health inequalities, focusing on prevention and early intervention.

The forum will take a thematic approach to explore specific inequalities in detail and develop a robust action plan that will underpin delivery of the inequality's priorities agreed by the Health and Wellbeing Board.

The forum has a representative membership however, to ensure ongoing engagement with wider stakeholder groups from across all sectors including statutory, higher education, third sector and independent organisations. The forum will hold wider stakeholder group workshops twice a year. The forum also has its presence and engages with stakeholders via its Linkedin group.

1.2 Current Circumstance

The initial meeting of the CCwI forum was held in September and chaired by Councillor John Cotton. The Terms of Reference and membership were discussed and agreed (appendix 1), and It was decided a shared narrative was required identifying the forums vision, objectives and work. A draft narrative and action plan have been developed and shared with the group (appendix 2)

Following the CCwI workshop in October key themes were identified which the group were asked to support as principles underpinning the forums strategic plan:
- Prevention and upstream action
- Equity
- Integration, coordination and connectivity across the whole system of services and support
- Co-production and value of lived experience
- Self-help and education

The forum also noted that plans to the address the above themes should be:
- Evidence-based
- Focus on outcomes, not just outputs
- Targeted

- Place-based (neighbourhood level action)
- Respect the opportunities and challenges of diversity and different cultures

    The second forum meeting held in December focussed on action planning against 4 of the 7 HWBB impact indicators:
- Gap in employment for mental health and learning disability
- Economic inactivity for health reasons
- Gap in school readiness for those with free school meal status
- Healthy life expectancy

    The action planning booklet (appendix 2) provides actions identified by forum members.
    The three remaining indicators were discussed at the last forum meeting in February to address the key drivers of health inequalities relating to the impact indicators.

- The recorded prevalence of diabetes and coronary heart disease
- Depression (gap between recorded and modelled prevalence)
- Smoking in pregnancy
    Each forum meeting has enabled the group to explore and contribute to in-depth discussions on each of the H&WBB impact indicators.

1.3   Next Steps and Delivery

The CCwI forum is working collaboratively with stakeholders to develop a joint action plan which will be measured against the H&WBB approved impact indicators.

The CCwI workshop will be held on the 20th March 2020 and will focus on poverty as one of the key drivers for Health Inequality in the city.

Appendices

Appendix 1 – CCwI ToR

CCwI Forum ToR.pdf

Appendix 2 – CCwI narrative and action plan

CCWi Forum action planning template v3.

Appendix 4 – Health Protection Forum Highlight Report

1.1   Context

1.1.1   The HPF has operated under a governance framework since inception (2012). It has terms of reference, a risk register, and an action log updated at each meeting

1.2   Current Circumstance

1.2.1   The HPF has not met since the last Health and Wellbeing Board highlight report. The HPF scheduled for 27th February 2020 is being rescheduled

1.2.2   In the last two quarters the HPF has contributed content on health protection issues (childhood immunisations and children's oral health) to the Director of Public Health Annual Report process. This has been in the update section for progress on last year's report recommendations

1.2.3   Learning from health protection incidents and outbreaks is continually noted and shared through the HPF to determine changes that need to be made to local processes and systems. This learning takes many forms and most recently multiagency meetings have been convened outside the formal incident response to address wider issues around clusters of communicable diseases, and homelessness and health (being looked at as a health protection incident for the first time)

1.2.4   New multiagency and internal groups have been setup to respond to the current Covid-19 incident. There has been no formal update to the HPF to date, but all agencies are working together to coordinate planning and response

1.2.5   The national HIV Commission has visited Birmingham (21/2/20) as part of their evidence-hearing process to inform their report to Government in the spring about how to eliminate HIV transmission by 2030

1.3   Next Steps and Delivery

1.3.1   Closely monitor uptake of the NHS seasonal flu vaccination programme; supporting promotion and uptake from the Public Health team and working with partners to maximise uptake for all child and adult target groups (Oct 2019-Mar 2020)

1.3.2   Work with Birmingham City Council Adult Social Care Directorate to audit seasonal flu vaccination uptake of Care Providers

1.3.3   Facilitate and contribute to a multi-agency homeless health Incident Management Team (IMT) to determine the scope and scale of health issues affecting the homeless community; identifying the main issues, common themes, and the need for new models of care or interventions to

reduce inequalities, infectious disease incidents (particularly TB, HIV, Invasive Group A Streptococcus) and improve general health. Conversations are already progressing with key partners

1.3.4   Continue discussions with HIV/ Hep B/ Hep C stakeholders as part of the preparations and planning for Birmingham becoming a HIV Fast-Track city by 1st December 2020 – Birmingham will include Hep B and C so will call it Fast-Track+

1.3.5   Partnership working through the HPF to incorporate learning from inequality research into screening and vaccination improvement plans (Feb-Apr 2020)

1.3.6   Deliver a multi-agency health protection workshop to ensure organisational roles and responsibilities are clear, and any gaps in the local system are identified (Mar/Apr 2020)

1.3.7   Future HPF meeting dates:
27th February 2020 (TO BE RESCHEDULED)
April/May 2020
July 2020
October 2020

Appendices
Appendix A – Health Protection Forum Action Plan

Birmingham Health Protection Forum

Action Log

No.	Date added	Action	Owner	Status
3	8/5/18	PHE to update next meeting on management and planning regarding XDR TB case	RG (PHE)	Updated 28/8/18: RG to email summary to BP. Update provided 28/11/18. Case ongoing Update provided 27/02/19; case ongoing Update 17/7/19: ongoing – action to be closed as this is now part of BAU
4	8/5/18	Suggestion for BCC EH to consider alternative ways to challenge 0 or 1 star hygiene rating food premises, e.g. taxes paid. Update at next meeting	JB (BCC EH)	Updated 28/8/18: 0&1-rated premises passed to business rates team. Update at next meeting. Update provided 28/11/18; ongoing Update provided 27/02/19; ongoing Update 17/7/19: action to be closed as this is now part of BAU
6	8/5/18	Update next meeting on PHE audit of EPRR system	RG	Update 28/11/18 – part of ongoing discussions between BCC/PHE

