BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD

TUESDAY, 27 SEPTEMBER 2022 AT 10:00 HOURS
IN COMMITTEE ROOMS 3 & 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1 **NOTICE OF RECORDING/WEBCAST**

The Chair to advise/meeting to note that this meeting will be webcast for live or subsequent broadcast via the Council's meeting You Tube site (www.youtube.com/channel/UCT2kT7ZRPFCXq6_5dnVnYlw) and that members of the press/public may record and take photographs except where there are confidential or exempt items.

5 - 8

2 **APPOINTMENT OF HEALTH AND WELLBEING BOARD - FUNCTIONS, TERMS OF REFERENCE AND MEMBERSHIP**

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

3 **DECLARATIONS OF INTERESTS**

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

4 **APOLOGIES**

To receive any apologies.

5 **DATES OF MEETINGS**

To note the dates of the formal meetings of the Board commencing at 1000 hours as follows:-
Tuesday 27 September 2022
Tuesday 29 November 2022

Tuesday 31 January 2023
Tuesday 28 March 2023
NB: All meetings will be held in Committee Rooms 3&4, Council House, Victoria Square, Birmingham, B1 1BB.

6 **MINUTES AND MATTERS ARISING**

9 - 24

To confirm and sign the Minutes of the meeting held on the 17 May 2022.

7 **ACTION LOG (10:15 - 10:20)**

25 - 36

To review the Actions arising from previous meetings.

8 **CHAIR'S UPDATE AND THANKS TO PAULETTE HAMILTON, MP, FORMER CHAIR OF THE HEALTH AND WELLBEING BOARD (10:20 - 10:25)**

To receive an oral update and to express thanks to Paulette Hamilton, MP and former Chair of the Health and Wellbeing Board.

9 **PUBLIC QUESTIONS**

Members of the Board to consider questions submitted by members of the public.

The deadline for receipt of public questions is 3:00pm on Thursday 22 September 2022. Questions should be sent to: HealthyBrum@Birmingham.gov.uk.
(No person may submit more than one question)
Questions will be addressed in correlation to the agenda items and within the timescales allocated. This will be included in the broadcast via the Council's You Tube site (www.youtube.com/channel/UCT2kT7ZRPFCXq6_5dnVnYlw).
NB: The questions and answers will not be reproduced in the minutes.

10 **BSOL JOINT PNA APPROVAL AND DELEGATION OF AUTHORITY (10:25 - 10:35)**

37 - 44

Jo Tonkin, Assistant Director (KEG), BCC will present the item.

11 **ICS INEQUALITIES STRATEGY UPDATE (10:35 - 10:50)**

45 - 70

Lisa Stalley-Green, Deputy Chief Executive and Chief Nursing Officer ICB, BSol will present this item.

12 **BETTER CARE FUND (BCF) END OF YEAR PLAN (11:00 - 11:10)**

71 - 110

Michael Walsh, Service Lead in Adult Social Care, BCC will present the item.

13 **SIGN OFF OF THE BETTER CARE FUND (BCF) PLAN 2022/23 (11:10 - 11:20)**

111 - 198

Michael Walsh, Service Lead in Adult Social Care, BCC will present the item.

199 - 234 14 **EARLY INTERVENTION PROGRAMME COMPLETION REPORT (11:20 - 11:30)**

Michael Walsh, Service Lead in Adult Social Care, BCC will present the item.

235 - 390 15 **BSOL DRAFT SEXUAL HEALTH STRATEGY 2023-2030 PUBLIC CONSULTATION REPORT (11:30 - 11:45)**

Dr Dyna Arhin-Tenkorang, Assistant Director (Population Health) will present the item.

391 - 396 16 **CREATING A CITY WITHOUT INEQUALITY FORUM - PROGRESS UPDATE AND FUTURE DIRECTION OF THE FORUM (10:50 - 11:00)**

Tessa Lindfield, Assistant Director (Wider Determinants) and Monika Rozanski, Service Lead (Inequalities) will present the item.

397 - 402 17 **FORWARD PLAN**

Dr Shiraz Sheriff**,** Service Lead (Governance), Public Health Division will present the item.

403 - 410 18 **- CREATING A HEALTHY FOOD CITY FORUM (CHFC) REPORT (11:45 - 12:00)**

Information item.

411 - 412 19 **CREATING A MENTALLY HEALTHY CITY FORUM (CMHCF) REPORT (11:45 - 12:00)**

Information item.

413 - 414 20 **CREATING A PHYSICALLY ACTIVE CITY FORUM (CPACF) REPORT (11:45 - 12:00)**

Information item.

415 - 416 21 **HEALTH PROTECTION FORUM (HPF) REPORT (11:45 - 12:00)**

Information item.

22 **OTHER URGENT BUSINESS**

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

APPOINTMENT OF HEALTH AND WELLBEING BOARD

FUNCTIONS, TERMS OF REFERENCE AND MEMBERSHIP 2022/23

In accordance with paragraph 6.9 of Article 6 (The Executive) of the City Council Constitution, the board is constituted as a Committee under the chairmanship of the Cabinet Member for Health and Social Care in order to discharge the functions of the board as set out in the Health and Social Care Act 2012, including the appointment of board members as set out in the schedule of required board members in the Act.

Functions

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

The Health and Wellbeing Board will:

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

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

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

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

e) participate in the annual assessment process to support Integrated Care Boards (formerly Clinical Commissioning Group authorisation

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

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

Terms of Reference

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

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

Each Local Authority may appoint additional Board Members as agreed by the Leader of the Council or their nominated representative. If additional appointments are made, these will be reported to Cabinet by the Chair of the Board.
For the Board to be quorate at least one third of Board Members and at least one Elected Member must be present

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

Membership

2022/2023
City Council Appointments to the Health and Wellbeing Board

Cabinet Member for Health & Social Care as Chair: Cllr Mariam Khan (Lab)	Cllr Mariam Khan
Cabinet Member for Children, Young People and Families: Cllr Karen McCarthy (Lab)	Cllr Karen McCarthy
Opposition Spokesperson on Health and Social Care – Cllr Matt Bennett (Con)	Cllr Matt Bennett
Vice Chair for 2022/2023 to be an NHS Birmingham and Solihull Integrated Care Board (ICB) representative (to be advised by the ICB) - to reinforce the Board as a joint body rather than a solely LA committee	Dr Clara Day - Chief Medical Officer
Corporate Director for Adult Social Care and Health Directorate	Professor Graeme Betts
Corporate Director for Children and Young People Directorate	Sue Harrison
Director of Public Health	Dr Justin Varney

External Appointments to the Health and Wellbeing Board

Representative of Healthwatch Birmingham	Andy Cave- Chief Executive
2 Representatives of NHS Birmingham and Solihull Integrated Care Board	Dr Clara Day – Chief Medical Officer and David Melbourne – Chief Executive
Representative from Sandwell and West Birmingham NHS Trust	Richard Beeken, Chief Executive Officer

2022/2023

Chair of the Birmingham Community Safety Partnership	Dr Justin Varney as substitute
Representative of the Department of Work and Pensions	Riaz Khan
Member of the Birmingham Social Housing Partnership	Peter Richmond
Chief Executive of Birmingham Children's Trust	Andy Couldrick
Representative of Birmingham Community Healthcare NHS Foundation Trust	Richard Kirby/Douglas Simkiss
Representative from the Education Sector	Professor Robin Miller, PhD
Representative from Acute Care	Mark Garrick
Representative from West Midlands Police	Chief Superintendent Mat Shaer
Representative from the Chamber of Commerce	Vacant

Co-Optees

Birmingham Voluntary Services Council	Stephen Raybould
Birmingham and Solihull Mental Health NHS Foundation Trust	Patrick Nyarumbu
Representative from SIFA FIRESIDE	Carly Jones

BIRMINGHAM CITY COUNCIL

BIRMINGHAM HEALTH AND WELLBEING BOARD MEETING TUESDAY, 17 MAY 2022

MINUTES OF A MEETING OF THE BIRMINGHAM HEALTH AND WELLBEING BOARD HELD ON TUESDAY 17 MAY 2022 AT 1500 HOURS AS AN ONLINE MEETING

PRESENT: -

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Professor Graeme Betts, Director of Adult Social Care
Andy Cave, Chief Executive Officer, Healthwatch Birmingham
Councillor Jayne Francis, Cabinet Member for Digital, Culture, Heritage and Tourism
Mark Garrick, Director of Strategy and Quality Development, UHB
Karen Helliwell, Interim Accountable Officer, NHS BSol CCG
Councillor Mariam Khan, Cabinet Member for Health and Social Care and Chair for the Birmingham Health and Wellbeing Board
Professor Robin Miller, PhD, Director of Global Engagement for College of Social Sciences, University of Birmingham
Patrick Nyarumbu, Executive Director of Strategy, People and Partnership, Birmingham and Solihull Mental Health NHS Foundation Trust
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Chief Superintendent Mat Shaer, West Midlands Police
Dr Douglas Simkiss, Medical Director and Caldicott Guardian, Birmingham Community Healthcare NHS Foundation Trust
Dr William Taylor, NHS Birmingham and Solihull CCG and Vice Chair for Birmingham Health and Wellbeing Board.
Dr Justin Varney, Director of Public Health, Birmingham City Council

ALSO PRESENT:-

Richard Beeken, Chief Executive Officer, Sandwell and West Birmingham NHS Trust
Carol Herity
Kalvinder Kohli, Service Lead CCoE, Adult Social Care
Ceri Saunders
Dr Mary Orhewere, Assistant Director, Environmental Public Health
Dr Shiraz Sheriff, Service Lead – Governance, Public Health Division
Errol Wilson, Committee Services

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NOTICE OF RECORDING/WEBCAST

639 The Chair welcomed attendees and advised, and the Committee noted, that this meeting will be webcast for live or subsequent broadcast via the Council's meeting You Tube site (www.youtube.com/channel/UCT2kT7ZRPFCXq6_5dnVnYlw) and that members of the press/public may record and take photographs except where there are confidential or exempt items.

DECLARATIONS OF INTERESTS

640 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

641 Apologies for absence were submitted on behalf of Richard Kirby, Birmingham Community Healthcare NHS Foundation Trust
Councillor Sharon Thompson, Cabinet Member for Vulnerable Children and Families
Carly Jones, Chief Executive, SIFA FIRESIDE
Andy Couldrick,
Sue Harrison, Director for Children and Families, BCC
Riaz Khan, Birmingham and Solihull District, Department for Work and Pensions
Peter Richmond, Birmingham Social Housing Partnership

DATES OF MEETINGS

642 The Board noted the following meeting dates for the Municipal Year 2022/23:

2022	**2023**
Tuesday 17 May	Tuesday 17 January
July 2022 - Development Session	Tuesday 21 March
Tuesday 20 September	
Tuesday 29 November	

All meetings will commence at 1500 hours unless stated otherwise.

MINUTES AND MATTERS ARISING

643 **RESOLVED: -**

The Minutes of the meeting held on 22 March 2022, having been previously circulated, were confirmed and signed by the Chair as a true record.

ACTION LOG

Dr Shiraz Sheriff, Service Lead – Governance, Public Health Division introduced the item and advised that there were no outstanding actions on the Action Log.

644 **RESOLVED: -**

The Board noted the information.

CHAIR'S UPDATE

645 The Chair advised that there was no update.

PUBLIC QUESTIONS

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

CORONAVIRUS-19 POSITION AND VACCINE UPDATE STATEMENT

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

(See document No. 1)

Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care commented that this was all positive news, but that we have spent a great deal of time talking about Covid over the last couple of years. Councillor Bennett Added that going forward whether we needed to have this level of information at the start of the meeting. He proposed that this be had for information, but that if things changed again for the worst we could revisit that but at the moment he wonder if it was worth taking up the start of the meeting going through this level of details particularly as Dr Varney stated that we did not have the level of data as we used to.

Dr Varney nodded in agreement to Councillor Bennett's comments.

The Health and Wellbeing Board noted the contents of the slide presentation.

The Chair expressed thanks to Dr Varney for presenting the item.

COMMONWEALTH GAMES UPDATES UPDATE

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

(See document No. 2)

The Health and Wellbeing Board noted the presentation.

ICS UPDATE

649 Karen Helliwell, Interim Accountable Officer, NHS BSol CCG introduced the item and gave the following update:

1. It was worth noting that for the Clinical Commissioning Group (CCG) representatives here today, this was our last and final meeting. For Dr William Taylor who was the Vice-Chair for the Health and Wellbeing Board, the CCG will be ceasing as an organisation in about six- and one-half weeks' time.
2. We were working hard now to established and get ready to put in place the new organisation the Integrated Care Board (ICB). We now have all of our executive team appointed to the ICB the details of which will be circulated but those appointments will be critical to taking forward the new agenda.
3. The organisation and the ICS were now working in shadow form and we will see a lot of readiness to operate in our governance and our arrangements were getting into place.
4. In terms of other key areas to note, one of the key areas of interest for this Board was the identification of a masterplan and a strategy which was for the Integrated Care Partnership. This was for the wider group of stakeholders that were going to be brought together across the system.
5. We were delighted that Dr Varney had agreed to lead the development of that masterplan so there were some links there with the work already undertaken in the Health and Wellbeing Board (HWB).
6. A lot of the work around Birmingham as a place – Professor Graeme Betts was leading on this and some of the development sessions there will be opportunities to work through the benefits for citizens.
7. It was not just about creating the organisation, it was about integrating care for the benefit of our citizens and patients and the focus now will be about improving that care and how we go about it. The Board will hear a lot more about that agenda going forward.

Dr Justin Varney, Director of Public Health formally thanked and acknowledged both Dr William Taylor, Karen Helliwell and Dr Manir Aslam. The journey we have been on and the Health and Wellbeing Board has not always been an easy one particularly through the various iterations the structures and governance etc. but it has been one that we have travelled as colleagues. It was important to minute our thanks to them as the journey continues in a new phase by the NHS. Dr Varney added that he valued personally their support and their robust challenge which has been helpful and keep us moving forward.

Professor Robin Miller, PhD, Director of Global Engagement for College of Social Sciences, University of Birmingham echoed Dr Varney's statement and stated that we were very fortunate with our Clinical Commissioning Groups (CCG) colleagues on the HWB. They have contributed to the discussions an brought a sense of their own roles equally we were happy to engage with others. Professor Miller added that the HWB was lucky in that regard.

Professor Miller enquired in terms of the involvement of people's lived experience in terms of health and social care and communities and the new integrated care system whether this was something that was developed and the approach as to how that was going to happen in practice, how it was going to work at different levels and whether this was something that could be shared with the HWB members.

Ms Helliwell made the following statement:-

- There that there was probably quite a few documents that we could start to share. There was a Communities and Engagement Strategy which She and Dr Taylor had just been in a meeting to sign off.
- We were very much looking to the expertise in the local authority for engagement and building on that with partners. It was not thought that the ICB organisation was looking to do it itself. It was looking to build on some of the work that Dr Varney spoke about as well in terms of the vaccination programme and learning that was part of it.
- The operating model of the ICB was very much about devolving responsibility and accountability as close to the citizen as possible ad that was the key part of that.
- There were various initiatives such as the Fairer Futures Fund pot of money which will be organised and led by the local authority to facilitate that change in community which was the key part of our strategy going forward.
- In our arrangements we were putting the resources and a lot of our staff in the CCG out with and into Birmingham. This was something I was passionate about in integrating community commissioning and working closer with neighbourhoods which will be a key part of our arrangements.

Dr William Taylor, NHS Birmingham and Solihull CCG and Vice Chair for Birmingham Health and Wellbeing Board advised that in relation to neighbourhoods, there was a workshop earlier today and the whole point was to have integrated care as close to the people and the communities as possible. Really thinking about how we integrate care in those communities in a way where people did not fall down between the gaps between services which we saw happening now. The key to that was understanding their stories and understanding their voice as we cannot do it without them.

Ms Helliwell commented that we were all going into a new system and a new organisation so clearly West Birmingham colleagues and ourselves were both joining a new system and a new organisation, and we very much welcomed that as well.

Richard Beeken, Chief Executive Officer, Sandwell and West Birmingham NHS Trust apologised for not attending the Board meetings before and that he had committed to Dr Varney that he or his deputy would attend all future HWB going forward. Mr Beeken stated that his question relates to West Birmingham – Ladywood and Perry Barr as a locality moving from the Black Country to the BSol system.

The West Birmingham Partnership Board as it currently exists made it very clear what the conditions for what success would be. Two of them related to subsidiarity and local determination and there was an articulation about how this would be measured. The second being in relation to ensuring that there was not where possible at least essentially two very different approaches to the development of community services in the widest sense between the two parts of the system that his organisation supports.

Looking through the lens of the Midlands Metropolitan Hospital. There was a risk because there was such a significantly different operating model for BSol as compared to the Black Country, there was a risk that two of the three key conditions for success we agreed were not going to be fully assured. There were mitigatable but we did not want to be discussing the details about how they could be mitigated here, but the question was whether you and others felt that there was still a risk. If it was, we have six- and one-half weeks to try and agreed some joint statements about how those risks would be mitigated.

Ms Helliwell advised that there was a level of governance and assurance that was in place to work collaboratively and that we always have between West Birmingham and ourselves, but she would take the point back to the ICB with Paul Athey who was leading on it. Ms Helliwell added that she felt that those risks could be mitigated and if it was identified that there were some outstanding areas, we would continue throughout the next six weeks and beyond as there will be some ongoing issues as place becomes an entity in its own right in the new way. I am sure we were all committed to that going forward as it was not thought that this was a hard and stop work that would be carried on beyond that. Our commitment was that we wanted the right services for citizens all across Birmingham and that inequity was something we would want to address.

Professor Graeme Betts, Director of Adult Social Care made the following statements:-

a. That he would focus on two things the new approach based on subsidiarity and place and this was the best opportunity we have to begin to transform our service to meet the needs of our communities.
b. As we know in Birmingham, the share scale of it was that we have five different localities with different communities within them.
c. Subsidiarity was a key principle and we needed to ensure that this services that was being delivered meet the needs of our local communities and we needed to understand those needs better than we did in the past.
d. This was a huge opportunity both for co-production with communities and community groups and the opportunity to begin to see services being delivered in different ways.

e. We would try to do this in two ways – to begin to build the infrastructure and the multi-disciplinary teams at a local level and the workshop this morning was beginning to take us forward in that way.
f. But there was also other work around strategic commissioning which was very much about getting the right pathways which meets the needs of our local communities. We would want to come back to the HWB about both those areas in terms of how they were being delivered in place.
g. The other key element was the interface with the service integrators like the main Acute Trust etc and about their development pathways. What would be interesting was to see how that would interface with place. This was all to be worked through and the role of the ICB was to help broker that.
h. In terms of the West Birmingham question the reality was that from a Birmingham perspective thinking in particular about the City Council, that was all there had ever been one Birmingham. The rest was several sections of it but one Birmingham.
i. Again we come back to that notion of place where this was recognised that there were different communities in Birmingham, and we need to meet the needs differently.
j. We were always open and remain open to ensure that we looked at best practice so that we could learn from the way West Birmingham was developed.
k. We could look at Solihull and there were lots of models we could build on. It was about learning from the best because ultimately that meant our citizens get the best possible services.
l. Going forward that was what we needed to be mindful of and put to one side what was and what was right or what was wrong. We needed to forget that as we have a great opportunity to move forward.
m. Professor Betts proposed that at the next Board meeting this issue be place on the Agenda so that we could give an update as to where things got to, how things were developing and improving.

The Chair commented that this was sensible idea and it was noted.

SANDWELL AND WEST BIRMINGHAM NHS TRUST FIVE YEAR STRATEGY

650 Richard Beeken, Chief Executive Officer, Sandwell and West Birmingham NHS Trust introduced the item and drew the attention of the Board to the information contained in the report on pages 47 – 55 of the Agenda Pack.

(See document No. 3)

Mr Beeken made the following statements:-

a. The Trust had a strategy that had elapsed in 2020 which was largely pointed to the opening of the new Midlands Metropolitan Hospital which did not open on that date.
b. Covid had happened since that point and the Integrated White Paper had happened since that point.

c. The national NHS approach to collaboration horizontally has happened since that point and at Sandwell and West Birmingham the Trust had slipped backwards in terms of both the regulatory opinion of the quality of its services but also staff and patients surveyed opinion of the quality of its services as well.
d. There was clearly a need in the context of all of that to look forward five years and try to align what we were doing to the ambitions of both of the systems that we served, and it was hoped that this strategy reflected that.
e. From our starting point was really to be clear about our purposes were and our organisation really should do that we were clear from the beginning that we wanted to do more than just being an organisation that treats the sick.
f. We could quite easily continue to structure ourselves to do that but by being one of the biggest employers around and by being the biggest health care providers around and by being the host of the place-based partners in Sandwell already we had the ability to do much more than that as a so-called anchor institution.
g. Our purpose was to contribute to improving the life chances in the health service with outcomes of the two very distinct populations that we serve.
h. We tried to keep things simple by saying that we have three strategic objectives the first of which relates to our service users and our patients and that was because as an organisation that was rated improvements required by the Care Quality Commission and as an organisation that was languishing in the bottom quarter with national survey opinion we have to get the fundamentals of care right and we were not doing so at the moment.
i. There was a structured and far reaching approach to the continuous quality improvement and launching to get the rock on which we stand to be far more stable than it had been in the last two to three years.
j. Firstly, we had been clear that the natural workforce crisis could be ignored, and we could stick our heads in the sand, or we could accept that the recruitment retention and inspiration of our clinical and non-clinical staff was going to help us deliver better outcomes for people and therefore we were focusing our approach on four areas.

   Obviously, culture and how we interact with each other was one of those. We were also taking international research evidence from the public sector which clearly stated that staff experience was also heavily influenced by how intuitive digital technology was that they used.

k. Secondly, by the physical environment in which they work and there was nothing more powerful than a tweet he had received a few weeks ago from an over exhausted junior doctor who basically stated *that I don't want yoga lessons, I don't want wellbeing sessions. What I want was a car parking space, somewhere to get hot food at 2:00am in the morning, enough colleagues to work with on my shift and somewhere to hang my coat and hat when I get to work*.

   Focussing on those fundamentals was a key part of our people plan as was perhaps the more highfaluting organisation development aspirations.

l. Thirdly and most critical to this Board was our third objective which was our population. We were stating the rather obvious statement, but it needed stating to a lot of his colleagues within my organisation that we were not an island and we would only improve health outcomes and life chances relations by working with other organisations both vertically through localities and places but also horizontally across the two systems that we serve.
m. We do have a bit of challenge within my organisation as we do serve two systems so that that horizontal partnership with colleagues in Birmingham and Solihull was going to be something that we had to give equal attention to because 47% of the activities within my organisation that delivers the patient care contacts comes from the Birmingham and Solihull system.
n. As regards population there was essentially two elements to our work the first was that either being a leader in the integration space in Sandwell or being a partner in Birmingham as we were in Ladywood and Perry Barr which was one half.
o. The other half was an unexplored area that I was starting to move into because it was quite clear when you look for example at the Midland Metropolitan Hospital development, its regeneration potential, the Trust existing work programme around and widening participation for some of the more marginalised members of our society.
p. The fact that we have a massive jump to make in terms of making what we do as an organisation greener more sustainable how we could contribute as a so-called anchoring institution for economic regeneration in improving the ability to economic participation for our citizens.
q. We did not believe we were a leader in that space and would not want to be trampling on other people's toes, but what we were saying to people was that we were more than an hospital and please see us as more than an hospital because we deliver community services.
r. We have an interest in ensuring that some of the more diverse and deprived communities that we serve as we all knew were some of the most deprived and diverse in the country we could play a part in helping those people get back on their feet as much as other statutory and non-statutory partners.
s. With regard to the Midland Metropolitan Hospital that was our biggest single strategic enabler that would underpin those three objectives that we were seeking to achieve as it will impact upon each of them because it will if we get our care model right enable us to provide better care in a better-quality buildings. It will enable us to attract and retain more staff and reduce our reliance on temporary staffing.
t. Thirdly it will through developments like the learning campus on site like the local universities and colleges it will give us the opportunity and our footprints would be necessarily more overtly wider than it was not just as a hospital or health care provider.

Dr Justin Varney, Director of Public Health made the following statements:-

i. Two things stood out for him – the ambition to become more than an anchoring institution. This was something where in Birmingham we had a network of anchoring institutions which clearly supports that the Board

had previous representations on. There was some opportunities for us to connect you with that.

ii. Also under the ICS inequalities programme there was a specific ambition around increasing the NHS and social care anchor footprint beyond large institutions.

iii. The question was how we work so that the large anchors connect to medium and smaller anchors reaching right down across to community pharmacy and primary care practice level so that we started to maximise all of those services that were fixed into place because they had bricks and mortars in a much more coherent way.

iv. There was a real opportunity to bring you into the ICS fold which was not just about place.

v. One of the things we were seeing was a slightly different way of behaving with the ICS was that there were pieces of work really anchored in place in localities around transforming services.

vi. Where there were things that it made much more sense for us to do across the 1.3m people at the system level we were now having real conversations about what does that meant.

vii. It would be wise to have a connection with Richard Kirby about how the Trust connected into the Inequalities Board and the Inequalities Programme as that was one of the opportunities where the Trust could forged new grounds.

viii. At the moment we did not have a Trust representative for any of the providers other than Mr Kirby as the Community Trust Chief Executive. There was some synergy there at the system level as well as at the place level and there were some real opportunities.

ix. Although some of our NHS anchors had done great work, there were some exemplary work from other non-NHS organisations that we were all learning from in the city.

x. This was one of the real opportunities particularly from the University of Birmingham who did some innovative work around place and anchorage. It was that cross pollination across the public sector that was key in this

Professor Robin Miller, PhD, Director of Global Engagement for College of Social Sciences, University of Birmingham commented that one of the things he saw a long time ago about the new Midland Metropolitan Hospital was that you were going to try and use and deploy social value through your purchasing and try to buy local produce and sustainability etc. Professor Miller enquired whether this was still part of the plan.

Mr Beeken stated that it was and that we tracked our performance against it as well. He added that he needed to cross-referenced his numbers. For example we stated that we could be committed in the business case from 2016 to 60% of the goods and services procured to essentially construct and open the building would be secured from organisations and procured from a 25 miles radius - that was the commitment. That was tracked on a not frequent basis but on a regular basis through our Boards Committee that was devoted to opening the Midland Metropolitan Hospital. He added that he could offer to provide the latest performance of that if that was useful off-line.

As you could imagine, the unavailability of sub-contractual labour because of HS2 and other things and the hyperinflation of materials leading us to look

elsewhere globally as well as nationally has perhaps put a dent in that in terms of latest figures because our priority now was to get that hospital open. We were providing services on the Dudley Road site that were now creaking at the seam in terms of their viability for the 21st Century health care provisions.

Professor Miller stated that linked to that going forward things like catering services, cleaning services etc. will there be any engagement with social enterprising with not for profit businesses as well as there would be a long-term commercial footprint that will be had.

Mr Beeken advised that prior to his time the trust made a commitment which he was now dealing with to provide estate maintenance services through a large multinational. However, catering remained stubbornly in-house, portering services and cleaning services remained stubbornly in house and will do so. The big opening space in the new hospital was the Winter Garden so-called. We have already got a partnership with local community groups and local artists and that he thought it would be outside of Birmingham City Centre the largest Art and Gallery space in the West Midlands when it was fully open. This was just an example of the social value stuff – it was #Morethananhospital that we were trying to push.

Dr Manir Aslam, GP Director, Sandwell and West Birmingham CCG made the following statement:-

- 45% of your referrals came from West Birmingham. From Primary Care 80% of our referrals were into City and Sandwell Hospitals which was a massive part of our referral process.
- It was not just about the hospital and it will not be juts about the hospital going forward.
- The integration we had done with consultants coming into our practices and managing our diabetes better, our respiratory services better having a gold standard or a CQC outstanding rating meant that we have had some of the best services in Birmingham.
- Although the hospitals were challenged, some of the services we provided for the most deprived population were some of the best that we got.
- What we did not wanted to do was to unpicked the great work we had done, we have not thought about organisations as we had been going along, but we had been thinking about our patients and what we provide to them. We maintained our focus and those services must stay in place.
- We must not be disadvantaged by moving – we have always been one Birmingham place and that has never been different. The way that our NHS functioned and the way that our Primary Care integrates with its hospitals were different.
- University Hospitals Birmingham (UHB) was the main provider or the rest of Birmingham, it was not for West Birmingham. We were functionally different, and it was a plea to say don't unpicked those things because putting them back together would be difficult.

(At 1600 hours Councillor Jayne Francis and Professor Graeme Betts left the meeting due to a prior engagement).

Dr Justin Varney in the Chair

BCC EARLY INTERVENTION AND PREVENTION PROGRAMME

Professor Graeme Betts, Director of Adult Social Care introduced the item and stated that it was important to state that one of the key programmes we had for transforming the Council was brought here and had huge implications for the work we were doing not just within the Council but a system as a whole. Professor Betts advised that he had taken this presentation to the Chief Executives across the BSol system and felt that it would be good to bring it to the HWB as well. He added that Kalvinder Kohli, Service Lead CCoE, Adult Social Care was leading on this and had done a fantastic job.

Professor Betts then invited Kalvinder Kohli to present the item.

Kalvinder Kohli, Service Lead CCoE, Adult Social Care presented the item and drew the Board's attention to the information contained in the slide presentation.

(See document No. 4)

Dr William Taylor, NHS Birmingham and Solihull CCG and Vice Chair for Birmingham Health and Wellbeing Board commented that it sounds like a comprehensive programme of work across a huge amount of areas. Dr Taylor made the following points:

The names were incredibly confusing given that we already got a partnership programme with the City Council called Early Intervention – we now have two. We needed to think about that as we cannot have the Early Intervention Partnership Programme with Birmingham City Council and this one. Having looked at it first I thought it was a completely different subject, so it was worth thinking about that.

It was not clear form the presentation how this interacts with place – things like the conversation we had this morning around neighbourhood integration, interaction with health, neighbourhood networks. These could not be seen from the presentation and it feels like something that sat within the Council rather than something that sat within the partnership. I have not seen much in terms of partnership work around this and its design into that place-based offer. He added that he would be interested in hearing more about that as this was important.

Dr Varney advised that there were a lot of external partners who were involved in shaping some of this.

Kalvinder Kohli apologised to Dr Taylor and advised that this was the shortened version of the presentation and that there was a Programme Board for the Early Intervention and Prevention Programme which includes ICS colleagues as well. In terms of the place-based agenda this would be routed in that place-based approach. As was stated at the beginning of the presentation, this was not a

programme that stand alone, it was connected to the much broader activity. Neighbourhood networks for example came up time and again – what we did know was that there were (when I spoke about fragmented experience) parts of the Council that did not utilised neighbourhood networks for example. It depended on where those citizens landed as to whether they were told about and were accessing our networks. It was about bringing all of those thigs together. Apologies we do have a longer slide which probably brings that information out far better than this had.

The point around the name, again, Dr Taylor was correct. The reason we were calling this Early Intervention and Prevention Programme at the moment was because we struggling to agree upon an appropriate name for the programme, but it was hoped that by the time we get to the Cabinet report in December we would have a better working title than the one we have at the moment.

Stephen Raybould, Programmes Director, Ageing Better, BVSC commented that this speaks to Dr Taylor's point earlier and that he wondered whether at some point this could be thought about in terms of adoption by the ICS and not just being a Birmingham City Council approach. He added that he appreciated that this was done with other partners, but he was just aware that we focussed on health and inequalities, but there was a lot of activities in what was in effect a similar space where gains had o be made there. Pulling all of this together was likely to give a better outcome across both programmes. Perhaps looking at a stronger alignment and then integration down the line would be a useful way to progress.

Dr Douglas Simkiss, Medical Director and Caldicott Guardian, Birmingham Community Healthcare NHS Foundation Trust commented that we feel like we were getting closer, but there were so many different elements of this. Dr Simkiss added that the bit he wanted to check was that you talked about this being about children, but mostly it seemed to be adult relate. Dr Simkiss enquired whether this was a life course strategy or whether it was largely an adult strategy. The vision talked about starting when we were children continuing through their life, but it seemed mainly adult related.

Kalvinder Kohli advised that this was whole life course and would evolved in terms of alignment, so we were working closely with our colleagues around the early help offer – example around children and families and how we aligned that into this space. This will form part of the detailed design work we engaged with including the Birmingham Children's Trust in terms of their early help offer to ensure that we could have a front door around early help that we complimented and supported that space. It was not an adult space exclusively, but similarly, we were mindful of the fact that the factors that brought people to the front door was often related around things like debt, income, abuse etc. If we look at domestic abuse and we look at the number of children in care, domestic abuse was part of their back story. By inference there was a whole life approach t this and as we developed the work packages it became clearer as to the work we needed to focussed on in the different cohorts of population.

Dr Simkiss stated that there were a number of different hubs, there were children centres, family hubs and there were chid development centres. There were a number of existing bodies which could be pulled together for the whole

families. The other bit was around homes and money advice and he as speaking to our registrar about trying to make every contact count. There as the physical activity and the health care parties and there was a number f ways in which we were drawing closer together in terms of a suite of interventions – we could end up with a single piece of paper with all of these and coming together as a whole workforce not juts across health and social care, but across all of the Council and all of the other things that work. They were coming together but they were still different elements.

The last one was the library and there had been a lot of discussions through the pandemic as we moved to virtual consultation around digital poverty and there was some work with her chief clinical information officer with libraries about whether they could become pods in libraries where they could do a consultation virtually if they did not have digital equipment at home.

651 **RESOLVED: -**

The Health and Wellbeing Board:-

a. Agreed to be mindful of EI&P programme and to help identify alignment opportunities with BHWB strategies and current priorities – implications of EI&P across BHWB strategic priorities and programmes, as detailed in the report;
b. Identified any additional stakeholders, including staff, citizens and partners, to be involved in research and codesign for EI&P;
c. Helped identify appropriate SMEs (internal and external); and
d. Defined cadence of board appearances receive reports or how best to work moving forward – to keep both parties aware and aligned of programme developments.

BIRMINGHAM AND LEWISHAM AFRICAN CARIBBEAN HEALTH INEQUALITIES REVIEW (BLACHIR)

652 Dr Justin Varney, Director of Public Health then presented the item and drew the attention of the Board to the information contained in the slide presentation highlighting the key points.

(See document No. 5)

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

Dr Mary Orhewere, Assistant Director, Environmental Public Health presented the item and drew the attention of the Board to the information contained in the slide presentation highlighting the key points.

(See document No. 6)

The Chair commented that he acknowledged Dr Orhewere and her team's hard work in putting the report together.

653 **RESOLVED: -**

The Health and Wellbeing Board:-

a. Noted the findings from the Director of Public Health Annual Report 2021/22:
Creating a built environment that makes Birmingham a healthier place to live.

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

AGENDA ITEMS 16 - 17

654 The Chair acknowledged Items 16 and 17 on the Agenda were for information only.

Birmingham Health and Wellbeing Board Chair

655 At this juncture the Chair invited Cabinet Member for Health and Social Care and new Chair for the Birmingham Health and Wellbeing Board who was observing today's session to address the Board.

OTHER URGENT BUSINESS

656 Professor Robin Miller, PhD, Director of Global Engagement for College of Social Sciences, University of Birmingham invited members of the Board to attend his inaugural lecture as a professor on the 6th June 2022. He advised that this will be about collaboration and leadership which he has drown a lot of experience from the HWB.

The meeting ended at 1636 hours.

……
CHAIRPERSON

Item 7

BIRMINGHAM HEALTH & WELLBEING BOARD

Action Log 2021

DRAFT

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: 10
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**22/08/2022**
TITLE:	**BIRMINGHAM PHARMACEUTICAL NEEDS ASSESSMENT**
Organisation	**Birmingham City Council**
Presenting Officer	**Dr Justin Varney**

Report Type:	**Approval**

1. Purpose:

1.1. To update the Birmingham Health and Wellbeing Board (HWB) on the progress towards producing the next Pharmaceutical Needs Assessment (PNA).

1.2. To seek approval from the Birmingham HWB to proceed with the joint arrangements between Birmingham and Solihull for producing a PNA.

1.3. To seek approval from the Birmingham HWB to delegate the sign-off of the draft and final PNA to the Birmingham Director of Public Health and the Birmingham and Solihull PNA Steering Group.

2. Implications (tick all that apply):

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

3. Recommendation

3.1. To approve the joint arrangements between Birmingham and Solihull for producing their PNA (a single joint PNA covering both Birmingham and Solihull).

3.2. To formally delegate the sign-off of the draft and final PNA to the Birmingham Director of Public Health (DPH) and Birmingham and Solihull PNA Steering Group.

4. Report Body

Background

4.1. A Pharmaceutical Needs Assessment (PNA) is a statutory requirement of Health and Wellbeing Boards (HWB) in England; its purpose is to assess the current provision of pharmaceutical services in an area and the 'need' for such services now and in the near future.

4.2. The Health and Social Care Act 2012 outlines the duty of local authorities, through the local HWB, to produce a PNA for their population. The PNA should be informed by the Joint Strategic Needs Assessment (JSNA) process and any other relevant needs assessments that identify a role for pharmaceutical services in addressing health needs.

Birmingham and Solihull PNA

4.3. Birmingham HWB and Solihull HWB have made joint arrangements for their PNA. This is in line with Section 198 of the Health and Social Care Act 2012, which allows two or more HWBs to work together to discharge their functions. It also supports the Birmingham and Solihull (BSol) Integrated Care System.

4.4. The joint arrangements were approved by the Solihull HWB Board on Tuesday 14th June 2022.

4.5. The production of the next (2022) PNA for Birmingham and Solihull has commenced. The final PNA should be published no later than 1st October 2022. However, this deadline will not be met as we will only have a Draft version ready by then due to the time frame we have, and the intention is to publish the final PNA in January 2023.

4.6. A Birmingham and Solihull PNA Steering Group has been established to produce the PNA. An external expert resource, Soar Beyond Ltd, has been commissioned to support the production of the draft PNA 2022 report. Soar Beyond has extensive expertise in producing PNAs, including eight PNAs in 2015 and twelve in 2018.

4.7. The PNA Steering Group held its first meeting on Tuesday, 14th June 2022. A Terms of Reference (Appendix 1) and the Project Plan (Appendix 2) were agreed upon.

4.8. The steering group has collected information from service providers, commissioners, and the public on current pharmaceutical service provision. Over the past months, surveys have been completed by the public, commissioners and community pharmacy contractors. This was to seek opinion on current pharmaceutical services in Birmingham and Solihull.

4.9. The aforementioned Soar Beyond Ltd is currently producing the draft PNA, which the PNA Steering Group will consider. If approved, it will be made available for a 60-day consultation between October and December 2022.

4.10. The Steering Group will consider the results of the 60-day consultation at its meeting in December. Following consultation, the final PNA will be produced for publication. The final assessment will be provided for information to the Birmingham HWB in January 2023.

5. Compliance Issues

5.1. HWB Forum Responsibility and Board Update

5.1.1. None

5.2. Management Responsibility

5.2.1. The Birmingham HWB has a statutory duty to publish a PNA and update it.

5.2.2. The Birmingham and Solihull PNA Steering Group is responsible for producing the next PNA, which will be provided for information purposes to the Birmingham HWB in January 2023.

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk

Appendices

Appendix 1 Birmingham and Solihull PNA Steering Group Terms of Reference
Appendix 2 PNA Project Plan

The following people have been involved in the preparation of this board paper:
Dr Albert Uribe
Dr Shiraz

Pharmaceutical Needs Assessment
Terms of Reference

Objective / Purpose

To support the production of the Pharmaceutical Needs Assessment on behalf of the Birmingham and Solihull Health and Wellbeing Boards, to ensure that it satisfies the relevant regulations including consultation requirements.

Delegated Responsibility

The Director of Public Health recommends that the Health and Wellbeing Board will delegate authority of the PNA to the steering group at the Health and Wellbeing Board meeting on the 27th of September 2022

Accountability

The Steering Group is to report to the Consultant in Public Health.

Membership

Core members:

- Consultant for Public Health / Nominated PH Lead
- NHSE&I representative.
- Local Pharmaceutical Committee representative.
- CCG representatives.
- Health Watch representative (lay member).

Soar Beyond are not to be a core member however will chair the meetings. Each core member has one vote. The Consultant in Public Health will have the casting vote, if required. Core members may provide a deputy to meetings in their absence. The Steering Group shall be quorate with three core members in attendance, one of which must be an LPC member. Non-attending members are unable to cast a vote – that vote may otherwise sway the casting decision.

Additional members (if required):

- CCG Commissioning Managers
- NHS Trust Chief Pharmacists

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www.soarbeyond.co.uk info@soarbeyond.co.uk
Tel: 01442 927 972

In attendance at meetings will be representatives of Soar Beyond Ltd who have been commissioned by Birmingham City Council to support the development of the PNA. Other additional members may be co-opted if required.

Frequency of meetings

Meetings will be arranged at key stages of the project plan. The Steering Group will meet in autumn 2022 to sign off the PNA for submission to the Health and Wellbeing Board.

Responsibilities

- Provide a clear and concise PNA process.
- Review and validate information and data on population, demographics, pharmaceutical provision, and health needs.
- To consult with the bodies stated in Regulation 8 of The NHS Regulations 2013:
    - Any Local Pharmaceutical Committee for its area.
    - Any Local Medical Committee for its area.
    - Any persons on the Pharmaceutical lists and any dispensing Doctors list for its area.
    - Any LPS Chemist in its area.
    - Any Local HealthWatch organisation for its area.
    - Any NHS Trust or NHS Foundation Trust in its area.
    - NHSE&I.
    - Any neighbouring HWB.
- Ensure that due process is followed.
- Report to Health & Wellbeing Board on both the draft and final PNA.
- Publish the final PNA as soon as practically possible following the 1st October 2022 deadline.

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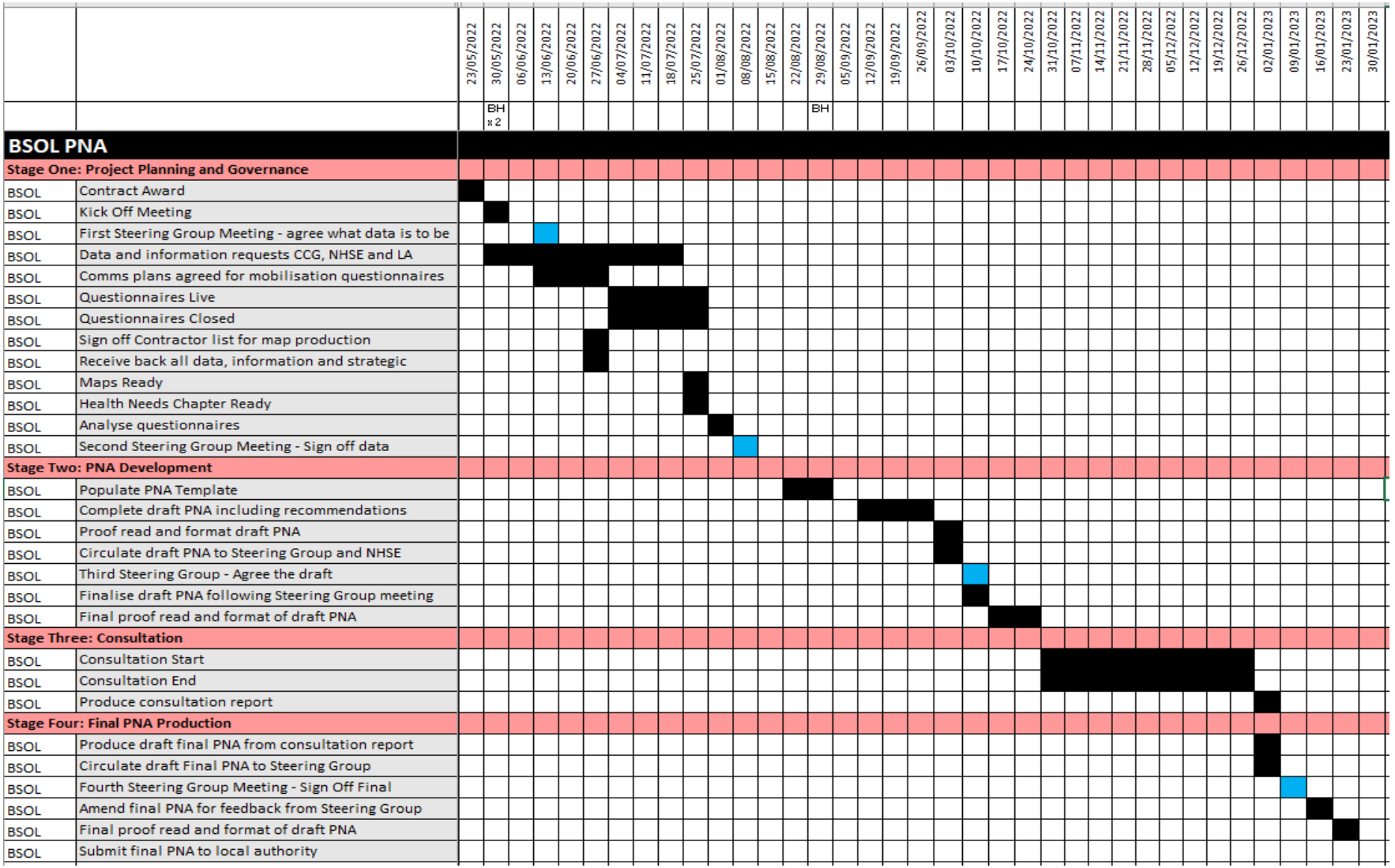
Draft BSOL PNA Project Plan 2022



		23/05/2022	30/05/2022	06/06/2022	13/06/2022	20/06/2022	27/06/2022	04/07/2022	11/07/2022	18/07/2022	25/07/2022	01/08/2022	08/08/2022	15/08/2022	22/08/2022	29/08/2022	05/09/2022	12/09/2022	19/09/2022	26/09/2022	03/10/2022	10/10/2022	17/10/2022	24/10/2022	31/10/2022	07/11/2022	14/11/2022	21/11/2022	28/11/2022	05/12/2022	12/12/2022	19/12/2022	26/12/2022	02/01/2023	09/01/2023	16/01/2023	23/01/2023	30/01/2023
			BH x 2													BH																						
BSOL PNA																																					
Stage One: Project Planning and Governance																																					
BSOL	Contract Award																																				
BSOL	Kick Off Meeting																																				
BSOL	First Steering Group Meeting - agree what data is to be																																				
BSOL	Data and information requests CCG, NHSE and LA																																				
BSOL	Comms plans agreed for mobilisation questionnaires																																				
BSOL	Questionnaires Live																																				
BSOL	Questionnaires Closed																																				
BSOL	Sign off Contractor list for map production																																				
BSOL	Receive back all data, information and strategic																																				
BSOL	Maps Ready																																				
BSOL	Health Needs Chapter Ready																																				
BSOL	Analyse questionnaires																																				
BSOL	Second Steering Group Meeting - Sign off data																																				
Stage Two: PNA Development																																					
BSOL	Populate PNA Template																																				
BSOL	Complete draft PNA including recommendations																																				
BSOL	Proof read and format draft PNA																																				
BSOL	Circulate draft PNA to Steering Group and NHSE																																				
BSOL	Third Steering Group - Agree the draft																																				
BSOL	Finalise draft PNA following Steering Group meeting																																				
BSOL	Final proof read and format of draft PNA																																				
Stage Three: Consultation																																					
BSOL	Consultation Start																																				
BSOL	Consultation End																																				
BSOL	Produce consultation report																																				
Stage Four: Final PNA Production																																					
BSOL	Produce draft final PNA from consultation report																																				
BSOL	Circulate draft Final PNA to Steering Group																																				
BSOL	Fourth Steering Group Meeting - Sign Off Final																																				
BSOL	Amend final PNA for feedback from Steering Group																																				
BSOL	Final proof read and format of draft PNA																																				
BSOL	Submit final PNA to local authority																																				

Birmingham and Solihull
Integrated Care System
Caring about healthier lives

BSol ICS Health Inequalities Work Prog

Lisa Stalley-Green

BSol ICS Dep CEO, SRO for Health Inequalities

Why addressing Health Inequalities matters

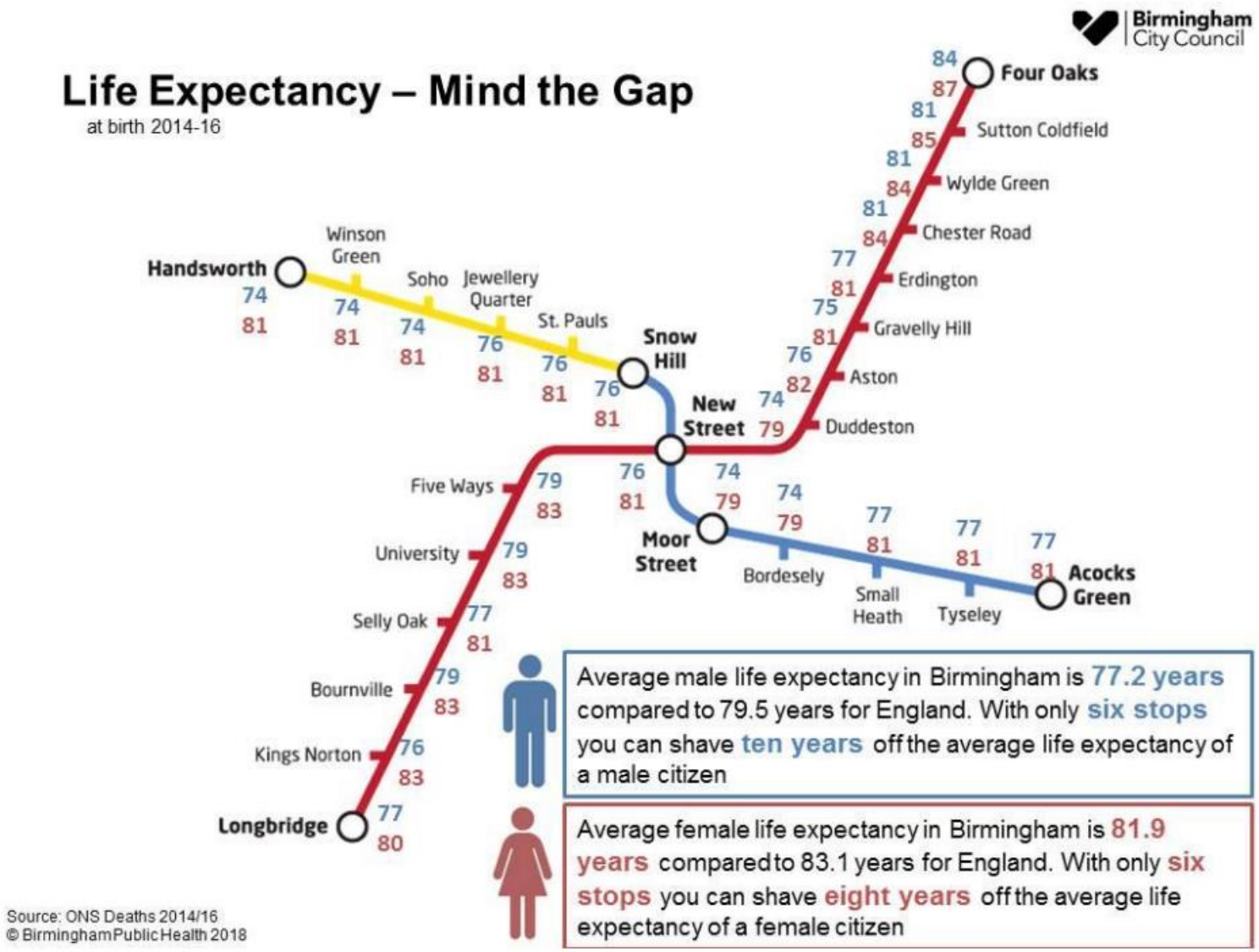
Birmingham and Solihull Integrated Care System
Caring about healthier lives

1. It is a matter of life and death – right now people living in Birmingham and Solihull's poorest areas are **dying a decade earlier** than their peers
2. It is a matter of quality of life – right now people in the poorest places, are spending **17 more years in ill health in their already shortened lives** compared to people living in better off areas

*"Within Birmingham there is a **ten-year gap** in the estimated life expectancy of a boy born in Castle Vale compared to one born in Sutton Mere Green. Similarly, within Solihull girls born in Chelmsley Wood are expected to live 9.5yrs shorter lives than those born in St. Alphege."*

ICS Health Inequalities Five-year Strategy, 2022-2027

Birmingham and Solihull Integrated Care System
Caring about healthier lives



"It's not your genetic code, it's your [post]code"

Larry Cohen,
Building a thriving nation

What actually determines our health?

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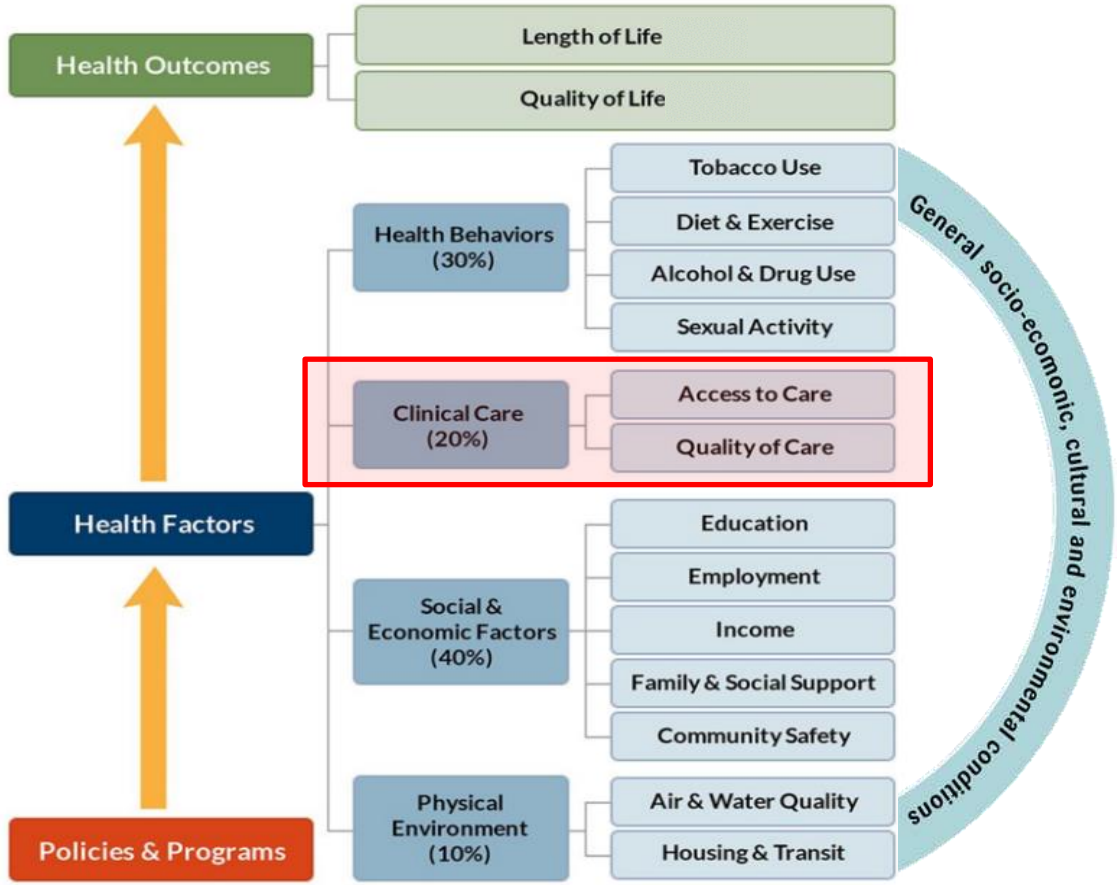
Health and care is more than services

Clinical healthcare is just one of the **building blocks** needed for good health. Some estimate clinical care accounts for around only 20 percent of the required blocks. The NHS was never meant to go it alone. To thrive we also need stable jobs, good pay, quality education and housing – that's why these are often referred to as **'wider determinants of health'.**

For example, when people have insecure or low-paid work it means that it is harder to afford decent housing. Living in cold, damp homes can result in health issues such as lung problems. Constantly worrying about making ends meet results in our bodies producing **more stress hormones, which means higher blood pressure and a weaker immune system.**

The Building Blocks of Health



Building blocks of health: what makes us healthy?

