BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD

TUESDAY, 16 MARCH 2021 AT 15:00 HOURS
IN ON-LINE MEETING, MICROSOFT TEAMS

A G E N D A

1 **NOTICE OF RECORDING/WEBCAST**

The Chair to advise/meeting to note that this meeting will be webcast for live or subsequent broadcast via the Council's 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.
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.

1 - 18

5 **MINUTES AND MATTERS ARISING**

To confirm and sign the Minutes of the meeting held on the 19 January 2021.

19 - 30

6 **ACTION LOG**

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 5 March 2021. Lines of questioning should be submitted via:
https://www.birminghambeheard.org.uk/place/birmingham-health-and-wellbeing-board-questions
(No person may submit more than one question)
Questions will be addressed in correlation to the agenda items and within the timescales allocated. This will be included in the broadcast via the Council's Internet site (www.civico.net/birmingham).
NB: The questions and answers will not be reproduced in the minutes.

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9 **BIRMINGHAM INTEGRATED CARE PARTNERSHIP**

Director for Adult Social Care

49 - 54

10 **BETTER CARE FUND**

Michael Walsh – Head of Service, Commissioning

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11 **JSNA - OLDER ADULTS CHAPTER**

Dr Marion Gibbon, Assistant Director of Public Health

12 **CORONAVIRUS-19 POSITION UPDATE**

Justin Varney, Director of Public Health

13 **CORONAVIRUS-19 VACCINE UPDATE**

Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG

14 **CORONAVIRUS-19 INEQUALITIES & RECOVERY DISCUSSION**

111 - 130

15 **BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM INEQUALITIES WORK PROGRAMME**

Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS

16 **FORWARD PLAN REVIEW**

Councillor Hamilton - Verbal Update

131 - 164

17 **WRITTEN UPDATE FROM THE LOCAL COVID OUTBREAK ENGAGEMENT BOARD**

Information Item

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18 **WRITTEN UPDATES FROM FORUMS**

Information Item

19 **OTHER URGENT BUSINESS**

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

20 **DATE AND TIME OF NEXT MEETING**

To note that the next Birmingham Health and Wellbeing Board meeting will be a Development Session and will be held on Thursday 29 April 2021 at 0900 hours as an online meeting.

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD TUESDAY, 19 JANUARY 2021

MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON TUESDAY 19 JANUARY 2021 AT 1500 HOURS AS AN ONLINE MEETING

PRESENT: -

Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and Chair of Birmingham Health and Wellbeing Board
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Councillor Kate Booth, Cabinet Member for Children's Wellbeing
Andy Cave, Chief Executive, Healthwatch Birmingham
Andy Couldrick, Chief Executive, Birmingham Children's Trust
Mark Garrick, Director of Strategy and Quality Development, UHB
Chief Superintendent Stephen Graham, West Midlands Police
Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG
Carly Jones, Chief Executive, SIFA FIRESIDE
Nichola Jones, Assistant Director, Inclusion and SEND, Education and Skills
Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS Foundation Trust
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Peter Richmond, Chief Executive, Birmingham Social Housing Partnership
Professor Robin Miller, Head of Department, Social Work and Social Care, Health Services Management Centre, University of Birmingham
Stan Silverman, Interim Clinical Chair, NHS Birmingham and Solihull CCG
Dr Ian Sykes, Sandwell and West Birmingham CCG
Dr Justin Varney, Director of Public Health, Birmingham City Council

ALSO PRESENT:-

Damilola Agbato, Programme Senior Officer, Public Health, BCC
Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG
Paul Campbell, Public Health Service Lead - Wider Determinants, Public Health
Dr Marion Gibbon, Acting Assistant Director of Public Health
Stacey Gunther, Service Lead – Governance, Public Health
Lucy Heath, Healthy Futures, Black Country and West Birmingham
Karen Helliwell, BCC CCG
Carol Herity, NHS Birmingham and Solihull CCG
Pip Mayo, Managing Director - West Birmingham, Black Country and West Birmingham CCGs
Patrick Nyarumbu, Executive Director of Strategy, People and Partnership, Birmingham and Solihull Mental Health NHS Foundation Trust
Monika Rozanski,

Ralph Smith, Service Lead, Knowledge Evidence and Governance
Kyle Stott, Public Health Service Lead, Place
John Williams, Assistant Director, Adult Social Care
Errol Wilson, Committee Services

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NOTICE OF RECORDING/WEBCAST

506 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

507 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

508 Apologies for absence were submitted on behalf of Professor Graeme Betts, Director for Adult Social Care and Health (but John Williams as substitute); Dr Peter Ingham, Clinical Chair, NHS Birmingham and Solihull CCG (but Stan Silverman as substitute); Toby Lewis, Chief Executive, Sandwell and West Birmingham NHS Trust; Waheed Saleem, Birmingham and Solihull Mental Health NHS Foundation Trust (but Patrick Nyarumbu) and 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:

509 **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

510 **RESOLVED: -**

The Minutes of the meeting held on 24 November 2020, having been previously circulated, were confirmed.

ACTION LOG

The following Action Log was submitted:-

(See document No. 1)

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

511 **RESOLVED: -**

The Board noted the information.

CHAIR'S UPDATE

512 The Chair welcomed everyone to the meeting and stated that it had been an extremely challenging few weeks and that she knew how extraordinarily busy our health colleagues continue to be with the new variants of Covid-19 that had put unprecedented pressures on our health and hospital settings.

The Chair stated that she was pleased that the new national lockdown imposed earlier this month appeared to be working as infection rates were gradually lowering - although the pressures within our hospitals may not yet have peaked.

The Chair highlighted that our Public Health team had been recruiting Covid-19 Champions and that she was delighted that we now had our 500 Covid champions. She added that our Covid champions played a vital role in ensuring our communities receive regular factual updates of the latest advice and guidance, with weekly webinars on key topics as well as the opportunity for them to share their insights and concerns. Through their local knowledge and networks, and by being a part of their communities, they could help us reach residents including those whom we may not reach in other ways. The Chair further stated that we were keen to increase the number of Covid Champions as we really do need to ensure we try and minimise the amount of mistruths being circulated in our communities. She encouraged those that would like to

help to please look at the Council's website and sign up to be a Covid Champion as she also was one of the champions.

The Chair stated that last week she was chairing an event with her LGA hat on responding to the Department of Health guidance on the establishment of Integrated Care Systems (ICS). She added that she welcomed the direction of travel and the role of Health and Wellbeing Boards going forward will have a significant part to play in the development of ICSs.

The Chair highlighted that moving on to today's agenda we have an action packed agenda and that she was delighted that we had Paul Jennings with us today to talk about the vaccine rollout as she knew that this was something of great interest to us all.

PUBLIC QUESTIONS

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

CORONAVIRUS-19 POSITION STATEMENT

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

(See document No. 2)

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

a. Dr Varney noted Dr Manir Aslam's queries concerning engagement with the vaccination programme and the level of misinformation around the vaccine being targeted to the groups that were most likely to be affected by Covid … and conversations with older Asian women and older members from the Black community who were saying that they did not want to take the flu and the Covid vaccines because of the misinformation. He added that Jane Salter Scott from Sandwell and West Birmingham was linking with us and Gemma from the Birmingham and Solihull CCG. We had been doing a number of awareness sessions.

b. With the Covid Champions we were running a three part vaccination education programme which was based on explaining what was a vaccine how it worked and how the Covid vaccine worked and were doing similar work with our faith leaders which covered different faith groups and with the community engagement partners which was focused on both ethnic and other dimensions of identity communities in the city.

c. We were working closely with the two CCGs engaging with their leads and ensuring that these were connected up and joining up the dots. We were taking an approach which was around promoting the fact and dispelling some of the myths rather than having arguments with Covid

anti-vaccinators which we knew was not productive. The reason there was misinformation being circulated was the pressure of social media which was difficult to undo.

d. We had put a lot of effort into making sure translated materials were available in people's first languages. It was thought that the most important aspect of this was the Covid Champions as people trust most what they got from people that they cared about most and that was the whole premise of the Covid Champions working through people's personal networks to provide accurate and factual information to them.

e. Dr Varney noted the Chair's enquiry concerning what work was being done with health professionals that could go out into some of those communities and advised that Public Health had provided the opportunity for the NHS to put forward spokes people.

f. Dr Sonia Ashcroft joined with him on Monday 18 January 2021 to meet with the Inter-Faith Leader Groups and members of the Asian community and local GPs. We had been doing this and as spokes people put forward by the NHS and we were working closely to mapped them into the speaking opportunities with the engagement sessions that we had to maximise that and will continue to do so as this vaccination programme moved forward.

The Board noted Dr Varney's slide presentation.

BIRMINGHAM AND LEWISHAM AFRICAN CARIBBEAN HEALTH INEQUALITIES REVIEW

Dr Justin Varney, Director of Public Health introduced the item and advised that the report was to give the Board an update on progress in relation to the Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR). Dr Varney then drew the attention of the Board to the information contained in the report.

(See document No. 3)

The Chair commented that this was something she was passionate about as she believed that we had to get to the issues why communities felt that they were being discriminated against and why certain inequalities kept happening. The Chair added that she knew how difficult this had been to get it off the ground to get to some of the key points that we needed to get to in order to start making change. For her as somebody who was African Caribbean and was in the community, she was trying to ensure that we engaged with the community as much as possible.

The Chair enquired whether the work with Lewisham particularly the issue about people wanting to remove the term 'black'; whether we had really started to get to the crux of what the issue was as to her this was not what she thought was a major issue.

Dr Varney gave the following response:-

- ✓ It ought to be remembered that this was an 18 months process and, in many ways, when we had been reflecting after the first meeting. The reason we talked about racism and discrimination in the first meeting was to some extent the topic, but knowing that this would be the one where there were many recommendations that would impact on it but would playout through the more specific topics as the system moved forward.

- ✓ The reason he had highlighted the one around language and monitoring was that although in many ways people would step back and say – oh that was not big a deal – both panels felt strongly about it and talked about the negative connotation about the language of black and the word black was associated which was quite uniquely associated to the African and Caribbean community compared to the Asian community. Colourism was described as something that was played out in people particularly in children's development.

- ✓ We talked about what was right or wrong, we talked about black and white so this was the way they had articulated these recommendations which very much came from them. What was important for the Board to recognised was that through each of these sessions we will build more and more recommendations. It was through the totality of these actions that we would see the shift of the community.

- ✓ We were quite firm with the Boards to get to concrete tangible deliverable outcomes. They were not ready at this point for the Board to see a version of these recommendations which the BLACHIR recommended that the Council did this by then. There were smart recommendations coming, but we wanted to bring those back to future Board with a full write up after the first meeting.

- ✓ Currently, because of the pressures in Lewisham who were leading that write up they were not able to get that done in time for today's Board meeting. There will be concrete smart recommendations for the review and they tied back to the evidence base and the lived experience of the people on the two Boards. It was the totality of the review that would achieve the step change and we should see each of these recommendations as a step forward in that direction.

Richard Kirby commented that the newly formed Birmingham and Solihull ICS Equalities Work Stream provide a place where we could pick up the insights from this review for the NHS in the city. He undertook to contact Dr Varney concerning the issue.

Andy Cave commented that it was interesting to hear some of those initial findings from this and a lot of it resonate with our report for the Somali community which had been published recently around discrimination, cultural language difficulties and diagnosis and referral where discrimination fits within that for health and social care services. It was interesting to see how those two report married up.

- ✓ Dr Varney advised that the Somali piece of work was feeding in as some parallel piece of work as we moved into this next session with them on pregnancy where Lewisham had done some good work on insight to maternal care with African and Caribbean mothers which was feeding in directly.

- ✓ One of the advantages we had with this joint partnership was that we were drawing all of this insight from local Healthwatch, maternal improvement partnerships etc. in from both areas and being able to draw across. The plan was that they would bring back to the Board probably at alternate meetings an update on the previous session or segments but also the completed chapters of the review.

- ✓ The aim was to bring the chapters as they were completed rather than wait for the final report at the end. As Mr Kirby alluded to there was a link with the Birmingham and Solihull Inequality work stream and similarly with Black Country and West Birmingham Inequality work stream and keeping both of our NHS system partners emerging inequalities narratives linked into this and the wider work of the Health and Wellbeing Board.

515 **RESOLVED: -**

The Board

i. Acknowledged the progress made by the BLACHIR project;
ii. Noted the new model that is being developed between the two Local Authorities; and
iii. Agreed to support the identified recommendations and promote outcomes to reduce health inequalities.

CORONAVIRUS -19 VACCINE UPDATE

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

1. We now had a third more patients in hospital beds with Covid-19 than we did towards the peak in April 2020. We had 150 people or thereabout in intensive care in the three University Hospitals Birmingham (UHB). There were more patients in Sandwell and West Birmingham (number not at hand).
2. We were having to pull out all the stops in terms of mutual aid and with colleagues who were working across the system working in different places in different roles to ensured that we kept our care system running. A story you often heard repeated but was worth repeating here – this was only working because of the marvellous collaboration with teams between organisations and systems.
3. If we did not had such close working with the community trust and care system, moving patients between the system, moving patients home, finding care for patients at home, finding other places for patients to go –

if we did not had that in place we would not had the beds we had in the hospital system for those patients we were now seeing with Covid-19.

4. The average age of those in ITU at the moment was 58 years old. This virus will strike wherever it strike and we all needed to be aware of it and needed to be conscious about doing whatever we could to resist it and follow the rules we needed to follow. The good news was that the vaccine had being received just before Christmas we started our vaccination programme.
5. That he was unable to say how much vaccines were delivered in Birmingham at present, but that he was unable to say as they were still having to work their way through the information systems and ensured that it worked properly to give the information. Over the last few weeks the programme had been escalated, building more capacity and we had run our system in such a way that we had virtually eliminated any wasted vaccine.
6. There were sometimes technical reasons where we could not use certain things but we had worked hard to ensure we got maximum benefit out of this. We had 27 sites operating across primary care excluding the sites that were also operating in West Birmingham. We had hospital hubs running at the Queen Elizabeth, Heartlands, Good Hope, Birmingham Children's Hospital and the Royal Orthopaedic Hospital. All of these were offering facilities for health and care workers and the over 80s which were our key target group.
7. In Primary Care we were focussing on the over 80s but also seeing health and social care workers. We had a massive programme to immunise those in care homes and were on target to finish all the care homes that we needed to visit within the next week or so. We had a lot of care homes within our system – 194 care homes – which was registered for older people.
8. We were now starting a programme of immunisation for the housebound. That he was confident that they would be able to work their way through those first few cohorts that had been identified by the Joint Committee on Vaccinations and Immunisations within the time scale we had been given to do it.
9. As anticipated the vaccine did not all flow at once, as the system gradually build up, we saw more and more coming through. We had capacity to get more and the more we could get we would made use of. It was not a competition, but it was known that the Midlands was a region that stood out a few days ago as having immunised the most number of people in this region. We were confident that in Birmingham and Solihull we were doing well in terms of making that work.
10. Mr Jennings expressed thanks to all for their work and a special word of thanks to those in Primary Care many of whom had been working 7 days per week since Christmas to make this programme work. They worked long days to ensure that nothing got wasted. GPs were leaving their surgeries at 2130 hours to find people to be vaccinated. The atmosphere in the vaccination centres was fantastic. The sense of those who were engaging in the vaccinating knowing they were doing good work was uplifting after a year of what felt like being downtrodden.
11. It was an emotional experience to see many of the folks who were coming forward for immunisation amongst the older cohorts, some of these people had not left their house now for the best part of a year,

coming out to receive their vaccine and beginning to see a light that came back on as we started to see a world that we recognised and as we began to meet with people. We were not there yet, but we were on our way and it was coming and was a fantastic piece of work that people were engaged in.

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

i. There was really little to over and above what Mr Jennings had stated. When we set out on the vaccination programme, we agreed that we needed to joined up the approach across Birmingham so that it was coherent for the population across the patch.
ii. All of our Trusts across the Black Country and West Birmingham and hospitals were doing the same as the ones were doing across the rest of Birmingham – vaccinating the local health and social care workers and were ensuring that older people who were going to the hospitals were vaccinated before discharge.
iii. Four Primary Care Networks (PCN) in West Birmingham were also vaccinating and using the same criteria as were implied for the PCNs in the rest of Birmingham. We had two sites that were operating on that. A couple of our PCNs came together so that they could deliver something slightly more at scale.
iv. Exactly the same observations as Mr Jennings stated. Having been able to attend our vaccination sites was probably one of the nicest things she had done for a while, seeing the smiles on people's faces as they got their vaccinations was fantastic. Also the boost to the Primary Care workforce as they had been working hard in relentless times to keep going.
v. One of the GPs commented that he might blew up the comments that were placed on the feedback forms from the vaccination centre and put them on his walls to keep him going on days when the work got tough. These were positive messages coming through and good work. We had exactly the same things happening in terms of care homes and was the same as the rest of Birmingham.

Councillor Bennett enquired What percentage of care home residents had been vaccinated and when do we expect to have done them all. There have also been reports in the press that up to a fifth of care home staff (nationally) have refused vaccinations. What the comparable figure for Birmingham was and how is this was being addressed.

Mr Jennings advised that within about a week we would finish the care homes in Birmingham. He added that the only powers we had were persuasions with care home staff, but we were increasing and starting to win that battle as colleagues had become encouraged. In terms of the information, we feed all of our vaccinations information to a system called Pinnacle and some of the connections of the system was not fully functioning yet. However, we got for the first time regional data over the weekend and it was understood that we would be getting weekly data by way of ICS, STPs later this week and it was hoped that we would have this soon. It was thought that the view which had been taken was that we did not want to give the information out until we were

absolutely certain that the information was correct as people wanted to know how many was done at each surgery, which hospital, how many had been done in each constituencies and in each Ward etc. Until we were able to give information that would answer the questions that the Board would rightfully want to asked, they were working on it but we were not quite there yet.

Councillor Bennett enquired whether we had an idea or sense of how this stocked up in Birmingham and on a practical level what could a care home do as they could not make people, but they could try and persuade them. He suggested that there was a risk management issue there and how this would work in practice or going to work in practice.

Mr Jennings advised that in practice you cannot change someone's employment status because they chose or chose not to have the vaccine. He stated that he understood that there were some care homes that were now saying that they would only take staff if they could demonstrate that they were vaccinated. This could be set as a rule at the beginning, but it could not be set mid-course. Mr Jennings stated that he had no information as to the level of resistance we had currently as he did not have access to that information. He added that he did not know anyone who would claim to know the numbers that were turning down the vaccine at this stage as it was so early in the process.

Stan Silverman, Interim Clinical Chair, NHS Birmingham and Solihull CCG echoed Mr Jennings and Ms Mayo's comments concerning the vaccination programme. Mr Silverman urged that everyone that after their first vaccination they were not immune to the virus and it was important to maintain social distancing, wearing a mask and washing your hands. All the physical things that reduces getting the infection and passing it on at least two or three weeks after your second dose.

Stephen Raybould, Programmes Director, Ageing Better, BVSC commented that the voluntary sector was keen to help around vaccine and to engage with those communities that were struggling. There was no data available yet either on a geographical or community of interest. He enquired at what point this would become available so they could start to make some headway there. The data around location and distribution of the sites would be useful and what the availability was across the city.

Mr Jennings advised that there were 27 local sites across Birmingham and Solihull and there were four in West Birmingham as stated earlier by Ms Mayo which makes 31 sites across the patch. Given the geographical size of Birmingham and Solihull this meant that most people could not be far away from one. There was millennium point which came on last Monday and there were other potential mass sites to be made available. It was thought that for most local people it was the local sites that they would be interested in as there were 31 of those.

Mr Jennings added that in terms of the information, the only information he had was that they were anticipating information by ICS later this week. The point at which we got this down to that granularity he was not sure. This was not a sprint it was a marathon and we will be on this vaccination programme for

another six months before we got to the end of it and there would be time to pick these issues up as we go along.

Dr Justin Varney advised that he had joined the National Vaccination Group which was hosted by the Local Government Association (LGA) to influence the development of the vaccination data to reporting to the directors of West Midlands Public Health. Dr Varney added that he was plugging in to some of those national developments at the moment.

The Chair commented that Dr Varney had been on this since the beginning of January 2020 and had done an exceptionally good job of ensuring the voice of Birmingham was heard across the country. The Chair expressed well done to Dr Varney and encouraged him to keep up the good work.

The Chair placed on record that we needed to start seeing some of that granular data as without it the vaccine hesitancy would continue to grow. People needed to know what was happening as that was part of the transparency that was needed at a local level.

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG commented that the hesitancy point was important. At the moment in our over 80s we had vaccinated about 55% (could be slightly higher), but that portion of the 45% of people that we had not vaccinated was not because we had not asked them. Some were refusing and some were taking the wait and see approach and in the same way with the flu vaccination. There was a piece of work to do. Vaccinating 50% of the population did not get us out of this mess, we needed to vaccinate a significant part of the population to get to our herd immunity. There was something important about that communication, that message about the hesitancy, not just the care workers but throughout our communities that it was important going forward.

The Chair commented that it is meant for us to work together concerning the hesitancy because the distorted information about the vaccines had caused more problems in some of those inner-city communities than anything else. The Chair stated that we needed to have this discussion and that she agreed with Dr Aslam's statement that it was an important point. It was not just the care workers, but people who were listening to the nonsense being spouted. They genuinely felt that it was true so unless we educate people, we were not going to get them to change.

Dr Aslam commented that the information that came out nationally was a trusted source and GPs and Primary Care Networks were a trusted source of information so that when they had that conversation, they were more likely to have the vaccination whether it be the flu vaccination or the Covid vaccination. We just needed to think through that process.

WORKING TOGETHER FOR A HEALTHIER POST-COVID FUTURE

Lucy Heath, Healthy Futures, Black Country and West introduced the item and drew the attention of the Board to the information contained in the slide presentation.

(See document No. 4)

Dr Aslam stated that we were on a cusp in West Birmingham, the Black Country and the rest of Birmingham. The decisions we make and the approaches we take were sensitive to the demographics of the needs of our communities. Dr Aslam enquired how we got a kind of the values of scale and continue to focus on individuals and population. How do we get that balance as this work you were doing was a function of that and the work of the Combined Authority will have some of the same as well. How do we work together so that we get the benefit of scale but it was focussed on individuals and communities.

Ms Heath advised that this was challenging and that we were facing that challenge in more than just this area as we were trying to get the balance between system and place and things like the West Midlands Combined Authority working about place. Ms Heath added that in her view we should be focussed on place and supporting work for that place and encouraging that with sharing of what happened at place so that people could learn it adopted it and spread it where it was appropriate and we could look up that shearing and learning as well so that spread was on a wider ICSs which might be her bid.

Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS Foundation Trust enquired whether BCHNFT could do some work together with Ms Heath (the answer which would be yes). The reason he had suggested it was that it built a bit on the point we were having. We were organising a similar ICS wide work stream to look on inequalities within Birmingham and Solihull. Mr Kirby added that with the Chair's permission he would like to bring a summary of what they were trying to do at a future HWB meeting and to do it for the Board's approval.

Mr Kirby stated that one of the things they were looking at in that was trying to find a way to build a model for really good Neighbourhood Primary Care Network level community engagement and work on things that drove local health behaviours and outcomes. This he thought would fit this framework well and answered Dr Aslam's point about how we balanced the small scale neighbourhood work with the wider work Ms Heath shared. Ms Heath might be ahead of us with the microwork but we might have something to share with the micro-end and it was hoped that they could put the two together. Perhaps he could set out the Birmingham and Solihull work similarly at a future HWB meeting that would be helpful.

Andy Cave, Chief Executive, Healthwatch Birmingham commented that across the Black Country and West Birmingham there were five local Healthwatch so it would be good to have one of us named as somebody to support that and would have that conversation from an Healthwatch level so we could support the work.

Ms Heath advised that as part of this they did had an interview with some of our Healthwatch colleagues coordinated by Tracey Creswell to feed into reports. Ms Heath agreed with Mr Cave that they needed to think about how they carried on working together and would take the recommendations forward.

Carly Jones, Chief Executive, SIFA FIRESIDE commented that the report was an interesting one and a lot of the things that came out were prevalent markers for what put people at risk of homelessness. The housing issues, quality of housing employment income and was the kind of analysis that stopped short of encapsulating that cohort around the risk of homelessness. Ms jones added that she would share something in the feedback survey as that would be helpful. When you spoke of specific groups, that was the specific group she was talking about and the generational issues of being at risk of homelessness as people were in poor quality housing and their physical health was deteriorating as a result etc.

Stephen Raybould commented that they were engaging in structures that Mr Kirby spoke about. It was thought that the voluntary sector contribution had been around information that was coming up from the ground from the different communities. When the report was finished, they would certainly be interested in disseminating the information around the next steps and would be happy to take that forward.

517 **RESOLVED: -**

The Health and Wellbeing Board input was requested into: -

- What priority should be given to each of the target socio-economic outcomes, and why?
- Are there additional intervention mechanisms that should be considered for realising the target outcomes?
- What specific candidate interventions might be considered?
- Are there specific population cohorts that whole-system action should focus on?

Feedback from the Birmingham Health & Wellbeing Board on these key questions will be fed into a report to the Healthier Futures Partnership Board in January 2021.

IMPACT OF ECONOMIC SHOCK ON HEALTH AND WELLBEING

Dr Marion Gibbon, Acting Assistant Director of Public Health and Damilola Agbato, Programme Senior Officer, Public Health, BCC presented the item and drew the Board's attention to the information contained in the slide presentation.

(See document No. 5)

Dr Aslam commented that this was a fantastically important piece of work and that what would be ideal here was to get a sense of what the economic impact was going to be in terms of unemployment. Dr Aslam enquired whether there was any modelling in terms of the number of people that were likely to be unemployed – ones that were furloughed. It was needed to get a sense of normality. In general practice we had tried in the last couple of years with the work programme to help people with getting back into work when they were using primary care services. The impact of that was good, but we needed to put that on *steroids* to get it moving for the volume of people that would be

unemployed in this environment and to create all our services to cope with that earlier intervention as in most situations it was more beneficial.

Mr Agbato advised that at the moment we had an indication of what the account was for the Birmingham area and the West Midlands. But quite a significant number of people were still on furlough and we did not know where that was going to go if some of those organisations were still going to open up and still be in business after that programme ends and how long it was going to be on for. We had an indication now and some numbers that we were working with in building that model.

Dr Gibbon stated that it was scare from the data that we had that was available. The numbers were in the thousands and would be a significant issue.

Dr Aslam enquired whether there was a programme of work that tells us about the skills of the new workforce in this new economy that developed post Covid. It would not go back to being exactly the same. Dr Aslam further enquired whether there a sense of what it might look like and how could we get the right people with the right skills to be ready for that environment if they were not working straight away.

Dr Gibbon advised that the King's Fund was doing some work in this area and there was other pieces of work that was being done to look at this as an issue. This was the next step as it was done in phases which will be one of the next pieces of work that we hoped to take forward from this. Mr Agbato advised that they were also linked with the Skills and Advice Employment Unit within the Council and was working with them and getting data from them looking at youth unemployment as well as a component of this. The work they were doing in trying to help with skills development and employability so they would also be a good source of information in terms of the skills set industries were requiring as the pandemic begins to wind down.

Mr Raybould commented that one of the big challenges were around systems and the working age population and getting interventions into people at the point at which they would need it quickly. He enquired whether there was any thought within this work as to how this could be kick-started following the pandemic.

Dr Gibbon advised that Dr Varney had a piece of recovery work that would take this forward. Dr Varney was intending that we had a Covid recovery strand of work within Public Health and would be able to share more of what was intended in due course.

518 **RESOLVED: -**

The Board noted the progress detailed in the report.

CREATING A HEALTHY FOOD CITY

519 The Chair advised that this item would be deferred to a future meeting.

Paul Campbell, Public Health Service Lead - Wider Determinants, Public Health stated that most of his updates were in the papers and if there were any questions people could get back to him. He added that the one thing that was time critical was that they were looking at holding a Workshop in early February 2021 to develop the Emergency Food Plan. This was a set of actions across the system partners and across Birmingham to try and mitigate the negative impact on the food system and food behaviour of the people of Birmingham based on the on-going Covid situation and the recent exit from the European Union.

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

Dr Justin, Varney, Director of Public Health introduced the report and advised that this was the report that was presented in draft just prior to the first national lockdown in 2020 which was now being properly type-set and formatted and was due for publication.

(See document No. 6)

Dr Varney stated that the Board was asked to note the report's previous publication and note the recommendations for action. Dr Varney advised that the annual Public Health report for 2021 would hopefully be presented at the next Board meeting so that we will get back into the right time frame. Unfortunately due to Covid-19 we were not able to complete this last spring.

Dr Varney highlighted that immense work had gone into this report and that he was particularly grateful to Monika Rozanski and his team who had led on the coordination on this report, but also to our partners in the community voluntary sector and not least the service users themselves and the citizens whose voices was threaded throughout the report. One of the challenges in writing reports like this was that it was easy to look at the numbers and forgot the people behind them. Dr Varney added that he was incredibly proud of what the team had done working with working with the researchers and citizens voices to tie every recommendation in this report into the stories of being Dionne that had threaded through it, but also the feedback from the focus groups and the staff working on the frontline to help shape and ensured that the recommendations would lead to meaningful change in our city for adults with multiple and sustained complex needs and challenges.

The Chair echoed Dr Varney's comments and stated that it had been a while, but when the report was completed it was a shame that it had taken us until now to show some of that good work. The Chair encouraged the Board to read the report and to feedback anything that could be done better. She added that Ms Rozanski had done a lot of work talking to others and this had been an interesting piece of work. The Chair expressed well done to the team for their hard work concerning the report.

520 **RESOLVED: -**

The Board:-

a. Noted the contents of the report; and

b. Agreed to support the identified recommendations of the report.

JSNA – ADULTS CHAPTER

Ralph Smith, Service Lead, Knowledge Evidence and Governance introduced the item and advised that the report was paused at the start of the pandemic. Mr Smith stated that some of the Public Health staff were able to move back to business as usual and had un-paused certain bits of work and this chapter of the Joint Strategic Needs Assessment (JSNA) was one of them.

(See document No. 7)

Mr Smith stated that the Health and Wellbeing Board's approach to the JSNA took on a life course approach and the first section of that for children and young people was approved by this Board early last year. The working age adult which was the one being tabled today and the next life course and finally one on older adults. The document available today had been around a few internal and external stakeholders and officers around the Council and contacts through the Board. It had been commented on a lot and all the comments were included in the document. Mr Smith advised that Dr Varney had taken it to the Corporate Leadership Team recently and gave them a final opportunity to comment on it. Mr Smith stressed that as it was a pre-pandemic document a considerable amount of the data was out of date and the document had not mentioned Covid at all. In some ways this could be a criticism of the document, but as we had done so much work on it, we were keen to get it out.

The Chair commented that it was know that the information was out of date and enquired whether there were more up to date figures that could be shared.

Mr Smith advised that when the up to date figures were requested, they were dealt with on a case by case basis. There was always the opportunity to revisit this document and update it not only with updated data but focussed on the bits of the JSNA that Covid had the biggest impact upon.

Dr Varney clarified that the decision that was made that they should publish the JSNA as complete as was as if we were going to publish it last spring as there had not been the capacity in the Public Health team to update the dataset as we had been doing Covid things. The aim was that by March the Board would have the final section completed and then over the next year we would do a refresh. This as you may recall was a substantive JSNA to rebased line the JSNA for the partnership and to do update as we move forward after we had this baseline published.

The Chair commented that presently there was a lot of work going on with the ICS and sought assurance that the figures being given to the ICS were up to date figures.

Dr Varney advised that any time we received a request from any of the partners we provide up to date data. It was just the publication of the JSNA, we did not have capacity during the Covid pressures to be able to update the whole document in real time. We were competing it as it was as this one was due to

come to the March Board in 2020, but because of the Covid we stood down the work and diverted to Covid focus. It was being deferred and sat on the shelf but we did not have the capacity to write it at this point. Any individual request that came through for local strategic operations were getting up to date data provided.

521 **RESOLVED: -**

The Board:-

a. Approved the publication of the Working Age Adults Chapter of the Birmingham Core JSNA; and
b. Noted the document was written in the pre-Covid era. The content will be refreshed in 2021/22 to include Covid data/impact.

DEVELOPER TOOLKIT

Kyle Stott, Public Health Service Lead introduced the item and drew the Board's attention to the information contained in the report.

(See document No. 8)

522 **RESOLVED: -**

The Board:-

a. Noted the role of the toolkit; and
b. Endorsed the toolkit and offered support to embedding of the toolkit throughout Birmingham City Council processes*

*At this early stage it is envisaged that the toolkit will supplement planning guidance and be routinely considered by applicants seeking planning consent and their associates, for example architects and developers.

*The toolkit has been endorsed by the Corporate Leadership Team (CLT) on the 30th November 2020, and it has been endorsed by the Creating a Physically Active City Forum of the Health and Wellbeing Board on the 16th December 2020.

INFROMATION ITEMS

523 The Chair advised that Agenda items 18 – 20 were for information only.

OTHER URGENT BUSINESS

524 No other urgent business was submitted.

DATE AND TIME OF NEXT MEETING

525 To note that the next Birmingham Health and Wellbeing Board meeting will be held on Tuesday 16 March 2021 at 1500 hours as an online meeting.

The meeting ended at 1655 hours.

……..…….
CHAIRPERSON

BIRMINGHAM HEALTH & WELLBEING BOARD

Birmingham City Council

Action Log 2021

Birmingham Health and Wellbeing Board

Rag rating :
- Overdue
- In progress
- Complete

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

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

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

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

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

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

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

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

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

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

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

Birmingham Health and Wellbeing Board

	Agenda Item: 9
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**16th March 2021**
TITLE:	**BIRMINGHAM INTEGRATED CARE PARTNERSHIP – REFRESH OF VISION**
Organisation	**Birmingham City Council**
Presenting Officer	**Professor Graeme Betts CBE, Chair of Birmingham Integrated Partnership Board**

Report Type:	**Information**

1.	**Purpose:**
1.1	To update the HWBB on the refresh of the vision for the Birmingham Integrated Care Partnership (formerly the Birmingham Older People Partnership).

2.	**Implications:**	
BHWB Strategy Priorities	Childhood Obesity	
	Health Inequalities	X
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	That the Board notes the refreshed vision for BICP.

4. Report Body

Background

4.1 The Birmingham Older People Programme (BOPP) was established in 2018 to tackle failures in the system that were acknowledged as letting down the people of Birmingham.

4.2 Since then the partnership has developed and has made much progress in terms of building stronger relationships for planning and delivery.

4.3 Strong progress has been made in delivering against the programme priorities – in particular in respect of the Early Intervention programme which has delivered a transformation in how partners work together to put the person at the centre and to promote "home first" as the default outcome for citizens who experience, or who are at risk of, the need for acute care. Good progress has been made against the other elements of the original programme vision – Prevention and Ongoing Personalised Support.