				Update provided 27/02/19; close action
7	8/5/18	Investigate IPC provision at SWB CCG, update next meeting	CB (BCC PH)	Update 28/8/18: CB to escalate with SWB CCG contacts. CB obtained update from Kathy Lyons Dec 2018. Ongoing work to identify what the gaps in provision are Update 17/7/19: update provided, and gaps are being worked through with SWB CCG
11	28/8/18	Clarification required about the information governance restrictions on PHE HPT notification emails	CB/RG	28/11/18: Ongoing internal discussions at PHE 27/02/19: **RG to follow up**; JV needs to be added to all PHE bulletins/cascades (**CB to facilitate**) Update 17/7/19: action to be closed as action resolved
16	28/8/18	NHS Core Standards paper due in September – update required at next meeting	NHS Eng EPRR/ CB	28/11/18: No update. CB to pick up with NHS Eng and update HPF 27/02/19: **JV to follow up with Michael Enderby**

19	28/8/18	Investigate pandemic flu planning with ME and Katie Spence	CB	28/11/18: BCC Resilience are rewriting the plan, CCG hasn't engaged with the multiagency plan. LHRP are mapping the whole system situation, probable gaps still in national planning. Possible idea for workshop? Ongoing 27/02/19: ongoing until BCC plans in place (**Resilience team**)
20	28/8/18	HPF Report to HWB: include a) requirement to cooperate with E. coli and other IPC investigations, b) highlight EH issues due to service reductions, c) highlight lack of EPRR assurance	CB	Ongoing 30/04/19: report presented - close
21	28/11/18	All partners asked to consider responding to the BCC budget consultation	All	27/02/19: close
22	28/11/18	Consider a proposal to set up an excess summer/winter deaths subgroup – following the proposed workshop	CB	Ongoing – consider after workshop Update 17/7/19: action to be closed, subgroup not required
23	28/11/18	Brexit planning assessments to be shared (JA sits on regional LRF Brexit Group	ME	Completed Nov 2018 27/02/19: close
24	28/11/18	Include a requirement for 6-month annual report update for the HPF to monitor actions	CB	Ongoing
25	28/11/18	Risk register – add in risk owners	CB	27/02/19: completed - close

26	27/02/19	HPF members to consider which other committees/meetings/networks could assist or connect with challenging issues that don't fall under the powers that sit with BCC EH	All	Ongoing
27	27/02/19	Issue log – CB to check what other HPFs do and all members to send comments to CB by 6/2/19	CB All	Update 17/7/19: action to be closed
28	27/02/19	HIV clusters – CB to monitor clusters affecting vulnerable groups	CB	Update 15/10/19: PHE have called an Incident Management Team to respond to a HIV cluster; close this action
29	27/02/19	JV and JB to have an induction meeting to explore EH/PH work areas	JB	Update 17/7/19: action to be closed as meeting has happened
30	27/02/19	AD to report back to the NHS Eng SIT that herd immunity for child vaccinations needs to be achieved by the Commonwealth Games 2022 CB to discuss with Dennis Wilkes/Fiona Grant to explore what imms outcomes are/can be in Early Years' service contracts	AD CB	Update 17/7/19: action to be closed (AD action completed, CB action completed and child imms included in the EY service contract)
31	27/02/19	IPC: DJ/CB to catch up after BSol system wide meeting on 13th March	CB/DJ	Update 17/7/19: ongoing; meeting happened and discussion of possible work projects discussed and to be explored by the BSol group
32	27/02/19	IPC: CB to find out what dental health IPC coverage looks like	CB	Update 17/7/19: discussion with PHE has shown a probable gap in proactive (non-response) IPC provision

33	27/02/19	CWG2022: RG to raise need for workforce development with PHE	RG	Update 13/12/19: close as action completed
34	27/02/19	IPC: need to develop a different conversation with the public about handwashing/hand hygiene, could link to national handwashing day, DJ/CB to discuss ideas/good practice	DJ/CB	Update 17/7/19: ongoing; meeting happened and discussion of possible work projects discussed and to be explored by the BSol group
35	27/02/19	Audit: suggestions to CB by 31st March	All	Closed 17/7/19
36	27/02/19	Exercise: RG to flag to Katie Spence that JV would like an exercise related to CWG2022 health protection in 2019	RG	Closed 17/7/19
37	27/02/19	Risks: risk owners to self-identify by end of week; unnecessary risks will be closed	All	
38	27/02/19	HPF: future dates to be set, 2-monthly, plan to alternate deep dive updates and exception reporting	CB	Ongoing

	Agenda Item: 19
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**17 March 2020**
TITLE:	**BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM ACCELERATOR PROGRAMME FEBRUARY UPDATE**
Organisation	**Birmingham and Solihull STP**
Presenting Officer	**Rachel O'Connor, Assistant Chief Executive – Birmingham and Solihull STP**

Report Type:	**Information**

1. Purpose:	
The purpose of this report is to provide an overview of the Birmingham and Solihull Integrated Care System (ICS) Accelerator Programme development. Providing an update on the national policy and how the work we have been undertaking together aims to support our development to becoming an ICS by April 2021.	

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

3. Recommendation	
This report is for information	

4. Report Body	

007592/2020

4.1 Context

4.1.1 An integrated care system is simply a way of working. Integrated Care Systems and are a new way of planning and organising the delivery of health and care services. They bring together NHS, local government, and third sector bodies to take on collective responsibility for the health and wellbeing of the people of Birmingham and Solihull, with the aim of delivering better, high quality, more joined-up care for local people within our collective resources.

4.1.2 The NHS Long-Term Plan sets a clear ambition that every part of the country should be an Integrated Care System by 2021. There are currently no rigid criteria or blueprint for what makes an Integrated Care System.

4.1.3 The intention of our local system and supported by the intentions outlined by NHS England and NHS Improvement is that this should be largely be defined locally, and enable our local system to join up care better for local people, improve their experience and quality of care, ensure improved quality and safety when they access care, enable us to tackle inequalities better together and ensure greater financial and service sustainability for future generations.

4.1.4 The NHS operational and contracting guidance 2020/21 is integral to the delivery of The NHS long term plan (LTP) in the next year, setting out how the long-term revenue settlement will be invested to transform services and achieve proposed outcomes by 2023/24.