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Friends, family and communities

Social isolation and loneliness are associated with a 30% increased risk of heart disease and stroke

Money and resources

Almost half of BSol population are living in poverty, and 68% of working-age adults in poverty live in a household where at least one adult is in work.

Housing

Children living in cold homes are more than twice as likely to suffer from respiratory problems than those living in warm homes.

Education and skills

People with lowest healthy life expectancy are 3x more likely to have no qualifications compared with highest life expectancy.

Good work

Young adults who are unemployed are more than 2x as likely to suffer from mental ill health than those in work

Transport

There are 9x as many fatal and serious injuries among pedestrians aged 5–9 in the most deprived areas than the least

Our surroundings

Children & young people in deprived areas have higher exposure to air pollution and poorer asthma outcomes.

The food we eat

It is 3x more expensive to get the energy we need from healthy food than unhealthy food

ICS vision for a better future

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In July 2022 we launched our Inception Framework outlining our vision for improving the lives of people in Birmingham and Solihull and how we will incentivise providers of health and care to make a real difference in tackling health inequalities going forward. This will include:

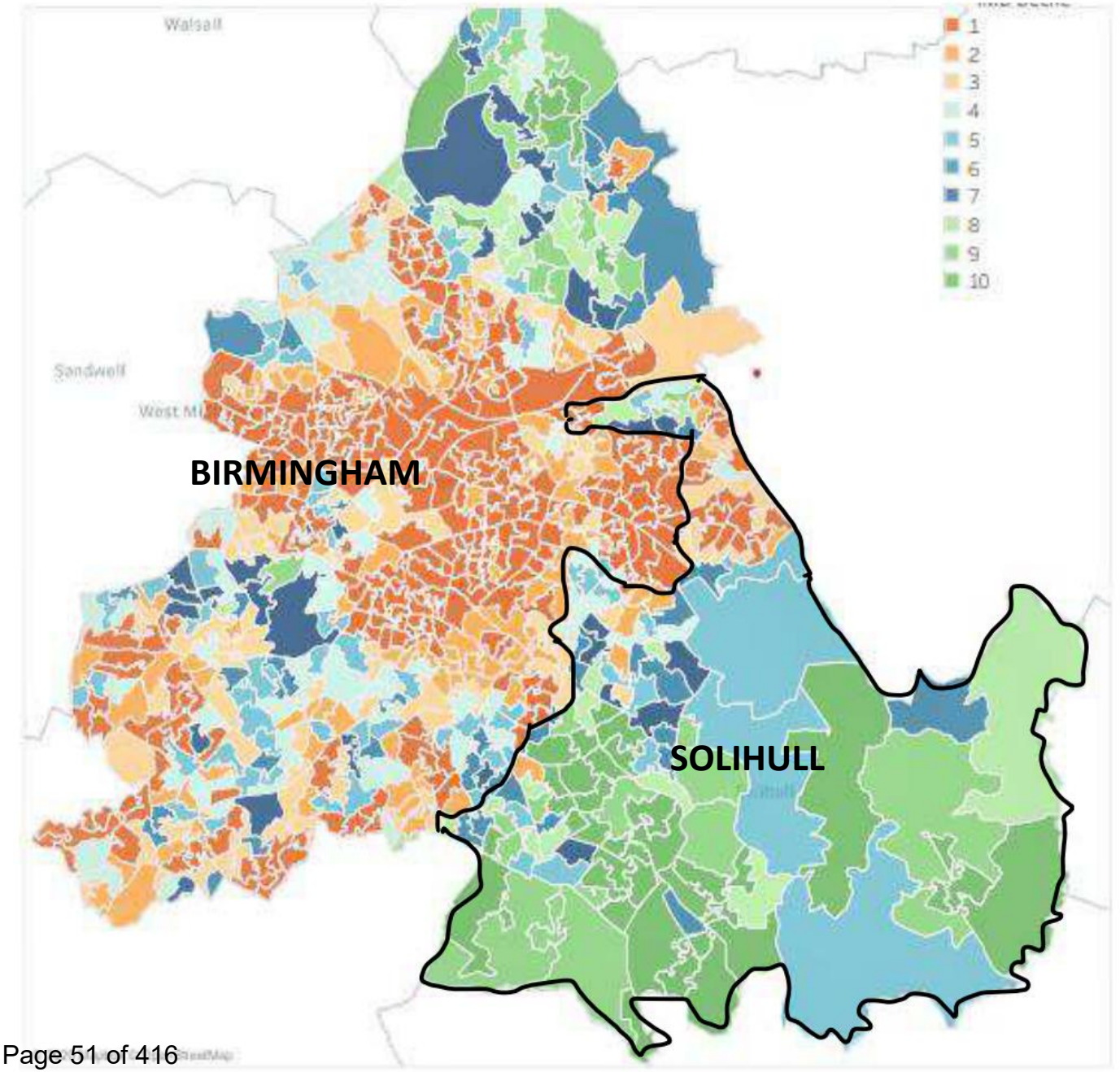
Our Fairer Futures Fund will provide immediate investment to local schemes to improve the health outcomes of our population;

Investment funding given to service integrators from the NHS Birmingham and Solihull's Integrated Care Board's £2.8 billion budget will need to clearly demonstrate how health inequalities will be reduced and will be enabled through our Outcome-based Allocation approach;

Our Partnership's 10 year Birmingham and Solihull Master Plan will clearly set out ambitious expectations for reducing health inequalities, with clear targets set at the three, five and 10 year stages.

Map of Index of Multiple Deprivation (IMD) Deciles for Birmingham and Solihull

- IMD is the official measure of relative deprivation
- Decile 1 (red) represents the most deprived 10 per cent (or decile) of neighbourhoods in England
- Decile 10 (dark green) represents the least deprived 10 per cent (or decile) of neighbourhoods in England
- Almost half of Birmingham's population live in the 20 per cent most deprived areas in England
- Solihull is relatively affluent, but there are pockets (eg in the north & west) which are very deprived



Ethnic Minority Communities are ‘majority’ in many parts of BSol

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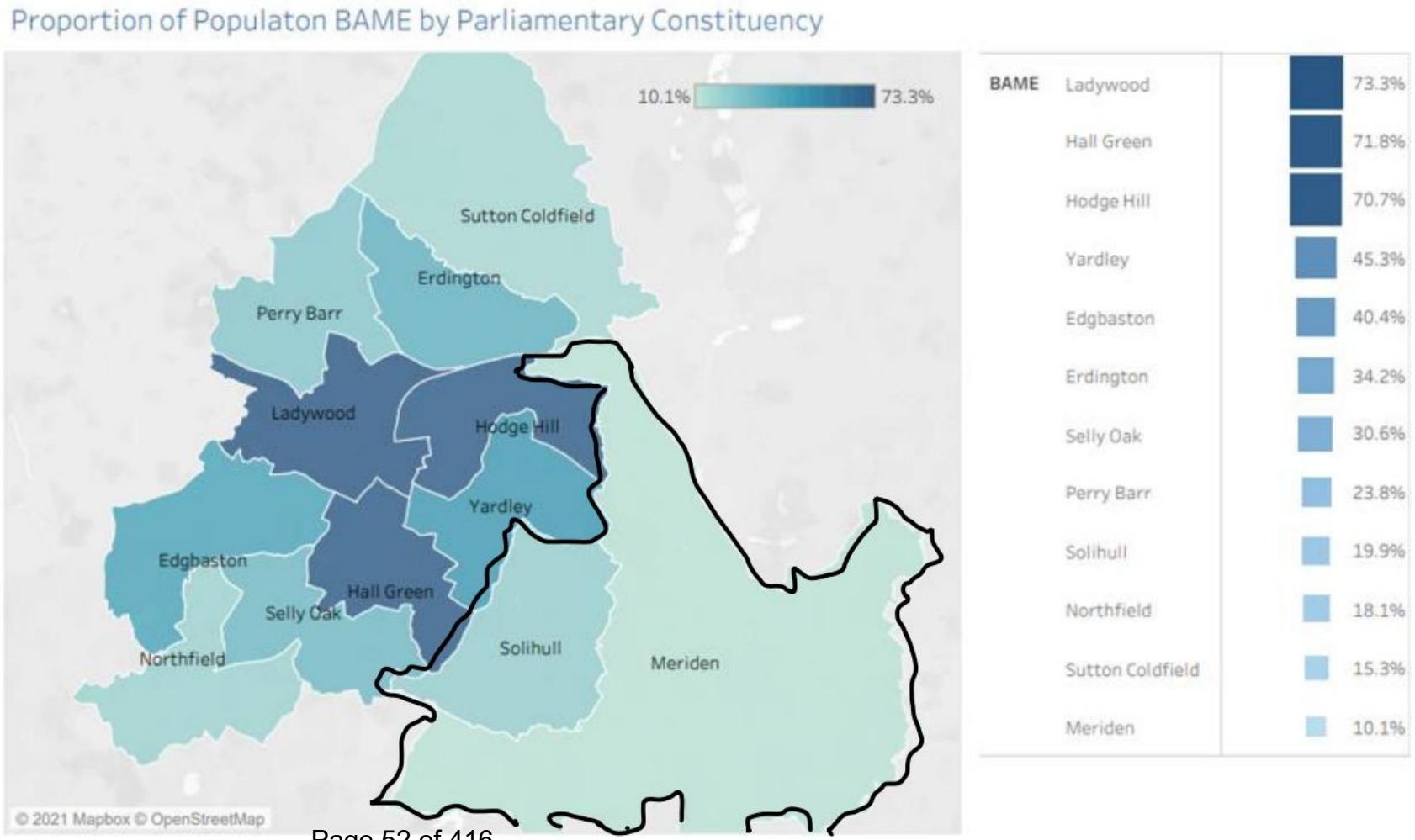
Over 70% in 3 out of 10 Birmingham constituencies and over 20 % in 1 out of the 2 Solihull constituencies

*Source: Midland & Lancashire CSU John O Neill



Ethnic health inequalities in the UK

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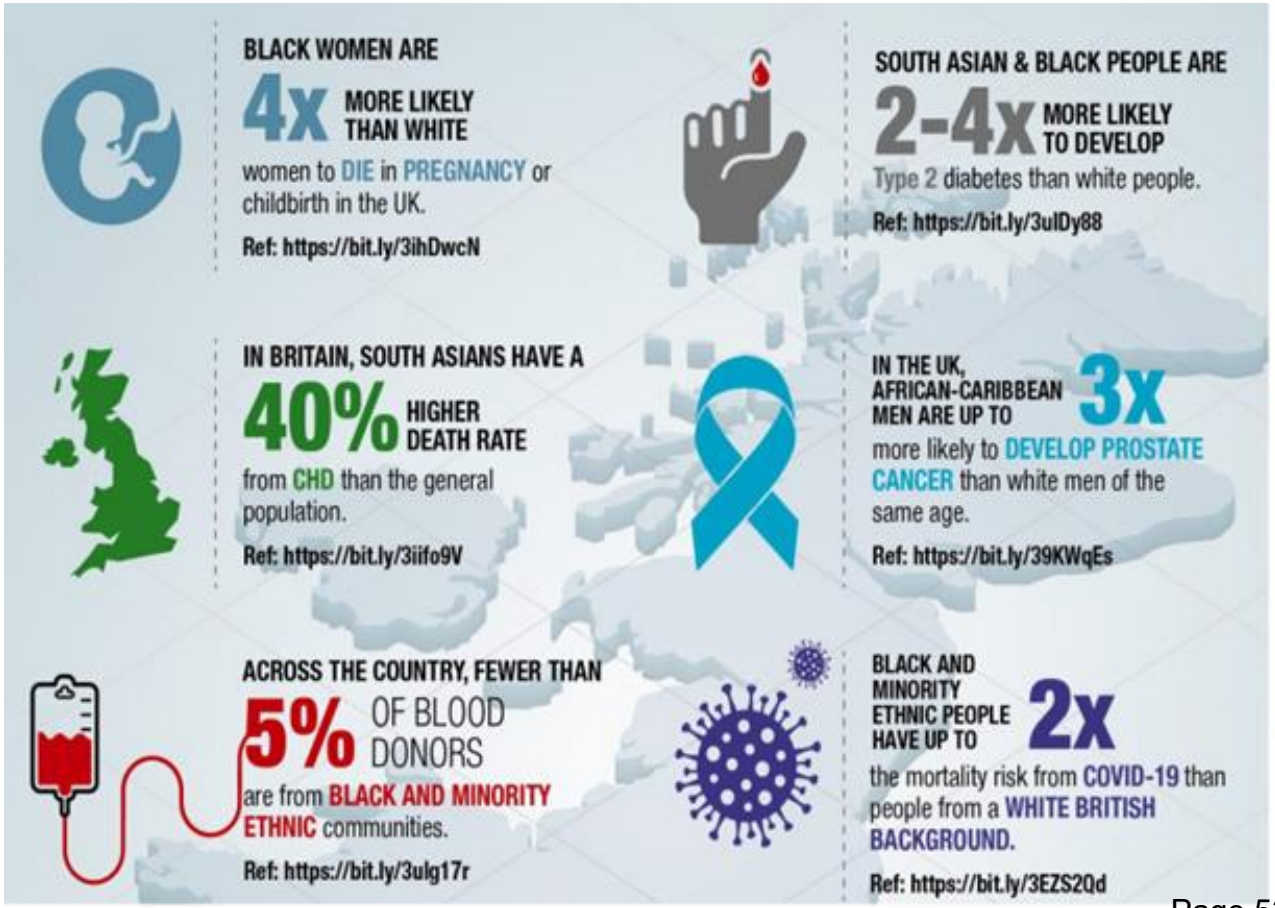

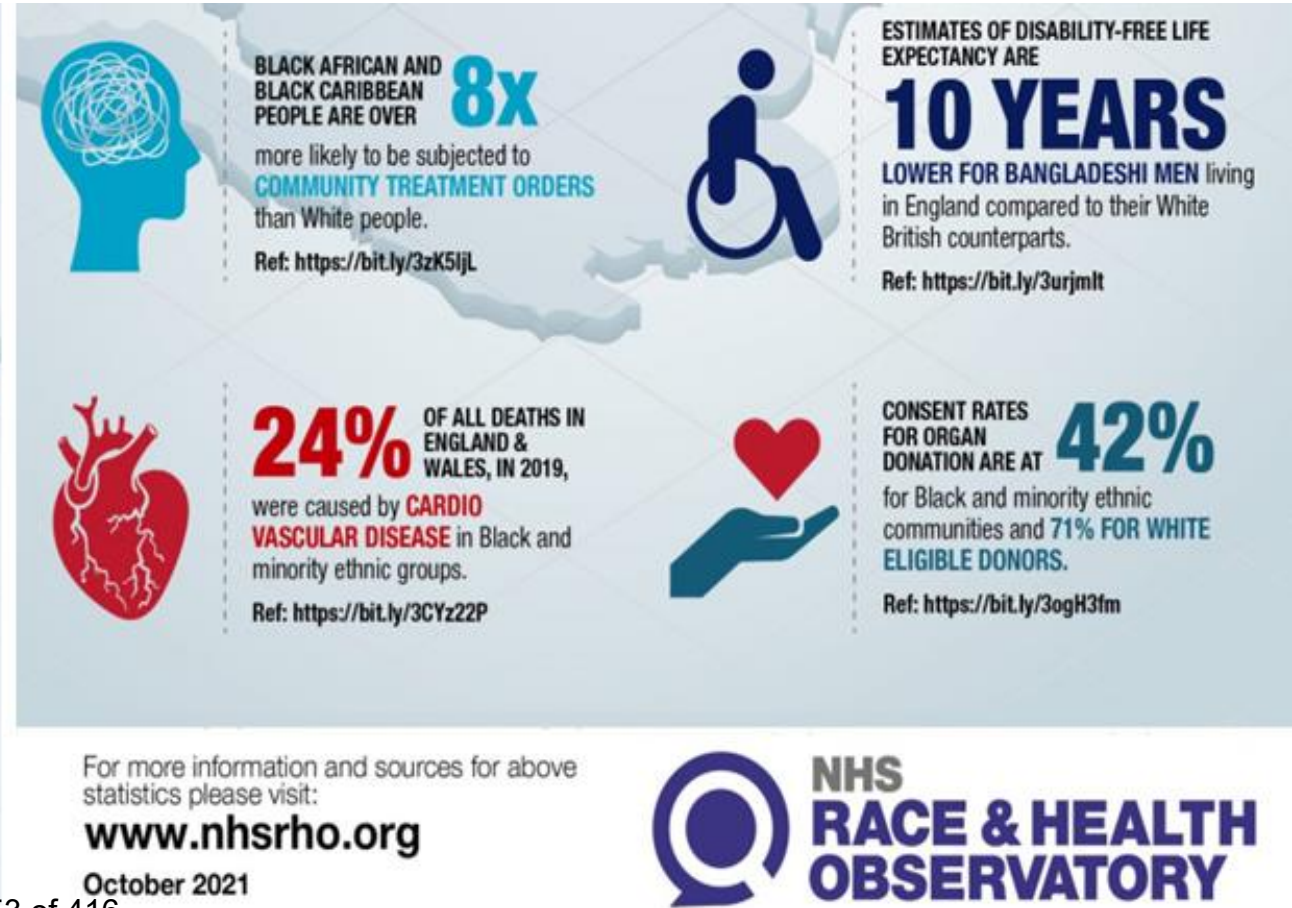

For more information and sources for above statistics please visit:
www.nhsrho.org
October 2021

NHS RACE & HEALTH OBSERVATORY

Further National Guidance: 8 Urgent Actions distilled to 5 Key Priorities and Core20Plus5 introduced in 2021

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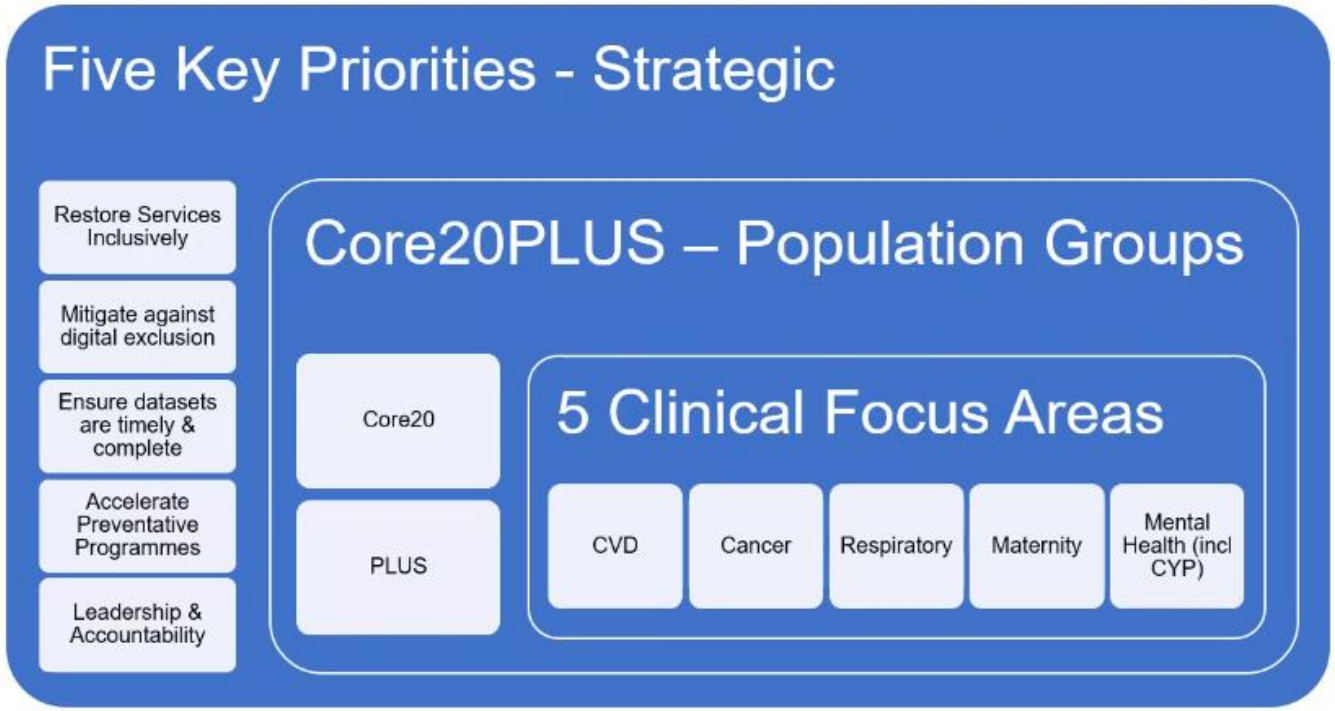
Context for Core20PLUS5



NHS England and NHS Improvement

REDUCING HEALTHCARE INEQUALITIES

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in health inequalities improvement

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

Target population

CORE20 PLUS 5

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

Key clinical areas of health inequalities

1. **MATERNITY**
ensuring continuity of care for **75%** of women from BAME communities and from the most deprived groups

2. **SEVERE MENTAL ILLNESS (SMI)**
ensuring annual health checks for **60%** of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities)

3. **CHRONIC RESPIRATORY DISEASE**
a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

4. **EARLY CANCER DIAGNOSIS**
75% of cases diagnosed at stage 1 or 2 by 2028

5. **HYPERTENSION CASE-FINDING**
to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke

BSol and Core20Plus5

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Core20:

- Around 50% of the population of the ICS are amongst the 20% most deprived nationally; 94% of the most deprived areas of the ICS are in Birmingham, and 6% are in Solihull.

Plus:

- Ethnicity was identified as a particularly important factor in poorer access, outcomes and experience in BSol to be included as our 'Plus'.
- The data for our population shows Diabetes and Learning Disabilities need to also be included as priorities.

5:

- Variations in all 5 clinical areas (CVD, COPD, Cancer, Maternal care, SMI) contribute significantly to shorter lives and ill health in BSol.

ICS Inequalities Five-year Strategy

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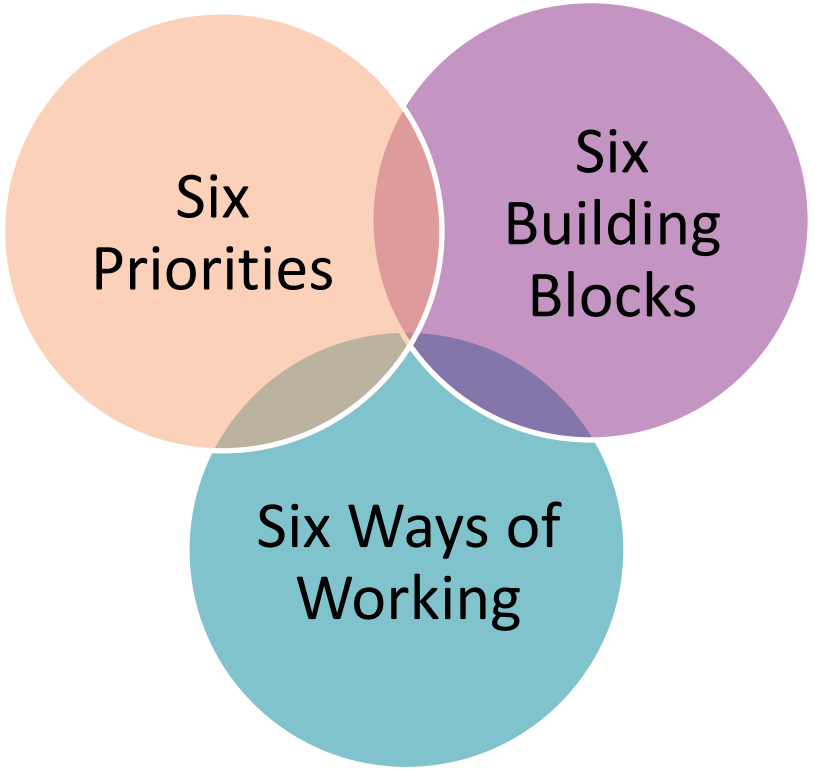
- The ICB has approved a five-year HI strategy based on the guiding principles within the ICS Inception Plan which will be incorporated in the ICS 10-year Master Plan currently being developed.
- The Strategy has 6 main priorities focused around those populations who experience the greatest inequalities in Birmingham and Solihull.
- These are supported by the six building blocks (to aid delivery) and six ways of working.



Inequalities Strategy Priorities

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Maternity Care & Infant Mortality

- Improve the experience and outcomes for mothers, parents, and babies and reduce the number of infants who die before their first birthday

Better Start for our Children

- Improve the health of children from our most deprived communities by supporting them to get the best start in life, focusing first on increasing uptake of vaccination and improving school readiness.

Better Prevention, Detection & Treatment of Major Diseases

- Improve the prevention, early detection and treatment of the diseases that drive early mortality for people, focusing first on cardiovascular disease, respiratory disease, cancer screening and diabetes.

Better Outcomes for People with Mental Illness

- Improve the experience and outcomes for people living with serious mental illness and improve their health and wellbeing to achieve their potential in life.

Better Outcomes for People with Disabilities including Learning Disability

- Improve the experience and outcomes for people living with a disability across the life course, starting with a focus on learning disability.

Improved Outcomes for Inclusion Health Groups

- Improve health and care outcomes for our most vulnerable citizens in inclusion health groups including new migrants, refugees and asylum seekers, homeless people, people with substance misuse difficulties and other “hidden populations”.

Six building blocks for delivery

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Insight & Impact.	Pathway Improvement.	Targeting our Prevention Programmes.	Working with Communities.	Supporting Health Literacy.	Anchor Institutions.
• Use data to identify drivers and consequences of inequality, set priorities and track impact of the changes we are making. • Committed to using data we have access to effectively and addressing gaps in our knowledge and understanding proactively	• Audit services to identify areas where existing pathways are widening inequalities, including waiting lists for hospital appointments and surgery and GP access. • Support service improvement methods that enable us to test innovations and new approaches in how we deliver health and care . • Working with patients and communities to deliver these at scale across our system where they demonstrate benefit.	• Work with prevention programmes (including alcohol, smoking, physical activity, nutrition) to support our focus on communities who currently experience the worst health. • Deliver these in a culturally appropriate way co-designed with citizens and embed prevention properly at every level of our system and in every pathway.	• Recognise our citizens are experts in their own situation. • Work closely with communities to co-design solutions to the challenges they face that will support us to deliver our priorities. • Address some of the structural discrimination and distrust and build culturally safe approaches with communities	• We will work across the system with citizens to build health literacy, increasing individual understanding of health and wellbeing and how to navigate the system to get support appropriately when it is needed.	• Use the full potential of our health and care providers as an “Anchor Institution” to address wider determinants of health such as poverty. • For example, prioritising procuring locally, ensuring we pay our own staff a Real Living Wage, and increasing opportunities for and employing people from our most deprived communities.

Finance and procurement will be integrated across all six priority areas and building blocks

Six ways of working for improvement

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At its most fundamental, improving health inequalities requires improving the lives of those with the worst health outcomes, the fastest. To achieve this aim, it is proposed that these six ways of working are adopted by every member organisation of the ICS:

1. Adopt proportionate universalism: this means providing services for all, but modifying them so they are at a scale and intensity proportionate to the degree of need.

2. Advocating that reducing health inequalities is mainstream activity that is core to, and not peripheral to, the work of your organisation. Addressing HIs as a golden thread across all commissioning and delivery.

3. Adopting a population health management approach, ensuring approaches to addressing inequalities are evidence-based. Have an understanding of the population you serve and routinely identify where inequalities exist. Being clear about the issues you are going to resolve and when.

4. Having the confidence to have the 'difficult conversations' based on the evidence - such as reprioritising resources towards prevention and early intervention where return on investment is highest.

5. Focused capacity to enable all departments to systematically self-assess how their work influences health inequalities and what they can do to reduce them, including identifying upstream causes and downstream effects.

6. Recognise the expertise within partner organisations such as LAs, VCSE, communities and patients themselves - and reflect that in co-production, and in governance and delivery structures.

Taking a Community Development Approach

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- Our Health Inequalities programme is ambitious both in terms of outcomes and scope across the system.
- To deliver it we need to take a new approach.
- A place-based approach which tailors services according to the needs of local populations is needed to promote health equity. ‘One size fits all’ approach may have had good intentions but has delivered widening inequalities
- With that in mind, we are determined to help communities take control of their own health journey and embed sustainable change.
- It relies us on acknowledging, harnessing and developing the many strengths and assets that exist within communities, and not just seeing certain places and people as ‘problems’ for ‘us’ to tackle. They are places and people that we can learn a lot from, and be helped to deliver better services ourselves too.

Building a Foundation: Working with our Primary Care Networks

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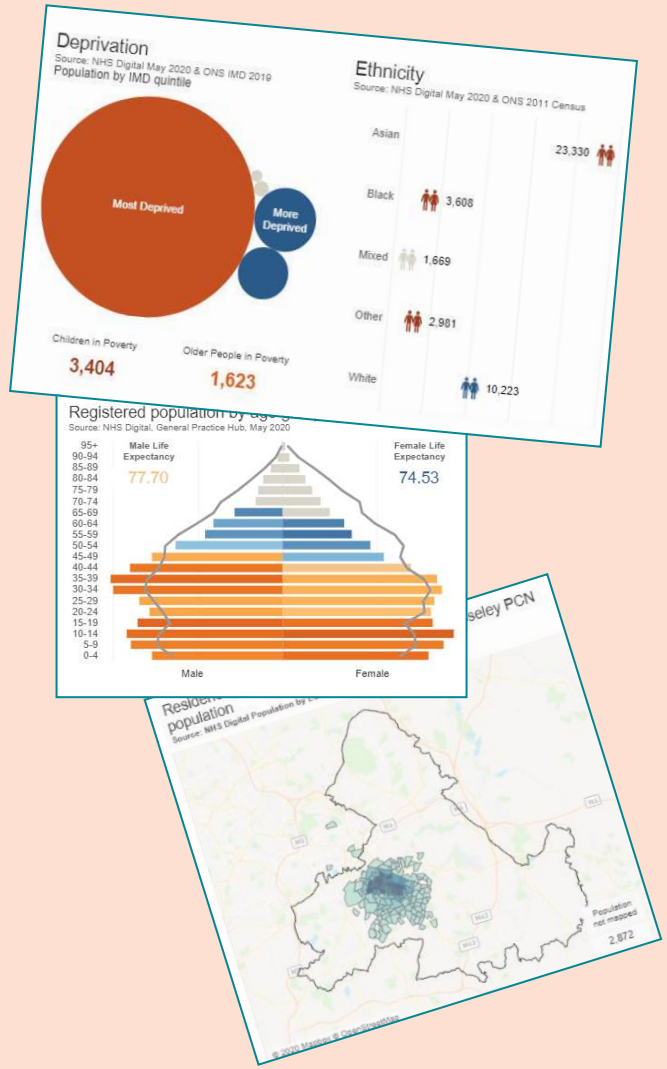
CASE STUDY ONE

- 36 Primary Care Networks in the ICS.
- We developed a framework for community co-production and development where:
  - Each PCN has a Health Inequalities Champion (HIC)
  - Monthly meeting of network of these champions to share learning and update on progress.
  - £36,000 sourced from HEP and £1000 allocated to each PCN to support the Health Inequalities Champions to take forward work on local priorities.
  - PCN population profiles alongside Locality shared alongside Locality JSNAs, and a Decision Support Tool to support evidence based prioritisation

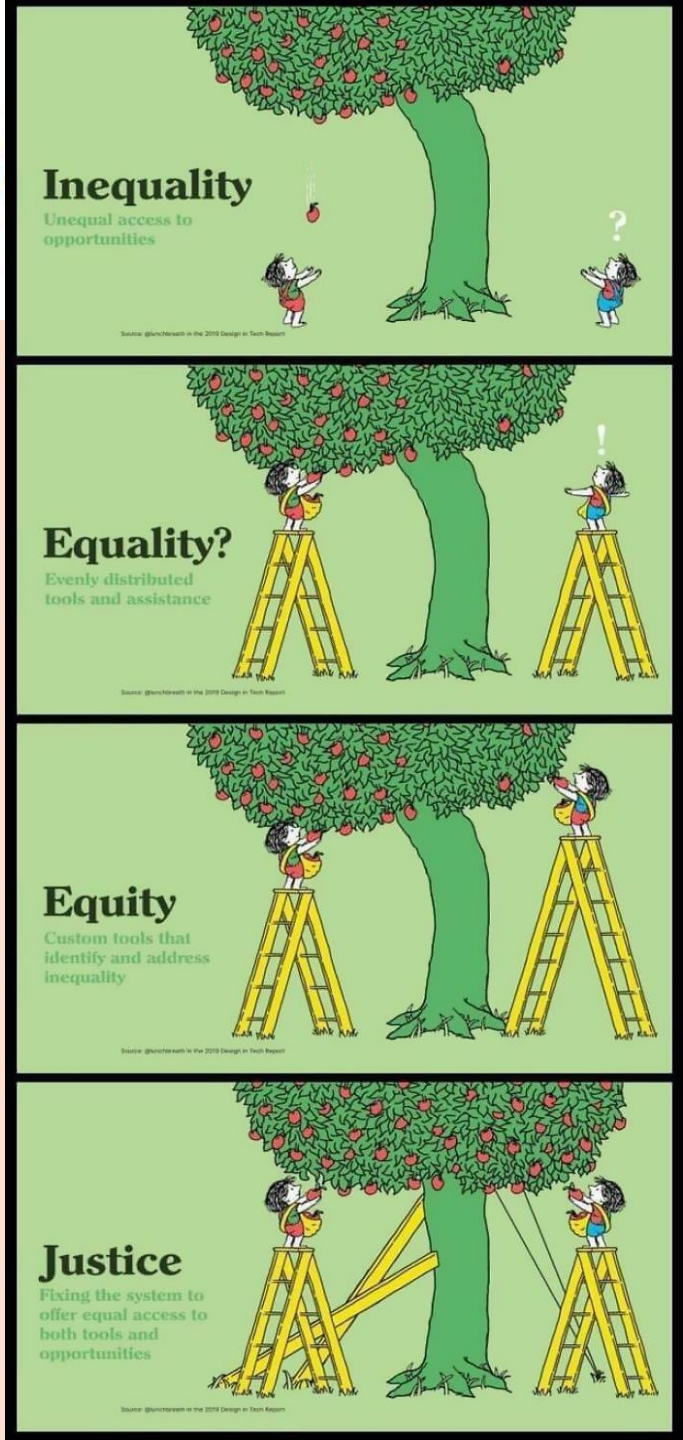


36 PCN Health Inequalities Projects

CASE STUDY ONE

- Each PCN has been working on its own projects. These projects include:
  - Addressing social isolation for older people
  - Increase awareness of HRT in BAME communities
  - Long term condition awareness (diabetes, obesity, hypertension, depression)
  - Improving access : promotion of 'safe surgeries' for asylum seekers and traveller communities
  - Targeted support for vulnerable groups such as homeless, veterans

…and many more



Working with communities in action

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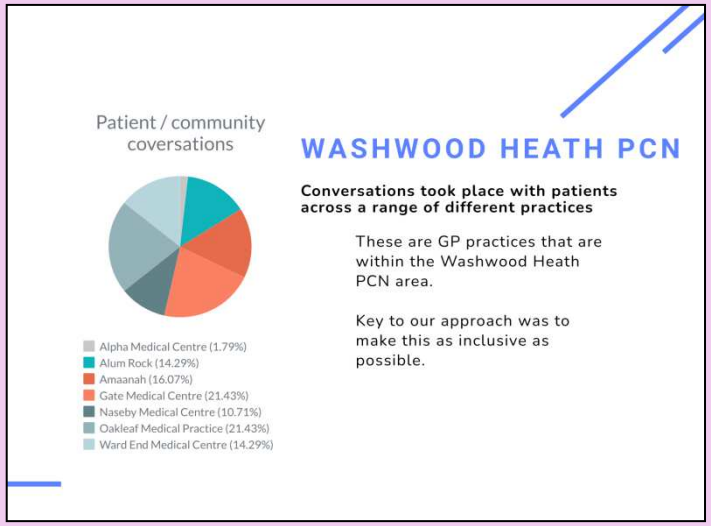
CASE STUDY TWO

- Washwood Heath PCN area was chosen to be a pilot/trailblazer site as it is one of the most deprived in the ICS region, and the population suffers a range of health inequality issues (including a disproportionately high prevalence of diabetes), as evidenced in JSNA & PCN Profiles.
- A Washwood Heath PCN Steering Group has been established whereby NHS and Local Authority representatives, including GP and hospital representatives, Neighbourhood Network lead, ICS Personalisation Care Lead, elected councillors and third sector organisations meet on a regular basis, supported by ICS HI team initially. It is the first time such a partnership has been established.



Working together to move from problems to solutions

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CASE STUDY TWO

- Listening exercise with local communities was carried out by health visitors from Bham Community Healthcare Trust and social prescriber link workers attached to GP practices in the PCN area to identify priorities and concerns
- Shared PCN specific and local JSNA data with the Steering Group and asked them what they collectively felt their most important priority was and would commit to addressing together.
- Working together with communities, and insights from the Steering Group, we decided to focus on tackling diabetes.
- GPs reported poor effectiveness rates of existing prevention programmes, and lack of knowledge/action in the community to tackle pre-diabetes behaviour.
- GPs identified a cohort of 6500 pre-diabetic patients from their registers that could benefit from targeted interventions.
- A local group, Saheli, worked with GP members to develop training for GPs on prevention measures, influencing factors and pathways. Also developed a series of interventions and patient engagement services.

Working together – Community and Personal Empowerment

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CASE STUDY TWO

- Saheli is a local community group that provides health improvement interventions.
- Different from previous approaches….
- Their link workers will be working with the cohort patients to provide:
  - Signposting and referral services
  - Physical interventions
  - Wellbeing checks and support
  - Personalised care budget support

Working together as a system

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We are working with different organisations, community groups, educators, voluntary organisations, NHS trusts and citizen groups to help identify the issues and best solutions. So far the following have worked together in our Health Inequalities Stakeholder Board, and have committed to support next stage of delivering HI strategy:

BSol ICS Strategic Boards and Committees	Primary Care Networks and GP Partners	Birmingham and Solihull Mental Health NHS FT	Birmingham City Council – Adult Social care	Birmingham City Council Public Health	Solihull MBC Public Health
Royal Orthopaedic Hospital NHS FT	Birmingham Women and Children NHS FT	Birmingham Community Healthcare NHS FT	University Hospitals Birmingham NHS FT	HealthWatch	Health Exchange
Citizens UK	The Community Foundation	Aston University	Birmingham Race Impact Group	GP Partners	Commissioning leads

Build Back Fairer – not 'old normal'

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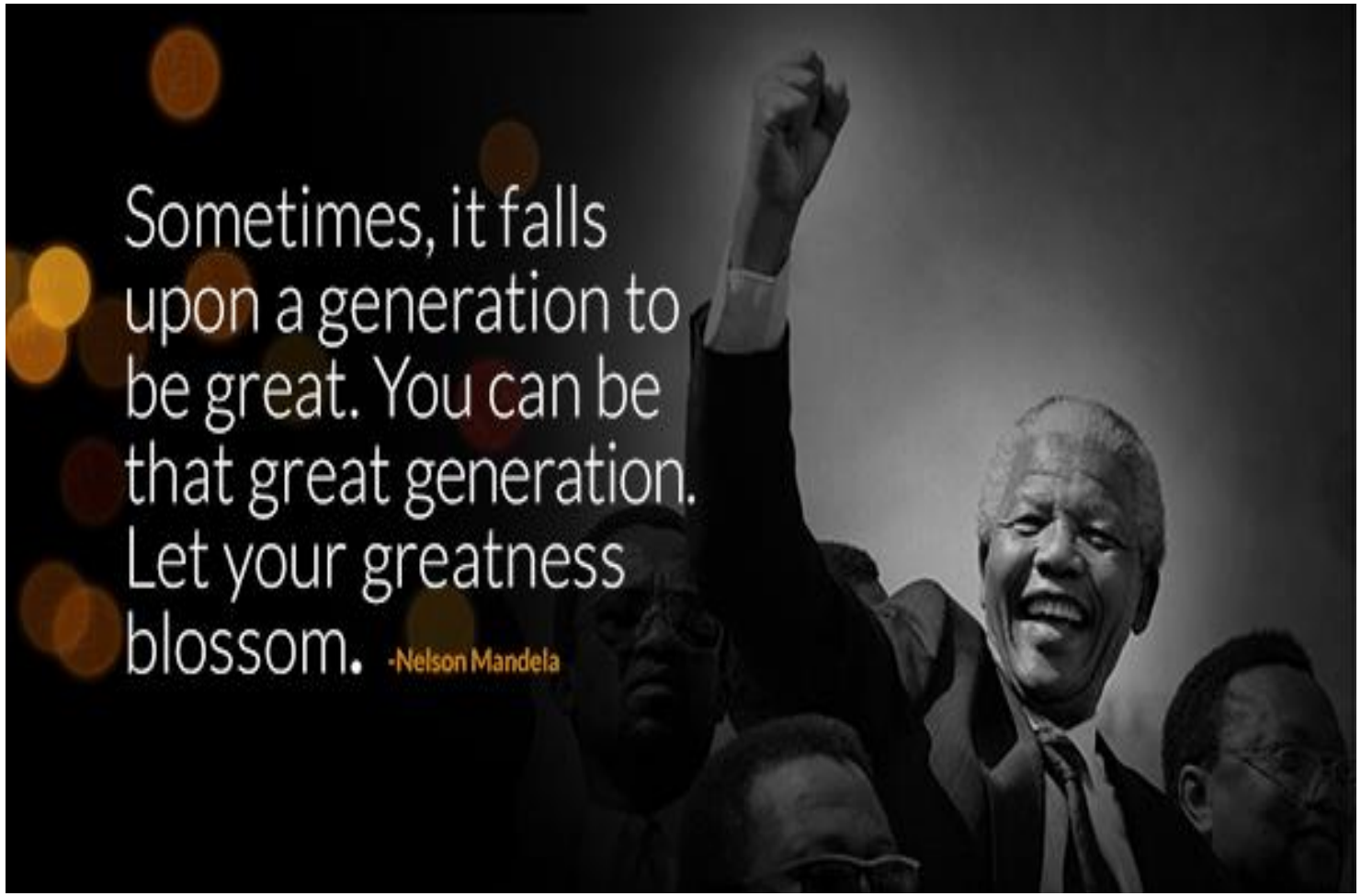
- Legacy of those who fought World War II was our NHS and public services
- What will be the legacy of our generation who are battling impact of COVID?
- Hopefully: Building Back Fairer by closing the inequalities gaps - we all have a role to play!



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Integrated Care System
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Thankyou

For more information please contact:

Salma Yaqoob

Programme Director for Health Inequalities

salma.yaqoob@nhs.net

	Agenda Item:12
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**27th September 2022**
TITLE:	**BETTER CARE FUND END OF YEAR PLAN FOR 2021/22**
Organisation	**Birmingham City Council**
Presenting Officer	**Michael Walsh and Helen Kelly**

Report Type:	**Approval**

1. Purpose:	
1.1	To approve the Birmingham Better Care Fund End of Year Plan for 2021/22

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	To approve the Birmingham Better Care Fund End of Year Plan for 2021/22

4. Report Body	
	Background
4.1	Each year the health and social care system is required to submit a Better Care Fund (BCF) Plan to outline the areas of income and expenditure, highlight areas of priority and set performance measures against the BCF metrics.

4.2 During Covid there was no requirement for a BCF Plan, so this financial year (2020/21) was the first time for a number of years that there was a requirement to develop and more comprehensive narrative plan. The Health and Wellbeing Board signed off the final submission of the Better Care Fund Plan

4.3 The focus for the BCF Plan for 2020/21 was about aligning and bringing together funding for the delivery of the Early Intervention Programme, and also starting to think about the other areas that are to be aligned under the Birmingham Integrated Care Programme.

4.4 The End of Year report highlights that there was a significant impact of Covid-19 and also the additional winter pressures seen by the health and social care system, which meant that:

- Length of stay metric – this was not achieved but the system was able to bring in local monitoring and the length of stay was on a downward trajectory

- Residential admissions – previously this metric was under reported which was affecting our performance but is now a better reflection of the work being completed including self-funders which was previously not reported

- Avoidable admissions – impact of covid had driven down admissions at this point, local monitoring in place to continue to work on this metric

4.5 The combined financial value of the BCF Plan is £199,403,618 this includes the required minimum Clinical Commissioning Group contribution of £92,657,315. The Plan also confirms that the minimum contribution of £36,750,065 towards Adult Social Care provision has also been achieved.

4.6 In 2020/21 through the approval of the Plan, it was agreed that a Transformation Fund would be created through the Better Care Fund in order to focus on clear priorities over the next 3 financial years, this meant that the BCF reported a underspend of £10,566,559. The areas the Transformation Fund will be utilised are:

- Further development of the Early Intervention
- Further development of the Neighbourhood Integration model
- Further development of the Care Homes model
- Technology enabled care
- Falls prevention

4.7 Overall, 2020/21 has seen great strides being made in the continual development of the Birmingham Better Care Fund and has laid the foundations for future delivery and development of a better improved health and social care system.

5.	Compliance Issues
5.1	**HWBB Forum Responsibility and Board Update**
5.1.1	The Better Care Fund Plan has been monitored through the Better Care Fund Commissioning Executive. A key focus of the Commissioning Executive is to take a whole system approach to maximise investment of any schemes funded under the BCF.

5.2	**Management Responsibility**
5.2.1	The Health and Wellbeing Board are ultimately responsible for the Better Care Fund providing strategic direction and decision making as required utilising the Better Care Fund Commissioning Executive.

6.	**Risk Analysis**		
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**

Appendices
1. Birmingham Better Care Fund End of Year Report 2021/22

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

- Michael Walsh – Head of Service (Birmingham City Council)
- Helen Kelly – Director of Acute and Community Integration (NHS Birmingham and Solihull Integrated Care System)
- Sarah Feeley – Commissioning Manager (Birmingham City Council)
- Andrew Healey – Adult Social Care Business Partner (Birmingham City Council)
- Heather Moorhouse – Director of Commissioning Finance (NHS Birmingham and Solihull Integrated Care System)

Better Care Fund 2021-22 Year-end Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2021-22, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Hosusing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) To confirm actual income and expenditure in BCF plans at the end of the financial year
3) To provide information from local areas on challenges, achievements and support needs in progressing
4) To enable the use of this information for national partners to inform future direction and for local areas to

BCF quarterly reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including clinical commissioning groups, local

BCF quarterly reports submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally and these reports are therefore part of the official suite of HWB

The BCF quarterly reports in aggregated form will be shared with local areas prior to publication in order to support the aforementioned purposes of BCF reporting. In relation to this, the BCF Team will make the aggregated BCF quarterly reporting information in entirety available to local areas in a closed forum on the

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

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

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

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, cont
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercaresupport@nhs.net
3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2021-22 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/publication/better-care-fund-planning-requirements-2021-22/

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met within the quarter and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: NHS contribution to adult social care is maintained in line with the uplift to CCG
National condition 3: Agreement to invest in NHS commissioned out-of-hospital services
National condition 4: Plan for improving outcomes for people being discharged from hospital

4. Metrics

The BCF plan includes the following metrics: Unplanned hospitalisation for chronic ambulatory care sensitive conditions, Proportion of hospital stays that are 14 days or over, Proportion of hospital stays that are 14 days or over, Proportion of discharges to a person's usual place of residence, Residential Admissions and
This section captures a confidence assessment on achieving the plans for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes that have been achieved.
The BCF Team publish data from the Secondary Uses Service (SUS) dataset for Long length of stay (14 and 21 days) and Dischaege to usual place of residence at a local authority level to assist systems in understanding

The metris worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric plans and the related narrative information and it is advised that:
- In making the confidence assessment on progress, please utilise the available published metric data (which should be typically available for 2 of the 3 months) in conjunction with the interim/proxy metric information for the third month (which is eventually the source of the published data once agreed and validated) to
- In providing the narrative on Challenges and Support needs, and Achievements, most areas have a sufficiently good perspective on these themes by the end of the quarter and the unavailability of published metric data for one of the three months of the quarter is not expected to hinder the ability to provide this useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any

Please note that the metrics themselves will be referenced (and reported as required) as per the standard

5. Income and Expenditure

The Better Care Fund 2021-22 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and CCGs. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant, and the minimum CCG contribution. A large

Income section:
- Please confirm the total HWB level actual BCF pooled income for 2021-22 by reporting any changes to the planned additional contributions by LAs and CCGs as was reported on the BCF planning template.
- The template will automatically pre populate the planned expenditure in 2021-22 from BCF plans, including additional contributions.
- If the amount of additional pooled funding placed intothe area's section 75 agreement is different to the amount in the plan, you should select 'Yes'. You will then be able to enter a revised figure. Please enter the
- Please provide any comments that may be useful for local context for the reported actual income in 20121-

Expenditure section:
- Please select from the drop down box to indicate whether the actual expenditure in you BCF section 75 is different to the planned amount.
- If you select 'Yes', the boxes to record actual spend, and expanatory comments will unlock.
- You can then enter the total, HWB level, actual BCF expenditure for 2021-22 in the yellow box provided and also enter a short commentary on the reasons for the change.
- Please provide any comments that may be useful for local context for the reported actual expenditure in

6. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2021-22 through a set of survey questions
The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 9 questions.

Part 1 - Delivery of the Better Care Fund

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:
- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2021-22
3. The delivery of our BCF plan in 2021-22 had a positive impact on the integration of health and social care

Part 2 - Successes and Challenges
This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration'

Please highlight:
8. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model)
9. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model)

For each success and challenge, please select the most relevant enabler from the SCIE logic model and provide a narrative describing the issues, and how you have made progress locally.
SCIE - Integrated care Logic Model

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural

2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

7. ASC fee rates

This section collects data on average fees paid by the local authority for social care.

Specific guidance on individual questions can be found on the relevant tab.

'Yes'.
chang

acts a

HM Government

NHS

Better Care Fund 2021-22 Year-end Template

2. Cover

Version 2.0

Please Note:

- The BCF end of year reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. Narrative sections of the reports will not be published. However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information, including that provided on local authority fee rates, will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

			Checklist
			Complete:
Health and Wellbeing Board:	Birmingham		Yes
Completed by:	Sarah Feeley		Yes
E-mail:	sarah.feeley@birmingham.gov.uk		Yes
Contact number:	07704 538632		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No, subject to sign-off		Yes
If no, please indicate when the report is expected to be signed off:	Tue 20/09/2022	<< Please enter using the format, DD/MM/YYYY	Yes

Please indicate who is signing off the report for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Director of Adult Social Care	Yes
Name:	Graeme Betts	Yes

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

Complete	
	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income and Expenditure actual	Yes
6. Year-End Feedback	Yes
7. ASC fee rates	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Year-end Template

3. National Conditions

Selected Health and Wellbeing Board: Birmingham

Confirmation of Nation Conditions	
National Condition	**Confirmation**
1) A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006? (This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the BCF policy?	Yes
3) Agreement to invest in NHS commissioned out of hospital services?	Yes
4) Plan for improving outcomes for people being discharged from hospital	Yes

If the answer is "No" please provide an explanation as to why the condition was not met in 2021-22:

Checklist
Complete:
Yes
Yes
Yes
Yes

Better Care Fund 2021-22 Year-end Template

4. Metrics

Selected Health and Wellbeing Board: Birmingham

National data may like be unavailable at the time of reporting. As such, please utilise data that may only

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highl

Achievements Please describe any achievements, impact observed or lessons learnt when consider

Metric	Definition	For information - Your planned performance as reported in 2021-22 planning			
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	1,433.1			
Length of Stay	Proportion of inpatients resident for: i) 14 days or more ii) 21 days or more	**14 days or more (Q3)**	**14 days or more (Q4)**	**21 days or more (Q3)**	**21 days or more (Q4)**
		9.9%	9.8%	4.8%	4.7%
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	94.3%			
Res Admissions*	Rate of permanent admissions to residential care per 100,000 population (65+)	468			
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	61.1%			

* In the absense of 2021-22 population estimates (due to the devolution of North Northamptonshire an

be available system-wide and other local intelligence.

light any support that may facilitate or ease the achievements of metric plar

ing improvements being pursued for the respective metrics

Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs
On track to meet target	The impact of covid has seen a reduction on all admissions in 2020/21 and 2021/22. Understanding the data and any trends in the context of not having a steady state.
Not on track to meet target	Combined impact of winter pressures and covid has increased the length of stay/occupancy up to and beyond covid levels
On track to meet target	Discharge to the usual place of residence was challenging during the Omicron surge as a consequence of workforce pressures reducing availability of home care. This is likely to be an ongoing issue as a result of
Not on track to meet target	Note that we have improved our process for measuring this metric which now includes self-funders who are being assisted to find residential care placements via BCC brokerage teams.
On track to meet target	We have made two changes to our reporting of STS004 this year. First, we are now including all citizens discharged from hospital into a multi-disciplinary Early Intervention Service. This reflects the

d West Northamptonshire), the denominator for the Residential Admissions

ıs

Achievements	Checklist Complete:
Local monthly monitoring is in place which highlights which of the NHSOF ASC conditions are showing any increase in admissions over the most recent time period, so that we are able to respond more	Yes
Local monthly monitoring in place. LOS is on a downward trajectory, and for the past 2 quarters, has been lower than the England average. The 21+ day LOS is below England average across 2021/22	Yes
Progress against this metric has been enabled by system improvements including the success of Early Intervention Community Teams - providing a trusted and safe P1 discharge route - and out of hospital	Yes
The impact of the changes we have made to measuring this metric is that we are now capturing a larger number of citizens who are accessing long-term residential care placement. This is the key factor in not	Yes
Effective reablement/rehabilation is the goal of the Early Intervention services that we have embedded in the system in recent years. This approach has enabled more citizens to return home, reduced re-	Yes

; metric is based on 2020-21 estimates

Better Care Fund 2021-22 Year-end Template

5. Income and Expenditure actual

Selected Health and Wellbeing Board:	Birmingham

Income

Disabled Facilities Grant	£12,943,092	
Improved Better Care Fund	£65,921,309	
CCG Minimum Fund	£92,657,315	
Minimum Sub Total		£171,521,716
	Planned	
CCG Additional Funding	£5,299,813	
LA Additional Funding	£22,582,089	
Additional Sub Total		£27,881,902

	Planned 21-22	Actual 21-22
Total BCF Pooled Fund	£199,403,618	£202,662,116

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2021-22	Additional Hospital Dis

Expenditure

	2021-22
Plan	£199,403,618

Do you wish to change your actual BCF expenditure?	Yes

Actual	£188,837,059

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2021-22	As stated in the develo has included the devel spent over the next 3 y Fund into 22/23 and b

2021-22

Actual		
Do you wish to change your additional actual CCG funding?	Yes	£8,558,311
Do you wish to change your additional actual LA funding?	No	
		£31,140,400

charge Funding included.

opment of the BCF Plan for 2021/22 and with our focus on transformation, this opment of a Transformation Fund with clear priorities on how that fund would be years. The fund remaining from 21/22 forms the basis for that Transformation eyond. The priorities for investment are areas of innovation to improve local

Checklist
Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Better Care Fund 2021-22 Year-end Template

6. Year-End Feedback

The purpose of this survey is to provide an opportunity for local are
changed the context. However, national BCF partners would value
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board:

Part 1: Delivery of the Better Care Fund
Please use the below form to indicate to what extent you agree wi

Statement:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2021-22
3. The delivery of our BCF plan in 2021-22 had a positive impact on the integration of health and social care in our locality

Part 2: Successes and Challenges
Please select two Enablers from the SCIE Logic model which you ha challenge in progressing. Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021-22
Success 1
Success 2

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021-22

Challenge 1
Challenge 2

Footnotes:

Question 4 and 5 are should be assigned to one of the following cat

1. Local contextual factors (e.g. financial health, funding arrangeme
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with
4. Empowering users to have choice and control through an asset b
5. Integrated workforce: joint approach to training and upskilling of
6. Good quality and sustainable provider market that can meet dem
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Other

eas to consider and give feedback on th
and appreciate local area feedback to

Birmingham

h the following statements and then d

Response:
Strongly Agree
Strongly Agree
Strongly Agree

ve observed demonstrable success in p

SCIE Logic Model Enablers, Response category:
9. Joint commissioning of health and social care
2. Strong, system-wide governance and systems leadership

SCIE Logic Model Enablers, Response category:

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
5. Integrated workforce: joint approach to training and upskilling of workforce

:egories:
:nts, demographics, urban vs rural facto

service users
ased approach, shared decision makin
workforce
nand

ıe impact of the BCF. Covid-19 had a significant impact on services and schemes delivered on t
understand views and reflections of the progress and challenges faced during 2021-22

etail any further supporting information in the corresponding comment boxes.