4.4 Following the conclusion of Phase 1 of the Early Intervention programme - in late summer 2020 - the BOPP board felt that the time was right to refresh the Board's vision and priorities. To this end the Board undertook a review in Autumn 2020.

4.5 The refreshed vision arising from the review is attached as **Appendix 1**.

4.6 The key outcomes of the review were:

- A new name – Birmingham Integrated Care Partnership; reflecting that the scope of activity goes beyond the older adult cohort;
- Reaffirming a commitment to personalised care as the cornerstone of our programme;
- Three priority workstreams:
    - Early Intervention
    - Care Homes
    - Neighbourhood Integration

4.7 Two additional cross-cutting themes of End of Life and Mental Health that need to be integrated across the three priority workstreams.

4.8 **Appendix 1** provides further detail on the key actions for the priority workstreams.

5.	Compliance Issues
5.1	**HWBB Forum Responsibility and Board Update**
5.1.1	BICP is accountable to both HWBB and to the STP Board. BICP is responsible for delivery of the STP Ageing Well portfolio in Birmingham.

5.2	Management Responsibility
5.2.1	The BICP programme is managed on behalf of system partners by BCC Adults Social Care Directorate.

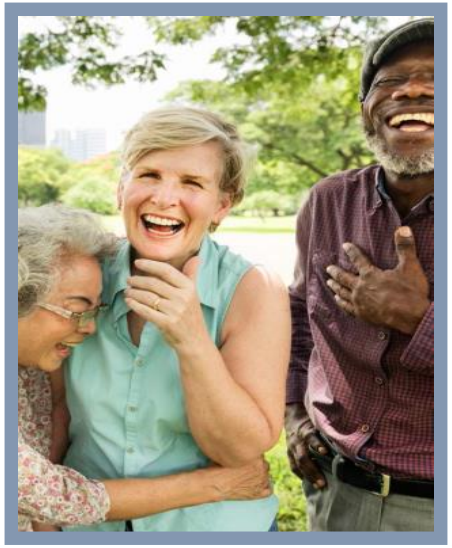
6. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
N/A			

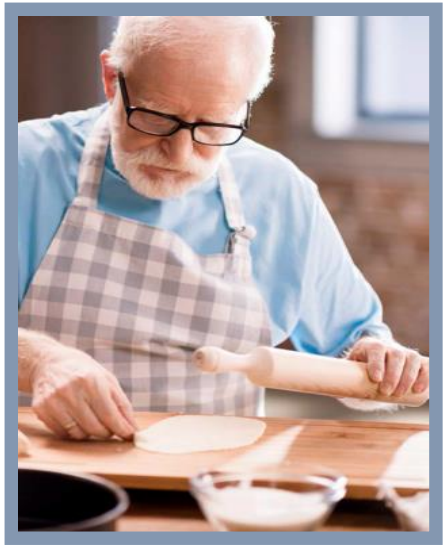
Appendices
Appendix 1 – BICP Vision

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

Michael Walsh, Head of Service – Commissioning ASC

Birmingham Integrated Care Partnership





Live healthy
Live happy
Birmingham and Solihull

Birmingham City Council

NHS

Welcome to our refreshed statement of how we will work together to improve health and well-being outcomes through integration of health, social care and well-being interventions in Birmingham. Much has changed since we first formed our partnership and we recognise that we need to keep challenging ourselves to ensure that we maintain our focus on the things that matter most to citizens. To that end we have looked again at our purpose, vision, objectives and strategies – re-affirming our commitment to move forward, together.

Cabinet Member for Health and Social Care

Birmingham City Council

NHS Birmingham & Solihull Clinical Commissioning Group

NHS Sandwell & West Birmingham Clinical Commissioning Group

Hospices of Birmingham

Brian Carr
Birmingham Voluntary Service Council

Healthwatch Birmingham

Derek Tobin
Birmingham & Solihull Mental Health NHS Foundation Trust

Birmingham Community Healthcare NHS Foundation Trust

Sandwell & West Birmingham Hospitals NHS Trust

University Hospitals Birmingham NHS Foundation Trust

Birmingham City Council

NHS

OVERVIEW

A Refresh not a Restart

What we have achieved

What we have learnt

Our Purpose and Vision

Commitment to Personalised Care

Our Delivery Priorities

Partners

A Refresh not a Restart

Partners within the local health and social care system came together in 2018 to form the Birmingham Older People Programme to tackle failures in the system that were acknowledged as letting down the people of Birmingham, including:

- Fragmented services, inconsistent capacity and an over-reliance on beds
- Citizen experience of poor outcomes from services that weren't joined up
- Sticking plasters as tactical responses to pressures
- The need to address financial pressures as a system

Since then we have come a long way as a partnership. The time is right to reflect on what we have achieved through working together and on what we still need to do in partnership. But this does not mean that we have to start again. Instead we need to refresh our approach to ensure that we are focussed on the critical areas where we need to work together for positive change.

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What we have achieved

We are proud but not satisfied or complacent with the progress we have made since forming the partnership.

Early Intervention has been our flagship programme. Commencing in October 2018, this has been the first integrated programme of work in Birmingham and was supported by an external change partner. The programme has delivered a transformation in how partners work together to put the person at the centre and to promote “home first” as the default outcome for citizens who experience, or who are at risk of, the need for acute care. Perhaps the most notable aspect of the programme has been the creation of new multi-agency Early Intervention Community Teams as the pivotal part of a programme that has enabled people to live more independently, reduced the length of stay in hospital and delivered financial benefits for the system.

Good progress has been made against the other elements of the original programme vision – Prevention and Ongoing Personalised Support. Neighbourhood Networks are established across all parts of the city, helping to build community capacity and to enhance the resilience of citizens. Similarly we have improved the consistency of our response to the management of long-term conditions and have commenced restructuring of service delivery towards neighbourhood working.

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What we have learnt

COVID 19 and our ongoing response to the pandemic has underlined and reinforced our existing learning as a partnership whilst highlighting the need to challenge our processes and outcomes.

As a partnership we have learnt:

- The value of strong relationships that allow for challenge, openness and transparency;
- To achieve impact we need to focus our capacity;
- The benefit of dedicated staff capacity for programme and project support;
- The importance of staff and citizens being at the heart of change;
- The need for a greater emphasis on addressing inequalities in citizen outcomes;
- That we can deliver transformational change when we commit to a shared purpose.

Our Purpose and Vision

The purpose of the Partnership is:

To work together so that we deliver better care for people in Birmingham

Our vision is that through working better together citizens will receive:

The right care, at the right time, at the right place

Commitment to Personalised Care

Underpinning our vision is an ongoing commitment to personalised care. This means that whoever is in contact with a 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 personalised care plans that are informed by the preferences of people and their carers
- Collaborate with partners to take a holistic approach to care planning and delivery through the integration of physical health, mental health and personal well-being interventions

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Our Delivery Priorities

We have refreshed our priorities based on our learning as a partnership and to reflect changes that have happened since we formed as the Birmingham Older People Partnership. We have recognised the need to broaden our scope to work for better health and care outcomes for all adults in Birmingham and that some of our work will also impact upon children and young people.

Our three priority programmes are:

- Early Intervention (Phase 2)
- Neighbourhood Integration
- Care Homes

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Early Intervention (Phase 2)

Objectives

The success of the programme is measured by monitoring performance against these aims:

- Increase the percentage of people going home from acute care and bed-based intermediate care
- Decrease the number of acute bed days used
- Decrease the number of non-acute bed days used
- Decrease the overall length of time that people experience in the intermediate care system
- Reduce the financial impact on long term care across the system (as a proxy for improved outcomes)

These measures are underpinned by a series of key performance indicators

Strategy

A systematic improvement programme is in place across four components of intermediate care:

- Older Persons Assessment and Liaison (OPAL) - based at acute hospital sites to reduce unnecessary admissions
- Integrated discharge hubs to ensure consistent decision-making to get people home first
- Community-based rehabilitation and assessment beds with a consistent care offer
- Early Intervention Community Team to enable safe return to home and to maximise recovery and independence

In addition, an integrated commissioning strategy and plan is in development

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Neighbourhood Integration

Objectives

- Immediate focus will be to support COVID-19 response, enabling Primary Care Network neighbourhood multi-disciplinary team's to focus on the needs of the most vulnerable, regardless of age
- Build on, and make improvements to what we are already doing
- Practical, flexible, clinically led with an agreed approach for communication and record sharing
- Primary Care Networks, BSMHFT and BCHC will be at the heart of this
- Linked to system strategy - keep partners informed
- Aspire to develop a shared culture with team members having a close working relationship and viewing themselves as a team
- Move away from mindset of 'referral' to culture of the team member best placed to meet current need for patient, supported by trusted assessor model
- All areas are covered by a neighbourhood team – accepting that teams may develop at a different pace in different areas

Strategy

- An integrated team is a local, multi-disciplinary team way of working that supports primary care, community services, community mental health services and adult social care to work together to support people to live well at home.
- Some elements of the team may share a local geography (e.g. community nursing teams aligned to PCNs); others will operate from a larger geography but will provide named links to the neighbourhood (e.g. community mental health teams, adult social care teams).
- The multi-disciplinary team will also link to local community and voluntary sector organisations e.g. through the social prescribing role.

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Care Homes

Objectives

The objectives of the programme are:

- COVID – reduce transmission within care homes
- Reduce infection rates (across a range of conditions) in residential and nursing care settings
- Reduce unplanned admissions into acute care from care homes
- Improve quality of citizen experience
- Improve workforce recruitment, well-being and retention
- Improve performance against care home quality ratings
- A care market that is financially sustainable for both provider and commissioners

Strategy

In response to the ongoing COVID-19 pandemic, short-term priorities are to support, advise and respond to immediate pressures within Birmingham's provider market, maximising take-up and use of financial support that is available – eg. for infection control - and co-ordinating vaccination programmes.

However, we recognise that planning for the longer term is required if we are to make the significant and lasting change this is needed to achieve our ambitions for the sector in Birmingham. To this end our strategy is to deliver on our objectives by:

- Connecting Care Homes with Neighbourhood Multi-Disciplinary Teams to ensure consistent access to primary care including mental health.
- Develop better processes to listen to and act on feedback from residents and their families, friends and advocates.
- Develop a joined-up system of quality assurance for the care market, led by one organisation on behalf of the system.
- Develop a sustainable, partnership led methodology for supporting and sustaining the care market including joined up commissioning arrangements.
- Create city-wide strategy and programme to support the care market to recruit, train and retain quality staff, including development of career pathways.
- Supporting and driving digital connectivity and data sharing across the health and social care market.

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Partners

The Birmingham Integrated Care Partners are:

- NHS Birmingham and Solihull CCG
- NHS Sandwell and West Birmingham CCG
- Birmingham City Council
- Birmingham and Solihull Mental Health NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust
- Sandwell & West Birmingham NHS Foundation Trust
- Birmingham Community Healthcare NHS Foundation Trust
- Hospices of Birmingham and Solihull
- Birmingham Voluntary Services Council
- Healthwatch Birmingham

Birmingham Health and Wellbeing Board

	Agenda Item: 10
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**16th March 2021**
TITLE:	**BETTER CARE FUND PLAN 2020/21 ASSURANCE**
Organisation	**Birmingham City Council**
Presenting Officer	**Michael Walsh – Head of Service, Commissioning**

Report Type:	**Information/Approval**

1.	**Purpose:**
1.1	To approve the Better Care Fund Plan for 2020/21 and provide assurance that the national conditions for the 2020/21 Better Care Fund have been met.

2.	**Implications:**	
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	The Health and Well-being Board is recommended to:
3.1.1	Approve the Better Care Fund Plan for 2020/21
3.1.2	Provide assurance that the national conditions for the Better Care Fund 2020/21 have been met.

4. Background

4.1 The Better Care Fund represents a unique collaboration between NHS England, the Ministry of Housing, Communities and Local Government (MHCLG), the Department of Health and Social Care (DHSC) and the Local Government Association (LGA). The four partners work closely together to help local areas plan and implement integrated health and social care services across England.

4.2 During 2020 we were advised that the annual BCF policy and planning requirements would not be published during the initial response to the COVID-19 pandemic and that we should continue to prioritise continuity of provision, social care capacity and system resilience pending further guidance.

4.3 Given the ongoing national pressures, Government departments and NHS England/Improvement have agreed that formal BCF plans will not have to be submitted for approval in 2020/21. However, Health and Well-being Boards are required to provide assurance that a set of national conditions have been met (see Section 5. Compliance).

4.4 In Birmingham, delivery through the Better Care Fund has continued. The BCF Commissioning Executive and Programme Board have continued to function throughout the pandemic; developing our annual plan and working collaboratively to ensure compliance until further guidance was released.

4.5 In line with guidance issued in August 2020 and updated in September 2020 the Better Care Fund Plan for 2020/21 includes a variation to take account of the Hospital Discharge Service (Operating Model). This made provision for short-term, emergency changes to the funding arrangements for post-discharge care that were introduced to facilitate faster discharge processes as a COVID response. The guidance included provisions for managing the financial implications of these changes through the Better Care Fund. Additional health funding has been provided non-recurrently in 20/21 to support costs within local authorities in excess of baseline resources and drawn down through the CCG on a monthly basis to support care packages arising from hospital discharge/prevention:

- For people discharged 19 March to 31 August with a care package – funding until reassessment of ongoing care needs or to 31st March 2021 at the latest if reassessment has not been completed,
- For people discharged in the period 1st Sept 2020 to 31 March 2021 – funding for a maximum of 6 weeks.

5. Compliance Issues

5.1 National Conditions and Role of the Health and Well-Being Board

5.1.1 On 3 December 2020 the Government set out a requirement for Health and Well-being Boards to provide assurance that the national conditions relating to the Better Care Fund are being met in local systems.

5.1.2 The national conditions for the BCF in 2020-21 are that:

- Plans cover all mandatory funding contributions have been agreed by the Health & Wellbeing Board and minimum contributions are pooled in through a Section 75 agreement;
- The contribution to social care from the CCG via the BCF is agreed by the Health & Wellbeing Board and meets or exceeds the minimum expectations.
- Spend on CCG commissioned out of hospital services meets or exceeds the minimum requirement
- CCGs and local authorities confirm compliance with the above conditions to their Health and Wellbeing Board

5.1.3 Plans cover all mandatory funding contributions have been agreed by the Health & Wellbeing Board and minimum contributions are pooled in through a Section 75 agreement -

The BCF plan attached for approval as **Appendix A** details the contributions from the Local Authority and the 2 CCGs. These are in excess of the minimum contribution required:

Organisation	Minimum Contribution	Contribution for 2020/21
Birmingham City Council	£78,864,401	£86,969,480
Birmingham and Solihull CCG	£74,912,094	£96,399,770
Sandwell and West Birmingham CCG	£12,908,448	£13,162,180

5.1.4 The contribution to adult social care from the CCG via the BCF is agreed by the Health & Wellbeing Board and meets or exceeds the minimum expectations -
The minimum requirement for the CCG contribution for spend on adult social care services for 2020/21 is £34,831,687. The planned spend is £34,831,687.

5.1.5 Spend on CCG commissioned out of hospital services meets or exceeds the minimum requirement. The minimum requirement for spend on CCG commissioned out of hospital services from the BCF for 2020/21 is £24,976,581. The planned spend is £50,865,841.

5.1.6 Following the publication of the Hospital Discharge Service (Operating Model), which set out how the health and social care system should support the safe and timely discharge of citizens, the Birmingham health and social care system had to act rapidly to implement the new policy. Significant work had already been undertaken through integrating services and bringing together operational teams under the Early Intervention Programme. Through the rapid mobilisation and enhancement of the Early Intervention Teams, Birmingham was able to quickly adapt and meet the guidelines delivering more rapid

hospital discharges meeting the timescales set out by the Government. This will continue to shape the Better Care Fund for the future with a greater focus on integration, prevention, preventing long term packages of care and reducing the number of citizens who go into hospital.

5.1.7 The additional cost of Early Intervention services as a result of the Covid pandemic has been met through the respective partners' base budgets with additional health funding claimed for external packages where required. In line with guidance the Council is required to pool its base budget alongside additional health funding claimed and this is now reflected in the contributions for 2020/21.

5.1.8 CCGs and local authorities confirm compliance with the above conditions to their Health and Wellbeing Board, this report is the mechanism for the local BCF delivery partners to demonstrate compliance with the national conditions to the Health and Well-being Board.

5.2	**Management Responsibility**
5.2.1	The BCF Commissioning Executive will provide regular reporting to the Health and Wellbeing Board on the progress of the BCF plan.

6.	**Risk Analysis**		
There are no identified risks with the plan as the funding and expenditure information has been developed and agreed between the Council and the two CCGs.			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**

Appendices	
A.	Better Care Fund Plan 2020/21

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

Michael Walsh – Head of Service, Commissioning (BCC)
Louise Collett – Assistant Director Commissioning (BCC)
Mark Astbury – Finance Business Partner (BCC)
Karen Heliwell – Deputy Chief Executive (BSol CCG)
Helen Kelly – Director of Acute and Community Integration (BSol CCG)
Heather Moorhouse – Director of Commissioning Finance (BSol CCG)
Debra Howls – Senior Operations Manager (SWBCCG)

APPENDIX A

BIRMINGHAM BCF FINANCIAL PLAN		2020-21			
		BSOL	SWB	BCC	TOTAL £
	Health/Social Care				
Enhanced Assessment Beds					
Bromford (32 beds)	Social Care	1,270,687	127,173	0	1,397,859
Perrywell (3 beds)	Social Care	15,236	130,008	0	145,244
Total EAB		**1,285,923**	**257,181**	**0**	1,543,104
Social Care					
Social Worker Capacity (Hospitals)	Social Care	719,123	8,714	0	727,836
7 Day Working -Original	Social Care	327,949	202	0	328,151
7 Day Working-New, City	Social Care	8,814	75,211	0	84,025
Home Care Capacity-enablement	Social Care	420,665	124,361	0	545,026
UHB Social Workers (4)	Social Care	296,270	184	0	296,454
Total Social Care		**1,772,821**	**208,671**	**0**	1,981,492
Reablement and Carers					
Reablement - Kenrick Centre	Social Care	1,356,501	297,287	0	1,653,788
Care Act	Social Care	2,760,776	611,570	0	3,372,346
Carers Strategy - Social Care	Social Care	1,102,571	51,398	0	1,153,968
Carers Strategy - Social Prescribing Commitment	Social Care	251,016	2,280	0	253,296
Eligibility Criteria (Former NHSE Allocation)	Social Care	20,351,779	2,407,582	0	22,759,362
Management of Programme	Health	89,598	13,535	0	103,134
Total Reablement and Carers		**25,912,242**	**3,383,652**	**0**	29,295,894
Other Areas of Spend					
Community Services	Health	42,951,473	6,503,887	0	49,455,360
Reablement - RAID	Health	1,483,356	287,451	0	1,770,808
Sandwell & West Birmingham Community Schemes	Health	0	375,096	0	375,096
SWB EAB & Social Worker Support (BCC) & GP Support	Health	0	327,080	0	327,080
HEFT OPAT (Outpatient Parenteral Antimicrobial Therapy)	Health	61,647	159	0	61,806
SWB CCG Community Wheelchair Services	Health	0	780,740	0	780,740
Dementia - NHS Funded	Health	2,477,246	283,093	99,527	2,859,865
Total Other		**46,973,722**	**8,557,507**	**99,527**	55,630,755
Birmingham Community Equipment Loans Service (BCELS)	Health	3,668,972	502,618	1,325,720	5,497,310
Disabled Facilities Capital Grant (DFG)	Social Care	0	0	12,943,092	12,943,092
Early Intervention Programme - Health	Health	1,125,626	8,405	0	1,134,031
Early Intervention Programme - Social Care	Social Care	585,566	124,547	0	710,113
2020-21 Additional Social Care Allocation	Social Care	616,402	0	0	616,402
Improved Capacity Team	Social Care	541,178	58,822	0	600,000
Additional Enhanced Assessment Beds	Social Care	0	0	1,031,242	1,031,242
Early Intervention Teams (Social Care)	Social Care	0	0	5,608,590	5,608,590
Out of Hospital Care Model (Homelessness/Rough Sleepers)	Social Care	0	0	40,000	40,000
Hospital Discharge Service (Operating Model)	Health	13,585,000	0	0	13,585,000
Contingency Reserve (Unallocated)	Health	332,318	60,778	0	393,096
TOTAL BCF		**96,399,770**	**13,162,180**	**21,048,171**	130,610,120
iBCF				60,321,014	60,321,014
Winter Pressures				5,600,295	5,600,295
Sub Total				**65,921,309**	65,921,309
GRAND TOTAL		**96,399,770**	**13,162,180**	**86,969,480**	196,531,429

Birmingham Health and Wellbeing Board

	Agenda Item: 11
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**16 March 2021**
TITLE:	**JSNA CORE DATA SET – OLDER ADULTS**
Organisation	**Birmingham City Council**
Presenting Officer	**Dr Marion Gibbon – Assistant Director Public Health**

Report Type:	**Presentation**

1.	**Purpose:**
1.1	To update the Board on the progress of the core Birmingham Joint Strategic Needs Assessment (JSNA) Older Adults Chapter.

2.	**Implications:**	
BHWB Strategy Priorities	Childhood Obesity	N
	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:
3.1.1	Approve the publication of the Older Adults Chapter of the Birmingham Core JSNA.
3.1.2	Note the document was written in the pre-Covid era. The content has been updated with the latest data and will be refreshed in 2021/22 to include Covid data/impact.

4. Report Body

4.1 Context

The approval of Birmingham JSNA 2020/21 chapters came to a halt in March 2020 due to the start of the pandemic. The Older Adults chapter was near completion and is presented today for comment and approval for publication.

4.2 Current Circumstance

Following the writing of a draft version by Public Health Knowledge, Evidence and Governance team, the document has been tabled at the Corporate Leadership Team and at the Cabinet Member's briefing. Comments and suggestions have been incorporated.

4.3 Next Steps / Delivery

The document will be published on the Public health website and advertised widely amongst stakeholders.

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
Appendix 1 - The Birmingham Core JSNA Older Adults 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

Older Adults
2019 Joint Strategic Needs Assessment

V3.1- January 2020

Version Control	Date	Amendments	Lead Authors
V1	07-02-2020	Draft version based on document prepared in Summer 2019	Jenny Riley
V2	07-02-2020	V1 prepared with new structure	Ralph Smith
V3	23/11/2020	Revisions after reformation of KEG	Ralph Smith, Mudassar Dawood
V3.1	18/01/2021	Draft version sent to BCC Corporate Leadership Team	Ralph Smith
V3.2	10/02/21	Draft version sent to the March 2021 HWBB following data update.	Ralph Smith, Mudassar Dawood

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
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Susan Lowe	Public Health Knowledge Evidence and Governance Lead
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Rachel Chapman	Public Health Specialty Registrar
Muna Mohamed	Officer Public Health
Henry Gowen	Officer Public Health
Rebecca Fellows	Officer Public Health

Contents

Executive Summary

Staying healthy for longer

Along with life expectancy at birth, life expectancy at aged 65 is an extremely important summary measure of mortality and morbidity. On average men and women in Birmingham aged 65 are predicted to live less long than the England average, with Birmingham residents who are most deprived living less long.

Physical health is hugely impacted by an individuals' lifestyle choices. Although not many lifestyle indicators are available at a City level, we know that hospital admission for alcohol-related conditions for Birmingham's men and women is higher than the national average.

Maintaining a high uptake of immunisations is also vital to remain healthier for longer. Birmingham uptake of vaccines aimed at the over 65s is below the national target for flu and PPV.

The screening coverage rate for bowel cancer and female breast cancer is significantly lower than that of England.

With the amount of over 65s with dementia projected to rise over the next 15 years, it is important that as many as possible have a formal diagnosis. It is estimated that on 67.1% of those who have dementia, have a formal diagnosis: which is lower than England.

Maintaining independence

Being disability free in old age leads to increased independence and improved health outcomes. Disability-free life expectancy for both men and women in Birmingham is less than the England average. Hospital admission rates for falls and hip fractures, which both lead to a loss of independence, are higher in the City's population compared to England.

Avoiding permanent placements in residential and nursing care homes is a good indication of delaying dependency. The number of permanent admissions of residents aged 65+ to residential care was significantly lower than the England average, and lowest of the Core Cities.

Being part of a community

Both loneliness and social isolation are associated with negative health behaviours, risks to mental and physical health, and increased mortality risk. Although difficult to measure we know there were a higher proportion of adults aged over 65 who live alone in the City than the England average (at the last census).

Age UK estimated that there are many small areas across the City where there is a high risk of loneliness in the over 65s.

The evidence shows that certain groups of older adults facing additional challenges consistently have worse health outcomes, whether they are adults with disabilities, carers, people at the end of life, or older LGBT+ adults. Little is known about the health status of some of the groups locally.

Based on current trends Birmingham will need to remain focused on improving adult's lifestyles, promoting health and wellbeing and managing chronic diseases. Addressing the wider determinants of health will help also improve overall health. A focus on prevention, removing barriers and creating opportunities and ensuring good homes and communities will hopefully lead to healthy ageing.

Staying healthy for longer

Definition/Overview of the topic

Due to advances in healthcare, population life expectancy is increasing and as a result, the population of those aged 65+ is increasing, with the rate of growth expected to continue to advance. However, although life expectancy is increasing, health in later life is not improving at the same rate[1]. This leads to poorer health in later years, thereby increasing health and care needs. The population of those aged 85 and over is anticipated to more than double in size over the next two decades[1] and they are the most likely cohort to require extra support due to frailty, long terms conditions and social isolation.

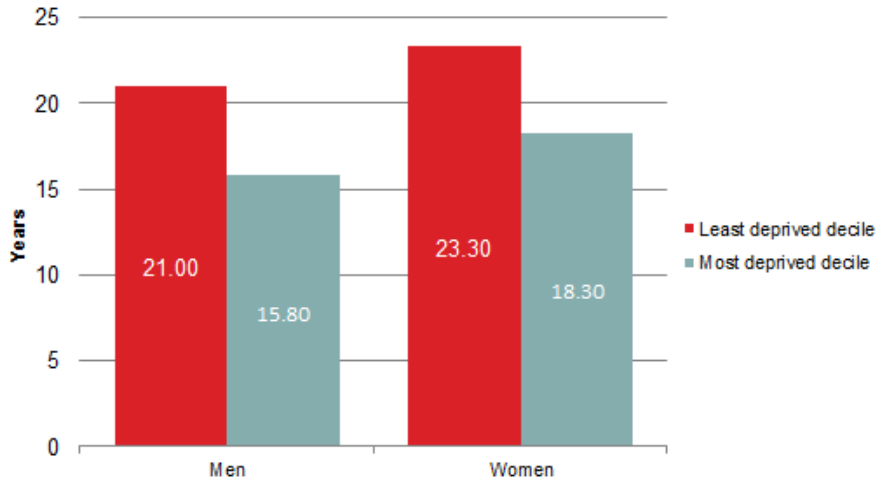
Key Statistics

Life Expectancy at 65

On average women in Birmingham aged 65 are predicted to live another 20.8 years and men another 18.3 years. These are both below the averages for England (21.3 years for women and 18.5 years for men) and below the average for other local authorities in the West Midlands region (21.0 years for women, 18.7 years for men). Compared to core cities Birmingham males and females are both second highest for life expectancy at 65 years old (2017-19).

There is a gap in life expectancy at 65, between people living in the most deprived areas of the city and those in the least deprived. People living in the most affluent parts of Birmingham are expected to live around 5 years longer than those in the most deprived areas. [1]

Figure 1 - Life Expectancy at 65 – Birmingham 2016-18

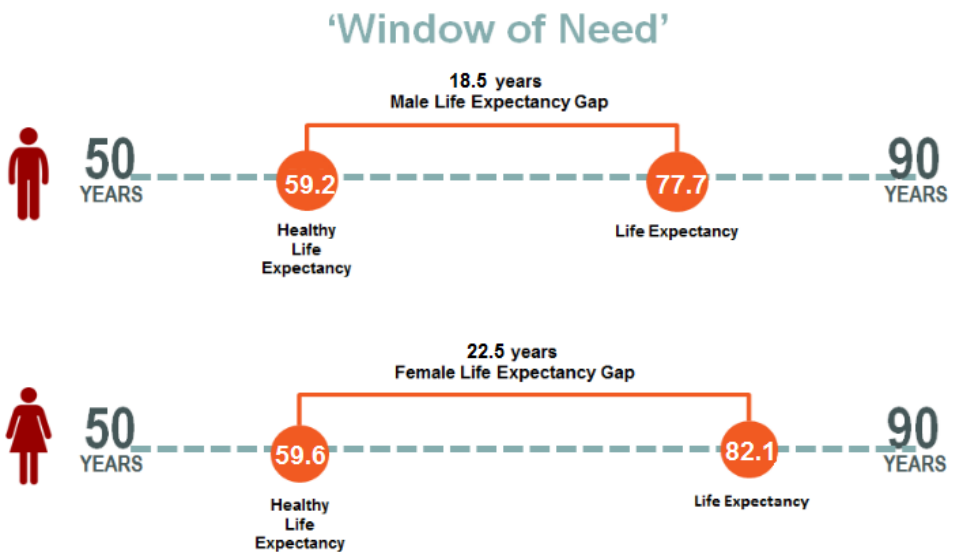


Healthy Life Expectancy

Healthy Life Expectancy (HLE) is the number of years a person can expect to live in good health. HLE in Birmingham is much lower than the national average with men expecting to live only 59 years in good health compared to 63 years nationally. HLE for women in Birmingham is 60 years, compared to 64 years nationally [1]. The gap between HLE and life expectancy (Figure 2) gives an estimate of how many years a person will need health and social care. While HLE is similar for men and women, women live approximately 5 years longer. Therefore, women are predicted to live more years in poor health. Both sexes are in the middle when compared with the core cities.

[1] 'Public Health England. Public Health Outcomes Framework [09-12-2019] https://fingertips.phe.org.uk © Crown copyright [2020]

Figure 2 - Life Expectancy and Healthy Life Expectancy (from Birth) 2016-18



Source: Public Health England – Public Health Profiles

Physical health

People who lead a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is associated with a reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer and improved mental health. The Active Lives report (2020) [2] shows that nationally 60% of 55-74 years and 40% of 75+ years engage in an active lifestyle (150+minutes of physical activity a week). These figures have increased year on year since 2015-16.

In older adults' physical activity is associated with increased functional capacities [3]. The data shows that disability-free life expectancy at 65 in Birmingham is 8.3 (2016-18, England 9.9) and 8.2 (England 9.8)[4] years for males and females respectively. In Birmingham 406 males and 482 females per 1,000 were reported to have a disability that limited them either a lot or little in their day to day activities compared to England at 345 (Males) and 394 (Females) per 1,000 [5].

Physical health is hugely impacted by an individuals' lifestyle choices. One of the leading causes of premature death, killing 78,000 people in England annually, has been attributed to smoking [6]. The Annual Population Survey reported the smoking prevalence for Birmingham (2019) as 14.8% for adults, compared to 13.9% for England. England had 7.6% current smokers in the 65+ group during 2018 [7]. Middle-aged or older adults who smoke commonly suffer from Chronic Obstructive Pulmonary Disease (COPD). The COPD prevalence (all ages) was 1.7% for Birmingham & Solihull CCG (England 1.9%)[8]. Birmingham is in the middle when compared to the core cities.

Alcohol- Admission episodes for alcohol-related conditions (narrow) for over 65s in Birmingham (2018/19) was 1669/100K for males and 690 for females. Comparatively England data was lower at 1501 & 679 for males and females[9]. Birmingham is second lowest when compared to core cities.

[2] Sport England 2019/20, Active lives adult survey. Accessed 02/12/2020
[3] Public Health England. Physical Activity Profile. 12/2020 https://fingertips.phe.org.uk © Crown copyright 2020
[4] 'Public Health England. Public Health Outcomes Framework [09-12-2019] https://fingertips.phe.org.uk © Crown copyright [2019]
[5] DC3602EW - Long-term health problem or disability by NS-SeC by sex by age
[6] Public Health England 2020, Smoking & tobacco: applying all our health.
[7] ONS 2020, Smoking habits in the UK and its constituent countries.
[8] 'Public Health England. Productive Healthy Ageing profile https://fingertips.phe.org.uk © Crown copyright [2021]
[9] 'Public Health England. Local Alcohol Profiles for England. https://fingertips.phe.org.uk © Crown copyright [2021]

Nutrition- In England, two thirds of adults are overweight or obese. Poor diet and obesity are leading causes of premature death and mortality (Global Burden of Disease, 2017), and are associated with a wide range of diseases including cardiovascular disease and some cancers, which can have a significant impact on an individual's physical and mental health and wellbeing.

Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults) for 2018/19 in Birmingham is 47.8% compared to 54.6 for England [10]. In England 65.4% of 65-74 years, 66.9% of 75-84 years and 57.8% of 85+ years meet the recommended 5 a day. Birmingham is third lowest when compared to core cities.

Malnutrition- One in ten people aged 65+ are malnourished or at risk of malnutrition in England [11].

Sexual health data

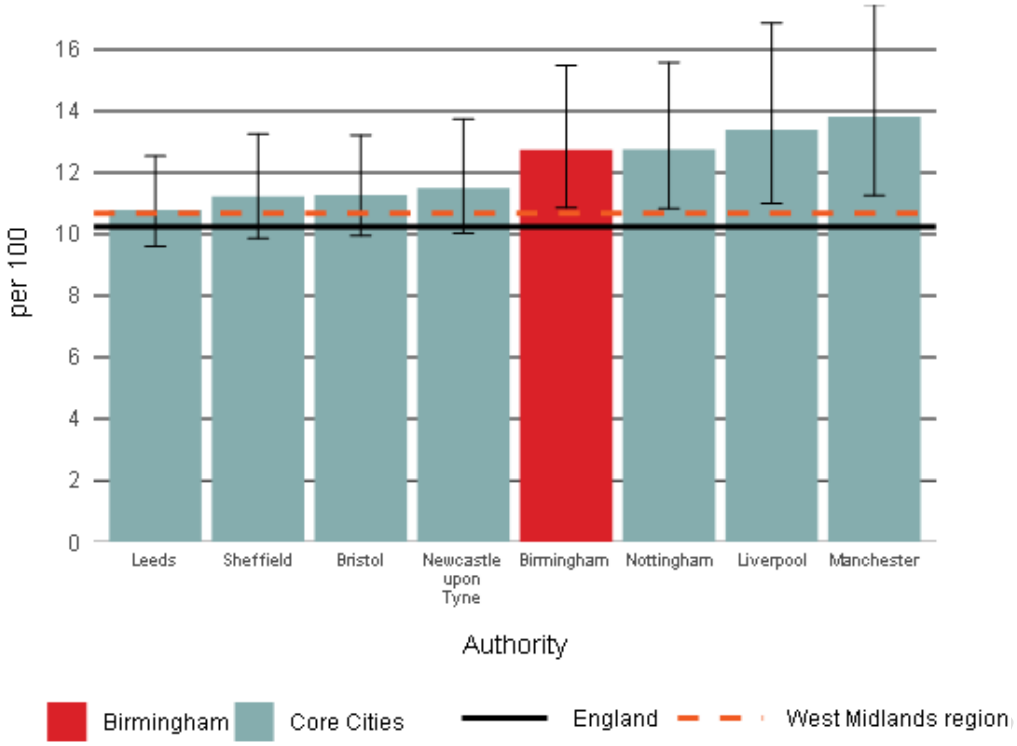
Older adults (65+) accounted for 0.78% of service users for Reproductive & Sexual Health (RSH) & Genitourinary Medicine (GUM) in Birmingham for 2018/19. These figures include individuals who could have accessed the service more than once. Birmingham is ranked in the middle when compared to core cities.