4.1.5 The NHS Long-Term Plan sets a clear ambition that every part of the country should be an Integrated Care System by 2021. There are currently no rigid criteria or blueprint for what makes an Integrated Care System. The intention of our local system and supported by the intentions outlined by NHS England and NHS Improvement is that this should be largely be defined locally, and enable our local system to join up care better for local people, improve their experience and quality of care, ensure improved quality and safety when they access care, enable us to tackle inequalities better together and ensure greater financial and service sustainability for future generations.
At the heart of the work we are doing in developing our ICS remain our key STP principles:

- A unity between health and local government to deliver improved outcomes, focussing on the wider determinants of health and wellbeing

- Birmingham and Solihull to be a place people want to work and live

- Our Integrated Care System has 2 places within our system, the place of Birmingham and Solihull

- Local democracy remains with Health and Wellbeing Board(s) and Overview and Scrutiny continuing their important roles in assurance and scrutiny of the STP and latterly the Integrated Care System as it develops

- Engagement and collaboration as a partnership and with local citizens

4.1.6 As part of this accelerator programme, Birmingham and Solihull Sustainability and Transformation Partnership Board and Chief Executives across health and local government identified and agreed the four key workstreams that for our system are important to achieve the outcomes described in section 4.1.5. The Integrated Care System accelerator programme has been structured around the following areas with overview of key outputs to be considered by Sustainability Transformation Board in March 2020:

- **Workstream 1 - System governance and decision making** – Output for this workstream includes an options paper for the future governance of our Sustainability Transformation Partnership (STP)/Integrated Care System (ICS)

- **Workstream 2 - Future integrated care model** – Birmingham and Solihull Transformation Partnership identified three 'life course integrated care model priorities' to provide a practical test case for each of our workstreams and also an opportunity to accelerate their development and achievement of outcomes.

- **Workstream 3 - System Change Management and Improvement** – Output for this workstream includes a practical change management and improvement toolkit (Recipe Book) which is currently being developed to provide a tangible and helpful system-wide resource to support any transformation and change programmes across the system.

- **Workstream 4 - Strategic Commissioning and Delivery** – Output for this workstream includes proposals for what commissioning functions and integrated care model delivery is most effective to achieve improved outcomes for local people at system, place and neighbourhood level.

4.2 Current Circumstance

4.2.1 At the time of writing this report, the development of key workstream outputs are still ongoing which will be concluded in anticipation of the Sustainability Transformation Partnership (STP) Board convening in March 2020.

4.2.2 It is requested that this paper is supported through the Health and Wellbeing Board and that regular updates are brought back to this meeting.

4.3 Next Steps / Delivery

4.3.1 In March 2020, the Sustainability and Transformation Partnership Board will meet for a development session to consider the options for our future governance and receive and outputs from the key workstreams for consideration by the board. Sponsor and ICS portfolio Chair and STP Portfolio Lead officer will present this to the board. Following this we will develop recommendations and a delivery plan for how we develop our integrated care system over the next 12 months.

5.	Compliance Issues

5.1	*HWBB Forum Responsibility and Board Update*

5.1.1	Following consideration by the Sustainability and Transformation Partnership Board we will develop recommendations and a delivery plan for how we develop out integrated care system over the next 12 months. The intention will be to report progress again this delivery plan to Birmingham Health and Wellbeing Board. Workstream 'quad' and core development team will manage the day to day progression against the delivery plan.

5.2	*Management Responsibility*

5.2.1	The following named individuals are leading the development of the Sustainability Transformation Partnership on behalf of the system. This has involved close and collaborative working with partner colleagues including Local Authority. Sarah-Jane Marsh, Sponsor and ICS portfolio chair; Rachel O'Connor, STP portfolio lead; Matt Boazman, STP Strategy lead officer; and STP Finance lead, Phil Johns

6.	Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Options for future governance and outputs from the key workstreams not ready for Sustainability and Transformation Partnership Board to consider	Low	High	Weekly updates from workstream 'quad' on the key workstream outputs required for board consideration will provide assurance and ensure timeliness of delivery. A further meeting is scheduled with workstream 'quad' and Sponsor/ICS portfolio Chair prior to board meeting to review final key outputs for consideration to board.

Appendices
1:      Birmingham and Solihull Integrated Care System Accelerator Programme February Update

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

Rachel O'Connor, Assistant Chief Executive Officer, Birmingham and Solihull STP (rachel.oconnor@nhs.net)

Lehnul Mansuri, Strategic Policy Officer, Birmingham and Solihull STP (lehnul.mansuri@nhs.net)

Item 19

Birmingham Health and Wellbeing Board

Birmingham and Solihull Integrated Care System Accelerator Programme

February Update

1.0   Introduction

The purpose of this report is to provide an overview of the Birmingham and Solihull Integrated Care System (ICS) Accelerator Programme development. Providing an update on the national policy and how the work we have been undertaking together aims to support our development to becoming an ICS by April 2021.

2.0   What is an Integrated Care System?

An integrated care system is simply a way of working. Integrated Care Systems and are a new way of planning and organising the delivery of health and care services. They bring together NHS, local government, and third sector bodies to take on collective responsibility for the health and wellbeing of the people of Birmingham and Solihull, with the aim of delivering better, high quality, more joined-up care for local people within our collective resources.

3.0   Designing Integrated Care Systems (ICSs) in England

The NHS Long-Term Plan sets a clear ambition that every part of the country should be an Integrated Care System by 2021. There are currently no rigid criteria or blueprint for what makes an Integrated Care System. The intention of our local system and supported by the intentions outlined by NHS England and NHS Improvement is that this should be largely be defined locally, and enable our local system to join up care better for local people, improve their experience and quality of care, ensure improved quality and safety when they access care, enable us to tackle inequalities better together and ensure greater financial and service sustainability for future generations.

At the heart of the work we are doing in developing our ICS remain our key STP principles:

- A unity between health and local government to deliver improved outcomes, focussing on the wider determinants of health and wellbeing
- Birmingham and Solihull to be a place people want to work and live
- Our Integrated Care System has 2 places within our system, the place of Birmingham and Solihull
- Local democracy remains with Health and Wellbeing Board(s) and Overview and Scrutiny continuing their important roles in assurance and scrutiny of the STP and latterly the Integrated Care System as it develops
- Engagement and collaboration as partnership and with local citizens

4.0   NHS Operational planning and contracting guidance 2020/21

The NHS operational and contracting guidance 2020/21 is integral to the delivery of The NHS long term plan (LTP) in the next year, setting out how the long-term revenue settlement will be invested to transform services and achieve proposed outcomes by 2023/24.

The areas of focus for 2020/21 include access to care; primary and community services; prevention; mental health; learning disability and autism; and environmental impact. The deliverables need to be achieved within agreed financial trajectories that deliver productivity and efficiency improvements and reduce unwarranted variation. Health and Wellbeing Board previously received our Birmingham and Solihull LTP submission that outlined our plans to deliver these outcomes.

The Operational Planning guidance provides greater clarification of the roles of Integrated Care Systems and key features system will need to have in place for April 2021. It outlines how Integrated Care Systems (ICSs) will undertake two core roles: system transformation and collective management of system performance.