Comments: Please detail any further supporting information for each response
Birmingham has been on a significant journey for a number of years now developing the partnership working across the health and social care system. This continues to be a priority locally looking for opportunities for joint commissioning and areas for collaboration in services
The proposed delivery of the BCF was delivered as expected with areas of underspend that have been developed as a result of the other funding streams available to support hospital discharge provision.
The strengthening of joint working continues as teams become more integrated with opportunities for colloaboration, which continues Birmingham on the journey of improving outcomes for our citizens and stands us in a good position through the development of the ICS

rogressing and two Enablers which you have experienced a relatively greater degree of

Response - Please detail your greatest successes
Birmingham has focused over the last 2 years on how the offer for citizens who present home be improved. This has led to the development of a homeless pathway with access to services vulnerable citizens, including the sucessful bid for additional funds from DHSC for the Out of H the last 6 months has seen over 300 citizens and worked with them to address their housing r swift discharge.
The ability to respond to Covid, the Omicron surge response was due to a whole system respc leadership. This included Chief Executive led Gold command, agreement of priorities and appr shared intelligence (both quantitative and qualitative). Agreeing areas to surge i.e. voluntary s leadership from the appropriate agency i.e. Local Authority. D2A joint commissioining approa response for the pressures across our P1 & P2 pathways, cross system support to enable flow

Response - Please detail your greatest challenges

Financial sustainability of the system is challenged. CCG/ICB and Local Authority face significa the impact of inflationary cost pressures with providers (NHS and wider health and care mark short term funding including nation hospital discharge programme on funding for new operat during the pandemic, consequences of cost of LA care exercise in 22/23, workforce pressures, non-pay supply chain issues e.g. for community equipment, ability to step down surge capacit
Recruitment and retention across the sytem is a challenge but this is especially acute in the in Omicron has particularly highlighted this when the availability of home care was restricted du shortages. This in turn impacted on flow through the system as well as hindering "home first" disparities in pay, terms and conditions will continue to create a challenge.

ɔrs)

g and co-production

he ground which may have

	Checklist Complete:
	Yes
	Yes
	Yes
eless at point of discharge can and support for our most Hospital Care Model which in need which in turns enables a	Yes
onse enabled through system ropriate actions informed by sector response and the ch led to an effective shared and effective market	Yes

nt financial pressures including et), consequences of the loss of ing models implemented /employer NI contributions and y/de-escalation costs and	Yes
dependent care market. e - in part - to workforce outcomes for citizens. Ongoing	Yes

Better Care Fund 2021-22 Year-end Template

7. ASC fee rates

Selected Health and Wellbeing Board: Birmingham

The iBCF fee rate collection gives us better and more timely insight into the fee rates paid to exte
Given the introduction of the Market Sustainability and Fair Cost of Care Fund in 2022-23, we are
with previous years.

These questions cover average fees paid by your local authority (gross of client contrib
need to be calculated from records of payments paid to social care providers and the nu

We are interested ONLY in the average fees actually received by external care provide
your local authority is able to afford.

In 2020-21, areas were asked to provide actual average rates (excluding whole market support s
management of the COVID-19 pandemic), as well as a 'counterfactual' rate that would have bee
of providing care to inform policymaking. In 2021-22, areas are only asked to provide the actual

Specifically the averages SHOULD therefore:
- EXCLUDE/BE NET OF any amounts that you usually include in reported fee rates but are r
- EXCLUDE/BE NET OF any amounts that are paid from sources other than eligible local aut
Nursing Care and full cost paying clients.
- EXCLUDE/BE NET OF whole-market COVID-19 support such as Infection Control Fund payments
- INCLUDE/BE GROSS OF client contributions /user charges.
- INCLUDE fees paid under spot and block contracts, fees paid under a dynamic purchasi
commissioned by your local authority and fees commissioned by your local authority as
- EXCLUDE care packages which are part funded by Continuing Health Care funding.

If you only have average fees at a more detailed breakdown level than the three service
of 65+ residential without dementia, 65+ residential with dementia) **please calculate for**
category: 1. Take the number of clients receiving the service for each detailed category.
2. Divide the number of clients receiving the service for each detailed category (e.g. age
relevant service (e.g. age 65+ residential).
3. Multiply the resultant proportions from Step 2 by the corresponding fee paid for each
4. For each service type, sum the resultant detailed category figures from Step 3.

Please leave any missing data cells as blank e.g. do not attempt to enter '0' or 'N/A'.

	For information - your 2020-21 fee as reported in 2020-21 end of year reporting *
1. Please provide the average amount that you paid to external providers for home care, calculated on a consistent basis. (£ per contact hour, following the exclusions as in the instructions above)	£15.27
2. Please provide the average amount that you paid for external provider care homes without nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions as in the instructions above)	£537.00
3. Please provide the average amount that you paid for external provider care homes with nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions in the instructions above)	£617.00
4. Please provide additional commentary if your 2020-21 fee is different from that reported in your 2020-21 end of year report. Please do not use more than 250 characters.	

Footnotes:

* ".." in the column C lookup means that no 2020-21 fee was reported by your council in the 20

** For column F, please calculate your fee rate as the expenditure during the year divided by t pick up any support that you have provided in terms of occupancy guarantees.
(Occupancy guarantees should result in a higher rate per actual user.)

*** Both North Northamptonshire & West Northamptonshire will pull the same last ye County Council.

ernal care providers, which is a key part of social care reform.

exploring where best to collect this data in future, but have chosen to collect 2021-22 data t

outions/user charges) to external care providers for your local authority's eligible clie
mber of client weeks they relate to, unless you already have suitable management inf

rs for your local authority's eligible supported clients (gross of client contributions/u

such as the Infection Control Fund but otherwise, including additional funding to cover cost pr
n paid had the pandemic not occurred. This counterfactual calculation was intended to provic
rate paid to providers (not the counterfactual), subject to than the exclusions set out below.

not paid to care providers e.g. your local authority's own staff costs in managing the co
thority funding and client contributions/user charges, i.e. you should EXCLUDE third p

s.

ng system, payments for travel time in home care, any allowances for external provid
part of a Managed Personal Budget.

types of home care, 65+ residential and 65+ nursing requested below (e.g. you have t
each of the three service types an average weighted by the proportion of clients th

65+ residential without dementia, age 65+ residential with dementia) by the total nur

detailed category.

Average 2020/21 fee. If you have newer/better data than End of year 2020/21, enter it below and explain why it differs in the comments. Otherwise enter the end of year 2020-21 value	What was your actual average fee rate per actual user for 2021/22?	Implied Uplift: Actual 2021/22 rates compared to 2020/21 rates
£15.27	£15.58	2.0%
£537.00	£548.00	2.0%
£617.00	£629.50	2.0%

)20-21 EoY report

he number of actual client weeks during the year. This will

ar figures as reported by the former Northamptonshire

:hrough the iBCF for consistency

ents. The averages will likely
formation.

user charges), reflecting what

ressures related to
de data on the long term costs

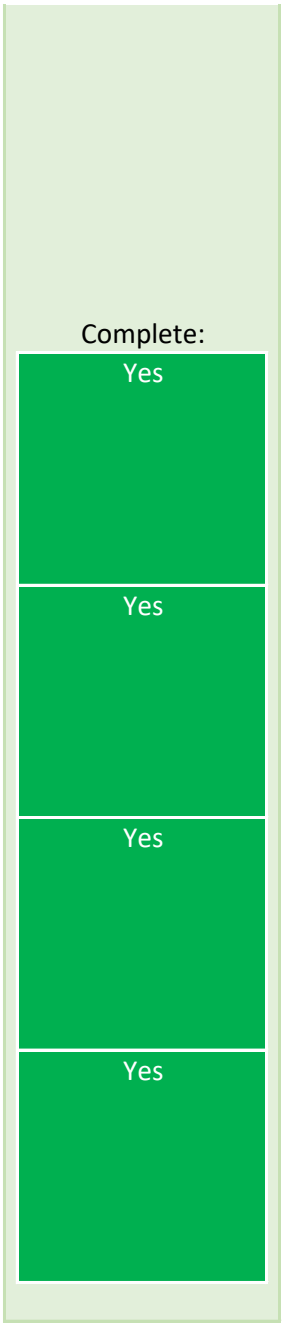
ommissioning of places.
arty top-ups, NHS Funded

er staff training, fees directly

:he more detailed categories
at receive each detailed

mber of clients receiving the

Checklist


Complete:
Yes
Yes
Yes
Yes

Birmingham Health and Wellbeing Board

	Agenda Item: 13
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**27th September 2022**
TITLE:	**HEALTH AND WELLBEING FORUM UPDATES**
Organisation	**Birmingham City Council**
Presenting Officer	**Michael Walsh**

Report Type:	**Information / Approval**

1.	**Purpose:**
1.1	To approve the Birmingham Better Care Fund Plan for 2022/23

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	To approve the Birmingham Better Care Fund Plan for 2022/23

4. Report Body

Background

4.1 Each year the health and social care system is required to submit a Better Care Fund (BCF) Plan to outline the areas of income and expenditure, highlight areas of priority and set performance measures against the BCF metrics.

4.2 The guidance on what was required for the BCF Plan was published by NHS England on the 19th July 2022, completed BCF plans should be submitted by 26th September 2022.

4.3 The following conditions must be met in order for a BCF Plan to be approved as compliant by NHSE:

- A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board.
- NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution.
- Invest in NHS commissioned out-of-hospital services.
- Implementing the BCF policy objectives.

4.4 National condition 1 - A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board. The plan has been jointly developed by officers from the Integrated Care Board and BCC including finance leads. Formal approval will be required from the ICB.

4.5 National condition 2 – NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution. The NHS total minimum contribution to the BCF plan has been uplifted by 5.66% to £97.902m. Consequently, the minimum contribution from this amount to Adult Social Care Provision should also be increased from last year by 5.66% to a figure of £38,830,118. The Plan confirms that this has been achieved.

4.6 National condition 3 - Invest in NHS commissioned out-of-hospital services. A minimum total of £27,843,716 should be allocated for provision of out-of-hospital services. The Plan confirms that this has been achieved.

4.7 National condition 4 - Implementing the BCF policy objectives. The narrative plan provides detail of how partners in Birmingham are working together to achieve the BCF policy objectives. These are:

- Enable people to stay well, safe and independent at home for longer.
- Provide the right care in the right place at the right time.

4.8 A new element has been added to the BCF planning process for 2022/23 with the requirement to complete a Capacity & Demand Template. This is intended

to provide an overview of the demand for intermediate care provision as a result of hospital discharge and "step-up" demand from the community alongside an understanding of the capacity available to meet this level of demand.

5. Compliance Issues

5.1 HWBB Forum Responsibility and Board Update

5.1.1 The Better Care Fund Plan will be monitored through the Better Care Fund Commissioning Executive. A key focus of the Commissioning Executive is to take a whole system approach to maximise investment of any schemes funded under the BCF.

5.2 Management Responsibility

5.2.1 The Better Care Fund Commissioning Executive will provide updates on the progress against the Plan to the Health and Wellbeing Board on regular intervals.

5.2.2 The Health and Wellbeing Board are ultimately responsible for the Better Care Fund providing strategic direction and decision making as required.

6. Risk Analysis

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Failure to meet NHSE assurance requirements	L	H	Joint ICB/BCC preparation of BCF plan and oversight from BCF Commissioning Executive.

Appendices

1. Birmingham Better Care Fund Narrative Plan 2022/23
2. Birmingham Better Care Fund Planning Template 2022/23
3. Birmingham Capacity & Demand Template 2022/23

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

- Michael Walsh – Head of Service (Birmingham City Council)
- Helen Kelly – Director of Acute and Community Integration (Birmingham and Solihull Integrated Care Board)

- Sarah Feeley – Commissioning Manager (Birmingham City Council)
- Andrew Healey – Adult Social Care Business Partner (Birmingham City Council)
- Heather Moorhouse – Director of Commissioning Finance (Birmingham and Solihull Integrated Care Board)

Department of Health & Social Care | Department for Levelling Up, Housing & Communities | Local Government Association | NHS England

Birmingham BCF narrative plan 2022-23

Responsible to the Birmingham Health and Wellbeing Board

This Better Care Fund Plan and programmes contained within it were developed in partnership by:

- Birmingham City Council
  - Adult Social Care
  - Housing
  - Public Health
- Birmingham and Solihull Integrated Care Board
- Birmingham Integrated Care Partnership (BICP)
  - Birmingham Community Healthcare NHS Foundation Trust
  - Birmingham and Solihull Mental Health NHS Foundation Trust
  - Birmingham Voluntary Sector Council
  - University Hospitals Birmingham NHS Foundation Trust

Executive summary

Our 22/23 BCF plan has been developed to support the delivery of ICS and Birmingham Integrated Care Partnership priorities. In particular the plan builds upon our well-established, place-based collaboration in respect of urgent and emergency care pathways in order to reduce admissions, improve flow and improve outcomes for citizens through a “home-first” focus and approach. As a partnership we also recognise the need to invest in community services to maintain well-being and independence. This is reflected in our plan in terms of investment in, for example, multi-disciplinary team working, support to carers, housing pathways and community equipment.

Our continuing response to and recovery from COVID remains a key priority. The plan supports investment to continue vital services set up in during the pandemic that have demonstrated benefits. This includes a commitment to 7-day working and enhanced therapy input for our Early Intervention Community Teams and support for a hospital homeless pathway.

The plan exceeds the national requirement in terms of the minimum required spend on NHS Commissioned Out of Hospital services and meets the minimum ICB contribution for Adult Social Care services.

In terms of developing our collaborative working in the current and future years we have also committed resources in the plan to invest in transformation capacity in respect of joint commissioning, learning disabilities and autism and neighbourhood integration.

DRAFT

Governance

Birmingham City Council (BCC) Cabinet and the Birmingham and Solihull Integrated Care Board (ICB) have a statutory responsibility for the delivery of services and are accountable for the proper use of BCF resources. BCC's Cabinet is made up of elected representatives and is accountable for making decisions on behalf of the local authority. The Integrated Care Board is responsible developing a plan for meeting the health needs of the Birmingham and Solihull population, managing the NHS budget and arranging for the provision of health services in the Integrated Care System (ICS) area. The ICB is led by a Chair and a Chief Executive. In addition, representatives from the local authorities, provider trusts, and, in progress, primary care attend bi-monthly board meetings. This ensures good governance and is intended to promote a culture of strong engagement with citizens, their carers, primary care, staff and other stakeholders.

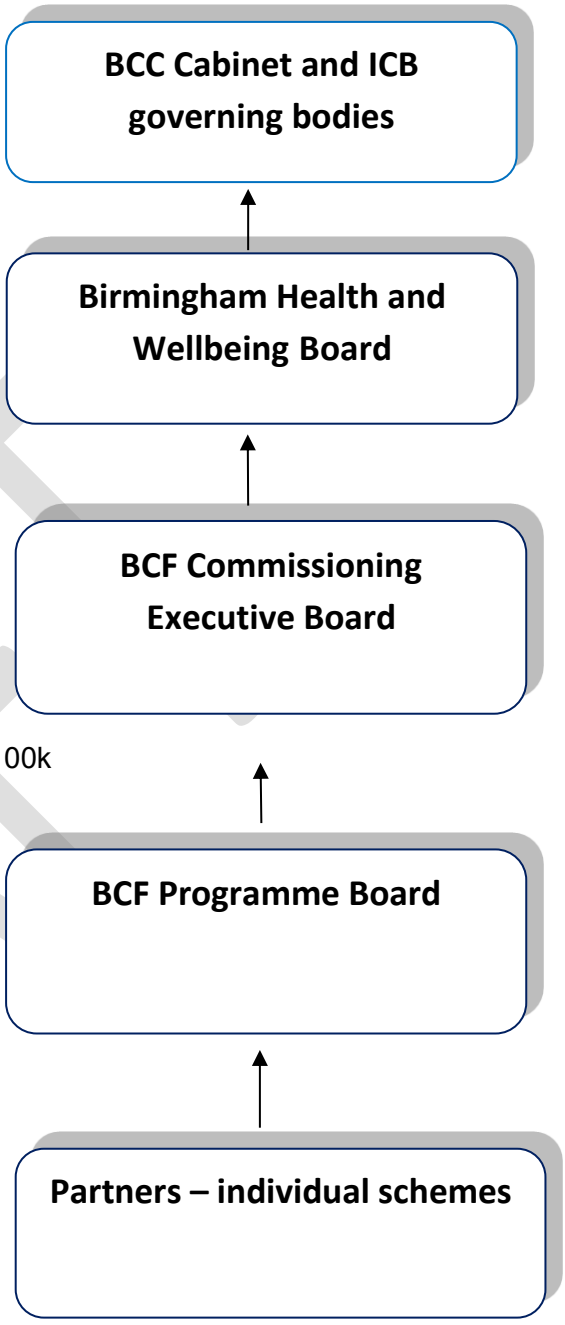
The Birmingham Health and Wellbeing Board has overall responsibility for ensuring the integration of health and social care functions within the city. The Board is the accountable body for the approval and implementation of the BCF plan for the whole of Birmingham and across the current ICB footprints that intersect with the local authority area. Membership of the board includes representatives from the local authority, ICB, NHS provider trusts and the Voluntary and Community Sector.

The BCF Commissioning Executive acts as a collective vehicle for integrated commissioning on behalf of the ICB and the LA. It has been established to develop and operate the BCF pooled budget arrangement (section 75) and to provide strategic oversight and decision making relating to the delivery of BCF plan. The group oversees the operational and financial delivery of BCF and monitors its performance through bi-monthly meetings. Furthermore, the role of the group is to undertake commissioning through the BCF in support of the priorities of the Birmingham Integrated Care Partnership – whose membership comprises representatives from the local authority, ICB, NHS provider trusts and the Voluntary and Community Sector – including Healthwatch, Birmingham Voluntary and Community Services Council and Hospices in Birmingham.

A key focus of the commissioning executive role is to take a whole system approach to maximise investment of any schemes funded under BCF. The board report regularly to HWB and make recommendations for the strategic direction and management of the BCF. The Commissioning Executive is supported by the BCF Programme Board. Workstreams within the BCF programme report back to the Programme Board and are led by a range of statutory and voluntary and community sector organisations.

It is recognised that the governance arrangements are likely to be reviewed and iterated over the year as ICB/ICS arrangements develop and are embedded.

BCF Governance – reporting structure overview



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Overall BCF plan and approach to integration

Our BCF Plan for 2022/23 continues to build upon the work we have undertaken as a system to embed integrated health, social care and housing services. Key developments and issues that have shaped this year's plan include:

- Creation of BSOL ICS – launched on 1 July 2022
- 100 Day Discharge Challenge and responding to the pressure on Urgent and Emergency Care
- Completion of the Early Intervention Programme
- Approval of a Staying Independent at Home Policy

The formation of BSOL ICS marks a further stage of system integration. In respect of the Better Care Fund, the move to ensure that all ICS boundaries are co-terminus with local authorities provides a streamlining of funding and governance arrangements for the Birmingham BCF programme. Whereas NHS contributions previously came via 2 CCGs there is now just a single relationship with BSOL ICS for the whole of the city. Since 2018, integration of health and social care has been driven through the Birmingham Integrated Care Partnership (BICP) – formed as a response to the system issues that were acknowledged as contributing to poor outcomes for our citizens. In developing the governance of the new ICB we have been careful to ensure that effective, existing arrangements are maintained whilst taking the opportunities for further integration. To this end BICP has been retained to provide oversight and will report into the new ICS Place Committee for Birmingham – a sub-committee of the statutory ICB.

Ongoing pressure on Urgent and Emergency Care remains the context for integration of health and social care. The system is experiencing unprecedented levels of pressure including hospital front-door activity levels, the elective recovery programme, demand for community discharge pathways, and a 15% increase in GP demand for same day access. A symptom of the overall pressure is ambulance handover delays and management of calls waiting for ambulance conveyancing, which increases the level of risk to patients. We recognise that the solution in addressing these challenges lies in the system working together to integrate, a shared understanding of issues and embedding good practice. In responding to these pressures, we further recognise the importance of investing in demand management, earlier intervention and prevention alongside more immediate responses to facilitating discharge. This is reflected in the two key priorities for BICP:

- Intermediate Care – collaboration across ICS partners in respect of Urgent Community Response (UCR), Discharge2Assess (D2A), virtual wards, single point of access and enhanced support to care homes.

- Neighbourhood Integration – multi-disciplinary team working to better manage long-term conditions in the community and intervene earlier for those at risk of admission to acute.

Delivery arrangements for these programmes are currently being developed in the context of emerging ICS responsibilities and delegations to place and provider collaboratives. However, we fully recognise the need for continuity and continued collaboration whilst the system works through the implications of the new ICS arrangements. Our work to ensure that resources for intermediate care are aligned within the BCF ensures that we have an effective joint mechanism across social care and health to manage resources across the system to respond to pressures and invest in transformation.

The Early Intervention Programme was launched in 2019 as the first large-scale, integrated transformation programme across health and social care partners in Birmingham. Supported

through the Better Care Fund, system partners came together to design a programme to address the identified issues relating to the experience and outcomes experienced by citizens at the interface of acute care and social care. Central to the programme was a commitment to promoting an ethos of “home first” – with the objective that we would co-ordinate our efforts to enable citizens to return to or remain in their own homes and that unnecessary and harmful delays associated with necessary or overlong stays in hospital were designed out of our processes. Following a design and testing phase, the programme was fully rolled out in early 2020. A review of impact between the start date and March 2022 identified the following key benefits:

- 120k acute bed days saved on an annual basis as a result of more rapid discharge
- Citizens were 45% more likely to go home following a stay in a non-acute bed
- A reduction from 12 to 4 days in the time taken for complex discharges from acute hospital
- 20k+ reduction in unnecessary admissions to acute hospital
- A reduction in ongoing care needs equivalent to an average of 6.5hrs of care per week for citizens going home following an early intervention service
- 18k+ referrals to the new Early Intervention Community Teams

The programme has now largely achieved the original ambitions. Consequently, Birmingham Integrated Care Partnership have taken to decision to bring this programme to an end and to now focus on a refreshed intermediate care transformation programme.

We are now in the process of ensuring continuous improvement for Early Intervention Teams. This includes working with Emergency Care Improvement Support Team (ECIST) across the system to identify key areas for further improvements. The improvements include reviewing our position against the adoption of the 100 day Discharge Challenge and the High Impact Change Model. A priority has been the establishment of a D2A dashboard which is a ‘single version of the truth’. Digital opportunities are key and there is a proposal for the current Discharge Hub Management System (DHMS) in already in use within the UHB to further develop DHMS and unlock wider benefits such as a complete view of the patient journey, optimise flow and productivity, provide a system view of the key performance measures and improve the focus on demand and capacity.

Headline changes within the BCF Plan

The Council has adopted a new Staying Independent at Home policy to broaden the assistance that is available to support people to remain in their own homes or to return home following a stay in acute or intermediate care. More information is provided in the Disabled Facilities Grant Section of this plan.

As part of supporting the health and social care system exit from the pandemic the Better Care Fund has taken on the funding of additional elements of the Early Intervention programme providing long term sustainability. There has also been a range of short-term funding offered to ensure that services delivered through the pandemic can be exited from in a planned way, such as the reduction in Pathway 2 beds and continued funding for the homeless pathways.

Financial Summary

In recognition of the integrated approach and the local system agreement to utilise the Better Care Fund to align our budgets for activity delivered as part of the Birmingham Integrated Care Partnership, there continues to be an increase in the level of additional contributions into the plan for this financial year.

Funding Area	Income	Planned Expenditure
DFG	£12,943,092	£12,943,092
Minimum NHS Contribution	£97,901,719	£97,901,719
iBCF	£67,918,344	£67,918,344
Additional LA Contribution	£30,608,926	£30,608,926
Additional NHS Contribution	£3,174,348	£3,174,348
Total	**£212,546,429**	**£212,546,429**

Required Spend

	Minimum Required	Planned Spend
NHS Commissioned out of Hospital spend from the minimum ICB allocation	£27,843,716	£48,335,844
Adult Social Care services spend from the minimum ICB allocations	£38,830,118	£38,830,119

Transformation Fund

In Birmingham the Better Care Fund is increasingly being used as a mechanism to support integration transformation. It is recognised that transformation in a complex system can take time and needs to be phased. To this end we have developed a system-wide Transformation Fund to support the system work and development under the Birmingham Integrated Care Partnership. This resource is critical to enable change, making up-front investment to realise future benefits. For 2022-23 commitments have been prioritised to stabilise the system recovering from the pandemic. The priority areas for years 2 and 3 include:

- Further development of the Early Intervention model, including development of the care centre model for Pathway 2
- Further development of the Neighbourhood Integration model
- Further development of the Care Homes model
- Technology enabled care
- Falls prevention
- BICP programme development
- Enablers including the Birmingham Community Loan Equipment Service

Implementing the BCF Policy Objectives (national condition four)

Birmingham Integrated Care Partnership priorities reflect the BCF Policy Objectives. Our Neighbourhood Integration theme is aligned to the objective of enabling people to stay well, safe and independent at home for longer whilst our Intermediate Care theme is our approach to delivering the right care, in the place, at the right time in respect of a home first, discharge process.

Supporting People to Remain Independent at Home for Longer

During 2022 – following a period when the focus of system working has, of necessity, been on responding to the pandemic – we have taken the opportunity to reset our ambitions in respect of neighbourhood integration. We have come together as a system around this theme and agreed:

- To get new integrated working within neighbourhoods up and operational by Autumn, ahead of Winter pressures
- To work with a cohort of frail citizens/service-users, with the aim of maintaining safe, independent living and avoiding crisis
- To accept the geographic constructs in Birmingham and work with them, not allowing them to become barriers
- A phased approach to implementation, starting in one area within each locality (pairs of constituencies c200k population) and then rolling out further, based on what we learn
- We will empower our teams to prioritise the building of relationships and new ways of working in their areas

A system design group has been established with active participation from primary care, NHS provider trusts, local authority and the voluntary and community sector. This group has progressed the development of:

- Communication and engagement plan
- Programme plan and governance
- An overarching model - articulated and tested with the design group and other groups
- Engagement with primary care via GP locality meetings and the multiagency partnership meetings
- Organisational Development work commissioned from an external organisation. Initial dates for the first phase have been set for September (one team in each locality).
- Surveys have been produced and distributed amongst frontline staff to provide a baseline for team working.
- An initial developmental evaluation tool
- Mapping to existing programmes (e.g., Mental health transformation and Neighbourhood Network Schemes)

As the recently designated Community Service Integrator, accountable to the Place Committee, responsibility for further development and implementation now rests with Birmingham Community Healthcare Trust.

Anticipatory care helps people to live well and independently for longer through proactive care for those at high risk of unwarranted health outcomes. We are working with our PCNs as part of the Neighbourhood Integration theme to focus on groups of patients who will be offered proactive care interventions to improve or sustain their health. This aims to benefit patients with complex needs and their carers, to reduce their need for reactive health care and to deliver better interconnectedness between all parts of the health and care systems. Anticipatory care should, potentially, encompass many different types of intervention which may include broad approaches to assessing needs and planning and

delivering the interventions required to meet them, or more specific interventions which target particular risks or health problems, singly or in combination. This approach will be reviewed when the anticipatory care national guidelines are issued in Q3 22/23.

ICS partners in Birmingham recognise the importance of a co-ordinated approach to supporting care homes in order to both improve personalised care and to reduce pressure on acute services. A pilot programme – supported through the BCF – to provide enhanced care into 26 care homes in the city was launched in 2021. An evaluation has been undertaken by the University of Birmingham which has demonstrated significant benefits in terms of reducing admission to acute across a range of conditions including UTIs and as a result of falls. We are now working to develop plans for implementation across the care home sector. A key consideration in terms of roll-out is how the offer can be integrated with the existing intermediate care components (virtual wards, UCR, discharge to assess) that are in place in the system.

Originally supported through the Better Care Fund, Neighbourhood Network Schemes are now funded through mainstream Adult Social Care funding. Each constituency in the city now has a NNS lead provider in place to connect citizens with local community assets as part of our preventative approach to improving outcomes. The new approaches to neighbourhood and locality working that are being introduced through the developing ICS arrangements provide further opportunities to build on the considerable impact of this programme through increasing integration with primary care and neighbourhood MDTs.

The section of this plan concerning Disabled Facilities Grants details the new forms of assistance that will be provided as a result of the development and adoption of a new Staying Independent at Home policy. Our approach has been designed with the objectives of enabling citizens with care and support needs to remain living in their own homes and removing housing-related barriers to discharge.

Providing the right care in the right place at the right time

Providing the right care in the right place at the right time in respect of intermediate care and discharge has been the key focus for integration and collaboration in the system. The legacy of our Early Intervention programme is an integrated system with the following components:

- Early Intervention Community Team (P1)
- Early Intervention Beds (P2)
- Integrated Referral Hub (IHub)
- (OPAL/OPAL+ at acute sites; not funded via BCF plan)

The components of EI and alignment of pathways are described in more detail below in terms of how they support effective discharge outcomes.

Pathway 0

The system approach to supporting Pathway 0 – for example the Home from Hospital service that is supported via the BCF will be reviewed during 2022/23 with the intention of reconfiguring resources into an integrated offer focused on enabling independence and resilience.

Pathway 1 - Early Intervention Community Team (EICT)

The Early Intervention Community Team (EICT) is an integrated offer across Birmingham. The service comprises of staff from Birmingham Community Healthcare NHS Foundation Trust (BCHC), University Hospitals Birmingham NHS Foundation Trust (UHB) and Birmingham City Council (BCC). In addition, the teams work alongside colleagues from Birmingham and Solihull NHS Mental Health Foundation Trust (BSMHFT).

The service provides a range of support from intermediate care to personal care within someone's own home. The care and support the service will provide will typically involve an assessment of health and social care needs and a level of therapy. The combination of these elements ensures that this service meets the goals of the citizens in a seamless way, where citizens should only have to tell their story once.

The whole ethos of the service is ensuring that there are clear and seamless routes for supporting discharge with the home first principle, in a timely way, with a same day response. The service brought together various other community services to ensure a single route out of hospital for pathway 1 eligible citizens. The intensive multi-agency, and multi-disciplinary nature of the team ensures that discharges are supported effectively in the community.

The EICT service was rapidly rolled out across the city through the height of the pandemic in 2020 and was integral to the community response to assist with discharge of citizens back home in a timely manner and to alleviate the pressures on acute hospitals.

Bringing three organisations together to work in an integrated way has provided the system with challenges – for example, we have had to address issues relating to organisation and professional line management; appointing a single lead officer for all partners at a locality level to provide a clear line of management and escalation. Ultimately the ethos of keeping the citizen at the centre drove the cultural change that was needed for Birmingham.

Pathway 2 - Early Intervention – Pathway 2 (P2) Beds

Our strategy to consolidate the number and location of P2 beds has been disrupted by successive waves of COVID. We have been unable to reduce the number of P2 beds due to the requirements to rapidly move patients from acute sites during the pandemic. However, we have continued to work with P2 sites to introduce new ways of working and reduce length of stay (see Ongoing Transformation Plan section).

Pathway 3

A range of pathway 3 beds are commissioned from the independent sector for patients who are unable to return home and are known to have complex needs that could not be met in pathway 1 or 2.

Commissioners are currently in the process of implementing a programme of work to ensure a single approach to managing the regulated care market. This will refine our system approach to market shaping of the care sector in the long term. During 2022/23 our ambition is to:

- Develop a joint Commissioning & Procurement Strategy for Domiciliary Care – Adults and Children
- Develop and implement joint Commissioning & Procurement Strategies for Pathway 2 and Pathway 3 Beds

Taking account of existing contractual arrangements, it is proposed to develop and implement joint strategies for care home and supported living commissioning in 2024/25.

Integrated Hub Team (IHub)

The Integrated Hub Team is in place to ensure effective discharge. The IHub has representation from BCHC, Birmingham City Council, UHB, the ICB, BSMHFT and Hospices. The aims of the hub are:

- To ensure consistent decision making in relation to pathway and service allocation
- To oversee system flow in and out of pathways

- To ensure that the pathways are appropriately managed and that citizens have a high-quality experience of the pathway

IHub delivery is a focus of continuous improvement from the ECIST team to ensure optimisation of the D2A pathway.

Older Person's Assessment and Liaison (OPAL) Team

OPAL is a recognised term used to describe front-door acute hospital services for older people and those with complex needs. The Birmingham services are available to any citizen aged over 18 who would benefit from the input of the team, there are no age or frailty-score related limits.

The service was first established at Queen Elizabeth Hospital in 2012 and is one of the interlinked components in the Early Intervention Programme and is therefore built on a strong evidence base and integration across health and social care.

The OPAL teams are based at the 'front door' of the hospitals, but face outwards to interface with all aspects of community care and services including statutory, private and third sector providers. The more integrated our care and health services are, the bigger role OPAL can play in the 'Home First' model, and the more successful the overall system model will be.

Core principles are a multi-disciplinary team including consultants, nursing, therapy and social work working in emergency departments and acute assessment areas to assess and treat older people and those with complex needs as soon as possible after they reach acute care. OPAL also supports community Advance Nurse Practitioners (ANPs) across the ICS, and West Midlands Ambulance Service (WMAS) to avoid citizens being unnecessarily conveyed to acute care.

The input of OPAL expertise involvement makes a person more likely to receive the care and support they need in their own home, or if they do need admitting their length of stay is reduced. In line with the Early Intervention strategy the future of OPAL will ensure a consultant workforce that will not just operate at the front door, but which will also be linked into the other EI services to maximise the home first approach.

OPAL+ is an extension of the OPAL service. In 2019 OPAL began a collaboration with the West Midlands Ambulance Service (WMAS) to take the approach one step further by introducing the use of technology to enable virtual consultations in the home. During 2021 OPAL+ received 2,490 calls, of which 1,815 remained in their own surroundings. The service has now been extended to include community and mental health teams as well as the community palliative care team to help reduce hospital admissions of palliative patients and ensure they are managed in the community.

Housing and Homeless Pathways

The impact of poor housing conditions or homelessness had already been identified as an area of improvement prior to the pandemic. Although the numbers being delayed due to housing issues were relatively small, the length of stay within acute per citizen was often significant.

In response, we have commissioned independent living, temporary accommodation to enable discharge from acute/enablement beds whilst long-term housing solutions are explored. This has been developed in collaboration with housing colleagues and the provision also includes dedicated Birmingham City Council Housing Officers who are able to prioritise and review those people who present as homeless at point of discharge with ongoing care and support needs. This has reduced admissions into short and long-term residential care for this cohort.

Birmingham was also successful in bidding for Out of Hospital Care Model funding from the Department for Health and Social Care, to improve the support and pathways for citizens who present homeless at the point of discharge. This aims to reduce the number of citizens presenting as homeless and rough sleeping within Birmingham. The funding has allowed Birmingham to have dedicated staff based within the 4 Birmingham acutes to provide support, assessments, advice and move on for those citizens referred into the service.

Each quarter has seen an increase in the number of citizens being referred as the service develops and expands the variety of support that it is able to offer, to date since 1st November 2021 there have been 655 referrals made. The service completes a bespoke Homeless Assessment that is a holistic view of the citizen, working alongside professionals within the hospital to decide the best pathway for the citizen which can be home, into independent living or alternative accommodation as a temporary measure to ensure we give the citizen the best opportunity of returning to community living or their usual place of residence. The model is being managed through the BCF programme.

To date there has been a considerable impact in the reduction of citizens being remaining in hospital for housing needs and the pathways as they embed within the acute settings are offering an alternative for fast-track support for housing and homelessness.

Birmingham Community Equipment Loan Service

Community equipment loans are critical in ensuring safe, timely and effective discharges. The service source, deliver, collect and decontaminate clinically prescribed rehabilitation equipment to individuals to support discharge to their usual place of residence. This service was commissioned through a joint collaborative approach between health and social care, to bring together funding, service provision and improve the outcomes for citizens which was extremely successful.

Provision of quality, clinically recommended equipment via clinical prescription from hospital discharge teams, who are supported by expert BCF funded Clinical Leads based within the service who:

- ensure appropriateness and availability of the standard stock catalogue items,
- ensure stocks at the peripheral stores are stocked,
- advise on the best options for order on special/bespoke orders.

As the 'Home First' approach has moved forward in Birmingham and more packages of care are delivered in citizens own homes we have seen an increase in demand, this has needed an increase in capacity within the teams who now also provide a service to continuing healthcare teams, as the timely service is aiding the pace of discharge of this cohort of citizens from a bedded setting. Increase demand is reflected in the BCF plan with an increased budget for community equipment.

Recent service developments include aligning Continuing Health Care equipment provision with BCELS provision to deliver efficiency benefits for the CHC service and a better experience for citizens. The service has also tested the use of lateral turners to reduce overnight care calls and double-handed care. Further service developments planned for 2022/23 include bringing dynamic pressure care within scope for BCELS.

Ongoing Transformation Plans

As BSOL ICS we recognise that by focussing on intermediate care as a specific area, and setting clear priorities, we have an opportunity to harness the resources and energy in the system to achieve the National Institute for Health and Care Excellence (NICE) aims of intermediate care:

- Remain at home

- Recover after acute illness or an operation
- Avoiding going into hospital unnecessarily
- Returning home more quickly after a hospital stay

We have collaborated across BSOL ICS to develop a proposed set of priority areas for intermediate care as an immediate focus within an overarching programme of work. The priority areas are all at different stages of development, with some that are brand new. All priority areas will require further detailed planning, with short, medium and long-term deliverables, and some will require decision making at place level.

Unscheduled Care Co-Ordination

We know there is a system opportunity in unscheduled care. As an illustration, a diagnostic of the BSol urgent community response (UCR) opportunity was undertaken by external consultants Newton Europe (Newton) and initial findings reported in July 2022. From the diagnostic sample of cases reviewed, Newton identified that if the urgent community response was enhanced, up to 31% of patients could have avoided conveyance to hospital, and up to 28% of patients who called an ambulance but were not conveyed could have been seen by a UCR response instead of an ambulance crew. In the context of this opportunity, we are proposing to explore the following areas for transformation:

- Single approach to access – address current fragmentation of urgent care pathways; emphasis on managing the needs of sub-acute people, who are not seriously ill, but who are at risk of attending hospital. Responding to calls from West Midlands Ambulance Service/111/999, primary care and care homes.
- Hospital Ambulance Reception Improvement System (HARIS) - HARIS or a similar approach, could form a pivotal element of the overall unscheduled care response. It is an approach that has been rolled out in other systems including Hertfordshire and West Essex and provides a range of initiatives for physical and virtual solutions to ensure patients' needs are met in the most appropriate setting, a reduction in the impact of handover delays, relieved pressure on ED, and migrating unscheduled care into a scheduled care environment. Discussions and workshops session are being held with the NHSE/I Emergency Care Improve Support Team (ECIST) to determine how the HARIS approach could be developed in BSol ICS as a lever for change. System workshop planned for September 2022 to set up a series of test of change over a 4-month cycle outcome will be a compelling case of change. Once complete will moved into the 'embed and sustain' process.

Discharge to Assess

The following priorities/opportunities have been identified:

- Standardising approach to discharge - There is an ambition to have a standardised transfer of care approach across the ICS as part of the implementation of the Hospital Discharge and Community Support Guidance (April 2022) and subsequent Integration and Better Care Fund implementation guide (May 2022). There is an opportunity to build on the current position across BSol by integrating hubs, processes and IT systems where it can be evidenced to have a positive impact on flow, patient outcomes and will meet local need at place level. Scoping work will identify the size and feasibility of the BSol and place level opportunities. Regardless of the specific delivery model for this priority, a single dataset and dashboard will be critical in enabling a common view of effective flow. The standardised approach to discharge will need to extend to involve the voluntary sector, housing, CHC, end of life pathways and any relevant providers.

- 7-day working for discharge teams – Linked to the standard approach to discharge above, hospital discharge and community support guidance (March 2022) is clear

that discharges from hospital should operate over seven days, and crucially, that a high proportion of people should achieve a same day discharge. Whilst statutory partners in Birmingham do operate across 7 days, at present discharges are predominantly over the five weekdays, with a large reduction in flow at weekends. We need to co-ordinate the approach to seven day working across all services that impact on discharge, to maximise the opportunity to optimise flow (e.g.care homes, transport, equipment, pharmacy).

- Home First Model (Discharge to assess pathway 1) **–** We want to build upon the progress that has been made against this theme through our Early Intervention programme. Further development work in Birmingham includes an ambition to further integrate operational teams and developing a sustainable approach to the personal care element of the workforce (currently provided by the independent sector). Across BSol ICS there is an ambition to maximise the number of patients discharged home via pathway 1, who may have historically being discharged to a pathway 2 bed-based setting. Achieving this will require a focus not only on the specific pathway 1 services, but also innovative approaches to technology enabled care and equipment and adaptations. Ensuring that patients are given the chance to continue their lives at home is vital for their long-term wellbeing outcomes.

- Pathway 2 bed-based care **–** Our focus will be on standardising the P2 offer, promoting recovery and assessment supported by an integrated health and care pathway. A more resilient, consistent medical workforce model and structure with integrated UHB/ BCHC medical roles and joint recruitment will be pivotal to providing a firm foundation for this work, alongside using technology to link in with the Older Peoples Assessment and Liaison Service (OPAL). A Birmingham business case is in development to specify this approach in the form of locality-based care centres, with the principle that there should be co-location with pathway 1 (EICT) where practical, to ensure patients can return home as soon as appropriate in a seamless transition. In the short-term there is a BSol wide need to improve bed utilisation through reducing length of stay. The use of BCF to support this immediate issue has been agreed.

- Agreed next steps – during Q3 22/23 dedicated enhanced system wide discharge team focused on system wide improvements to drive flow, timely and effective discharge over 7 days. All improvement work will focus on data and measures of improvement.

Virtual Wards

Virtual wards allow patients to get the care they need at home safely and conveniently rather than being in hospital. This supports discharge from hospital settings, but crucially, also avoidance of inappropriate admissions supported by a community response. For BSol the specific plan is:

- UHB sites up to 340 adult virtual ward beds by April 2024 (including those already within the baseline), with a commitment to undertaking an assessment of the evidence base in Q4 2022/23 to determine the case for further expansion.
- Sandwell and West Birmingham Hospitals (SWBH) have provided current assumptions of 78 virtual ward beds by April 2024 (further work to take place during Q2 to test assumptions).
- By April 2024 the overall ambition for BSol is to create 418 virtual ward beds (national planning guidance minimum of 423 virtual ward beds)
- Build in the use of technology, and remote monitoring, and links with the overall evolving approach/ framework for unscheduled care so if a patient deteriorates or feels unwell, a co-ordinated response can be provided.

Enhanced Health in Care Homes

During 22/23 the system has agreed to test/ deliver UCR, Virtual Wards and discharge to assess in care homes as part of an overall enhanced health in care homes offer to improve outcomes, reduce hospital admissions, and release capacity. A support to care homes team has been prototyped across 26 homes in Birmingham. However, given the rapid developments, overall strategic direction and financial investment in UCR, discharge to assess and Virtual Wards, it has been agreed to test how these system pathways impact on care home patients and how this compares to the return on investment from the prototype. Delivering this requires a systematic, structured approach to mobilisation and communication, including training and education for the care home workforce so they know when to call for support. The roll out of technology will be key to maximise efficiency.

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Supporting unpaid carers

Birmingham Carers Hub (Hub) Service provided by Forward Carers is jointly commissioned by Birmingham City Council Adult Social Care and Birmingham and Solihull Integrated Care Board and funded by Adult Social Care budget and Better Care Fund. The service follows a pathway approach linking to young carer and mental health carers services and their commissioners building on the collaborative approach as an integrated care system. In addition, the service will work in partnership with other organisations bringing additionality and added value throughout the service delivered.

The Hub delivers a range of services to enable carers to continue in their role, feel supported and manage and prevent the likelihood of crisis with early interventions which include; statutory assessments as required by the Care Act, wellbeing assessments and payments, an emergency service, a health liaison project, Partners in Care cards issued in hospitals so that the carer is recognised and actively involved in the person they care for plans and discharge process, group sessions and one to one support. There are over 17,500 carers registered with the service. The Hub will be expected to take a place-based approach having locations across the city to deliver support on a locality basis and link and work with Neighbourhood Networks Services.

The current contract for the Hub ends on 31st March 2023 and recommissioning is currently taking place. Additional funding has been secured to develop a wellbeing break/sitting service for carers to provide much needed breaks to support their mental and physical wellbeing and to expand the health liaison project to support the carer when the person cared for returns home following discharge from hospital.

Co-production will commence on the refresh and review of Birmingham Carers Strategy with the consultation opened at a launch event for the new contract in May 2023. The strategy will seek Cabinet approval and be launched in 2024 allowing time for full consultation and co-production with carers, providers, partners and key stakeholders.

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Disabled Facilities Grant (DFG) and wider services

It is widely acknowledged that home is best for most citizens, their families and carers, it is where they are happiest and thrive with the right support. We know that poor quality housing is thought to cost the NHS an estimated 1.4 billion pounds per year, over half of which is attributed to poor housing among older adults.

In March 2022 the Staying Independent at Home Policy was approved by Birmingham Cabinet that brings together the responsibilities and duties under:

- The Housing Grants, Construction and Regeneration Act 1996
- Care Act 2014
- The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO 2002).

As housing is a key determinant of health the policy sets out how the council will reduce the health inequality brought about by poor living standards, by providing support in the form of grants, loans or services to improve housing conditions. Ensuring that homes are decent, accessible, safe and secure, this is not only important for the health and wellbeing of the citizen but is also vital for the sustainability of communities.

The policy clearly sets out both the assistance that the Council has a duty to provide (mandatory) and assistance that will be provided through the use of discretionary powers. The discretionary assistance through the policy will be to:

- Support disabled citizens to secure necessary adaptations which cost more than the maximum allowed under the Disabled Facilities Grant
- Secure prompt discharge from hospital of citizens who might, due to accommodation difficulties, otherwise remain in hospital longer than necessary
- Address accommodation difficulties which, if not resolves, might lead to an avoidable admission to hospital, or residential care or which impact upon the ability of the citizen to live safely and independently at home.

In order to deliver the new discretionary assistance, the commissioning of a new integrated service to deliver the principles in the new policy and meet the demands of the citizens of Birmingham has commenced. It is expected that a new service model will be implemented from July 2023. In the meantime, services have been adapted and scaled up in order to deliver the new discretionary assistance from October 2022.

As already detailed within the homeless and housing pathways section (page 11) there has been a considerable amount of work to develop effective pathways for citizens who are not able to return home for various reasons including, not having a home or this not meeting their needs (homeless), hoarding, cleanliness, health and safety and domestic abuse. The pathways have been developed through integration of housing and adult social care teams and recongising for citizens who are being discharged from hospital that a one service approach means better outcomes and the right accommodation offer being made at the right time. During this year a detailed outcomes and provision document will be developed in partnership with the National BCF Team to share the learning and good practice from the pilot and widen homelessness work.

DRAFT

Equality and health inequalities

Addressing health inequality has been, and remains, central to our approaches to delivering integrated health and care services. As a system the BSol ICS has a larger proportion of citizens living in deprivation compared to any other health and care system in England. Within Birmingham four in 10 people live in the 10% most deprived areas of England. Birmingham residents are more likely to die of diabetes, cancer or respiratory disease than in most other parts of England. Stark spatial variations exist within the city; for example, there is a ten-year gap in the estimated life expectancy of a boy born in Castle Vale compared to one born in Sutton Mere Green Not only are people living in the poorest neighbourhoods in Birmingham and Solihull dying a decade earlier than those living in the most well-off neighbourhoods, but they are spending almost 2 decades (17 years on average) of their shorter lives in ill health.

Inequalities exist between communities of place, often reflecting poverty and deprivation as the headline but this sits on top of inequalities between communities of identity e.g. different ethnic groups, LGBTQ+ communities, and communities of experience e.g. homeless populations, veterans, migrants and carers. Birmingham's Public Health team have developed a series of community health profiles to explore in detail the specific health inequalities faced by different communities of identity and experience.

A range of connected factors drive inequality in health outcomes in Birmingham.

- Deprivation - Around 50% of the population of the ICS are amongst the 20% worst off people nationally (the "Core20"); 94 percent of the most deprived areas of the ICS are in Birmingham.
- Ethnicity - Around 40% of the people of Birmingham are from Black, Asian and minority ethnic groups. Many (though not all) of these communities live in the most deprived neighbourhoods, and additionally suffer the impact of structural racism, worsening already poor outcomes related to poverty. We recognise the variation in access and outcomes between different ethnicities. Pakistani communities are largest ethnic minority group in the ICS, but experience some of the worst health outcomes. Black and African Caribbean communities are the second largest ethnic grouping. People from Gypsy and Traveller Groups are a small minority but have very poor health outcomes. White groups also include a range of ethnicities such as English, Irish, Polish, with their own unique experiences. Evidence shows they are more likely to be impacted by issues related to alcohol and tobacco, and white men have a disproportionately high suicide rate.
- Children - We have the largest population of children and young people in the country. Having the youngest population should mean fewer health challenges. However, one in three children in our system – over 130,000 children in Birmingham - live in poverty and we have some of the highest rates of infant mortality in the country. Studies have shown that adverse experiences in early years have life-long impacts which can entrench generational inequality. Conversely, intervening positively in early years has the biggest impact in improving life chances including healthy outcomes.
- Long Term Conditions - Our system has high numbers of people living with long term conditions and outcomes that vary significantly. We perform worse than the England average on many of the factors that drive good health. The biggest 'killer' in our system is circulatory disease (CVD), followed by respiratory disease (COPD) and cancer. High prevalence of preventable diabetes in our system contributes to these diseases and their impact.
- Mental Health & Learning Disabilities - Outcomes for people with mental illness and learning disabilities are worse than outcomes for the population as a whole. On average people with serious mental illness or a learning disability die 15-20 years earlier than

those without. Not because these conditions are killers, but due to treatable physical conditions not being diagnosed or treated appropriately.

These are deep-seated issues that will not be easily turned around. The Health Inequality Strategy sets an ambition over the next ten years to visibly and meaningfully reduce the gap in healthy life expectancy for citizens. The strategy set out system priorities based on:

- factors that drive poor healthy life expectancy for our citizens;
- priorities of the Birmingham Health & Wellbeing board;
- patients waiting longer for diagnostics and surgery;
- opportunities for improvement identified in the Birmingham & Lewisham Black African and Caribbean Health Inequalities Review (BLACHIR);
- lessons learnt from the way in which COVID-19 hit hardest those who were already worst off; and
- national “Core20plus5” priorities for reducing inequalities.

The priorities are:

1. Maternity Care & Infant Mortality - Improve the experience and outcomes for mothers, parents, and babies and reduce the number of infants who die before their first birthday

2. Better Start for our Children - Improve the health of children from our most deprived communities by supporting them to get the best start in life, focusing first on increasing uptake of vaccination and improving school readiness.

3. Better Prevention, Detection & Treatment of Major Diseases - Improve the prevention, early detection and treatment of the diseases that drive early mortality for people, focusing first on reducing waiting lists for diagnosis and surgery, cardiovascular disease, respiratory disease, cancer screening, diabetes and addressing the backlog of elective treatment.

4. Better Outcomes for People with Mental Illness - Improve the experience and outcomes for people living with serious mental illness and improve their health and wellbeing to achieve their potential in life.

5. Better Outcomes for People with Disabilities including Learning Disability - Improve the experience and outcomes for people living with a disability across the life course, starting with a focus on learning disability and autism.

6. Improved Outcomes for Inclusion Health Groups - Improve health and care outcomes for our most vulnerable citizens in inclusion health groups including new migrants, refugees and asylum seekers, homeless people, people with substance misuse difficulties, women, people experiencing racial disparity and LGBTQIAplus.

In tackling these six priorities and in taking forward our work on inequalities, we have also made a commitment to the principle of subsidiarity which is being enacted in the HWB area through the creation of an ICS place committee and locality forums for pairs of constituencies in Birmingham. This will provide the infrastructure for approaches that are more responsive to local needs and communities. The work of locality forums has already commenced with an initial aim of developing delivery plans that address both ICS outcomes

and local priorities. Our shared experience through the pandemic has shown the value of reflecting local diversity in the delivery of system-wide objectives.

The Better Care Fund programme is an opportunity for health and social care partners to work together to address these priorities – with a particular focus on priorities relating to prevention, early intervention, mental illness and disability and outcomes for inclusion health groups. The origins and development of the programme means that it is predominantly focused on older residents and specifically to address the poor outcomes experienced by older citizens and the opportunities to make improvements through the implementation of consistent and equitable pathways.