Mental health

Birmingham is in the middle when compared to core cities for common mental disorders.

Figure 3- Estimated prevalence of common mental disorders: % of Birmingham population aged 65+ (2017)

[10] 'Public Health England. Obesity Profile. https://fingertips.phe.org.uk © Crown copyright [2021]
[11] Malnutrition Task Force 2017, State of the nation.



Source: PHE Mental Health and Wellbeing JSNA

Depression

In 2017there were estimated to be 18,687 older people with Common Mental Disorders (CMD). This equates to 12.7% of the population aged 65 and over for Birmingham, 10.7% for West Midlands and 10.2% for England[12]. CMD are defined as any type of depression or anxiety. However, this estimate of the prevalence is likely an under-estimate as it is calculated using CMD prevalence proportions based on individuals living in private households, which excludes those who are homeless and those living in institutional settings (e.g. care homes) who are likely to have poorer mental health. Birmingham is ranked in the middle when compared to core cities.

It is estimated that in 2020 over 4,132 older people in Birmingham had severe depression. This represents nearly 3% of the population aged 65+. By 2040 this is predicted to rise to 5,393 people.[13].

Prevention

Immunisations and Vaccinations

In 2019/20, 67.7% of people aged 65 and over received an influenza vaccination compared to the England average of 72.4%. This is below the national target of at least 75% coverage. There has been a continued decline in vaccination rates between 2010/11 and 2019/20 with rates falling as low as 68%. Birmingham is the lowest when compared to core cities.

65.2% of Birmingham adults aged 65 and over received a pneumococcal polysaccharide vaccine

[12] 'Public Health England. Mental Health and Wellbeing JSNA. https://fingertips.phe.org.uk © Crown copyright [2021]
[13] Institute of Public Care 2020, Projecting older people population information.

(PPV) compared to 69% for England (2019/20) [14]. PPV protects against 23 types of Streptococcus pneumoniae bacterium. Pneumococcal disease is a significant cause of morbidity and mortality. Certain groups are at risk for severe pneumococcal disease; these include young children, the elderly and people who are in clinical risk groups. Pneumococcal infections include bronchitis, septicemia, pneumonia and meningitis.

Screening

Cancer screening involves testing apparently healthy people for signs of the disease. Cancer is a condition where cells in a specific part of the body grow and reproduce uncontrollably. There are up to 200 known cancers.

Key statistics

Prevalence

Bowel cancer- The bowel cancer screening coverage rate for persons aged 60-74 who are Birmingham residents was 48.9% (England 60.1%). This is statistically significantly lower then the national figure [14].

Breast screening- The female breast cancer screening coverage rate for women aged 53 - 70 who are Birmingham residents was 68.2% (England 74.5%). This is statistically significantly lower then the national figure [14].

Service models and Data

Expecting to live disability free beyond the age of 65 years will depend on family history (genetics), the risk one has been exposed to (occupational or recreational), the opportunity to measure and act upon an assessment of the likelihood of developing cardiovascular disease and diabetes and the use of tobacco, alcohol, and drugs.

NHS Health Check for screening

This is a health check-up for adults in England aged 40 to 74. It's designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. As we get older, we have a higher risk of developing one of these conditions. An NHS Health Check helps find ways to lower this risk.[15]. The percentage of Birmingham eligible residents receiving a NHS Health Check in 2019/20 was 10.5% (England 7.7%). [16]

Immunisations

The routine immunisation schedule is determined nationally and commissioned locally by NHS England with support from an embedded Public Health England team (Screening and Immunisation Team – SIT) as part of the Section 7A agreement [17]. For older people there are three immunisations in the schedule for different age groups:

Table 1 Older people's immunisation schedule

Age due	Disease protected against	Vaccine given	Target uptake
65 years old	Pneumococcal (23	Pneumococcal Polysaccharide	75%

[14] 'Public Health England. Productive Healthy Ageing Profile https://fingertips.phe.org.uk © Crown copyright [2021]
[15] NHS Health checks
[16] 'Public Health England. NHS Health Checks Profile https://fingertips.phe.org.uk © Crown copyright [2021]
[17] Department of Health & Social Care 2018, NHS public health functions agreement 2018-2019

	serotypes)	Vaccine (PPV)	
65 years of age and older	Influenza (each year from September)	Inactivated influenza vaccine	75%
70 years old (up to age 80)	Shingles	Shingles	60%

All three of the immunisations are provided in Primary Care GP settings universally to all people meeting the age and clinical criteria. Some people may not be able to have a specific vaccine depending on their health status. Additionally, in Birmingham the seasonal influenza vaccine is available in community pharmacies across the city, and for people that reside in care, residential or nursing homes. GP Practice staff will visit and deliver the vaccination at the residence (this is also the case for housebound patients). All GP Practices in Birmingham provide the universal immunisation schedule described above.

Physical health

Birmingham ‘s Health and Wellbeing Service provides residents facilities to improve their social, physical and mental wellbeing. The Be Active and Plus and Active Wellbeing Society (TAWS) 18 contribute to Active parks, bikes and streets. Age UK delivers Tai Chi in community settings.

Trends and future analysis

The UK population is now living longer because of medical advances, better medication, lifestyles and safer workplaces. A girl born in the UK today has a 1 in 3 chance of living to 100, and the chance of living to 100 will double in the next 50 years. Given this trend the government’s “Grand Challenge mission” acknowledges that to it’s time to radically change the way approaches to each life stage. This includes working towards a mission of giving people at least 5 extra health independent years of life by 2035 whilst narrowing the gap between rich and poor [18].

The future trend shows that socio-economic inequalities are widening in both sexes as a result of greater gains in life expectancy in less deprived populations. Between 2012–14 and 2015–17, the difference in life expectancy between the most and least deprived widened by 0.3 years among males and 0.5 years among females. Among females living in the most deprived areas life expectancy fell by 100 days over this period, in contrast to the gain of 84 days among females living in the least deprived areas [19].

Older people are also at greater risk for depression which affects around 22% of men and 28% of women aged 65 years and over. Estimates show that 85% of older people receive no help at all from the NHS in the managing illness [20].

Managing illnesses

Definition/Overview of the topic

Older people generally have health as well as care needs and as life expectancy increases, more older people are having to cope with managing multiple chronic conditions alongside conditions typically associated with older age such as frailty, visual impairment and cognitive decline.

Older people account for 62 per cent of all hospital bed days and 52 per cent of admissions that

[18] Department for Business, Energy & Industrial Strategy 2019, The Grand Challenge missions
[19] The Kings Fund 2020, What is happening to life expectancy in the UK?
[20] Mental Health Foundation 2016, Mental health statistics: older people

involve hospital stays of more than seven days[21] . The increasing pressure on the Health Service is being replicated in social care. This means that there is not just increased demand for health care in clinical settings when people are ill, but an increased need for support in the community for people to stay well and remain independent in the face of reduced funding.

By the age of 65, most people will have at least one long-term condition and by the age of 75 most will have at least two[22] and as a result, their care and support needs can change and increase. There has been a move toward developing integrated models of care to address the needs of older citizens whose 'window of need' (figure 3) is growing. People often receive fragmented care when they have both health and social care needs. This can have a negative impact on their health, wellbing and independence as well as inefficiency and poor experiences. Integrated models of care aim to move away from traditionally independent service provision to integration within the NHS and across health and social care particularly for those in contact with multiple services, including our growing population of older adults and people living with multiple long-term conditions.

The nature of support required for daily living or to encourage independence in activities in the home and community is dependent upon the nature of the impairment, disability, disease or frailty experienced by the individual. In order to meet the needs of our older population, we need to understand the scale of the challenge of mental and physical illness and decline.

Key statistics

Frailty and physical disability

The term 'frailty' is often used in a broad sense when we talk about aging, and while it is a distinct condition of ageing, it is not inevitable. Clinical definitions of frailty refer having three or more symptoms from weight loss, self-reported exhaustion, low energy expenditure, slow gait speed and weak grip strength, and evidence suggests that around 11% of the population aged over 65 have frailty using this definition[23]. Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication.

In Birmingham around 16,522 people are considered frail with three or more symptoms, with a further 63,084 (42%) classified as pre-frail (1 or 2 symptoms from the above list). Therefore over half of Birmingham's over 65 population may be at higher risk of falls, disability, hospital admissions, long term care needs and premature mortality.

In 2019 it is estimated that over 28,000 people who are aged 65 and over in Birmingham are unable to manage at least one mobility activity[24]. This represents 18.7% of people in this age group, which rises to 44% in those aged 85+. Mobility activities include going outdoors, walking down the road, getting around the house, getting to the toilet, getting up and down stairs and getting in and out of bed, all of which potentially impact on quality of life and independence.

Table 2. Birmingham Population Unable to Manage at Least One Mobility Activity (2019)

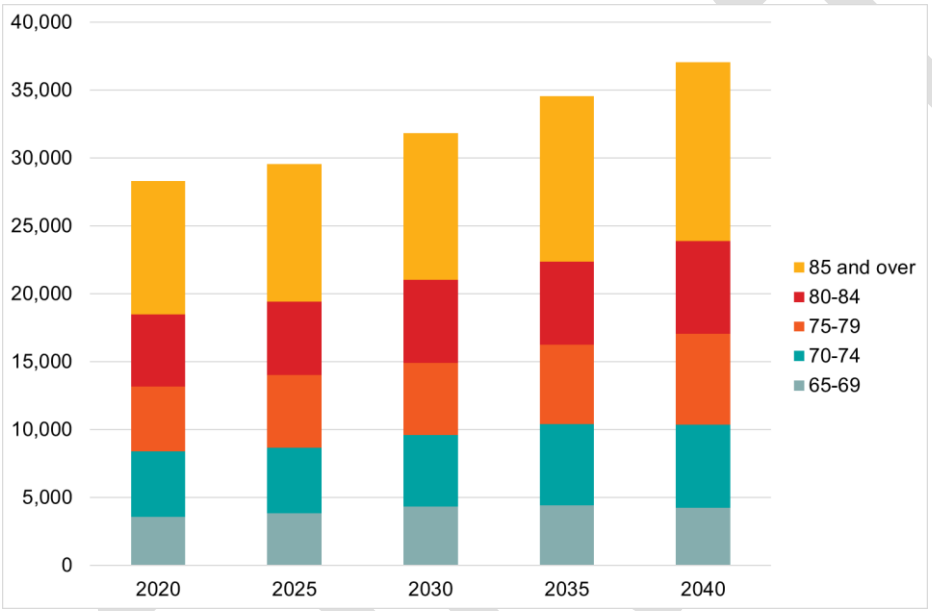
[21] National Audit Office (2016)
[22] The Kings Fund 2016, Social care for older people
[23] Collard, RM *et al.* 2012. Prevalence of frailty in community-dwelling older persons: a systematic review. J Am Geriatr Soc. doi.org/10.1111/j.1532-5415.2012.04054.x
[24] Institute of Public Care 2020, Projecting older people population information

	No.	%
Aged 65-69	3,558	8%
Aged 70-74	4,788	13%
Aged 75-79	4,725	17%
Aged 80-84	5,393	24%
Aged 85 and over	9,685	44%
All aged 65 and over	28,149	19%

Source: Projecting Older People Population Information - Mobility

The relative proportion of individuals experiencing mobility difficulties is predicted to increase slightly over the next 20 years, however, with high projected growth in the older adult population, absolute numbers of people unable to manage one or more activities could increase by approximately 8,700 by 2040.

Figure 4 - Projected Population Unable to Manage at Least One Mobility Activity



Source: Projecting Older People Population Information - Mobility

It is estimated that 19% (28,295) of Birmingham adults aged 65 and over in 2020 need help with at least one self-care activity, such as washing, dressing, using the toilet and eating. This is projected to rise to 37,000 by 2040[25].

Dementia

As the population ages and people live for longer, dementia has become one of the most important health and care issues today. After the age of 65, the likelihood of developing dementia roughly doubles every five years[26] and over 4% of this age group have a recorded diagnosis[27]. At present there is no cure for dementia and although medication can slow progression if diagnosed early, progression itself cannot be stopped completely and over time care needs increase significantly. Outside of formal care provision, it is estimated that there are around 700,000

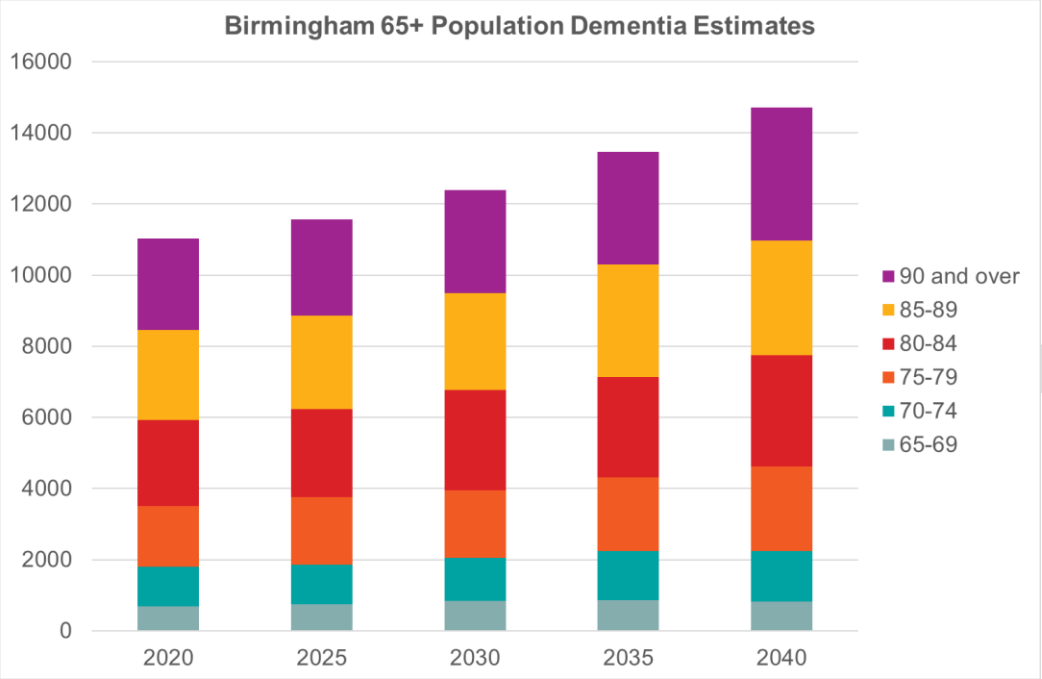
[25] Institute of Public Care 2020, Projecting older people population information
[26] NHS, Dementia Accessed 06/01/21
[27] Public Health England 2018, Statistical commentary: dementia profile, March 2018 update

informal carers for people living with dementia in the UK [28].

In 2019 there were 7,387 people on dementia registers in Birmingham GP practices. However, evidence suggests there are many more people living with dementia than are diagnosed and recorded, and this could be almost 13,026 for Birmingham and Solihull CCG patients [29].

By 2040 this is predicted to increase to 14,716. The incidence of dementia increases with age and estimated prevalence among those aged over 80 is around 17% compared to 3% in those aged 65-79 (based on 2020 estimates [31]

Figure 5 - Birmingham 65+ Population Dementia Estimates



Source: POPPI

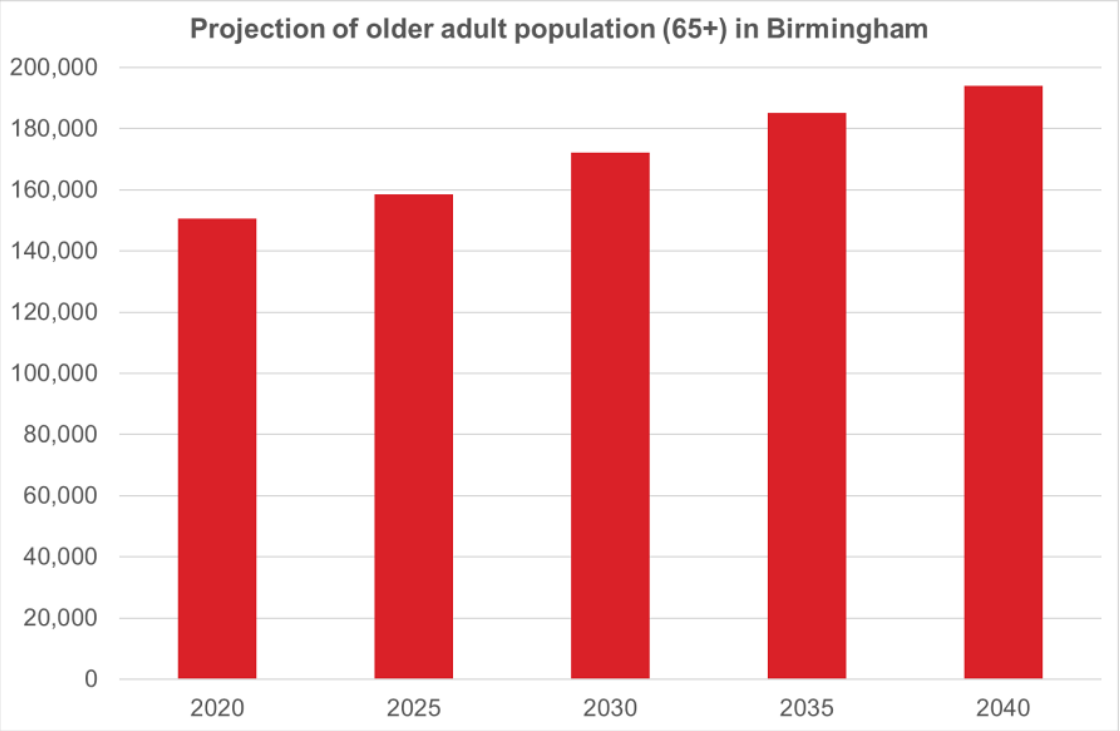
In Birmingham (2020) it is estimated that 65.2% of those aged 65+ living with dementia have a formal diagnosis. This diagnosis rate is below the rate for England and the core cities and has decreased when compared to the previous year (67.9%)[30].

Older peoples population projection

By 2040 population of older people is predicted to rise to over 194,000 (an increase 43,000 from the 2020 estimate). Life-limiting long-term illness and disability also becomes more common with age, by 2040 affecting 75% of the population aged 85 and over [31]. Prevention, delaying onset and slowing the progression of long-term conditions of principal importance for the health and wellbeing of population of older people.

Figure 6 Older adult population projection

[28] Office of Health Economics 2014, The trajectory of dementia in the UK – making a difference
[29] NHS Digital Recorded Dementia Diagnoses - March 2020
[30] Public Health England. Dementia Profile. 2020 https://fingertips.phe.org.uk © Crown copyright 2020
[31] Institute of Public Care 2020, Projecting older people population information



Current services to meet this need

Local communities can help residents to engage and contribute to life. The Neighbourhood Network scheme is making local opportunities visible for older age residents and as social prescribing services increase, they will enable individuals to find opportunities to meet a variety of needs. The need for more formal or complex social and healthcare interventions may be identified by residents and delivered by generic or specialised community based services, including nursing, occupational therapy, physiotherapy, speech and language therapy, dietetics and nutrition, medical and homecare. Recent moves to organise these systems on a more localised geographical basis will increase the accessibility according to need.

When an older person falls their lower physiological strength and weaker bones make bone injury more likely. The e-Frailty tool can identify the cohort of older people at risk of falling for whom medication reviews will reduce that risk further. Muscle tone and balance can be improved by postural exercises, of which Tai Chi is the most well-known. These are available across the city but neither on a systematic or universal basis.

There are a number of services in Birmingham to support older people who fall or are at risk of falls. This includes the following:

- Community services to support people to connect and access activities in their local area
- Home environment assessments, with support to access equipment or adaptations in the home to prevent falls
- Safe and well checks by the fire service, which assess risks in the home
- A wide range of community exercise classes for older people, and courses that focus on improving strength and balance
- Services that offer podiatry, eye sight and hearing tests
- A therapy-led community falls service, that provides multi-factorial assessments and interventions, aimed at those who are high risk
- Services in the acute setting such as falls clinics and Fracture Liaison Service to identify

those with osteoporosis
- GPs carry out falls risk assessments for people with frailty and will review medication and/or refer to other services as needed

Early diagnosis of dementia requires individuals to recognise the problem earlier and the increased use of memory clinic assessments in the past decade has helped with this. There remains limited beneficial medical interventions to reduce the progression of dementia current services focus on increasing support for patients. The support to daily living and community activities has been improved by the wider understanding of the effects of dementia by communities and employers. Adjustments can be made to enable people to remain connected to their communities of interest. The condition is progressive and results in physical and behavioral changes in the later stages that require more specialist assistance and supported living environments have emerged.

Depression in older people can be difficult for a generalist to separate from declines in memory, thinking, and activity from other degenerative brain conditions. An older age psychiatric service is available across the city which has close links with the older age physical clinical services, forming a virtual neuro–psychiatric service for older age. Drug therapies are commonly used but talking therapies are available when required. Services supporting the elderly in activities of daily living and to stay socially connected have been variable in the past and the development of the Neighborhood Networks will improve this.

NHS Primary and Secondary Care diagnoses and initiates treatment of all long term conditions, including mental illness, cardio-vascular disease, respiratory disease and cancer, which account for most of the deaths in this age group. Early identification by prompt attention to the first presentations and easy access to diagnostics are important to allow early and effective interventions. This will change the natural history of untreated or late treated illness thereby reducing the impact of the condition on the quality of life in these early years and the need for early specialist or complex care.

Primary Care is universally available under a national contracting framework. The quality of the practice is assessed by inspection carried out by the Care Quality Commission. Three practices in Birmingham and Solihull CCG are judged to be inadequate and twelve require improvement. These practices are supported by the Primary Care Quality team and, where appropriate, the Royal College of General Practitioners.

Secondary Care is commissioned according to the volume of patients seen and the complexity of the conditions managed. The quality of the service is assessed by inspection carried out by the Care Quality Commission.

The Birmingham and Solihull Sustainability and Transformation Partnership is developing a systems approach to the care of common conditions connecting Primary and Secondary Care with Adult and Children's Social Care and the well-established Third Sector of community provision and the incremental development towards an Integrated Care System has begun across the BSol STP footprint. The building blocks of a single CCG commissioner coterminous with the STP are already in place by working with the Birmingham Provider Alliance and collaborative integrated system planning, strategy development and integrated programmes of delivery. This will be focused on enabling integrated delivery, prevention, and development and use of community assets to reduce inequalities and improve outcomes for local people.

Within Sandwell and West Birmingham CCG, The Connected Care programme is a multi-specialty

community provider (MCP) vanguard in NHS England's New Models of Care Programme. iCares is a service and an approach to managing adults with long term conditions irrespective of their diagnosis, location or age. It includes a whole range of staff including nurses and therapists providing specialist community interventions to avoid unnecessary admissions to hospital; help maintain health and well-being through care management; and improve independence and function with community rehabilitation.

Future projections for need

The increasing number of people surviving into the older age groups will influence future need and demand. If primary and secondary preventative measures are successful there will be greater proportions of this age group disability free until more advanced age. However, without a change in the factors which influence the onset of the condition, the difference in the disability-free life expectancy between affluent and disadvantaged communities will not change.

If adults of working age continue with their current high rates of inactivity, there will be limited improvement in bone density, postural strength and balance. This combined with the increasing number of people surviving into older age will result in more falls and fractures.

Reducing the risks of vascular disease reduces the number of individuals developing vascular dementia. However, the increasing number of people surviving into older age will result in more people developing the condition and therefore requiring specialist support and care in the later stages.

Increasing life expectancy will result in more people living alone or with dependent partners and restricted social networks. This is compounded by smaller family sizes, reduced mobility and a change in economic circumstances over time. This makes forecasting or modelling the patterns of impact and available support in the future unpredictable.

Maintaining independence

Definition/Overview of the topic

Loss of independence can be discouraging to adults. They have spent their entire lives living independently, working jobs, raising families and making decisions. The natural effects of aging can sometimes make independent living harder than it once was. Independence is important to the physical and mental well being of older adults. Difficulties with mobility, behavioral health conditions such as isolation and loneliness, and financial strains are just some of the contributors to a loss of independence in aging adults. While we cannot avoid some barriers to independence, we can take the time to understand the importance of independence in seniors and look for ways to increase opportunities for independent living. Independence gives seniors a sense of purpose, they have opportunities for achievement, can contribute to the lives of their family, friends and neighbours and enjoy activities that they have always done. [32]

Birmingham's vision for commissioned services in Birmingham, for both older people and younger adults, is:

> 'To have a vibrant, diverse and sustainable local health and social care market, which supports the achievement of better outcomes, increased independence and choice and control for adults'.

This vision for commissioned adult social care services is underpinned by three clear aims to:

- Improve outcomes for those with health, care and support needs
- Improve the quality of commissioned health and care services

Improve the resilience and sustainability of our health and social care system

This recognises that if people are to live better lives and achieve better outcomes, then we need to help people, their families and the community to have greater choice and control about the care that they receive, to promote independence and ensure that all adults have access to the support that they require to live safely and healthily.

To deliver this vision a whole systems approach is required which recognises that much of the need for care and support is met by people's own efforts: including their families, friends or other carers, and through their community networks. Services commissioned by the Council and NHS need to consider resource needs and support and complement their individual and personal care.

Key statistics

Older people's housing

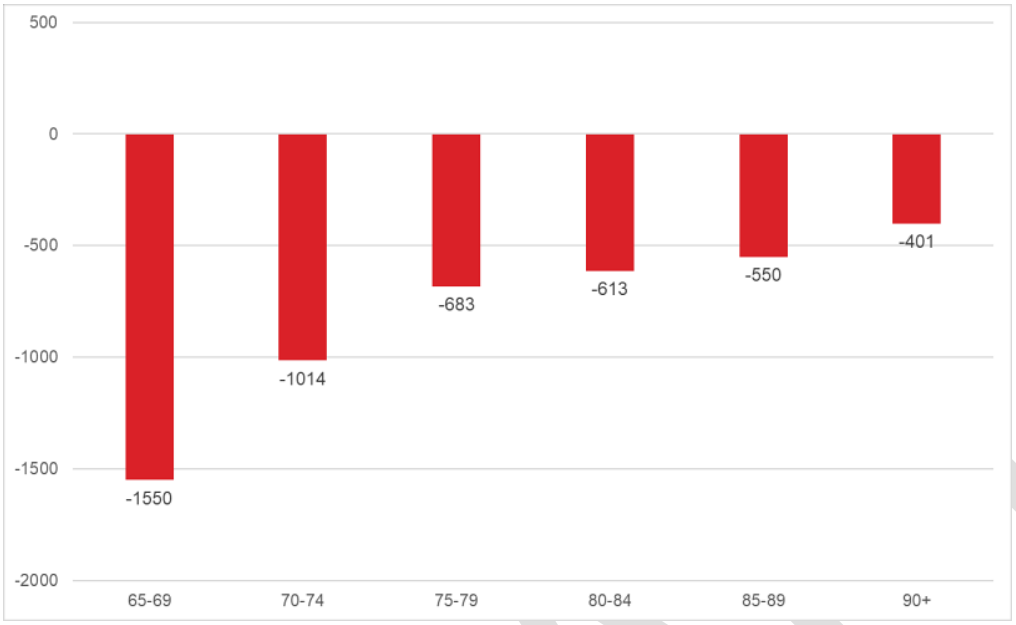
At the time of the 2011 Census there were nearly 71,000 Birmingham households where all occupants were 65 and over. Of these 47,645 lived on their own, equating to 11.3% of the households in the city compared to an England average of 12.6%.[33] There was variation in lone pensioner households reported across the city ranging from 15.4% of households in Sheldon, to 7.4% in Washwood Heath, Lozells and East Handsworth [34]. Birmingham is in the middle when

[32] Vantage Aging, 4 reasons independence is important for seniors Accessed 06/01/2021
[33] ONS 2012, 2011 Census: key statistics for local authorities in England & Wales
[34] Birmingham City Council 2011, Census 2011 KS105EW household composition

compared to core cities for adults aged 65 or over living alone[35].

National migration data shows that between 2015 and 2019 there has been consistently more people over 65 moving out of Birmingham than moving in. The greatest net outflow has been among the 65-69 age group (-1550 people) and 70-74 age group (-1014).[36]

Figure 7 – Net Internal Migration by Older People in Birmingham 2015-2019



Source: ONS

Across the city 20% of men and 29% of women aged 65-74 live alone. For those 75 and over these increase to 29% for men and 50% for women. Higher rates for women are partly due to women's higher life expectancy and that by the age of 65, most women have been married and husbands are typically older than their wives. These two factors mean that more women than men become widowed, which may lead to living alone. [37]

With an ageing population older people are now key players in the wider housing market. They live in a third of all homes and population ageing will account for around 60 per cent of household growth, with the highest levels of increase amongst those over 85 years. Nationally the number of people aged over 65 is forecast to rise over the next decade, from 11.7 million to 14.3 million by 2025, a 22% rise. This means that one in five of the total population will be over 65 in 10 years' time, which will become one in four by 2050.[38]

The suitability of the housing stock is of critical importance to the health and wellbeing of individuals and the capacity of public services to sustainably support healthy ageing over the long term, delivering both improved outcomes and huge efficiencies. In the UK, the vast majority of over 65s currently live in the mainstream housing market. Only 0.6 per cent of over 65s live in housing with care, which is 10 times less than in more mature retirement housing markets such as the USA

[35] ONS 2013, 2011 census: quick statistics for local authorities in England & Wales
[36] ONS, Internal migration: by local authority and region, five-year age group and sex
[37] Institute of Public Care 2020, Projecting older people population information
[38] Local Government Association 2017, Housing our ageing population

and Australia, where over 5 per cent of over 65s live in housing with care.[39]

Mobility

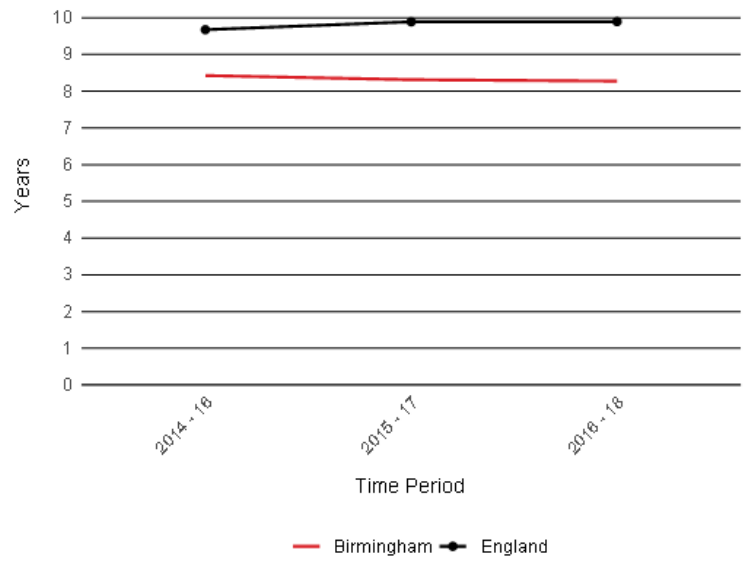
Key statistics :-

Mobility limitations are impairments in movement and affect between one third and one half of adults age 65 or older. [40] Mobility also promotes healthy ageing, the benefits of physical activity include: helping maintain the ability to live independent and reducing the risk of falling and fracturing bones; helping to maintain healthy muscles, bones and joints and also helping to control joint swelling and pain associated with arthritis.[41]

The recent trend for Birmingham males and females aged 65 has them having significantly less disability free years compared with males and females aged 65 nationally. The recent trend shows a slight decrease for the Birmingham males going from 8.4 years in 2014-2016 to 8.3 years in 2016-18. The reverse national picture is true, with males showing a slight increase in disability free year 9.7 years (2014-2016) to 9.9 years (2016-2018).

However, Birmingham females aged 65 fare significantly worse than the females nationally for the same period. Although disability free years have increased, from 7.7 years (2014-16) to 8.2 (2016-18) women in Birmingham still have less disability free years than women nationally: where there has been an increase from 9.7 years in 2014-16 to 9.8 years in 2016-18. Birmingham is mid-range when compared to core cities for both genders.