4.1   2020/21 Operational planning requirements for Integrated Care Systems

Although different systems are at different levels of maturity, there are some consistent operational arrangements that NHSE/I expect all systems to agree and put in place during 2020/21.

- System-wide governance arrangements to enable a collective model of responsibility and decision-making between system partners.
- A leadership model for the system, including a Sustainability Transformation Partnership/ Integrated Care System leader with sufficient capacity, and a non-executive chair appointed in line with NHS England and NHS Improvement guidance.
- The system capabilities including population health management, service redesign, workforce transformation, and digitisation required to fulfil the two core roles of an ICS. The system should also agree a sustainable model for resourcing these collective functions or activities. NHS England and NHS Improvement will contribute part-funding for system infrastructure in 2020/21.
- Agreed ways of working across the system in respect of financial governance and collaboration (noting that we propose, under the 2020/21 NHS Standard Contract, to require Clinical Commissioning Groups (CCGs) and NHS trusts/NHS foundation trusts to participate in a System Collaboration and Financial Management Agreement.
- Streamlining commissioning arrangements, including typically one CCG per system. Formal written applications should be made at the latest by 30 September 2020 for a merger which is proposed for 1 April 2021.
- Capital and estates plans at a system level, as the system becomes the main basis for capital planning, including technology.

Birmingham and Solihull Sustainability Transformation Partnership is currently part of an Integrated Care Systems accelerator programme enable us to bridge the gap between being a mature Sustainability and Transformation Partnership and a developing Integrated Care Systems in line with these requirements and other we have identified as a system that are importance to delivering the benefits from us working together in a more joined up way.

5.0   Birmingham and Solihull Integrated Care System Accelerator Programme Workstreams

As part of this accelerator programme, Birmingham and Solihull Sustainability and Transformation Partnership Board and Chief Executives across health and local government identified and agreed the four key workstreams that for our system are important to achieve the outcomes described in

section 3.0. The Integrated Care System accelerator programme has been structured around these areas:

1. System governance and decision making

System leaders need to be able to take appropriate decisions, delegate authority to individuals to deliver, and hold each other to account. Considering what is possible within current legislation to enable closer collaboration in decision making, assurance and accountability.

In the 2020/21 operational plan, system-wide governance arrangements need to be established to enable a collective model of responsibility and decision-making between system partners for the Integrated Care Systems two core functions of transformation and management of system performance and how this enables and support our place based partnerships role in transformation and improving outcomes such as the Birmingham Children's Partnership, Solihull Together etc.

Birmingham and Solihull Sustainability Transformation Partnership has a good foundation to build upon in is collaborative working and examples of where we are working together in transformation (i.e. Early Intervention, Digital) and performance improvement (Mental Health, Preventing Future Deaths, Children's and Ageing Well) and our existing Sustainability Transformation Partnership governance through the Birmingham and Solihull Sustainability Transformation Partnership Board.

Further work is underway supported by the Good Governance Institute (external provider) to produce an options paper for the future governance of our Sustainability Transformation Partnership/ICS. The two key elements that the options will consider relate to our future ICS Partnership Board and Provider entities to enable integrated care delivery/service offer for local people. Partner Interviews, focus groups and reviews of wave 1 and wave 2 ICS sites are taking place to inform this work and options under consideration.

2. Future integrated care model

This workstream looks to identify key priority areas where we can only improve outcomes or citizen experience of care through an integrated care delivery approach. These priority areas will provide a test bed to develop a future life course for Birmingham and Solihull integrated care operating model for integrated health and care. This will include a focus on the key enablers (e.g. digital front door, reduced estate footprint) to transform how care is delivered.

There are a number of pressing system issues facing Birmingham and Solihull now where we want to make significant outcomes as quickly as possible. Because of this Birmingham and Solihull Transformation Partnership identified three 'life course integrated care model priorities'. Each of these represented an area where we were already working together or had identified as a key issue for Birmingham and Solihull. These were aligned to the programme of work both to provide a practical test case for each of our workstreams and also because we felt that the programme offered an opportunity to accelerate their development and achievement of outcomes.

Our life course priorities are:

1. **Integrated model of vaccination and immunisation**- as first phase to ensure our children and young people are vaccinated against MMR; increasing our vaccination level to and beyond the national 92% target.
2. **Digital first access to urgent care**- to create a new model of supporting access to urgent care, building on digital technology and to alleviate urgent care pressures
3. **Early intervention to support older people** to enable them to live independently in their own homes for longer and ensure they are not unnecessarily or prematurely admitted to hospital or residential care

We conducted a baseline/diagnostic piece of work across the life course priority areas to determine what we wanted to accelerate and this formed the basis of our Accelerated Design Event.

We used an Accelerated Design Event held on 30/1 facilitated by NHS Horizons to accelerate the development of the three life course priority areas; Digital First Urgent Care, Early Intervention and Immunisations and Vaccinations. Great attendance from over 90 delegates of multi-agency, multi professional system influencers which stemmed across Birmingham and Solihull including West Birmingham. Various change management tools were presented and explored on the day. Attendees have captured and identified relevant tools relating to their programme and will be using these tools more thoroughly to help steer and explore future challenges. The key actions from each life course group were shared and summarised at the end of the event. This provided clear deliverables for each life course area to progress through following the event.

Pictures taken from Accelerated Design Event 30 January 2020.

3. System Change Management and Improvement

This workstream is considering how we have an Integrated Care Systems agreed change management and improvement approach for when we come together to deliver system-wide transformation and improvements. This will allow partners to collaborate to create system

improvement, prevent failure and rapidly respond to issues when they arise using a common approach and improvement methodology.

A practical change management and improvement toolkit (Recipe Book) is currently being developed to provide a tangible and helpful system-wide resource to support any transformation and change programmes. The 'recipes' will help to provide some step-by-step instructions on how to complete some key aspects of transformation and bring together a range of tools and information for the system to utilise. These will be 'living' documents which can be updated to bring the most up-to-date thinking and learning from the system.

4. Strategic Commissioning and Delivery

Chief Executive Officers and the Sustainability Transformation Partnership Board have commissioned the Strategic Commissioning and Delivery workstream to develop proposals for how we could move to a strategic commissioning approach, proposals for a system financial framework and options for provider entities delivering an integrated care service offer. This will include proposals for what commissioning functions and integrated care model delivery is most effective to achieve improved outcomes for local people at system, place and neighbourhood level.

In the 2020/21 operational plan, Integrated Care Systems will need to have agreed ways of working across the system in respect of financial governance and collaboration. It also notes the need for capital and estates plans at a system level, as the system becomes the main basis for capital planning, including technology and receiving transformation funding.