Of necessity, our focus to date has been on improving services across the city in a consistent way to ensure that there is equality of access irrespective of where citizens live - particularly in regard to reducing delayed transfers of care, reducing the use and length of stay in P2 beds and increasing the independence of people being discharged from reablement services. This work has been supported by the BCF both in terms of investment in a system transformation programme – Early Intervention – and through the use of BCF to invest in capacity in P1 to facilitate a home-first approach and in P2 capacity to enable discharge for those who are unable to immediately return to their usual place of residence. Notwithstanding the need to focus BCF resource on these key challenges, our BCF programme includes a number of schemes that address specific inequalities and challenges such as investment in jointly commissioned support to carers, dementia, development of out of hospital homeless and bariatric pathways and funding capacity to develop a joint approach to improving outcomes for citizens living with learning disabilities and/or neurodiversity.

All new proposals for Better Care Fund support are subject to an Equality Impact Assessment so that decisions are made with the benefit of a consideration the impact on people with protected characteristics.

DRAFT

BCF Planning Template 2022-23

1. Guidance

Overview

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

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

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

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

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

Item 13

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2022-23. It will be pre-populated with the minimum NHS contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.

2. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

3. Please use the comment boxes alongside to add any specific detail around this additional contribution.

4. If you are pooling any funding carried over from 2021-22 (**i.e. underspends from BCF mandatory contributions**) you should show these on a separate line to the other additional contributions and use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

5. Allocations of the NHS minimum contribution (formerly CCG minimum) are shown as allocations from ICB to the HWB area in question. Mapping of the allocations from former CCGs to HWBs can be found in the BCF allocation spreadsheet on the BCF section of the NHS England Website.

6. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

5. Expenditure (click to go to sheet)

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Conditions 2 and 3 and is used by assurers to ensure that these are met.

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

On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where ‘Social Care’ is selected and the source of funding is “NHS minimum” then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.
6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend under National Condition 3. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2022-23:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2022-23 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2022-23. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2022-23.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2022-23. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2020)
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Exact script used to pull pre-populated data can be found on the BCX along with the methodology used to produce the indicator value:
https://future.nhs.uk/bettercareexchange/viewdocument?docid=142269317&done=DOCCreated1&fid=21058704
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2021-22, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2022-23 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

3. Residential Admissions (RES) planning:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

4. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2022-23 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.
1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2022-23 Template

2. Cover

Version 1.0.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2022-23.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.
- Where BCF plans are signed off under a delegated authority it must be reflected in the HWB's governance arrangements.

Health and Wellbeing Board:	Birmingham
Completed by:	Sarah Feeley
E-mail:	sarah.feeley@birmingham.gov.uk
Contact number:	07704 538632
Has this plan been signed off by the HWB (or delegated authority) at the time of submission?	No
If no please indicate when the HWB is expected to sign off the plan:	Tue 27/09/2022 << Please enter using the format, DD/MM/YYYY
If using a delegated authority, please state who is signing off the BCF plan:	Graeme Betts

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Director - Adult Social Care
Name:	Graeme Betts

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Mariam	Khan	mariam.khan@birmingham.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		David	Melbourne	david.melbourne@nhs.net
	Additional ICB(s) contacts if relevant		Helen	Kelly	hkelly@nhs.net
	Local Authority Chief Executive		Deborah	Cadman	deborah.cadman@birmingham.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Professor	Graeme	Betts	graeme.betts@birmingham.gov.uk
	Better Care Fund Lead Official		Louise	Collett	louise.collett@birmingham.gov.uk
	LA Section 151 Officer		Rebecca	Hellard	rebecca.hellard@birmingham.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	No
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: Birmingham

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£12,943,092	£12,943,092	£0
Minimum NHS Contribution	£97,901,719	£97,901,719	£0
iBCF	£67,918,344	£67,918,344	£0
Additional LA Contribution	£30,608,926	£30,608,926	£0
Additional ICB Contribution	£3,174,348	£3,174,348	£0
Total	**£212,546,429**	**£212,546,429**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£27,843,716
Planned spend	£48,335,844

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£38,830,118
Planned spend	£38,830,119

Scheme Types

Assistive Technologies and Equipment	£6,470,121	(3.0%)
Care Act Implementation Related Duties	£3,760,623	(1.8%)
Carers Services	£1,191,000	(0.6%)
Community Based Schemes	£290,000	(0.1%)
DFG Related Schemes	£12,443,092	(5.9%)
Enablers for Integration	£13,534,141	(6.4%)
High Impact Change Model for Managing Transfer of C	£13,805,106	(6.5%)
Home Care or Domiciliary Care	£19,273,429	(9.1%)
Housing Related Schemes	£900,000	(0.4%)
Integrated Care Planning and Navigation	£2,977,117	(1.4%)
Bed based intermediate Care Services	£12,928,140	(6.1%)
Reablement in a persons own home	£18,015,178	(8.5%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£42,434,393	(20.0%)
Prevention / Early Intervention	£0	(0.0%)
Residential Placements	£64,524,089	(30.4%)
Other	£0	(0.0%)
Total	**£212,546,429**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	0.0	0.0	0.0

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	94.2%	94.5%	94.4%

Residential Admissions

		2020-21 Actual	2022-23 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	400	464

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementing the BCF policy objectives	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2022-23 Template

4. Income

Selected Health and Wellbeing Board: Birmingham

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Birmingham	£12,943,092
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£12,943,092**

iBCF Contribution	Contribution
Birmingham	£67,918,344
Total iBCF Contribution	**£67,918,344**

Are any additional LA Contributions being made in 2022-23? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Birmingham	£18,371,368	2021/22 Carry Forward
Birmingham	£12,237,558	Early Intervention Fund
Total Additional Local Authority Contribution	**£30,608,926**	

NHS Minimum Contribution	Contribution
NHS Birmingham and Solihull ICB	£97,901,719
Total NHS Minimum Contribution	**£97,901,719**

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	Yes

Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS Birmingham and Solihull ICB	£3,174,348	Community Health Services
Total Additional NHS Contribution	**£3,174,348**	
Total NHS Contribution	**£101,076,067**	

	2021-22
Total BCF Pooled Budget	**£212,546,429**

Funding Contributions Comments Optional for any useful detail e.g. Carry over
2022/23 BCF Plan includes £18,371,368 of carry forward which will be used as a transformation fund over the next 2-3 financial years.

Better Care Fund 2022-23 Template

5. Expenditure

Selected Health and Wellbeing Board: Birmingham

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£12,943,092	£12,943,092	£0
Minimum NHS Contribution	£97,901,719	£97,901,719	£0
iBCF	£67,918,344	£67,918,344	£0
Additional LA Contribution	£30,608,926	£30,608,926	£0
Additional NHS Contribution	£3,174,348	£3,174,348	£0
Total	**£212,546,429**	**£212,546,429**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£27,843,716	£48,335,844	£0
Adult Social Care services spend from the minimum ICB allocations	£38,830,118	£38,830,119	£0

>> Link to further guidance

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Pathway 1 provision	Early Intervention - Homecare capacity	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Private Sector	Minimum NHS Contribution	£2,495,275	Existing
2	Pathway 1 provision	Early Intervention - Homecare capacity	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Private Sector	Additional LA Contribution	£3,327,658	Existing
3	Pathway 1 provision	Early Intervention - Homecare capacity	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Private Sector	iBCF	£3,259,376	Existing
4	Pathway 1 provision	Early Intervention - Community Team	Reablement in a persons own home	Reablement to support discharge - step down		Community Health		LA			NHS Community Provider	Minimum NHS Contribution	£6,128,869	Existing
5	Pathway 1 provision	Early Intervention - Homebased therapy	Reablement in a persons own home	Reablement service accepting community and		Community Health		CCG			NHS Community Provider	Additional LA Contribution	£1,249,480	New
6	Pathway 1 provision	Early Intervention - Homebased therapy	Reablement in a persons own home	Reablement service accepting community and		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£897,520	New
7	Pathway 1 provision	Early Intervention - Physiotherapy Capacity	Reablement in a persons own home	Reablement service accepting community and		Community Health		CCG			NHS Community Provider	Additional LA Contribution	£657,000	New

8	Pathway 2 provision	Pathway 2 beds	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	Additional LA Contribution	£1,411,756	Existing
9	Pathway 2 provision	Pathway 2 beds	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	iBCF	£703,872	Existing
10	Pathway 2 provision	Pathway 2 beds	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	Minimum NHS Contribution	£3,562,517	Existing
11	Pathway 2 provision	Pathway 2 beds	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			Private Sector	Minimum NHS Contribution	£5,244,769	Existing
12	Pathway 2 provision	Social work capacity delivering pathway 2 approach	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Additional LA Contribution	£1,681,981	Existing
13	Pathway 2 provision	Social work capacity delivering pathway 2 approach	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	iBCF	£1,945,600	Existing
14	Pathway 2 provision	SIP P2 Challenging Behaviour beds	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	Minimum NHS Contribution	£629,000	New
15	Pathway 2 provision	Pathway 2 beds - Surge de-escalation	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	Additional LA Contribution	£1,376,226	New
16	D2A enabler	Hospital discharge teams - Social work	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Additional LA Contribution	£4,039,404	Existing
17	D2A enabler	Hospital discharge teams - Social work	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	iBCF	£3,591,754	Existing
18	D2A enabler	Hospital discharge teams - Social work	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,553,831	Existing
19	D2A enabler	EI Integrated Hub	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Additional LA Contribution	£992,536	Existing
20	Community Loan Equipment	Community Loan Equipment service	Assistive Technologies and Equipment	Community based equipment		Community Health		LA			Private Sector	Minimum NHS Contribution	£4,846,508	Existing
21	Community Loan Equipment	Community Loan Equipment service	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Private Sector	DFG	£500,000	Existing
22	Community Loan Equipment	Community Loan Equipment service	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Local Authority	Additional LA Contribution	£1,123,613	Existing
23	Neighbourhood Integration	Integrated multi-disciplinary teams	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£39,260,045	Existing
24	Neighbourhood Integration	Other community support	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Additional NHS Contribution	£3,174,348	Existing
25	Carers service	Carers service	Carers Services	Other	Carers Hub	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£1,191,000	Existing
26	Dementia Services	Dementia community based services	Integrated Care Planning and Navigation	Care navigation and planning		Mental Health		CCG			NHS Mental Health Provider	Minimum NHS Contribution	£2,675,413	Existing

27	Dementia Services	Dementia community based services	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		CCG			NHS Mental Health Provider	Minimum NHS Contribution	£198,097	Existing
28	Dementia Services	Dementia community based services	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		CCG			Charity / Voluntary Sector	Additional LA Contribution	£103,607	Existing
29	Packages of Care - Residential, Nursing and	Residential, Nursing and Supported Living packages	Residential Placements	Other	Combination of sub types	Social Care		LA			Private Sector	Minimum NHS Contribution	£19,542,428	Existing
30	Packages of Care - Residential, Nursing and	Residential, Nursing and Supported Living packages	Residential Placements	Other	Combination of sub types	Social Care		LA			Private Sector	iBCF	£44,981,661	Existing
31	Care Act	Safeguarding, advocacy and occupational therapy services	Care Act Implementation Related Duties	Other	Safeguarding, advocacy and occupational	Social Care		LA			Local Authority	Minimum NHS Contribution	£3,760,623	Existing
32	Disabled Facilities Grants	Delivery of aids and adaptations	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Private Sector	DFG	£12,443,092	Existing
33	Transformation Fund	BICP Programme Capacity	Enablers for Integration	Integrated models of provision		Community Health		CCG			NHS Community Provider	Additional LA Contribution	£118,372	Existing
34	Transformation Fund	BICP Programme Capacity	Enablers for Integration	Integrated models of provision		Social Care		LA			Local Authority	Additional LA Contribution	£270,000	Existing
35	Transformation Fund	Transformation fund years 2 and 3	Enablers for Integration	New governance arrangements		Social Care		LA			Local Authority	Additional LA Contribution	£12,967,293	Existing
36	Transformation Fund - Health	Transformation fund years 2 and 3	Enablers for Integration	New governance arrangements		Continuing Care		LA			Local Authority	Minimum NHS Contribution	£18,476	Existing
37	Accommodation and Support	Housing and Health Development activity	Housing Related Schemes			Social Care		CCG			Local Authority	Minimum NHS Contribution	£60,000	New
38	Accommodation and Support	Independent living accommodation and support to facilitate	Housing Related Schemes			Social Care		LA			Private Sector	Additional LA Contribution	£840,000	Existing
39	Home from Hospital	Support, befriending, food parcels and handy man	Community Based Schemes	Low level support for simple hospital discharges		Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£290,000	Existing
40	Autisim and LD Transformation Partner	Transformation and planning for future LD provision	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	Additional LA Contribution	£160,000	New
41	Packages of Care - Home	Home care packages	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum NHS Contribution	£5,837,348	Existing
42	Packages of Care - Home	Home care packages	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£13,436,081	Existing

Further guidance for completing Expe

National Conditions 2 & 3

Schemes tagged with the following will count towards th

- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribu

Schemes tagged with the below will count towards the p

- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, o
- **Source of funding** selected as 'Minimum NHS Contribu

2022-23 Revised Scheme types

Number	Scheme type/ services
1	Assistive Technologies and Equipment
2	Care Act Implementation Related Duties
3	Carers Services
4	Community Based Schemes

5	DFG Related Schemes
6	Enablers for Integration
7	High Impact Change Model for Managing Transfer of Care
8	Home Care or Domiciliary Care
9	Housing Related Schemes

10	Integrated Care Planning and Navigation
11	Bed based intermediate Care Services
12	Reablement in a persons own home
13	Personalised Budgeting and Commissioning
14	Personalised Care at Home

15	Prevention / Early Intervention
16	Residential Placements
18	Other

nditure sheet

he planned **Adult Social Care services spend** from the NHS min:

ution'

planned **Out of Hospital spend** from the NHS min:

nly the NHS % will contribute)
ution'

Sub type
1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other
1. Carer advice and support 2. Independent Mental Health Advocacy 3. Safeguarding 4. Other
1. Respite Services 2. Other
1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other

1. Adaptations, including statutory DFG grants
2. Discretionary use of DFG - including small adaptations
3. Handyperson services
4. Other

1. Data Integration
2. System IT Interoperability
3. Programme management
4. Research and evaluation
5. Workforce development
6. Community asset mapping
7. New governance arrangements
8. Voluntary Sector Business Development
9. Employment services
10. Joint commissioning infrastructure
11. Integrated models of provision
12. Other

1. Early Discharge Planning
2. Monitoring and responding to system demand and capacity
3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge
4. Home First/Discharge to Assess - process support/core costs
5. Flexible working patterns (including 7 day working)
6. Trusted Assessment
7. Engagement and Choice
8. Improved discharge to Care Homes
9. Housing and related services
10. Red Bag scheme
11. Other

1. Domiciliary care packages
2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)
3. Domiciliary care workforce development
4. Other

1. Care navigation and planning
2. Assessment teams/joint assessment
3. Support for implementation of anticipatory care
4. Other

1. Step down (discharge to assess pathway-2)
2. Step up
3. Rapid/Crisis Response
4. Other

1. Preventing admissions to acute setting
2. Reablement to support discharge -step down (Discharge to Assess pathway 1)
3. Rapid/Crisis Response - step up (2 hr response)
4. Reablement service accepting community and discharge referrals
5. Other

1. Mental health /wellbeing
2. Physical health/wellbeing
3. Other

1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other
1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other

Description
Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'

The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
Provides support in your own home to improve your confidence and ability to live as independently as possible
Various person centred approaches to commissioning and budgeting, including direct payments.
Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of ‘home ward’ for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.

Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: Birmingham

8.1 Avoidable admissions

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population	Indicator value	340.3	302.9	336.5	309.4	The plan of 1,155 for 22/23 is based on a straight line projection of the past 8 years' (excluding 20/21 - COVID) quarterly and annual out-turn, profiled according to recent quarterly out-turn. A small reduction in the population (denominator)	Maximise alternative pathways to the Emegency Department to ensure people receive the right care at the right time, first time. This includes maximising and delivering the Urgent Community Response, Same Day Emergency Care,
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
(See Guidance)	Indicator value	289	261	316	289		
	Denominator	1,139,202	1,139,202	1,139,202	1,139,202		

>> link to NHS Digital webpage (for more detailed guidance)

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Quarter (%)	94.1%	94.5%	94.3%	93.9%	The plan of **94.0%** for 22/23 is based on a straight line projection of the past 3 years' monthly outturn, profiled according to recent quarterly out-turn. The pandemic caused a downturn in the proportion being discharged to their usual place of residence, but this has now recovered to pre-pandemic levels, and we forecast will stay fairly level going forward	There continues to be a significant amount of work through the delivery of the Early Intervention programme which promotes the home first principle.
	Numerator	24,496	24,528	23,579	22,644		
	Denominator	26,024	25,966	24,995	24,109		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
(SUS data - available on the Better Care Exchange)	Quarter (%)	94.2%	94.5%	94.4%	94.0%		
	Numerator	23,960	23,979	23,055	22,144		
	Denominator	25,445	25,375	24,430	23,569		

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	399.6	468.5	482.3	463.8	As highlighted last year Birmingham took the opportunity to re-baseline the figure on this metric to include all admissions. Therefore, the ambition is higher than previous years but keeps focus on the home first principle.	The vision for Adult Social Care keeps focus on the home first principle, ensuring citizens are able to remain home for as long as possible. The provision through the Early Intervention programme provides robust multi-disciplinary team
	Numerator	597	710	731	710		
	Denominator	149,412	151,561	151,561	153,092		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	48.8%	61.1%	80.5%	80.0%	The plan is as a result of the work around the Early Intervention Programme and the focus on keeping people at home.	Previously we have manually scoured through case notes and system observations to try and identify where people were on the 91st day (assuming they were not marked deceased or in BCC commissioned services). While we had
	Numerator	291	1,100	1,392	1,440		
	Denominator	596	1,800	1,730	1,800		

Please note that due to the demerging of Northamptonshire, information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

Better Care Fund 2022-23 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Birmingham

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between ICB(s) and LA; been submitted? Has the HWB approved the plan/delegated approval? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	Narrative Plan (Governance page 3, DFG page 17)		
	PR2	**A clear narrative for the integration of health and social care**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally • The approach to collaborative commissioning • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these. The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.	Narrative plan	Yes	Narrative Plan (Integration pages 5-6, equality and health inequalities pages 18-20)		
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	Staying Independent at Home Policy Narrative Plan (page 17)		
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution?**	Does the total spend from the NHS minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Implementing the BCF policy objectives	**PR6**	**Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?**	Does the plan include an agreed approach for meeting the two BCF policy objectives: - Enable people to stay well, safe and independent at home for longer and - Provide the right care in the right place at the right time? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? •Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided? • Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care? • Does the plan include actions going forward to improve performance against the HICM?	Narrative plan Expenditure tab C&D template and narrative Narrative plan Narrative template	Yes	Narrative Plan (pages 13-15)		

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 31 – 43 of Planning Requirements) (tick-box) • Has the area included a description of how BCF funding is being used to support unpaid carers? • Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plan Narrative plans, expenditure tab and confirmation sheet	Yes	Narrative Plan (page 16)		
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching ambitions been agreed locally for all BCF metrics? • Is there a clear narrative for each metric setting out: - the rationale for the ambition set, and - the local plan to meet this ambition?	Metrics tab	Yes			

Better Care Fund 2022-23 Capacity & Demand Template

1.0 Guidance

Overview

The Better Care Fund (BCF) requirements for capacity and demand plans are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme. The programme is jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

Appendix 4 of the Planning Requirements sets out guidance on how to develop Capacity and Demand Plans,

This template has been designed to collect information on expected capacity and demand for intermediate care. These plans should be agreed between Local Authority and Integrated Care Board partners and signed

The template is split into three main sections.

Demand - used to enter the expected demand for short term, intermediate care services in the local authority (HWB) area from all referral sources from October 2022-March 2023. There are two worksheets to
- Sheet 3.1 Hospital discharge - expected numbers of discharge requiring support, by Trust.
- Sheet 3.2 Community referrals (e.g. from Single points of Access, social work teams etc)

Intermediate care capacity - this is also split into two sheets (4.1 Capacity - Discharge and 4.2 Capacity - community). You should enter expected monthly capacity available for intermediate care services to support discharge and referrals from community sources. This is recorded based on service type.
Data for capacity and demand should be provided on a month by month basis for the third and fourth

Spend data - this worksheet collects estimated spend across the local authority area on intermediate care for the whole year ie 2022-23. This should include all expenditure (NHS and LA funded) on intermediate care services as defined in appendix 4 of the BCF Planning Requirements.

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

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

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

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, cont
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green

england.bettercarefundteam@nhs.net

(please also each copy in your respective Better Care Manager)
If you have any queries on the template then please direct these to the above email inbox or reach out via

3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway (as set out in the Hospital Discharge Guidance avalable on Gov.uk)
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-
We suggest that you enter data for individual trusts where they represent 10% or more of expected discharges in the area. Where a Trust represents only a small number of discharges (less than 10%), we recommend that you amalgamate the demand from these sources under the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and
Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from acute hospital.
You should input the expected available capacity to support discharge across these different service types:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step up or step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest level of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with

4.2 Capacity - community

This sheet collects expected capacity for intermediate care services where a person has been referred from a community source. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- VCS services to support someone to remain at home
- Urgent Community Response (2 hr response)

- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:

- Overall spend on intermediate care services - using the definitions in the planning requirements (BCF and non-BCF) for the whole of 2022-23
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

:acts a

-disch

Better Care Fund 2022-23 Capacity & Demand Template

2.0 Cover

Version 1.0

Health and Wellbeing Board:	Birmingham
Completed by:	Alan Butler
E-mail:	alan.butler3@nhs.net
Contact number:	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	
If no, please indicate when the report is expected to be signed off:	

Please indicate who is signing off the report for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	
Name:	

How could this template be improved?	

Question Completion - Once all information has been entered please send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

[<< Link to the Guidance sheet]

[^^ Link back to top]

Better Care Fu

3.1 Demand - Hospital Discharge

Selected Health and Wellbeing Board:

3. Demand
This section requires the Health & Wellbeing Board to re
Data can be entered for individual hospital trusts that ca
each trust by Pathway for each month. The template use
https://www.gov.uk/government/publications/hospital-
If there are any 'fringe' trusts taking less than say 10% of
The table at the top of the screen will display total expec
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB le
- Data from the NHSE Discharge Pathways Model.

Any assumptions made:

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)
(Please select Trust/s……)
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATIO
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TR
(Please select Trust/s……)
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATIO
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TR
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SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TR
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UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TR

nd 2022-23 Capacity & Demand Template

Birmingham

cord expected monthly demand for supported discharge by discharge pathway.
re for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You w
s the pathways set out in the Hospital Discharge and community support guidance -
discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance
patient flow then please consider using the '**Other**' Trust option.
ted demand for the area by discharge pathway and by month.

vel from NHS plans for 2022-23

Totals Summary (autopopulated)	Oct-22
0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)	25547
1: Reablement in a persons own home to support discharge (D2A Pathway 1)	610
2: Step down beds (D2A pathway 2)	291
3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)	39

Data in this sheet is derived from the BSOL ICS Operational Planning 2022/2023 submission. Data has been disaggregated from the planning return based on Birmingham LA activity and over 18's. SWB represents as small amount of activity and has been forecast based on actual 21-22 activity.

Demand - Discharge	
Pathway	Oct-22
0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)	
	21592
	3115
1: Reablement in a persons own home to support discharge (D2A Pathway 1)	
	545
	65
2: Step down beds (D2A pathway 2)	

	259
	32
3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)	
	36
	3

ill then be able to enter the number of expected discharges from

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
25832	25026	25347	23703	24738
610	610	610	610	610
291	291	291	291	291
39	39	39	39	39

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
21877	21071	21392	19748	20783
3115	3115	3115	3115	3115
545	545	545	545	545
65	65	65	65	65

259	259	259	259	259
32	32	32	32	32
36	36	36	36	36
3	3	3	3	3

Better Care Fund 2022-23 Capacity & Dema

3.0 Demand - Community

Selected Health and Wellbeing Board: Birmingham

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from commur
The template does not collect referrals by source, and you should input an overall estir
discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. Tl
purposes of this exercise.

Any assumptions made:	UCR demand re return. Reablement or The focus for 'st wards, and path

Demand - Intermediate Care

Service Type	Oct-22
Voluntary or Community Sector Services	5
Urgent community response	356
Reablement/support someone to remain at home	361
Bed based intermediate care (Step up)	7

nd Template

ıity sources, such as multi-disciplinary teams, single points of access or 111.
nate each month for the number of people requiring intermediate care (non-

his includes the NICE Guidance definition of 'intermediate care' as used for the

flects the trajectory already submitted to NHSE/I in the Operational Planning

rehab in a persons own home line - consists of the EICT service.
tep up' activity is in maximising the opportunity afforded by UCR, virtual
ıway 1 to support patients to remain at home.

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
5	5	5	5	5
356	356	373	374	374
389	464	510	463	579
6	3	3	5	4

Better Care Fund 2022-23 Capacity & Demand

4.0 Capacity - Discharge

Selected Health and Wellbeing Board:	Birmingham

4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from discharge across these different service types:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this wil service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or av

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a pe own home. For services in a person's own home then this would need to take into accoun

Any assumptions made:	Expected capacity has been aligned to exp VCS activity is the Home From Hospital Se Patients are not directly discharged to resi

Capacity - Hospital Discharge	
Service Area	**Metric**
VCS services to support discharge	Monthly capacity. Number of new clients.
Urgent Community Response (pathway 0)	Monthly capacity. Number of new clients.
Reablement or reabilitation in a person's own home (pathway 1)	Monthly capacity. Number of new clients.
Bed-based intermediate care (step down) (pathway 2)	Monthly capacity. Number of new clients.
Residential care that is expected to be long-term (discharge only)	Monthly capacity. Number of new clients.

Template

acute hospital. You should input the expected available capacity to support

l be (Caseload*days in month*max occupancy percentage)/average duration of

erage length of stay in a bedded facility

rcentage? This will usually apply to residential units, rather than care in a person's
t how many people, on average, that can be provided with services.

ected demand. UCR activity is in tab 4.2
rvice.
dential care.

Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
120	120	120	120	120	120
0	0	0	0	0	0
545	545	545	545	545	545
259	259	259	259	259	259
0	0	0	0	0	0

Better Care Fund 2022-23 Capacity & Demand

4.2 Capacity - Community

Selected Health and Wellbeing Board: Birmingham

4.2 Capacity - community
This sheet collects expected capacity for community services. You should input the expecte You should include expected available capacity across these service types for eligible refer services to support recovery, including Urgent Community Response and VCS support. The - Voluntary or Community Sector (VCS) services - Urgent Community Response - Reablement or rehabilitation in a person's own home - Bed-based intermediate care (step up) Please consider the below factors in determining the capacity calculation. Typically this wil service or length of stay Caseload (No. of people who can be looked after at any given time) Average stay (days) - The average length of time that a service is provided to people, or av Please consider using median or mode for LoS where there are significant outliers Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a pe own home. For services in a person's own home then this would need to take into accoun

Any assumptions made:	Expected capacity has been aligned to den

Capacity - Community	
Service Area	**Metric**
Voluntary or Community Sector Services	Monthly capacity. Number of new clients.
Urgent Community Response	Monthly capacity. Number of new clients.
Reablement or rehabilitation in a person's own home	Monthly capacity. Number of new clients.
Bed based intermediate care (step up)	Monthly capacity. Number of new clients.

Template

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template is split into 5 types of service:

l be (Caseload*days in month*max occupancy percentage)/average duration of

erage length of stay in a bedded facility

rcentage? This will usually apply to residential units, rather than care in a person's
t how many people, on average, that can be provided with services.

nand.

Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
5	5	5	5	5	5
356	356	356	373	374	374
361	389	464	510	463	579
7	6	3	3	5	4

5.0 Spend

Selected Health and Wellbeing Board:

5.0 Spend
This sheet collects top line spend figures on intermediate care which includes: - Overall spend on intermediate care services (BCF and non-BCF) for the whol - Spend on intermediate care services in the BCF (including additional contribu These figures can be estimates, and should cover spend across the Health and beyond these two categories.

Spend on Intermediate Care

	2022-23
Overall Spend (BCF & Non BCF)	£64,267,000
BCF related spend	£32,266,000
Comments if applicable	

3 Capacity & Demand Template

Birmingham

le of 2022-23
utions).
Wellbeing Board (HWB). The figures do not need to be broken down in this template

These are working estimates and subject to further validation and review across health and social care partners.

Birmingham Health and Wellbeing Board

	Agenda Item: 14
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**27th September 2022**
TITLE:	**BIRMINGHAM INTEGRATED CARE PARTNERSHIP – EARLY INTERVENTION PROGRAMME COMPLETION REPORT**
Organisation	**Birmingham Integrated Care Partnership**
Presenting Officer	**Michael Walsh/Chris Holt**

Report Type:	**Information**

1. Purpose:	
1.1	To receive a completion report outlining the delivery and impact of the Early Intervention Programme

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	To consider the attached report.

4. Report Body

Background

4.1 The Early Intervention (EI) programme was designed in response to the findings of a 2017 Care Quality Commission (CQC) review which identified a fragmented intermediate care system with poor relationships and variations between providers, inconsistent capacity, an overreliance on hospitals beds and tactical 'sticking plaster' responses to pressure only set to get worse without direct action. This was impacting negatively on patient outcomes. The conclusion was that the system was failing Birmingham's older and frail citizens.

4.2 Supported through the Better Care Fund, system partners came together to design a programme to address the identified issues relating to the experience and outcomes experienced by citizens at the interface of acute care and social care. Central to the programme was a commitment to promoting an ethos of "home first" – with the objective that we would co-ordinate our efforts to enable citizens to return to or remain in their own homes and that unnecessary and harmful delays associated with necessary or overlong stays in hospital were designed out of our processes.

4.3 The attached report provides an overview of the design of the programme – including the creation of new multi-disciplinary Early Intervention Community Teams – alongside an assessment of the impact of the programme.

4.4 Following a design and testing phase, the programme was fully rolled out in early 2020. A review of impact between the start date and March 2022 identified the following key benefits:

- 120k acute bed days saved on an annual basis as a result of more rapid discharge
- Citizens were 45% more likely to go home following a stay in a non-acute bed
- A reduction from 12 to 4 days in the time taken for complex discharges from acute hospital
- 20k+ reduction in unnecessary admissions to acute hospital
- A reduction in ongoing care needs equivalent to an average of 6.5hrs of care per week for citizens going home following an early intervention service
- 18k+ referrals to the new Early Intervention Community Teams

4.5 The programme's performance has been achieved throughout Covid-19 and against the backdrop of new Discharge to Assess guidance (D2A), issued by the government in March 2020 and updated in August 2020. Whilst these factors have to some extent skewed the original rationale of the objectives; it is clear that citizen outcomes have measurably improved from this innovative whole system approach. The decision to fully launch the programme during the pandemic was vindicated with the new ways of working significantly contributing to the system's ability to respond to the pressures of the pandemic in respect of safely and quickly moving people out of acute care.

4.6	The programme has now largely achieved the original ambitions. However, the need for improvement is ongoing in the face of increasing pressures on intermediate care. In this context Birmingham Integrated Care Partnership have taken to decision to bring this programme to an end and to now focus on a refreshed transformation programme to address new requirements including 2 hr Urgent Community Response and Virtual Wards.

5.	**Compliance Issues**
5.1	**HWBB Forum Responsibility and Board Update**
5.1.1	The Early Intervention Programme was managed via the Birmingham Integrated Care Partnership and funded through the Better Care Fund; with oversight in relation to funding provided by the BCF Commissioning Executive.

5.2	**Management Responsibility**
5.2.1	As a key programme funded by the Better Care Fund it appropriate to report on progress to the Health and Well-being Board.

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

Appendices

1. Early Intervention Completion Report.

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

- Michael Walsh – Head of Service (Birmingham City Council)

Making Birmingham

a great place to grow old in.

The Early Intervention Programme

Part of the Birmingham Integrated Care Partnership (BICP)

Project Completion Report

June 2022

EARLY INTERVENTION PARTNERS

John Taylor Hospice · Birmingham St Mary's Hospice · Marie Curie · St Giles Hospice · HoBS (Hospices of Birmingham and Solihull) · NHS · Birmingham and Solihull Mental Health NHS Foundation Trust · Sandwell and West Birmingham Clinical Commissioning Group · Birmingham and Solihull Clinical Commissioning Group · Birmingham Community Healthcare NHS Foundation Trust · University Hospitals Birmingham NHS Foundation Trust · Birmingham City Council

Birmingham and Solihull Integrated Care System
Caring about healthier lives

Birmingham City Council · NHS

Contents **Page**

1. Welcome by Graeme Betts, Chair of BICP Board 3
2. Overview by Chris Holt, SRO for Early Intervention 4
3. Background
   - 3.1 Early Intervention 5
   - 3.2 Response 6
   - 3.3 Approach 6
   - 3.4 Vision 6
   - 3.5 Strategy 7
   - 3.6 Goals 7
   - 3.7 Method 8
   - 3.8 Pilot testing 8
     - 3.8.1 OPAL – Front Door 9
     - 3.8.2 Complex Discharge Hub 9
     - 3.8.3 EICT 9
     - 3.8.4 EI Beds 9
     - 3.8.5 Mental Health 9
   - 3.9 Covid-19 9
4. Programme Structure and Resource 10
   - 4.1 Improvement Managers & PMO 10
   - 4.2 Steering Group & Governance 10
   - 4.3 Objectives 10
5. Impact 10-12
   - 5.1 Areas of Success 13
   - 5.3 Lessons Learned 13
6. The Future 14
   - 6.1 Journey of integration 14
   - 6.2 Next steps
     - 6.2.1 EICT 14
     - 6.2.2 EI Beds 15
     - 6.2.3 OPAL 15
     - 6.2.4 iHub 15
     - 6.2.5 Commissioning 16
     - 6.2.6 Infrastructure 16
     - 6.2.7 Mental Health 17
   - 6.3 Future Transformation Programme 17
7. Case Studies
   - 7.1 Mary 18
   - 7.2 Anna 18
   - 7.3 Hilda 18
   - 7.4 Mental Health and OPAL+ 19
   - 7.5 Dennis 19-20
8. Appendices - PMO
   - A Project Highlights 21-22
   - B Baseline Objectives & progress against them 23-26
   - C Lessons learnt and areas for improvement 27-28
   - D Test site details and results 29-31
   - E Key deliverables transferred to Business as usual 32

1. Welcome by Graeme Betts, Chair of BICP Board

Welcome to this report which celebrates the success of the Early Intervention (EI) programme, reports on its progress to date and outlines how future work will build on its legacy.

EI has been delivered as one of three workstreams in the Birmingham Integrated Care Partnership (BICP), the remaining two being Care Homes and Neighbourhood Integration (NI). In many respects, EI has been our flagship programme and was our first integrated programme of work in Birmingham.

EI is remarkable in so many ways. It has transformed how partners work together to put the person at the centre, promoting "home first" as the default outcome for citizens who experience, or who are at risk of, the need for acute care.

I would like to acknowledge the effort, determination and commitment of our 1000+ colleagues who took those first steps in not only introducing a new way of working across the city's health and social care teams, but doing so during a global pandemic, the path, duration and outcome of which was unknown to global health leaders, let alone us here in Birmingham.

On behalf of the BICP Board, I would also like to pay tribute to colleagues in the wider health and social care system who are not directly involved in EI, but who have also stepped up to the plate to support those who are.

Perhaps the most notable aspect of EI has been the creation of the new Early Intervention Community Teams which are playing the pivotal part of enabling people to live more independently, reduce the length of stay in hospital and deliver financial benefits for the system.

The BICP collaboration demonstrates that transformational change can be delivered when we all collaborate and commit to a shared purpose.

I would like to take this opportunity to thank each and every one of my colleagues for their ongoing collaboration and commitment, and their perseverance in helping to deliver the right care at the right time in the right place.

BICP and all who work within our programme have achieved some amazing results: simply outstanding given the backdrop and demand on our services. I sincerely look forward to the next stage in our journey.

EI VISION

'For older people to be as happy and healthy as possible, living self-sufficient, independent lives, able to have choice and control over what they do and what happens to them."

Professor Graeme Betts

2. Overview by Chris Holt, SRO for Early Intervention

Chris Holt

Can I begin by saying what a privilege it has been to work on this programme with so many fantastic colleagues across our health and social care services, and for part of the journey at least, to help provide some leadership.

Overall, our EI and our collective determination to create a Home First care approach to ensure that people remain as independent as possible in their own home, for as long as possible, has delivered some fantastic results. Not least that our achievements, measured against our performance before the programme started, took place in the midst of an unprecedented global pandemic.

EI has helped put Birmingham on the health and social care map, evidenced by the fact that the programme is showcased by NHS England as a best practice model in delivering Home First integrated health and social care across Birmingham; the programme has also been shortlisted for four national awards for the same reason.

This has also been a collaborative effort not really seen before across Birmingham's health and care system. As a city, we have successfully taken multiple, separate teams and services and brought them together to deliver a coherent service model to the benefit of the 1.3m+ citizens we serve.

We have also learnt many lessons. We know that it is essential that each partner organisation needed to commit to deliver the shared vision and maintain that conviction throughout. Our colleagues embraced the opportunity to work outside their traditional organisational boundaries to the benefit of Birmingham's citizens but needed this regular endorsement that it is okay to do that.

We have learnt that it is important to make decisions based on data and evidence and not anecdotal information, involve front line staff in redesign and decision making and embed this into operational management frameworks and standard operating procedures.

And possibly most importantly, we have also learnt that equipped with the right tools, our front-line colleagues are highly effective in continuing to improve the way we work to meet our goals and delver enhanced care to our service users. We provided a structured approach to help them do this with the support of our dedicated improvement team. The delivery of the Early Intervention is a success, and the model is now firmly embedded across our services and considered ***business as usual***.

Our EI efforts have always been about intervening early to enhance the independence of citizens whilst adopting a Home First ethos in all that we do. This will not change. Early Intervention has delivered as a programme and this approach is here to stay. I look forward to working with you all in the next chapter of Birmingham's Home First journey.

Chris Holt
Senior Responsible Officer for Early Intervention
Chief Operating Officer for Birmingham Community Healthcare Community Foundation Trust

3. Background

In October 2018, more than 1000 staff from health and social care partner organisations across Birmingham joined forces for the first time in the city's history, to deliver EI programme.

This was one of the largest integrated programmes of work in Birmingham, and was supported by an external partner, Newton Europe.

EI marks a new integrated approach for Birmingham – targeting the interface between health and social care, particularly at the point of crisis. It aims to support people, who have experienced an illness or injury, to avoid hospital admission, prevent premature admission to long term residential care, recover faster and live healthier and more independent lives, ideally at home. It is driven by a fresh approach to data-led decision-making, front-line staff design, personalised care, testing and iterating programme changes.

The purpose of this project completion report is to assess the project's impact, ensure completion, and derive lessons learned and best practices to be applied to future projects.

3.1 Development of Early Intervention

The EI programme was designed in response to the findings of a 2017 Care Quality Commission (CQC) review which identified a fragmented intermediate care system with poor relationships and variations between providers, inconsistent capacity, an overreliance on hospitals beds and tactical 'sticking plaster' responses to pressure only set to get worse without direct action. This was impacting negatively on patient outcomes. The conclusion was that the system was failing Birmingham's older and frail citizens.

Birmingham City Council also held citizen forums to gain further feedback and a number of 'I' statements were agreed at these sessions (Figure 2) which have been used to structure the BICP programmes.

Figure 2 – The 'I' statements

'I' Statements

"I want to tell my story only once"

"I only want to be assessed once if possible"

"I want to be in control and plan my care together with professional people who understand my culture and are non- judgmental"

"If I'm receiving my support at home I want as few strangers as possible entering my home"

"I want help, not barriers put in place for me to get the support I need"

"I don't want to go into hospital unless I need to"

3.2 Response

In response the Birmingham and Solihull Sustainability and Transformation Partnership (STP) and Birmingham City Council's Health and Wellbeing Board set the independence of older people as a top priority for Birmingham

The two organisations established the Birmingham Older People's Programme (now known as the Birmingham Integrated Care Partnership (BICP) in October 2018 to deliver three key areas of work to meet the city's goals: Early Intervention, Neighbourhood Integration and Care Homes. ***Early Intervention would be the first of the three to be launched across five localities (Figure 3)and be the flagship of the BICP strategy.***

BICP partners are Birmingham City Council, Birmingham Community Healthcare NHS Foundation Trust, University Hospitals Birmingham, Birmingham & Solihull Mental Health Foundation Trust, Birmingham and Solihull CCG and Sandwell and West Birmingham CCG, Sandwell and West Birmingham NHS Trust, Birmingham Voluntary Services Council and Healthwatch Birmingham.

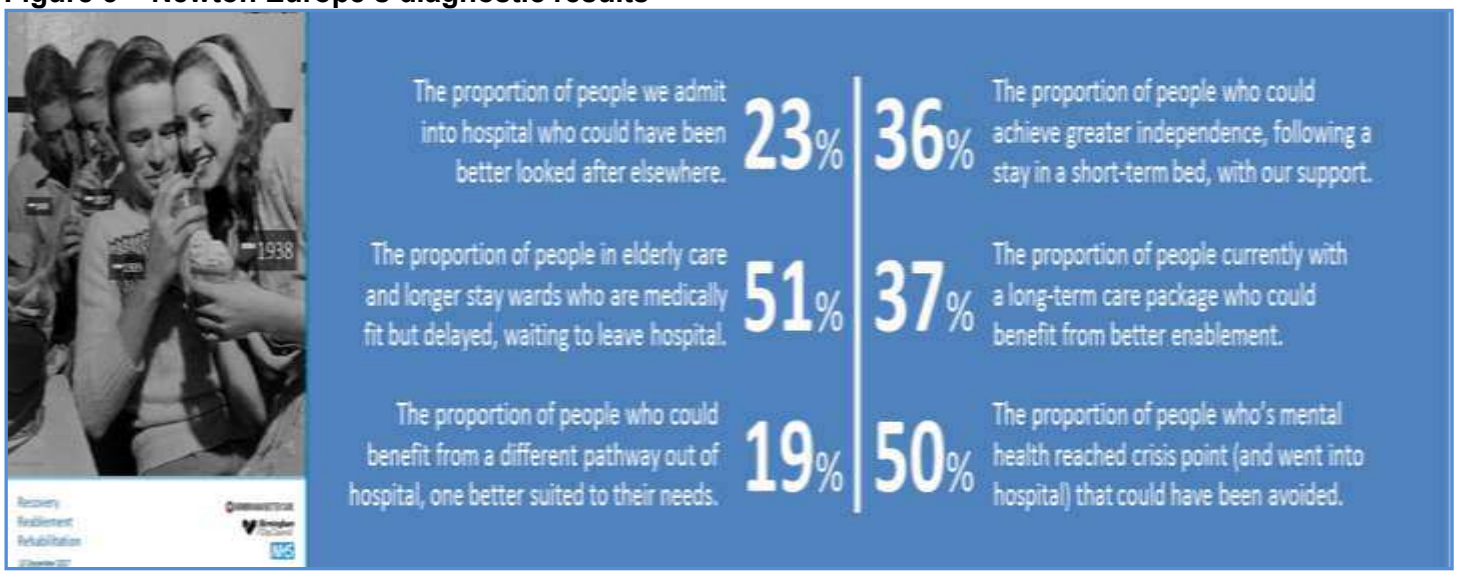
3.3 Approach

BICP identified it needed specialist external capacity and capability to support the city to deliver a common evidence-based approach to change with three criteria for success:

- Have we delivered intended outcomes?
- Have we made required savings?
- Have we created a solid platform for the next phase?

Newton Europe was appointed to support this work following a competitive tender process. The Newton team undertook a diagnostic of the city's recovery, reablement and rehabilitation (early intervention) system in November and December 2017. The diagnostic findings are highlighted in Figure 3.

Figure 3 – Newton Europe's diagnostic results



Combined, these reviews and insights into Birmingham's system highlighted fragmented services, inconsistent capacity, an overreliance on hospital beds, tactical 'sticking plaster' responses to pressures and an increasingly difficult financial situation only set to get worse without direct action.

3.4 Vision

In a first for Birmingham, its health and care system set out to solve the issues together. Using the Birmingham Older People's Programme, it began with a vision "***for older people to be as happy and healthy as possible, living self—sufficient, independent lives, able to have choice and control over what they do and what happens to them."***

3.5 Strategy

Behind the vision were three strategic areas: prevention, early intervention and personalised ongoing support. All of these centred around people receiving services.

The EI programme was tasked with creating an integrated approach to urgent and intermediate care services that it person and care centred and encompasses physical, mental health and social care needs that support older people, before, during and following a crisis. This is defined as:

- Recovery, ensuring people recover from illness or injury as quickly as possible.
- Rehabilitation – preventing unnecessary hospital admission and premature admission to long-term residential care
- Reablement – supporting timely discharge from hospital, maximising independent living.

Ultimately this programme was going to be about achieving consistent, safe, high-quality services and outcomes for older people across the city. This would ensure that thousands more citizens emerge from a health or social crisis as independent from care as possible – and ideally in their own home. And at the same time, delivering financial benefits for the system.

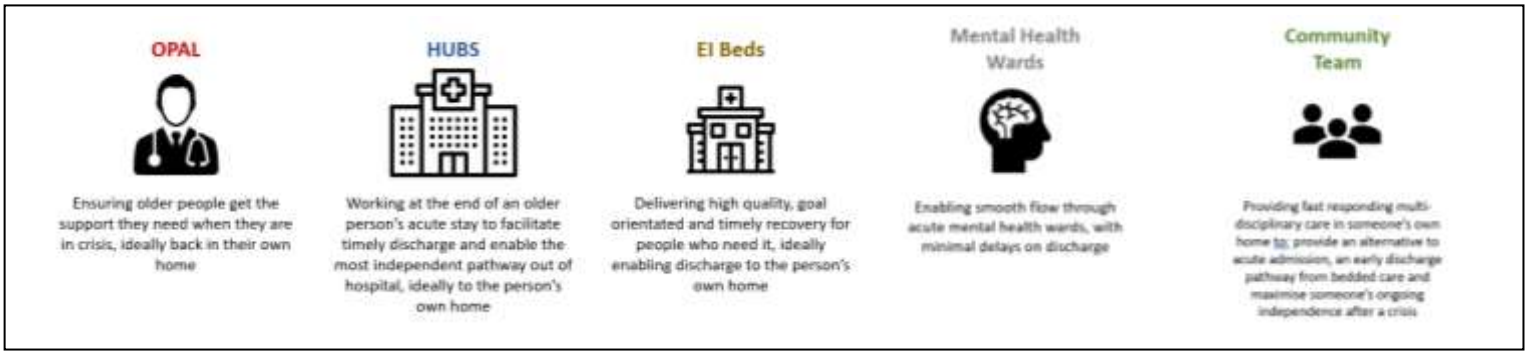
3.6 Goals

Newton's assessment (Figure 3) identified some significant opportunities which became the Early Intervention programme's broad goals:

- Improving support for people in their own home would result in 6,000 people living more independently
- Reducing avoidable acute hospital admissions whilst helping get people out of hospital more quickly would result in 40,000 fewer beds spend in acute beds per year.
- Reducing avoidable admissions to intermediate care beds would result in 20,000 more days spent at home living independently
- Annual financial benefit for the system of between £27m and £37m as a result of improving outcomes for people.

The process also identified the five "component" parts of our EI model that provided the basis for the programme (**Figure 4**).

Figure 4 – Early Intervention programme components.



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3.7 Method

To achieve this, teams from across the system worked with Newton Europe to help co-design new ways of working and established an evidence-based frontline-led plan to help realise the city's vision. This involved interviews with hundreds of frontline staff. 28 practitioners from all partners then spent time developing a set of recommendations about what needed to change and where these changes needed to happen. This was the first-time teams from across the system had come together in this way and so breaking down cultural and organisational barriers, myth busting and building trust formed an important part of these sessions.

They came up with a guiding set of principles:

To have one integrated model across our entire system

- The person must be at the centre of everything we do (with family and carer input also valued).
- Our aim is to support an older person's life not simply deliver a service.
- We need to make sure each person receives the right care, at the right time, in the right place, by the right professional, at the right cost.
- People should have to tell their story as few times as possible.
- Staff across organisations work together (co-locating where appropriate) to champion 'home first'.

Working this way would mean:

- Organisational boundaries should not have a detrimental impact on an older person's care.
- No wrong door for someone that needs help.
- Clearly defined roles to maximise skills and capacity.
- Efficient distribution of resources within a locality.
- Overall consistency accepting local variation where it makes sense.

3.8 Pilot Testing

The decision was taken to trial new ways of working before implementing them on a wider scale. The 28 strong team of practitioners helped to identify five sites in the south of the city, where testing the new model through design and iteration of the component parts (3.3) would take place. This meant setting up multidisciplinary teams of practitioners from all partners and a wide variety of disciplines including therapy, nursing, medicine and social work.

Eight newly trained 'Improvement Managers' were also recruited from across the partners to work with Newton to support the programme and to help establish the whole-system approach. The approach of the Improvement Team adopted four fundamental underlying principles:

- The identification of need for change is data driven
- The change is co-designed with front line staff
- The change will be delivered through the following approach – changes to process designed, tools designed to help process change and identifying impact, people coached to use tools
- The latter is delivered through a series of improvement cycles

To provide the necessary senior and corporate support, appropriate forums were also put in place with senior representation from all partners, operational and financial sponsors at director level, finance mangers, informatics and data teams, estates and services and primary care engagement through three representative GP's.

Finally, direct links were created with Healthwatch, the independent body focussed on incorporating citizen insight, experience and involvement into health and social services.

Full details of the test sites and the results are outlined in Appendix D**.** They included the following areas:

3.8.1 Hospital front door (OPAL) – Queen Elizabeth Hospital

The OPAL team provides a timely, multidisciplinary, patient-centred, comprehensive assessment to those who have an urgent need. The team provides patients with early access to expert advice, regardless of whether they are referred by a GP, community services or arrive at the front door.

3.8.2 Hospital back door (COMPLEX DISCHARGE HUB) – Queen Elizabeth Hospital

The Complex Discharge Hub at the QE assesses and sources support for people that require further care after a stay in an acute hospital bed. The team provides health and social work expertise as well as liaises with therapy teams in order to provide timely discharge into the most appropriate care.

3.8.3 EARLY INTERVENTION COMMUNITY TEAM - Norman Power Centre, Birmingham

A new service providing urgent assessment, treatment and care for people in their own home or usual surroundings was introduced and tested. The team delivered a range of integrated services provided by multiple professionals who promoted recovery and independence.

3.8.4 Test site 4: Early Intervention beds – Norman Power Centre, Birmingham

EI Beds provide an inpatient rehabilitation and recovery service for older adults who no longer need the acute medical care of a hospital, but are not yet ready to return home

3.8.5 Acute Mental Health – Juniper Centre and Reservoir Court, Moseley

The Juniper Centre and Reservoir Court provide inpatient services for older adults with a functional or organic acute mental health issue. This includes comprehensive assessment by a multidisciplinary team, diagnosis and treatment, responding to a wide range of needs of the service user in a person-centred approach.

3.9 Covid 19

Following the completion of the test phase in the South of the city; EI was rolled out citywide in March 2020 as the pressure on Birmingham's health and social care system intensified due to Covid-19. The success of the test phase demonstrated that embedding the approach citywide would be critical to Birmingham's response to the pandemic, in particular, the creation of new EICT teams for all parts of the city would be essential in order to respond to the need to rapidly and safely return people to their homes following a stay in hospital. However, there was a need to do some redesign work (**Figure 5**) to respond to the new nationally mandated hospital discharge requirements - *COVID-19 Hospital Discharge Service Requirements (March 2020)*. This created a resilient and sustainable Early Intervention programme and put its services in a positive place to respond.

Additional information on the impact of Covid-19 on Early Intervention is outlined in 4.2.

Figure 5 - Changes made within each Early Intervention component in response to Covid-19.

Changes made within EI components to meet national discharge to assess guidelines 2020
OPAL
The service created "OPAL+" – a functionality for ambulance teams to call in for advice from OPAL remotely, before making the decision to convey, which operates out of the QE.
EICT
The service was a focal point for redeployment of over 150 practitioners from across the system in order to provide the capacity needed. This enabled the service to: • utilise Advanced Clinical Practitioners to enhance the clinical oversight of patients within EICT • utilise additional therapists to provide a 7-day therapy service
iHub
The iHub was created to act as a focal point for referrals to EI Beds and manage flow and discharge through these beds too. This was done by co-locating BCHC's bed management and BCC's EAB management team at Moseley Hall Hospital. The remit of the iHub is being widened to become a single point of access for Discharge to Assess in Birmingham.
EI Beds (P2)
The changes to EI Beds, over and above those introduced by the iHub work and the cessation of certain assessment frameworks, mainly centred around taking steps towards making the staff at all sites more uniform so that there is greater flexibility in the demand that each site can receive.

4. Programme structure & resource

4.1 Improvement Managers and PMO support

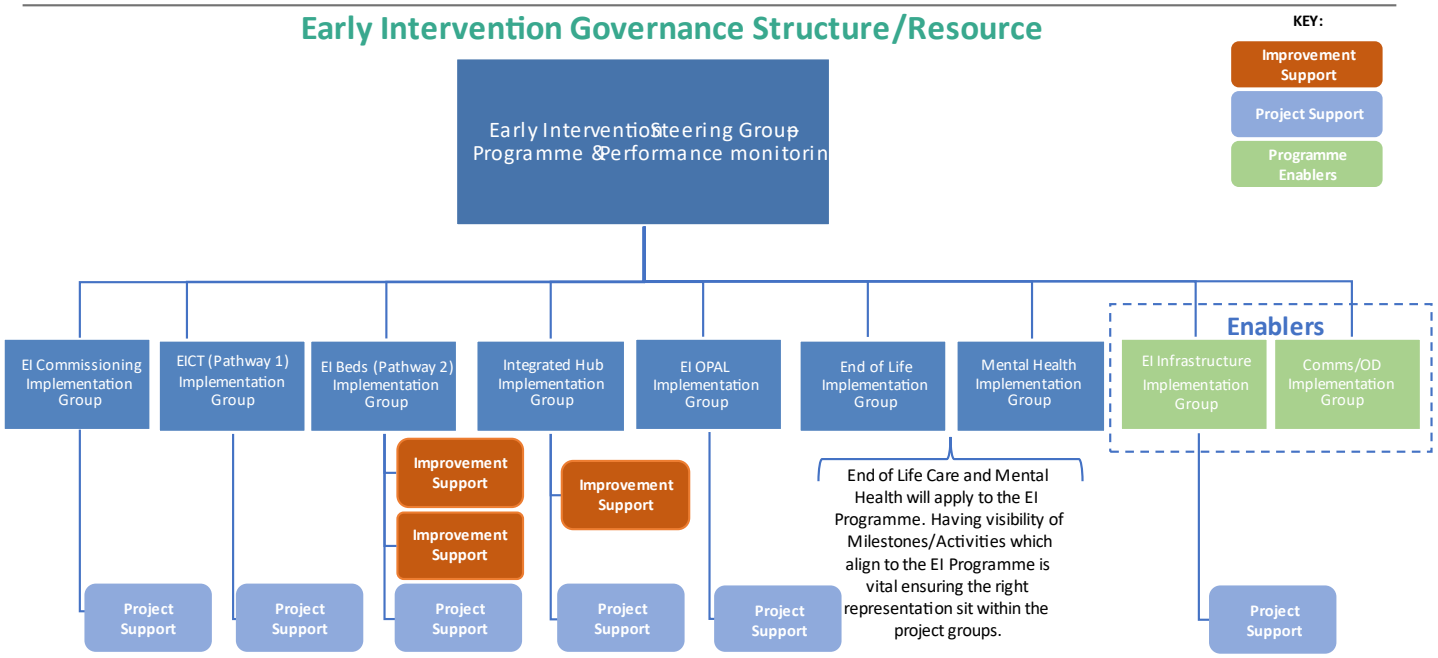
The system commissioned an improvement approach, capacity and expertise from Newton Europe. The approach also included recruiting and developing staff from within the system to lead the change. They were known as the Improvement Managers. Alongside this, project management support was also sourced which allowed for overseeing the programme and component level for delivery and reporting.