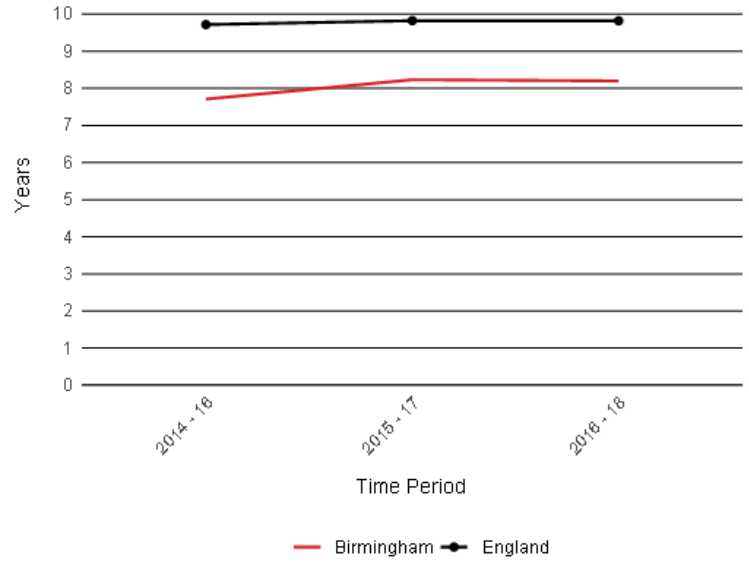
Figure 8 Disability-free life expectancy at 65 (Male) for Birmingham



Source : Public Health Outcomes Framework

[39] Local Government Association 2017, Housing our ageing population
[40] Rosso, AL *et al* 2013, Mobility, disability, and social engagement in older adults. J Aging Health. doi:10.1177/0898264313482489
[41] NHS, Physical activity guidelines for older adults Accessed 06/01/2021

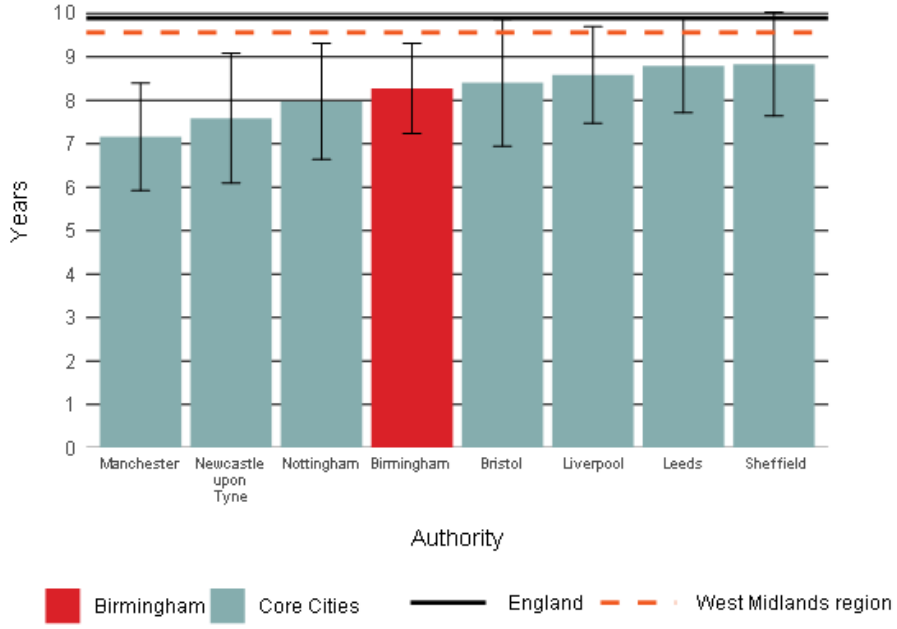
Figure 9 Disability-free life expectancy at 65 (Female) for Birmingham



Source : Public Health Outcomes Framework

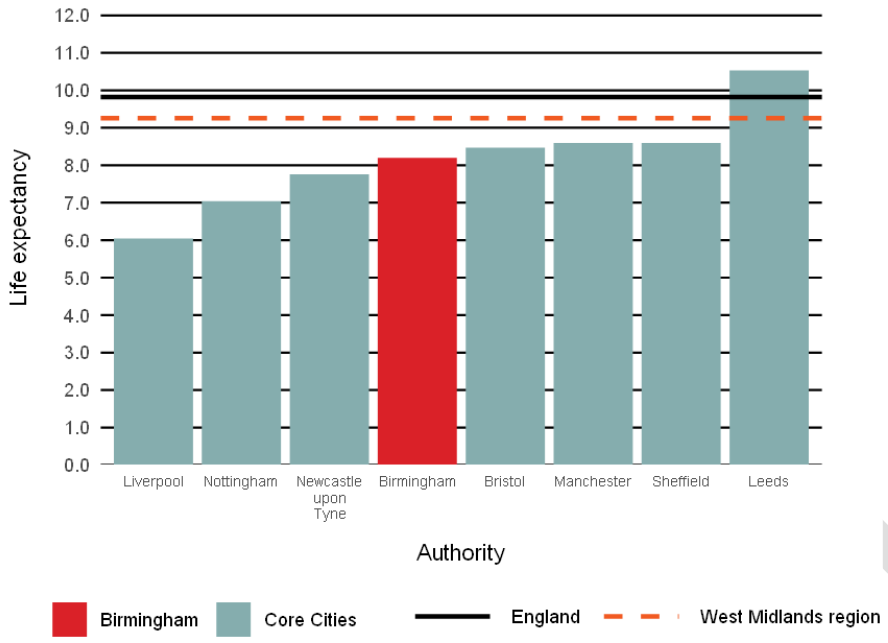
When looking at core cities, the latest period for 2016/18 has the Birmingham males aged 65 having slightly more disability-free years compared with Manchester, Newcastle or Nottingham and the Birmingham females aged 65 have more disability-free years compared with Liverpool, Nottingham and Newcastle.

Figure 10 Disability-free life expectancy at 65 (Male) in period 2016/18



Source : Public Health Outcomes Framework

Figure 11 Disability-free life expectancy at 65 (Female) in period 2016/18



Source : Public Health Outcomes Framework

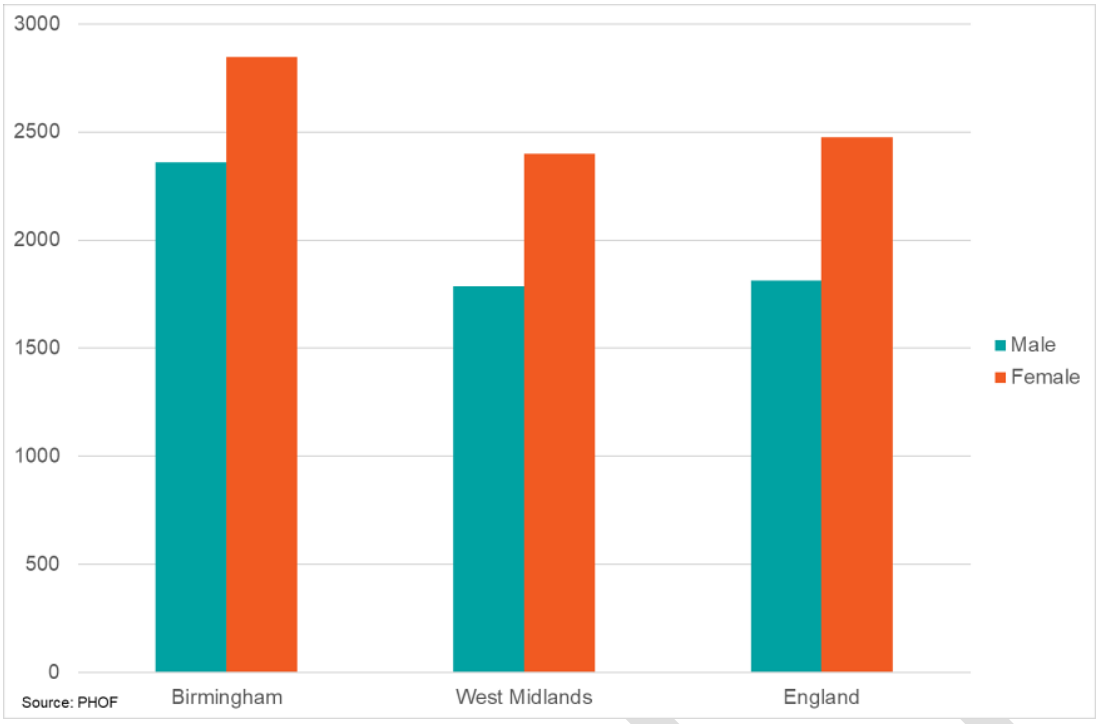
Falls and hip fractures

In 2018/19 there were 4,135 emergency hospital admissions in Birmingham due to falls in people aged 65 and over. This equates to 2,657 per 100,000 of the population in the city, which is significantly higher than England (2,198 per 100,000) and the West Midlands region (2,114). Rates per 100,000 are standardized to account for different population age structures in local authority areas. Like many health problems, nationally, the admissions rate for people living in the most deprived areas is higher than those in the most affluent. Birmingham is in the middle when compared to core cities. Further breakdown of the Birmingham data shows that:

- Admissions were higher in women (2,846 per 100,000) compared to men (2,360 per 100,000).
- Admissions were over 4 times higher in those aged 80 and over (6,337 per 100,000) compared to those aged 65-79 (1,387 per 100,000). [42]

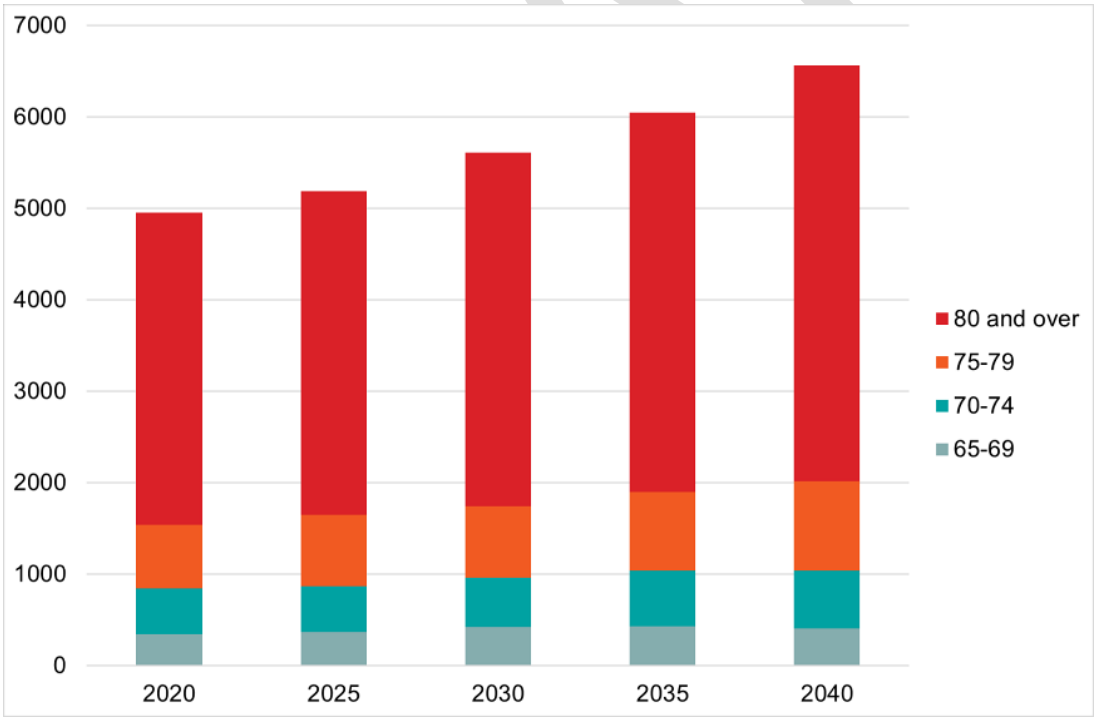
Figure 12 - Emergency Hospital Admissions Due to Falls per 100,000 Population Aged 65+ - 2018/19

[42] Public Health England. Public Health Outcomes Framework. 2020 https://fingertips.phe.org.uk © Crown copyright 2020



In line with population growth, projections suggest there will be around 1,600 more falls-related hospital admissions per year by 2040. Most of these are among those aged 80 and over[43].

Figure 13 - Projected Hospital Admissions due to Falls



Source: POPPI

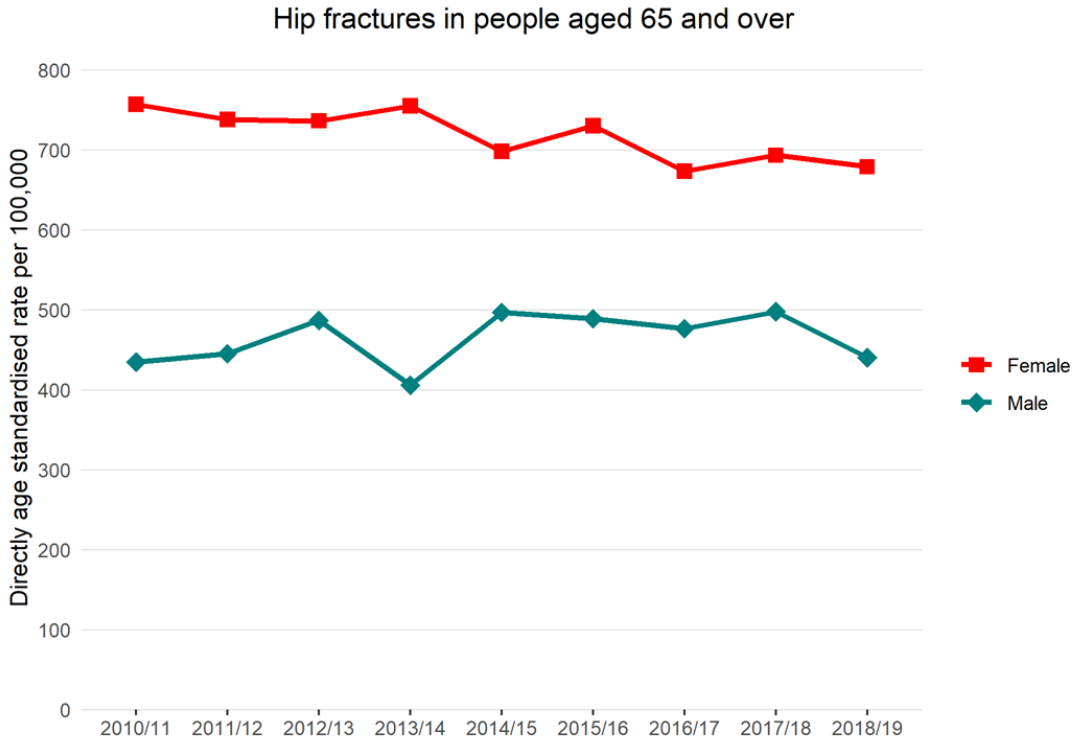
Hip fracture is a debilitating condition – only one in three sufferers returns to their former levels of independence and one in three ends up leaving their home and moving to long-term care. The average age of a person with a hip fracture is about 83 years and 73% of hip fractures occur in women[44]. Postmenopausal women have a higher prevalence of osteoporosis and greater

[43] Institute of Public Care 2020, Projecting older people population information
[44] NICE 2011, Hip fracture: management Accessed 06/01/2020

incidence of fracture than older men[45] and this is reflected in consistently higher rates for women in the city.

In 2018/19 there were 915 hip fractures in people aged 65 and over in Birmingham. This equates to a rate of 583 per 100,000 people, which is higher than the rates for England (558 per 100,000) and the West Midlands region (585 per 100,000). There were 679 fractures per 100,000 for women and 440 per 100,000 for men[46].

Figure 14 - Hip Fracture Rate in 65+ Birmingham Population



Excess Winter Deaths/Warmth

Excess winter deaths (EWD) refers to extra deaths from all causes that occur in the winter months (December to March) compared to the expected number of deaths, based on the average of the number of non-winter deaths.

The number of EWDs depends on the temperature and the level of disease in the population: as well as other factors, such as how well equipped people are to cope with the drop in temperature. Nationally, (during the winter of 2019-20) respiratory diseases such as influenza accounted for almost 40% of EWDs, followed by circulatory disease (21%). EWDs are also highest in the elderly population, in particular, females and those aged 85 and over [47].

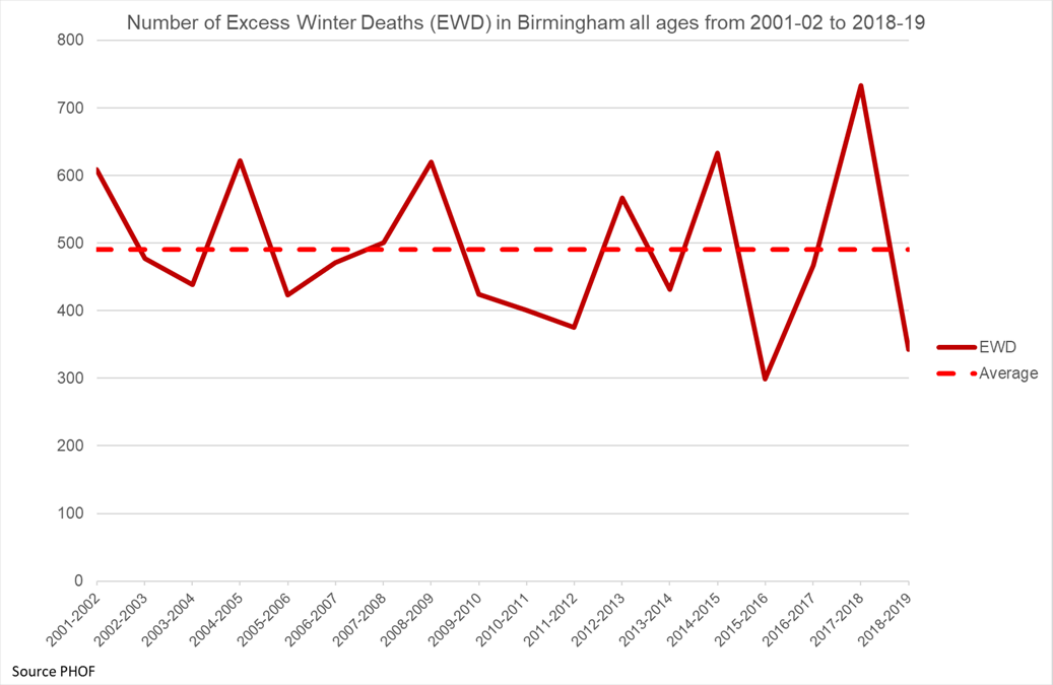
Variation in EWDs is not always related to the relative winter temperature and it has been observed that colder European countries have fewer deaths than the UK suggesting that many more deaths could be preventable[48]. Flu epidemics, poor housing and cold homes are also known

[45] Cawthorn, PM 2011, Gender differences in osteoporosis and fractures Clin Orthop Relat Res. https://doi.org/10.1007/s11999-011-1780-7
[46] Public Health England. Public Health Outcome Framework. 2020 https://fingertips.phe.org.uk © Crown copyright 2020
[47] ONS Statistical Bulletin: Excess Winter Mortality in England and Wales
[48] Healy, JD 2003, Excess winter mortality in Europe: a cross country analysis identifying key risk factors. JECH/BMJ 10.1136/jech.57.10.784

risk factors for EWDs, especially among older and vulnerable people.

Both nationally and in Birmingham, EWDs fluctuate significantly on an annual basis, with variation between 299 and 734 deaths since 2001, and a period average of 485 per year. Over the past 5 reporting periods Birmingham has had statistically lower excess winter deaths than England.

Figure 15 - Number of Annual Excess Winter Deaths (EWD) in Birmingham - all ages



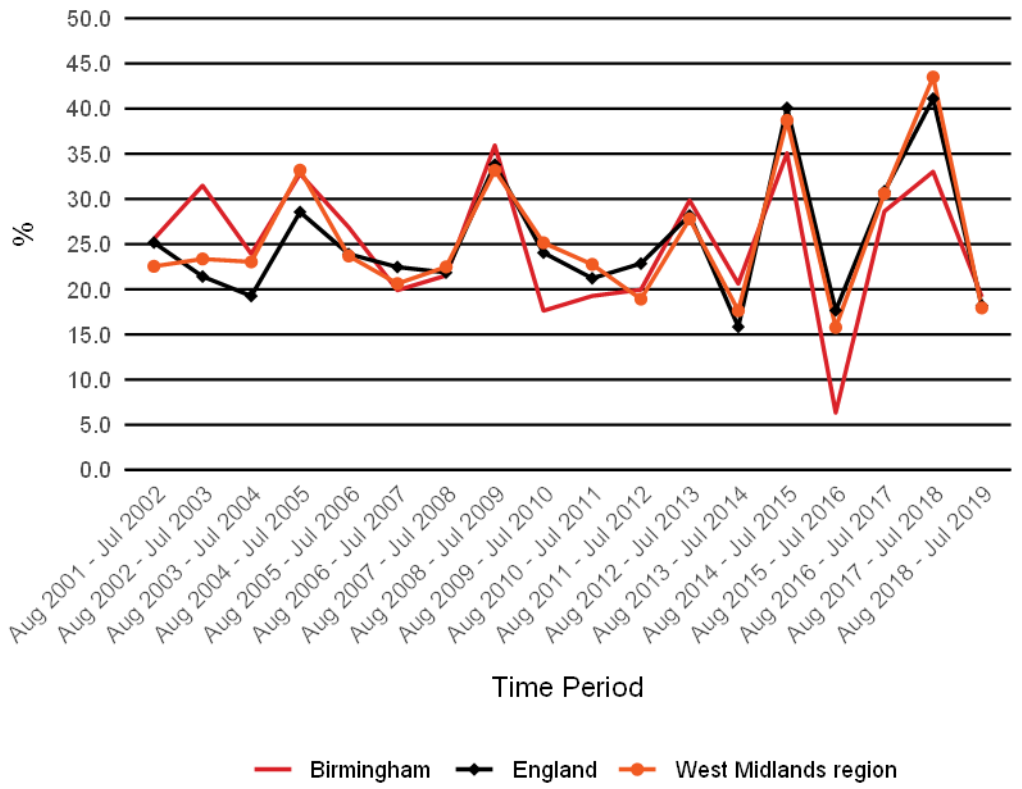
Source: Public Health England

National data reports EWDs as a percentage (which is an index), so that population size is accounted for. In the winter of 2018/19 the number of deaths in Birmingham during the winter months was 13.1% higher than the rest of the year. This is lower than the average for England (15.1%) and the West Midlands region (13.9%)[49]. Birmingham is the lowest when compared to core cities.

In line with evidence, the EWD rate is highest among those aged 85+ and patterns in this population in Birmingham have followed national and regional trends since 2001.

Figure 16 – Birmingham Excess Winter Death Rate (85+)

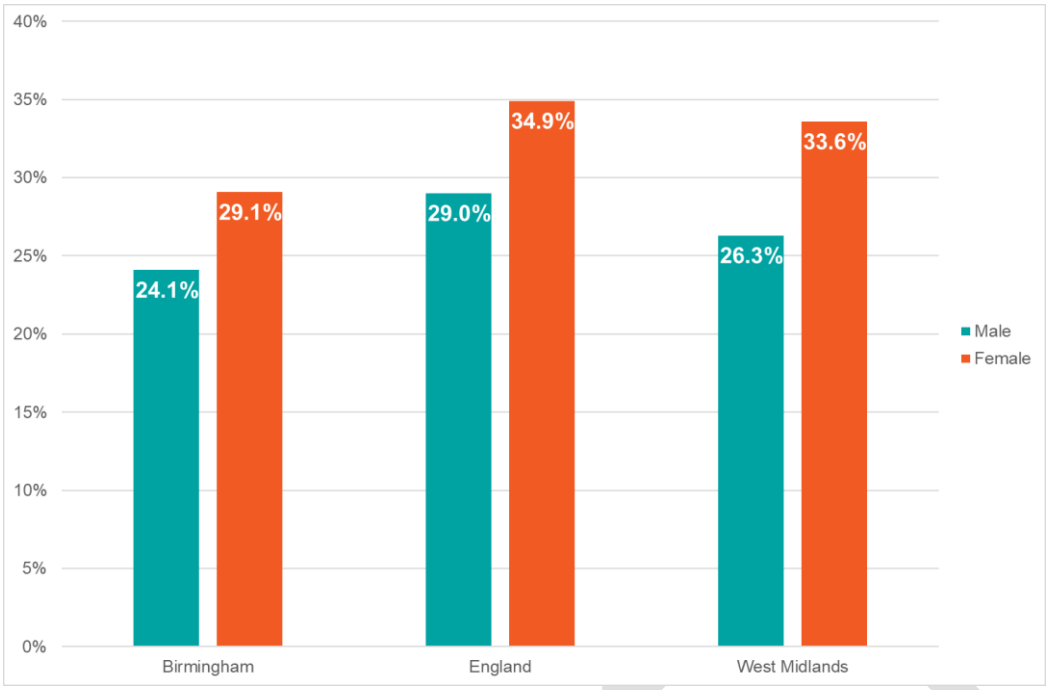
[49] Public Health England. Public Health Profiles. 2020 https://fingertips.phe.org.uk © Crown copyright 2020



Source: Public Health England

Among the 85+ age group, the EWD rate (winter 2018 – 19) was 17.2% for men and 20.4% for women, both of which are higher than the rates for England. This pattern of higher rates for females is reflected in data at both national and regional level. Birmingham is mid-table when compared to core cities.

Figure 17 Excess Winter Deaths – 3 Year average, age 85+ (2016/17 to 2018/19)



Source: Public Health England – Public Health Profiles

Transport

Transport represents one of the largest items of weekly household spending, at 14% for the West Midlands region and 13.6% for the UK.[50] Staying connected to communities and social networks enables older people to contribute and connect with society and is associated with positive mental and physical health, facilitating independence and physical activity while reducing social isolation. Changes in physiology and cognition associated with later life mean longer journeys may have to be curtailed.[51]

Similar to the rest of the West Midlands, older adults resident in Birmingham aged 65 and over qualify for a free travel pass. This travel pass entitles senior citizens to free local train, bus and metro travel between 9.30 am and 11.59 pm Monday to Friday, all day weekends and on public holidays.[52] In 2015/16 there were a total of 443,682 travel passes for older adults in use across the West Midlands and the take-up rate is estimated to be around 95%, which resulted in 61.3 million bus journeys.[53]

For those elderly residents with mobility issues, throughout the West Midlands there is also a door to door accessible transport service available known as “Ring and Ride”, run by the charity West Midlands Special Needs Transport Ltd. The bus service operates from 8 am until 11 pm from Monday to Saturday and from 8.30 am to 3.30 pm on Sundays. In 2015/16 there were an estimated 270,00 passenger ring and ride journeys in Birmingham, a decrease from the year before of 230,000 which was the result of a drop in funding for the service resulting in an increase of fares.[54]

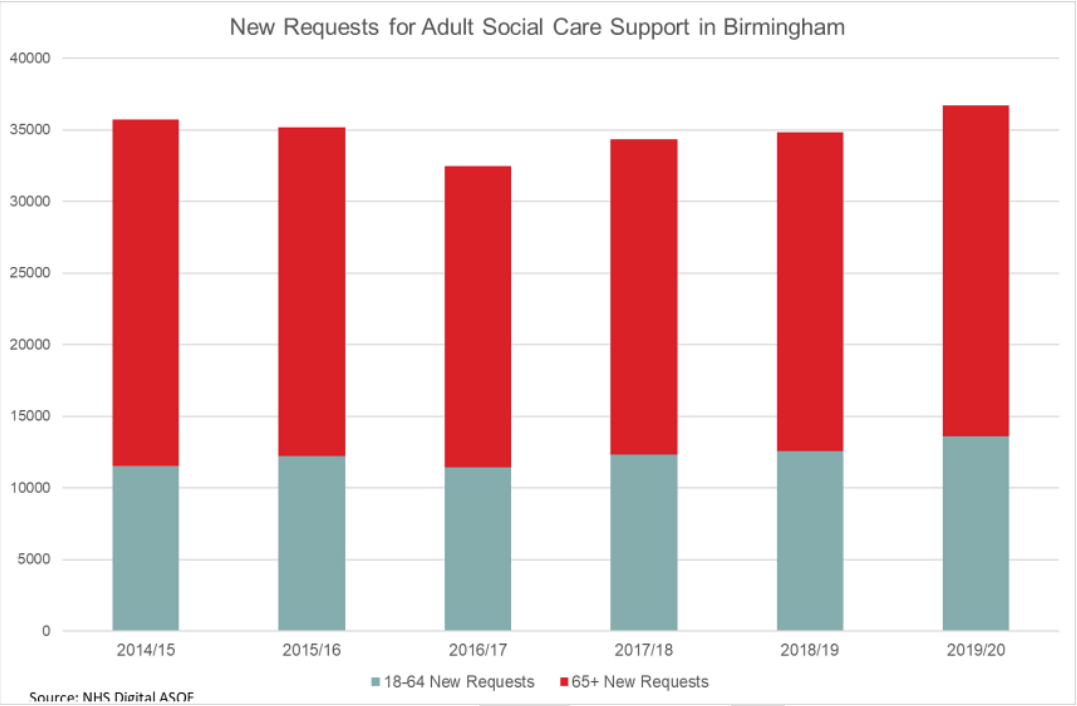
Social Care

In 2019/20 there were 23,115 new requests for social care support for those Birmingham residents

[50] Transport for West Midlands 2016, West Midlands travel trends
[51] Musselwhite, C *et al*. 2015, The role of transport and mobility in the health of older people J Transp Health.
[52] West Midlands Network 2020, Older person’s free travel pass Accessed 07 January 2021
[53] West Midlands Network
[54] Transport for West Midlands 2016, West Midlands travel trends

aged 65 and over, which is over half (58.8%) of all new requests.[55]

Figure 18 - New Requests for Adult Social Care Support in Birmingham



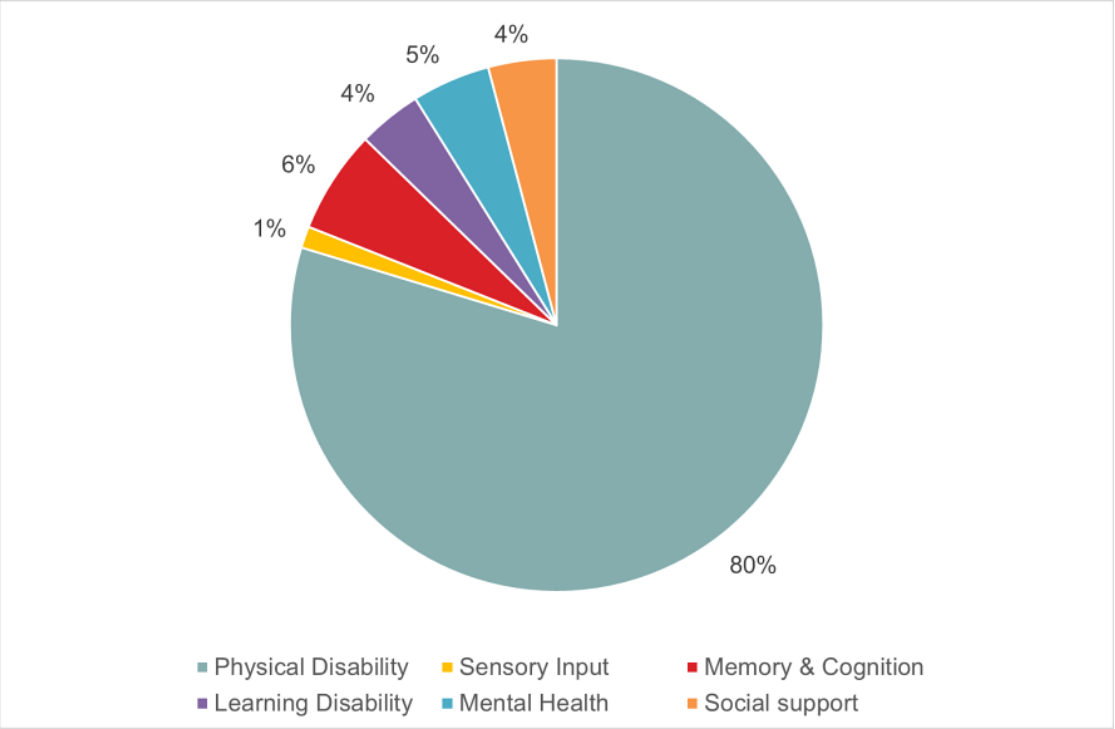
Source: NHS Digital

A total of 10,185 people in this age group were receiving long-term support during the 2019/20. This equates to 68.2 people per 1,000, compared to the England average of 53 per 1,000.[56] This number has decreased annually since 2017/18.

80% of people receiving long term support received it for physical disability, 6% with memory and cognition, and 5% for mental health problems[57].

Figure 19 – over 65 Birmingham clients accessing service by primary support reason (2019/20)

[55] NHS Digital SALT STS001 - Number of requests for support received from new clients
[56] NHS Digital - SALT LTS001a - The number of people accessing Long Term Support during the year to 31st March
[57] NHS Digital SALT LTS001a - The number of people accessing Long Term Support during the year to 31st March



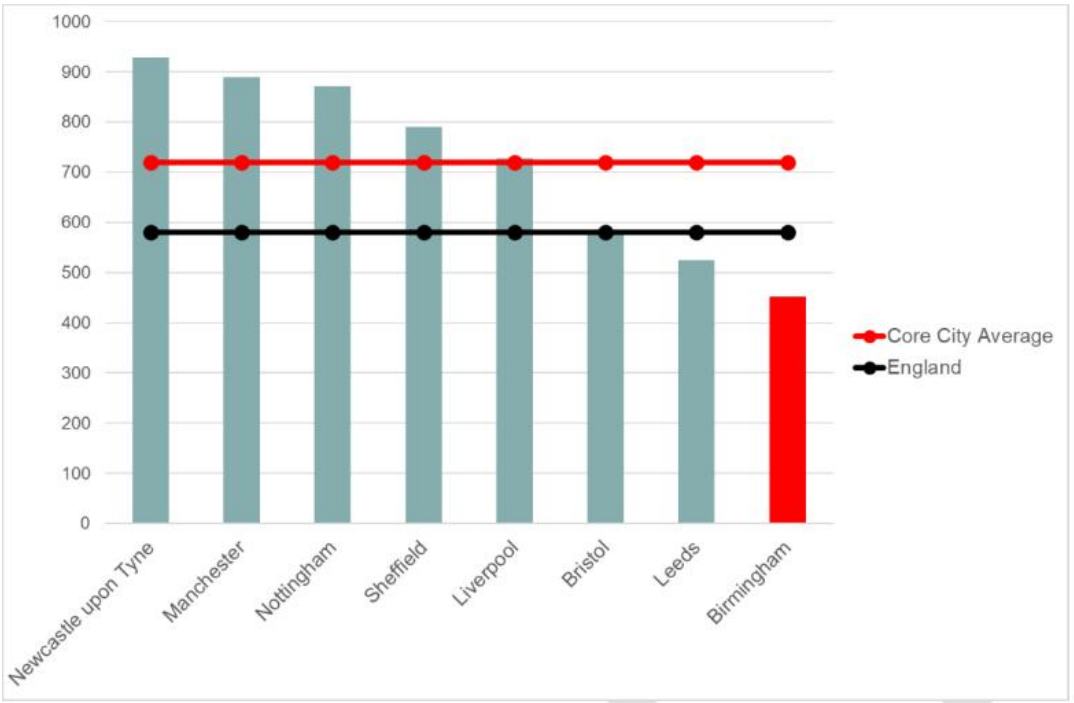
Source: NHS Digital

In 2019/20, 62% of the older age population receiving long term support were cared for in the community or received direct payments, 23% received residential care and 15% received nursing care. Since 2017/18 the number receiving direct payments has increased, with the number receiving other long term community support decreased.