6.0   Delivery of the Integrated Care Systems Accelerator Programme

In line with our STP way of working and collaboration across the partners the programme was been delivered and shaped by partners throughout. Additionally, we recognised that the nature of the programmes would require more support and insight than one individual could offer so established the concept of the workstream 'quad'. Each workstream has the benefit of support from:

- The workstream lead;

- A representative chair;

- A clinical or professional representative; and

- A local government representative.

Core Development Team	Lead
Sponsor and ICS portfolio Chair	Sarah -Jane Marsh
STP Portfolio Lead officer	Rachel O'Connor
STP Strategy Lead officer	Matt Boazman

STP Finance Lead	Phil Johns		

ICS Functional Area	Core Dev Team	Chair	Clinical/ professional lead	Local Government
Governance & Decision Making	Matt Boazman Phillippa Hentsch	Jacqui Smith	Dr. Richard Mendelsohn	Cllr. Karen Grinsell
Integrated Future Care Model	Rachel O'Connor	Bruce Keogh	Dr. Vish Ratnasuriya	Ruth Tennant
Change Management & Improvement	Suzanne Cleary	Yve Buckland	Michelle McLoughlin	Jonathan Tew
Strategic Commissioning & Delivery	Karen Helliwell	Sue Davis	Dr. Peter Ingham	Graeme Betts

Local Government officers, Health and Wellbeing Board Chair(s) and Vice Chair(s) have attended a wide range of workshops, stakeholder interviews, provided best practice material to contribute to the design and development of the future Integrated Care System and the specific deliverables such as the change management recipe book and future governance options.

7.0   Next steps

In March 2020, the Sustainability and Transformation Partnership Board will meet for a development session to consider the options for our future governance and receive and outputs from the key workstreams for consideration by the board. Following which we will develop recommendations and a delivery plan for how we develop our integrated care system over the next 12 months.

Birmingham Health and Wellbeing Board

		Agenda Item: 20
Report to:	**Birmingham Health & Wellbeing Board**	
Date:	**17 March 2020**	
TITLE:	**DELAYED TRANSFERS OF CARE – WORKSHOP FEEDBACK**	
Organisation	**Birmingham City Council**	
Presenting Officer		

Report Type:	**Information**

1.	**Purpose:**
	To provide the Health and Wellbeing Board with an update on Delayed Transfers of Care (DTOC)

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

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

007593/2020

4.	Report Body

4.1 Context

4.1.1 A Delayed Transfers of Care (DTOC) from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. NHS England defines a patient as being ready for transfer when:

- a clinical decision has been made that the patient is ready for transfer, and;

- a multidisciplinary team has decided that the patient is ready for transfer, and;

- the patient is safe to discharge/transfer.

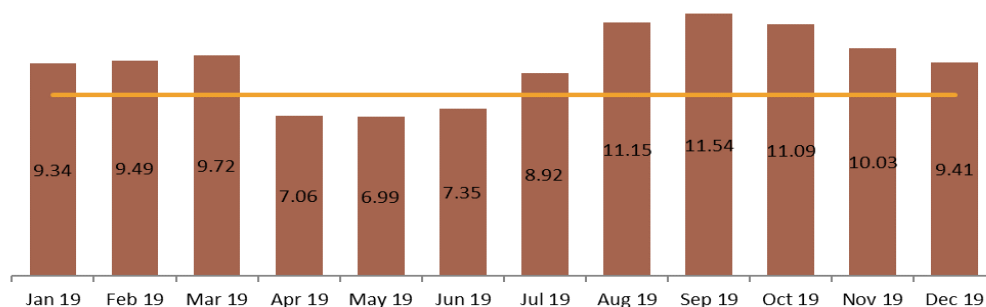4.1.2 Two measures of delayed transfers of care are published monthly by NHS England:

- The total number of bed days taken up by all delayed patients across the whole calendar month.

- The average daily number of delayed transfers across the month. Referred to as 'delayed transfer of care beds', this measure is calculated by dividing the number of delayed days during the month by the number of calendar days in the month.

4.2 Current Circumstance

4.2.1 In December 2019, delays for citizens who were being discharged from hospital, reduced for a third consecutive month. This was despite a high level of demand at all hospitals. An overview of performance is provided below:

Daily Average Delay beds per day per 100,000 18+ population – combined figure (Social Care only and Joint NHS and Social Care)

Source: UNIFY data as issued by NHS Digital. Data collated by health, available a month in arrears.

	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19
	9.34	9.49	9.72	7.06	6.99	7.35	8.92	11.15	11.54	11.09	10.03	9.41

4.2.2 An integral component of the strategy to reduce Delayed Transfers of Care is the implementation of the Early Intervention Programme. Adult Social Care and NHS commissioners and providers are working in partnership to deliver the programme. This involves a range of targeted interventions to promote faster recovery from illness or injury, prevent unnecessary hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living. The new approach to delivery enables partners to respond quickly, minimise delays and not make decisions about long-term care in a hospital setting. The programme was launched in November 2018 and new ways of working are now being rolled out city-wide, with local teams leading on the design and implementation of the model in their part of the city. From mid-March, the most critical part of the new integrated care model - Early Intervention Community Teams - will "go live" in all parts of the City.

4.3 Next Steps / Delivery

4.3.1 DTOC performance continues to be closely monitored to ensure that activity continues to be adapted to meet any changes in demand and capacity. The roll-out of the Early Intervention Programme will commence from mid-March and will be embedded during 2020.

---

5. Compliance Issues

5.1 HWBB Forum Responsibility and Board Update

Day to day management of DTOC performance is undertaken by Adult social Care and the NHS. Periodic updates can be provided to the Health and Wellbeing Board as required

5.2 Management Responsibility

Balwinder Kaur, Assistant Director is responsible for day to day delivery by Adult Social Care

---

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Increased levels of delayed transfers of care	Medium	Medium	Full implementation of Early Intervention Programme

---

Appendices

1. AEDB DTOC Report January 2020

ASC DToC Briefing note to A&E Delivery Board, 21st January 2020

Author: Andrew Marsh
Sponsor: Balwinder Kaur

Trends for the Period 2016 – 2019

The graph in table 1 below shows the number of delayed beds per day per 100k population across the system. The trend line between Jaunary 2016 and October 2019 indicates that:

- Delays attributable to Adult Social Care has decreased marginally
- Delays attributable to Health has increased
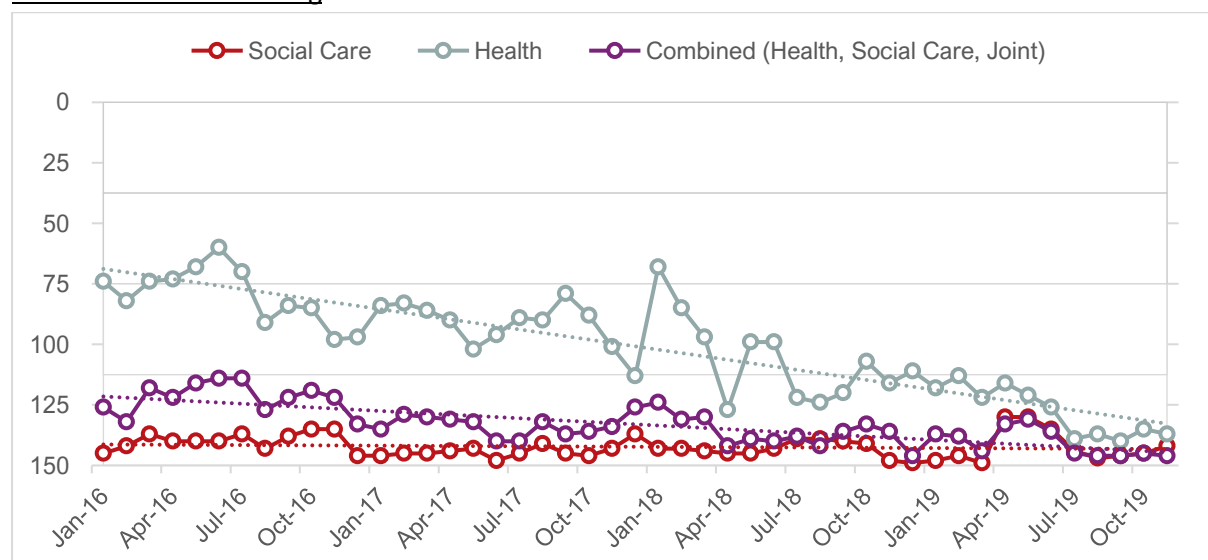- The combined delays have increased

Table 1. Birmingham Beds per Day (100k)
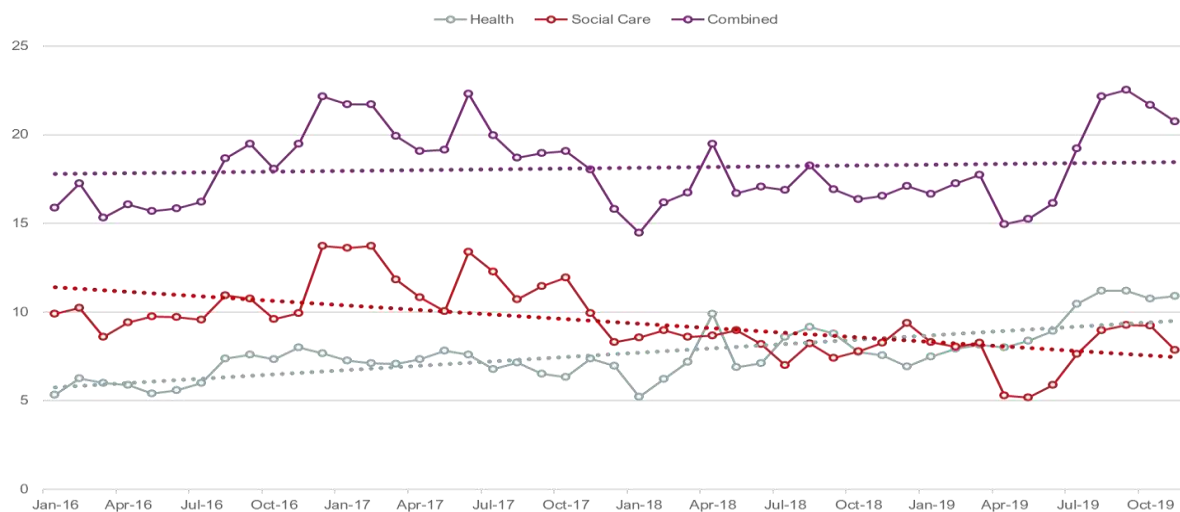
It is worth noting the volatility within the trend. Two further important points to note are:

- A rapid deterioration between June and September 2019
- The trend lines for Health intersecting that of Adult Social Care

Table 2. National Ranking

007593/2020

As shown in table 2, Birmingham is nationally ranked amongst the lowest performing for delayed transfers of care.

Delay Reasons by Acute / Non Acute – Unify Data for November 2019

Acute Delay Reasons

	Acute			Non-Acute		
	Social Care	NHS	Joint	Social Care	NHS	Joint
A_COMPLETION_ASSESSMENT	9	0.8	1.6	0.1	2.3	0.9
B_PUBLIC_FUNDING	0.8	0.4	0	0.5	0.8	0.8
C_FURTHER_NON_ACUTE_NHS	0	12.2	0	0	13.3	0
DI_RESIDENTIAL_HOME	14	1.3	0	6.7	0.2	0
DII_NURSING_HOME	20	3.2	3.4	2.1	1.2	8.8
E_CARE_PACKAGE_IN_HOME	5.9	3	0.4	6.4	2.4	0.5
F_COMMUNITY_EQUIP_ADAPT	0.1	3.9	0.5	0.3	1.9	0.3
G_PATIENT_FAMILY_CHOICE	1	12	0	0	13.1	0
H_DISPUTES	0	0	0	0	0	0
I_HOUSING	0	10	0	0	2.1	0
Other				0	2.1	0
Grand Total	50.8	46.8	5.9	16.1	46.2	11.2

Table 3. Weekly Overview 9/01/20 – 15/01/20 (Delays attributable to Adult Social Care) – Local Data

	Thu	Fri	Sat	Sun	Mon	Tue	Wed
A - Awaiting Assessment	4	3	3	6	1	3	2
B - Public Funding	-	-	-	-	1	1	1
C - Non-Acute NHS Care	-	-	-	-	-	-	-
D1 - Residential	20	21	25	29	30	28	26
D2 - Nursing	19	18	18	18	17	18	16
E - Home Care Package	10	11	12	12	13	9	6
F - Community Equipment/Adaptions	1	-	-	-	-	-	-
G - Patient/Family Choice	1	1	1	1	2	1	2
H - Disputes	-	-	-	-	-	-	-
I - Non Care Act Housing	-	-	-	-	-	-	-
O - Other	2	-	-	-	-	4	2

Table 4. Snapshot as 15/01/20 (Delays attributable to Adult Social Care)

	City	Good H.	Heartlands	MHH & WHH	Q.E.	Solihull	Totals
A - Awaiting Assessment	0	2	0	0	0	0	2
D1 - Residential	1	0	8	5	12	0	26
D2 - Nursing	3	1	3	5	4	0	16
E - Home Care Package	0	1	1	0	3	1	6
Other Delays	0	0	2	3	0	0	5

The main contributor to delays in the week ending 15th January 2020 was access to EAB and housing issues. Long term placement delays are still an issue with one Learning Disability case at the Heartlands Hospital struggling for a placement for 48 days. Assessment delays have however reduced significantly.