4.2 Steering Group & Governance

A weekly EI steering group under-pinned the programme structure (**Figure 6**) and discussed the progress of deliverables outlined in the brief for each project as well as the operational performance of the EI components. For the duration of the project, all risks and issues were reported to the Early Intervention Steering Group and escalated as appropriate. All issues and risks are now being reported via business as usual (BAU) meetings.

The progress of the programme was regularly reported to the Birmingham Integrated Care Partnership (BICP) Board where high-level risks are reported.

Figure 6 – Resource and governance aligned to the EI project programme



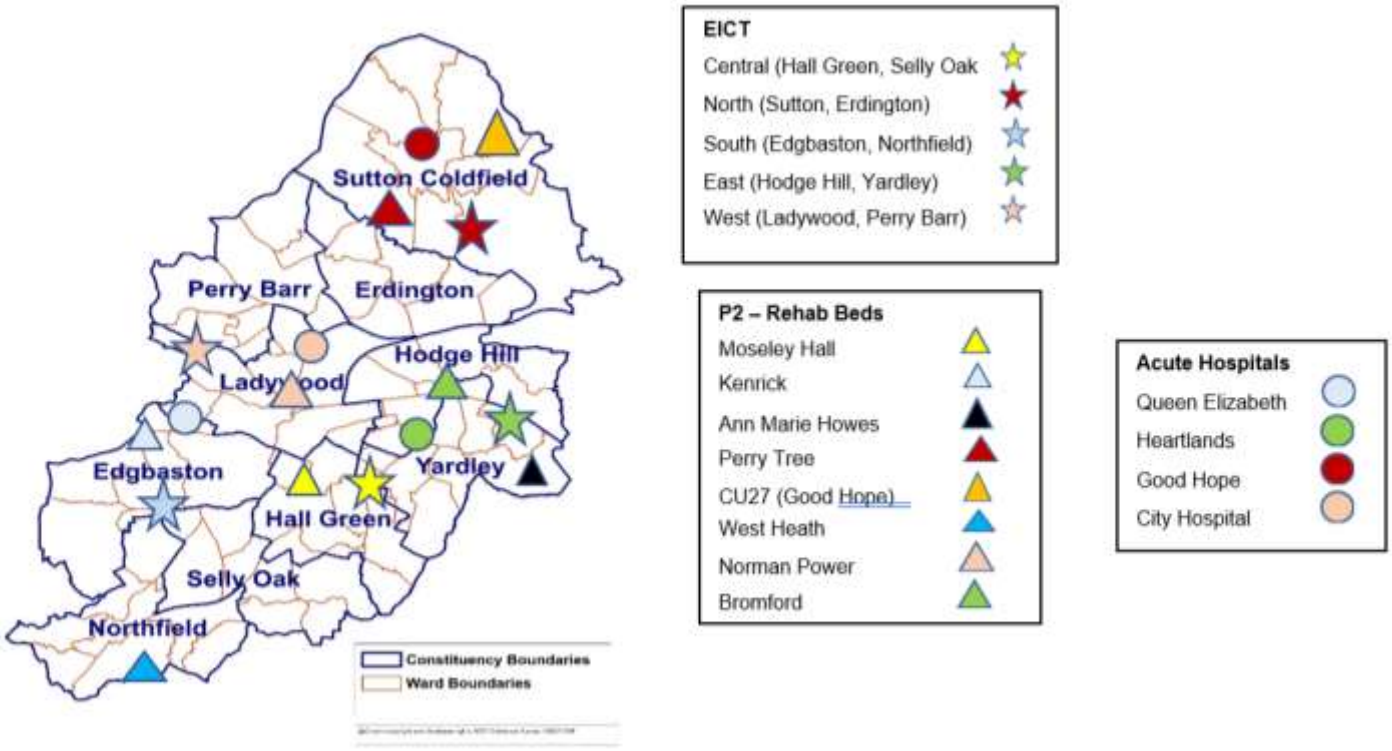
4.3 Baseline objectives for each EI component

Key baseline objectives were agreed for each component, signed off by all key stakeholders and used to measure progress as the EI developed. **Appendix A** outlines all the key baseline objectives outlined in the project plan.

5. Impact

By October 2020, all EI components were fully launched across Birmingham (**Figure 7)** and real time data was being gathered to enable all decisions to be made on clear data and evidence.

Figure 7 – the current spread of Early Intervention across the city



The data, summarised in **Figure 8,** shows that since the Early Intervention (EI) model was rolled out in early 2020. **Appendix B** outlines the key milestones that the project has achieved to date.

Figure 8 – EI programme results

Results overview March 2020-March 2022

120,000+
acute bed **days saved** annually

20,000+
unnecessary admissions avoided

45% more **likely to go home** when leaving non-acute beds than before EI started

6.5 hours/ week
Ongoing **care needs reduced** on average

12 to 4 days
Reduction in average time to be **discharged** from acute hospital

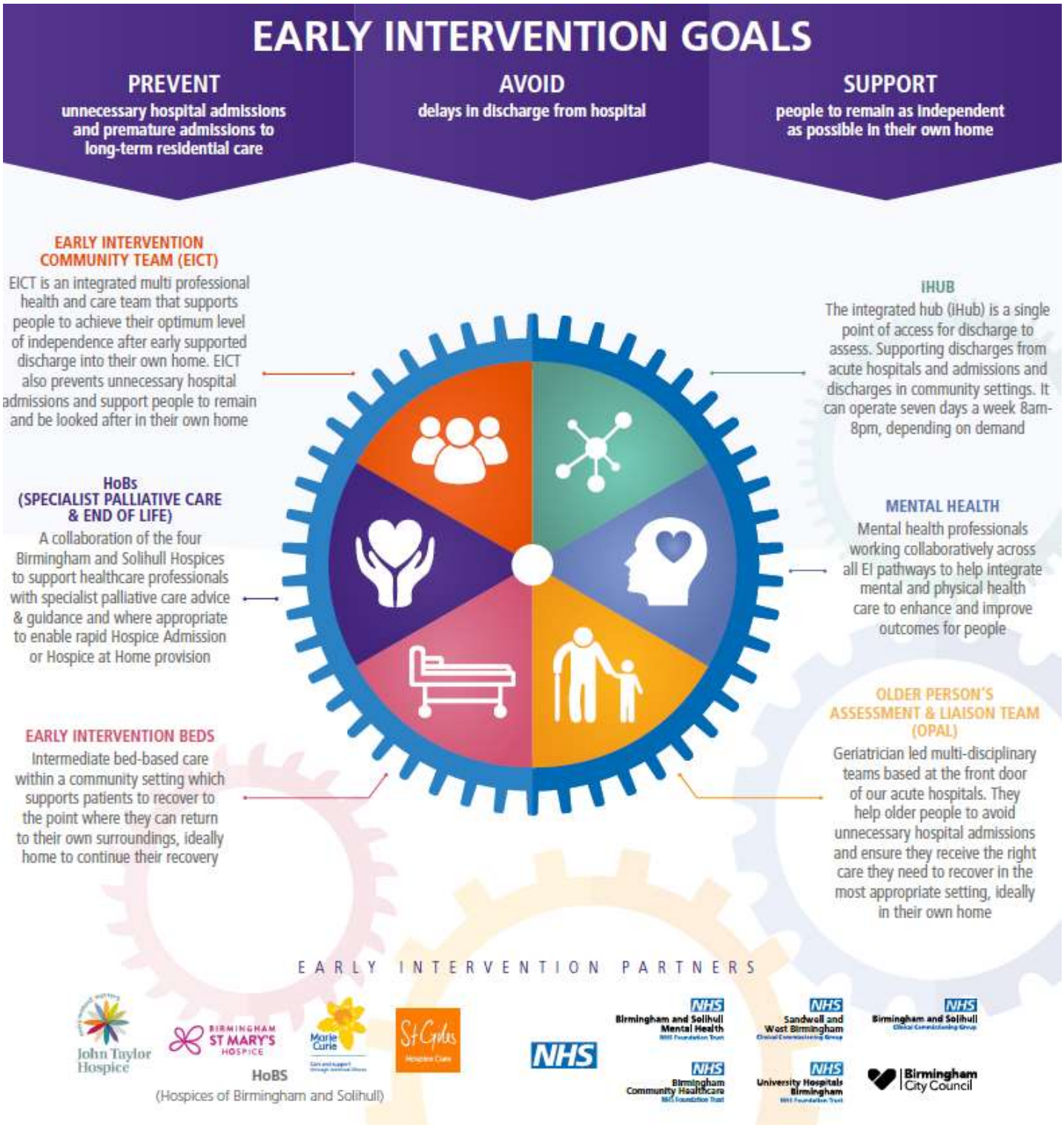
18,000+ referrals into **new EICT** service

There has been a financial benefit equivalent to £26.7m to Birmingham's health and social care system. This has enabled the programme to do more with the resources that it has available to it.

The programme's performance has been achieved throughout Covid-19 and against the backdrop of new Discharge to Assess guidance (D2A), issued by the government in March 2020 and updated in August 2020. These factors have skewed the original rationale of the objectives. What is clear is that citizen outcomes have measurably improved from this innovative whole system approach.

Each component has continued to test and develop new ways of working to evolve its approach. The current Early Intervention model is shown in **Figure 8**.

Figure 8 – EI across Birmingham



5.1 Key Areas of Success

Innovative Collaboration: 1000+ staff from seven health and social care organisations spanning five localities across Birmingham joined forces for the first time in the city's history to launch the EI programme. There is clear evidence of comradery across Birmingham and historical barriers between organisations were quickly addressed.

Data Led: Decisions were made on data &evidence, not anecdote and front-line staff were involved in redesign and decision making. Tools were developed to support staff to make the right decisions and focus on operational management framework and sustainability of standard operating procedures was maintained throughout.

Impact on citizen outcomes: The EI programme rolled out in March 2020. In response to Covid-19 its model was quickly adapted, creating a resilient and sustainable service that has helped to prevent more than 20,000 unnecessary hospital admission and reduced ongoing care hours by 6.5/week. There was huge support across all EI partner organisations in redeploying staff during Covid.

Continuous Improvement: A continuous improvement cycle was introduced and maintained.

Adaptability of the EI model: EI is an integrated care system already in action. Its process has been mapped out to enable others to adapt their services and embed the same approach to help improve system, staff, patient and citizen outcomes with their own organisations.

5.2 Lessons learned for future programmes

In a complex system like Birmingham, whole-system, integrated working is a long-term commitment. Key lessons are outlined below. **Appendix C** outlines further details of what has worked well and which areas require improvement.

- Jointly agree a vision and purpose for the programme at the start and ensure regular and consistent communication of the key messages to all staff and stakeholders throughout the programme.
- Have a greater focus on culture change and multi-disciplinary working as part of one team; consider integrated management structures as an enabler and invest in OD to support/reinforce/embed this change
- Properly resource additional improvement capacity to support operational teams to deliver transformation.
- Have a dedicated finance lead from the system to maintain oversight of the programme.
- Put robust programme governance in place – supported by a dedicated PMO function.
- Create a single enabling workstream to work across the programme and support components.
- Ensure that Mental Health and End of Life are integrated from the start and engaged throughout.
- Ensure all professional groups working in the programme have access to the same sources of information – ideally a single source.
- Set a clear methodology for benefits realisation before the programme starts

6. The Future

6.1 A journey of integration

The delivery of the Early Intervention project is complete and its workstreams are now fully integrated across Birmingham's health and social care system. As a result, the Early Intervention Steering Group meetings have been stood down and all Component Groups have all finalised their respective completion reports. The project team has been disbanded. **Appendix E** outlines key deliverables transferred to Business as Usual and adopted into the workstream groups.

EI continues to be a journey of integration and colleagues continue in their ambition to become the largest integrated health and social care 'home-first' teams in the country. This is in addition to

- enabling innovative workforce opportunities (qualified/non-qualified)
- attracting and retaining staff,
- provide a simple offer for the population - I statement (Figure 2)
- to do what is required in supporting 1.3m+ Birmingham citizens to improve their outcomes.

6.2 Next steps

All core components continue to evolve to meet the ongoing needs of the changing landscape of integrated care and the introduction of the Integrated Care System (ICS). These are outlined below:

6.2.1 EICT

<u>System Wide Requirements</u>

- Continue to develop EICT response to Urgent Community Response (UCR) to ensure EICT teams can respond within 2 hours. Ensure EICT teams have the right skills and knowledge to provide a confident and robust approach to this new requirement.
- Enable locality-based health and social care working across all services
- Enable a Discharge to Assess pathway across community bedded units to community teams across the health and social care sector

<u>Infrastructure to support</u>

- Single IT system to track patient journey
- Roll out supporting technology initiatives
- Standardise sustainability & continuous improvement process across five EICT localities
- Ensure teams are located in the right place, providing the right care to meet the needs of the population
- Ensure EICT staff have the right tools, space and equipment to meet those needs

<u>Quality Assurance</u>

- Operational & Quality service review. Gap analysis to ensure competence, training & development
- Revision of KPI and targets

6.2.2 EI Beds

There is a strategy to deliver the next steps of the EI Beds. There is an ambition to roll out the EI approach into a locality-based model that maximises outcomes for citizens – ideally returning home and maintaining their independence.

Phase 1: Exit from COVID-19 pandemic response and planning

- Return to a 'steady state' in a managed way
- De-escalate surge beds that were mobilised as a pandemic response

Phase 2: Consolidation and interim planning

- Monitor capacity, demand, and length of stay in a more 'steady state'
- Adjust model as required for all bed types to inform bed/site requirements for phase 3
- Engagement and consultation with service users to inform phase 3

Phase 3: Locality-based model

- Move to a locality-based model with consistency across all sites – a generic model
- Optimised outcomes – maximising citizens returning home
- Optimised length of stay
- Adjust overall beds (based on modelling in phases 1 and 2) and retain the appropriate number of sites
- Implementation of other bedded pathways as appropriate

6.2.3 OPAL

OPAL will continue to support the OPAL and OPAD operational teams at the Heartland site to help them to function at their optimum level. Remaining vacancies will be filled through the cross-site recruitment strategy and development of the DHMS system will continue including the training of staff and final go-live. OPAL will develop links with the Birmingham and Solihull Mental Health Trust to monitor the impact on patient outcomes. Continue to expand OPAL+. The OPAL+/BT pilot is in the process of being evaluated – next steps for development of OPAL+ and future collaborations will be worked through following the evaluation.

6.2.4 iHub

The iHub has progressed despite the challenges of the pandemic but there is significant work ahead.

There is now a joint BCHC and BCC bed management team and the work for the short to medium term is to have a seamless operating process that links to the EI beds strategy and means the bed management team manage across provider boundaries.

An MDT approach has been put in place to support flow. The work ahead is to improve the robustness of the approach. Within the discharge pathways this means ensuring a clear focus on the principles of setting an expected date of discharge with the right MDT engagement based on the needs of citizens, progress tracking and escalation process to ensure timely discharges.

Significant improvements have been made in the complex discharge hubs and the work ahead is aimed at moving to a single iHub. The needs of the citizen being described in the acute with the iHub then determining the optimal discharge pathway and coordinating admission into the discharge pathway.

This will see social work capacity currently in acute hospitals working across D2A therefore creating better flow. A draft SOP and core team structure was developed during the pandemic and will now be revisited to account for the changes described above.
The review of the SOP and team structure will seek to reaffirm organisational and team commitment to developing the model further. A key enabler will be an IT solution that gives practitioners access to necessary records and allows flow to be tracked and reported on across D2A.

The focus for the iHub over the longer term includes a full BSol approach and progressing the opportunities of a single point of access for discharge to assess.

6.2.5 Commissioning

Commissioning and funding to support discharge has been pooled across health and social care under the Better Care Fund section 75 to support the services at the interface of health and social care system to deliver EI. This will continue to develop to ensure that we jointly plan, commission and deliver appropriate care and support that meets population needs and is affordable within existing budgets available to NHS commissioners and local authorities.

The COVID-19 pandemic has shown the benefit of NHS providers working together to address challenges. Although collaboration existed prior to COVID-19, the experiences during the pandemic and the formation of an ICS helps us build on collaboration and partnership working

An EI commissioning road map has been set out as to the steps to bring this to life and to potentially commission a single EI service for Birmingham.

Key elements of the EI road map are:

- Health inequalities – understanding the profiles of who is using EI services to support decisions and plans to improve local people's health and reduce health inequalities.
- Strategic planning – assessing needs, reviewing provision and deciding priorities
- Procuring services – designing services, shaping structure of supply, planning capacity and managing demand
- Monitoring and evaluation – supporting patient choice, managing performance, seeking public and patient views

Significant work has already taken place to expand EI beds provision (now referred to as pathway 2 beds and aligned to national Discharge to Assess guidance); moving us closer to a locality model that provides an integrated, standardised, therapy and assessment response to support citizens' home

6.2.6 Infrastructure

The infrastructure group consisted of key stakeholders from across the System with the aim of delivering against five key workstreams:

- P1 - Identify what we have now, new KPIS and data streams. align with other component groups to enable list for sharing.
- Collection of data and processes in place to extract clinical activity from our systems to enable reporting of Urgent Community Response to CSDS.
- Effective governance arrangements for access and sharing of data and information.
- A single performance, finance and outcome dashboard created and in use across the programme - complete for EICT available on One Vision.
- Estates Strategy - short and long term estates plan in place to support pathways 1, 2 & 3

The five key deliverables broadly covered both the digital infrastructure developments that were required to deliver the EI programme, as well as, to develop an estates strategy which would underpin the revised clinical and operational models which had been developed as part of EI.

Key achievements include -

- Significant work was undertaken which consolidated the myriad of data collection and reporting providing a suite of metrics which could be adopted and embedded as part of the continued operational delivery of EICT.
- UCR data now submitted via CSDS templates
- DSA reviewed and informing longer term commissioning arrangements
- EICT dashboards reconfigured and presented in Finance, Operational and Outcome sections
- Review of current estates and gap analysis completed identifying a number of short term actions required to ensure sites are fit for purpose
- Options appraisal of all potential sites to support P1 and P2 clinical operational delivery model

6.2.7 Mental Health

The pathways between all Mental Health and other EI components, including End of Life, have made significant progress and will continue to be strengthened to enhance the flow through mental health wards and reduce waiting times for transfer of patients from the acute hospitals, ensuring that a person receives the right care at the right time in the right place, ideally in their own surroundings.

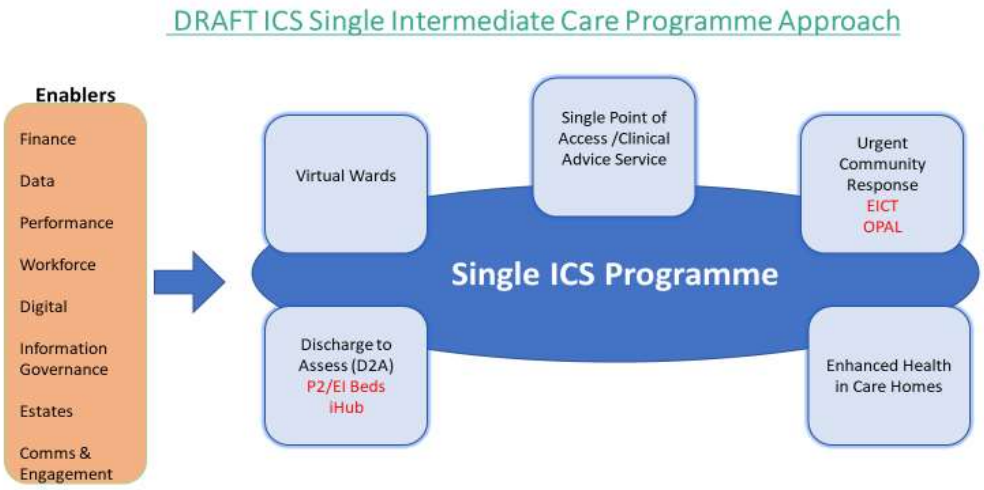
Continuing with the ethos of Home First, work will continue to develop across the mental health community teams, memory assessment units, rare dementia service, care home liaison and community enablement and rehabilitation service. This will ensure that specific issues related to mental health across partner services are picked up and addressed at the earliest opportunity, in the interest of those who experience mental health problems.

6.3 Future Transformation Programme

Much has been achieved and much has changed since the EI programme was launched. The programme as designed has delivered lasting transformation but there is still further work to do. Improvement in the health and care sector is a continuous process and as we finalise the completion of this programme we are developing and configuring our next transformation programme – building on the foundations, successes and lessons from EI to date. Our new programme will enable the ongoing actions for EI components identified above to be progressed within a new programme structure that is fit for purpose for the current and future challenges that we face.

A draft outline of our new “Intermediate Care” programme is shown below in Figure 11:

Figure 11 – a draft model of the new Intermediate Care programme.



It is proposed that this programme operates across BSol ICS with delivery at Place.

7. Case Studies

7.1 Mary

OPAL, West Midlands Ambulance Service (WMAS) & EICT partnership working

OPAL at Good Hope hospital received a call from West Midlands Ambulance Service (WMAS) crew at 7.30am. Mary, a 94-year-old lady had called an ambulance as she had tripped and fallen and had difficulty in mobilising. She had also fallen the week before and had a swollen hand which the crew were concerned about. There were no family members, Mary lived alone and there was no package of care or any assistance at all.

WMAS felt that Mary needed to attend ED for an x-ray and that a package of care needed to be arranged as she could no longer manage her personal needs; she was sleeping on the sofa and struggling to climb the stairs to use the bathroom, as well as get out to do food shopping for herself However, Mary flatly refused to attend hospital as well as accept any support on offer. After they had been with Mary for an hour, the crew called OPAL+ for advice and assistance and to see if the team could persuade Mary to attend ED just for an x-ray.

Mary finally agreed, but only to go for an x-ray then she was **"definitely going home!"** The x-ray showed no broken bones, just soft tissue injury. Mary's main objective was once again "**to return home**."

Following Mary's discharge from ED, OPAL GHH gave her a full assessment and once again tried to persuade her that a package of care would be great support for her at home.

"Various services were offered such as therapy assessment and community physio which she initially declined but finally agreed to. She was discharged back home with agreement that the EICT would visit her until her long-term care was arranged.

7.2 Anna

P2 (rehabilitation beds), OPAL+, mental health team partnership working

Anna **is 85-years of age** and was **recuperating at Norman Power (NP**) after being transferred from the **Queen Elizabeth Hospita**l. Anna has **dementia.** As well as supporting her with **rehabilitation**, **NP** was helping her and her family with **long-term residential care planning**.

One morning, Anna became **agitated** and **aggressive**. The NP team (pictured right) contacted OPAL+ who determined Anna's behavioural and psychological symptoms related to the dementia and urgent intervention was essential.

Rather than admit Anna to hospital, OPAL+ contacted the Birmingham & Solihull Community Mental Health Team who visited Anna that same day and prescribed new medication which would support her going forward. It was late in the day at this stage but OPAL+ has the facility to prescribe and deliver medication out of hours. Anna was able to take her first dose of the new medication that evening and her behaviour quickly stabilised.

Prior to EI, Anna would have been taken to the Emergency Department, waited for several hours to be seen & admitted until she had been stabilised and assessed**. Listen to the consultant involved tell the story in his own** words

7.3 Hilda

GP, EICT, End of Life team partnership

Hilda's GP had recently prescribed antibiotics for her to clear up a water infection. Two days later her distressed daughter, Jan, phoned the GP to advise she was calling 999 as her mum was deteriorating and refusing food and fluids.

The GP referred Hilda to the Urgent Community Response service which is delivered by the Early Intervention Community Team. On examination the team found that Hilda had oral thrush which made eating and drinking uncomfortable. Her dementia had been restricting her ability to communicate this.

The UCR prescribed for thrush and to Jan's relief, helped develop a care plan for her mum. Hilda had never wanted to be admitted to hospital and her daughter respected these wishes. UCR and the GP supported Jan with the RESPECT process too and referred Hilda to palliative care at home.

These actions prevented an unnecessary hospital admission, possible admission to long term residential care and respected the wishes of Hilda by keeping her in her own home with the support they both needed.

The UCR team visit included an advanced clinical practitioner (ACP) and a therapist.

Whilst the ACP was talking to the daughter and the GP, the therapist started to play music that Hilda would be familiar with.

Hilda became more lucid and animated to the extent that mother and daughter were able to communicate with each other; plenty of tears of joy were shed.

7.4 Mental health and OPAL+ trial success

A recent trial between Birmingham & Solihull Mental Health Trust (BSMHFT) and OPAL+ has been confirmed a success. It improved pathways between the two services, including how to reduce the time it takes for referrals and the type of patients that can be referred.

Over four-weeks OPAL+ received eight calls from BSMHFT Reservoir Court. Of these, seven people remained at Reservoir Court and received the appropriate care they needed. The next steps are to ensure that this approach is sustainable for BSMHFT and OPAL+ across 50+ sites citywide. BSMHFT now working with OPAL to achieve the same. The trial has helped more patients in the unit to avoid unnecessary hospital admission and recover in their own surroundings.

7.5 Dennis

111, UCR, OPAL+, QE team partnership

Dennis lived alone and was supported by daily carers. His daughter, Mrs B, visited him regularly. When he fell poorly in December, she rang 111 for help and was referred to the Urgent Community Response service.

Dennis was visited the same day by the team who assessed that he had a possible water or chest infection. As per the OPAL+/community service approach, the community team contacted OPAL+ to agree the best course of care.

Following a multi-disciplinary assessment between the OPAL+ consultancy team at the Queen Elizabeth Hospital, the community team, Dennis and his daughter, it was agreed that he did not need to be taken to hospital. Instead, Dennis would be prescribed antibiotics and cared for by the community team over the next few days until he recovered.

Mrs B said: "I am in awe of the way that my dad's care plan seamlessly unfolded. The collaboration between different teams was amazing. Dad and I were fully involved at every step of the way starting with the assessment

and dialogue between the community team and OPAL+ about keeping dad at home through to when the community team were visiting and their thoughts on how he was recovering.

“The fact that he and I were part of all these discussions made a huge difference. We felt that people were properly listening to us, especially my dad who wanted to stay safe, secure and comfortable in his own home. Above all we were shown great humanity.”

Pre-OPAL+, Dennis would have been admitted to hospital where, especially in Covid times, he may have acquired further infections and definite muscle loss.

“I wish I could bottle the seamless care and emotional approach we experienced. It would be priceless.” Mrs B, daughter of Dennis (left)

Pictured: Dennis and his granddaughter Laura and great grandson, Daniel.

“

APPENDIX A

EARLY INTERVENTION PROJECT BASELINE OBJECTIVES & PROGRESS AGAINST THEM

Baseline		
Community Teams		
MDT working not in place	Significant Progress	MDT approach adopted in each locality
Fragmented Services provided by individual partners to enable rapid discharge, supporting people in their homes or prevent admission to acute	Significant Progress	Mostly resolved with scoping plan underway to identify any continuous improvement opportunities, gaps and to include private provider element
Multiple hand offs for some individuals, no co-ordinated approach	Significant Progress	Much improved, but some gaps identified in therapy and social work
Multiple assessments and plans	Significant Progress	One professional now undertakes assessment & develops plan with input from others where required.
P2 (rehabilitation beds)		
Significantly more beds than best performing equivalent systems	Significant Progress	In 2017 there were 409 beds across the system - reduced to 370 prior to Omicron with further right sizing of bed numbers due to be incorporated in phase 3 business case.
Multiple commissioning arrangements and providers including specialist beds with inconsistent access across city	Significant Progress	We have reduced from 19 sites to 14 sites and further reductions planned to nine sites in 2022.
Variable access criteria ,including acuity accepted	Significant Progress	Harmonised access criteria for NHS beds and reducing variability in privately commissioned beds.
Multiple medical management arrangement	Limited Progress	The approach to a single model has been agreed. A detailed implementation plan is underway for governance/ approval.
Inconsistent/poor outcomes	Significant Progress	Consistency of approach has been adopted in NHS beds.
Hospital pre-admission assessment and intervention		
Different "front-door" services in places in places at acute hospitals	Significant Progress	OPAL teams are now in place at all UHB acute hospital sites. Some operational challenges at the BHH site are being worked through systematically.
Limited multi-disciplinary working	Significant Progress	Workforce models agreed, funded and largely recruited to. Remaining vacancies are being filled. Strong multidisciplinary approach taken. Further work is needed around physical space for co-location of social workers at GHH and BHH sites.
Not effectively linked to community teams	Significant Progress	Strong links between OPAL+ and community teams, including mental health . Future BAU work programme aimed at expanding OPAL+ and extending access to OPAL to all BSMHT services
Different operating models and facilities	Significant Progress	OPAL services now in place at all sites. Current SOPs to be reviewed over the next few weeks via BAU. Work is ongoing around consistency of medical input 7 days per week at all sites - this will be improved as additional consultant workforce is recruited at BHH and GHH sites as part of the phased approach to consultant recruitment.
Inconsistent/poor outcomes	Significant Progress	Standardised OPAL service now in place at all acute hospital sites. Work is ongoing to ensure consistent approach and outcomes at all sites

Acute discharge planning		
Different "Hub" services in places in at acute hospitals	Significant Progress	There has been significant progress in getting consistency across the complex discharge hubs. The work ahead will deliver greater consistency through a single iHub.
Limited multi-disciplinary working	Significant Progress	There is much greater MDT working in the complex discharge hubs and similarly within the iHub. The work to develop a single iHub model will improve this further.
Not effectively linked to community teams	Significant Progress	Much greater links with the community teams via the iHub, this includes links with housing, mental health, homelessness. Further work being done to strengthen.
Different operating models & facilities	Significant Progress	iHub now has shared office space & staff have access to shared trackers. The MDT approach is consistent and being further developed. Model is a hybrid of virtual MDT input & physical co-location.
Inconsistent/poor outcomes	Significant Progress	Initial sites were working in different ways, but this has been resolved. Work has continued throughout the year on firming up the D2A processes and improving outcomes for citizens leaving the D2A pathways.
Older People's Mental Health		
Long lengths of stay for those requiring short- or long-term care placements	Fully Completed	Clear process in place to support this work with additional system support for example: **Acute inpatient dashboard** to monitor LOS & reasons for delays. **Joint working** with the iHub to address blockages. **Clearly defined** pathways between mental health & EICT. **Closer links** between mental health and social care which enables assessments to be carried out in a much-reduced timescale.
Limited multi-disciplinary working	Significant Progress	MDT working has been significantly strengthened with an ongoing review to ensure a continuous improvement approach.

APPENDIX B

EARLY INTEVENTION PROJECT HIGHLIGHTS & MILESTONES

The table below outlines key project highlights/milestones that have been achieved to date per EI component:

1. Early Intervention Community Team (EICT)

Mobilised five Early Intervention Community Teams
Patient level data tracking was set up so that performance can be reported at locality and city levels
Performance dashboards have intelligent prompting built in to guide the user to clear operational priorities (hosted on BCHC systems)
Front line governance established including structured, data-informed MDTs and weekly performance reviews. This has included coaching staff to break down organisational and professional boundaries to enable a more collaborative management team.
A single integrated assessment and review methodology was bespoke designed and implemented, reducing duplication between professions
Feedback from unregistered Sevacare staff visits is collated in a structured way and fed back to registered staff
During COVID the EICT was deemed an integral part of the city's response, forming the primary part of Pathway 1. This required additional work primarily involving redeploying 150 staff into the EICT. The result of this was that during the entire COVID response the EICT had only one instance of having to reject a referral due to capacity.
Collaborative agreement and data sharing agreement signed off
Quality process in Localities complete and implementation plan in place
CIF tool in use by appropriate staff in all localities
E - Triage process signed off
Decision to commence consultation with UHB staff and future Therapy funding for BCC agreed
Recommendations for ongoing OD approach agreed
Leadership and management development project completed
Future funding for EICT Agreed and implemented
Clear commissioning plan in place based on outcomes/need
Estates - Review infrastructure and plan for staff moves
Stable staffing structures in place – Staff transferred to BCHC
Recruitment (7 day service) process for all disciplines complete
People and culture plan in place for all localities and service-wide priorities identified
Agree & finalise In-reach model & Finance
Review of Service Specification

2. Beds

Implement performance monitoring framework to all non-acute sites from December 2021
Agree timeline for implementation of Improvement cycle in care centres
Evaluate service improvement trial at PTC and based on the outcomes agreed with P2 bed Implementation group, agree a roll out plan for remaining sites from September 2021
Agree exit from pandemic response plan (covid wave 1)
Confirm needs and demand 'steady state' Apr to Oct 2021
Commence a three-month remote consultation trial at AMH from March 2021
Evaluate the three-month remote consultation trial at AMH and agreed next steps with P2 bed Implementation group by end July 2021
Confirm site scoring evaluation criteria
Business Case for Phase 2 - approved 30 Aug 21
Determine funding available for 9/10 sites for phase P2 (consolidation stage) by end of July 2021
Implement performance monitoring framework to all non-acute sites from December 2021
Agree P2 Consolidation Business Case (phase 2) with BICP Strategic Group by end September 2021
Consolidate number of P2 sites: 14 P2 sites in use compared to baseline of 17 by end of September 2021
Commence consolidating bed base from 14 to 9/10 bed sites in a13 month period starting from October 2021
Evaluate the three-month remote consultation trial at AMH and agreed next steps with P2 bed Implementation group by end July 2021
Agree performance monitoring framework incl KPIs,(LOS, Cost)
Agree timeline for implementation of Improvement cycle at PTC
Evaluate service improvement trial at PTC and based on the outcomes agreed with P2 Bed Implementation group, agree a roll out plan for remaining sites from September 2021.
Confirm needs and demand 'steady state' Apr to Oct 2021
Draft (update) Service Spec for Phase 2
Site desktop assessment for care centres
Confirm bed numbers required

3. OPAL

Heartlands Older Persons Assessment and Diagnosis Unit (OPAD) is now entirely separate from OPAL and is operating 24 hours a day. The bedding in of the OPAL service at Heartlands is now enhanced by the team having their own dedicated space in a separate area. The OPAL and OPAD teams are now meeting regularly to review operational processes and issues as part of business as usual
Single, cross site recruitment process has been very successful, and many posts have been filled despite ongoing challenges, for example fewer candidates than vacancies. The recruitment process will be repeated until remaining gaps are filled as part of business as usual.
There has been progress with the development of DHMS and it is expected to go live towards the end of Q1 2022/23. A set of OPAL performance indicators has been produced for approval and can be found in table 1. An appendix with charts showing daily and weekly contacts and discharges over time is also attached to this document. However, work still needs to be completed on the DHMS dashboard in order for the current manual data collection and reporting processes to be fully automated. This will be picked up via business as usual.

The development of OPAL+ has progressed well. The OPAL+/BT pilot is in the process of being evaluated.
Successful links have been established between OPAL and community mental health services. The number of referrals and the impact they are having is being monitored with a view to assessing the future resources required to provide OPAL access across the whole of BSMHT as part of business as usual.
Completion OPAL Business Case
OPAL+ Project Manager in place
OPAL communications plan being delivered
Agree KPIs and performance measures being reported on

4. Integrated Hub

New 'description of needs form' developed and shared with the system. Several workshops were held throughout the early July. Evaluation of the form took place in July and August and feedback to the IHub component group resulted in sign off of the DoN on 03/09/2021. Following a roll out of communication to all system partners the new form went live on 11th October 2021
Reporting metrics agreed, Metrics reviewed during August 2021 and a full suite agreed and signed of 16/09/2021
Roll out access to DHMS for non UHB staff - A full roll plan was established that commenced in October 2021 and completed February 2022
Completion of DRAFT iHub SOP - The IHub SOP has been compiled, it has been reviewed by the group and operational leads. Go Live with the first iteration of the SOP on the 1st April 2022. The SOP will be reviewed every 3 months during 2022 and changes made accordingly.
P3/CHC, MH, EoL input defined - Workshop held and GAP analysis of SOP in September 2021. Process in place and key individual identified
Homelessness pathway confirmed - Referral processes and pathways in place. Escalation routes identified.
iHub - Discharge Facilitator Recruitment (Round Two)- New starters in post on the 1st September 2021
Work to create a single office complete - One shared office March 2022
Planning for the testing of the early discharge planning in the iHub using an MDT approach

5. Commissioning

Map of BCF Outcomes to programme KPI's
Financial envelope
Plan for commissioning each component
Pathway 1
Establishment of reporting of outcome measures and contractual KPI's in line with national requirements, local need and assurance
DQIP to be put in place to ensure all national mandated reporting requirements are available through CSDS
Commissioning arrangements for non-qualified elements of EICT.
Service specification for EICT to be finalised
Pathway 2
Business Case for phase 2
Confirm P2 needs and demand based on 'first cut' of new 'steady state' data post covid-19 pandemic

Draft service specification for phase 2
IV Therapy Commissioning
Develop winter plan for IV therapy
OPAL
Review OPAL business case 21-22
OPAL Business Case amended based on System Investment Committee comments. To be resubmitted to SIC for consideration
OPAL Financial requirements for 21/22 to be considered by System Investment Committee. Paper to be completed by EQ4 Group.
Clarification of OPAL funding streams for 21/22 & 22/23 onwards
Confirm governance of OPAL+

Infrastructure

A new and refreshed governance structure and clear objectives were developed quickly which helped the group to clearly understand what its remit was, with clear dates and a plan behind each to deliver
We are pleased to say that we developed a single performance dashboard which is now fit for use across the system. EICTs performance data is now available on One Vision and is being used through our GOLD Meetings and daily performance huddles to monitor the performance of the locality based teams

We picked up the requirement to ensure that the data and processes were in place to enable effective data and reporting of our response to UCR, bringing our knowledge and understanding as a system to :
• Gain approval of £12k of additional funding from DITE for a developer role
• Obtained approval for
  ○ Data entry on referral priority
  ○ Future process for clinical triage
  ○ Single data point for collection of referral priority

Implemented RiO config changes necessary to enable data recording
Ensuring that our Community Services Data Set included the 2 hour and 2 day validated dataset
We wanted our patient's journey through the Birmingham system to be as seamless as possible. We have come a long way in our discussions and plans to enable this, through a shared system that enables improved integration and management of the patient's journey.
Our initial work to ensure estates are fit for purpose for the EICT has now been planned and costed out for phase 1. A scoping paper has been produced and signed off. It was agreed to undertake the desktop exercise to identify the preferred EI sites before undertaking any site works

APPENDIX C

LESSONS LEARNT AND AREAS FOR IMPROVEMENT

Culture

What has worked well	Could be improved
Regular communication and consistent drumbeat of embedding the EI approach of "why not home why not today'	Further understanding of Culture Change, as this is a slow process and take several years for systems to behave as an integrated care system
Having a MOU ensured there was a common vision across EI Programme	Operational difficulties were encountered due to different Operational Management Structures. This could have been mitigated through a joint management structure
Great partnership working has enhanced confidence with implementing UCR through EICT	Partners need to work together to agree a shared vision as to what integrated and inclusive care means across the system, specifically around Mental Health
EI approach demonstrates the benefits of an inclusive and integrated system	Limited staff & stakeholder engagement from the offset had implications to staff not understanding the purpose which effected working practises ie OPAL
EI has embedded a collaborative system wide approach with clear pathways and a triage process that enables improvement in patient outcomes and quality of care	

Resource/Capacity

What has worked well	Could be improved
Having a Improvement Team aligned to the programme, ensured any resource requests for Improvement Managers, Project Managers etc. were sourced efficiently	Organisations committing to supplying appropriate resource with the right skills mix ahead of any issues being escalated.
Excellent cross site recruitment process was successful. It was efficient, maximised the use of valuable clinician time and helped to fill vacancies faster than a site specific process.	The use of care programmes within the ICS should be an enabler in terms of having a clearer view of total resources and ability to manage use of resources across the system.
Having BCF resources in one place has provided flexibility and enabled system resources to be used where they are needed to meet pressures and enable transformation	

Planning/Processes

What has worked well	Could be improved
Clear defined processes in place for a persons journey which aims to achieve the least restrictive outcomes	Limited involvement with partners/stakeholders resulted in unrealistic timelines
Having embedded good governance with key stakeholders, kept us up to date on whole system requirements	Consideration in planning of SMART objectives taking into consideration available resources and competing priorities
Having one single enabling work stream to cover IT, Estates and other infrastructure requirements across the whole programme ensured alignment with the component groups	Having a dedicated system finance lead for key transformation projects would bring greater focus and control.
The inclusion of specific groups to be part of the initial scoping of the programme i.e. MH/EOL enhanced a more sustainable and proactive approach that improves service user / carer and staff experience.	Understanding organisational partners governance structures but also being clear on what the structures are for the project
	Planning ahead, ensure funding and resource requirements for large programmes of work are determined and agreed early on
	Having a dedicated PMO function for the programme, would have improved visibility, Top down strategic alignment in the PMO, bottom up, execution driven alignment etc.

Data/Intelligence

What has worked well	Could be improved
Having access to reliable data can support objective assessment of service improvement	Having a dedicated data control group early in the project would help support flow of information across the different systems
Benefits achieved for the people of Birmingham which is regularly monitored through an effective performance management framework	Limited access to joined system. Having one system to follow patient journey

APPENDIX D

TEST SITES DETAILS AND RESULTS

Test Area 1: Hospital Front Door

The OPAL team at the front door of the Queen Elizabeth Hospital provides a timely, multidisciplinary, patient-centred, comprehensive assessment to those who have an urgent need. The team provides patients with early access to expert advice, regardless of whether they are referred by a GP, community services or arrive at the front door.

The testing work focused on improving how the team could help as many older people as possible as they enter the hospital to get the support they need, ideally back in their own home, thereby reducing the number of people that end up in a ward. The key focuses within the team to achieve this were:

- Enhancing leadership within the team
- Visibility of activity and performance
- Improving efficiency and productivity within the team
- Quantifying un-met demand and modelling what is required to meet this.

Test site results

Before changes were put in place, OPAL were already getting 6.6 people home every day; around 2,400 a year.

By December 2019, this had increased to between 9.5 and 10 people going home each day, with the support of the team. That's around 1,000 more people every year.

Additionally, testing found that if an older person was seen by the OPAL team, they had a 70% chance of going straight home compared to a 52% chance of being admitted onto a ward when they weren't seen by the team.

These results were achieved by changing the data captured on a daily basis; improving the quality and access to that new data; optimising the mix of skills in the department and giving those that needed it, access to the new community team.

Test site 2: Hospital Back Door

The Complex Discharge Hub at the Queen Elizabeth Hospital assesses and sources support for people that require further care after a stay in an acute hospital bed. The team provides health and social work expertise as well as liaises with therapy teams in order to provide timely discharge into the most appropriate care.

The work as part of the Early Intervention Programme has focused on maximising the independence of outcomes for patients and minimising the time spent in a hospital bed whilst medically fit. This has been done with a focus on multidisciplinary working and empowering frontline staff through the collaborative and patient-focussed discussion. Specifically, this involved:

- Enhanced insight on both current caseloads and broader themes
- Empowering the front line through collaborative decision making
- Collaborative working across discharge teams and post-acute services
- A focus on multidisciplinary working an cross-discipline discharge planning.

Test site results

Before the changes were put in place, the average time it would take to get a person out of hospital once they were declared medically fit was 12 days.

Since the end of testing this has reduced to 8.7 days. This has major benefits for the hospital with the equivalent of approximately 6,500 bed days per year being freed up and which can be put to better use.

People going from the hospital directly into long term placements also reduced significantly. Within the Edgbaston constituency (test site area), every week, two or three older people would be discharged into long term care settings such as residential or nursing homes. In a three-month period after the testing, only one person went into long term care. That means in Edgbaston alone, the testing showed that more than 130 people every year could return home as opposed to going into a long-term placement.

This has been achieved by changing the data captured; improving the quality and access to the new data; improving the actions taken by the team using the new data; improving how the social workers and nurses work together and giving people who need it, access to the new community team (Early Intervention Community Team).

Test site 3: New Community Team

A new team providing urgent assessment, treatment and care for people was introduced and tested. The team was delivering a range of integrated services provided by multiple professionals who promote recovery and independence.

Through the Early Intervention programme, the aims of this new approach have been to prevent unnecessary hospital admission and premature admission to long-term residential care, support timely discharge from hospital, promote faster recovery from illness or injury and champion independent living wherever possible. This included

- Breaking down barriers and setting up a brand new multi-disciplinary teams
- Driving citizen-centred plans which aim to promote independence
- Creating a strong and productive relationship between all system partners
- Driving operational performance and caseload visibility

Test site results

As a new team there is no direct comparison to ‘before’ the changes. However, of those supported by the test site, 76% of the people that remained in their own homes are now enjoying full independence with no reliance on either health or social services.

Everyone that was discharged from the service was offered a feedback card; 100% of family or carers said they would be happy to recommend the service.

For the full duration of testing, people being supported by the service have consistently became more independent. This was measured through a reduction in the number of hours of support someone needs, which has reduced by an average of 7.8 hours per person, per week.

Test site 4: Early Intervention Beds

Early Intervention Beds provide an inpatient rehabilitation and recovery service for older adults who no longer need the acute medical care of a hospital. The team sets out to help people identify what is important to them in their ongoing care and treatment, maximising independence and working with families and communities to give as many people as possible the opportunity to return to their own homes.

Early Intervention work showed that multi-disciplinary goal-setting and improved communication between health and social care professionals enabled better outcomes for patients. It iasl identied some key areas for continued work in making sure that the right people are being referred to these beds and moving on to go home or to other appropriate care at the right time. This involved:

- Creating a clear leadership in a multi-disciplinary, multi-organisational setting
- Reinforcing a 'home first' principle with daily patient reviews and performance measurement
- Creating a common goal setting approach, across organisations and professions, with patients and families
- Improving the key processes that enable people to progress towards being discharged.

Test site results

Testing took place at the Norman Power Centre in Edgbaston. During testing, approximately 50% of people were going home rather than onto other care settings, against a starting point of 25%. In addition, the length of time that people were staying in these beds reduced to 30 days from a starting point of 44.

This was achieved through changes in a number of areas: introducing specific, measurable and timely 'therapy goal setting', a regular team meeting attended by a multidisciplinary team aimed at tracking an progressing towards the ideal outcome for everyone, ensuring the person and their carer/family have a say in what's happening and that their expectations are managed.

During the testing period, the complexity levels of people staying in the beds increased. On one hand this makes the increase in people going home all the more significant. However, it also means that the length of stay started to increase, at one point rising from 36 to 49 days. However, these are people who would have previously gone into long term care settings such as residential/nursing homes.

Test site 5: Acute Mental Health

Acute mental health wards at the Juniper Centre and Reservoir Court provide inpatient services for older adults with a functional or organic acute mental health issue. This includes comprehensive assessment by a multidisciplinary team, diagnosis and treatment, responding to a wide range of needs of the service user in a person-centred approach.

The work as part of EI focussed on reducing the amount of time people were staying in hospital as a result of unnecessary delays to getting them healthier or getting them home. This allows people to spend less time in an acute setting and enables others to access the service who otherwise might have had to wait. The work included:

- Visibility of live and accurate information
- Bringing the multidisciplinary team together more frequently
- Re-thinking the way that long term care needs are assessed
- Improving the key processes that enable people to progress towards being discharged

Test site results

Before the changes the number of people being discharged averaged at six per day. Changes were introduced including a new social worker process, which reduced the number of people delayed waiting for social worker input from 14% to 2%, new data, tracking and reporting on referrals, allocations, timescales and activities – with a focus on having a clear next step for every person on the wards. This increased the proportion of people waiting for 'active treatment' from 30% up to 58%. These changes combined to increase the number of people being discharged every day from 6 up to 6.5 – the equivalent to every person spending nine few days in hospital. These performance figures are above what was anticipated.

APPENDIX E

KEY outstanding DELIVERABLES TRANSFERRED TO BUSINESS AS USUAL (BAU)

Component	Description
OPAL	Implementation of DHMS
OPAL	KPI development and performance monitoring
OPAL	OPAL Service Development/Business Development
Commissioning	Health Inequalities (Understanding who is using EI services, what is it telling us about the provision and design of the service)
Integrated Hub	iHub SOP Completion
Integrated Hub	iHub - Training for Changes to services that sit outside the iHub
Integrated Hub	Early Discharge MDT roll out
Integrated Hub	Document baseline service specification for the iHub
Integrated Hub	Stabilise teams with significant vacancies or reliance on Bank/Agency staff
EICT	Revisit and refine referrals diagnostic undertaken by Newton
EICT	All staff will be utilising iPads and Total Mobile
EICT	KPI reviewed and rolled out
EICT	Quarterly review of People and Culture plans
EICT	Implement Demand and capacity modelling for BAU and 2 UR
EICT	Final Service Specification for the Year after

BIRMINGHAM HEALTH AND WELLBEING BOARD

	Agenda Item: 15
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**27 September 2022**
TITLE:	**CONSULTATION FINDINGS - DRAFT BIRMINGHAM AND SOLIHILL SEXUAL AND REPRODUCTIVE HEALTH STRATEGY 2023 20230**
Organisation	**Birmingham City Council**
Presenting Officer	**Juliet Grainger**

Report Type:	**Information**

1. Purpose:
1.1. The purpose of the report is to provide feedback on the public and stakeholder consultation on the draft strategy that took place between May – July 2022

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

3.	Recommendation
3.1	The Board is asked to accept the consultation findings and to endorse the conclusion that the draft strategy is supported by respondents and reflects the results of the needs assessment that was completed in 2021.
3.2	Based on the conclusion, the Board is asked to ratify the strategy.
3.3	The Board is also asked to endorse the proposal to use the consultation findings to inform the design and co-production of the future sexual health service model during 2023.

4.	Report Body
4.1	**Background**
4.1.1	The consultation was on the draft Sexual and Reproductive Health Strategy 2023-2030, which sets out themes, priorities, and approaches to meeting the sexual health needs of the populations of Birmingham and Solihull.
4.1.2	The strategy's content provides Birmingham City Council's (BCC) and Solihull Metropolitan Borough Council's (SMBC)'s joint response to tackling increasing rates of sexually transmitted infections (STIs) and HIV, and inequalities in sexual and reproductive health, which impacts negatively on health and wellbeing.
4.1.3	The strategy is informed by the findings from the Sexual Health Needs Assessment (SHNA) for Birmingham and Solihull.
4.1.4	The objectives of the strategy are to: ➢ Ensure that every resident has access to sexual health services that meet their individual needs. ➢ Enable services that are local, relevant, approachable, confidential, non-judgemental, to provide services to anyone in need, while respecting all human protected characteristics. ➢ Enable citizens to have control of their own sexual health with services providing support where needed.
4.1.5	The themes within the strategy, which were used to structure the consultation were: ➢ **Theme One**: Priority groups ➢ **Theme Two**: Reducing the rates of sexually transmitted infections ➢ **Theme Three**: Reducing the number of unwanted pregnancies ➢ **Theme Four**: Building resilience ➢ **Theme Five**: Children and young people
4.2	**Consultation Process**
4.2.1	The consultation on the draft Sexual and Reproductive Health Strategy 2023-2030 was undertaken across Birmingham and Solihull during May – July 2022.

The purpose of this was to provide assurance that the strategy adequately reflected the findings of the needs assessment that was completed in 2021, and to incorporate public and stakeholder feedback on the draft vision and themes in the strategy.

4.2.2 The consultation obtained views across Birmingham and Solihull bringing together stakeholders and community representatives for focus groups and using an online survey through Be Heard, publicised via a media and communications cascade. Through focus group discussion and presentations, the consultation directly engaged with 35 community representatives, 8 community members and professionals, 75 primary care leads and 35 practitioners from the current sexual health service provider, Umbrella

4.3 Consultation findings

4.3.1 Demographics of Online Respondents**-** Most survey respondents (n.77) were between 30 – 60 years of age (67%). Over half (57%) were female, 6% of respondents declined to answer. In terms of ethnicity, 74% were White British/White European, 10% of respondents declined to answer. On sexual orientation, 62% of respondents identified as heterosexual, 12% bisexual and 8% homosexual, gay or lesbian, 13% declined to answer. Percentages may not have added up to 100% as respondents could choose more than one option.

4.3.2 Agreement on the strategy's vision and aims was unanimous, with only a few areas being identified as possible gaps - male sexual health education, mental health aspects of sexual health, older people, and the enhancement of primary care as vehicle to deliver improvements in localities.

4.3.3 Key feedback in response to the themes in the strategy:

- **Priority groups** – challenges in providing the service to the homeless should be addressed by reviewing outreach and multi-disciplinary working. In addition, better integration of sexually transmitted infection (STI) and contraceptive advice as an important aspect of prioritising women who may be at risk due to termination of pregnancy, sexual violence, domestic abuse, or cultural and language barriers.
- **Reducing rates of STI** - accessible, walk-in 7-day clinics are a requisite, and building on practitioners' knowledge of the motivation of different client groups (e.g., gay men, trans people and those with gender dysphoria) for attending clinic could be used to increase opportunistic sexual health screening and uptake of HIV medication, Pre-Exposure Prophylaxis **(**PrEP).
- **Reducing unplanned pregnancies** – requires removing barriers to accessing pregnancy tests, increasing access to long-acting reversible contraception (LARC) and emergency contraception with guaranteed confidentiality.
- **Building resilience** - Relationships and Sex Education (RSE) is essential and could also combat the unwanted norms of abuse in relationships. Also important is specialist support for schools and colleges and the use of

appropriate and novel media, such as social media sites and billboard on buses/bus shelters.

- **Children and young people** - services and pathways tailored to the needs of vulnerable groups (i.e., under 13s, young sexual assault victims, children in care, or foster homes). Clinics in Schools, such as lunchtime drop-in clinics achieved through collaboration with schools, school nurses and pastoral teams is a potential solution for young people unable to attend standard clinics and could provide safe spaces for identifying safeguarding issues.

4.4. Conclusions

4.4.1. The consultation findings indicate that there is strong support from the community and professionals for the content of the draft strategy and that the strategy adequately reflects the results of the needs assessment that was completed in 2021. Additionally, the consultation provides valuable feedback on how the strategy may be implemented.