The number of permanent admissions to residential care was 453 per 100,000 which was lower than the England average of 580, lower than the average for other core cities and lowest of all core cites. These admissions have been consistently going down for the last 3 years. Avoiding permanent placements in residential and nursing care homes is a good indication of delaying dependency, and local health and social care services will work together to reduce avoidable admissions. Research suggests where possible people prefer to stay in their own home rather than move into residential care [58]

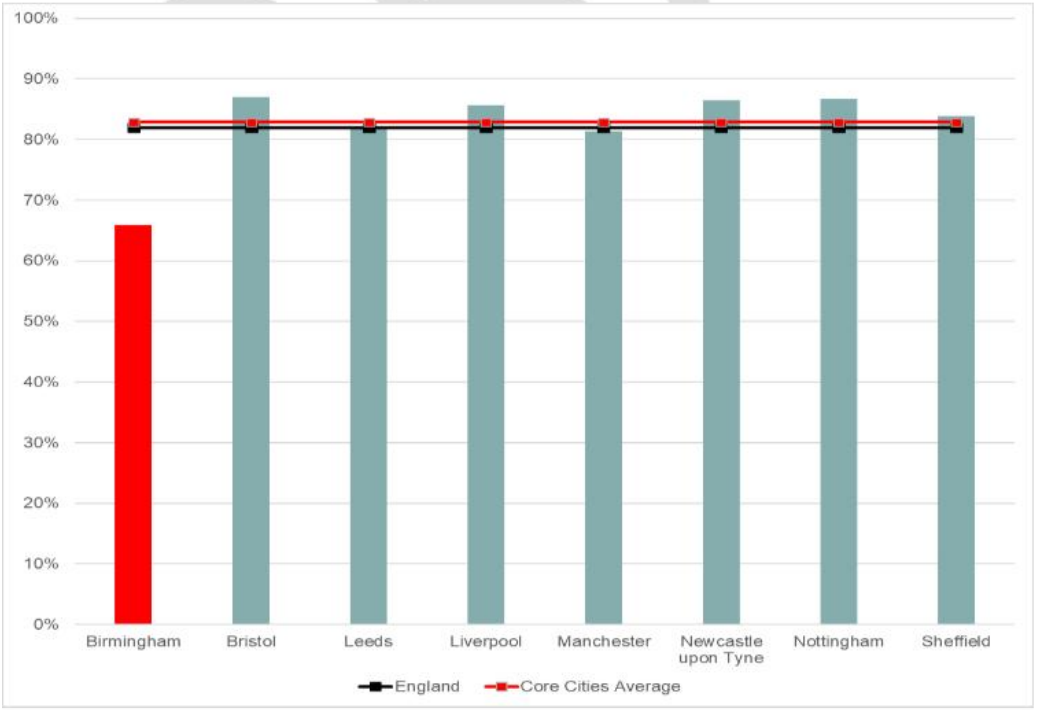
Figure 20 - Permanent admissions to residential and nursing care homes per 100,000 aged 65+ (2018/19)

[58] 'Public Health England. Productive Healthy Ageing Profile https://fingertips.phe.org.uk © Crown copyright [2021]



Reablement and rehabilitation services in Birmingham help people recover skills and confidence to live at home after a spell of illness or hospital stay; allowing them to live independent lives, with minimal support. This indicator below measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge. In the City, in 2018/19, 66% of older people receiving reablement services are still at home 91 days after discharge from hospital. This is the lowest of the core cities, lower than the core city average (83%) and England average (82%).

Figure 21 - % of Older People Still at Home 91 Days after Discharge from Hospital into Reablement 2018/19



Source: NHS Digital:ASCOF

A delayed transfer of care occurs when a patient is ready for discharge from acute or non-acute care and is still occupying a bed as they are unable to go home. Reasons for this include awaiting a care package or nursing home placement, the need for adaptations or delayed funding amongst others. Historically, delayed transfers of care from hospital have been a challenge in Birmingham. The average number of delayed transfers in 2018/19 were 19.6 per 100,000 compared to 10.8 per 100,000 for England (Birmingham was18.3 per 100,000 for 2017/18, England 12.3)[59].

Self-funders of care and support

We do not know exactly how many people in Birmingham are paying for their own care services because in addition to those who do not meet the eligibility criteria for services, or assets threshold, there is also a cohort of people who do not approach local authority for help with their care. Using data from the English Longitudinal Survey of Aging (2006-7) we can estimate 3,069 people purchasing help with care-related tasks.[60] Additionally in 2018/19, 7,495 people aged 65 and over received a direct payment or other long term community package of care.[61]

Service Model and Data

Social Care

The Birmingham Integrated Care Partnership [62] has built upon their Birmingham Older peoples programme in delivering their flagship Early Intervention initiatives. Commencing in October 2018, this has been the first integrated programme of work in Birmingham and was supported by an external change partner. The programme delivered a transformation in how partners work together to put the person at the centre, to promote "home first" as the default outcome for citizens who experience, or who are at risk of, the need for acute care. Perhaps the most notable aspect of the programme has been the creation of new multi-agency Early Intervention Community Teams as the pivotal part of a programme that has enabled people to live more independently, reducing the length of stay in hospital and delivering financial benefits for the system. Underpinning the Partnership's vision of "The right care, at the right time, at the right place" is a commitment to personalised care. The Partnership's refreshed prioities include,

- Early Intervention (Phase 2)
- Neighbourhood Integration
- Care Homes

Over half of the long-term packages of social care commissioned by Birmingham City Council for people aged 65 and over are domiciliary care packages. The majority of these are in people's own homes, but some are for people living in the city's growing number of housing with extra care developments. Birmingham has a significant number of Extra Care villages (also known as Housing with Care). This is a sector that is continuing to grow both locally and nationally, and the council supports this model of care as an alternative to some residential care packages. This model of care has the potential to improve outcomes for older people, and help to free up larger homes in the city for the use of younger families.[63]

Just under a quarter of long-term care is in residential care homes and 11% in nursing homes.

[59] NHS 2019, 2c – delayed transfers of care from hospital, and those which are attributable to adult social care
[60] Birmingham City Council Commissioning Team
[61] Birmingham City Council Social Care Information Team - 2018/19 SALT LTS001a return
[62] Partners include Birmingham City Council, NHS, Hospices, Birmingham Voluntary Services Council and healthwatch
[63] Birmingham City Council Commissioning Team

This is a relatively low percentage compared to other local authorities of a similar size. However, the council still aims to increase the number of people living independently or receiving care and support in their own homes.

Birmingham is in the process of producing a new Day Opportunities Strategy, which will seek to improve the quality of daytime opportunities for all age groups, as well as diversifying the choice of options available.

The community based services including General Practice, community nursing and therapies and Adult Social Care focus more on the maintenance of independent living.

Self-funders

Self-funders access generally the same suite of social care services that are provided by the Local Authority. Residential care homes, nursing homes, home care services, Extra Care centres, supported living and sheltered housing, day opportunities and personal assistants are all established markets in Birmingham, used by both self-funders and the Local Authority. Birmingham City Council provides an online portal, Connect to Support, which is a resource for use by self-funders, as well as those using Direct Payments. Connect to Support is a central source of information and links to services and service providers in the city, for those who wish to find information, advice, guidance, care services or products.

Additionally, the Council inspects contracted care homes and home care providers and publishes the results and quality ratings of these services online to make them accessible to members of the public to help make decisions about care. There are high-cost providers of (for example) residential and nursing care, who cater largely for self-funders with significant incomes/ capital reserves, which because of the high cost of their services are not contracted with the Local Authority. Additionally, Birmingham has a large number of extra care villages (also known as housing with care). These centres typically have a mix of council-funded residents, owner-occupiers and private renters, and this is a growing model of accommodation (with care provided on site), both in Birmingham and the UK as a whole.

Extra Care Housing

In 2018/19 there were 386 people aged 65 and over who had received an Extra Care service from the Local Authority during the year. Extra care housing is specialist housing designed for older people. It is similar to sheltered housing but also offers help with personal care and household chores. This by no means covers everyone and there has been a big increase in extra care developments and the majority are self-funded.

Housing

Birmingham City Councils approach to housing an ageing population is to stimulate the market by promoting downsizing and housing diversity through diverse and innovative housing models. Birmingham City Council has an ambitious plan. It will have 150,000 additional people and 89,000 additional households by 2031. Birmingham is a city of growth. New homes are needed to accommodate a growing population and to help drive and support the economic development of the city and the city region. The council estimates that 89,000 new homes are needed from 2011 to 2031, including a growing the market for housing for older people. The Birmingham Development Plan seeks to encourage housing growth. The council uses planning powers positively to enable and accelerate delivery. The council plans to build at least 51,000 new homes in the city by 2031. Including completions to date, it has identified sites with capacity for 46,247

new homes. However new homes completions in Birmingham have fallen from 4,000 in 2005/6 to 1,809 in 2014/15. As a result of a focus on increasing the delivery of new homes, Birmingham City Council (BCC) now builds over 25 per cent of all new homes across the city – for social and affordable rent, sale, and now private rented sector housing[64].

Reducing the number of EWD attributable to the impact of cold homes requires measures to increase the energy and heating efficiency of homes thereby reducing the amount and cost of energy used to maintain a stable internal living temperature. Birmingham City Council supports the national schemes mediated by the energy industry to achieve this. While uptake of these schemes is monitored, the number of homes needing remedial action is unknown accurately. This is why frontline health & social care staff who are in direct contact with people in the community are encouraged to link people to the schemes. (More sourced info – try this as a starter https://www.kingsfund.org.uk/projects/improving-publics-health/warmer-and-safer-homes)

Trends & Future Analysis

Although Birmingham is a young city, as life expectancy increases the number of older people meeting the criteria for the pneumococcal, flu and shingles vaccines is expected to increase.

The need for supportive care in the older (85+ years old) age groups will also increase with rising life expectancy. The nature of that support and its' setting will be influenced by expansions in provision of some sectors (such as house owner occupiers sharing facilities) and challenges to financial viability in others (residential care homes) with reduction in provision. There will also be an impact of technological developments enabling care to be delivered in different ways and/or more cost-effectively.

There are varying methods of estimating self-funders, all of which have flaws, but which taken together may give a reasonable picture of the number of self-funders in Birmingham and thus estimate future need. Most estimates (national prevalence studies) for self-funders focus on older adults, as they are the group most likely to be self-funding care. Therefore the figures below are for the over 65 age group. In some circumstances, people with adult onset disabilities may also pay for their care, especially if they have large accident-related compensation payments. Using data from the English Longitudinal Survey of Aging (2006-7) we can estimate 3,069 people purchasing help with care-related tasks. If we apply population growth estimates to the prevalence figure shown above, we find that by 2030, the number of self-funders may have increased to 3,700 people.[65]

There are differing levels of economic deprivation across the city, along with diverse ethnic backgrounds, and so the needs of the population will be very different. Linked to this, the ethnic profile of the older adult population will change significantly in the coming years, with a large predicted increase in people from an Asian (particularly Pakistani) background passing the age of 65.

Regarding transport there is a wide range of initiatives proposed from increasing and modernising bus services, increasing the metro line and improving rail links within the city and beyond. The latest Birmingham transport plan has already started to shift the balance towards a greener future to reduce car dependence part of which involves the introduction of a clean air zone which sets out to penalize motorists with heavy polluting vehicles and to deliver a better environment for the

[64] Local Government Association 2017, Housing our ageing population
[65] Birmingham City Council Commissioning Team

inclusive growth for the residents of Birmingham.[66]

[66] Birmingham City Council 2020, Draft Birmingham Transport Plan

Being part of a community

Definition/Overview of the topic

There is a wide body of evidence showing that being part of a community and having social connections is protective towards mental and physical health. The opposite can be said for individuals who are socially isolated or feel lonely. Working and volunteering are recognised as effective ways to maintain social connections and play an active part in a community.

Social connections can be affected by life events such as bereavement, retirement and loss of mobility, all of which are factors associated with the ageing process.

Government strategy in the UK recognises the importance of social connections and tackling loneliness. The strategy sets out goals to improve the evidence base on loneliness, embed loneliness as a consideration across government policy and raise awareness of the impacts of loneliness.[67]

Key statistics

Loneliness and social isolation

Loneliness and social isolation are terms that are often used interchangeably to mean the same thing, but are in fact different but related concepts. Social isolation is an objective measure of how much contact with other people an individual has. Social isolation is measured using a series of questions including marital/cohabiting status, monthly contact with family and friends, and involvement in groups/organisations[68]. Loneliness, on the other hand, is subjective and was defined in the Jo Cox Commission on Loneliness as "A subjective, unwelcome feeling of lack or loss of companionship. It happens when we have a mismatch between the quantity and quality of social relationships that we have, and those that we want."[69] Loneliness is assessed by three items of the UCLA (University of California, Los Angeles) loneliness scale: lack companionship, feeling left out, and feeling isolated. Higher scores for both indicated greater loneliness and social isolation. A fourth question asks directly if a person is feeling lonely[70]. Both loneliness and social isolation are associated with negative health behaviours, risks to mental and physical health, and increased mortality risk.[71]

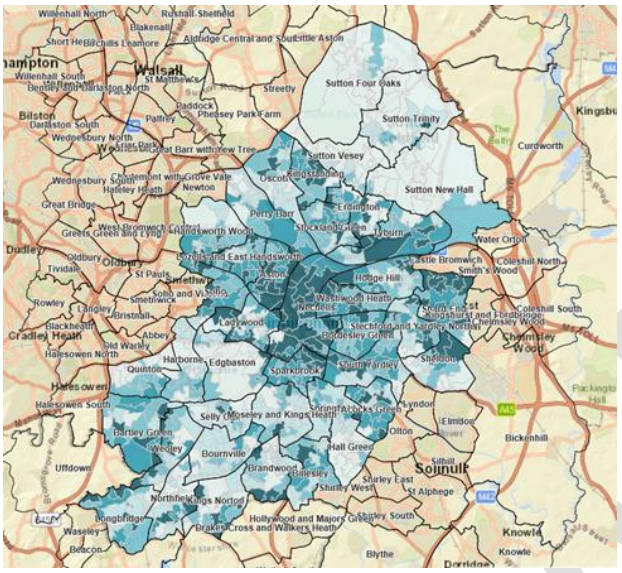
Birmingham has a higher proportion of adults aged over 65 who live alone (34.4% Census 2011) than the England average (31.5%). However, there is a similar proportion of adult social care users who have as much social contact as they would like in Birmingham (40.3%) compared to England (43.5%).

The ONS Community Life Survey (2019/20) showed that 9% of people over 65 felt lonely some or all of the time.[72]. Other studies estimate between 5 and 15% of those aged 65 or over often feel lonely[73]. The ONS is currently developing a standardised national measure for loneliness but this is not yet in use. Evidence suggests that loneliness is linked to being widowed and an increase in

[67] HM Government 2018, A connected society: a strategy for tackling loneliness
[68] Institute for Fiscal Studies 2018, The dynamics of ageing
[69] Age UK 2017, Combatting loneliness one conversation at a time
[70] Compaign to End Loneliness, Measuring loneliness. Accessed 10/12/2020
[71] Public Health England 2015, Reducing social isolation across the life course
[72] Department for Digital, Culture, Media & Sport 2020, Community life survey 2019-20
[73] Campaign to End Loneliness 2015, Measuring your impact on loneliness in later life.

the number of people living alone associated with an ageing population[74].

Age UK used data from the English Longitudinal Study of Ageing (ELSA) survey to obtain and test predictors of loneliness. The results were then applied to Census 2011 data to predict loneliness at small geographical area (LSOA) level across England. Whilst there are limitations to the validity of the Age UK model (particularly around the effects of ethnicity), it is the only model that is currently available and could reasonably be used as a starting point to identify areas with high risks of loneliness. The model estimates that the highest risk of loneliness amongst those aged over 65 in Birmingham is in the central and Eastern parts of the city[75].



Risk of loneliness aged 65+ by LSOA within Birmingham 2016

Social connections

Social capital is a term that the Office for National Statistics (ONS) defines as

"...the connections and collective attitudes between people that result in a well-functioning and close-knit society."

Social capital is positively associated with individual and societal wellbeing along with economic growth and sustainability.[76] ONS measure social capital using 25 indicators across 4 broad domains of personal relationships, social support networks, civic engagement, and trust and comparative norms. Using these measures ONS reported that,

> "Our social capital findings show that we are engaging less with our neighbours but more with social media. We also note that we feel safer walking alone after dark in our neighbourhoods, but more recently fewer of us feel like we belong to them." (Eleanor Rees [77])

Improvements noted include we felt safer walking the streets at night. However, some concerns were noted including positive engagement with neighbours had declined recently, as had our sense of belong to our neighbourhood. On an individual level, reported membership of political, voluntary, professional or recreational organisations had declined

The social connections and attitudes measured as social capital can help prevent social isolation

[74] Compaign to End Loneliness, The facts on loneliness Accessed 08/01/2021
[75] Age UK 2016, Age 65+ risk of loneliness Accessed 10/12/2020
[76] ONS 2014, Measuring social capital
[77] ONS 2017, Social capital in the UK: 2020

and loneliness. Current research suggests that cognitive decline could be slowed down by having close family and friend relationships and participating in meaningful activities. It may also help maintain thinking skills as people grow older[78]. The role of social connections and communities in preventing loneliness and supporting people to age well has been recognised by national bodies concerned with healthy ageing. The Centre for Ageing Better advocates promoting age friendly and inclusive volunteering along with developing age-friendly communities (based on the WHO Age-Friendly Cities Framework)[79].

Currently no data is available at a local level to measure social capital amongst the older population as the data are collected through national surveys. Further consideration on measures or proxy measures for social capital at a local level may be required in the future.

Contribution to society

In the West Midlands just 9% of adults aged 65 or over are economically active.[80] Evidence suggests that whilst working in older age can be damaging to health due to factors such as stress and physical exhaustion, suitable work for older adults can be protective towards mental and physical health.[81] A review by the British Medical Association states that due to a falling birth rate and an ageing population there is increasing need for people to work to an older age. The review suggests that reasonable adjustments should be made to protect the health of older workers and noted that these adjustments should benefit the workforce as a whole.[82]

Evidence on the mental and physical health benefits of volunteering is strong and identifies the mechanism of improved social connections as a key element of this relationship.[83] Volunteering helps older adults feel part of a community and aids to strengthen social connections.

For more information on the impact of volunteering on older adults' wellbeing, see 'Further Information' at the end of this section.

Current services to meet this need

Following 'prevention first' vision and framework, there are a number of new and existing services and activities being commissioned or updated to create a greater focus on social isolation and loneliness.

- Neighbourhood Network Schemes – these are locality and place based networks which enable the engagement with and investment in community assets.
- Prevention & Communities Programme – the council is in the process of renewing its previous investment in a "Third Sector Grants Programme", providing £4.9million of funding to support voluntary and community sector activity.
- Three Conversations – the success of the two initiatives referenced above is partly dependent on the implementation of a new social care model for Adult Social Care. The Three Conversations model places a focus on developing conversations and relationships with citizens which recognizes their strengths, assets and aspirations, as well as those in the community in which they live. This is for the purposes of reconnecting citizens to

[78] Age UK, Social connections and the brain Accessed 16/12/2020
[79] WHO The WHO age-friendly cities framework. Accessed 16/12/2020
[80] Office for National Statistics, Annual Population Survey. Oct 2019 – Sept 2020 Accessed through https://www.nomisweb.co.uk/
[81] Taylor, P 2019, Working longer may be good public policy, but it is not necessarily good for older people J. Aging Soc. Policy.
[82] BMA 2016, Ageing and the workplace
[83] NCVO 2018, Impactful volunteering

communities and enabling them to live a better quality of life. This is an important change as a key driver of demand on adult social care is social isolation and chronic long-term loneliness.

- Local Area Coordination – this is a new service which the council is developing, putting into place 13 Local Area Coordinators across 13 of the city's neighbourhoods. Local Area Coordination is a model and way of working which has been developed internationally and in a number of other Local Authorities over the last 20 years, with a focus on the strengths and assets of citizens and communities. Local Area Coordinators will work with and support anyone, having a focus on reconnecting citizens to their communities and developing new community networks.
- Ageing better in Birmingham – a local programme that aims to reduce social isolation and loneliness in those over 50. There are four main priority areas with seven elements: Ageing Better Networks, Hubs and Funds; Directory of services; Local Action Plans; Supporters Scheme; and Age of Experience Group.

Future projections for need

The number of older people in the population is increasing, as is the number of older people who aren't living healthy and happy lives. For some time there has been a sustained increase in the complexity of needs which voluntary and community sector organisations and groups have been responding to. There is also a growing demand for adult social care services. Additionally the current trajectory of community investment is also decreasing. This is in part due to changes to public spending since the recession in 2008. A unique consideration for Birmingham is its diversity and some of its strengths are in the strength of the faith and community networks, particularly amongst BAME communities. However, it is inevitable that changes to family structures and cultural norms will create and amplify the conditions for social isolation and loneliness amongst BAME communities.

- There is a significant and growing evidence-base about what works to tackle loneliness and social isolation, but one which straddles different policy areas – particularly social care and health, and community development. In short the evidence shows that working differently with citizens to help them improve quality of life, as well as valuing the importance of informal activity in communities, can have profound impacts on the prevalence of social isolation and loneliness.

A few relevant resources which specifically address social isolation and loneliness include:

- The National Lottery Community Fund: Insights to social isolation and loneliness Bringing people together: how community action can tackle loneliness and social isolation
- The National Lottery Community Fund: Building Connections Fund - funding specifically to prevent or reduce loneliness
- ONS: Community Life Survey: Focus on Loneliness
- What Works Wellbeing: Tackling loneliness
- loTUK: Social Isolation and Lonliness In The UK; With a focus on the use of technology to tackle these conditions

- **For further information:**
  - Public Health England blog: Public Health Matters
  - International Longevity Centre-UK: Health and Wellbeing Innovation Commission Inquiry

- What Works Wellbeing: Places, spaces, social connections and people's wellbeing: what works?
- Journal of Physical Activity & Health: Health for older adults: The role of social capital and leisure-time physical activity by living arrangements.
- The Gerontologist. A global view on the effects of work on health in later life.
- The Gerontologist. Effects of volunteering on the wellbeing of older adults.
- The Gernontologist. Formal volunteering as a protective factor for older adults psychological wellbeing.
- Mental Health Foundation. What are the health benefits of altruism?
- The Journals of Gerontology. Is working later in life good or bad for health? An investigation of multiple health outcomes.
- Journal of Aging and Social Policy. Working longer may be good policy, but it is not necessarily good for older people.
- CFE Research. Evaluation of ageing better in Birmingham-Year 2 report.
- National Health Service (NHS). Loneliness in the elderly: how to help.
- Economic and Social Research Institute. The impact of social prescribing on general practice use.

Older Adults Facing Additional Challenges

Carers

Our population is ageing and people with disabilities and long-term conditions are living longer. Most of us will be carers for family members or friends at some point in our lives. Caring is as common as owning your own house yet the public conversations about caring are far less common. Becoming a carer can happen suddenly, through an accident or sudden illness, or it can creep up gradually through a long-term condition or increasing frailty.

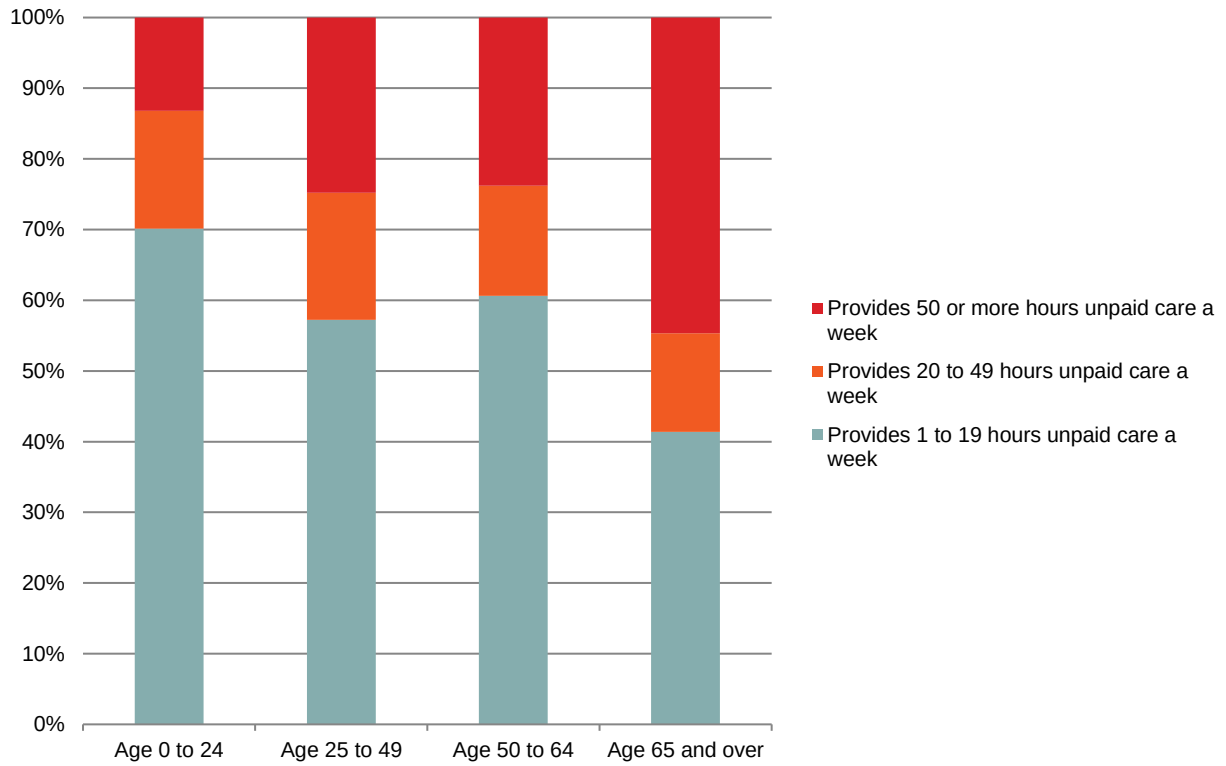
Caring for someone can take its toll on a person's health and wellbeing. Carers UK estimate that 600 people a day give up paid work to care. Caring can seriously affect health, wellbeing and relationships. 72% carers have suffered mental ill health as a result of caring. Carers save the economy £132 billion per year, an average of £19,336 per carer[84].

Key statistics summary

In the 2011 Census 107,380 people in Birmingham were providing unpaid care, 11% of the Birmingham population, slightly higher than England (10.2%). 57% of carers provided 1 to 19 hours of unpaid care, 16% provided 20 to 49 hours and 27% provided 50 hours or more.[85] Some 8,373 (8%) of all carers in Birmingham said their own health is bad or very bad. 50% of carers in the city were in employment.

There were 18,408 carers aged 65 years and over, 13.9% of that age group. Carers aged 65 and over are the most likely to provide 50 or more hours of unpaid care a week.

Figure 22 - Hours of Unpaid Care Provided, by Age of Carer- Birmingham



Source: ONS Census 2011

[84] Carers UK, Facts & figures Accessed 07/01/2021
[85] ONS 2013, Provision of unpaid care by general health by sex by age

During 2018/19 4,013 carers were supported by Birmingham City Council. 1,430 of these were aged 65 years or more.[86] However, this is well below the number of carers reported in the last Census which suggests the majority of carers in the city are not receiving any support from the local authority.

Table 3 - Local Authority Carer Support During 2018-19

Age of Carer	Direct Payment only	Part Direct Payment	Personal Budget	Commissoined Service	Information / Advice / Signposting	No Direct Support Provided to Carer	Total Carers Supported
Carer aged under 18	7	0	0	0	3	0	10
Carer aged 18-25	83	0	0	0	82	3	168
Carer aged 26-64	1350	3	4	10	909	129	2405
Carer aged 65-84	526	8	0	13	395	82	1024
Carer aged 85+	169	3	0	6	195	33	406
TOTAL	2135	14	4	29	1584	247	4013

Source: BCC

The NHS Survey of Carers in Households tells us the majority (62%) of carers were looking after someone whose condition affected them only physically, 11% were caring for someone whose condition affected them only mentally and 22% said their main cared for person was affected both physically and mentally.[87] 52.9% of Birmingham carers were caring for someone with a physical disability, 35.7% for someone with a long-standing illness and 30.6% for someone with dementia.

The Birmingham survey included a range of questions asking respondents about their quality of life. The responses were less favourable than for England overall.

- 22.9% did not do anything they value or enjoy with their time (England 15%)
- 19.3% felt they had no control over their daily life (England 13.9%)
- 22.1% felt they were neglecting themselves (England 15.8%)
- 2.0% were extremely worried about their personal safety (England 1.4%)
- 23.4% had little social contact with people and feel socially isolated (England 16.2%)
- 55% had experienced financial difficulties due to caring (England 45.6%)
- 69.6% spent 100 or more hours per week caring (England 35.7%).[88]

Service model & data

Carers have the right to a statutory carer assessment under the Care Act 2014. This is a discussion to understand the physical, emotional and practical impact of caring and ensure access to appropriate support services. Birmingham Carers Hub provide these assessments.

Birmingham Carers Hub is run by Birmingham Forward Carers and offers a range of support to carers in the city. Information and support for carers can be found on the Birmingham Connect to Support website.

In January 2020 NICE published guidelines on supporting adult carers[89]. The guidance aims to help health and social care practitioners identify people who are caring for someone and give them the right information and support. This should be achieved through carers' assessments, practical,

[86] BCC: Carer support during the year
[87] NHS Digital - Survey of Carers in Households
[88] NHS 2017, Personal social services survey of adult carers in England, 2016-17: Annex tables
[89] NICE 2020, Supporting adult carers

emotional and social support and training, and support for carers providing end of life care.

The NHS long term plan emphasises the contribution of carers and the need for more integrated and personalised support (including greater use of personal health budgets). The Care Act 2014 expects the NHS and social care to work together and where possible to integrate services and support.

Headline Analysis

Good quality, consistent support helps carers to reduce social isolation and depression, and to maintain quality of life. There is more that can be done to ensure that people are more prepared for the responsibilities of caring and to provide the support and information that they need to support them. A key barrier to the provision of appropriate support to carers is that they are often not identified. Many carers do not think of themselves as carers or are not identified by health and social care practitioners as such and do not know about the support available. There is a need for greater understanding of the impact of caring particularly in the workplace. Women are more likely to be carers and there is the issue of gender equality. Employers should ensure carers are aware of their rights, let them know where to get help and support and raise awareness of the needs of carers.

Older people with Learning Disabilities

Background

A learning disability refers to a group of conditions which effect intellectual ability and social functioning which are present before adulthood[90] and affect someone for their whole life. The effect on brain development can happen before an individual is born, during birth or in early childhood. Learning Disabilities can be mild, moderate or severe with some people being able to live independently while others require more high-level complex support.

Our population is living longer and while life expectancy of people with a learning disability is still on average, shorter than the general population, they are also living longer with some people living into their 70s and 80s.

Improvements in healthcare and a move away from long term institutional settings means that more adults with LD are growing older in the community than ever before. Many people with LD live with family carers who are themselves ageing and require support. However despite these positive trends in life expectancy, health inequalities remain. While these older adults experience many of the same conditions as those without learning disabilities, some conditions are more prevalent and occur younger such as dementia, epilepsy and sensory impairment and there is a greater risk of death from illnesses such as pneumonia due to late diagnosis[91]. It can also be a challenge distinguishing the symptoms of a condition such as dementia from those associated with learning disabilities.

Key statistics summary

In Birmingham (2019/20) almost 8,400 people of all ages are on the QoF Learning Disabilities register at GP Practises equating to a prevalence of 0.6%[92] However as many people with learning disabilities, especially those with milder disability, are not known to health or social services[93].

Service model & data

Learning disabilities services are proved by BCC Adult Social Care and Health (ASC&H) under a Section 75 agreement. The latter is a mechanism designed to enable integrated commissioning for health and social care, in this case between Birmingham City Council and Birmingham and Solihull or Sandwell and West Birmingham CCG. The service includes placements, home support and supported living, provision of day services and direct payments. Birmingham Community Healthcare Trust teams provide healthcare for people with learning disabilities living in the community. The service aims to provide high quality care through multidisciplinary working and close collaboration with other agencies.

There are around 365 people with LD receiving service from Birmingham City Council Social Care who are 65+. There are an additional 763 between the ages of 50 and 64 who may experience age related challenges earlier than the traditional definition of 'older adult'[94].

Owing to the gaps in provision for older people, Initiatives such as GOLD (Growing Older with Learning Disabilities) are working to improve care and support for older people with LD and a

[90] NICE 2015, Challenging behaviour and learning disabilities
[91] NICE 2018, Care and support of people growing older with learning disabilities
[92] NHS Digital: Quality and Outcomes Framework 2018/19
[93] 'Public Health England. Learning disability profiles https://fingertips.phe.org.uk © Crown copyright [2021]
[94] BCC - CF6 as at Feb 2020

specific support group has been set up to help people with learning disability and Dementia.

Headline Analysis

While there is limited health data available on older people with learning disabilities , we do know that there are significant health inequalities from existing evidence. Research also suggests that the population of older people with learning disabilities will increase 4 times faster than the overall adult learning disability population[95] so we need to ensure that services meet the needs of this growing population.

A specific age limit for 'older people' is not used in national guidelines when talking about people with learning disabilities because they learning typically experience age-related difficulties at different ages, and at a younger age, than the general population. However there are still significant gaps in provision for the older LD population. For people living in homes designed for adults with learning disabilities, these may be considered unsuitable for them as they age. Older people with learning disabilities are likely to be placed in older people's residential services at a much younger age than the general population, even though this may not meet their preferences or needs, especially in relation to communication, support and activities[96].

[95] Centre for Disability Research 2008, People with learning disabilities in England
[96] BCC and BSOL CCG 'Growing Older with Learning Disabilities'

People at end of life

The National Institute of Health and Care Excellence (NICE) guidance defines the '**end of life**' stage as people with:

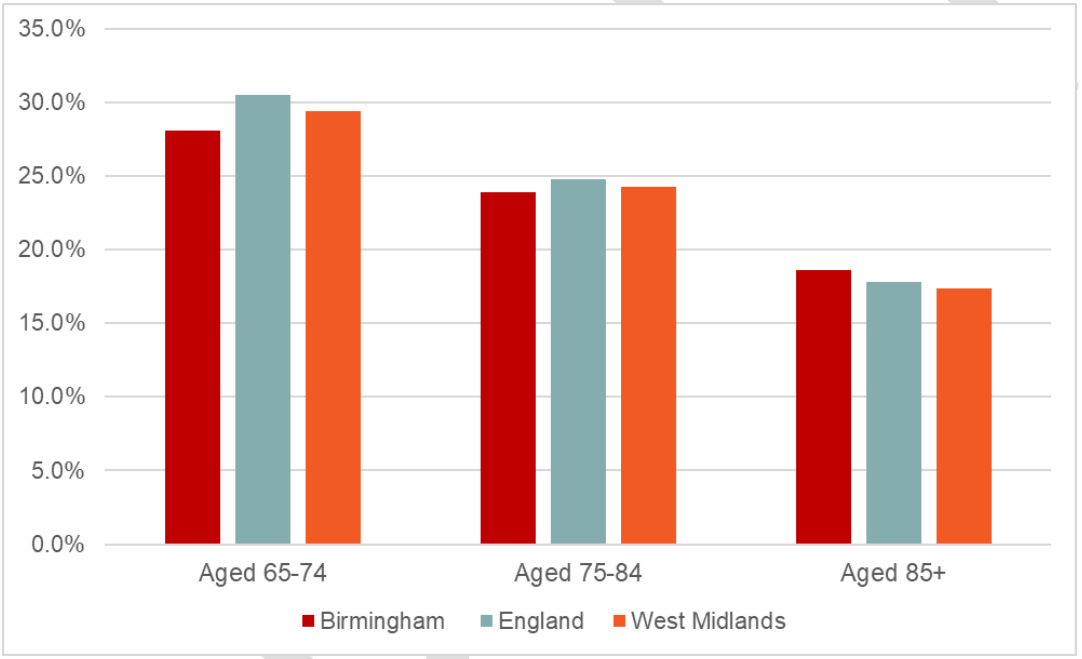
- advanced, progressive, incurable conditions; and/or
- those who may die within 12 months; and/or
- those with life-threatening acute conditions

End of life care therefore covers any support and treatment for those nearing death: includes palliative care.