Balwinder Kaur, Assistant Director for Adult Social Care is leading the work with system partners on behalf of Graeme Betts, Director of Adult Social Care. This is to ensure there is a firm operational grip on the complex issues impacting on delays. In keeping with this, a workshop was held with system partners on the 14th January 2020; to gain a collective understanding of the factors which contributed to the deterioration of delays in summer 2019, and the volatility across the period shown in table 1. A set of system actions framed in the context of the work on Early Intervention and the BCF will be developed. The A&E Delivery Board will be briefed on this and receive regular updates on progress.

Birmingham Health and Wellbeing Board

Draft Forward Work Programme

2019-20 to 2020-21

Board Members:

Councillor Paulette Hamilton (Board Chair)	Cabinet member for Adult Social Care and Health	Birmingham City Council
Dr Peter Ingham (Vice Chair)	Clinical Chair	NHS Birmingham and Solihull CCG
Councillor Kate Booth	Cabinet Member for Children's Wellbeing	Birmingham City Council
Councillor Matt Bennett	Opposition Spokesperson on Health and Social Care	Birmingham City Council
Dr Justin Varney	Director of Public Health	Birmingham City Council
Professor Graeme Betts	Corporate Director for Adult Social Care and Health Directorate	Birmingham City Council
Sarah Sinclair	Interim Assistant Director for Children and Young People Directorate	Birmingham City Council
Paul Jennings	Chief Executive	NHS Birmingham and Solihull Clinical Commissioning Group
Ian Sykes	Chair, Sandwell and West Birmingham CCG.	Sandwell and West Birmingham CCG.
Andy Cave	Chief Executive of Healthwatch	Healthwatch Birmingham
Andy Couldrick	Chief Executive of Birmingham Children's Trust	Children's Trust
Dr Robin Miller	Head of Department, Social Work & Social Care Co-Director, Centre for Health & Social Care Leadership	University of Birmingham Education Sector

1

007594/2020

Chief Supt John Denley	Representative of the Birmingham Community Safety Partnership	West Midlands Police
Gaynor Smith	Senior and Employer Partnership Leader	Department for Work and Pensions
Peter Richmond	Chief Executive of Birmingham Housing Trust.	Birmingham Social Housing Partnership
Richard Kirby	Birmingham Community Healthcare NHS Foundation Trust	Birmingham Community Healthcare NHS Foundation Trust
Co – optees		
Carly Jones	Chief Executive of SIFA FIRESIDE.	SIFA FIRESIDE
Charlotte Bailey	Executive Director Strategic Partnership.	Birmingham and Solihull Mental Health Trust
Stephen Raybould	Programmes Director (Ageing Better)	Birmingham Voluntary Services Council
Toby Lewis	Chief Executive, Sandwell and West Birmingham Hospitals and NHS Trust	West Birmingham Alliance

Board Support:

Committee Board Manager
Landline: 0121 675 0955
Email: errol.wilson@birmingham.gov.uk

Business Support Manager for Governance & Compliance
Landline:0121 303 4843
Mobile : 07912793832
Email : Tony.G.Lloyd@birmingham.gov.uk

2

Schedule of Work: April 2019-March 2020

Board Meeting Date	Deadlines	Scheduled Agenda Items	Presenting Officers
Formal Meeting 30th April 2019 Venue : Committee Rooms 3 & 4, Council House, 3pm -5pm	Draft Report Deadline for Pre- agenda : 4th April Final Report Deadline: 18th April Agenda and Reports Dispatch Date: 20th April	**Presentation Items** Health Protection Report Update **PRIVATE ITEM** Health Protection Incident Report Update Birmingham joint strategic needs assessment: diversity and inclusion deep dive 2019/20 Joint strategic needs assessment update **Information Items** Feedback on Public Health Green Paper Consultation **(verbal)** Care Quality Commission Quarterly Update – Combined with Birmingham Older People Programme(BOPP) Sustainable Transformational Plan (STP) Bi – Monthly Update Proposal to relocate and improve the Adult Sexual Assault Referral Centres which serve Birmingham, Solihull and the Black Country. Primary Care Network	Chris Baggott Chris Baggott Elizabeth Griffiths Elizabeth Griffiths Elizabeth Griffiths

3

Board Development Day 14th May 2019, Venue: 10 Woodcock Street , Aston Birmingham	Time : 1pm - 5pm	**Workshop Group Discussion Items** **Health Inequalities** **Childhood Obesity**	Elizabeth Griffiths Kyle Stott
Informal Meeting 18th June 2019 Venue : Committee Rooms 3 & 4, Council House, 3pm – 5pm	Draft Report Deadline for Pre- agenda : TBC Final Report Deadline: tbc June 2019 Agenda and Reports Dispatch Date: tbc June 2019	**Themed : Place** **Discussion Items** Air Quality Update Report Active Travel Update Report Developers Toolkit Update Report Feedback on the Health and Wellbeing Board Development Session Changes Places Live Healthy , Healthy Happy STP Update Report	Duncan Vernon Duncan Vernon Kyle Stott Kyle Stott and Elizabeth Griffiths Maria Gavin Paul Jennings
Formal Meeting 30th July 2019 Venue : Committee Rooms 3 & 4, Council House, 2pm – 5pm	Draft Report Deadline draft reports : 3TH July 2019 Pre – agenda meeting – 8th July 2019 Final Report Deadline: 19th July 2019 Agenda and Reports Dispatch Date: 22nd July 2019	**Discussion Items** Development of Health & Wellbeing Board Sub-Committee structure Making every adult matter overview Complex severe mental health : Dual diagnosis /personal disorder Drug and alcohol – Change , Grow and Live : Peer mentor Birmingham older people programme : Update on the ageing well programme Homelessness overview	Justin Varney Justin Varney Tom Howell Max Vaughan Andrew McKirgan, Andy Lumb Cllr Sharon Thompson and