4.4.2. Some stakeholder groups provided feedback that were focused on specific areas of the vision and aims and advocated for increased focus during implementation to interventions in these areas.

5. Next Steps

5.1 In view of these conclusions, it is proposed that the content of the draft strategy is maintained without changes and therefore ratification of the strategy is requested from the Health and Wellbeing Board.

5.2 It is also propose that findings of the consultation regarding implementation of the strategy are used during 2023 to shape the model of delivery for the future sexual health service in Birmingham and Solihull, particularly where comments highlight actions to meet specific needs for those group's we know are already vulnerable to poorer sexual health outcomes.

6. Compliance Issues
6.4. HWBB Forum Responsibility and Board Update
We will provide an update to the Health and Wellbeing Board following the outcome of the future sexual health commissioning and procurement programme. We anticipate that this will be complete by Q3 2023 2024.
6.5. Management Responsibility
Dr Justin Varney, Director of Public Health, Birmingham City Council Dyna Arhin-Tenkorang, Assistant Director, Birmingham City Council Juliet Grainger – Service Lead – Adults, Birmingham City Council

7. Risk Analysis			
Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
The sexual health contract expires in March 2023. Further time to assimilate and implement the findings into a commissioning process that continues to incorporate co-production with local stakeholders for a new sexual health service is required. A process that does not include the translation of local feedback on the draft strategy and ongoing inclusion may not adequately meet population needs and expectations.	Low	Significant	The Boards endorsement of the findings and the application within the design and co-production of the future service model is being sought, alongside that of Cabinet, at the meeting of 11 October 2022.

Appendices
Birmingham and Solihull Draft Sexual and Reproductive Health Strategy Consultation Report August 2022: **Appendix 1** – Copy of Consultation Survey **Appendix 2 –** Free Text Survey Responses **Appendix 3** – Draft Sexual Health Strategy Birmingham and Solihull 2023 - 2030 **Appendix 4** – Needs Assessment Summary **Appendix 5 -** BSoL SH Consultation Report

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

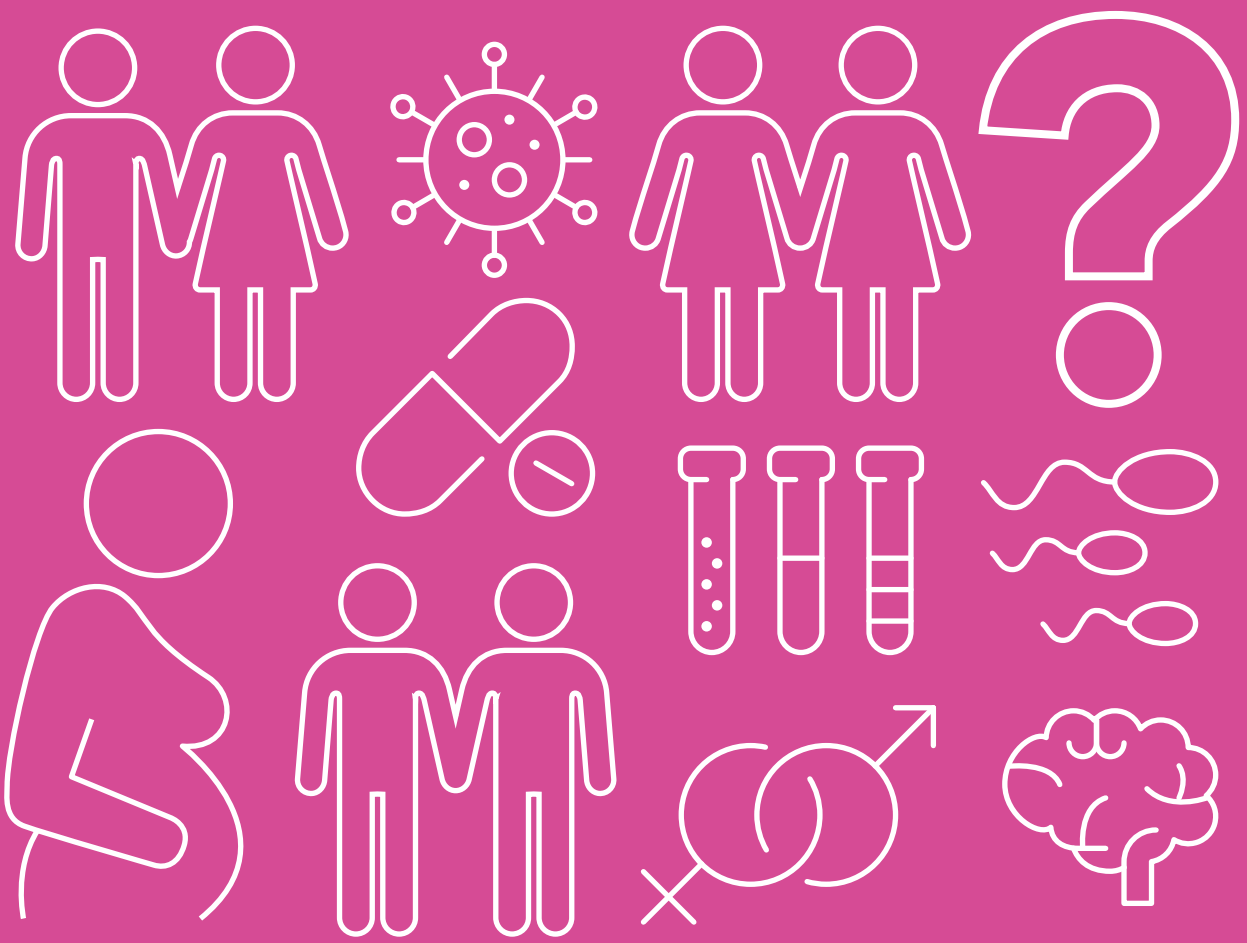
Dyna Arhin-Tenkorang, Assistant Director, Birmingham City Council
Juliet Grainger – Service Lead – Adults, Birmingham City Council

SEXUAL AND REPRODUCTIVE HEALTH STRATEGY

2023-2030

Reducing sexual and reproductive health inequalities is our priority

CONSULTATION QUESTIONNAIRE



Solihull Metropolitan Borough Council

Birmingham City Council

CONTEXT & VISION

Reducing sexual and reproductive health inequalities is our priority

Context

This 2023-2030 Sexual and Reproductive Health Strategy sets out Birmingham City Council's (BCC) and Solihull Metropolitan Borough Council's (SMBC) themes, priorities and approach to meeting the sexual health needs of Birmingham and Solihull. It sets out plans to respond to increasing sexually transmitted infections (STIs), HIV rates and reproductive sexual health which can have long lasting impacts on sexual health and wellbeing. Sexual Health can impact an individual's emotional, physical and mental health, their economic means and social relationships. The effects of poor sexual and reproductive health are far reaching and for those affected, the impacts are compounded by social stigma and fear.

We are asking you, the Citizens of Birmingham, Strategic Partners and Key Agencies (including current service providers) to give us your views on our Sexual and Reproductive Health Strategy 2023-2030. Our proposed approach is set out in the draft strategy and is intended to direct our actions in Birmingham and Solihull.

The draft strategy has been developed using findings from a needs assessment and highlights the following themes:

Theme One: Priority groups

Theme Two: Reducing the rates of sexually transmitted infections

Theme Three: Reduce the number of unwanted pregnancies

Theme Four: Building resilience

Theme Five: Children and young people

We would like to take on board the voices and experiences of citizens and stakeholders through a wide-ranging public consultation. This consultation will provide information to help us understand whether we have taken the correct approach and to enable you to help us to shape the future.

Vision

A key vision of the strategy is to address the joint common themes identified by the Sexual Health Needs Assessment for Birmingham and Solihull. This strategy will provide a tool to enable appropriate action and enhance existing pathways to meet the needs of citizens.

The key objectives of the strategy are to:

- Ensure that every resident has access to sexual health services that meet their individual needs.
- Enable services that are local, relevant, approachable, confidential, non-judgemental, to provide services to anyone in need, while respecting all human protected characteristics.
- Enable citizens to have control of their own sexual health with services providing support where needed.

The strategy will play a key role in realising the joint vision for sexual health services for the future, and will facilitate:

- A fully integrated, free and confidential sexual health service for all citizens across the life course
- A reduction in the high rates of teenage and unwanted pregnancy, abortion and STIs, which can have far reaching consequences for individuals and society
- Open and equitable access to sexual health services

A key outcome of the strategy will be to equip the citizens of Birmingham and Solihull to have healthy sexual relationships, positively impacting the wider emotional, mental and physical health and wellbeing of citizens.

CONSULTATION QUESTIONS

1. **To what extent do you agree or disagree with the vision and aims within the draft Sexual and Reproductive Health Strategy 2023-2030?**

- ☐ Strongly Agree
- ☐ Agree
- ☐ Don't Know
- ☐ Disagree
- ☐ Strongly Disagree

Please add any additional comments in the box below (optional)

2. **To what extent do you agree or disagree with the 5 themes (page 2) in the draft Sexual and Reproductive Health Strategy 2023-2030?**

- ☐ Strongly Agree
- ☐ Agree
- ☐ Don't Know
- ☐ Disagree
- ☐ Strongly Disagree

Please add any additional comments in the box below (optional)

On the following pages are sets of statements based on each of the five themes within the draft Sexual and Reproductive Health Strategy 2023-30.

For each statement, please:

- Tick **Yes** if you **agree**.
- Tick **No** if you **do not agree**.
- Tick **Don't know** if you are **not sure**.

Please only tick one response for each statement.

At the end of each theme, there is a comments box where you can add comments or suggestions for consideration in the final version of the Sexual and Reproductive Health Strategy 2023-2030, should you wish to do so.

THEME ONE
Priority Groups

Please tick one of the statements for each question that you agree with below, please do not tick more than one box per question. For more detail on the topic of Priority Groups, please see pages 12 and 13 of the Draft Strategy.

1. **Deliver sexual and reproductive health services in partnership with Drug and Alcohol Services**

- ☐ Yes
- ☐ No
- ☐ Don't Know

2. **Link sexual health nurses between homeless and substance use services**

- ☐ Yes
- ☐ No
- ☐ Don't Know

3. **Use focus groups to involve underserved communities and groups better**

- ☐ Yes
- ☐ No
- ☐ Don't Know

4. **Work more closely with disability services to ensure sexual and reproductive services are accessible**

- ☐ Yes
- ☐ No
- ☐ Don't Know

5. **Deliver sexual and reproductive health services via Homeless Hubs**

- ☐ Yes
- ☐ No
- ☐ Don't Know

THEME ONE
Priority Groups

6. Continue effective training for GPs, pharmacies, practitioners and partners

- ☐ Yes
- ☐ No
- ☐ Don't Know

7. Recognise the connections between race, gender, sexuality, disability, class or any protected characteristics that impact on an individual's needs and their ability to access services.

- ☐ Yes
- ☐ No
- ☐ Don't Know

Please add any additional comments you may have below (optional)

THEME TWO

Reducing the Rates of Sexually Transmitted Infections

Please tick one of the statements for each question that you agree with below, please do not tick more than one box per question. For more detail on the topic of Reducing the Rates of Sexually Transmitted Infections, please see pages 14 and 15 of the Draft Strategy.

1. **Ensure Sexually Transmitted Infection self-testing kits are available and strengthen chlamydia testing for young people**

- ☐ Yes
- ☐ No
- ☐ Don't Know

2. **Ensure Sexually Transmitted Infection self-test kits are available from a number of suppliers**

- ☐ Yes
- ☐ No
- ☐ Don't Know

3. **Establish a clear sexual health outreach strategy which includes the availability of pop-up clinics to improve access**

- ☐ Yes
- ☐ No
- ☐ Don't Know

4. **Maintain the walk-in sexual health services in Birmingham and Solihull**

- ☐ Yes
- ☐ No
- ☐ Don't Know

5. **Ensure safe spaces for young people to discuss health and relationships and receive condoms**

- ☐ Yes
- ☐ No
- ☐ Don't Know

THEME TWO

Reducing the Rates of Sexually Transmitted Infections

6. **Ensure all pharmacies are trained to provide sexually transmitted infection treatment and advice**

- ☐ Yes
- ☐ No
- ☐ Don't Know

7. **Localise the HIV Action Plan to increase the promotion and take-up of PrEP**

- ☐ Yes
- ☐ No
- ☐ Don't Know

8. **Commit to tackling HIV, hepatitis B, hepatitis C and tuberculosis as part of Fast Track Cities+ by increasing HIV testing**

- ☐ Yes
- ☐ No
- ☐ Don't Know

Please add any additional comments you may have below (optional)

THEME THREE

Reduce the Number of Unwanted Pregnancies

Please tick one of the statements for each question that you agree with below, please do not tick more than one box per question. For more detail on the topic of Reduce the Number of Unwanted Pregnancies, please see pages 16 and 17 of the Draft Strategy.

1. Work with stakeholders and providers to plan post-natal contraception pathways

- ☐ Yes
- ☐ No
- ☐ Don't Know

2. Ensure contraceptive services are culturally competent

- ☐ Yes
- ☐ No
- ☐ Don't Know

3. Increase access to long-acting reversible contraception (LARC) by extending pharmacy services to include sub-dermal implants

- ☐ Yes
- ☐ No
- ☐ Don't Know

4. Increase the availability of LARC and emergency hormonal contraception (EHC)in Solihull

- ☐ Yes
- ☐ No
- ☐ Don't Know

5. Abortion and sterilisation services to provide access to LARC together with appropriate contraceptive and sexual health advice

- ☐ Yes
- ☐ No
- ☐ Don't Know

THEME THREE

Reduce the Number of Unwanted Pregnancies

6. **The pharmacy contraception offer in Solihull should be the same as the offer in Birmingham to reduce inequalities**

- [ ] Yes
- [ ] No
- [ ] Don't Know

7. **Provide free pregnancy tests, where deemed appropriate, in several settings**

- [ ] Yes
- [ ] No
- [ ] Don't Know

8. **Regularly review the quality of information available on all platforms**

- [ ] Yes
- [ ] No
- [ ] Don't Know

Please add any additional comments you may have below (optional)

THEME FOUR

Building Resilience

Please tick one of the statements for each question that you agree with below, please do not tick more than one box per question. For more detail on the topic of Building Resilience, please see pages 18 and 19 of the Draft Strategy

1. **Ensure accurate information is available to support healthy, safe and consensual sexual relationships**

- ☐ Yes
- ☐ No
- ☐ Don't Know

2. **Produce campaigns on reducing stigma related to HIV & around Fast Track Cities+**

- ☐ Yes
- ☐ No
- ☐ Don't Know

3. **Challenge stigma and discrimination, address misconceptions, bust myths and normalise good sexual health**

- ☐ Yes
- ☐ No
- ☐ Don't Know

4. **Promote and support evidence-based resilience programmes in schools**

- ☐ Yes
- ☐ No
- ☐ Don't Know

5. **Provide education and awareness for older people to break down myths and barriers to good sexual health**

- ☐ Yes
- ☐ No
- ☐ Don't Know

THEME FOUR

Building Resilience

6. Develop voluntary sexual health champions in communities where engagement is difficult

- ☐ Yes
- ☐ No
- ☐ Don't Know

7. Address peer pressure and social norms through consistent messages, information and education

- ☐ Yes
- ☐ No
- ☐ Don't Know

8. Provide targeted engagement & support programmes for those affected by sexual and/or domestic abuse

- ☐ Yes
- ☐ No
- ☐ Don't Know

Please add any additional comments you may have below (optional)

THEME FIVE

Children and Young People (Everyone up to the age of 25 years)

Please tick one of the statements for each question that you agree with below, please do not tick more than one box per question. For more detail on the topic of Children and Young People, please see pages 21 and 22 of the Draft Strategy.

1. **Design an appropriate integrated sexual health service pathway for under 13s with child-focussed sexual health provision**

- ☐ Yes
- ☐ No
- ☐ Don't Know

2. **Continue to provide a young person's abuse survivors' clinic and set up a well-promoted child-specific sexual abuse survivors' clinic**

- ☐ Yes
- ☐ No
- ☐ Don't Know

3. **Prioritise children in need and care leavers up to the age of 25 years**

- ☐ Yes
- ☐ No
- ☐ Don't Know

4. **Include Sexual Health Wellness as part of the social care health check for children and young people**

- ☐ Yes
- ☐ No
- ☐ Don't Know

5. **Increase the provision of good quality contraception, advice and information for children, young people, parents and carers**

- ☐ Yes
- ☐ No
- ☐ Don't Know

THEME FIVE
Children and Young People

6. Support schools and colleges to provide high quality "Relationships and Sex Education (RSE)"

- ☐ Yes
- ☐ No
- ☐ Don't Know

7. Ensure support is available for young people not in education, employment and training

- ☐ Yes
- ☐ No
- ☐ Don't Know

8. Rollout of the Bystander Intervention programme[1] to all higher education settings to support healthy relationships in young adults

- ☐ Yes
- ☐ No
- ☐ Don't Know

Please add any additional comments you may have below (optional)

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/941380/Bystander_interventions_report.pdf

ABOUT YOU

We would like you to tell us some information about yourself. You do not have to tell us if you do not want to, but if you do, it will help us understand if we have engaged with specific community groups. Any information you provide is anonymous.

1. Are you providing this response for yourself, or on behalf of someone else or an organisation?

- ☐ Myself
- ☐ On behalf of someone else
- ☐ On behalf of an organisation

If on behalf of an organisation, tell us which organisation the response is from

---

2. Are you (please tick one box that best describes your interest in the consultation)

- ☐ A member of the public
- ☐ A public health specialist
- ☐ A health or care professional
- ☐ An academic
- ☐ Other

If other please state

---

3. Where do you live, work, study or socialise?

a. Location (Please tick all that apply)

- ☑ Birmingham
- ☑ Solihull
- ☑ Prefer not to say

b. Activity (Please tick all that apply)

- ☑ Work
- ☑ Study
- ☑ Socialise
- ☑ None of the above

---

4. Please tell us the first part of the postcode of your home address (e.g. B1, B26, B54)

5. Which age group applies to you? (Please tick one box)

- ☐ Under 16
- ☐ 16 to 19
- ☐ 20 to 24
- ☐ 25 to 29
- ☐ 30 to 34
- ☐ 35 to 39
- ☐ 40 to 44
- ☐ 45 to 49
- ☐ 50 to 54
- ☐ 55 to 59
- ☐ 60 to 64
- ☐ 65 to 69
- ☐ 70 to 74
- ☐ 75 to 79
- ☐ 84 plus

6. What best describes your gender? (Please tick one box)

- ☐ Male
- ☐ Female
- ☐ Non-binary
- ☐ Prefer not to say
- ☐ Other (please state)

☐

7. What is your sexual orientation? (Please tick one box)

- ☐ Bisexual
- ☐ Homosexual, gay or lesbian
- ☐ Hetrosexual (straight)
- ☐ Prefer not to say
- ☐ Other (please state)

---

8. Which of the following best describes your ethnic background? (Please tick one box)

Asian or Asian British

- ☐ Bangladeshi
- ☐ Chinese
- ☐ Indian
- ☐ Pakistani

Black or Black British

- ☐ African
- ☐ Caribbean

White

- ☐ English, Irish, Scottish or Welsh
- ☐ Eastern European
- ☐ Gypsy or Irish Traveller

Mixed ethnic

- ☐ White and Asian
- ☐ White and Black African
- ☐ White and Black Caribbean
- ☐ Prefer not to say ☐ Other (please state)

9. What is your religious belief? (Please tick one box):

- ☐ Buddhist
- ☐ Hindu
- ☐ Muslim
- ☐ Christian
- ☐ Jewish
- ☐ No religion
- ☐ Prefer not to say
- ☐ Other (please state)

10a. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months (include any problems related to old age)? (Please tick one box)

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

10b. If you answered yes, have any of the following affected your access to sexual and reproductive health services?:

- ☐ Physical disability
- ☐ Learning disability
- ☐ Sensory impairment
- ☐ Prefer not to say
- ☐ Other (please state)

---

11. Do you look after, or give help or support to anyone because they have any long-term physical or mental health conditions or illnesses, or problems related to old age?

- ☐ No
- ☐ Yes, 10 to 19 hours a week
- ☐ Yes, 20 to 34 hours a week
- ☐ Yes, 35 to 49 hours a week
- ☐ Yes, more than 50 hours a week

ADDITIONAL INFORMATION

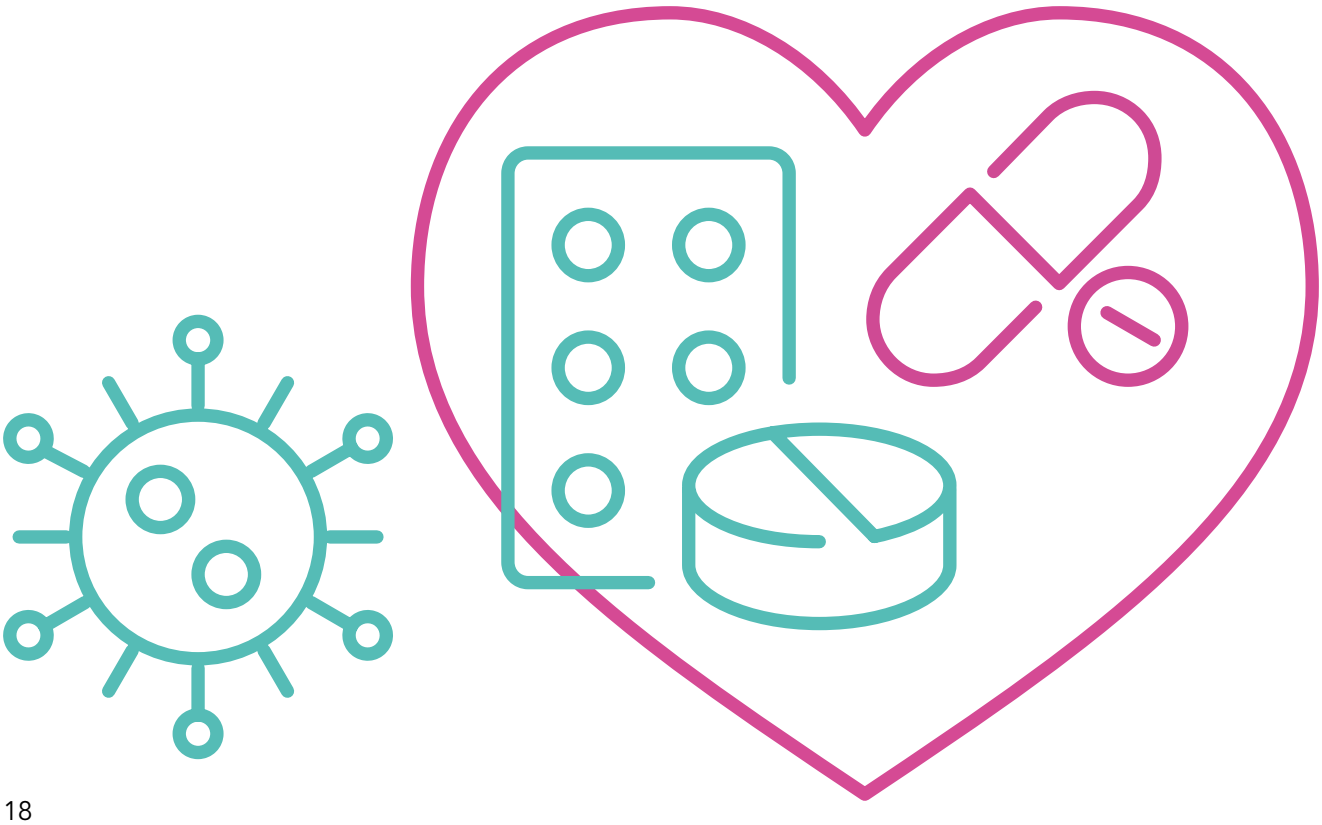
Data Protection Act 1998

The personal information on this form will be kept safe and is protected by law.

You can find out more about data protection on our website at:

www.birmingham.gov.uk/privacy

www.solihull.gov.uk/about-the-council/data-protection



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Appendix 2 - Free Text Survey Responses

Free text comments were received under the vision and each of the themes during the consultation. These have been grouped into subject areas and illustrate where further work may be needed to inform and develop our future approaches to service delivery.

Vision

I have no issues against the strategy

Very concise

Prevention is key.

I'm glad to see it's being addressed.

Whilst overall the vision and aims are well-meaning, there are some contradictions that are illuminating.

I have only focused on the areas relevant to myself and I was positively impressed with the depth of understanding especially around the need for integrated teams, widening outreach, promoting PREP and working in partnership

Agree with need for voices of lived experience and proper consultation and involvement Is there space for co-production too, rather than just consultation?

Support the strategy but want to know how this will be implemented and no money given to UHB for providing all services.

I'd like to see a resourcing plan to support delivery of the strategy

Values and beliefs:
Stopping the pervading belief that sexual availability and activity is cool/fashionable/desirable but in a way that is not old fashioned or religious. Privacy and choice not to be sexually active is a right and not prudish or frigid.

I believe in the sanctity of life and therefore the rights of the unborn child. I therefore cannot in good conscience support abortion services.

……although the vision suggesting that it is important to reduce stigma and shame, by positioning abortion as a 'bad outcome' or 'failing at contraception', the strategy actually reinforces abortion stigma. This is extremely unhelpful, and does nothing to encourage open and meaningful conversations with healthcare providers

A key part of the vision stated is 'to enable citizens to have control' - which is exactly what it should be. However, within the strategy, there is a strong emphasis on increasing LARC take up and reducing abortions. For many this will be what they want and be welcomed, but this should not be universally assumed.

I particularly agree that the aim to see "A reduction in the high rates of teenage and unwanted pregnancy, abortion and STIs, which can have far reaching consequences for individuals and society" is very important and in part stems from the hyper-sexualised culture that teenagers now grow up in.

The Strategy should include more focus on education that includes learning and understanding about genetic literacy and the associated risks and mitigations from a non-judgemental perspective. This needs to start from primary school and in faith settings.

Gaps:
It is very focussed on female issues with little regard to issues affecting men unless they are marginalised or have a sexually transmissible disease

There is nothing for people experiencing sexual dysfunction such as impotence or vaginismus. This is a big issue for older men and men with diabetes. Education on the subject and availability of Viagra, psychosexual counselling etc should be included You mention gender dysphoria but there is nothing specific planned. Counselling outside of specialised clinic appointments that are typically 3 months apart for the index person and also for their close contacts should be available locally. They have big issues to consider regarding their reproductive health and the sexuality of their partners

You mention sexuality and disability but there is nothing specific planned

There has been very little progress in terms of developing learning for foster carers in SMBC these past years so I very much welcome this

Enable services that are local, relevant, approachable, etc while responding to human protected characteristics. I hope this also includes the consideration that some women only services as protected by sex are needed too

Current Offer:
They hold too much power already and are the Goliath in health care. They care more about their research papers than their clients.

Sexual health provision in the city is appalling and has deteriorated in recent years. Trying to get an appointment with umbrella is almost impossible. Since removal of the walk in GP centres in Birmingham if you need PEP, you have to wait 8 hours in A&E who are overstretched.

COVID has negatively impacted sexual health services everywhere. There needs to be a step change to ensure services that were reduced or removed during this period are re-established and additionally improved upon to manage vision and aims of the strategy.

Additionally, there is not enough focus on diagnosis of STIs. Approximately 80% of patient management decisions are as a result of a pathology diagnosis, this is no different in sexual health, and yet given the potential stigma and barriers, we still find it acceptable to allow patients to wait excess time for results and treatment, we still find it acceptable to assume patients will manage their own health via on-line / postal services for testing and education; some vulnerable groups need more attention.

Healthcare Sector Comments:
On behalf of NHS England I think it would be good to see reference to the commissioning of Opportunistic Cervical Screening at Sexual Health clinics. We would be keen to discuss how we move forward with this

We need to better manage testing and the time to diagnosis and treatment.
Please refer to Whitlock et al., Rapid Testing and treatment for sexually transmitted infections improve patient care and yield public health benefits. International Journal of STD and AIDS., 0(0) 1-9 https://doi.org/10.1177/0956462417736431

Gilead Sciences has worked with sexual health services across the world to ensure that people who are diagnosed with HIV and HCV have access to the most appropriate treatment as quickly and securely as possible. We therefore welcome the opportunity to provide a written submission to this inquiry and support the ambitions of Birmingham's Sexual and Reproductive Health Strategy in providing the best prevention, treatment, and care for all those living with and at risk from HIV and HCV. In alignment with Birmingham's Vision, we see four main actions that need to be undertaken across all sections of society to make progress:

1. People living with HIV are not a homogenous group, it is important that the individual concerns and needs are considered when implementing measures and actions and the voice of people living with HIV must be at the heart of any policies and actions and their voices must be heard
2. Data collection should be improved to include a greater cross-section of society, including lesbian and bisexual women, migrant communities, people who inject drugs, and people who are homeless
3. Specific measures should be introduced to tackle areas of concern for people living with HIV such as mental health, social care, stigma and discrimination, supported by education for healthcare professionals
4. Easy-to-access testing initiatives must be a key focus for sexual health services. Early access to testing plays a vital role in reducing late diagnosis for BBVs and rates of transmission.

Terminology:
Vision seems robust and appropriate. However, next to aim 1 and 3 you mention "resilience." I do not think this word is user friendly (many MH service users do not like this overused phrase), it also suggests that people "just need" to be stronger/more resilient in the face of difficulties (some of which will include very traumatic and adverse situations.) Some users of services feel that this is a way which unhelpfully only focuses on their supposed lack of resilience, rather than failures in systems, multiple disadvantage and appropriate distress responses to very traumatic and adverse situations.

Agree that Access for every resident to meet their individual needs is key. Would like to see removal of barriers and providing equity of service here instead of resilience.

Enable citizens to have control of their own sexual health with services providing support where needed, agree it is key but would like to see the word resilience replaced with something else. Alongside the client feedback, it also isn't clear of what is meant by this anyway.

Theme One: Priority groups

Older people:
I'm concerned there is a theme focused on young people but not older people (although full lifecourse is mentioned).

The relationship and sexual health needs of older people should be treated as a separate theme due to the different presenting needs and the lack of focus on this population group in previous service delivery.

Agree but need to address a broad range of ages eg: over 40's and older people within this strategy

Victims of Domestic Abuse:
Is there scope to provide training for pharmacists around domestic abuse? Birmingham currently has IRIS and an IDVA based within sexual health services to facilitate this training but pharmacists, who may provide an excellent safe space for women to disclose experiences, do not receive training as far as I'm aware

Women experiencing domestic violence and abuse also need to be a priority group, ensuring safe confidential access to services at the GP practice. STIs and repeat emergency contraception / abortions can be an indicator for DVA. DVA needs to be brought up through sexual health training for practices.

Work with Women's Refuges, Chem-Sex and Sex Worker support groups (if there are any) and HIV Support Groups

Above there is NO mention of those subjected to sexual and domestic abuse, which is referenced in the draft strategy. This is a vital priority group and the work of the last SH strategy where it was an outcome should be maintained, built on and grown. By not mentioning it here, there will be a loss of focus on this priority group which affects a large proportion of people, and as evidence shows esp those who are women, young people and those with disabilities (all 3: sex, age and disability are protected characteristics too)

HIV & Blood Borne Viruses:
To protect and support people living with HIV, it is key to understand who they are, their needs, and how they can be appropriately supported. In addition to gay and bisexual men as well as Black African communities, there are other priorities groups requiring support in order to remain on effective treatment to control their viral load. These groups include women, people who are ageing with HIV, people who are homeless, migrant communities, and people who inject drugs. To support all these groups to live well with HIV, the following steps should be taken:

Greater support should be provided for increasingly marginalised communities to ensure adherence to treatment plans is easier and these individuals can access the support they need. Advances in treatment and care have meant that the epidemic has been reduced to primarily impacting marginalised communities. The National AIDS Trust has warned that, unless action is taken to provide support to these marginalised communities, 'a larger outbreak in England is possible'. This group are likely to make up the majority of the 20% of people without viral suppression

Prioritise women living with HIV in both research and policy agendas, while ensuring greater collaboration between HIV services and sexual health and reproductive services to provide a stronger healthcare network for women with HIV. The experiences of women living with HIV are under-assessed and under-recognised. To address these inequalities, it's important that women are prioritised in policy and research agendas and community groups are included to ensure this work is community-led

To reduce the rates of HIV, the HIV Action Plan for England sets out two recommendations which should be included in Birmingham's plans:
• Action 4: Reduce missed opportunities for HIV testing and late diagnosis of HIV
• Action 8: Ensure all late diagnoses are investigated as a serious incident by the National Institute for Health Protection, working with BHIVA, NHS Trusts, local authorities, and CCGs

Early access to testing plays a vital role in reducing late diagnosis for all BBVs and reduces the number of people who are not aware of their status unknowingly passing the virus on. BBV testing in sexual health services is lowest among women (56%) and late diagnosis is highest among BAME groups, closely followed by older people and white women. With this

in mind, testing initiatives must be targeted and easy-to-access for service users, with opt-out BBV testing being the end goal.

In addition to the national actions that have been set, there are a number of other actions that should be implemented to address late diagnosis and tackle HIV, HBV and HCV in Birmingham. These can be implemented alongside the Fast Track Cities plus Project (a project aiming to reduce new cases of BBVs):
• Expand opt-out BBV testing into non-traditional settings, such as community centres, A&E, and primary care, to address late diagnosis and reduce onward transmission of HIV. Whilst Gilead notes the commitment to rolling out BBV testing in A&E and GP practices, further steps could be taken through opt-out testing. London recently launched an opt-out BBV testing approach which stipulated that all patients over 16 who require a blood test as part of their treatment at A&E departments receive a HIV test. Testing of this kind is thought to be the single most effective intervention to find most people living with HIV who are not yet diagnosed
• Expand HIV testing campaigns to raise awareness and address stigma across local areas, focusing on non-traditional settings. National HIV Testing Week (NHTW) runs once a year targeting the wider public. In 2021, NHTW had its most successful day on record with 8,200 HIV test kits requested. Due to high demand, Public Health England (PHE) funded an additional 10,000 kits to enable more people to know their HIV status. Campaigns such as NHTW could hold value if recreated in Birmingham through raising awareness of HIV among the general public, and ensuring that people are aware of their HIV status
• Ensure all HIV services are sufficiently supported to undertake a formal published review of all patients who are diagnosed late to gain better understanding of the population. A 2016 paper showed that almost a quarter (22%) of deaths in people with HIV in London were attributable to AIDS-defining illnesses, which is largely attributed to late diagnoses and/or a lack of engagement with care and treatment services.

Within the homeless [population], there's quite high rates of bloodborne viruses, but there aren't necessarily high rates of STIs

Improving testing for bloodborne viruses by blood spot testing - I think that would be well worthwhile doing.

Engagement:
I think working in partnership with other organisations is key to delivering this service to priority groups who may require these services.

Need to see more outreach provision for those hard to reach communities as there is currently lack of assertive engagement across the city due to cuts to funding over the years leaving people vulnerable and at increased risk.

More needs to be done to reach the hard to reach groups. More health promotion / education roles need to be put into place that focus on breaking barriers and negative attitudes towards sexual health .

General comments:
Sex and alcohol/drugs aren't always hand in hand and people shouldn't feel that they will be tared with the same brush….. those engaged in substance misuse support would likely need to concentrate their efforts on one issue at a time...

Curious to know why sex workers and chem-sex users are not included as priority themes in the strategy. In fact they are hardly mentions anywhere in the strategy

Recognise the need to better genetic literacy in some communities to reduce risks around consanguinity including
1. miscarriages
2. infant mortality
3. child mortality
4. child disability

Theme Two: Reducing the rates of sexually transmitted infections

Access:
Give a true 7 day service.

Pop-up clinics would be ideal

Walk in clinics are vital

Walk-in centres need to be better placed and not in Boots!!!

We are in 2022 and don't want the world to know we are going to a Sexual Health Clinic.

Needs to be better managed!!!

Need to move sexual health out of the hospitals and medical settings plus reduce shame around the topic of sexual health.

There need to be more localised places for sexual health screenings. Some of the local ones don't have blood testing functions and for some people/communities, being seen in the City Centre GUM clinic or around it would be shameful, equally, some might not have the money to travel.

If by pop-up services you mean for example clinics as gay saunas and sex clubs then yes. As a user of STI clinics and a gay man on PREP I have serious concerns about self-test Kits. I know they save time and resources but how effective are they? What research has been done on their effectiveness? I have found them to be difficult to use and have given up using them. Getting blood into the tiny vile is very tricky and messy. And I've had several comments of Umbrella staff saying that users don't like them and find them difficult and impractical to use

The Walk in (with available booked appointments) in Solihull is vital. Maintaining both walk in and self-test as part of a spectrum of options to reach the most people is key. Some people are unable to use the self test kits.

Make it 7 day testing walk in centres. The home test kit results take far too long to come through. Access to PEPSE on a Saturday or Sunday is awful.

Completely agree. There needs to be more localised offer, one that also is quicker than the current one where you sometimes have to wait quite a long time for an appointment for example when you work and can't do day time hours.

Have walk In Sexual Health Centres had their day? Is it now better to integrate them into other services?

Don't want to go to the hospital for testing or GP or even Boots in town centre. Want to have testing that is easy to get to and close to where I live.

The Hubs seems like a good idea

I would also like to see the utilisation of frontline support/outreach staff in delivering community-based sexual health link work

Inclusion:
It is important to link cross services to provide holistic services, but it is also important to not exclude those that may need sexual health but not drugs and alcohol or even if people need both to not put them off accessing one because they are not ready to talk about the other.

Not just young people need safe spaces to discuss their health and relationships

You have included little for women with genital mutilation who have NRPF and may find genital examinations difficult and birth almost impossible.

There is a distinct absence of issues arising from the menopause such as vaginal dryness, loss of sexual desire

There is a much closer link to the above than ever before realised. Inequalities/substance misuse/intersectionality really affect people's choices and accessibility but also understanding of risks and accessing services.

You have to [check] what people's prime motivators are [for attending sexual health services], nd they aren't necessarily the same as ours… We might see what they need but they don't."

I am shocked how quickly CHEMSEX is on the increase. It's like a little pandemic of its own. If you go on some of the dating applications, you start seeing the number of people looking for it/selling it etc. It's really worrying for health reasons, MH reasons but also of course around safe-sex practice which tends to go out the window in those situations. I presume abuse might also take place in those situations.

STIs can be a signifier of DVA. Please ensure clinic, pharmacy and outreach teams are aware to look out for DVA.

I am a survivor of historical sexual abuse. Whilst I've been asked in a clinic about any previous such incidents and I disclosed them, once I said I didn't need help, it was left. I actually would sign up to some sort of focus group or some help around dealing with past abuse, not just sexual but I've also been subjected to emotional and physical, which has affected my whole life and still does. It'd be great to see some help offered in that space

Primary Care
Primary care (GPs) should be having more involvement in managing sexual health , currently with contracts sitting with external providers it is duplicating work, we need to share our notes and communication has to be robust, we seem to be lacking an effective communication and wonder if the new process will look into this - Best wishes, A caring GP

Pharmacies are probably better served for public use than GP's as you would have discuss private information with the receptionist first. Pharmacy staff are more helpful.

Women from many BAME communities are not allowed to attend sexual health services on their own and cannot discuss embarrassing issues in front of family members. In my experience, many will talk about such matters openly to a health professional on their own. Some worry that their husbands are gay or carrying STIs from sex outside marriage and even have symptoms of STIs that they cannot disclose in front of a relative. Some say that

their GP needs to pretend to send for them to discuss their child's health for them to be allowed to attend without a relative or insist that the consultation is just for them with no one else present.

I agree with the statements in general but would prefer more information about how it will be done e.g. item 6 ensure all pharmacies ..... Which ones will be trained first ? any priority of area or target group… how many and by when

Funding for GP practices to deliver sexual health services as part of contraception services (currently not part of the service which Umbrella GP partners can provide when fitting LARCs for non registered patients which makes no sense)

Education:
Much more needs to be done in reducing stigma and providing education - all around accessibility.

How can education AND high value reliable laboratory quality testing be achieved in outreach areas?

Testing:
Point of Care testing has developed over time and can no longer be considered lower quality than the laboratory - addressing this would improve access and discussion as well as potentially reduce time to treatment, reduce transmission of STIs and reduce stigma.

Gilead Sciences welcomes any action taken to reduce the rates of HIV transmissions, while improving the health-related quality of life for people living with HIV. The commitment of the aims set out in Birmingham's draft strategy represents a positive step in helping and supporting people living with HIV. However, in order to enact meaningful change, sexual health services must shift their focus to a wider BBV approach and consider what local steps can be taken to reach the Government's target to eliminate Hepatitis C by 2025 and end new transmissions of HIV by 2030.

More could be done in collaboration with services that already provide a rapid diagnostic and faster treatment approach, especially in PWIDS and homeless populations (refer to Midlands ODN and The Hepatitis C Trust) who already have focus and these groups and could work with other services to support (AT THE SAME TIME) STIs, as well as other infectious disease possibilities. This could save time and revenue in faster diagnosis and treatment as well as staff time with multiple services chasing the same patient.

Would self testing with a RAPID lab quality result be more appropriate for people who have been sexually abused or assaulted - to reduce the anxiety of waiting for results, why not provide laboratory quality POC testing? to provide results within hours that can then be reliably acted upon.

More needs to be included about smear tests and HPV vaccinations.

[STI] testing in other services e.g. TOP services needs to be addressed as this has really suffered with the changes in legislation and procedures which means that women are often not being seen.

Are you including tests for hepatitis and tuberculosis with the HIV test? From what is written it looks that way and if you are some people are going to object and possibly refuse any test.

Easy access to self-testing kits should be for everyone, not just under 25s.

Local clinics don't do blood tests in some cases, that should change.

The self-testing kits have not long ago changed the tube for a blood sample. It is now much bigger and it's IMPOSSIBLE to get enough blood out of the finger to provide a sample. I've given up now and so many of the people I know have - we just send the other tests off without bloods.

Having a number of different STI testing kit suppliers would not support the majority of laboratory testing broad assay menus on a single platform that allows consolidation and the ability to run more tests. Maintaining multiple contracts with suppliers would be unwieldy and in many cases impractical given the primary supplier, Hologic is used by the majority of laboratories and changing would involve major costs and disruption to the current platforms used by laboratories.

Number 8 is a non sequitar and the other infections require attention outside of HIV testing. Include reference to monkey pox?

Values and Beliefs:
It would be great if we could try and promote chastity, as opposed to offering free condoms which unfortunately will be more geared to promoting promiscuity.

In addition, the drivers and motivations for sexual promiscuity also need to be looked at rather than just addressing the result (i.e STIs etc)

Your objectives and questions above seem obvious. It isn't the what, it's the how, how do you do it? how do you assess effectiveness? how do you follow up. More subtly, how do you work around political and religious nonsensical certainties?

But should be a way to reduce shame

The provision for young people to talk about healthy relationships is key as otherwise the main learning ground is likely to be the internet and/or pornography which leads to damaging and unhealthy relationships.

Effectiveness:
Once again to provide the sexual and reproductive health services in an efficient way and to reduce the rates these equipment and other services are vital to the programme.

Don't know is more "why focus this on young people only?" other than that the statements are fine.

PREP is brilliant and the service and nurses are great. More people should have it.

The PREP clinics have been really good, very friendly, informative, non-judgmental, quick, reminding of the need to test and pick up PREP - fantastic. Promotion needs to increase to prevent further HIV infection rates.

Whilst the need for ongoing partnership is recognised there needs to be an increase in funding in order to ensure that there are enough resources are in place to meet the needs of the city.

Your questions and required responses are leading. Yes to all of the above but HOW CAN THIS BE ACHIEVED DIFFERENTLY AND MORE EFFECTIVELY? You are assuming here

that when the response is YES then your approach or offer is adequate or on track - what about being better, being innovative?

Theme Three: Reduce the number of unwanted pregnancies

The name of this theme is hugely problematic – it adopts a stigmatising approach from its inception, and should be renamed. A preferable approach would be to 'Increasing contraceptive access', but even switching to 'unintended pregnancy' would help.

The phrase 'reduce unwanted pregnancies' could be interpreted as 'increase the number of abortions', which I would not agree with.

Contraception:
Want easy access like it used to be

Better information online

Needs to be like a one-stop shop

I've never heard of LARC before but the concept is sound and should be encouraged.

Free, accessible pregnancy tests are important. Accessible LARC and emergency contraception with guaranteed confidentiality and DVA awareness are also essential. Specialised DVA training and advisors for pharmacy and clinic teams is one step that could make this service more accessible. Ensuring it is culturally sensitive and aware of inequalities with a high level of anti-racism training could also make this service more accessible.

Why there is not a pharmacy contraception offer in the centre of Solihull is beyond me. Having to go to the GP or the walk-in when other services are not required does not seem to be best use of resources and possibly more stigmatising than walking into the pharmacy after the initial GP or walk-in issue.

You do not mention the removal of some of the invasive contraception. Some of it requires a doctor. You do not mention ensuring the competency of IUD fitting doctors is regularly tracked / ensured

What is the evidence that providing the same pharmacy contraception offers in Birmingham and Solihull is the most effective way of reducing inequalities, given the very different demographics?

Better access to contraception is really important, but the overemphasis on LARC is problematic. There is strong evidence that when certain populations deemed by providers and policymakers as potentially 'bad mothers' are targeted for LARCs, there is a lack of attention to the reproductive autonomy of individuals, and issues such as side effects are not properly explained. In addition, the difficulties faced by people asking for LARC removal are becoming well known, and this is also likely to contribute to a lack of uptake.

I'm a cis gender straight female no longer in need of contraception but I think services are much worse now than they were. I liked being able to get contraceptive advice and free contraception from a stand alone FP clinic. Given the impossibility now of getting appointments in GP surgeries I think I would definitely prefer that still. But as a working person the huge benefit was evening clinics so I didn't have to take time off work. I see that it is impossible to see an Umbrella practitioner after 1830 or even 1630 in some clinics. I get that there may be risks to staff that did not exist so much 30 years ago but I think more

should be done to ensure that every woman knows free contraception and advice is available outside of GPs, all men know free condoms are available (I hope they still are) and that every step is taken to extend possibility for appointments / walk in across the city at extended times.

[We need to] understand about why is it that we are so far behind [the GP LARC prescribing rate] and understanding what it is that we need to do to address that.

As women who are sexually active do we routinely test women attending for contraception for HIV? If not why not?

Do not weaken family planning services and access to appropriate contraception in favour of sexual health as happening during the pandemic when PreP was still available and supported but women had to give up we'll working forms of contraception as they could not be seen in clinics!

I don't think people like pharmacists who have not had a fuller grounding in all contraceptive options and potential complications should be fitting implants. More should be done to train people thoroughly rather than just how to put an implant in

Strengthen access to post natal contraception including LARC methods and missed opportunities post ectopic/miscarriage across the city - no provision currently

Think there should be express provision for LARCs for YPs and generally opening of services for YP

Abortion:
Work to stop accidental pregnancies so that abortion becomes a thing of the past.

I do not agree with killing the unborn.

The emphasis on abortion providers providing LARCs is based on negative stereotypes of why people access abortion, which again illustrates that this strategy has been produced to further stigmatise abortion rather than increase autonomy and decision making in this area.

I think this is too weak. Does it say over 1/4 conceptions lead to abortion? Surely more should be done to tackle that. The strategy's focus is on marginalised groups. Do they make up the majority of that statistic? Agree for health inequalities that is right. But it can only happen after a really strong baseline services are in place.

Abortion services improve contraception and testing for early medical abortions needs significant overhaul, these are high risk groups

Engagement:
To Reduce the Number of Unwanted Pregnancies, working with other key stakeholders and organisations is vital.

tests should be available free where needed but the settings should be able to offer some ongoing /appropriate support

Again I would like to see the utilisation of charities such as Trident Reach, with an already established in-reach into some of Birmingham's & Solihull's most vulnerable and underrepresented communities in delivering sexual health link work, education and support.

Whereas the desire to avoid unwanted pregnancies is good and people should be encouraged to seek to have family situations (e,g marriage) that will be stable and conducive to having children.

Theme Four: Building resilience

I don't think the word resilience fits here to be the best umbrella term for these action plans and aims. It is also not liked by many users (see previous comments on earlier questions.) This section to me seems to be about breaking down stigma and barriers to services.

Education and Advice:
Education in schools important

If it's not on Insta, it doesn't exist in the world

Building Resilience, means more help and information should be put out there to raise awareness on such issues and provide advice

Abuse within young people's relationships could be key here. There are huge gaps in clarity around consent

Education around sexual health and healthy relationships needs to address the patriarchal norms of society. Men and boys need to be given more comprehensive education around contraception and the risks of not using it. Better healthy relationships education from a young age to combat the norms of abuse in relationships is also needed.

Focus on people's right to choose not engaging in sex if they want to live that way, minimise the effects coercion and peer pressure to engage in sex.

I agree that Building Resilience, means more help and information should be put out there to raise awareness on such issues and provide advice.

Provide community promotion highlighting the risks of unprotected sex under the influence of drugs and alcohol and details of where to access condoms in all venues that sell alcohol. Resilience for people living with HIV can be defined as having the ability to engage effectively with health and care services, such as taking regular treatment and seeking mental health support where necessary. While each individual living with and affected by HIV will have their own understanding of Health-Related Quality of Life. The concept is subjective and, as has been recognised by HIV Outcomes, must be assessed from an individual perspective.

I'd want to know what will be promoted and what is evidenced re resilience programmes in schools. Unsure what progs this refers to, who has evidenced it and whether young people have been consulted. So would want to know more before I can say whether I support this. Many progs in schools are not young person friendly or centred and miss the needs of young people. We need to be sure their views are heard.

Peer pressure may need to be addressed via more than consistent message info and education. It is also about providing safe spaces where over time young people can explore, undo and challenge peer pressure and also examine why they may be the ones doing the pressure of peers. We need to help young people talk and explore (safely, over weeks and in single sex and then later perhaps in mixed sex spaces) about all aspects to sexual health. E.g. consent; sexual and domestic abuse; what they have seen in pornography and undo some of what they have seen, as much porn does not support consent, safe relationships,

interactions which are free of pressure etc.

Values and Beliefs:
"Normal" sexual health has become increasingly mis-represented since the sexual revolution. Proper / appropriate sexual union only belongs within traditional marriage.

The word I pick out here is 'normal'. Good practice should be normal, unspectacular, taken for granted.

Depends what the 'social norms' are that are being challenged as some traditional values around sex and relationships are what actually lead to human flourishing as opposed to the direction that much of the current social norms are moving, which has no real vision for human flourishing but is more motivated by a 'freedom from restrictions' approach.

Domestic Abuse:
It would be good to have a programme for those affected by sexual /domestic abuse.

Availability of support for both men and women experiencing rape or other sexual violence. Joint work with the police to make reporting easier and information for victims on what to expect when they do report such as genital evidence

There needs to be an increase in accessibility for those who have been victims of domestic and sexual abuse into appropriate therapies if requested without the need to sit on waiting lists. There needs to be an increase in resources to meet the growing numbers in sexual and domestic abuse and also there needs to be clear and timely consequences for perpetrators in terms of policing and the courts.

Sexual health has done a lot to build on support for anyone affected by domestic and sexual abuse. E.g. IDVA and ISVA services are excellent. ASC is a brilliant service. As reports of sexual violence are increasing this needs to be maintained as a minimum and built on, developed and expanded as best practice.

Stigma:
Agree that shame and embarrassment about services including abortions is a barrier.

As my previous comments, the vision to reduce stigma is good, but the strategy actually reinforces abortion stigma and makes judgements about conceptions that it doesn't feel are appropriate rather than focusing on improving access and autonomy for individuals.

Stigma and discrimination have a myriad of impacts on individuals living with HIV, including (but not limited to): poor mental health, reluctance to access medical care, and poorer health choices, these in turn can lower resilience. It is important to realise that, while stigma and discrimination affects all people living with HIV, it can be worse for certain groups, including those from lower socioeconomic backgrounds, communities where English may not be their first language, ageing populations, and groups with high HIV prevalence. viii
To improve health-related quality of life and build resilience, Gilead welcomes Birmingham's commitment to developing a stigma-reducing campaign as part of the Fast Track Cities plus Project, and believe it is key that people living with HIV are at the heart of any campaign and their voices are heard and valued. The following recommendations could create these improvements:

• Ensure all people living with HIV are supported to manage any co-morbidities, including from primary care and sexual health services. People living with HIV are disproportionately vulnerable to a wide range of other conditions (co-morbidities), including cardiovascular disease and chronic kidney disease and are more likely to develop certain types of cancer at

a younger age. All people living with HIV need ongoing support from across the care continuum to manage co-morbidities
• Make available appropriate and accessible mental health support with professionals who have knowledge and understanding of HIV. Around half of people living with HIV express mental health concerns, compared to 24% of the general public. A wide spectrum of mental health and support services such as peer support, counselling, psychology and health and wellbeing-related services should be made available to all who need them
• Work with local health services across primary care, dental, and secondary health services to eliminate HIV-related stigma, allowing people living with HIV to access healthcare without discrimination. People living with HIV continue to experience stigma and discrimination. These attitudes transgress to healthcare, with one in nine people with HIV having been refused healthcare or had their treatment delayed because of their HIV status.viii Quality of life will not be improved unless these attitudes change. Public awareness campaigns, training for NHS staff, and education in schools would help tackle stigma and discrimination
• Implement the National Standards for Peer Support in HIV when developing peer support networks for people living with HIV to develop mutual learning and understanding of HIV, while enabling people to develop communities and support networks. Peer support is a relationship through which people are seen as equals and the focus is on 'mutual learning and growth'. Peer support can improve the confidence, well-being and overall quality of life for people living with HIV. As the population living with HIV is so diverse it is important that this diversity is recognised in both the people providing the peer support, and the locations of the sessions

Take a look at Dean Street and Dean Street Express - this service has transformed the attitude to STIs and testing in Soho by making it acceptable, approachable and accessible. Do the sexual health clinics in Birmingham and Solihull provide the same in the current format / environment? or are they still very sterile and have negative perception, would you want to go to Whitthall Street?

General Comments:
Also where it states develop champions where engagement is difficult. I would rephrase this. Usually engagement is difficult because the right approach, right engagement, right people, right methods or appropriate engagement has not been followed. It is usually about seldom heard groups, multiple disadvantaged or discriminated against groups that are so called "hard to engage with". I would change this to seldom heard or marginalised groups.

Need to add older people into the strategy

Need to integrate with the voluntary sector

Theme Five: Children and young people

Similar to previous comments - I'd like all services for all ages…

Better funding in GP services would support this. Primary care staff outreach to local schools would encourage young people to realised they can approach GPs and practice nurses.

Age Appropriate:
Theme Five - should not refer to Children only Young People since Sexual Health Services do not cover Children. Children should be managed within Paediatric services.

Unsure of response to under 13's. Not sure of what is meant here and what an integrated pathway for under 13's would look like. Whatever it is, needs to be age appropriate, mindful of age of consent and lack of ability for u-13's to consent and also high risk that under 13's will face sexual abuse, coercion and control. U-13's do need safe spaces where they can

continue to come to discuss consent, relationships, healthy relationships, explore their sexuality, ask questions, etc.