Key statistics summary

In 2019 23.5% of adults aged 65+ died in their own homes, 15.8% in care homes and 52.8% in a hospital. The percentage of older people dying at home decreases with age, offset by an increase in deaths in care homes and hospitals. The percentages of deaths occurring at home are broadly consistent with England and the West Midlands region. [97]

Figure 23 - Percentage of deaths that occur at home – Adults 65 and over - 2019



Service model & data

The goal of palliative care is the achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness at the same time as other curative treatments. In Birmingham, this is carried out by health professionals, holistic practitioners, and staff from the various hospices in and around the city.

'**Advance Decision' or Advanced care plan** (ACP) enables an individual to think about what they would like to happen to them in the event that they lose the capacity to make or communicate

[97] 'Public Health England. Palliative and End of Life Care Profiles https://fingertips.phe.org.uk © Crown copyright [2020]

decisions about their care. Examples of such decisions include:

- The use of intravenous fluids and parenteral nutrition.
- The use of cardiopulmonary resuscitation.
- The use of life-saving treatment (whether existing or yet to be developed) in specific illnesses where capacity or consent may be impaired - for example, brain damage, perhaps from stroke, head injury or dementia.
- Specific procedures such as blood transfusion for a Jehovah's Witness.

Normally, the ACP is discussed between a health professional and the patients.

Headline Analysis

The local CCGs in unison during 2014/15 created a strategy document. The review recommended the following:

- Raising the profile of end of life care and changing attitudes to death
- Strategic commissioning challenges
- Identifying people approaching the end of life
- Care planning with patients and families
- Coordination of care between agencies
- Rapid access to care
- Delivery of high quality services in all locations
- Last days of life and care after death
- Involving and supporting carers
- Education and training and continuing professional development of clinical and non-clinical staff
- Measurement and research of trends and issues
- Funding challenges.

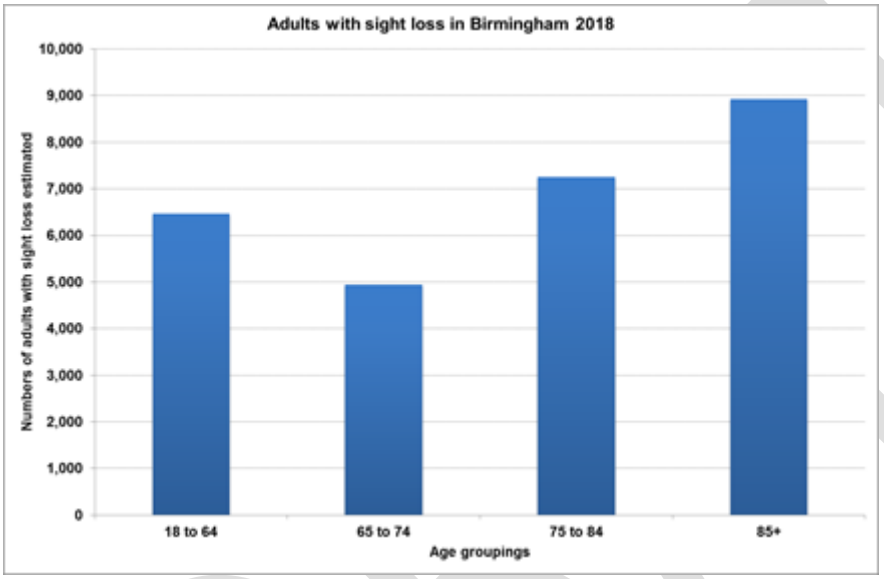
During 2019/20 Public Health as part of its deep dive JSNA reviewed these strategies and highlighted that many need to be continued and improved. Particularly, bereavement care following the death of a patient in the ‘end of life care’ scenario. Whilst in general hospices provide excellent care to the patients and relatives; the report highlighted that bereavement assistance was not consistent across the city and some of the more deprived areas virtually non-existent relying on local community groups, religious institutions and relatives who were also grieving.

Visual impairment

Sight loss is the inability to identify objects, people or data without assistance from glasses. The loss of sight can be debilitating and life changing particularly for those who experience total loss of sight. In Birmingham, there were approximately 28,100 people current living with sight loss in 2018.[98] Other sources estimate the number of people aged 65+ predicted to have a moderate or severe visual impairment will be 13,343 in 2025: rising to 17,534 by 2040.[99] RNIB have calculated that 75% of those with sight loss in Birmingham are over 65; nationally the percentage of people over 65% living with sight loss is 13%. Birmingham therefore has a far largest percentage in the 65+. The figure below shows those with sight loss in Birmingham.

Key statistics summary

Figure 24 Adults with sight loss in Birmingham 2018



Source: RNIB

Table 4: Registered blind or partially sighted by age band[100]

Age band	Registered blind	Registered partially slighted	Total
0-17	150	150	300
18-49	650	570	1,220
50-64	500	470	970
65-74	310	365	675
75+	2,420	3,030	5,450
Total	4,035	4,585	8,620

[98] Pezzulo et al (2017). The Economic impact of sight loss and blindness in the UK adult populations. RNIB and Deloitte Access Economics. Prevalences applied to subnational population projects.
[99] Institute of Public Care 2020, Projecting older people population information
[100] ONS 2019, Population estimates for the UK: mid 2018

4,005 of the people registered as blind or partially sighted in Birmingham have also been recorded as having an additional disability by the local authority.

In Birmingham, the direct cost of sight loss is estimated to be £39,900,000 each year[35]. This of course is for all age groups but as 75% of those with sight loss are over 65 the cost would be estimated at £29,925,000. The main elements of these costs are hospital treatments, sight tests, prescriptions and social care. The main elements of this cost are:

- unpaid care provided by family and friends
- devices/modifications.

Service model & data

Public Health England estimates the rate of Certificates of Visual Impairments (CVIs) for three of the main causes of preventable sight loss. In Birmingham:

1. The rate of age-related macular degeneration was 123 Certificates of Visual Impairments per 100,000 people over 65 years. In the main local opticians supported financially by the NHS via the CCG pay for regular eye checks. Equally, when the degeneration begins to affect daily life Social Services with the local council assist in making life easier for sufferers.
2. The rate of glaucoma was 11 CVIs per 100,000 people over 40 years. Glaucoma is care for by the local hospitals funded by BSOL CCG
3. The rate of diabetic eye disease was 4.2 Certificates of Visual Impairments per 100,000 people over 12 years. Treatment of this disease is again supported by local hospital via BSOL CCG

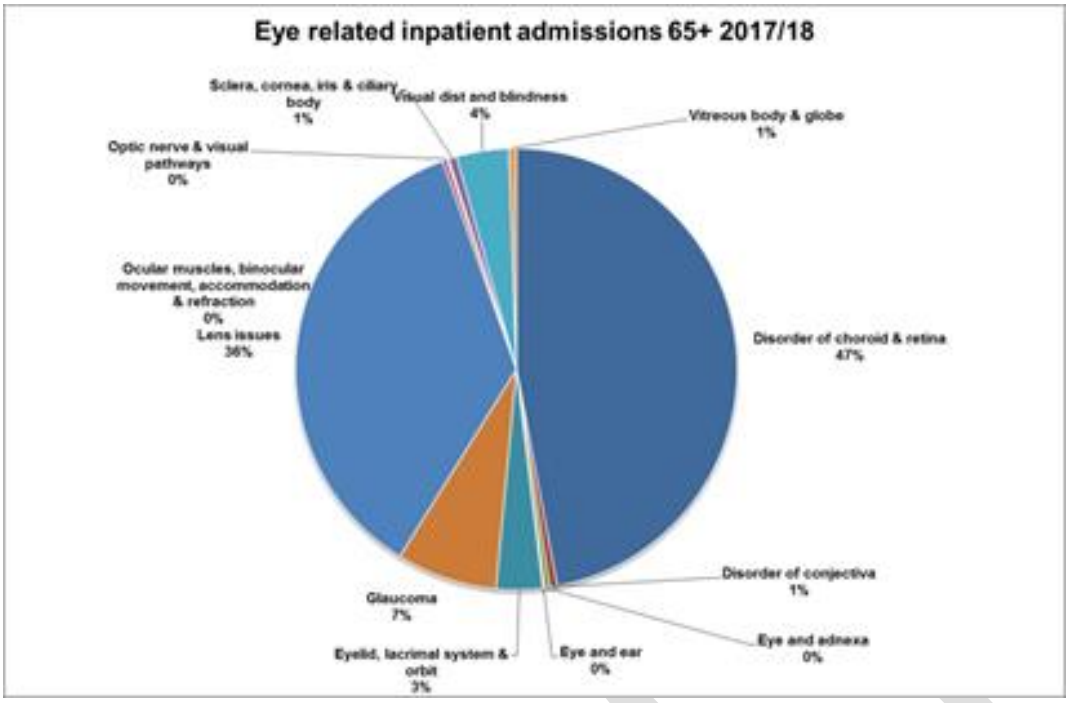
Headline Analysis

Birmingham	UK Stats	Main Causes
147,944 65+ Population	13% age 65+	Uncorrected refracted error (39%)
19% of all 65+ have sight loss	42% from ethnic minority communities	AMD (23%) mostly affects those over 65
28,120 with sight loss in total	56% from Most deprived LA	Cataract (19%)
21,120 over 65 (75%)		Glaucoma (7%)
Estimated 3,220 people over 65 experience a fall in any given year		Diabetic eye disease (5%)
29% from BAME groups in hospital admissions		
25% of hospital admissions from the Most affluent quintile 2019 IMD		

Sources: RNIB and PHE tool

During 2017/18 there were 21,535 inpatients admissions in Birmingham through visual impairment; of these 13,964 (64.8%) were 65+; 34% of inpatients admissions for visual impairment are for removal of cataracts. The figure below shows main causes of inpatient admissions.

Figure 25 Eye related inpatient admissions for persons aged 65+ (2017/18)



Source: NHS Digital 2017/18

Hearing Loss

Recent estimates suggest that there are 11 million people (approximately one in six) in the UK with hearing loss, making it the second most prevalent disability, and that 8m of these are aged 60 or above. Hearing loss increases sharply with age – nearly 42% of those aged over 50 years have hearing loss, increasing to about 71% of people aged 70+.[101]

Despite being a widespread and serious condition, it is unfortunately not well researched, with some charities suggesting that "less than 1% of the total public and charity investment in medical research (is) spent on hearing research".[102]

Hearing loss can be caused by a variety of means, broadly defined as:

- *congenital* where hearing loss will manifest at birth or shortly after, including such specific means as hereditary genetic factors, low birth weight, neonatal jaundice, inappropriate use of drugs during pregnancy.
- *acquired* hearing loss that can occur at any age, which includes injury to the head or ear, excessive noise either through recreation or work, infectious diseases such as measles, and age-related degeneration of sensory cells.[103]

The NHS Action Plan on Hearing Loss details the multiple impacts that hearing loss can have on individuals and wider society. In older age, hearing loss is a major challenge and can make it difficult to follow speech without hearing aids this increases the risk of social isolation and reduced mental well-being, additionally hearing loss can be correlated with mental illness, and cognitive decline including dementia. More widely hearing loss has been shown to have a negative effect on economic activity and the ability to learn new skills.[104]

Key statistics summary

Data around hearing loss beyond childhood screening programmes is sparse, however NHS estimates based on prevalence of hearing loss by age of population would indicate that as of 2020 there are 152,158 persons in Birmingham with hearing loss of 25dBHL or more (the level of hearing loss that would be consider clinically significant[105]), and that over half of these would be aged 65+. The same estimates also suggest that there are potentially 11,525 persons in Birmingham aged over 70 who have severe or profound hearing loss, and that all these figures are expected to increase over the next 10 years.[106]

Service model & data

The World Health organisation suggests that approximately half of all hearing loss could be preventing using Public Health measures earlier in the life course. They cite examples such as reducing exposure to loud sounds, screening for early signs, legislative enforcement, and campaigns to raise awareness.[107]

Treatments for hearing loss include:

- watch and wait, as sometimes hearing loss may only be temporary
- cleaning of wax from the ear
- hearing aids – several different types are available on the NHS or privately
- implants – devices that are attached to your skull or placed deep inside your ear, if hearing

[101] Hearing Link 2018, Facts about deafness & hearing loss
[102] RNID, Facts and figures Accessed 10/01/2021
[103] WHO 2020, Deafness and hearing loss
[104] Department of Health 2015, Action plan on hearing loss
[105] WHO, Grades of hearing impairment Accessed 10/01/2021
[106] NHS 2019, Hearing loss data tool
[107] WHO 2020, Deafness and hearing loss

aids aren't suitable
- different ways of communicating – such as sign language or lip reading

In the first instance anyone worried about hearing loss in themselves or others should seek advice from a GP, who can then refer on to specialist services if required. Social Care services can also provide support with day-to-day living for those affected by hearing loss or their carers.[108]

There are also charities that support people with hearing loss, the largest in the UK being Action on Hearing Loss who provide advice, guidance, support, and undertake independent research to better understand hearing loss.

[108] NHS 2018, Hearing loss

Older LGBT people

Lesbian, gay, bisexual and transgender (LGBT) older adults experience health inequalities and barriers to accessing health care.[109] Examples of these include:

- Poorer health outcomes due to lifestyle behaviour especially relating to drugs and alcohol
- Difficulties accessing health care
- Denial of sexuality and identity in health and social care settings
- Increased risk of requiring formal care
- Increased difficulty during end of life care and during bereavement
- Challenges creating new social networks and a higher risk of mental health issues
- Experiences of homophobia, aggression and violence.

Key statistics summary

There is no data available to calculate the numbers of LGBT people in Birmingham. National surveys estimate that 2.3% of the UK population identify as lesbian, gay or bisexual.[110] In the West Midlands regional the percentage was 2.3%. However, the proportion is likely to be higher than this, a 2011 Birmingham survey[111] found that two-thirds of LGBT people in the city were not completely out (open about their sexuality) and BAME people were less likely to be out than White people. This local survey highlighted issues with alcohol and drug use and that 20% of respondents had attempted suicide.

Service model & data

The UK Government's Equalities Office has a LGBT Action Plan.[112] One of the aims is to ensure LGBT people's needs are addressed by the NHS. This is being done through a National Advisor, improved monitoring and taking into account needs through Care Quality Commission inspections of health and social care settings.

Birmingham LGBT is a local charity advocating for and supporting lesbian, gay, bisexual and trans communities in the city. The charity offers a range of services including sexual health, events, domestic violence, counselling and more. Birmingham LGBT's strategic priorities for 2015-2020 include those relating to health and wellbeing: increasing resilience against poor health outcomes, improving mental and physical health and increasing awareness of the needs of LGBT people in mainstream services. In 2018 Birmingham LGBT launched a 12-month "Ageing with Pride" campaign[113] to empower LGBT people to be themselves and addressing issues around ageism.

The Sage Project in Leeds offers activities for older LGBT people as well as a drop-in session and

[109] Kneale, D *et al*. 2019, Inequalities in older LGBT people's health and care needs in the UK: a systematic scoping review. Ageing Soc.
[110] Sexual orientation, UK: 2018 Office for National Statistics, 2020
[111] Birmingham LGBT 2011, Mapping LGBT lives in Birmingham Keeble, S.E., Viney, D., Out & About: mapping LGBT lives in Birmingham, 2011
[112] Government Equalities Office 2018, LGBT Action plan 2018
[113] Birmingham LGBT 2019, Ageing with Pride

support group. The project also raises awareness through talks and workshops with professionals.

Headline Analysis

Older LGBT people experience health inequalities through unhealthy lifestyle behaviour and also through poor experiences in the health and social care system. There is a need to build trust and raise awareness with the health and social care sector.

The risk of social isolation and loneliness is greater in older LGBT people due to being more likely to be single, live alone and have lower levels of contact with relatives. Programmes to reduce this risk and provide support should be considered.

Birmingham Health and Wellbeing Board

	Agenda Item:15
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**16th March 2021**
TITLE:	**BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM INEQUALITIES WORK PROGRAMME**
Organisation	**Birmingham & Solihull Integrated Care System**
Presenting Officer	**Richard Kirby, Chief Executive, Birmingham Community Healthcare NHS FT**

Report Type:	**Information**

1. Purpose:	
1.1	The purpose of the report is to share the Birmingham and Solihull Integrated Care System Inequalities Work Programme with the Birmingham Health & Wellbeing Board for endorsement by the Board.

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

3. Recommendation	
	The Health & Wellbeing Board is recommended to:
3.1	Offer views on the 9 proposed areas for work as the programme develops including which should be our immediate priorities;
3.2	Endorse the approach to health inequalities within the work of the ICS as set out in this report.

4. Report Body

4.1 The evidence-base for the impact of inequalities in society and their impact on health is clear. COVID19 has underlined this dramatically.

4.2 Inequalities in health are affected by unequal access to and treatment within the NHS. They are, however, caused by much deeper inequalities in society including poverty and deprivation and access to housing, education and employment. Tackling these deeper causes requires a wider partnership especially with local government.

4.3 The Health & Wellbeing Boards and JSNAs for Birmingham and Solihull set clear strategies for tackling inequalities that the ICS should support.

4.4 The ICS Long Term Plan commits us "to "*reduce inequalities in health and wellbeing across our diverse communities".*

4.5 This work programme makes a commitment that the NHS organisations in the ICS will make tackling inequalities part of all we do and sets out how we propose to put tackling inequalities at the heart of our ICS.

4.6 We aim to do this by supporting ICS partners to each play their full role, to fully understand what the data tells us about access to and outcomes in healthcare, to build inequalities into all of our ICS programmes and to ensure that the ICS plays a full role in wider initiatives to tackle inequalities and their impact.

4.7 Our ICS Inequalities Group has set out 9 areas for action over time: understanding the challenge, place-based approach, community co-production, Anchor institutions, COVID19 response, preventative programmes, digital, children and leadership for equality.

4.8 This approach was approved by the ICS Partnership Board at its meeting in December 2020.

4.9 The Birmingham Health & Wellbeing Board is asked to consider and endorse the developing ICS Inequalities Work Programme.

5. Compliance Issues

5.1 HWBB Forum Responsibility and Board Update

5.1.1 Creating a City without Inequality

5.2 Management Responsibility

5.2.1 Richard Kirby, ICS Inequalities Lead and Chief Executive, Birmingham Community Healthcare NHS FT.

6. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
That a lack of engagement undermines impact.	Low	High	Engagement workstream within the programme to address this during the first half of 2021/22.
That a failure to align work with partners reduces impact.	Medium	High	Engagement with Health & Wellbeing Boards and ongoing work with local authorities and Directors of Public Health.
That a failure to commit resources reduces impact.	Medium	High	Commitment from the ICS Board to the work programme and initial support for the programme team.

Appendices
Appendix 1 - ICS Inequalities Work Programme (version 5, February 2021).

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

- The ICS Inequalities Group – see page 16 of the report

Birmingham & Solihull Integrated Care System

ICS Inequalities Work Programme

15th February 2021

Version 5. For discussion with Birmingham and Solihull Health & Wellbeing Boards

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Executive Summary (1)

- The evidence-base for the impact of inequalities in society and their impact on health is clear. COVID19 has underlined this dramatically.
- Inequalities in health are affected by unequal access to and treatment within the NHS. They are, however, caused by much deeper inequalities in society including poverty and deprivation and access to housing, education and employment. Tackling these deeper causes requires a wider partnership especially with local government.
- The Health & Wellbeing Boards and JSNAs for Birmingham and Solihull set clear strategies for tackling inequalities that the ICS should support.
- The ICS Long Term Plan commits us "to *"reduce inequalities in health and wellbeing across our diverse communities".*
- This work programme makes a commitment that the NHS organisations in the ICS will make tackling inequalities part of all we do and sets out how we propose to put tackling inequalities at the heart of our ICS.

Executive Summary (2)

- We aim to do this by supporting ICS partners to each play their full role, to fully understand what the data tells us about access to and outcomes in healthcare, to build inequalities into all of our ICS programmes and to ensure that the ICS plays a full role in wider initiatives to tackle inequalities and their impact.
- Our ICS Inequalities Group has set out 9 areas for action over time: understanding the challenge, place-based approach, community co-production, Anchor institutions, COVID19 response, preventative programmes, digital, children and leadership for equality.
- This approach was approved by the ICS Partnership Board at its meeting in December 2020.
- The Birmingham Health & Wellbeing Board is asked to consider and endorse the developing ICS Inequalities Work Programme.

Richard Kirby
On behalf of the ICS Inequalities Working Group
15th February 2021

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Our Process

- Aiming to set the scope and approach for the ICS inequalities workstream.
- Developed by the STP Inequalities group – a volunteer group of experts and / or enthusiasts with experience drawn from the NHS organisations in the ICS.
- Supported by separate conversations with and input from the two local authority Directors of Public Health and their teams.
- "Check in" with the ICS CEOs in August 2020.
- Drawn on existing work and the national guidance / ICS planning for Phase 3 during the early autumn.
- An earlier version of this document has been shared with the partners to the ICS for comments ahead of the ICS Partnership Board in December 2020 at which this approach was approved.
- We are now sharing this approach with the Health & Wellbeing Boards in Birmingham and Solihull for further development.
- The hope of the group is that we use this work at this time to make a real change in the way we work together to reduce inequality.

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Background (1)

- There is a well-established evidence base that inequalities in society drive inequalities in health outcomes. For example The Marmot Review (2010), The Marmot Review: 10 Years On and Build Back Fairer: The COVID19 Marmot Review.
- There is also a well-established picture of the impact of these inequalities in Birmingham and Solihull. For example the Birmingham JSNA and local area profiles, the Solihull JSNA and Solihull Health & Wellbeing Strategy.
- Inequalities in health outcomes are affected by unequal access to and treatment within the NHS. They are, however, caused by much deeper inequalities in society including poverty and deprivation and access to housing, education and employment. Tackling these deeper causes requires a wider partnership especially with local government.
- Through the Health & Wellbeing Boards in Birmingham and Solihull there are clear strategies for tackling inequalities which we want to engage with as an ICS.

Background (2)

- Work continues within both local authorities on tackling inequality including:
  - Birmingham Health & Wellbeing board "A City without Inequality" Forum;
  - Solihull are developing a strategy for tackling inequality.;
  - the North Solihull & East Birmingham inclusive growth corridor.
- The Birmingham & Solihull ICS Long Term Plan includes a commitment to *"reduce inequalities in health and wellbeing across our diverse communities in Birmingham and Solihull. . . .We want to promote inclusive communities, reducing social isolation, as well as valuing mental health equally with physical health."*
- The ICS has commissioned a pragmatic review of evidence from the University of Birmingham to inform our life course strategy which sets out evidence of impact for some key interventions (e.g. early years support).
- COVID19, the Black Lives Matter movement and economic impact of lockdown all reinforce the impact of poverty, deprivation, racism and discrimination on people living in the communities we serve.

Background (3)

- Reports by Public Health England highlight the impact of inequality in the context of COVID19 including for BAME people and people with a learning disability. A range of risk factors for COVID19 including combination of ethnicity, deprivation, disability, obesity and long-term conditions are affected by inequality.
- The NHS is committed to playing its part in tackling inequalities. The national Phase 3 Implementation Guidance included specific requirements for systems.
- Understanding what our data tells us about variation in access to healthcare and variation in outcomes for different conditions amongst different communities is important for the NHS to play its full role in tackling inequalities and their impact on health. There is national evidence for example of differences in outcomes for different communities in the treatment of diabetes.
- This report seeks to respond to this by setting out how we propose to put the issue of inequalities at the heart of our ICS.

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ICS Inequalities Work Programme: Purpose

- Purpose: to contribute to improving the health and wellbeing of the people of Birmingham and Solihull by putting action to tackle inequalities and the impact of inequalities on health at the heart of the work of the ICS.
- We aim to do this through:
  - supporting ICS partners play their part fully in reducing inequalities and their impact on health aligned to the Health & Wellbeing Boards for Birmingham and Solihull;
  - building reducing inequalities and their impact on health into all of the programmes of the ICS;
  - ensuring the ICS partners are fully engaged in wider initiatives that reduce inequalities including housing, regeneration, sustainability, education and skills.
- In undertaking this work we will seek to:
  - work with the communities we are aiming to serve;
  - build on and share good practice where it already exists;
  - include the West Birmingham ICP as a core partner.

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Potential Frameworks

We considered a range of ways we could approach this agenda. We want to balance **place-based** and **life course** approaches to get the best of each. Three possible frameworks we considered are set out here.

Marmot 6 Policy Objectives

1. Give every child the best start in life.
2. Enable people to maximise capability and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.

NHS National Phase 3 Priorities

1. Protect the most vulnerable from COVID19.
2. Restore NHS services inclusively – monitor uptake and impact.
3. Develop digitally-enabled pathways that support inclusion.
4. Accelerate preventative programmes – aimed at those at greatest risk.
5. Support those who suffer mental ill health.
6. Strengthen leadership and accountability for inequalities.
7. Ensure datasets are complete and timely.
8. Collaborate locally to deliver action to address health inequalities.

STP "Agenda for Action" (August)

1. Role of NHS Providers as "Anchor Institutions".
2. Inequalities and COVID19 recovery – and Wave 2.
3. Supporting our Citizens.
   a. Working with those who are most vulnerable.
   b. Promoting resilience and good health.
   c. Working with communities in particular need.
4. Engagement and co-production.
5. Building a population health management system.

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Proposed Areas for Work (1)

1. Understanding the Challenge. Bring together the data we have available on inequality in relation to the delivery of health and social care to support setting of priorities. This should include a proper understanding of the impact of differences in access to and outcomes from healthcare delivery.
2. A Place-based Approach. Working with PCN CDs develop an ICS programme of support to enable our PCNs to understand inequalities in their populations and take local action in response. Build on existing approaches to community assets in developing this work.
3. Community Co-production. Identify and support good practice in engaging communities in the design of services.
4. Anchor Institutions. Review the action we are already taking (e.g. social value procurement policies) and set a small number of priorities for delivery across all the partners in the ICS.
5. COVID19 Response. Ensure our COVID19 response is providing support to those most vulnerable to COVID19 (e.g. due to ethnicity, age, co-morbidities, disability and/or obesity).

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Proposed Areas for Work (2)

6. Preventative Programmes. Identify priority preventative programmes for our population and ensure we are supporting them to deliver maximum impact.
7. Digital. Through the ICS's Digital work programme ensure that our approach to digital transformation is reducing inequalities in access to healthcare and wherever possible in outcomes for patients.
8. Children. Given the well-established importance of early years experience for longer-term inequality, work with the Birmingham Children's Partnership and the children's partners in Solihull to make maximum impact for this group.
9. Leadership for Equality. Ensure our organisations have board-level designated leads for this work. Launch an ICS-wide leadership development programme focussed on tackling inequalities.

We propose that work on equality, diversity and inclusion for NHS organisations as employers will be led through the ICS People Board and we will ensure we work closely together for maximum impact.

Making A Difference

In developing this work programme we have considered how we can have an impact through the ICS in different ways for different areas of our work.

1. Work led directly by the ICS Inequalities Board	• 1 Understanding the challenge – bringing the data together. • 4 Anchor institutions – supporting ICS-wide delivery. • 9 ICS-wide leadership development programme for inequalities.
2. Work led through other ICS-wide programme boards influenced by the Inequalities Board	• 5 COVID19 Response – building inequalities into our response. • 7 Ensure digital transformation reduces inequalities. • Plus the ICS People Board work on inclusion.
3. Work that is "place –based" and supported by the Inequalities Board	• 6 Preventative programmes. • 3 Community co-production work.
4. Work that needs "place-based" and ICS-wide work to be joined up through the Inequalities Board	• 1 PCN "place-based" work on inequalities • 8 Children – focus on making an impact at the start of the "life course".

Live healthy Live happy Birmingham and Solihull

Getting the Programme Set Up

- STP Inequalities Board. Establish an ICS Inequalities Board to lead this work, reporting to the ICS Partnership Board and chaired by a system non-executive director. Aim for first meeting in April 2021.
- Programme Leadership. System non-executive chair (to be appointed) Chief Exec lead (Richard Kirby, BCHC); programme lead (to be appointed).
- Organisational Leadership. Executive leads and non-executive "champions" from NHS ICS organisations have been identified. Build a network of these leads to support their work.
- Areas of Work. Agree initial areas for work from the 9 proposed workstreams. Identify leads and scope work. Aim to complete by end March 2021.
- Engagement. Share approach with Health & Wellbeing Boards. Organise community and stakeholder engagement within localities (in Birmingham) and in Solihull to develop the work programme further with wider input from across the ICS.

Establishing our Workstreams.

1. Stakeholder and community engagement. Health & Wellbeing Boards, "locality" engagement events and develop a prototype for community engagement at PCN-level working with 2 PCNs initially (1 x East Birmingham and 1 x North Solihull).
2. Data. Linking closely to other work on population health datasets to establish how we use what we already know.
3. Anchor Institutions. Identify 2-3 shared priorities for the NHS organisations in the ICS for 2021/22.
4. COVID19. Engage with the vaccination programme and the ICS COVID19 recovery workstream to support work on inequalities.
5. Service Priorities. Agree approach to services priorities across the life course including:
    a. Early years / best start in life – all the evidence says this is where impact can be greatest;
    b. Living with long-term conditions – diabetes, hypertension, obesity; linked to COVID risk factors.
    a. Mental health

Conclusion & Next Steps

- This report has proposed an approach to putting tackling inequalities and their impact on the health of our citizens at the heart of the work of our ICS for consideration by the Health & Well Being Board.
- The HWB is recommended to:
  1. Offer views on the 9 proposed areas for work as the programme develops including which should be our immediate priorities;
  2. Endorse the approach to health inequalities within the work of the ICS as set out in this report.

Thank You to . . .

ICS Inequalities Group (as at February 2021)

- Dr Anand Chitnis, Solihull GPs
- Suzanne Cleary, BCHC
- Carol Cooper, BCHC
- Natalie Daley, BWCH
- Dr Phil Debenham, BWCH
- Carl Harris, BSMHT
- Carol Herity, BSol CCG
- Garry Marsh, ROH
- Sue Marsh, BCHC
- Pip Mayo, SWB CCG
- Jane Powell, BWCH
- Rachel O'Connor, BSol CCG / BSol ICS
- Terence Reed, SWB CCG
- Sean O'Rourke, BSol CCG
- Lakhvir Rellon, BSMHT
- Dr Doug Simkiss, BCHC
- Dr Fay Wilson, B'ham GPs

Birmingham Health and Wellbeing Board

	Agenda Item: 17
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**16 March 2021**
TITLE:	**Local Covid Outbreak Engagement Board**
Organisation	**Birmingham City Council**
Presenting Officer	**Elizabeth Griffiths, Assistant Director of Public Health**

Report Type:	**Information**

1.	**Purpose:**
1.1	To inform the Board of Governance and purpose of the new sub-Group of the Health and Wellbeing Board, the Local Covid Outbreak Engagement Board.

2.	**Implications:**	
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	The Board is asked to note this update of the Local Covid Outbreak Engagement Board.

4.	**Report Body**
4.1	The Local Covid Outbreak Engagement Board is a new sub-committee of the Birmingham Health and Wellbeing Board. The Board is required by national guidelines for each upper tier local Authority's response to the Covid 19 outbreak.

4.2 The purpose of the Board is to provide political ownership and public-facing engagement and communication for outbreak response to Covid19 in Birmingham.

4.3 The Board has been set up to:

- Take an overview of the progress of the local implementation of Test and Trace.
- Ensure that the Test and Trace response in Birmingham is delivering the right interventions to protect the health and wellbeing of citizens
- To influence the development of the local Test and Trace programme.
- To promote communication and engagement with stakeholders and residents of Birmingham related to Covid 19 and the Test and Trace programme.

4.4 The Board is chaired by the Leader of the Council; membership comprises five elected Members, the Director of Public Health, Assistant Director of Public Health, the Birmingham and Solihull and the Sandwell and West Birmingham Clinical Commissioning Groups, WM Police, BVSC and Birmingham Healthwatch.

4.5 The first meeting of the Local Covid Outbreak Engagement Board (LCOEB) was held on 24 June 2020, with meetings held on a monthly basis.

4.6 The LCOEB receives a regular Covid19 situation update – both at the monthly meeting and on a weekly basis to members of the Board. These updates include the latest position in relation to Covid19 cases across the city, testing uptake, the proportion of tests taken that return a positive result. As the this is a rapidly changing situation the latest epidemiology is presented to the Board.

4.7 Appended to this report are the publicised minutes of the LCOEB.

5. Compliance Issues

5.1 HWBB Forum Responsibility and Board Update

5.1.1 Whilst Birmingham's emergency plan is activated, the Test and Trace Cell will form part of the "Silver" command structure as a cell of the Tactical Cell. In parallel, the Test and Trace Cell feeds into the Birmingham Health Protection Forum, chaired by the Director of Public Health, which is a sub-group of the Health and Wellbeing Board.

5.1.2 Recognising that Test and Trace is likely to extend beyond twelve months, at such a time as the emergency response structures are stood down, formal governance of the Test and Trace Cell will be via the Health Protection Forum.

5.1.3	The Local Covid Outbreak Engagement Board will provide democratic oversight to the Test and Trace response.

5.2	***Management Responsibility***
	The Director of Public Health is responsible for publishing the Local Outbreak Response Plan for the City and Chairs the Health Protection Forum. The Assistant Director of Public Health chairs the Test and Trace Cell and is responsible for the local operational delivery of Test and Trace in Birmingham.

Appendices
Appendix 1 - Local Covid Outbreak Engagement Board Minutes - 14.12.20 Appendix 2 - Local Covid Outbreak Engagement Board Minutes - 27.01.21

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

Elizabeth Griffiths, Assistant Director of Public Health

BIRMINGHAM CITY COUNCIL

LOCAL COVID OUTBREAK ENGAGEMENT BOARD MONDAY, 14 DECEMBER 2020

MINUTES OF A MEETING OF THE LOCAL COVID OUTBREAK ENGAGEMENT BOARD HELD ON MONDAY 14 DECEMBER 2020 AT 1500 HOURS ON-LINE

PRESENT: -

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG
Andy Cave, Chief Executive, Healthwatch Birmingham
Chief Superintendent Stephen Graham, West Midlands Police
Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and Deputy Chair of the LCOEB
Councillor Brigid Jones, Deputy Leader of Birmingham City Council;
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Councillor Paul Tilsley
Councillor Ian Ward, Leader of Birmingham City Council and Chairman for the LCOEB

ALSO PRESENT:-

Professor Simon Ball, Chief Medical Officer, University Hospitals, Birmingham
Elizabeth Griffiths, Assistant Director of Public Health
Gary James, Operations Manager, Environmental Health, Neighbourhoods, BCC
Rachel O'Connor, NHS Birmingham and Solihull CCG
Dr Mary Orhewere, Interim Assistant Director of Public Health
Errol Wilson, Committee Services

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NOTICE OF RECORDING/WEBCAST

92 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.