			Kalvinder Kohli
		Birmingham Health & Wellbeing Board Forward Plan	
Formal Meeting 24th September 2019 Venue: Committee Room 3&4, Council House, 3pm – 5pm	Draft Report Deadline for Pre- agenda : 28th August 2019 Pre –agenda meeting : 2nd September 2019 Final Report Deadline: 13th September 2019 Agenda and Reports Dispatch Date: 14th September 2019	**Presentation Items** Suicide Prevention Strategy NHS Long Term Plan: BSOL CCG Response Health and Wellbeing Board Priorities Update: Health Inequalities, Forward Trajectory CAMHS Access and Mental Health Pathway Improvement **Information Items** JSNA Deep Dive Forward Plan Public Health Priorities Green Paper Response Better Care Fund Governance Agreement Report **Private Items** NHS Long Term Plan: BSOL CCG Response	Justin Varney Harvir Lawrence Justin Varney Carol McCauley Harvir Lawrence

5

Formal Meeting 26th November 2019 Venue: N/A	Draft Report Deadline for Pre- agenda : 30th October 2019 Pre – agenda meeting : 4th November 2019 Final Report Deadline: 14th November 2019 Agenda and Reports Dispatch Date: 15th November 2019	**Cancelled due to Pre-Election Preparation Period**	
Formal Meeting 21th January 2020 Venue: Rooms 3 & 4, Council House, 3pm -5pm	Draft Report Deadline for Pre- agenda : 2nd January 2019 Pre – agenda meeting : 6th January 2020 Final Report Deadline: 9th January 2020 Agenda and Reports Dispatch Date: 13th January 2020	**Presentation Items** Creating a Healthy Food City Forum Update JSNA Deep Dives – Progress Report NHS Long Term Plan West Birmingham Alliance Update **Information Items** Health and Wellbeing Board Fora updates Public Health Budget **Private Items** JSNA Core Data Set – Children and Young People Chapter	Kyle Stott Paul Campbell Harvir Lawrence Toby Lewis Paul Campbell Dr Justin Varney Dr Justin Varney

6

Formal Meeting	Draft Report Deadline for Pre- agenda : 19th February 2020	**Presentation Items**	
17th March 2020 Venue : Rooms 3 & 4, Council House – 3pm -5pm		Better Care Fund 2019/20 Plan	Mike Walsh
		Creating a Mentally Healthy City Forum Update	Elizabeth Griffiths
Peter Ingham to Chair	Pre – agenda meeting : 24th February 2020	JSNA Core Data Set – Children and Young People Chapter	Ralph Smith
	Final Report Deadline: 5th March 2020	Pre-Conception Conversation	Marion Gibbon
		Birmingham Forward Steps / Early Years Contract	Richard Kirby
	Agenda and Reports Dispatch Date: 6th March 2020	Families in Temporary Accommodation	Saba Rai
		East Birmingham Corridor Consultation	Mark Gamble
		Triple Zero	Chris Baggott
		Coronavirus Update	Justin Varney
		Information Items	
		Health and Wellbeing Board Fora updates	
		ICS Update	
		Delayed Transfers of Care workshop Feedback	
		Private Items	
		Director of Public Health Annual Report	Justin Varney
		JSNA Core Data Set – Working Age Adults Chapter	Ralph Smith

Development Day			
28th April 2020 Venue: TBC	Draft Report Deadline for Pre- agenda : 1th April 2020 Pre – agenda meeting : 6th April 2020 Final Report Deadline: 16th March 2020 Agenda and Reports Dispatch Date: 17th March 2020	TBC	TBC

Formal Meeting		Presentation Items	
July 2020		Appointment and Terms of Reference	TBC
		Social Prescribing	Pip Mayo
		Birmingham Community Safety Partnership Consultation	Amelia Murray
		Creating an Active City Forum Update	Kyle Stott
		JSNA Core Data Set – Working Age Adults Chapter	Ralph Smith
		JSNA Core Data Set – Needs of Older People Chapter	Ralph Smith
		JSNA Core Data Set – Wider Determinants Chapter	Ralph Smith
		JSNA Deep Dives – H&WB of Armed Forces Veterans in Birmingham(TBC)	Susan Lowe
		JSNA Deep Dives – Death and Dying in Birmingham (TBC)	Susan Lowe
		JSNA Deep Dive – H&WB of Public Sector Workforce in Birmingham (TBC)	Susan Lowe
		JSNA Deep Dive – Diversity and Inclusion (TBC)	Susan Lowe
		Information Items	
		Health and Wellbeing Board Fora updates	TBC
		Sustainability and Transformation Plan Update	Paul Jennings
		Healthwatch Birmingham Annual Report	Andy Cave

9

Formal Meeting September 2020		**Presentation Items**	
		Health Protection Forum Update	Chris Baggott
		Information Items	
		Health and Wellbeing Board Fora updates	TBC
Formal Meeting November 2020		**Presentation Items**	
		Creating a City without Inequality Forum update	Monika Rozanski
		JSNA Deep Dive – topic TBC	Susan Lowe
		Information Items	
		Health and Wellbeing Board Fora updates	TBC
		Sustainability and Transformation Plan Update	Paul Jennings
Formal Meeting January 2021		**Presentation Items**	
		Creating a Healthy Food City Forum Update	Kyle Stott
		JSNA Deep Dive – topic TBC	Susan Lowe
		Information Items	
		Health and Wellbeing Board Fora updates	TBC

10

Formal Meeting		Presentation Items	
March 2021		Creating a Mentally Healthy City Forum Update	Mo Phillips
		JSNA Deep Dive – topic TBC	Susan Lowe
		Information Items	
		Health and Wellbeing Board Fora updates	Paul Campbell
		Sustainability and Transformation Plan Update	Paul Jennings
Development Day			
April 2021		Health and Wellbeing Board Priorities – Review and Refresh	TBC

Standard Agenda

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

Notes

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

Health Inequality Focus and Childhood Obesity Focus agenda presentations can be several items if appropriate but all must include decision(s) and / or action(s) for the Board.

Health and Wellbeing Board Fora will provide a written update to each Board meeting; each will have an annual formal presentation to the Board on a rotational basis.

Any decisions and actions shall be subject to providing an update to the Board on the substantive outcomes, either via presentation or information item as deemed appropriate by the Board, at a future date to be agreed as part of said decision or action.

Supporting Documents Requiring Development

Agenda change request form
Report draft template
Report final template
Action / Decision request form
Action / Decision update report template