Design an appropriate integrated sexual health service pathway for under 13s with child focussed sexual health provision" - this seems odd phrasing as sexual activity under 13 is abuse so agree provision should be made but could rephrase

The increase the provision of good quality contraception, advice and information should not include children, but should include young people, parents and carers

Safeguarding issues relating to Children that are identified within Sexual Health are reported to the correct safeguarding agencies.

Sexual health pathways need to include monitoring of provision to guard against abuse of vulnerable children and young adults

……safe spaces for young people to discuss health etc... should also give consideration to physical and emotional safety and how they can feel safe discussing consent, when they have been subjected to domestic and sexual abuse, when they are uncertain of what may have happened in a relationship etc. Location is important here, it needs to be a safe environment that is young person centred and friendly (boots was not experienced by young people as safe.) Also training and approach of staff is important for safety too (do they know how to respond when a young person discusses when they are not safe for example). For some safety will be about specialised service provision, sex worker clinics, where only sex workers are seen; women only spaces and services; LGBT specific spaces etc.

Education:
Importance of specialists supporting schools and colleges around educating children and young people on positive sexual health.

Healthy relationships programmes need to have an understanding of the role that gender plays, need to have a VAWG context

Work with schools and colleges - commission out RSE service.

Education is key, help young children to understand what British law says about adults trying to engage in sex with children so they know it's wrong and how they can get help to stop sexual interference by adults or other ages, family or stranger.

For Children and Young People is imperative that children and young people are supported to health clinic like sexual clinics to get this service when it's needed for them at a time when they may require the service and can also be easily accessible in contacting.

Bystander Intervention programme Not enough information to make a judgment

I don't know what Bystander Intervention is but the name sounds right for much of our society. My qualified approval of the concept.

Consideration should be given to The Bystander Intervention Programme being delivered in all educational settings (Secondary, Colleges, 6th Form Centres and University) and not just Universities

More information and training awareness is required on the Bystander Intervention programme1 before it can be rolled out.

RSE needs to be updated in the schools, youth clubs and sports clubs

Better sex education across all organisations

The age appropriate content is very important as much of what is reportedly taught to children in some schools does not seem age appropriate and contains adult content. support and training for foster carers will support this

This is so key, if we can promote effective sexual health education at schools then it will pave the way for other services for this demographic later on.

Child friendly genetic literacy education around risks and mitigations to be delivered in school as part of the curriculum and access to support services made available

RSE is needed and support to schools and colleges. BUT... We can't leave teachers to do it all, they are often not trained, lack experience to do this and lack confidence too. Also for young people their teachers doing this work are the wrong people. Outside RSE is often better. BUT... RSE external providers should have consistent standards though and your strategy could have a role in ensuring that all RSE is 1. NOT victim blaming and instead puts responsibility on those who harass, abuse, pressure to change; 2. Supports correct messages re consent; 3. Offer challenges to males who don't treat females right and perpetuate sexism/misogyny and safe spaces for them to share their views, explore, change and also share where these views may have developed (e.g. in response to what they have seen in porn, in response to what the adults around them have modelled about relationships and in response to what they may have witnessed/been subjected to at home-e.g. domestic abuse in home. This gives proper chances for behaviour to be changed and better relationships to be developed. Girls also need space to discuss what is consent, health relationships, red flags etc. Both need to be informed and supported to call out sexual harassment, red flags, sexual abuse, domestic abuse, so called "banter" which is sexist and derogatory etc.

It was nice to have a [drop-in] clinic available [in certain schools] because we could talk to the school and talk to social workers who were attached to the school, not just from a contraception and sexual health point of view but also from a safeguarding point of view… Teenage pregnancy rates within those schools did drop significantly once these services were put in place.

Better education around the diagnosis and management of PCOS and sexual health from early teens. Affecting 1 in 10 females. See https://daisypcos.com/

HIV:
Young people and children with HIV, must be recognised as a distinct group. Growing up with HIV presents a unique set of challenges and experiences, different from any other cohort living with HIV. In the UK, as of 2019, levels of viral suppression were lowest for individuals aged 15-24 and about a third of all young people will experience virological failure within two years of beginning treatment. Such statistics highlight the need to continue to focus on improving HIV care, treatment, and education for young people both in the UK and abroad. The cohort of young people (under 25s) living with HIV is among the most marginalised of groups of people living with HIV

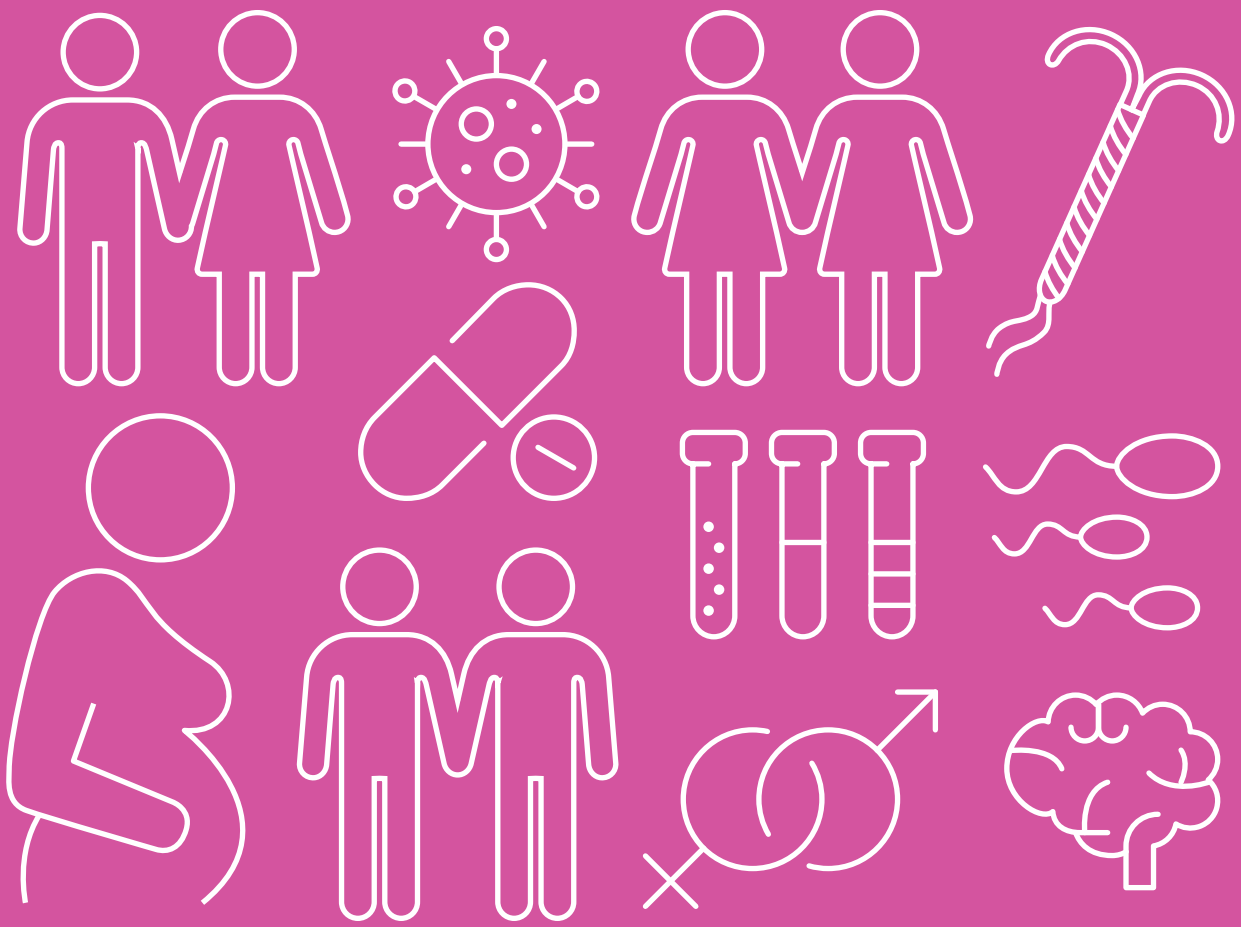
In order to fully support children and young people living with HIV, it is important that the following are taken into consideration alongside the points previously regarding a reduction in stigma and discrimination and accessible mental health support:
Young people living with HIV must be given autonomy to manage their own care by healthcare professionals. Children and young people should be better supported as they

transition to adult services, this includes the need to ensure continuity in healthcare professionals. Moving from paediatric to adolescent and adult clinics presents a range of complex challenges as young people adapt to new medical teams, changing routines and unfamiliar environments. Challenges relating to daily medicine adherence are common at this time. Patients who switch from paediatrics to adult HIV care have an increased risk of being lost to follow-up which increases the risk of treatment non-adherence.

SEXUAL AND REPRODUCTIVE HEALTH STRATEGY

2023-2030

Reducing sexual and reproductive health inequalities is our priority



Solihull Metropolitan Borough Council

Birmingham City Council

CONTENTS

Executive Summary 04

Foreword 05

Context & Purpose of the Strategy 06

The Current Landscape 08

Our Vision 10

Theme One: Priority groups 12

Theme Two: Reducing the rates of sexually transmitted infections 14

Theme Three: Reducing the number of unplanned pregnancies 16

Theme Four: Building resilience 18

Theme Five: Children and young people 20

Governance 22

Glossary 23

References 24

Notes 26

EXECUTIVE SUMMARY

Reducing sexual and reproductive health inequalities is our priority

This 2023-2030 Sexual and Reproductive Health Strategy sets out Birmingham City Council's (BCC) and Solihull Metropolitan Borough Council's (SMBC) themes, priorities and approach to meeting the sexual health needs of Birmingham and Solihull. It sets out plans to respond to increasing rates of sexually transmitted infections (STIs) and HIV and improve the reproductive health of our citizens. Sexual Health can impact an individual's emotional, physical and mental health, their economic means and social relationships. The effects of poor sexual and reproductive health are far reaching and for those affected, the impacts are compounded by social stigma and fear.

This strategy and associated action plan recognise that sexual health and wellbeing impact on and are affected by wider determinants of health (such as social, economic and environmental issues, which shape daily life and affect people's health), and so partnership working with all relevant organisations nationally, regionally and locally is crucial. This will also ensure that the right actions are carried out for the right people, in the right place and at the right time.

With challenges around reductions in public funding, it is vital that clear priorities focus on reducing sexual health inequalities and provide accessible services to all.

A strong evidence-base has informed this Strategy to tailor its approach to address the needs of Birmingham and Solihull's population through the following fve themes:

Theme One: Priority groups
Theme Two: Reducing the rates of sexually transmitted infections
Theme Three: Reduce the number of unwanted pregnancies
Theme Four: Building resilience
Theme Five: Children and young people

A key enabler that runs through all fve themes is the use of innovation and technology.

Through the themes and priorities, this strategy stands to have the greatest impact on those health inequalities and vulnerabilities at all ages and aims to improve the sexual health of the entire population.

Prevention is a priority and although this strategy focuses on a universal approach, there must be targeted interventions for certain groups such as under 25s, men who have sex with men (MSM) and minority ethnic groups who are disproportionately affected.

This strategy is supported by and refects our local Sexual Health Needs Assessment (SHNA), which is a live document and responds to the variable landscape and needs of our population and sits alongside the development of the Integrated Care System (ICS).

The Sexual and Reproductive Health Strategy works towards integrating all priorities in order to address the wider determinants of good sexual and reproductive health.

This strategy was developed by Birmingham and Solihull Council's Public Health and Commissioning Teams. Interested members of the public and stakeholders have been invited to give their views on the strategy, and those views have been incorporated.

A fnal version of the strategy will be published after approval by Cabinet Members and the Health & Wellbeing Board.

Clear aims and objectives are vital in reducing sexual health inequalities

FOREWORD

Paulette Hamilton

Councillor Paulette Hamilton

Cabinet Member for Adult Social Care and Health, Birmingham City Council

A.F. Dicicco

Councillor Tony Dicicco

Cabinet Portfolio Holder for Adult Social Care and Health, Solihull Metropolitan Borough Council

As Cabinet Members in Birmingham and Solihull, we support this Joint Birmingham and Solihull Sexual and Reproductive Health Strategy.

Sexual and Reproductive health is a fundamental part of our lives. Supporting a healthy approach is important at every age and our approach should be holistic and value the diversity of relationships, not just focus on procreation and sexually transmitted diseases. This new strategy embodies the World Health Organisation's recommendation to take a holistic approach to sexual and reproductive health across the life course for the citizens of Birmingham and Solihull.

This strategy recognises that there are areas of excellence being delivered in partnership with communities and clinicians across Birmingham and Solihull, however there is still potential to be even better. This strategy has achievable aspirations to respond to the rates of sexually transmitted infections and Blood Borne Viruses, improving reproductive health outcomes including prevention of unwanted pregnancies and ensuring that all citizens of Birmingham are provided with timely information and advice.

We also recognise that the recovery from the pandemic will bring additional challenges, however, we will work closely with partners and people living, working and studying in Birmingham and Solihull to ensure that the aims of this strategy are successfully met and we support all our citizens to achieve their potential for healthy sexual and reproductive health.

CONTEXT & PURPOSE OF THE STRATEGY

1.1 Why a Sexual and Reproductive Health Strategy is important for Birmingham and Solihull

This strategy sets out Birmingham and Solihull's vision, ambitions and priorities for sexual and reproductive health services over the next seven years, and provides a framework to guide the planning, commissioning and delivery of sexual and reproductive health services to improve sexual and reproductive health outcomes for Birmingham and Solihull citizens across the life course.

The provision of sexual health services is statutory and local authorities are mandated to commission open access sexual health services, including free STI testing and treatment, partner notifcation of infected persons, advice on and reasonable access to a broad range of contraceptives and preventing unplanned pregnancy.

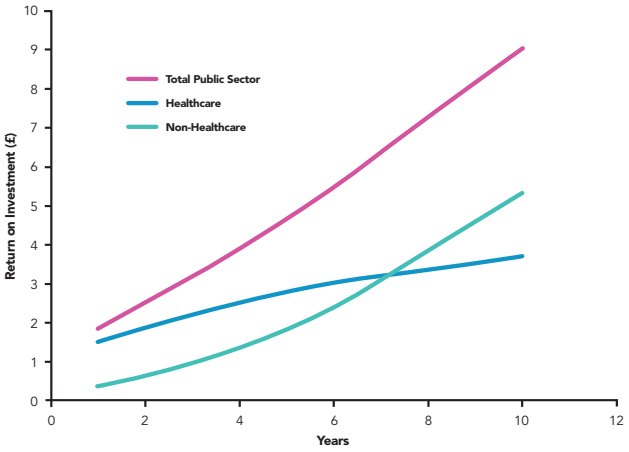
Our strategy is built on the most up to date intelligence and information we have on sexual and reproductive health (SRH), sets out several themed areas for priority from 2023 to 2030 and the actions we will take to address these priorities.

We recognise that the National Sexual Health Strategy is due to be released by the Department of Health and Social Care post December 2021, however, our strategy is designed to complement the expected release and will be fexible to meet any additional requirements.

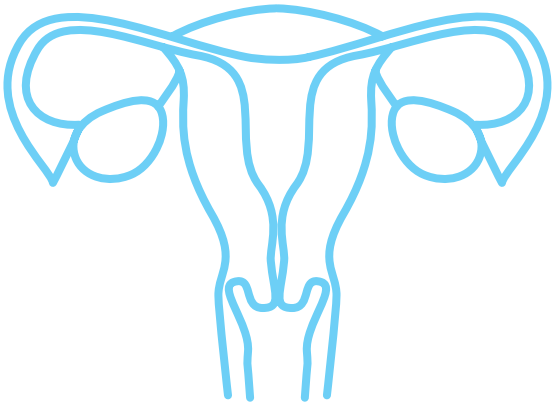
This strategy is complementary and embracing of other local policies and strategies, such as Domestic Abuse, Substance Use, Education, Relationships and Sexual Education (RSE), HIV, Women's Health and so on.

1.2 Investing in Sexual Health Services

Investing in sexual health services has demonstrated value for money and a substantial return on investment. A national study has shown that every £1 spent on contraceptive services saves £9 across the public sector[1]. The data also shows that 52% and 12% of unplanned pregnancies end in abortion and miscarriage respectively[2]. Collectively, this can provide a cost saving per averted pregnancy of £23.91 over 10 years, which translates to £3.68 healthcare saving per £1 invested and £5.32 non-healthcare saving per £1 invested over a 10-year period[3].



The SHNA[4] has identifed key ar eas to continue and enhance investment, namely training of staff and the future workforce. Education and early intervention investment are also important, which will help further achieve the return on investment for Birmingham and Solihull on sexual and reproductive health services.

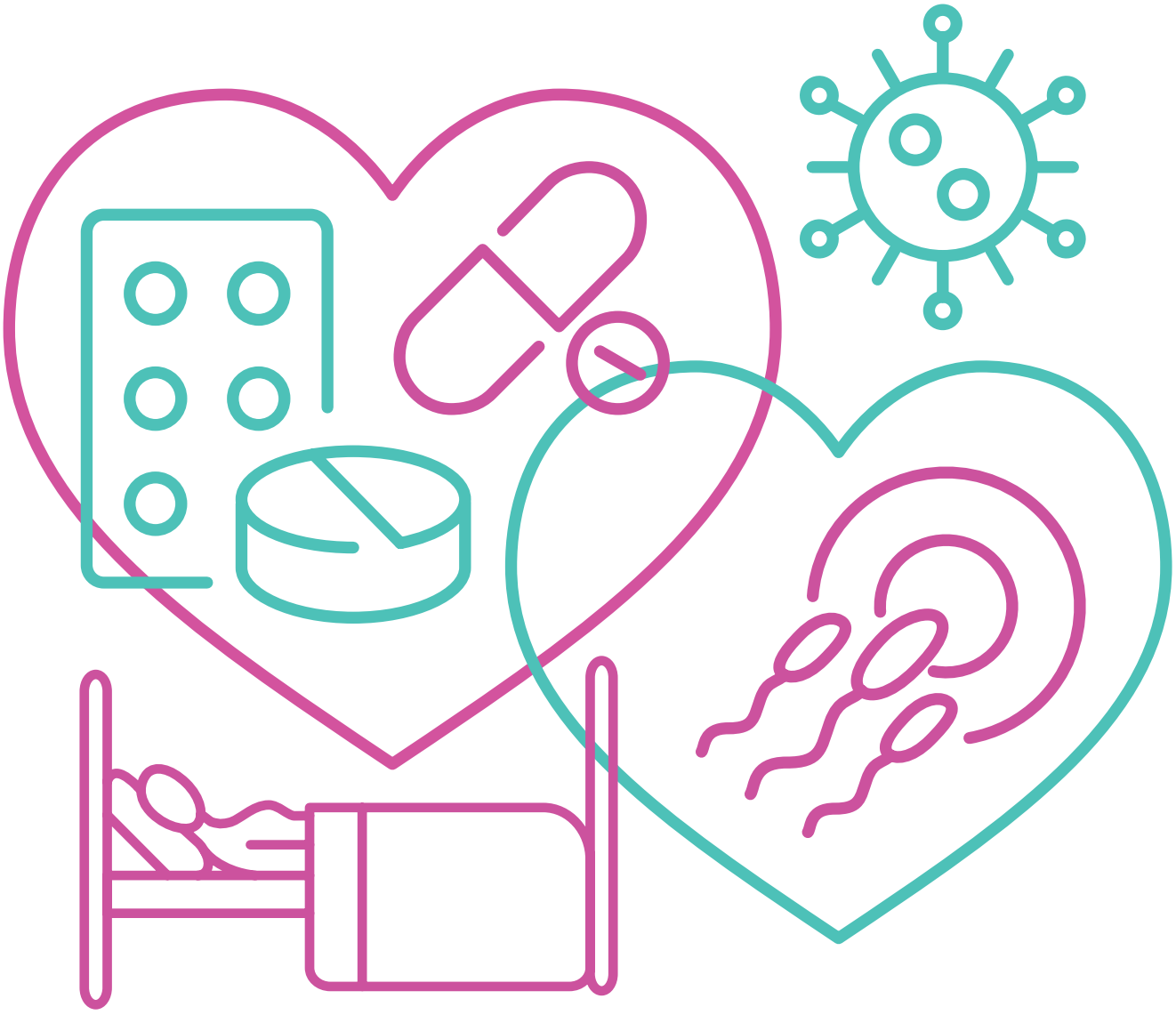


1.3 Why We Need a Joint Strategy

Birmingham and Solihull face some of the greatest sexual health challenges nationally, including high rates of HIV, STIs, emergency contraception use and abortions[4].

Although Birmingham has a younger population than Solihull, the challenges are similar, and due to the Clinical Commissioning Group (CCG)/ ICS footprint crossing borders, the approach to have a joint strategy is to match the local NHS footprint.

As the challenges we face are similar, Birmingham and Solihull are in a stronger position to meet the needs of our populations through collaborating on Sexual Health Commissioning and this strategy. This approach allows us to pool both human and fnancial resources to avoid duplication in service delivery and fnancial overlap, saving each ar ea both time and money. However, certain elements of service delivery are tailored to be able to meet the differing requirements of each geographical area. To underpin our collaboration, we need a clear strategic vision with a clear action plan, which this strategy will provide.



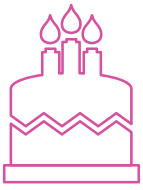
THE CURRENT LANDSCAPE

2.1 The Local and National Evidence Base

Birmingham's population is one of the youngest and most deprived in England[3].

Proportionally, Solihull has an above average population of people aged 65 and over. The borough is considered a relatively affuent ar ea, but does have pockets of deprivation where 16% of the population live[4].

33 years is the median age in **Birmingham**



43 years is the median age in **Solihull**

The proportion of total prescribed LARCs (excluding injections) per 1,000 is lower in Birmingham (26.5) and Solihull (28.9), compared to nationally (34.6)[4].

26.5 per 1,000 LARCs were prescribed in **Birmingham**

28.9 per 1,000 LARCs were prescribed in **Solihull**

The proportion of repeat abortions in under 25s is higher in Birmingham and Solihull, compared to England's average (29.2%)[4].

31.8% of abortions in<25s in **Birmingham** were repeat abortions

34.8% of abortions in<25s in **Solihull** were repeat abortions

There were 485 new STI diagnoses (excluding chlamydia) per 100,000 of those aged under 25 in Birmingham, and 269 per 100,000 in Solihull, both lower than the national rate of 619[4].

2.69 per 1,000 people aged 15-59 were diagnosed with HIV in **Birmingham**

0.82 per 1,000 people aged 15-59 were diagnosed with HIV in **Solihull**

The impact of COVID-19 meant that more sexual health interventions were conducted online and over the phone. Only one walk-in clinic was available during the peak of the pandemic across both local authorities[4].

2.2 Current Service Provision and Planning for the Future

What works well?

Access to free condoms, contraceptive advice, general sexual health information, HIV advice, identifying and supporting abuse victims/ survivors of rape and sexual violence, support for patients who identify as LGBTQ, access to chlamydia screening/treatment.

What could be better?

Vasectomies, sterilisation, delays in LARC appointments, complex contraception services, emergency coil fttings, infor mation for gender dysphoria, information for PEPSE and PrEP, services for homeless, refugees, asylum seekers and newly arrived migrants, rapid testing for STIs, community-based testing.

The 2021 SHNA consulted members of the public and key stakeholders about current service provision and future needs.

2.3 Key Achievements of the Service (2015-2021)

2.4 Birmingham Specific Areas of Focus

Public Health Outcomes Framework (PHOF)[5] and locally agreed outcomes:

- Increasing the use of good quality contraception to reduce under-18 conceptions and abortions for all ages (PHOF Indicator)
- Reducing late diagnosis and transmission of BBVs and STIs to prevent reinfection by ensuring prompt access for earlier diagnosis and treatment (PHOF Indicator)
- Providing better access to services for high-risk priority groups
- Improved support for people vulnerable to, and victims of, sexual coercion, sexual violence and exploitation
- Increasing the chlamydia diagnostic rate in the 15–24 age group (PHOF Indicator) and in line with the national chlamydia screening pathway.

2.5 Solihull Specific Areas of Focus

As per Birmingham, with the following additions:

- Improve access and take up of long-acting reversible (LARC) contraception
- Develop access to EHC across the borough to provide equitable access
- Improve sexual health education as part of prevention.

OUR VISION

3.1 A Joint Vision for Birmingham and Solihull

A key vision of this strategy is to address the joint common themes identifed by the SHNA for Birmingham and Solihull. This strategy will provide a basis to enable appropriate action and enhance existing pathways to meet the needs of citizens.

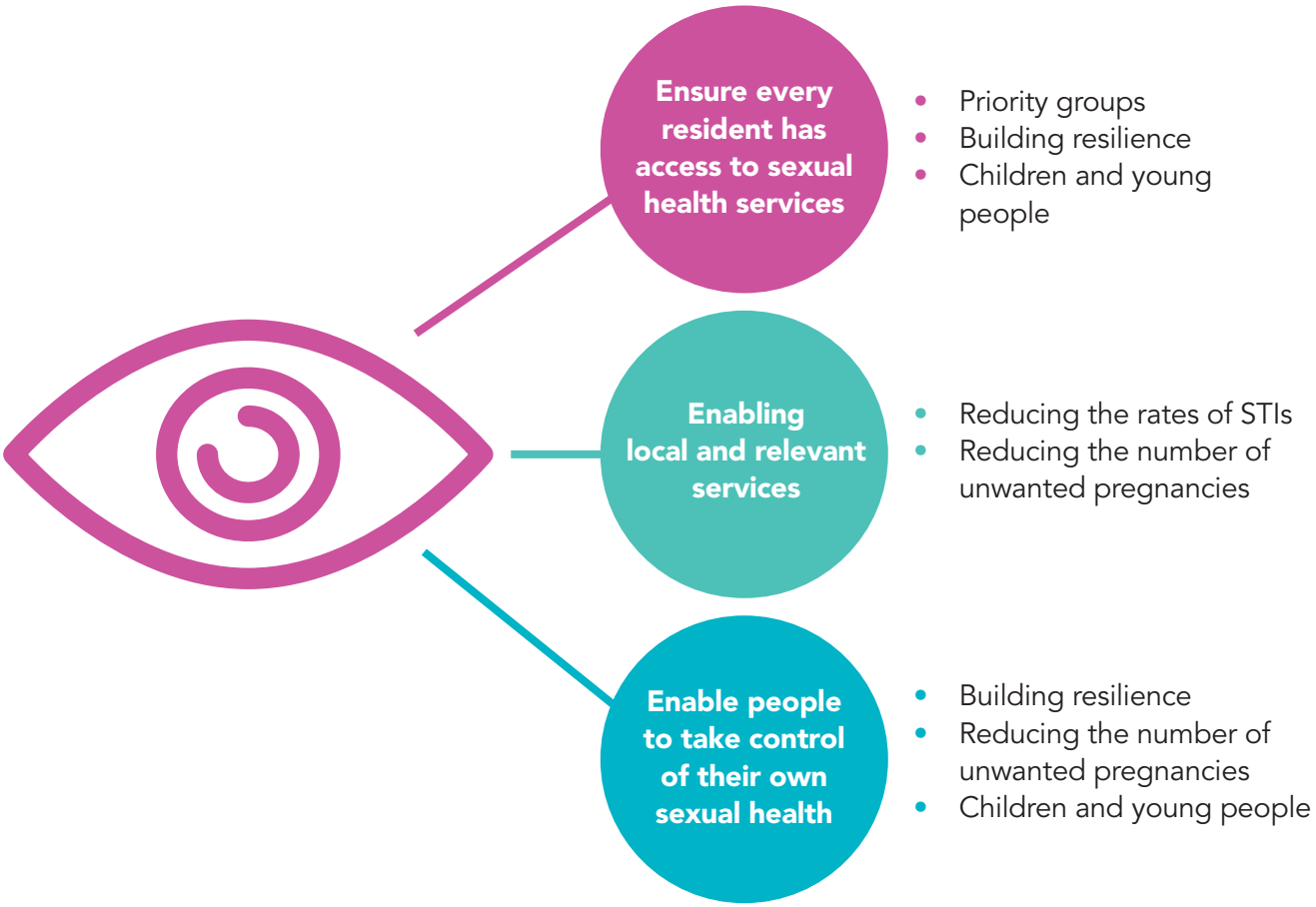
The key objectives of this strategy are to:

- Ensure that every resident has access to sexual health services that meet their individual needs.
- Enable services that are local, relevant, approachable, conf dential, non-judgemental, and accessible to anyone in need, while respecting all human protected characteristics.
- Enable citizens to have control of their own sexual health with services providing support where needed.

This strategy will play an important role in realising the joint vision for sexual health services for the future, and will facilitate:

- A fully integrated, free and confdential sexual health service for all citizens across the life course
- A reduction in the high rates of teenage and unwanted pregnancy, abortion and STIs, which can have far reaching consequences for individuals and society
- Open and equitable access to sexual health services, in line with the Equality Act[6].

A fundamental outcome of this strategy will be to equip the citizens of Birmingham and Solihull to have good reproductive health and healthy sexual relationships, positively impacting the wider emotional, mental and physical health and wellbeing of citizens.



3.2 Realising Our Joint Vision

To develop sexual and reproductive health services in Birmingham and Solihull, we will focus on these key themes

THEME ONE	THEME TWO	THEME THREE	THEME FOUR	THEME FIVE
Priority groups	Reducing the rates of sexually transmitted infections	Reducing the numbers of unwanted pregnancies	Building resilience	Children and young people

Developing KPIs and targets for an efficient patient journey

Community support | **In-person and online offer** | **Targeted support for all protected characteristics**

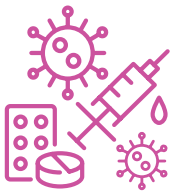
THEME ONE

Priority Groups

Why is it a theme?

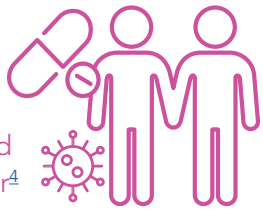
Low rates of attendance to sexual health screens in Birmingham and Solihull for those from Bangladesh, India and Pakistan.

Substance users' lifestyles make them more vulnerable to **poor sexual health** (including increased risk of HIV) and unwanted pregnancies



29.2%

of **gay men living with HIV** reported having had **Chemsex** in the last year[4]



Digital Divide
Citizens living with disabilities and those without access to technology are more likely to be digitally excluded, making accessing services harder, especially during the pandemic

A high proportion of **MSM** not accessing testing despite disclosing condomless sex with multiple partners[7]

Homeless people are less able to access services due to rigid timings and conditions

National and Local Evidence

Our needs assessment identified the following priority groups:

People from **minority ethnic communities**

Individuals vulnerable to or experiencing **sexual and/or domestic abuse**, including care leavers

Offenders in custody or under community supervision

Homeless people & **rough sleepers**

Gypsies and **Travellers**

People who are **lesbian, gay, bisexual or trans**

New arrivals from abroad (including **trafficked people**)

Men who have **sex with men**

Substance users

Neuro-diverse conditions eg Autism and ADHD

People with **mental health** conditions

People with **learning difficulties**

Sex Workers

People affected by **female genital mutilation** (FGM)

Action Plan

Establishing **focus groups and user involvement** for those hardest to reach

Continued **training packages** for GPs, sexual health practitioners & partners to include information on **gender dysphoria** and **LGBTQ**

Co-delivery between **drug and alcohol services** and sexual health services as recommended by the HIV commission[8]

Link nurses between homeless and substance use services to help break barriers

Explore the provision of sexual health services in existing **homeless hubs**

To recognise the connections between race, gender, sexuality, disability, class or any protected characteristics that impact on an individual's needs and their ability to access services.

Work with disability services to ensure:

1. Information on sexual health is accessible and understandable
2. Those working with and for people with disabilities, have the confidence and tools to raise sexual health issues
3. Locations of sexual health services are accessible

Aims and Outcomes

Providing **targeted health promotion** for priority groups

Streamlined process for identifying **CSE, FGM & safeguarding** issues

Reduction in **stigma and discrimination**

Providing better access to services for priority groups

Improved support

for people vulnerable to, and victims of:

- sexual coercion
- sexual violence
- sexual exploitation

through SARCs, survivors' clinics & psychological support

THEME TWO

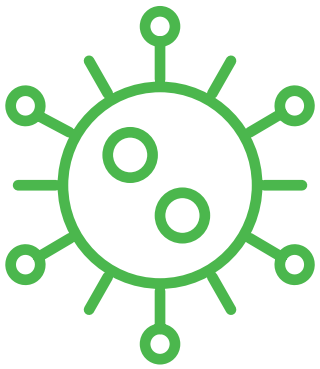
Reducing the Rates of Sexually Transmitted Infections

Why is it a theme?

Chlamydia can lead to long-term complications including infertility[9]

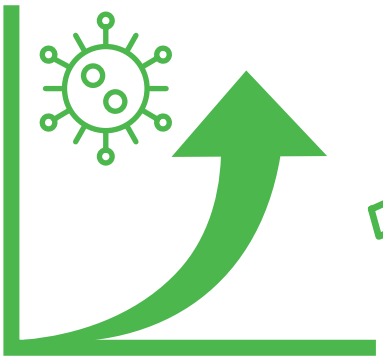
STIs, like chlamydia, are sometimes **asymptomatic** so may be **unnoticed** by individuals and passed on

A signifcant number of people ar e **diagnosed at a late stage** of infection which means that they may have had HIV for some time and may be very unwell as a result of **damage to their immune system**[9]



STIs are associated with inequalities and deprivation

In Birmingham there has been a significant increase in the number of **gonorrhoea diagnoses** & there are strains that are **resistant** to treatment[4]



National and Local Evidence

Chlamydia accounts for the majority of new **STI diagnoses**[11]

57% & **56%** of diagnoses from **GUM** and **non-GUM** services in Birmingham and Solihull, respectively, were of chlamydia[4]

During 2020, there were **6.6** new HIV diagnoses per 100,000 people aged 15+ in Birmingham and **1.7** per 100,000 in Solihull[11]

Most **outreach services** were stopped during COVID-19

Engagement feedback revealed that the current sexual health provider website is not user friendly and that patients had to call to find about pharmacy availability

In Solihull there are 2 sexual health clinic locations – provision in the north had to be relocated and only recently been made available

During the **COVID-19** pandemic, calls were triaged so that those who needed to be seen could pre-book for appointments, including at a walk-in clinic in Birmingham

A **73 year-old woman**, recently asked for condoms at a London Family Planning Clinic. The nurse replied, "*You don't need condoms, you won't get pregnant, you're too old.*"

STI rates are **increasing** in the 50-70 year old age group[4]

Action Plan

Service Locations:

- **Maintain** the availability of **walk-in services** in Birmingham and Solihull
- Temporary or '**pop-up**' clinics to widen access in the community
- Establish a clear sexual health **outreach strategy**

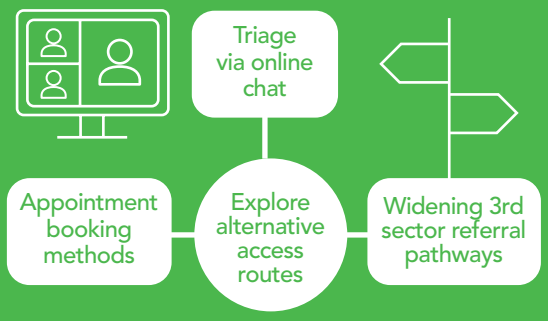
Open access sexual health services should be available to the whole population to provide testing [11]

STI Testing:

- Sexual health providers to have access to **multiple STI self-testing kit suppliers**
- Ensure STI self-testing kits are always available **via multiple channels**
- Strengthen opportunistic chlamydia **testing for young people**
- Strengthen **partner notification**

HIV action plan:

- Localising the national **HIV Action Plan**
- Increase marketing of **PrEP** to increase take up
- Sexual Health Provider/s to commit to tackling HIV, Hep B, Hep C and TB transmissions and stigma through the **Fast-Track Cities+** initiative
- Offer HIV testing in GPs and A&E
- Introduce post-abortion HIV testing in abortion services [13]



Ensure all **pharmacy staff** are trained to provide STI treatment & advice

Ensure **safe spaces for young people** to discuss their health & relationships and **receive condoms** [12]

Aims and Outcomes

To **increase the chlamydia diagnostic rate** for 15–24-year-olds

To **reduce the transmission of STIs** by ensuring rapid access to testing

Reduce the burden of STIs by improving access to services

More people on PrEP to reduce HIV transmission rates

To reduce the **burden of HIV infection** and rates of late and **undiagnosed HIV**

THEME THREE

Reduce the Number of Unwanted Pregnancies

Why is it a theme?

Unplanned pregnancy can cause **financial, housing, social and relationship pressures as well as impact other children in the family**

Closely spaced pregnancies increase the baby's risk of morbidity and mortality yet **post-partum family planning** is often ignored [15]

Savings from preventing unintended pregnancies are estimated at **£1 billion** nationally per year[14]

Current sexual health services do not offer free **routine pregnancy testing**

Health impacts of an unplanned pregnancy on the mother include16:

- obstetric complications
- antenatal/postnatal depression

And on the child15-16:

- low birthweight
- developmental abnormalities

National and Local Evidence

In Birmingham:

0.4 **pharmacies** per square km provide free EHC[4]

In Solihull:

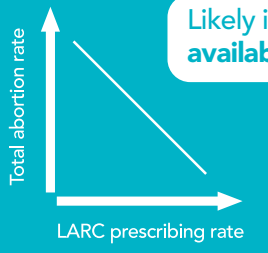
0.1 **pharmacies** per square km provide free EHC[4]

LARC **prescribing rate of 42.1** per 1,000 (national avg. = 50.8)[4]

In Solihull, the **abortion rate is 22.1** per 1,000 (national avg.=18.7)[4]

Likely impacted by limited **availability of EHC**

LARC is recommended by **NICE** because it is easier for the user, than e.g. a daily pill



Lack of knowledge amongst practitioners on vasectomies and sterilisations

25% of respondents would use a local pharmacy for contraception advice

28% of respondents would go to a loca pharmacy for non emergency contraception

49% of respondents would go to a local pharmacy for emergency contraception

28.5% of conceptions lead to abortions

Action Plan

The sexual health provider and other partners to provide **free pregnancy tests** where appropriate, in several settings

Work with stakeholders to **plan post-natal contraception** pathways

Develop **culturally competent** contraceptive services

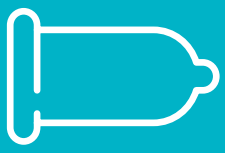
Increase access to **LARC** in Birmingham including exploring the possibility of expanding subdermal implants into pharmacies

Increase availability and prescribed rates of **LARC** and **EHC** in Solihull

Regularly review the **quality of information** on contraception

Abortion services to provide access to **LARC** together with appropriate contraceptive and sexual health **advice**

The **pharmacy** contraception offer in Solihull should be **the same** as the offer in Birmingham to reduce inequalities



Aims and Outcomes

Continue to **minimise unplanned pregnancies**

Highly **visible**, **accessible** and **comprehensive contraceptive services** including services for young people

To **empower women** to make **informed choices** about their reproductive health by providing good quality information and advice on contraception

To ensure that women can **access** the **full range** of **contraception**

To **improve post-partum family planning**

To **reduce repeat abortions**

THEME FOUR
Building Resilience

Why is it a theme?

Good relationships and **sex education** are linked with improved sexual health outcomes[17]

Stigma and **myths** associated with STIs can create a **barrier to good sexual health** and access to services[11]

Living with shame can detrimentally affect **mental health**

National and Local Evidence

There is **stigma and insensitivity** relating to HIV, STIs, sex and relationships in Black African, Latin American and South Asian communities[18] and adults aged 50+ years

Adults over 50 face a misconception that they do not need condoms, information on sexual health, or even consent. This is **perpetuated by peers & professionals** alike

"A client used to be able to collect condoms from clinics, now asked to go queue at pharmacies, which young patients find embarrassing."
- Young Person's Counsellor

The main barriers Birmingham's population face in accessing sexual health services are[4]:

- **Embarrassment & shame**
- **Lack of knowledge** of sexual health
- People do not believe they can **catch an STI**

There are misconceptions and stigma surrounding **disabled people and sex**

Drugs may be used to cope with the **emotional distress** following a sexual health problem and related stigma[19]

Action Plan

As part of Fast-Track Cities+, a **stigma reducing campaign** will be developed

To ensure all have accurate information to develop healthy, safe and consensual sexual relationships

To provide **targeted engagement** and **support programmes for those affected by sexual** and/or **domestic abuse**

Break down barriers for older adults by training healthcare professionals on having conversations about sexual health with people aged 50+

Challenging stigma and discrimination by addressing misconceptions, busting myths, normalising good sexual health, providing advocacy and empowering communities

Addressing peer pressure and social norms though consistent messages, information and education

Develop voluntary **community sexual health champions** in communities where there is traditionally poor engagement

To promote and support **evidence -based resilience programmes** in schools

Aims and Outcomes

To have a **positive sexual health culture** that is accepted as part of human behaviour

Provide **information** that is **accessible** and **acceptable for all**, regardless of whether it is spoken or written information

To **work across sectors** to ensure consistent messaging and stigma-reduction

For **information** and **services** relating to sexual and reproductive health to always be informed by the latest evidence

To **enable citizens to access services** confidently and confidentially, and without fear of stigma or judgement

THEME FIVE

Children and Young People (Everyone up to the age of 25 years)

Why is it a theme?

Young people under 25 are the age group most affected by STIs[11]

Women in their early twenties are most likely to have an **unplanned pregnancy** and most likely to access abortion services[16]

In Birmingham:

17.9 Under 18s conception rate per 1,000

In Solihull:

13.6 Under 18s conception rate per 1,000

(England avg. = 15.7 per 1,000)[4]

Sexual health and sexual experiences as a child and young person can impact their sexual health and mental health in the future

Young people want more **information** on sexual health[20]

National and Local Evidence

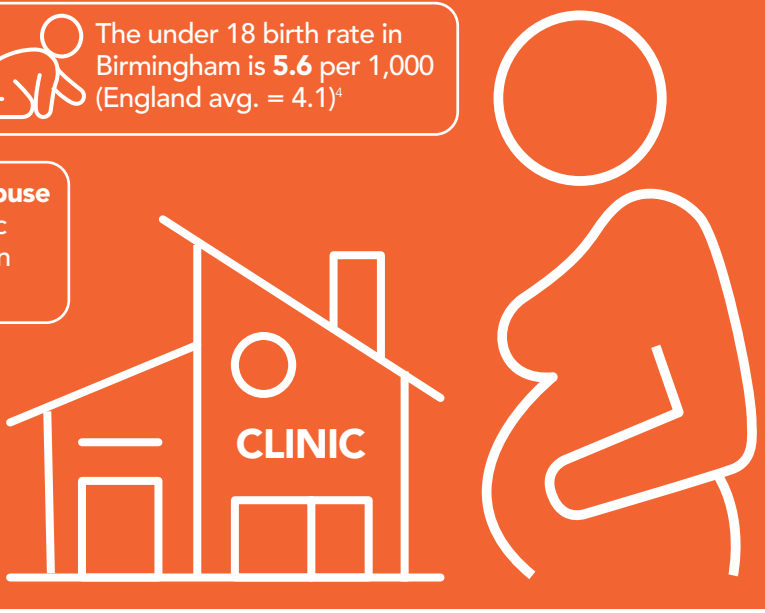
60% In Birmingham and Solihull, teenage pregnancies have decreased by approximately 60% from 2009 to 2019[4]

In Solihull **69% of conceptions** in those aged under 18 led to an abortion – this reflects an increase in abortions[4]

In Birmingham **48% of conceptions** in those aged under 18 led to an abortion[4]

The under 18 birth rate in Birmingham is **5.6** per 1,000 (England avg. = 4.1)[4]

Whilst there is a **Young Person's abuse survivors' clinic**, there is no specific child sexual abuse survivors' clinic in Birmingham or Solihull



Action Plan

Designing a **specific integrated service pathway** for Under 13s

Incorporate Sexual Health Wellness assessments as part of **social care health check** for CYP entering care

Provide access to **appropriate and effective contraceptives, including LARC**

High risk groups:

- Ensure support is available for **young NEETs** and young people in **high need groups**
- To set up a **well-promoted child-specific** sexual abuse survivors' clinic
- Prioritise **children in need** and **care leavers** up to age 25 years

Increase provision of **good quality advice and information** for children, young people, parents & carers

To support schools & colleges to provide **high quality RSE**

Rollout of the **Bystander Intervention** programme[21] to all higher education settings to support healthy relationships in young adults

Aims and Outcomes

Equip young people with the **knowledge** they need to make **healthy sexual choices**

For **schools** and **other settings** children are in, to promote healthy and positive sexual relationships

Ensure all **young people** and children know **where** they can go and **who** they can **talk to confidentially** about sexual health and related issues

To **reduce under 18** conceptions and abortions

Targeted, acceptable services for CYP **most in need**

GOVERNANCE

Joint Local Authority Meetings

Birmingham and Solihull service leads and commissioners will work closely to ensure the joint successful delivery of this strategy. This group will be responsible for the performance management of services and actively working with the appointed service provider/s to ensure effcient and ef fective service delivery and to ensure Sexual Health Services are equitable and providing equality of service to citizens.

Commissioning & Contracts Board

The Commissioning & Contracts Board will consist of Commissioners from both Birmingham and Solihull, including key delivery partners.
This Board will review on a regular basis the commissioning intentions, contract performance, changes in services required and implementation of any variations to the contract.
The Commissioning & Contracts Board will have overall autonomy on successful delivery of this strategy and outcomes along with the fnancial responsibility to ensure the service is equitable, accessible and delivering value for money.

Health and Wellbeing Boards

The Sexual Health Service will be accountable to each local authority's Health and Wellbeing Board. The Health and Wellbeing Boards will receive an annual (or upon request) update on performance against the strategic actions outlined in this strategy.
The Health and Wellbeing Boards will have responsibility of reviewing the services delivered against the evidence base, and including this within, the wider health and wellbeing considerations for the local populations.

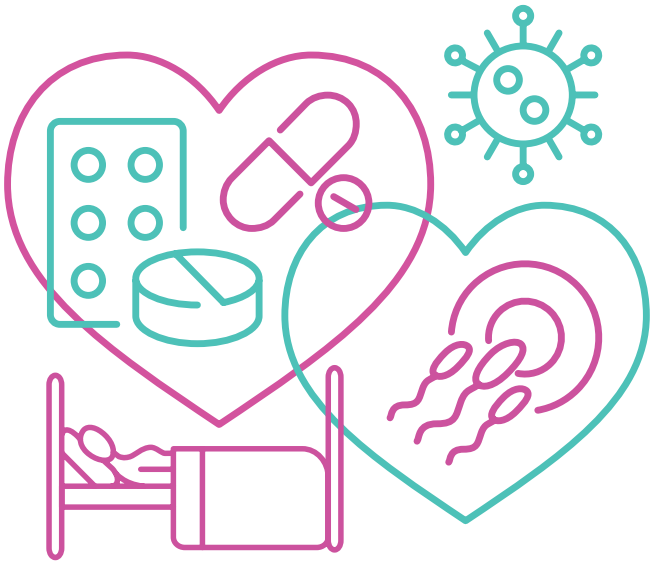
Overview & Scrutiny Committee

The progress on service delivery is presented to the Overview and Scrutiny Committee annually, where the following will be presented:

- Review of services and their delivery, including the service model and accessibility
- Evidence review and policy change
- Partnership arrangements
- Performance and outcomes

Overview and Scrutiny Committee meetings can be attended by the public where there is an opportunity to discuss certain elements of service delivery i.e. what is working well, what is not, challenges and triumphs.

Good governance is the key to successful outcomes



GLOSSARY

BBV	Blood Borne Virus
BCC	Birmingham City Council
BHIVA	British HIV Association
Bsol	Birmingham and Solihull
CCG	Clinical Commissioning Group
CSE	Child Sexual Exploitation
CYP	Children and Young People
DH	Department of Health
EHC	Emergency Hormonal Contraception
FGM	Female Genital Mutilation
GP	General Practice/Practitioner
GUM	Genito-Urinary Medicine
HIV	Human Immunodefciency V irus
ICS	Integrated Care System
LA	Local Authority
LARC	Long Acting Reversible Contraception
LD	Learning Disabilities
LGBTQ	Lesbian, Gay, Bisexual, Trans & Queer
MSM	Men who have Sex with Men
NEET	Not in Education, Employment and Training
NHS	National Health Service
NHSE/I	NHS England and Improvement
NICE	National Institute of Clinical Excellence
OHID	Offce for Health Impr ovement and Disparities
PEPSE	Post-Exposure Prophylaxis following Sexual Exposure
PHE	Public Health England
PHOF	Public Health Outcomes Framework
PrEP	Pre-Exposure Prophylaxis
RSE	Relationships and Sexual Education
SARC	Sexual Assault Referral Centres
SHNA	Sexual Health Needs Assessment
SMBC	Solihull Metropolitan Borough Council
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UKHSA	UK Health Security Agency

REFERENCES

1 Faculty of Sexual and Reproductive Healthcare. (2018, 3 Aug) *PHE tool estimates that ever £1 spent of contraceptive services saves £9 across the public sector*. Available from: **https://www.fsrh.org/news/phe-tool-return-investment-contraceptive-services-public-health/** [Accessed 20th Dec 2021].

2 Sedgh, G., Singh, S. & Hussain, R. (2014) *Intended and Unintended Pregnancies Worldwide in 2012 and Recent Trends. Studies in Family Planning*, 45(3), 301-314.

3 Public Health England. (2018) *Contraception: Economic analysis estimation of the return on investment (ROI) for publicly funded contraception in England*. Public Heath England. Report number: 2018172

4 S Squared. (2022) *Birmingham and Solihull Sexual Health Needs Assessment*. S Squared.

5 Offce for Health Impr ovement and Disparities. (2013) *Public Health Outcomes Framework* (PHOF). Available from: **https://www.gov.uk/government/collections/public-health-outcomes-framework** [Accessed 20th Dec 2021].

6 Government Equalities Offce & Equality and Human Rights Commission. (2013) E*quality Act 2010: guidance*. Available from: **https://www.gov.uk/guidance/equality-act-2010-guidance** [Accessed 20th Dec 2021].

7 Public Health England. (2020) *The impact of the COVID-19 pandemic on prevention, testing, diagnosis and care for sexually transmitted infections, HIV and viral hepatitis in England*. Public Health England. Report number: GW-1789.

8 HIV Commission. (2020) Partnerships. Available from: **https://www.hivcommission.org.uk/final-report-and-recommendations/partnerships/** [Accessed 21st Dec 2021].

9 NHS. (n.d.) Chlamydia: Complications. Available from: **https://www.nhs.uk/conditions/chlamydia/complications/** [Accessed 21st Dec 2021].

10 UKHSA. (2021) *HIV testing, new HIV diagnoses, outcomes and quality of care for people accessing HIV services: 2021 report*. UKHSA. Report number: GOV-10491

11 Public Health England. (2019) *Health matters: preventing STIs*. Available from: **https://www.gov.uk/government/publications/health-matters-preventing-stis/health-matters-preventing-stis** [Accessed 21st Dec 2021]

12 Brook & Public Health England. (2014) *C-Card condom distribution schemes: Why, what and how*. Brook & Public Health England. Report number: 2014159

13 Rasch, V., Yambesi, F. & Massawe, S. (2006) *Post-abortion care and voluntary HIV counselling and testing–an example of integrating HIV prevention into reproductive health services*. Tropical Medicine & International Health, 11(5), 697-704.

14 Thomas, C.M. & Cameron, S. (2013) *Can we reduce costs and prevent more unintended pregnancies? A cost of illness and cost-effectiveness study comparing two methods of EHC*. BMJ open, 3(12), e003815.

15 Royal College of Obstetricians and Gynaecologists. (2015) *Best practice in post-partum family planning*. Royal College of Obstetricians and Gynaecologists. Report number: 1

16 Public Health England. (2018) *Health matters: reproductive health and pregnancy planning*. Available from: **https://www.gov.uk/government/publications/health-matters-reproductive-health-and-pregnancy-planning/health-matters-reproductive-health-and-pregnancy-planning** [Accessed 21st Dec 2021].

17 Macdowall, W., Jones, K.G., Tanton, C., Clifton, S., Copas, A.J., Mercer, C.H., Palmer, M.J., Lewis, R., Datta, J., Mitchell, K.R. & Field, N. (2015) *Associations between source of information about sex and sexual health outcomes in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles* (Natsal-3). BMJ open, 5(3), e007837.

18 Love Sex Life. (2020) *Transforming sexual and reproductive health for BAME communities in Lambeth, Southwark and Lewisham*. Available from: **https://secureservercdn.net/160.153.138.163/zps.998.myftpupload.com/wp-content/uploads/2020/11/LSL-Report-Final-3.pdf** [Accessed 21st Dec 2021]

19 Bowden, J. (2017) *Joining up sexual health and drug services to better meet client needs*. EMCDDA.

20 Tanton, C. et al. (2015) *Patterns and trends in sources of information about sex among young people in Britain: evidence from three National Surveys of Sexual Attitudes and Lifestyles*. BMJ Open, 5, e007834.

21 Bystander Intervention programme
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/941380/Bystander_interventions_report.pdf

NOTES

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BIRMINGHAM AND SOLIHULL SEXUAL HEALTH NEEDS ASSESSMENT

RECOMMENDATIONS AND EXECUTIVE SUMMARY v3

September 2021

S2 Analytics

CONTENTS

PAGE	CONTENTS
3	AT A GLANCE
8	INDEX OF RECOMMENDATIONS
9	OUR APPROACH
10	SEXUAL HEALTH COMMISSIONING
11	OVERVIEW OF SEXUAL HEALTH SERVICES
12	OVERVIEW OF PRACTITIONER ENGAGEMENT
14	DEMOGRAPHICS
17	FUTURE TRENDS
18	REPRODUCTIVE HEALTH
22	CONTRACEPTION
36	ABORTIONS
39	STIs
60	SPECIFIC COHORTS
72	CERVICAL SCREENING

AT A GLANCE

INTRODUCTION

This Sexual Health Needs Assessment is part of the commissioning process being run by Birmingham City Council and Solihull Metropolitan Borough Council. The needs assessment analyses quantitative and qualitative data and reports and summarises findings in a concise and detailed manner.

This needs assessment seeks to identify gaps, opportunities, and efficiencies in current services based on identifiable unmet needs of the children and adult populations of Birmingham and Solihull.

KEY FINDINGS

DEMOGRAPHICS

In the UK, poor sexual health disproportionately affects those experiencing poverty and social exclusion.

43% of the population living in LSOAS[1] in Birmingham are in the 10% most deprived areas in England.
Birmingham is the 7th most deprived local authority in England and the 3rd most deprived English Core City. Deprivation is most heavily clustered around the city centre.

Solihull is the 32nd least deprived upper tier local authority in England, and the least deprived upper tier local authority across the West Midlands.
Despite the overall low average deprivation for Solihull, there is significant polarisation between the neighbourhoods.

Over half of the North Solihull population live in the most deprived 10% of LSOA neighbourhoods in England, including one in five living in the most deprived 5% LSOAs.