APOLOGIES

93 An apology for absence was submitted on behalf of Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care; Paul Jennings (but Rachel O'Connor as substitute); Mark Croxford (but Gary James as substitute) and Elizabeth Griffiths. Councillor Brigid Jones, Deputy Leader will only be able to attend the first hour of today's meeting due to a prior engagement.

DECLARATIONS OF INTERESTS

94 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.

WELCOME AND INTRODUCTIONS

95 The Chair welcomed everyone to the Local Covid Outbreak Engagement Board meeting.

MINUTES

96 **RESOLVED:-**

The Minutes of the meeting held on 26 November 2020, having been previously circulated, were confirmed by the Chair.

CHANGE TO ORDER OF BUSINESS

97 The Chair advised that he would take agenda item 7 ahead of the remaining reports.

ENFORCEMENT UPDATE

Gary James, Operations Manager, Environmental Health, Neighbourhoods, BCC introduced the item and drew the attention of the Board to the information contained in the report

(See document No. 1)

In response to questions and comments, Mr James made the following statements:-

- Mr James noted the Chair's enquiry concerning the wearing of face masks in shops and its enforcement and advised that the regulations for

members of the public was the requirement of the Police were to enforce the wearing of face coverings in shops.

- That the Police also had under those regulations the powers to deal with members of staff within the businesses from an enforcement point of view through the Health and Safety at Work Act, Environmental Health also required that businesses had that within their risk assessments.

- Although the regulations did not give that specific powers to deal with the wearing of face coverings for employees, we were using our health and safety powers to deal with that.

The Chair commented that the Police will find it difficult to enforce that now that retailers had reopened as it would be a hugely logistical task. Mr James further advised that the information they were getting from the Police was that they had increased their enforcement of the non-wearing of face coverings.

98 **RESOLVED: -**

That the Board noted the report.

COVID-19 SITUATION UPDATE

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

(See document No. 2)

The Chair commented that Dr Varney and his team had done an excellent job over the period of this pandemic and dealing with it in the City of Birmingham. All of whom were in the Public Health team was a credit to the City Council. The Chair requested that his thanks be passed on to that team and the work that had been done over this period.

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

a. Dr Varney noted Councillor Tilsley's queries concerning the increase in Covid cases in Garretts Green and Sheldon Wards and whether Covid Wardens could be directed to the shopping centre to ensured that face coverings rules were being followed and advised that Public Health had undertaken an analysis of those Wards that were changing and that was the latest data that came today. Public Health was starting that work to look at whether there were any patterns that could be seen.

b. Dr Varney added that Public Health would pick up with colleagues in Enforcement to see how the Covid Marshalls could be deployed. The Covid Marshalls were gradually working through the shopping high streets of the City and we were starting to look at what else we could do to help direct this a bit more.

c. One of the key limitations we had was that unless individuals told the National Contact Tracing Service that they went to the shopping centre for example, Public Health would not know that information.

d. This was one of the request of anyone who was watching that if they tested positive and they were contacted by the service the more information you could give that service about where you had been in the days before you developed symptoms the easier it would be for Public Health to try and contact you.

e. The issue was whether there was any common points of contact so that we could follow-up and try and do our best without it spreading any further in the community. As of last week Public Health had started to write out to Ward Members in the highest ranked Wards with a bit more analysis of the data to support and lead them in their local response partnership with local NHS colleagues. Dr Varney undertook to follow up the issue with Councillor Tilsley.

f. Dr Varney noted Dr Aslam's query concerning schools and his assurance that they were not a problem and the different views taken by schools in London and whether London was looking at data differently and advised that there were two things: - if the data looked different if he looked at the heat map for London, their case rate had shot up in the under 15 and under 20 age groups. Birmingham's had not and had been stable.

g. London's problems looked very different and that was true across the country. We were looking carefully at the single age group and our case rate per age group. Dr Varney added that the reason he was at pains to stressed each time as he gets asked each time whether a school was doing it.

h. The second thing was that in Birmingham Public health had set up early additional support for schools. Much like we did care homes we had a multi-disciplinary team supporting schools when they got cases, doing regular webinars with Head teachers, meeting with Trade Unions. All of that was going on so we had good intelligence about what was happening in schools.

i. This was slightly different from the approach taken by London. These were different patterns in Birmingham, but was one that every time he looked at the date, he looked at whether there was anything they were missing, were there anything they could draw even if it was tenuous was there enough of a link there for us to step in and try and get this outbreak further under control. We were not seeing this in our schools at present. One of the things that was being though about in London and which many parents were thinking about was preparations for the Christmas bubble.

j. This was one of the tension point but was a national position and the Department of Education was clear on that, but in terms of the data Public Health was not seeing that spiking in children in Birmingham. It

was very stable and had since late September been the same. When we delved down into individual year groups it did not fluctuate much. There was nothing there that would justify us pushing schools to move online before the end of the term.

k. Dr Varney noted Councillor Hamilton's enquiry regarding the increase in cases in the Holyhead Ward and whether this was caused by cases in schools or multi-generational households and advised that in Holyhead what was seen was that we had got of relatively large houses. We had what was called clusters where there were more than two people associated with a postcode and what was seen in Holyhead was that there were 12 clusters.

l. Although the average size of those clusters were only two people, which would fit with a household, there was a couple where there was a household of 6 people. These were focused in a particular postcode, but it was known that Holyhead was a small Ward in terms of postcode. When we looked at somewhere like Garretts Green it was a slightly different picture but in Garretts Green there were fewer clusters as there was only eight in one of the postcodes, but they were larger.

m. The average size of the cluster was three so those would also go against it being say a care home or a school for example because those would be specific postcodes and you get a larger number. Public Health looked at the data in terms of how many schools we had. One of the things that skewed the data which was whether care homes as residential settings were more likely to skew data particularly if you had a relatively small numbers.

n. A care home could generate 10 to 15 cases and for one of the smaller Wards that did make a difference. Dr Varney undertook to get back to Ward Members with more details on what was happening in their individual Wards and whether there was more Public Health could tell them as to what was happening.

o. In terms of schools what Public Health was seeing was that some schools were persistently having children who tested positive but they had two children that tested positive this week in Year Group 10 for example and then in two weeks' time they had a child in Year Group 6 and a child in Year Group 8.

p. What the parents were feeling was a lot of bubbles of children being sent home continually from one school, but when we looked at how many children had tested positive form that school it was a small number compared to the overall number of children in the school. From the parents view point what they felt was a lot of children coming home repeatedly because a child was infected in their bubble and then it was another child three weeks later. But the children did not connect to each other and this was a bit of the tension Public Health had at the moment but we kept an eye on it.

The Board noted the slide presentation.

UPDATE FROM THE NHS

100 Rachel O'Connor, NHS Birmingham and Solihull CCG and Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG presented the item.

Ms O'Connor drew the attention of the Board to the information contained in the slide presentation.

(See document No. 3)

Ms O'Connor highlighted the following points: -

1. That the impact of the previous lockdown and the restrictions kicking in did not really had an impact on the health system and hospital numbers for about a month. This was the reason we would still see the current picture within our hospitals still having increases in the number of cases that were presenting.

2. There was typically a log time of around a month and it would be a few more weeks before we started to see the impact of those lockdown restrictions. The current position remained that we still saw a rising demand across all of our access points for health and all of those settings.

3. In terms of numbers we currently had 430 Covid admissions and we were yet seeing a plateau so they continued to increase. What we were seeing however, was that the numbers today at University Hospitals Birmingham (UHB), our ITU our critical care numbers for Covid admissions was down to 36 so we had seen a decrease as that was around 50 last week which was good news.

4. Ms O'Connor advised that she would caveat that as they could have fluctuations and it was a bit early to draw attention to that particularly as we saw the numbers increasing of those that had been admitted into hospital.

5. A review of the position would be taken on Wednesday at Gold Call across the system to look at potential contingency options if we continue to see those rising in increasing numbers particularly for the health sector as January in particular after the festive period was our busiest time in the health sector with our general winter increases in hospital admissions and people accessing support.

6. On top of what was already a busy period and the complexity of Covid admissions we needed to ensured that we had the best flow and the right capacity available and needed to look at options on Wednesday if the numbers continue to increase. It was important to emphasised that even with that particularly with the public watching that for those with serious conditions the need to access help to please continue to do that.

7. It was important for those who required emergency and urgent treatments that they still access the care that they needed. We were also seeing for those patients that required support for serious mental illness those numbers were up.

8. The impact of the wider isolation as people had been impacted by lockdown and potentially started to take effect. It was good news that we started to see those potentially UHB numbers come down as this had an impact on the number of planned care – elective procedures and being able to be continued.

9. We have had over the last month to take some difficult decisions about what planned care or elective care we could continue to do but it was important to reiterate that those who needed those urgent elective procedures they were doing their best to protect that capacity and keeping those procedures and operations available for those that needed it.

10. We knew there was a general interest about the vaccine availability, but would reinforce that when it's your time to come forward for the vaccination you will be contacted. It was important that GPs phones were not clogged with calls for people who needed to access treatment, speak to Primary Care as those lines were free. Please be assured that you will be contacted when your time was ready. Sickness levels amongst health staff were higher than the previous year

The Chair commented that the number of people being admitted to hospital particularly those occupying or being ventilated in ITU beds were one of the best methods the government looked at. The Chair added that he had paid close attention to those numbers in discussions with Government last week about which Tier Birmingham should be in.

Dr Aslam made the following statements:-

i. The position was as described by Ms O'Connor and that in West Birmingham they find themselves in a similar position. We had seen a drop in the community rate and the Black Country the community rate had fallen during the lockdown but they were starting to rise again.

ii. We had seen a reduction in the number of people that were admitted with Covid into hospital but the intensive care beds had remained stubbornly stable from week on week and that was a picture that was replicated across Birmingham as seen from Ms O'Connor's evidence.

iii. This was a bit of a worry as we had two conflicting priorities – a vaccination programme going alongside control of the Covid-19 pandemic and testing people appropriately and then reacting to that. We had to significant pieces of work going on.

iv. We had the vaccination programme which Professor Simon Ball, Chief Medical Officer, University Hospitals, Birmingham will speak about in his presentation later on for Birmingham wide. We had been working with the rest of Birmingham to ensure that the vaccination programme was

appropriate for all of the Birmingham residents and had been working closely and well on that.

v. Walsall had been self-right in the Black Country and left Birmingham to have their vaccination. They had them last week and had gotten through all their vaccination in the time frame. We had two Phase 1 sites that were going up tomorrow one in West Birmingham and one in Sandwell and they had booked in 800 patients in each of the sites already.

vi. The national programme had not quite transpired as yet but they had been able to book in. The demand in the population of people we were looking to vaccinate was high and this was something that we should continue to encourage.

vii. There was a group of people in the younger population that were probably more reluctant and were more concern about the vaccination. They were not the priority in terms of the vaccination and part of the process so they would continue to support that.

viii. Again with the challenge around the flu vaccination for West Birmingham we were better than we were last time. There had been a push on those vaccinations but it was going to be difficult to vaccinate people once they had the Covid vaccination programme.

ix. Dr Aslam encourage people in the same way Ms O'Connor had to get vaccinated. To get vaccinated for flu you had to wait at least a week before you had your Covid vaccination and then a further three weeks wait at least before you could have the second Covid vaccination and a week after that before you were likely to have a significant level of immunity.

x. It was important for this period of time now for people to have the flu vaccination. There was something about the communications that we do with Dr Varney and ourselves to ensure that the communication around Covid, stopping the spread, we will have a lot of older people to go out and get vaccinated. We had a 15 minutes wait time within each vaccination site which was going to complicate the flow.

xi. We needed to thing carefully what the flow of patients were but we did not want lots of Covid in the community when we were trying to get our most vulnerable people out to get vaccinated. There was a challenge that we needed to meet not only from a communications perspective but from a logistical view point as well.

Councillor Paul Tilsley enquired whether colleagues who may have had the news that which was leading to a spike in cases which was of concern.

In response to questions Dr Aslam made the following statements: -

1. Dr Aslam noted Councillor Hamilton's query concerning the clinically extremely vulnerable in relation to vaccinations in that group especially

adults with down syndrome and advised that they were currently following guidance at the moment about who were to be vaccinated.

2. The people we were told to vaccinate at the moment were age specific and there were some pilots around the country around care homes. Learning disability and people with down syndrome were included in that and were areas that would be high priority, but we had not been given the guidance on when on the priority list they would be.

3. As you may be aware, we were probably in the process of having a second vaccine going through the approval process which would have much more vaccine and much easier to store. It would be more amenable to be going to places whether that were care homes or institutes. This would be much more amenable to taking on the vaccination approach. There was a programme and this was decided nationally about the criteria that were being applied to the vaccination programme.

4. Dr Aslam noted Councillor Tilsley's enquiry concerning BBC news report that there was possibly a variant of Covid in London and the South East and advised that they needed to follow the science. He added that fairly early on in this pandemic the Covid virus was mapped out in terms of its R and A sequencing so we needed to follow the science on that. Dr Aslam stated that he was not aware of the new variant as they had not yet been given any update on it.

Dr Varney advised that he understood that the Secretary of State for the Department of Health was currently speaking in the Houses of Parliament and had made reference to this. The Secretary of State had stated that he was not clear whether the new variant was causing the rapid spread in the south or not but he did highlight that the virus was spreading in all ages. Dr Varney added that it was known that the Covid virus varies as it spreads as we had seen the mink variant that came out of Denmark a few weeks ago which did not change anything in particular with the virus.

Dr Varney advised that there were new variants that were identified through the genetic typing of virus. There was a very rapid piece of work that was being done globally to look at what this tells us, whether it suggested that the virus was changing the way it behaved. But for everyone watching and listening today the key message was that the virus had not gone away. It was still dangerous and it was still spreading and the things that we all had to do to stop the spread was – *washing our hands; covering our face and keeping our distance*. These were the things that protected the people that we loved and cared about. Whether it was a new variant or not it did not change those things it was just another thing that meant we had to stay on our toes and keep on top of this pandemic.

The Chair commented that we were all in one way or another beholden to the NHS perhaps over the last 9 or 10 months. We were more beholden to the NHS than we ever had been. The Chair expressed thanks to Ms O'Connor and Dr Aslam and all of their colleagues in the NHS for everything they had done

during this present pandemic as it was an incredible response and by science around the world.

The Board noted the report.

TEST AND TRACE IMPLEMENTATION AND ENGAGEMENT PLAN UPDATE

101 Dr Mary Orhewere, Interim Assistant Director of Public Health presented the item and drew the attention of the Board to the information in the slide presentation.

(See document No. 4)

The Chair commented that there was potentially some change in the Tiers being announced this week. But if we remained in Tier 3 and there were expectations that we would then all of the restrictions that applied for Tier 3 we carried with us if we moved into a different area for whatever reason as we were still restricted by the restrictions that applied to Tier 3.

The Chair further commented that people should think carefully about the easing of restrictions on those five days over Christmas and what they do. As stated earlier the virus was still out there and it was known that it killed people and he did not think anyone would want to place any of their loved ones at increased risk over the Christmas period. The Chair urged everyone to think carefully over that period of restrictions in what they do and who they met with.

The Board noted the presentation.

TESTING STRATEGY

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

(See document No. 5)

The Board noted the presentation.

VACCINATION ROLLOUT

103 Professor Simon Ball, Chief Medical Officer, University Hospitals, Birmingham presented the item and reinforced the Chairs comments with regards to responsible behaviours around Christmas and stated that this was absolutely crucial. Professor Ball added that as Ms O'Connor had alluded to, we had not seen any change in the number of patients we had as in patients at University Hospitals Birmingham over the last month or so.

Professor Ball highlighted the following:-

- The number of admissions we had during the course of November for example was 1273 which was 43 fewer than we admitted in April.

- Alongside all of that we had been doing a lot more of the normal types of work that we do both from A&E and a degree of elective work as well which was very different to the situation we had in April.
- It was absolutely crucial that we collectively and with our population understand that we were not out of the woods by any means. It was hoped that the vaccination programme would give us the opportunity to navigate our way out of this over the course of the next many months.
- We were in close contacts with Sandwell and West Birmingham Hospitals with his colleague Dr David Carruthers and he would echo these comments very much.
- As for the vaccination programme, this was progressing which was a good thing. We went live at the Queen Elizabeth Hospital site on Saturday vaccinating 240 people. As you had heard we were targeting the over 80s specifically but also residential care home workers and other important groups and health care workers.
- This was continuing and we now had a supply of Pfizer/BioNTech vaccine currently going live not just on this site but delivery was due today with a view to starting vaccination across 12 different Primary Care Networks across Birmingham and Solihull. Professor Ball stated that he had been told that they had got high levels of bookings already into their vaccine programme which was excellent news.
- Realistically in terms of mass vaccination and going live with the mass vaccination site that we were preparing the work around that was looking into the early part of 2021 and would clearly be significantly be facilitated by availability of the Astra Zeneca vaccine which as we know the requirements for a cold chain were significantly less stringent than they were for the Pfizer vaccine.
- Professor Ball stated that they would be able to give the Board more information over the coming month with regards to that. This was a rapidly evolving scenario and we would be dependent on delivering into our care homes upon our colleagues in Primary Care Network and would come back and touch on that.
- Across Birmingham and Solihull alone we were talking about essentially delivering 1.92m doses of vaccine over the coming months. This was a huge undertaking to achieve whilst maintaining significant levels of social distancing for those who were attending the programme. This was certainly the largest logistic exercise many of us had ever been involved in.

The Chair commented that it was a huge logistical task to inoculate the population of Birmingham and it would take some time to do that. The Chair added that Councillor Matt Bennett unfortunately could not be present at the meeting but that he had a question on the vaccination roll out which was as follows:

What arrangements are being made for those who are in the priority group and are housebound? My understanding is that home visits to administer the vaccine are not currently possible, but there will be people – particularly those who live in multi-generational households with people who are going out to work or school every day – who are very much at risk and will require vaccination.

Councillor Paulette Hamilton enquired how local government could support the NHS in what they were doing as this was a massive undertaking for the NHS.

Professor Ball advised that a lot of this was around communications and we had this strange dichotomy where we promote the importance of vaccination close to complete coverage as we possibly achieved. It was clearly an important goal for all sorts of reasons but at the same time, it was crucial that we were targeting vaccinations to the right people and not overloading particularly if you looked at our general practices with members of the population directly contacting Primary Care for example for vaccinations. That communication would come out of the major logistical exercise along with the CCG going on around targeting the appropriate age groups.

In terms of the extremely vulnerable, that particular group came in alongside those aged 70 and above, relatively prioritised and not yet identified as the same risk with those aged 80 or above. With regards to those who were unable to attend either a mass vaccination site or their GPs then arrangements would unfold rapidly over the next few weeks and in particular it was suspected that (but he hesitated to comment on the work that was being delivered by the CCGs, Primary Care Networks and GP colleagues). It was suspected that this would then be rolled out through GPs who knew their patients well and who often for patients who could not attend their general practices visit those patients.

Dr Aslam stated that conversations were had with the Health Care Trust and that every winter they had a scenario where the District Nurses would be visiting housebound patients on a regular basis. They took a few vaccinations from us and vaccinated those people in their own homes. We had a further conversation with them this year about Covid vaccine about not only vaccinating housebound patients when the logistics of the vaccine became more amenable to that but we needed to be given guidance on it. We were also having conversations about vaccinating carers as there was a strange situation in the first batch of vaccines where a 79 year old partner of an 80 year old gentleman came in and was not vaccinated.

We needed to take a more pragmatic view of getting to the point that we needed to get to which was a large portion of the population, particularly the at risk groups were vaccinated. Whatever we needed to do in terms of flexibility we needed to show to meet that agenda was an important one to bear in mind. The housebound patients fit into our vulnerable groups and we will be visiting them to give them their vaccination if they were unable to leave their homes.

Dr Aslam commented that we appeared to have three separate areas – hospital vaccination sites, mass vaccination sites and what the networks will deliver. Caveating that we will have some patients it was though that the networks would take some responsibility as well. We knew who they were and would be able to vaccinate them. Dr Aslam enquired how they could be assured that they were not competing with each other in terms of getting people into the vaccination sites as this was clearly a challenge. Dr Aslam added that if we had the IT infrastructure that would be great as we would know who to vaccinate and we could carry on vaccinating the people we needed to

vaccinate. To avoid the competition, clearly communication would be important.

Professor Ball advised that a lot of trouble had been gone through to develop an IT system. If it did not link up, we would be at least be able to provide reports or reporting back out on a daily basis. This was probably the way to mitigate much of this as possible. Obviously, the team that was delivering the vaccination programme particularly the mass vaccination programme, the hospital based vaccination programme were the same team with members of the CCGs and working closely with members off the Primary Care Networks.

That level of communications was on-going but it was a real challenge and it would not be surprising to hear him say that although we worked in the NHS it was remarkably how difficult it was to send communications and information across different sites in terms of that messaging. We were majoring on using the NHS numbers as the key for that and working closely with the CCGs in identifying those 80 year olds who were attending UHB. There was a kind of dual communication both to you and the UHB at present and then identifying those individuals whom we had managed to vaccinate. It was a real challenge and the challenge of rolling this out rapidly and was a challenge also about clarity in communication which was working better at a local level than it was at a central level.

The Chair commented that we as a local authority will do all we could to assist with communications.

The Board noted the presentation.

PUBLIC QUESTIONS SUBMITTED IN ADVANCE

104 The Chair introduced the item and advised that there was no public question submitted for this meeting.

TEST AND TRACE BUDGET OVERVIEW

Dr Justin Varney, Director of Public Health presented the item and drew the attention of the Board to the key information contained in the report.

(See document No. 6)

Dr Varney advised that a reprofiled budget report would be submitted to the Board in January 2021.

105 **RESOLVED: -**

That the Board noted the report.

OTHER URGENT BUSINESS

106 No items of urgent business were raised.

DATE AND TIME OF NEXT MEETING

107 It was noted that the next Local Covid Outbreak Engagement Board meeting would be held on Wednesday 27 January 2021 at 1400 hours as an online meeting.

The Chair advised that there were no private items for this meeting and that the private part of the agenda will not be needed.

The meeting ended at 1647 hours.

CHAIRMAN

BIRMINGHAM CITY COUNCIL

LOCAL COVID OUTBREAK ENGAGEMENT BOARD WEDNESDAY, 27 JANUARY 2021

MINUTES OF A MEETING OF THE LOCAL COVID OUTBREAK ENGAGEMENT BOARD HELD ON WEDNESDAY 27 JANUARY 2021 AT 1400 HOURS ON-LINE

PRESENT: -

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Andy Cave, Chief Executive, Healthwatch Birmingham
Elizabeth Griffiths, Assistant Director of Public Health
Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and Deputy Chair of the LCOEB
Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG
Councillor Brigid Jones, Deputy Leader of Birmingham City Council;
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Councillor Paul Tilsley
Councillor Ian Ward, Leader of Birmingham City Council and Chairman for the LCOEB

ALSO PRESENT:-

Mark Croxford, Head of Environmental Services, Neighbourhoods
Dr Mary Orhewere, Interim Assistant Director of Public Health
Errol Wilson, Committee Services

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NOTICE OF RECORDING/WEBCAST

108 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.

APOLOGIES

109 Apologies for absence was submitted on behalf of Chief Superintendent Stephen Graham, West Midlands Police; Dr Justin Varney, Director of Public Health and Pip Mayo.

DECLARATIONS OF INTERESTS

110 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.

WELCOME AND INTRODUCTIONS

111 The Chair welcomed everyone to the Local Covid Outbreak Engagement Board meeting.

MINUTES

112 **RESOLVED:-**

The Minutes of the meeting held on 14 December 2020, having been previously circulated, were confirmed by the Chair.

CHANGE TO ORDER OF BUSINESS

113 The Chair advised that he would take agenda items 6 and 10 together ahead of the remaining reports.

COVID-19 SITUATION UPDATE AND TEST AND TRACE IMPLEMENTATION AND ENGAGEMENT PLAN UPDATE

114 Elizabeth Griffiths, Assistant Director of Public Health and Dr Mary Orhewere, Interim Assistant Director of Public Health and will present the item introduced the items and drew the attention of the Board to the information contained in the slide presentations

(See document Nos. 1 and 2)

The Chair advised that the Secretary of State had reached out to the City Council asking whether the Council had any insight as to why as it appeared that case rates were falling more slowly in the West Midlands than they were elsewhere in the country, and whether the Council had any suggestion to make to the Government about actions that might be taken to speed up the decline in case rates across the West Midlands. The Chair added that these matters were considered by the Metropolitan Leaders along with the Directors of Public Health in the weekly Metropolitan Leaders meeting yesterday. We had set a not back into the Government command structure should they go into Gold Command Plan via Helen Carter of Public Health England. The Chair further stated that the Metropolitan Leaders had made three statements to the Government that might help speed up the decline in case rates across the West Midlands:

- Firstly, that Government provide us with some support and help around the workplace lateral flow testing in order to increase that capacity so that we might get workplace lateral flow testing into more workplaces; and by doing that ensuring that we get people self-isolating when they tested positive through a lateral flow test.

- Secondly, that the Government thing again or give some further consideration to self-isolation payments, particularly where people were finding it a financial issue self-isolating when they tested positive or if there were any contact with someone who had tested positive. The current situation appeared that there was a barrier to people self-isolating as they were suffering financially.

- Thirdly that the Government provide some clarity on what was defined as an essential business that needed to remained open during the current lockdown. We further went on to suggest that the Government provide that clarity and also looked again at the guidance by giving example of that. It was still possible to purchase a take-away coffee from behind a counter in a café and we had suggested that it may be pragmatic move to limit that service in these types of business to being at the front door so there was not a need for people to fully enter business premises to purchase a cup of coffee or a take away.

- The Chair highlighted that these were passed on to Helen Carter who attended the Gold Command meetings that the Government held each week and we will await to see if the Government took notice of those suggestions that we have made. The Chair stated that it was a positive thing in the first instance that the Secretary of State had reached out for suggestions from Metropolitan Leaders and Directors of Public Health across the West Midlands.

Councillor Bennett sought further information on the lateral flow testing as it was not entirely clear as to how successful we had been in terms of expectations. It was known that lateral flow testing was piloted in Liverpool and other areas and it was seen as a good way of driving the infection rate down and was trying to keep businesses and the economy moving. In terms of where we expected it to be at this point how and where were we. Were we doing better than expected or as good as was expected and some of the things the Chair had mentioned concerning supporting businesses.

Stephen Raybould stated that we had two periods in which we had a slower decline than in other areas. There was a period last year where close to the West Midlands generally, Birmingham had risen to the top around information that concerned Covid case rates. He enquired whether this was attributed substantially due to the structure of the work in the West Midlands and what was it that differentiated Birmingham from other areas. Also it appeared that the instruction *work from home if you can* be being interpreted differently within different businesses and whether some further guidance could be offered around that.

The Chair commented that this was the reason the Metropolitan Leaders requested that the Government looked again at the definition of what was essential and non-essential businesses.

In response to questions and comments, Ms Griffiths and Dr Orhewere made the following statements:-

a. Ms Griffiths noted Councillor Bennetts enquiry and advised that in terms of lateral flow testing before Christmas Birmingham was one of the areas that was asked to put forward a proposal for a six week period to trial lateral flow testing and within that our main model of delivery was through a hub site which was the Utilitia Arena Birmingham and a number of different work place sites in terms of our spokes.

b. Very quickly after making those original proposals we went into lockdown which had an impact on the number of people that were walking around Birmingham City Centre and so uptake of the Utilitia Arena Birmingham had not been as high as Public Health wanted it to be. We had been working on an exit strategy with the Utilitia Arena Birmingham and this was to push out into community centre locations across the city.

c. As of Friday Public Health had submitted a new proposal to the Department of Health to take us up to the end of March 2021 with our lateral flow proposal and setting out the numbers that we wanted to see. Within that we were projecting to move away from the one large hub site into 24 different community site locations in addition to pushing out our work force, the mobile sites and the community pharmacy.

d. In terms of how we were doing compared to what we were doing we were slightly less on our assumptions for usage of the large hub site but we saw more cases coming through in our pharmacy locations and different community sites. The majority of our proposals that took place up to the end of March was about community and so it will be through the pharmacy locations and opening up fixed community sites across the city, but also pushing for workplace spokes.

e. All of those operate in isolation so they would be impacted by decisions on lockdown for example and any subsequent changes to what that essential workforce was because that would limit the pool that we had. This was constantly evolving and we will continue to monitor how well they were and adopt our plans to try and maximise the opportunity for lateral flow testing.

f. Ms Griffiths noted Mr Raybould's enquiry about what differentiates Birmingham from other areas and advised that what had been observed from the beginning was that Birmingham was slightly different. It was thought that what may be affecting laterally was that at the moment we had seen a slightly slower reduction than in some of the other areas. This could be due to any number of things driving this and in truth it could be a mixture of all of those.

g. Public Health had seen a surge in the new variant later than some of the other areas, example London and the South East as they saw very sharp increases in cases just before Christmas largely led by this new variant whereas we had not seen that yet. It was thought that it was the delay in the variant coming to Birmingham and as it was more transmissible this was leading to a delay in that reduction coming down.

h. There was also something about our workforce, the demographics of our area - deprivation and learning that was coming through regionally and particularly with some of our neighbouring local authorities was that their spread was being led by workplaces, particularly manufacturing industries that were part of the potential chain supplies for our hospitals and those people who were having to go into work. Those interactions were happening within those workplace settings.

i. This was something as the Chair had stated was of great interest to Directors of Public Health and the Department of Health and Social Care and Public Health England. They were doing a detailed analysis of the available data currently as there was a working group on this now so that we could understand what was happening and to present why it was happening in this region and what we were doing about it.

   Councillor Bennett requested more details about employers who were engaging with the lateral flow test. From the chart the vast majority were walk-ins so we did not know … it was hoped that the big supermarkets were encouraging their staff to get tested regularly. Cllr Bennett enquired whether it was known which of the large employers were participating in this and whether this information could be shared.

j. Ms Griffiths advised that there were a number of different programmes happening in parallel and from our part we had the open access which was members of the public and many different organisations could use the testing centres. We were not able to capture at that point what workforce they were a part of. Public Health was also implementing workforce spokes directly with companies and we had a number of different organisations that we had been working closely with.

k. The West Midlands Fire Service was one of these organisations that had one of those spokes available for their workforce and the Blue Lights. There were also other organisations they were working with and that she would be happy to share this information with Councillor Bennett outside the meeting.

l. Ms Griffiths added that there was a national programme and the Government was working directly with some businesses as well to do their testing and these were happening in parallel. As these did not include the local authority, we did not have the names of all of those organisations currently, but we were trying to engage as quickly as we could with the range of enterprises, we had in the city to encourage that testing and to encourage businesses to come forward should they wish to do so.

That the Board noted the presentations.

VACCINATION ROLLOUT AND UPTAKE

115 Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG and Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG presented the item.

Mr Jennings made the following statements: -

1. That the figures were for Birmingham and Solihull but he did not yet have a breakdown that could be shared just for the city. Up to the 21st January 2021, we had undertaken just under 98,000 vaccinations. Part of those were for health and social care workers. We had a target figure of approaching about 120,000 health and social care workers who needed to be vaccinated.

2. The balance of those, just under half, were for the over 80s and for the care homes. 35,000 first vaccines for the over 80s and approaching 10,000 second vaccines for the over 80s. those were all set up before the second vaccine period was extended from three weeks to 12 weeks. We were currently focussing on four cohorts: - residents who were older adults, carers all those over 80 and those over 75; those over 70 and front line health and social care workers who we will attend the vaccination hub to meet the Government's target by the middle of February 2021.

3. We had across the patch just short of 40 sites either set up or ready to go when the vaccine supplies allowed it. This include the three sites in West Birmingham. We had plenty of geographical coverage and plenty of opportunity for people to get to centres as they were invited and as bookings were made. We opened one of the first seven mass sites in the country at Millennium Point on the 14th January 2021 and we had capacity there over time to get to 3,000 vaccinations per day.

4. There were other mass sites which had not yet been opened for two reasons: - Firstly, the invitations had not yet been extended in sufficient quantity to make it viable to open them. Secondly, because vaccine supplies were not there to enable us to deploy, but we had a bank of staff that was ready for us to call on.

5. Public Health England was responsible for sending out letters of invitations to the over 70s and to those who were categorised as clinically extremely vulnerable. It was understood that many of these letters would be arriving in the coming week. On receipt of those letters people were invited if they wished to attend one of the mass vaccination sites. This meant that the mass sites were by definition available to people from a wide range of settings geographically and it was about what suits them.

6. We had thought that about a third of the people had been through Millennium Point since we had been opened and they were not just residents of Birmingham or Solihull but that was fine as this was what the mass sites were there to do to ensure that people could get the opportunity if they were able to travel. The progress was good, the commitment was fantastic and he had been out to a few sites to see how they work.

7. It was brilliant to see that in local situations people had made adaptations and had put marquees up to give the space and the room to make it work. The kind of sense and the mood in all of these facilities were fantastic and people were pleased and delighted to be going out to receive their vaccines. Certainly for some of the primary care centres he had been to particularly in the earliest days when people were coming for their vaccines there were people over 80 who literally had not left home since last March and it was quite moving to see them moving to the vaccination centre and receiving this first ray of light and opportunity for the future.

8. We had a couple of pharmacies as vaccination centres one of which was in a mosque in Balsall Heath. We were really excited about that as it was a great way of getting across the message and encouraging our sisters and brothers from BAME community to come forward for their vaccines. We knew that there were some anxiety and some mis-information. Having a vaccination centre in one of the mosque had helped to counter some of that.

Dr Aslam made the following statements:-

i. We had offered or vaccinated all of our care homes in the entire Black Country and West Birmingham and there were few remaining care homes that had Covid outbreaks that were difficult to get into. We had been given our allocation for the next set of vaccines and that was 34,000 vaccines that we had been given which roughly was an estimate of the people that fit in the top four categories as described by Mr Jennings.

ii. We had a good uptake in the over 80s, we had up to about 80% in the Black Country and West Birmingham. In some areas that was not quite high as that as in one of the practices in West Birmingham everybody had been contacted to invite them to attend for a vaccination, but we had about 60% uptake which was a challenge.

iii. With all of the euphoria around this being our opportunity to get out of this Covid mess that we were in still there was a hesitancy. It was not thought that people were refusing and people saying I would like to wait and see which was fine, but we do need to ensure that the opportunity for those people were made available again and they should have a number of opportunities.

iv. We had vaccination sites as described by Mr Jennings in hospitals, general practices and nationally 75% of the vaccinations that had been

given were given by GPs. When you think of the scale of what we were trying to achieve it was fantastic.

v. We knew throughout this pandemic that the heavy listings through Covid in our hospital sector and intensive care units this was an opportunity for general practice to demonstrate what it was capable of doing and it had stood up to that. Dr Aslam stated that he was proud of what was being achieved and they had lots more to achieve and at the moment it was going well subject to us having the vaccine.

The Chair commented that the effort of rolling out the vaccine was absolutely tremendous and was a credit to GPs up and down the country that this had been done. The Chair added that everybody involved in the NHS who were endeavouring to get the vaccine out to as many people as possible as quickly as possible was to be congratulated for everything they were doing on our behalf.

Councillor Paul Tilsley commented that he was in one of the targeted groups, but that he did not receive a letter, but his wife had received one. Councillor Tilsley stated that on Saturday on a local news page he had subscribed to it came up with NHS vaccinations so he scrolled down and was able to put his NHS number and other personal details in and he was given about 8 different sites that he could be vaccinated from. He added that he chose Millennium Point and that he wished to thank the City Council and the CCG for all the work that they had put in to Millennium Point particularly the Chair Councillor Ian Ward who was instrumental in making it happen. Councillor Tilsley advised that he had booked the appointment at 2:00pm and at 10:30 am the following morning he had received the inoculation.

Councillor Tilsley added that it went well, smoothly and that he had checked on the CCG page and it stated that he should *wait for his letter* but there was no need to wait for the letter but he was anxious to raise the profile and ensured that there was many people in the target group that could get vaccinated as quickly as possible.

Mr Jennings advised that he would have that information tweaked on the CCGs website.

Mr Raybould expressed thanks on behalf of the workforce in the voluntary sector and that it was appreciated the way in which the vaccine had been rolled out. Lots of colleagues within health and social care had received a vaccine and it was much appreciated. Mr Raybould stated that his query was about equity of access. Mr Jennings stated that there were 40 sites that could be accessed which could have included Solihull as well. When we had the information earlier the place with the highest case rate was Lozells. Ladywood and Perry Barr had a … of the population of the city but it seemed there were only three sites within that space where people could get vaccinated. Mr Raybould enquired what could be done to expand that.

The Leader enquired for the people who were housebound who had received a letter asking them to go and get a vaccination, obviously if they were

housebound, they could not get out of the house. The Chair enquired what the arrangement was for vaccinating people who found themselves in that position.

Dr Aslam then made the following statements:-

a) That the housebound patients they had an arrangement with Birmingham Community Health Care Trust (BCHCT) who were aware of all the housebound patients as they provide the care for them. They had taken a list of each of the general practices to tell that these are the housebound patients who will then go and inoculate those patients at home.
b) We have had scenarios where housebound patients had made it to Millennium Point and other places. BCHCT had taken the opportunity and we were working closely with them to ensured that the housebound patients could get vaccinated. A lot of them would be on our over 80s case load but were clinically extremely vulnerable if they were housebound. We were involved in those discussions and were looking to have this completed shortly.
c) Regarding West Birmingham, we had five networks in West Birmingham. We had four networks sites – a site at City Hospital which involved three of the networks getting together so that we could inoculate more people on a daily basis than we would anticipate on our own individual sites. It was a little bit of economies of scale. What we were able to inoculate on those sites in a mass vaccination site and we had one opening at the Black Country Living Museum we would inoculate about 1000 people per day.
d) At the City Hospital site we were inoculating around 600 patients per day. This was much more than we would be able to vaccinate given the individual practices or smaller networks working together. That was the reason we chose to have vaccination to cater for a greater number of people.
e) There was an element of speed and convenience and the City Hospital had been kind to give us the opportunity to use one of their estates with no charge. They had taken away their parking charges there and it was really a convenient place local to us where people could go and have a vaccination in relative comfort and we could get through the volumes that comes in the vaccines as it comes in huge doses which enabled us to use them.
f) Dr Aslam noted Mr Raybould's comments concerning the issues with Perry Barr and Lozells and advised that we had now been working on the Pfizer vaccine which comes in a 1000 doses or 975 doses that had to be used in three and one half days. This led us to thinking of the model over having the large centre which was the best option. We now had the AstraZeneca vaccine which did not require the same level of utilisation as quickly and it also enabled us to transport it.
g) As we got to the point where we vaccinated all of these top groups that Mr Jennings had described earlier, we will ensure that the access was as equitable as possible. We knew there were challenges with people not wanting to go to mass vaccination sites but wanting to use their GPs and we would work with them to ensured that the vaccination rates were good as possible. That would require us to be blended about the approach that we take and we would adopt. At the moment we had the

challenge to get the top four groups vaccinated as much as possible. We were doing well on those lines and it was anticipated that by February 15 to have vaccinated as many as possible but certainly to have gotten through the doses that were allocated.

Mr Jennings advised that they had vaccinated all the care homes that they were supposed to have vaccinated. Community pharmacies started to come on stream and it was expected that this would be another route for local delivery. Again this relied on us having access to the AstraZeneca vaccine in sufficient quantity to make this possible because the Pfizer vaccine would not work in those smaller settings.

The Board noted the verbal update.

ENFORCEMENT UPDATE

Mark Croxford, Head of Environmental Health, Neighbourhoods introduced the item and drew the Board's attention to the information in the slide presentation.

(See document No. 3)

The Chair commented that it could not be emphasised enough for people to wear face coverings whenever they go out. Councillor Tilsley voiced concerns about his Ward, Sheldon. He stated that prior to the start of the meeting he had a conversation with the Chair who represents the Shard End Ward. He added that the case in Garretts Green was quite high just prior to Christmas and that the common denominator between the three Wards was the Radley's Shopping Centre. Councillor Tilsley enquired whether the Covid Marshalls could pay a visit to the shopping Centre to see whether this was an issue as far as transmission was concerned.

Mr Croxford advised that the Marshalls had visited the Radley's Shopping Centre a number of times but would continue to do so. He added that the statistics that were coming from Public Health was looked at on a regular basis in relation to the rate of cases within the Wards. Mr Croxford undertook to have a further look at the issue and to speak with the Police to see if there were any call outs that they had received to see if there was any commonality around those Wards that were identified.

116 **RESOLVED: -**

That the Board noted the report.

UPDATE FROM THE NHS

117 Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG and Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG presented the item.

Dr Aslam gave the following verbal update:-

- That it was a less optimistic picture than the vaccination picture. The lag in hospital admissions was always two weeks after the community numbers came to us and these have been very high over a period of time. Unfortunately what did not happen was that they had not dropped significantly enough for us to notice any real benefit in the hospitals and we did not anticipate that to happen for another two weeks.

- At the moment across the Black Country we had been running at 200% of our critical care capacity and all those beds were occupied. We had daily calls with our intensive care doctors and yesterday on the call there was only one bed available and there was a person sitting in A&E cubicle waiting for that bed.

- The situations in hospitals were extremely difficult and the number of people in hospitals across the Black Country was above 1,200 which was a 10% increase on the week before. There was a 20% increase in the number of people in intensive care beds and the number of deaths kept rising with 208 people having passed away from having a positive test within the last 28 days.

- It was an extremely difficult scenario as it was difficult for hospital staff and patients having to be in hospital by themselves when they were extremely sick and vulnerable. Given the infection rates that we had – in Birmingham they were described as 761 per 100,000. In Sandwell the rates was 168 and these were the two areas that most fed into Sandwell and West Birmingham system.

- Bearing in mind that those infections were today and in two weeks' time it was anticipated that those patients would be hospitalised and the percentage of those patients in hospital beds. These numbers were not going up in the mass inoculation that was happening previously but it was extremely a precarious situation.

- The impact of this on all of those people in intensive care and all those admitted with Covid-19, but for all the things we were unable to do because these patients were in hospital beds, hospital staff were focused on supporting these patients on their recovery. But it affects what we were able to do in terms of care, outpatient appointments. Cancer care was also affected as the hospital system was very challenged at the moment.

- We were coping and had coped throughout this period but it was difficult and was wearing on all of our hospital staff. The vaccination was a way out of this scenario and we were doing well with the vaccination but that was not impacting on the numbers in our hospital system at the moment.

Mr Jennings then gave the following verbal update:-

- That it was a similar story although we thought that we might be just at the peak of our ITU demand across the UHB hospitals now. That demand had crept to around 250% of what we normally had to deal with.

- We had at one point last week nearly 1,100 patients across the three UHB hospitals who were Covid positive and we had seen over 11,000 patients in total since last March which was the largest for any hospital system by about 5,000.

- There was something about what was happening in this part of the world including what Dr Aslam had stated about the Black Country as well as Birmingham as we seemed to have been hit hard in the Midlands. We struggled to recover after our second peak back in September after schools went back. We did not really settle down as we launched back again into the third peak from quite a high level.

- What would make a difference to all those things Dr Aslam referenced in all the recovery of the services we had to put to one side was how quickly we came down the other side. We were at extraordinary levels if we think back to last summer where a case rate of 20/100,000 would put us on the Government's watchlist and now we were talking about hundreds.

- Although this was from the NHS, we had to broaden it out into the system as Dr Aslam had stated that the case rate result in hospital admissions two weeks later, people then stayed in ITU three to four weeks. Also what we were seeing was that as that wave moves through there was a massive demand on our health and social care systems as we were desperately trying to discharge patients in all of our hospitals to crate space to bring these new patients in. So that pressure was amplified and almost visible in ITU with queues of ambulances. This pressure was right through the whole system including social care and everybody was working at an astonishing pace with an amazing endurance to keep going.

The Chair commented that anybody that was working either in the NHS or in social care system was doing an incredible job at the moment under incredible pressure. The Chair stated that the word ***Heroes*** were often over used, but for those doctors and nurses who were on the frontline to this and dealing directly with patients who were suffering from the virus heroes was precise and apt. Anyone who had seen Clive Myrie's, report on the BBC recently direct from hospital wards cannot helped but being touched by the amount of effort that was going in and the stresses and strains those staff was under on a daily basis.

The Chair added that we might not be going out on a Thursday evening and applauding at the moment, but each and every one of us was very grateful for all of the work that was undertaken by the doctors and nurses in the NHS and all the others involved in the system and including the social care system it was a marvellous work with the numbers rising to where they were currently. We saw daily case rates into the 60,000s so there had been huge stresses on the system here. It was remarkable that the NHS and the social care system were coming through it all and no doubt anybody that were working in these systems was going to need at some point later in this year a rest from all of this and

inevitably in some instances will also need some care themselves for their mental health and wellbeing.

The Chair requested that Dr Aslam and Mr Jennings took back the Board's thanks and support for all those working in the NHS system at the moment.

The Board noted the update.

PUBLIC QUESTIONS SUBMITTED IN ADVANCE

The Chair introduced the item and commented that having not receive any questions for a number of meetings we had now received an avalanche of questions. The Chair advised that the Board would answer some of them and that there would be a different process for answering the rest of them.

(See document No. 4)

Elizabeth Griffiths, Assistant Director of Public Health presented the item and advised that there were 32 questions from members of the public for this meeting. Three of these were received within sufficient notice of the meeting for us to get detailed response from a range of partners. The remaining 29 came through in the last couple of days and we were still pulling together the response for those. Ms Griffiths further advised that these had been themed and that she would give a brief overview of the response but was committed to have a detailed update within a written report by the 10th February 2021 as the general plan for responding.

Essentially, the questions were around vaccinations, testing, transport and lockdown restrictions. In terms of the vaccination there were certain questions around the priority groups that were going to be invited for vaccination testing and Mr Jennings had covered some of this earlier in his presentation. We would detail the 10 priority group areas within our return. The decisions on those priority groups was made by the Joint Committee on Vaccination and Immunisations and was a national level decision. The decisions had been made to minimise the risk of death and hospitalisation at this stage on the basis of those groups.

In terms of vaccinations and when people were delivered direct payments treatments could be drawn forward within Adult Social Care, within City Council, there were a range of ways of finding out who those deliveries of care were from contacting all of those in receipt of direct payments and find out who were delivering those care. To look at the links from the Learning and Development Service so that it could be identified who those personal assistance might be and also to all of the contracted organisations to find out their workforce. There was a range of different ways that those people could be picked up and contacting us was another way to do it.

Regarding the lateral flow tests we have had questions on home testing and the response for the decisions on which groups were eligible for home testing were being made nationally. This was under continual review and so we were

having a number of this rolled out to a number of different sectors and were expecting further movement on that. This was detailed in our paper response.

The question on transport was in two parts – whether buses should display the QR code for the test and trace App and whether windows should be opened on trains. A detailed response from Transport for West Midlands was received but there were some restrictions in terms of the fleet for windows opening in that the majority of them did not have that capability. However, there was an enhanced cleaning regime that was introduced across all of the trains and the longest trains were being operated wherever possible to maximise the space between people to keep social distancing opportunities to the maximum. With regard to the QR codes this was under active discussions and after reviewing this the decision was taken to keep those QR codes at the bus stop or at the train station to avoid that cluster of people around the QR code within a restricted space within a bus or train.

There were also questions around testing and where people could go for that and there were two different routes dependent on whether you were symptomatic or asymptomatic. If you do have coronavirus symptoms then you could go on the .GovUK site and book onto a test or request for a postal kit to be sent to your home. If you did not have any symptom thee were a range of local offerings as stated earlier, but would ensure that there was a link to the Birmingham website that had all of that details there and let you know how you could make those bookings.

Lockdown restrictions was another theme that came through and all of the national lockdown had been a national led decision based on internationally recognised evidence to reduce those opportunities for social interaction which was known to be driving the spread of the coronavirus. This was under continual review, but that decision was made by the Government.

Dr Aslam commented that it was important for people to engage with this forum and ask questions. There was a plan for us to engage in different ways with people in particularly about the vaccination for the people that were getting misinformation around the vaccination. If we could focus on doing our communication together that would be helpful. Dr Aslan stated that he had had a conversation with Councillor Hamilton and would been keen to engage with different sections of our communities in a way that enabled them to ask the questions they were interested in asking and to challenge some of the myths that was out there.

The Chair reiterated that vaccinations worked and was the way out of this pandemic. The Chair added that anyone who was saying anything different to that was misleading the public.

Councillor Paulette Hamilton stated that Dr Aslam was spot on and that what was planned through Public Health was a series of Roadshows. Rather that having just one Health and Wellbeing Board or one meeting of this kind, we would be doing a meeting in each part of the city i.e. an online meeting in the west, south east and central part of the city. The idea was that we would have doctors, Public Health and it was hoped to have local Members of Parliament and local Councillors so that we got some joined up work both with the NHS

and local government just as we were doing in this forum. We will ask for questions and the local professionals will then give a response to the questions all in the aid of trying to get people who were hesitant to ask questions as it was important for people to get vaccinated.

The Chair expressed thanks to Faith leaders across the city for helping to debunk some of the myths and reassuring communities across the city that the vaccine was safe and did not breach any of the religious protocols of any of the religions. We should all when we got our turn to come forward and have the vaccination as this was the way out of the current pandemic.

118 **RESOLVED: -**

The Board considered the public written questions and responded accordingly.

TEST AND TRACE BUDGET OVERVIEW

Dr Mary Orhewere, Interim Assistant Director, Test and Trace implementation presented the item and drew the attention of the Board to the key information contained in the report.

(See document No. 5)

The Chair commented that it would be helpful to have some information from the Government about the time period for this money. At the moment it was not known whether this money was until the end of this financial year or whether it was for the 12 month period when we first received the first tranche or a period beyond that. The Chair added that it would be helpful if the Government could provide some clarity on this in order that we could have a little more certainty over committing the funds.

119 **RESOLVED: -**

That the Board noted the report.

OTHER URGENT BUSINESS

120 No items of urgent business were raised.

DATE AND TIME OF NEXT MEETING

121 It was noted that the next Local Covid Outbreak Engagement Board meeting would be held on Wednesday 24 February 2021 at 1400 hours as an online meeting.

The Chair advised that there were no private items for this meeting and that the private part of the agenda will not be needed.

The meeting ended at 1537 hours.

CHAIRMAN

Birmingham Health and Wellbeing Board

	Agenda Item: 18
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**16 March 2021**
TITLE:	**HEALTH AND WELLBEING FORUM UPDATES**
Organisation	**Birmingham City Council**
Presenting Officer	**Stacey Gunther, Service Lead, Public Health**

Report Type:	**Information**

1. Purpose:

1.1 This update report details recent, current and future work related to:

- Creating a Healthy Food City
- Creating a Physically Active City Forum
- Creating a Healthy Food City Forum
- Creating a City Without Inequalities Forum
- Health Protection Forum Update

1.2 Sub forum meetings, excluding the Health Protection Forum, were initially paused as the Public Health Division diverted resource to support Covid-19 response. Forums are currently working online with partners or holding meetings online via Teams to move Covid-19 related items forward. It is anticipated that forums meetings will restart during 2021.

2. Implications:

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

3.	Recommendation
3.1	It is recommended that the board note the contents of the report.

4.	Report Body

Background

4.1 The Birmingham Health and Wellbeing Board has five thematic forums. The forums oversee the development and delivery of shared action to drive city-wide improvement. The forums are: Creating a Mentally Healthy City, Creating a Healthy Food City, Creating an Active City, Creating a City Without Inequality, and the Health Protection Forum.

4.2 All forums are providing written updates for the March 2021 Board meeting. Following the March meeting, forums will continue to present on a rota basis, with each theme presenting at least annually.

4.3 This report is formed of 5 written updates. Further detail specific to each Forum can be found in **Appendices 1-5.**

4.4

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 Mo Phillips, Service Lead, Public Health Paul Campbell, Service Lead, Public Health Kyle Stott, Service Lead, Public Health Frances Mason, Service Lead, Public Health Chris Baggott, Service Lead, 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

Appendices
Appendix 1 - Creating a Physically Active City Forum Appendix 2 - Creating a Healthy Food City Forum Appendix 3 – Creating a City Without Inequalities Forum Appendix 4 – Creating a Mentally Healthy City Forum Appendix 5 – Health Protection Forum

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

Stacey Gunther, Service Lead, Public Health
Mo Phillips, Service Lead, Public Health
Paul Campbell, Service Lead, Public Health
Chris Baggot, Service Lead, Public Health
Kyle Stott, Service Lead, Public Health
Frances Mason, Service Lead, Public Health
Elizabeth Griffiths, Assistant Director, Public Health

Birmingham Health and Wellbeing Board

Appendix 1 – Creating A Physically Active City (CPAC) Forum Highlight Report

1.1 Context

The CPAC met on Wednesday 10th February and has met as scheduled throughout the disruption caused by COVID-19. The CPAC has continued to ensure that the focus on Active Travel is aligned to the aspirations of the Emergency Active Travel fund that is awarded by the Department for Transport. It was agreed with the Chair of the CPAC (Cllr Zaffar) that the meeting on the 10th February would have a focus on discussing and agreeing the development of an action plan for the forum in line with the objectives of the terms of reference for forum to consider the wider priorities for creating an active city.

1.2 Current Circumstance

The forum received updates on:

1. Activity Alliance Webinar
2. Uniting Birmingham, the new Sport Birmingham Strategy for Sport and Physical Activity
3. Canals and Rivers Trust opportunities for physical activity
4. Physical Activity Webinars
5. Engagement on Earth Stories from the Future Parks Accelerator
6. Health of the Region Report

The focus of the agenda was to consider the creation of an action plan that would address the objectives adopted by the forum under the Terms of Reference. It was agreed by the Chair that the forum was now in a place to address this piece of work as COVID-19 pressures were being responded to in such a way across the city that business as usual capacity was now being made more available to the forum members.

The action plan is proposed to be in draft form in April, with adoption of the action plan being agreed at the next meeting on the 21st April. Examples of objectives within the plan will include co-produced solutions to the awarding of Commonwealth Games money for physical activity opportunities in Birmingham, and how the forum can inform the JSNA process.

1.3 Next Steps and Delivery

- The forum is working towards the production of an action plan by April 21st, 2021
- The forum is working together to inform how Commonwealth Games physical activity funding allocations can be best distributed throughout the city
- Consideration is being given to JSNA opportunities; current options include an Active Travel JSNA
- The forum continues to steer the implementation of tranche 2 of the Active Travel fund awarded to Birmingham City Council

Birmingham Health and Wellbeing Board

Appendix 2 – Creating a Healthy Food City Forum Highlight Report

1.1 Context

The main purpose of the Forum is 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 last met 10 March 2021 for the first time since June 2020. Due to timing of the Forum and Board governance this report focuses on activity that does not include the discussion of the most recent Forum.

1.2 Current Circumstance

1.2.1 Food Strategy

During late 2019 and early 2020 there were multiple rounds of consultation with partners on the Birmingham Food Strategy, with the intention of public consultation shortly thereafter. The COVID-19 response placed these conversations and the strategy itself on hold.

The most notable update to the strategy since the previous draft is the inclusion of a resilience workstream. This has become more important than ever considering the upcoming COVID-19 recovery phase, and the potential implications of the exit from the European Union.

As part of the Forum held 14 January 2021 there was a call for volunteers to support the development of the Food Strategy into a robust, shared document that all partners can subscribe to. Several organisations present are willing to contribute, and a task and finish group will be established to develop the draft into a document that can be taken to consultation in summer 2021.

1.2.2 Emergency Food Plan

There have been some preliminary discussions on creating an Emergency Food Plan as an interim measure during the ongoing COVID-19 response to ensure that parts of the Birmingham Food Strategy that have been placed on hold, but would be of assistance to the response, can be strategically shaped and implemented.

A workshop was convened for 19 February 2021 with invitations extended to members of the Health and Wellbeing Board, the Creating a Healthy Food City Forum, the Food Justice Network, and the Food Poverty Core Group.

The information collated will be incorporated into the plan and shared. The Emergency Food Plan will be a live document that allows for the co-ordination of food systems activity in relation to the COVID response and recovery phases.

1.2.3 Birmingham Food Conversation

The Birmingham Food Conversation consisted of two substantial pieces of primary data collection.

Firstly, the **Birmingham Food Survey**; although this was cut short to prevent the bias inherent on continuing the survey during the COVID-19 response there were 394 responses received and results highlights were provided to the previous Health and Wellbeing Board. We are currently developing internally how the findings of this report can better inform the food systems approach to multiple strands of work.

Secondly, thirty-one different organisations were commissioned to deliver **'Seldom Heard Food Voices' research**. The groups were facilitated by community research consultants, employees of organisations serving the needs of specific target groups, and occasionally a combination of organisations matching research expertise with organisational reach. All organisations reported details of scripts and resources used as well as the structure focus group. All groups covered the questions highlighted in the tender specification. The facilitators delivered these questions in a range of ways, adapting them where appropriate for the groups they were working with. We have completed draft version of the final report, and are in the governance process around the consensus opinions on what is required to create a healthy city (as well as some unexpected and unsolicited comments on how to engage better as part of future consultation processes) and how these can be best taken forward.

1.2.4 Food Poverty

In November 2020 Birmingham City Council re-established the Food Poverty Core Group to better understand the systems level responses we can put in place across the local systems in Birmingham to ensure a robust and coordinated response to the various issues around food poverty. The three themes we need to focus on;

1) prevention of people going into food poverty.
2) crisis management – how do we get them out of it.
3) recovery – moving forward, long term impact.

A rapid evidence review will be completed on each theme for action / discussion by the group.

The January 2021 meeting focused on prevention of food poverty and the results of the conversation have been used as part of the conversation in relation to the Emergency Food Plan. The next meeting will focus on crisis management, and the date / time will be arranged by committee to maximise attendance.

1.2.5 International Partnerships

The **Food Foundation Partnership** contract was finalised to assist with implementation of national and international food policies and guidelines, and specialist advice, support and management of Birmingham's international

relationships launched on 01 July 2020 and will be effective for two years.

The partners have been in ongoing conversations to discuss key project deliverables by quarter over the life of the contract, and a draft delivery plan has been drafted.

Milan Urban Food Policy Pact have shown interest in the Birmingham City Council Emergency Food Plan and we were invited to discuss our approach with other cities on 23 February 2021.

There has been agreement in principle that the Delice network will refocus from gastronomy to policy levers and as a result of this that lead organisation status for Birmingham will pass to Birmingham City Council. The DPH decision notice to formalise this has been drafted for Assistant Director approval.

Commonwealth Cities 2022 launch took place on 27 January 2021 and the initial conversation focused on the announcement of the plans to convene a meeting of the cities in Birmingham to coincide with the Commonwealth Games in the city.

1.2.6 Sustainable Food Places Application

The Sustainable Food Places Award is designed to recognise and celebrate the success of those places taking a joined-up, holistic approach to food and that have achieved significant positive change across six key food issues. We have held discussions with the awarding body to finalise the application and be accredited as a food partnership that is making healthy and sustainable food a defining characteristic of Birmingham.

The deadline for final submission has now been extended to 15 April 2021. There are ongoing conversations regarding which the food system partners in Birmingham who can assist with finalising the application which will be led by Birmingham City Council.

1.2.7 Childhood Obesity Trailblazer Project

The Childhood Obesity Trailblazer is a national project to encourage Local Authorities to focus their efforts on becoming healthy food places. In Birmingham we have three workstreams to enable this ambition.

Workstream 1 - **Creating a health food planning and economic climate through creation and implementation of a developer toolkit.** The content of the toolkit is for the most part created, and we will shortly enter the design phase. The delivery been led by the Place Service Lead within the Wider Determinants Team of Public Health to enable better resource capacity to deliver, and to ensure that benefits of the toolkit are maximised by considering as many Public Health place based development outcomes as possible and also be complementary to a healthy food city environment. The developer toolkit has been well received and the conversations are now focused on how best to operationally deliver and embed the toolkit.

Workstream 2 - Creating a better **understanding of food in the city through**

the Birmingham Basket. Through initial market scoping we have identified at least one supplier capable of delivering the required data, information and insight to understand how the people of Birmingham purchase food. However, we have decided a full competitive tender process should be utilised to ensure we commission the most innovative, and value for money solution. The draft invitation to tender documents were submitted to Procurement colleagues in February 2021.

Workstream 3 - **Creating a healthy apprenticeship workforce that understands health, healthy eating and can support a healthier food economy.** We are using our leverage through the corporate management team and health and wellbeing board to ensure that commissioning specifications for employment, skills and apprenticeships services for Birmingham City Council employees carry a health and wellbeing spiral curriculum. A spiral curriculum is an approach to education that involves regularly re-visiting the same educational topics over the course of a student's education. Each time the content is re-visited, the student gains deeper knowledge of the topic. Base line data collection commenced 12 October 2020 having agreed the evaluation process and methodology. As part of a workshop with employment, skills and apprenticeship providers on 15 October 2020 we gauged interest of providers and on the whole engagement was positive amongst the 15 organisations who attended. Issues were identified as part of the workshop that meant the initial approach was deemed unworkable in practice, however the project delivery has been reframed. A new draft of the operational implementation has been drafted for review by the key partners.

1.3 Next Steps and Delivery

- Establish task and finish group to develop the **Food Strategy** and provide regular updates on progress.
- Continue to shape, refine and deliver the content of the **Emergency Food Plan**.
- Ensure named leads against each action within the **Emergency Food Plan**.
- Finalise governance on both **Food Conversation** and **Seldom Heard Voices** reports and begin to implement findings.
- Rapid evidence review on next area of focus for the **Food Poverty Core Group**.

Birmingham Health and Wellbeing Board

Appendix 3 - Creating a City Without Inequalities Forum Highlight Report

1.1 Context

As Public Health Division are refocusing capacity to support the health protection response to Covid-19 on the 21st September future meetings of the forum have been postponed. Communication with the forum has continued in the interim via the LinkedIn group, with several projects continuing virtually.

1.2 Current Circumstance

The Poverty Truth Commission contract has commenced, and the inequalities team are working with the provider Thrive Together Birmingham to initiate phase 1 of the project. The aim of the project is to build on the legacy of the previous truth commission and develop a new rolling engagement model that strengthens the connection between the Council and its city partners and the citizens. The project is projected to run until the end 2022. The initial theme of exploration is lived experiences in relation to housing.

1.3 Next Steps and Delivery

- Forum Terms of Reference to be revisited in line with 2021 business plans. Forum to be re-established 2021.
- The inequalities team are working to set objectives and will develop a proposal for the focus on the forum for its restart in mid-2021.
- The forum is working in collaboration with Birmingham Youth Service to ensure youth representation on the forum to provide an important voice from this group. The intention is for the forum to have representation from up to three young people, who will attend meetings with a member of the Birmingham Youth Service. The recruitment of these young people is anticipated to commence in the coming months.

Birmingham Health and Wellbeing Board

Appendix 4 - Creating a Mentally Healthy City Forum Highlight Report

1.1 Context

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

1.1.2 The aim of the CMHC is to work with strategic partners, stakeholders, Third and Voluntary sectors, Academics, and Faith Groups to improve mental wellbeing.

This includes access to mental health services for the most vulnerable and disadvantaged groups through the programmes mentioned in the Joint Strategic Needs Assessment (JSNA), the call to action in the Prevention Concordat, and the Suicide Prevention Strategy, along with other HWBB Fora: Creating a City without Inequality; Creating a Healthy Food City; and Creating a Physically Active City.

1.1.3 The scheduled bi-monthly meetings were disrupted by the COVID-19 pandemic as has the ongoing work with regards to mental health and wellbeing throughout response Covid-19. The Forum last met on 10th June 2020, since then communication has been on a virtual basis via the LinkedIn.

Public Health resource has been diverted to focus on health protection and on a work programme at population level, aimed at reducing the risk of becoming seriously ill from COVID-19. The forum is currently stepped down until June 2021.

1.1.4 Full Council ratified The Birmingham Suicide Prevention Strategy which sets out a series of key priorities bringing together partners 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.

This work programme, too, has been disrupted and a refresh of the strategy and action plan will be undertaken at the next, currently unscheduled meeting.

1.2 Current Circumstance

1.2.1 The Covid-19 crisis poses the greatest threat to mental health since the second world war, with its impact set to last years. The combination of the disease, its social consequences and the economic fallout are having a profound effect on mental wellbeing and it will continue until long after the pandemic is under control.

1.2.2 At the start of the pandemic, demand for mental health services dropped as people stayed away from GP surgeries, hospitals and support organisations, or thought treatment was not available. The dip has been followed by a surge in people seeking help and it shows no sign of abating. There is greater

demand for services and a need to provide help across the life course.

1.2.3 The Public Health Covid-19 Wellbeing Cell launched the BHealthy series of webinars which was supported by sector experts and local partners. Their aim was to improve community health and wellbeing and reduce the risk of becoming seriously ill from COVID-19.

They included behaviour changes, advice on how to handle long-term conditions, lifestyle changes e.g. smoking, alcohol, gambling, and advice on managing mental health and wellbeing issues.

The webinars were aimed at professionals who had direct reach to communities through their trusted relationship with community leaders, social prescribing links workers, and faith leaders who could disseminate messages on improving the health and wellbeing of local people.

There were two webinars specifically aimed at mental health and wellbeing: Getting Mind Ready and Sleep which can be found on the Healthy Brum YouTube channel. Together they have been viewed over a hundred times.

1.3.4 Inequalities within our communities have been highlighted further by Covid. The areas with the greatest Covid mortality and the highest rates of Covid infection – which often corresponds to areas of greatest deprivation are where we have particularly high rates of mental illness.

1.3.5 Loneliness and isolation are a cause for concern which was exacerbated as a result of almost a year of restrictions such as lockdown and social distancing measures, depriving people of elemental human contact.

A combination of the first lockdown, shielding for the most vulnerable, Care Home visit prohibition, self-isolating as a result of guidance messages as well as isolating due to Covid infection has spread fear for their own wellbeing and highlighted the social need for togetherness.

1.4 Next Steps and Delivery

1.4.4 To re-establish both the CMHC Forum and Suicide Prevention Advisory Group as soon as practicable, in the most appropriate way, to progress in earnest discussions on moving forward post pandemic.

1.4.5 Review and fresh both the purpose, strategy and group membership to ensure both are pertinent post Covid-19.

1.4.6 An Options Paper and draft Emergency Mental Health Plan are being developed as an interim measure during the ongoing COVID-19 response.

Options have been put forward which aim to prevent and respond to the different needs on services (both mental wellbeing and suicide prevention) highlighting the need for alternative services and encourage communities to come together – inject the *blitz spirit a*nd help each other and reduce isolation and foster greater compassion and kindness.

Initial thoughts are that the plan would take a life course approach and include Neurodiversity and a Universal theme where the focus would be Bereavement services, LGBGT, BAME. This will ensure mental wellness and inequalities in mental wellbeing are addressed.

1.4.7 To hold a workshop as soon as possible to co-develop the plan with CMHC Forum where partners and stakeholders are encouraged to participate and sign-up to actions and encourage others to participate in the development of the Emergency Mental Wellness Plan.

- To deliver on the actions at pace and ensure regular shared updates to Creating a Mentally Healthy City Forum and the Health and Wellbeing Board

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

1.4.8 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.

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

Birmingham Health and Wellbeing Board

Appendix 5 – Health Protection Forum Highlight Report

1.1 Context

Due to the covid outbreak the Health Protection Forum (HPF) had been meeting every 2 weeks since the 30th June 2020. At the meeting on the 19th January the Forum decided to move to monthly meetings. Approximately 80% of each meeting is devoted to discussing the current coronavirus situation and response, with the remainder covering other health protection concerns.

1.2 Current Circumstance

The standing agenda items remain the same as in the last update report and cover the following issues:

The HPF coronavirus discussions include:

1. Current situation regarding case rates, test positivity rates, geographical spread
    a. This is the report of the latest weekly slides produced by the Public Health Division that is also shared in various corporate and strategic meetings
2. Testing – infrastructure, logistics and activity
3. Mobile testing logistics
4. Outbreak summaries and learning
5. Testing results – trends, patterns, rates of change
6. Development of plans in response to 1-5 above
7. Infection prevention and control plans and issues
8. Vaccination plans and updates
9. Review of activity from the working groups
    a. Residential and clinical settings (including care homes, hospitals, primary care, children's' residential settings)
    b. Education settings
    c. Other settings (including homeless settings, workplaces etc)

Non-coronavirus discussions include:

1. Challenging health protection cases
    a. TB and blood-borne viruses
    b. Any other communicable disease or environmental hazard situations

2. Vaccination and screening programme plans and delivery (including flu, MMR and other childhood vaccinations)

    a. CCGs/STPs have produced detailed local delivery plans with all local providers (incl. GPs); plans address limitations due to coronavirus, higher uptake targets, additional target cohorts and expected higher demand for vaccination of particular vaccines.

1.3 Next Steps and Delivery

- The NHS seasonal flu programme that is commissioned by NHSE&I and delivered by GPs, pharmacies, hospitals and vaccination service providers is now nearing the end of the season and discussions will move to lessons learned and planning for the 2021/22 season. Planning is led by BSol STP (and includes the West Birmingham area) and uptake activity will be reported into the HPF

- Delivery of the SARS-CoV2 (known as covid) vaccination programme is ongoing and will report into the HPF. This is being led by the NHS.

- The Forum will also be seeking assurance on plans for catch-up child vaccination programmes and national screening programmes that have been impacted by the pandemic.

- Monitoring of covid case/contact data, outbreaks, intelligence will continue and be used to inform the response.