Young people as a demographic have particular needs regarding sexual health in relation to high diagnoses of the most common STIs, low 'sexual competence', and unplanned pregnancies.

At 43, the median age in Solihull ranks near the median of the nearest neighbours.
There is a higher average age in the south of the borough.

At 33, the median age in Birmingham ranks as one of the lower median ages of local authorities.
Birmingham is 'Europe's youngest city', with under 25s accounting for nearly 40% of its population. Wards in the centre of the city have median ages of between 21 and 28.

[1]Lower Layer Super Output Areas (LSOA) are a geographic hierarchy designed to improve the reporting of small area statistics in England and Wales. Lower Layer Super Output Areas are built from groups of contiguous Output Areas and have been automatically generated to be as consistent in population size as possible, and typically contain from four to six Output Areas. The minimum population is 1,000 and the mean is 1,500.
There is a Lower Layer Super Output Area for each postcode in England and Wales.

REPRODUCTIVE HEALTH

CONCEPTIONS

Birmingham has seen a decrease in conceptions when using 2009 as the baseline.
The rate of decrease is greater than that of the CSSSNBT[2] nearest neighbours.

Solihull has seen an increase in conceptions since 2009, with the numbers peaking in 2015 and 2016.
The rates have declined and stabilised between 2017 and 2019.

TEENAGE PREGNANCIES

Nationally, the teenage pregnancy rate in the UK fell by over 60% between 2000 and 2018. England still experiences higher teenage birth rates than peers in Western European countries. Outcomes for young parents and their children are still disproportionately poor.

Using 2009 as the baseline, Birmingham experienced decreases in teenage pregnancies of around 60% to 2019.

Using 2009 as the baseline, Solihull experienced decreases in teenage pregnancies of around 60% to 2019.

CONTRACEPTION

The provision of contraception is widely recognised as a highly cost-effective public health intervention, reducing the number of unplanned pregnancies which bear high financial costs to individuals, the health service and to the state.

In Birmingham, Umbrella have partnered with GPs and pharmacies to offer a comprehensive contraception service including LARCs (available via GPs). There is a plan for pharmacists to start delivering the contraceptive injection, improving coverage.

The total abortion rate, at 21 per 1,000, is higher than that of the nearest neighbours (20.4) and the national rate (18.7).

The total prescribed LARCs excluding injections rate, at 42.1 per 1,000, is lower than that of the nearest neighbours (47.7) and the national rate (50.8).

In Solihull, GPs and pharmacies are not partnered with Umbrella. GPs and pharmacies are commissioned directly by Solihull Metropolitan Borough Council (SMBC) to offer LARCs (GPs) and Emergency Hormonal Contraception (pharmacies).

The total abortion rate, at 22.1 per 1,000, is higher than that of the nearest neighbours (16.7) and the national rate (18.7).

[2] CSSNBT Children's Services Statistical Neighbours Benchmarking Tool (CSSNBT). Statistical neighbour models provide one method for benchmarking progress.

The total prescribed LARCs excluding injections rate, at 47.9 per 1,000, is lower than that of the nearest neighbours (57.3) and the national rate (50.8).

There are a number of wards where there have been no LARC insertions by SMBC-commissioned GPs (2020-21).

Elmdon, Lyndon, Olton, and St Aphege wards have had no LARC insertions by SMBC-commissioned GPs in either 2019-20 or 2020-21.

There is a strong correlation score between abortion rate and total prescribed LARCs rate, based on Solihull and the nearest neighbours.

LARCs

In Birmingham, the total prescribed LARCs (excluding injections) rate is lower than the England average and is also lower than that of the nearest neighbours.

The rate of 42.1 per 1,000 in 2019 was below 47.7 for the nearest neighbours and 50.8 for England. The rate of LARCs prescribed by GPs was comparable to the nearest neighbours and England; however the rate of SRH Services prescribing LARCs was low. LARCs rank low as a choice of contraception at SRH Services in Birmingham.

In Birmingham, LARC insertions at GPs were severely impacted by COVID-19 at the beginning of lockdown..

Activity during April to June 2021 saw a significant decrease; however performance resumed to normal levels soon afterwards.

In Solihull, the total prescribed LARCs (excluding injections) rate is less than that of England and the nearest neighbours.

The total abortion rate, at 22.1 per 1,000, is higher than that of the nearest neighbours (16.7) and the national rate (18.7). The total prescribed LARCs excluding injections rate, at 47.9 per 1,000, is lower than that of the nearest neighbours (57.3) and the national rate (50.8). There is a strong correlation score between abortion rate and total prescribed LARC rate based on Solihull and the nearest neighbours.

In Solihull, GP IUCD fittings and reviews saw notable decreases in 2020-21; however removals increased.

IUCD fittings saw a decrease of 18%, whilst IUCD reviews saw a decrease of 39% when comparing 2020-21 against 2019-20. This is likely due to COVID-19. The number of IUCD removals saw an increase of 14%. Contraceptive implant insertions and removals increased.

VASECTOMIES AND STERILISATIONS

The pause on elective surgeries during the COVID-19 pandemic meant there was a reduction in the number of vasectomies.

There has been a reduction in total vasectomy consultations between 2019-20 and 2020-21 in Birmingham.

Consultations reduced by 38%.

There has been a reduction in total vasectomies between 2019-20 and 2020-21 in Birmingham.

Vasectomies reduced by 41%.

There has been a reduction in total vasectomy consultations between 2019-20 and 2020-21 in Solihull.

Consultations reduced by 55%.

There has been a reduction in total vasectomies between 2019-20 and 2020-21 in Solihull.

Vasectomies reduced by 46%.

EMERGENCY HORMONAL CONTRACEPTION

Pharmacy provision is particularly important for young people requiring emergency hormonal contraception, in terms of convenient locations and flexible hours.

In Birmingham, Umbrella have partnered with GPs and pharmacies to offer a comprehensive contraception service including LARCs (available via GPs). There is a plan for pharmacists to start delivering the contraceptive injection, improving coverage.

In Birmingham, there are 0.4 pharmacies per square kilometre providing free EHC.

In Birmingham, there is a rate of 1,569 EHCs prescribed per 100,000 of the female 16-45 population.

In Solihull, GPs and pharmacies are not partnered with Umbrella. GPs and pharmacies are commissioned directly by Solihull Metropolitan Borough Council (SMBC) to offer LARCs (GPs) and Emergency Hormonal Contraception (pharmacies).

In Solihull, there are 0.1 pharmacies per square kilometre providing free EHC.

In Solihull, there is a rate of 723 EHCs prescribed per 100,000 of the female 16-45 population.

ABORTIONS

Reducing abortion rates is linked to the provision of good quality sexual and reproductive health care and effective contraception.

There has been a slight reduction in abortion consultations in Birmingham.

There has been a slight increase in abortions in Birmingham.

There has been a slight reduction in abortion consultations in Solihull.

There has been a slight increase in abortions in Solihull.

STIs AND HIV

GENERAL

COVID-19 had a greater impact on STI-related indicators in Birmingham compared to its nearest neighbours.

Between 2019 and 2020 (all excluding chlamydia):

- The STI testing rate fell by 50% (nearest neighbours fell by 17%).
- The new STI diagnoses rate fell by 54% (nearest neighbours fell by 30%).
- STI positive testing rates fell by 45% (nearest neighbours fell by 20%).
- The proportion of 15-24-year-olds screened for chlamydia was below national rates and that of the nearest neighbours.
- There was a significant decrease in gonorrhoea diagnoses.

COVID-19 had a greater impact on STI-related indicators in Solihull compared to its nearest neighbours.

Between 2019 and 2020 (all excluding chlamydia):

- The STI testing rate fell by 48% (nearest neighbours fell by 25%).
- The new STI diagnoses rate fell by 58% (nearest neighbours fell by 31%).
- STI positive testing rates fell by 43% (nearest neighbours fell by 21%).
- The proportion of 15-24-year-olds screened for chlamydia was below national rates and that of the nearest neighbours.
- There was a significant decrease in gonorrhoea diagnoses.

GONORRHOEA

In 2020, there was a significant decrease in gonorrhoea diagnoses in Birmingham.

In 2020, there was a significant decrease in gonorrhoea diagnoses in Solihull.

These decreases can be linked to the reductions in testing and diagnosing as a result of the COVID-19 pandemic.

SYPHILIS

In 2020, there was a decrease in syphilis diagnoses in Birmingham.

Syphilis diagnoses remained low in Solihull.

These decreases can be linked to the reductions in testing and diagnosing as a result of the COVID-19 pandemic.

GENITAL HERPES

In 2020, there was a significant decrease in herpes diagnoses in Birmingham.

In 2020, there was a significant decrease in herpes diagnoses in Solihull.

These decreases can be linked to the reductions in testing and diagnosing as a result of the COVID-19 pandemic.

HIV

Up until 2019, Birmingham had greater testing coverage compared to its nearest neighbours and England.

Up until 2019, Birmingham had a lower rate of HIV late diagnosis compared to its nearest neighbours and England.

In 2019, Birmingham's HIV testing coverage was greater than that of its nearest neighbours and England.

Up until 2019, Solihull had greater testing coverage compared to its nearest neighbours and England.

Up until 2019, Solihull had a lower rate of HIV late diagnosis compared to its nearest neighbours and England.

Up until 2019, Solihull's HIV testing coverage was lower than that of its nearest neighbours and England.

INDEX OF RECOMMENDATIONS

Key Finding	Page	Title	Summary
1	19	POST-NATAL CONTRACEPTION	Post-natal contraceptive services should meet appropriate guidance.
2	21	PREGNANCY TESTING	Offering of free pregnancy testing.
3	29	LARC PRESCRIBING IN SOLIHULL	Review LARC delivery model in Solihull.
4	30	LARC PRESCRIBING IN BIRMINGHAM	Improve access to LARCS in Birmingham.
5	33	SOLIHULL PHARMACY PROVISION	Expand accessibility to sexual health services through pharmacy provision in Solihull.
6	35	VASECTOMIES AND STERILISATIONS	Improved pathways and increase practitioner knowledge.
7	38	SOLIHULL ABORTION RATE	Improve availability of LARCs. Review contraception provision at abortion services.
8	40	ACCESSING SEXUAL HEALTH APPOINTMENTS	Improve availability of walk-in clinics.
9	41	UMBRELLA WEBSITE	Improvements to pharmacy information on website.
10	42	SOLIHULL CLINIC LOCATIONS	Ensure those in the North of the borough have good access to clinics.
11	43	SEXUAL HEALTH OUTREACH	Clear Outreach Strategy including plan for 'pop up' clinics to meet needs of hard to engage groups.
12	44	PHARMACY OFFERINGS	Ensure good promotion of sexual health offerings in pharmacies.
13	51	STI SELF-TESTING KITS	Develop purchasing strategies to reduce risks of kit shortages.
14	52	COVID-19 IMPACT	Follow PHE initiatives regarding mitigating impacts of COVID-19.
15	59	HIV TESTING	Enhance HIV testing in GPs and other health settings.
16	64	CHILD-SPECIFIC ABUSE SURVIVORS' CLINIC	A child-specific Abuse Survivors' Clinic should be set up.
17	65	CHEMSEX	Improved response from sexual health and substance misuse services to those who engage in chemsex.
18	66	GENDER DYSPHORIA	Review of guidance and pathways for gender dysphoria services.
19	67	IMPROVE RESPONSE TO THOSE FROM SOUTH ASIAN COMMUNITIES	Clear engagement plan to understand fully the needs of this cohort.
20	68	NEEDS OF THOSE WITH A DISABILITY	Improve response to those with a disability, including increasing the confidence and knowledge of those working with and for this cohort.
21	69	TRAINING NEEDS FOR THOSE WORKING WITH HARD-TO-REACH GROUPS.	Ensure all information on sexual health is accessible to all.
22	70	HOMELESS COHORT	Improved joined-up working with this cohort.
23	71	SUBSTANCE MISUSE COHORT	Improved joined-up working with this cohort.
24	72	CERVICAL SCREENING	Complete cervical screening in sexual health services to increase access.

OUR APPROACH

SURVEYS

106 COMMUNITY SURVEYS COMPLETED

130 PRACTITIONER SURVEYS COMPLETED

LGBT SERVICES

DISABILITY SERVICES

SUBSTANCE MISUSE SERVICES

MIGRANT SERVICES

YOUNG PEOPLE SERVICES

OLDER PEOPLE SERVICES

SEXUAL HEALTH SERVICES

GPs / PHARMACIES

FOCUS GROUPS

Focus Groups Completed

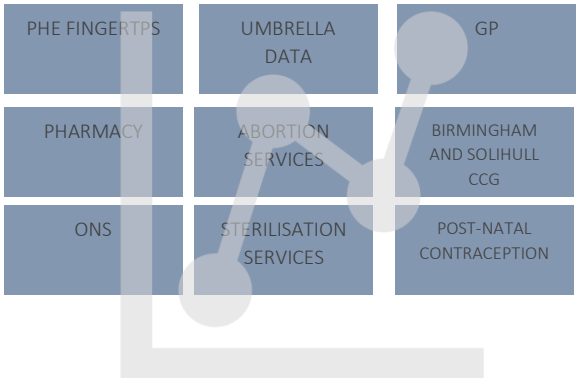
FAST TRACK CITIES DISCUSSION GROUP

WOMEN FROM SOUTH ASIAN COMMUNITIES

THOSE WITH DISABITLITIES

DATA ANALYSIS

Multiple Data Sources Analysed



1-2-1 INTERVIEWS

20+ 1-2-1 INTERVIEWS COMPLETED WITH KEY STAKEHOLDERS

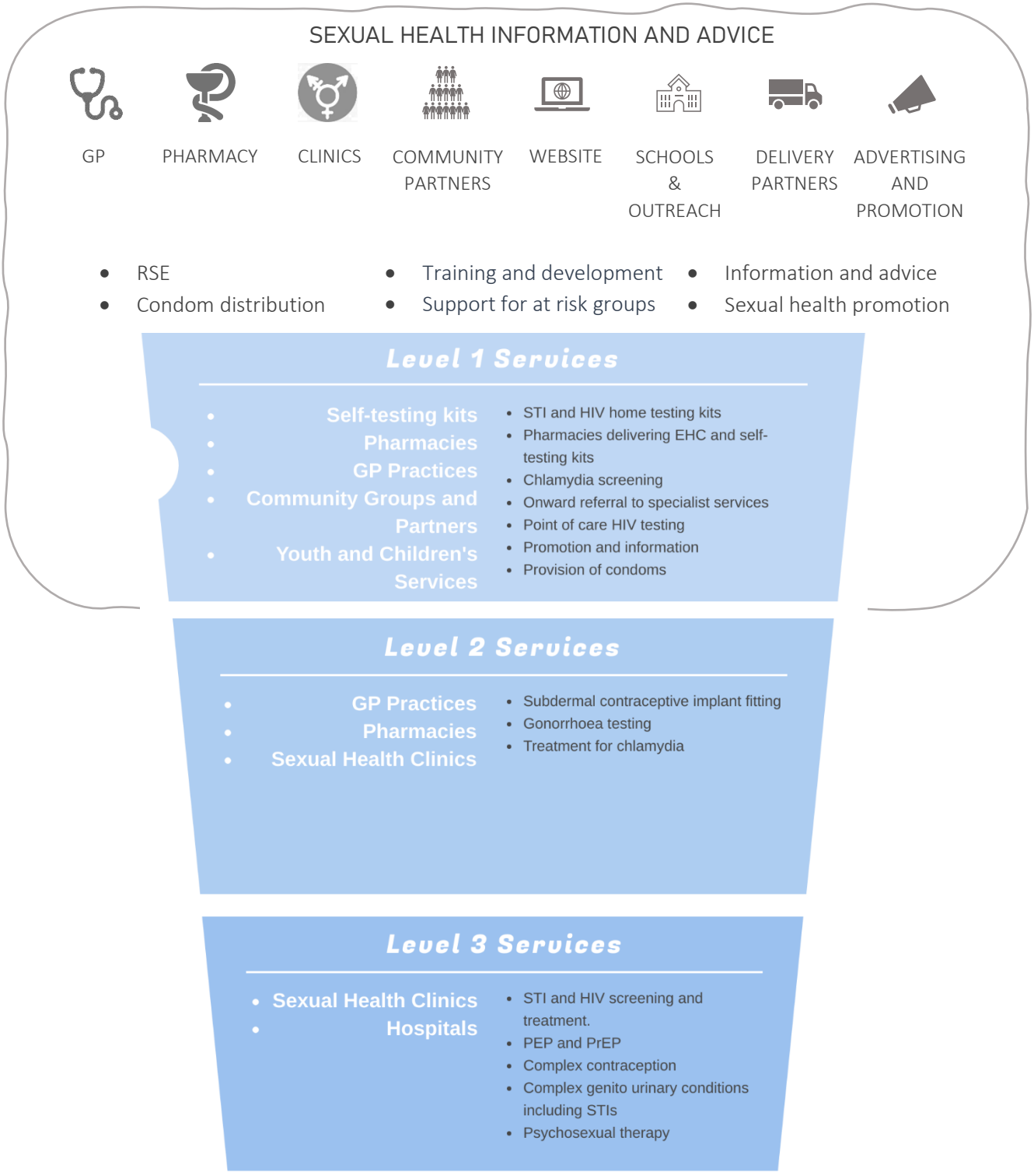
SEXUAL HEALTH COMMISSIONING

Birmingham City Council / Solihull Metropolitan Borough Council	Birmingham and Solihull Clinical Commissioning Group	NHS England
Contraception services STI testing and treatment Specialist services* Psychosexual services	Abortion services Sterilisation Vasectomy Gynaecology	HIV treatment and care Prison sexual health services SARCs Cervical screening

*Specialist services include young people's sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools, colleges and pharmacies.

OVERVIEW OF SEXUAL HEALTH SERVICES

The diagram below illustrates the sexual health model in Birmingham and Solihull.



OVERVIEW OF PRACTITIONER ENGAGEMENT

CONTRACEPTION SERVICES

Working Well

- Access to free condoms.

Areas for development

- Vasectomies and sterilisation. A high proportion of survey respondents are unsure if services are meeting need.
- Practitioners were generally happy with LARC services, although some highlighted delays in appointments as an issue.
- Complex contraception services.
- Emergency coil fittings.

Pharmacy staff fed back that they were unsure about the pathways for complex contraceptives

There was a gap in information relating to gender dysphoria and PEP

ADVICE AND INFORMATION

Working Well

- Contraceptive advice
- General sexual health information
- HIV advice
- Identifying those who have suffered abuse

Areas for development

- Information for gender dysphoria
- Information for PEP
- Information for PrEP

RESPONSE TO HARD TO REACH GROUPS

Working Well

- Support for victims/ survivors of rape and sexual violence
- Support for patients who identify as LGBTQ

Areas for development

- Homeless
- Refugees, asylum seekers and newly-arrived migrants

Feedback from some third sector practitioners working with older people and those with disabilities was that sexual health needs are not raised routinely.

BARRIERS TO SERVICES

The reduction in walk-in appointments was highlighted as an issue in young person's practitioner interviews and in focus groups with those engaging in risky sexual activity.

Important practical considerations

- Easy to reach by public transport
- Open outside of 'normal' working hours
- Languages other than English

Important service/staffing considerations

- Availability of a range of treatments at a location

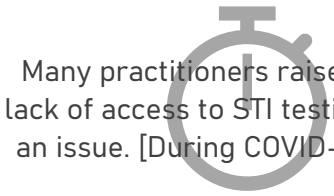
STIs AND BBVs

Working Well

- Access to chlamydia screening/treatment

Areas for development

- Rapid testing for STIs
- Community-based testing



Many practitioners raised that the lack of access to STI testing kits was an issue. [During COVID-19 period]

DEMOGRAPHICS

IN THE UK, POOR SEXUAL HEALTH DISPROPORTIONATELY AFFECTS THOSE EXPERIENCING POVERTY AND SOCIAL EXCLUSION.

IN BIRMINGHAM

- Birmingham, like most urban conurbations, has areas of high deprivation. 43% of the population live in the 10% most deprived areas of England.

IN SOLIHULL

- Solihull is the 32nd least deprived upper tier local authority in England, and the least deprived upper tier local authority across the West Midlands.
- Over half of the North Solihull population live in the most deprived 10% of LSOA neighbourhoods in England, including one in five living in the most deprived 5% LSOAs.

YOUNG PEOPLE AS A DEMOGRAPHIC HAVE PARTICULAR NEEDS REGARDING SEXUAL HEALTH.

- Young people under 25 report relatively larger numbers of sexual partners than other age groups.
- Young people experience the highest diagnosis rates of the most common STIs, and this is likely due to higher rates of partner change among 16-to-24-year-olds.
- A high proportion of 16-to-24-year-olds were not 'sexually competent' at their first sexual intercourse.
- Unplanned pregnancy can be associated with lack of sexual competence.
- The House of Commons report into sexual health (2019) lists pornography and online dating applications as two influences on risky sexual behaviour amongst younger people.

IN BIRMINGHAM

- Birmingham is 'Europe's youngest city', with under-25s accounting for nearly 40% of its population.
- Wards in the centre of the city have median ages of between 21 and 28.

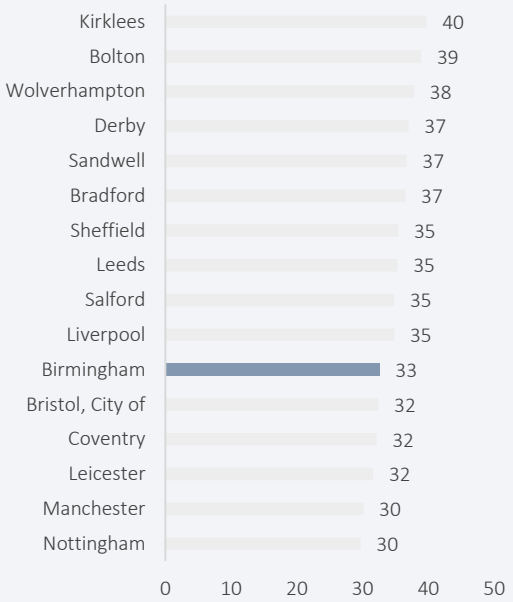
IN SOLIHULL

- Solihull has a higher average age than Birmingham; however, there are wards in the north of the borough where there are a high proportion of younger people.

BIRMINGHAM

AT 33, THE MEDIAN AGE IN BIRMINGHAM RANKS AS ONE OF THE LOWEST AMONG LOCAL AUTHORITIES.

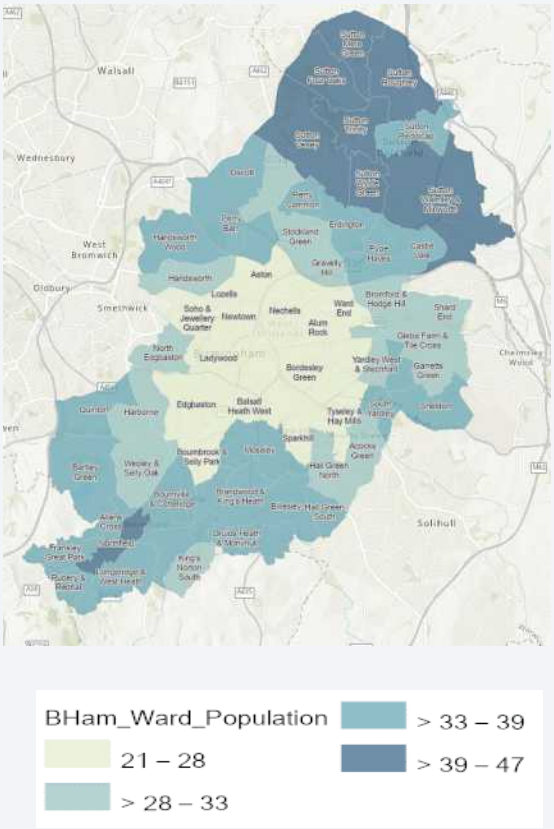
- Below shows the median age in Birmingham against the CIPFA* Nearest Neighbours.



**The Chartered Institute of Public Finance and Accountancy (CIPFA) Nearest Neighbours model seeks to measure similarity between Local Authorities.*

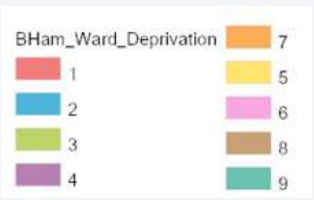
THE CENTRE OF THE BIRMINGHAM HAS THE LOWEST MEDIAN AGE.

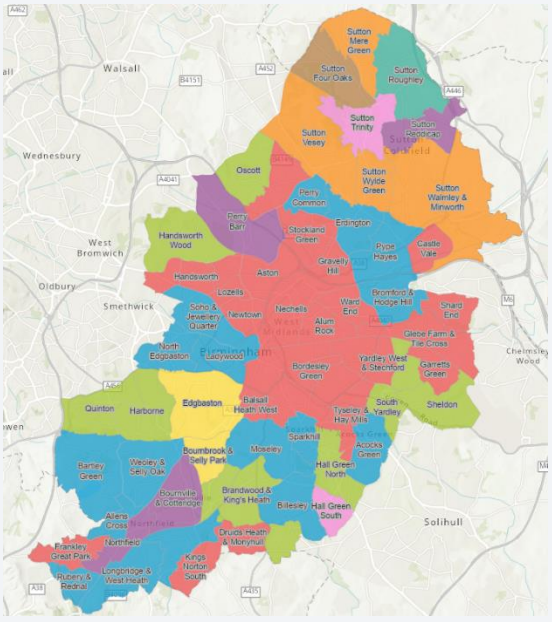
- The map below shows the median ages in Birmingham by ward.



43% OF THE POPULATION LIVING IN LSOAs ARE IN THE 10% MOST DEPRIVED IN ENGLAND

- Birmingham is the 7th most deprived local authority in England and the 3rd most deprived English core city.
- Deprivation is most heavily clustered around the city centre.
- The map shows the Index of Multiple Deprivation (IMD) decile by ward, where 1 is the most deprived and 10 is the least deprived.

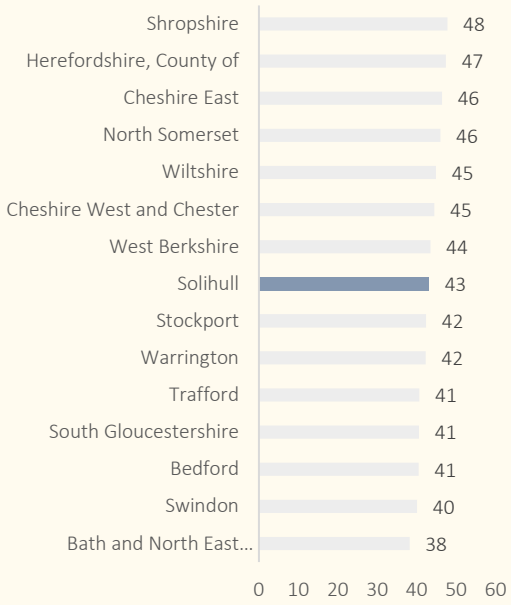




SOLIHULL

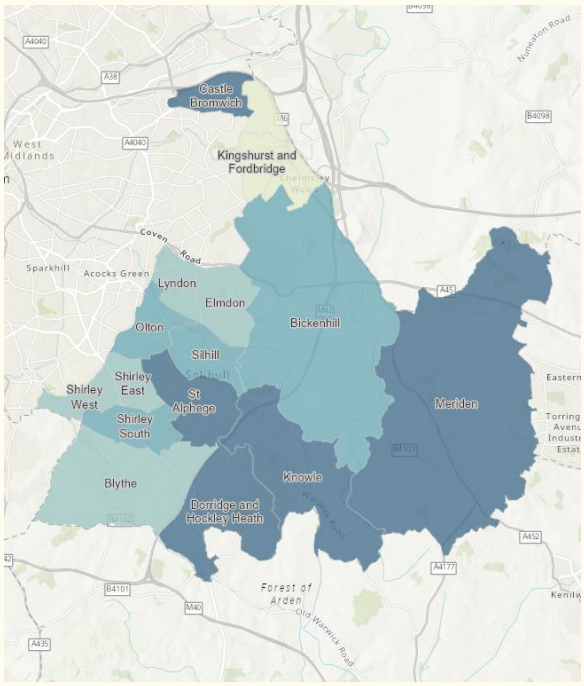
AT 43, THE MEDIAN AGE IN SOLIHULL RANKS NEAR THE MEDIAN OF ITS NEAREST NEIGHBOURS.

- Below shows the median age in Solihull against the CIPFA Nearest Neighbours.



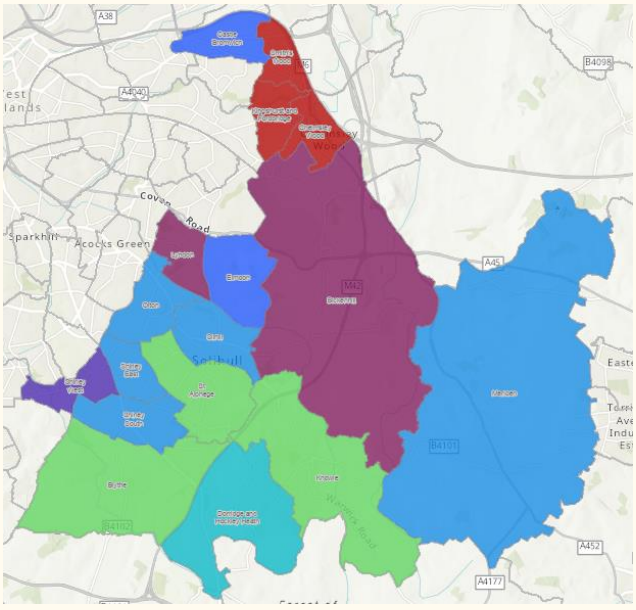
THE NORTH OF SOLIHULL HAS A LOWER AVERAGE AGE.

- There is a higher average age in the south of Solihull.



SOLIHULL IS THE 32ND LEAST DEPRIVED UPPER TIER LOCAL AUTHORITY IN ENGLAND, AND THE LEAST DEPRIVED UPPER TIER LOCAL AUTHORITY ACROSS THE WEST MIDLANDS.

- Despite the overall low average deprivation for Solihull, there is significant polarisation between the neighbourhoods as demonstrated on the map.
- The map shows the IMD decile by ward, where 1 is the most deprived and 10 is the least deprived.



FUTURE TRENDS

GROWTH OF POPULATION

2018–based subnational population projections show that in 2020, Birmingham's population was expected to be 1.2 million (ONS, 2020). By 2025, Birmingham is projected to grow by 2.8% and by 4.9% in 2030.

FAST-TRACK CITIES+ AND ELIMINATION OF HIV BY 2030

The purpose of the Birmingham Fast-Track Cities+ initiative is to ensure availability and access to effective testing and treatment to significantly reduce and therefore eradicate new cases of the blood-borne viruses (BBVs); HIV, Hepatitis B, Hepatitis C, and Tuberculosis (TB). The aim is to strengthen communities and ensure timely provision of services that support the population living with these conditions, without prejudice or stigma.

DIGITAL AND REMOTE ACCESS TO SEXUAL HEALTH SERVICES

Online services will become a greater part of the sexual health care system. Online services can reduce the time it takes patients to be treated and they move less complex treatments away from sexual health clinics. There are opportunities to explore online treatment for simple sexual health issues such as genital chlamydia infections. The move towards digital and online access raises challenges in relation to how safeguarding issues can be identified.

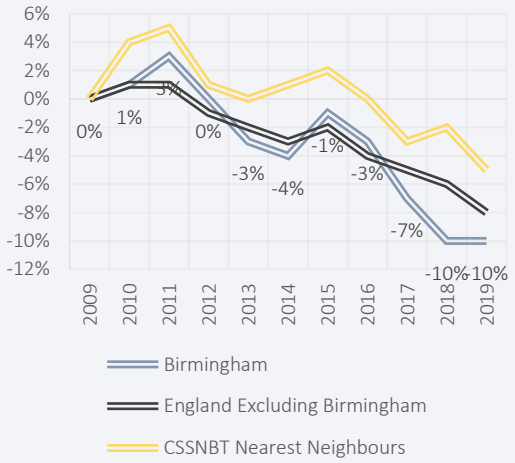
OTHER

- The evolution of cervical screening to HPV screening increases the opportunity for it to be carried out at sexual health clinics, improving the reach of sexual health services and early cancer diagnoses.
- There is a national sexual health strategy due to be released in early 2022.
- Birmingham will be the host city for the Commonwealth Games in 2022; providing opportunities to promote sexual health.

REPRODUCTIVE HEALTH

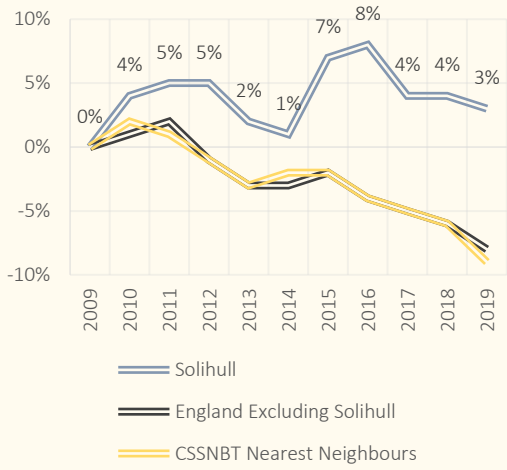
CONCEPTIONS

BIRMINGHAM HAS SEEN A DECREASE IN CONCEPTIONS. THE RATE OF DECREASE IS GREATER THAN THE CSSSNBT* NEAREST NEIGHBOURS.



*CSSNBT Children's Services Statistical Neighbours Benchmarking Tool (CSSNBT). Statistical neighbour models provide one method for benchmarking progress.

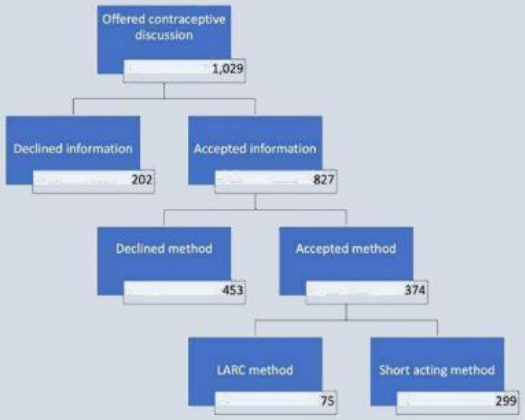
SOLIHULL HAS SEEN AN INCREASE IN CONCEPTIONS WITH NUMBERS PEAKING IN 2015-2016. THE RATES HAVE DECLINED AND STABILISED BETWEEN 2017 TO 2019.



RECOMMENDATIONS

KEY FINDING 1 – POST-NATAL CONTRACEPTION

- Postpartum women are at risk of rapid repeat, unplanned pregnancy with associated adverse outcomes for mother and child. (Thwaites A, et al. BMJ Sex Reprod Health 2019;45:111–117).
- There is currently no formalised offering of post-natal contraception in Birmingham and Solihull.
- There have been successful pilot post-natal contraceptive services offered in Edinburgh, Leeds, Cardiff and Lewisham.
- There was an informal offering of training to midwives and other maternity practitioners from Umbrella sexual health staff who were seconded to hospitals during the COVID-19 pandemic.



Flowchart illustrating contraception uptake in postnatal women from 20th April to 29th June 2020 (Campbell KJ, Barlow-Evans R, Jewell S, et al 'Our COVID-19 cloud silver lining': the initiation and progress of postnatal contraception services during the COVID-19 pandemic in a UK maternity hospital. BMJ Sexual & Reproductive Health 2021;47:224-227)

IMPACT

- The provision of postnatal contraception can prevent unplanned rapid repeat pregnancies, which are associated with worse outcomes for mother and child such as premature birth, lower birth weight and neonatal death.
- With almost one in 13 women presenting for abortion or delivery having conceived within one year of giving birth, providing LARC to new mothers also reduces the likelihood of abortion in the one to two years following childbirth.
- Providing postpartum contraception and advice in postnatal wards, where it is currently rare, could help reach more vulnerable groups, including women with drug, alcohol or mental health problems, who may not attend for routine postnatal care or proactively seek contraception.

RECOMMENDATION

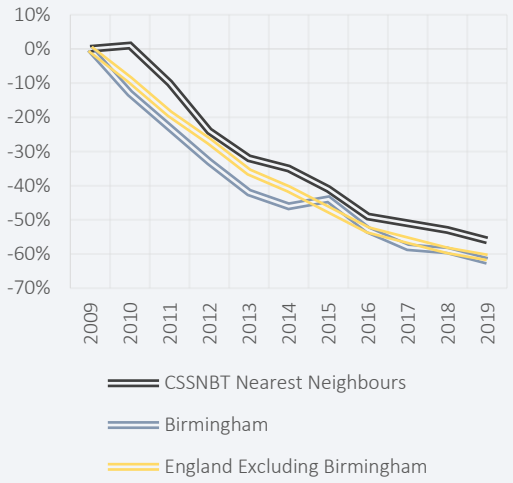
- Post-natal contraceptive services should meet the guidance published by the Royal College of Midwives and the Royal College of Obstetricians & Gynecologists (2021) and the FSRH guideline on Contraception After Pregnancy (2017).
- Post-natal pathways are complex and require buy-in from key stakeholders. It is recommended that the following key stakeholders work together to plan a whole systems approach to developing appropriate post-natal contraception pathways:
    - Sexual health services
    - Community midwives
    - General Practice
    - Labour midwives
    - Obstetricians
- There is an opportunity for further investigation to be completed on the financial benefits of embedding post-natal contraceptive services using the PHE return on investment tool.

TEENAGE PREGNANCIES

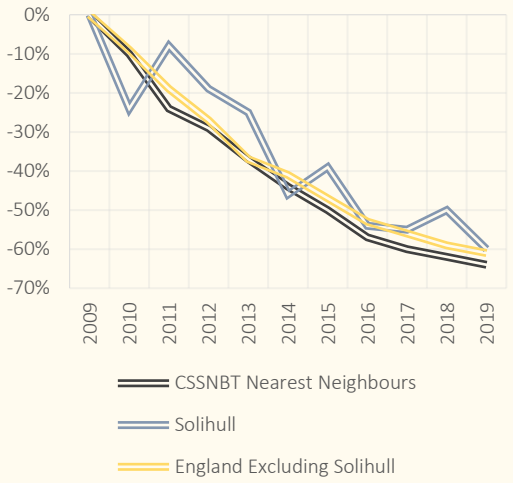
NATIONALLY, THE TEENAGE PREGNANCY RATE IN THE UK FELL BY OVER 60% BETWEEN 2000 AND 2018.

- The Teenage Pregnancy Prevention Framework (updated May 2020) attributed this fall to a long-term evidence-based teenage pregnancy strategy.
- England still experiences higher teenage birth rates than peers in Western European countries.
- Outcomes for young parents and their children are still disproportionately poor.

USING 2009 AS THE BASELINE, BOTH BIRMINGHAM AND SOLIHULL EXPERIENCED DECREASES OF AROUND 60% TO 2019.



USING 2009 AS THE BASELINE, BOTH BIRMINGHAM AND SOLIHULL EXPERIENCED DECREASES OF AROUND 60% TO 2019.



RECOMMENDATIONS

KEY FINDING 2 – PREGNANCY TESTING

- Current sexual health services do not offer free pregnancy testing as a standard offer.
- Purchasing a pregnancy testing kit in a chemist or shop is not confidential.
- In Leeds, there is an offer of free pregnancy testing to those under 25.

5.6 per 1,000

UNDER-18s BIRTH RATE

BIRMINGHAM (2019)

Birmingham Nearest Neighbours: 5.9

England: 4.1

1.9 per 1,000

UNDER-18s BIRTH RATE

SOLIHULL (2019)

Solihull Nearest Neighbours: 2.8

England: 4.1

IMPACT

- An opportunity to engage with patients who have had unprotected sex regarding their sexual health needs may be missed.
- When not interacting with those seeking a pregnancy test, risk factors impacting younger people (underage sex, coercion, exploitation) may not be identified.

RECOMMENDATION

- Umbrella partners, particularly those working with the children and young adult cohort should offer free pregnancy testing kits. The offering of kits can provide an opportunity to explore other potential sexual health needs and provide sexual health advice.

CONTRACEPTION

THE PROVISION OF CONTRACEPTION IS WIDELY RECOGNISED AS A HIGHLY COST-EFFECTIVE PUBLIC HEALTH INTERVENTION, REDUCING THE NUMBER OF UNPLANNED PREGNANCIES WHICH BEAR HIGH SOCIAL AND FINANCIAL COSTS TO INDIVIDUALS, THE HEALTH SERVICE AND TO THE STATE.

- There is a clear public health benefit in comprehensive contraception services, through the prevention of unintended pregnancies and STIs. One study estimates that there is a £9 saving for every £1 invested in contraception provision in England. (PHE, 2018)
- Ideally, all forms of contraception should be made available at the point of access or through an established referral pathway, to provide the full range of choice for women. Longer acting methods - implants and intra-uterine devices/systems are more effective and cost-effective than others and women should be informed of this. (PHE, 2018)

IN BIRMINGHAM

- Umbrella has partnered with GPs and pharmacies to offer a comprehensive contraception service including LARC (available via GPs). There is a plan for pharmacists to start delivering the contraceptive injection, improving coverage.
- The total abortion rate, at 21 per 1,000, is higher than that of the nearest neighbours (20.4) and the national rate (18.7).
- The total prescribed LARC excluding injections rate, at 42.1 per 1,000, is lower than that of the nearest neighbours (47.7) and the national rate (50.8).

IN SOLIHULL

- GPs and pharmacies are not partnered with Umbrella. GPs and pharmacies are commissioned directly by Solihull Metropolitan Borough Council (SMBC) to offer LARCs (GPs) and Emergency Hormonal Contraception (pharmacies).
- The total abortion rate, at 22.1 per 1,000, is higher than that of the nearest neighbours (16.7) and the national rate (18.7).
- The total prescribed LARC excluding injections rate, at 47.9 per 1,000, is lower than that of the nearest neighbours (57.3) and the national rate (50.8).
- There are a number of wards where there have been no LARC insertions by SMBC-commissioned GPs (2020-21).
- Elmdon, Lyndon, Olton, and St Alphege wards have had no LARC insertions by SMBC-commissioned GPs in either 2019-20 or 2020-21.
- There is a strong correlation score between abortion rate and total prescribed LARC rate based on Solihull and the nearest neighbours.

LARCs

KEY FINDINGS

For the total prescribed LARCs (excluding injections), the rates in 2019 for both Birmingham and Solihull were lower than the rates of their nearest neighbours.

In both Birmingham and Solihull, the rate for total prescribed LARCs (excluding injections) rate is lower than the rates for both their nearest neighbours and the national average. Historically, this has been the case.

Birmingham is below average for LARCs prescribed via Sexual and Reproductive Health (SRH) services, whilst in Solihull, GP-prescribed LARC is an area which is below the average.

The rate of GP-prescribed LARCs in Birmingham is similar to that of the nearest neighbours; however the rate for SRH-prescribed LARCs is lower than that of the nearest neighbours.

In Solihull, the rate for SRH-prescribed LARCs is comparable to that of the nearest neighbours; however there appears to be a gap in provision for GP-prescribed LARCs.

The percentage of women in contact with Sexual and Reproductive Health Services who choose LARCs (excluding injections) as their main method of contraception is low in both areas, particularly for Solihull.

For the under-25s, the average for the nearest neighbours to Birmingham and Solihull is similar at 27%. The rate for Birmingham is slightly lower, at 24%, with Solihull at only 17%.

For over-25s, both Birmingham and Solihull report lower rates than their nearest neighbours. Unlike the under-25 age group, Birmingham and Solihull have similar rates to each other.

Geographical analysis in Solihull has found areas with low rates of LARC activity.

The local data for 2020-21 shows that some wards (based on GP location) have had no LARC insertions (Blythe, Dorridge and Hockley Heath, Elmdon, Olton, St Alphege, and Shirley West).

In Solihull, there has been a decrease in IUCD insertions whilst the number of implant insertions has increased.

Comparing 2020-21 against 2019-20, there has been a decrease from 416 IUCD insertions to 332. In contrast, Implanon insertions have increased from 184 to 203.

The analysis by ward shows different patterns for method of insertion. For example, Chelmsley Wood has seen a decrease in IUD/S insertions and an increase in Implanon insertions. Conversely, Shirley East has seen the opposite trend.

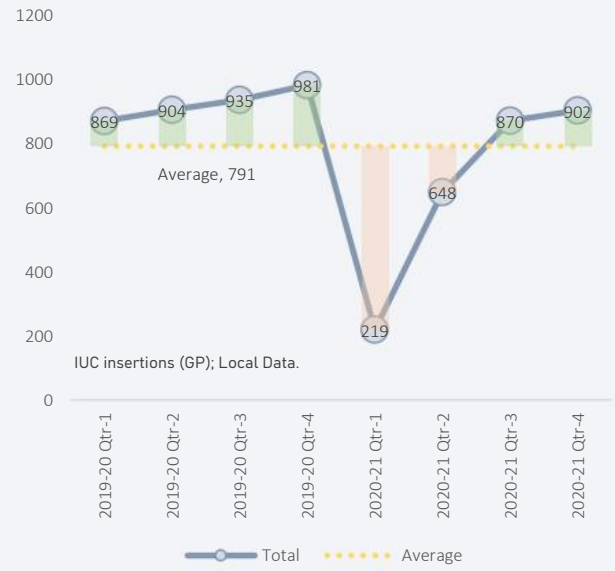
THE TOTAL PRESCRIBED LARC (EXCLUDING INJECTIONS) RATE IN BIRMINGHAM IS LESS THAN THAT OF ENGLAND AND THE NEAREST NEIGHBOURS

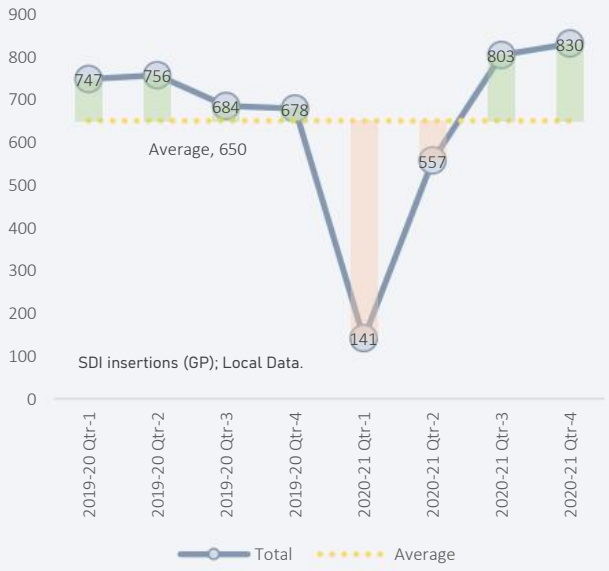
- The rate of 42.1 per 1,000 in 2019 was below the rate of 47.7 for the nearest neighbours and 50.8 for England.
- The rate prescribed by GPs was comparable to the rates for the nearest neighbours and for England; however the number of LARCs prescribed by SRH Services was low.
- LARCs rank low as a choice of contraception at SRH Services in Birmingham.

Indicator Name	England	Birmingham Nearest Neighbours	**Birmingham**
Total prescribed LARCs excluding injections rate per 1,000	50.8	47.7	**42.1**
GP-prescribed LARCs excluding injections rate per 1,000	30.0	28.0	**28.2**
SRH Services-prescribed LARCs excluding injections rate per 1,000	20.8	19.7	**13.9**
Under-25s choose LARCs excluding injections at SRH Services (%)	27.6	27.2	**23.8**
Over-25s choose LARCs excluding injections at SRH Services (%)	43.8	45.3	**38.6**
KEY:	Lower	Similar	Higher

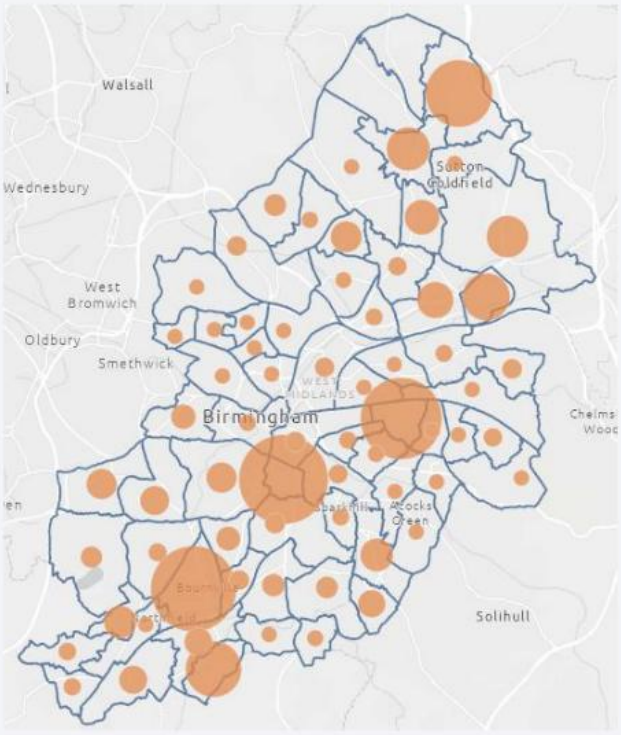
GP LARC FITTINGS WERE SEVERELY IMPACTED BY COVID-19 AT THE START OF THE LOCKDOWN PERIOD

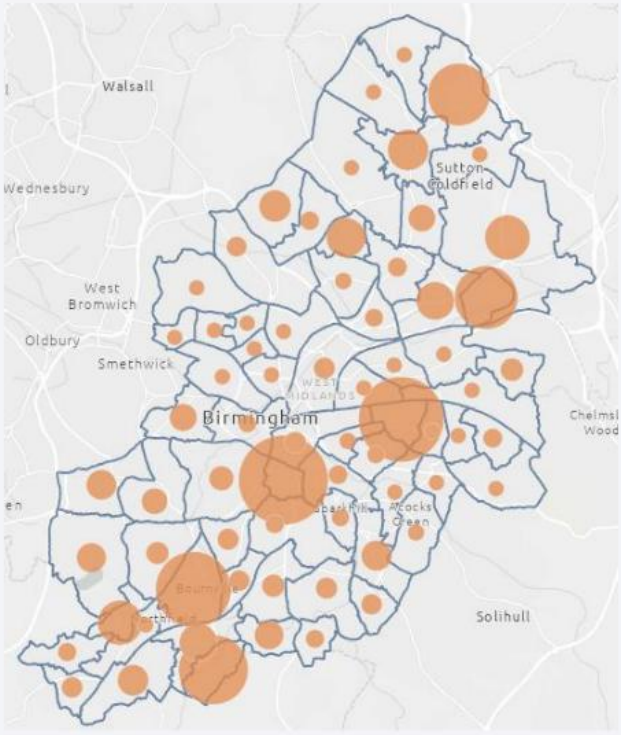
- Activity during April to June 2021 saw a significant decrease; however performance resumed to normal levels soon after.





GEOGRAPHICAL ANALYSIS HAS IDENTIFIED WARDS WITH LOW RATES OF PRESCRIBED LARCs.





THE TOTAL PRESCRIBED LARCs (EXCLUDING INJECTIONS) RATE IN SOLIHULL IS LOWER THAN THE RATES FOR ENGLAND AND THE NEAREST NEIGHBOURS.

- The total abortion rate, at 22.1 per 1,000, is higher than that of the nearest neighbours (16.7) and the national rate (18.7).
- The total prescribed LARCs excluding injections rate, at 47.9 per 1,000, is lower than that of the nearest neighbours (57.3) and the national rate (50.8).
- There is a strong correlation score between abortion rate and total prescribed LARCs rate, based on Solihull and the nearest neighbours.

Indicator Name	England	Solihull Nearest Neighbours	Solihull
Total prescribed LARCs excluding injections rate per 1,000	50.8	57.3	**47.9**
GP prescribed LARCs excluding injections rate per 1,000	30.0	43.5	**33.4**
SRH Services-prescribed LARCs excluding injections rate per 1,000	20.8	13.8	**14.6**
Under-25s choose LARCs excluding injections at SRH Services (%)	27.6	26.7	**16.7**
Over-25s choose LARCs excluding injections at SRH Services (%)	43.8	46.4	**37.8**
Total abortion rate per 1000	18.7	16.7	22.1
KEY:	Lower	Similar	Higher

(GP) IUCD FITTINGS AND REVIEWS SAW NOTABLE DECREASES IN 2020-21; HOWEVER REMOVALS INCREASED.

- IUCD fittings saw a decrease of 18%, whilst IUCD reviews saw a decrease of 39% when comparing 2020-21 against 2019-20. This is like due to COVID-19.
- The number of IUCD removals saw an increase of 14%.
- Implanon insertions and removals experienced an increase.

Activity	IUCD Fitting	IUCD Reviews	IUCD Removal	Implanon Insertion	Implanon Removal
2019-20	422	241	317	196	225
2020-21	346	146	362	206	251
Change: #	-76	-95	45	10	26
Change: %	-18%	-39%	14%	5%	12%

GEOGRAPHICAL ANALYSIS HAS IDENTIFIED WARDS WITH LOW RATES OF LARC INSERTIONS PER 100,000.

- The local data for 2020-21 shows that some wards have no LARC insertions (Blythe, Dorridge and Hockley Heath, Elmdon, Olton, St Alphege, and Shirley West).
- The below figures are shown as a rate per 100,000.

Ward Name / Rate Per 100,000	IUCD Fitting	IUCD Reviews	IUCD Removal	Implanon Insertion	Implanon Removal
Bickenhill	0	0	0	56	75
Blythe	0	0	0	0	0
Castle Bromwich	506	142	567	304	526
Chelmsley Wood	358	151	245	847	1073
Dorridge and Hockley Heath	0	0	21	0	0
Elmdon	0	0	0	0	0
Kingshurst and Fordbridge	163	145	363	381	236
Knowle	144	62	186	103	103
Lyndon	105	53	88	35	35
Meriden	999	981	1166	555	555
Olton	0	0	56	0	0
St Alphege	0	0	0	0	0
Shirley East	1101	200	600	340	440
Shirley South	2390	486	2185	934	1102
Shirley West	0	0	0	0	0
Silhill	440	211	996	134	383
Smith's Wood	113	38	151	151	151
Total	367	145	386	224	272
Sheldon	169	181	156	36	60

COMPARING INFORMATION BETWEEN 2019-20 AND 2020-21 SHOWS THERE HAS BEEN A DECREASE IN IUCD INSERTIONS.

- The below figures are actual IUCD insertions.

Ward Name	2019-20	2020-21	Change
Bickenhill	0	0	0
Blythe	15	0	-15
Castle Bromwich	30	25	-5
Chelmsley Wood	32	19	-13
Dorridge and Hockley Heath	2	0	-2
Elmdon	0	0	0
Kingshurst and Fordbridge	14	9	-5
Knowle	26	7	-19
Lyndon	0	6	6
Meriden	35	54	19
Olton	0	0	0
St Alphege	0	0	0
Shirley East	40	55	15
Shirley South	133	128	-5
Shirley West	10	0	-10
Silhill	55	23	-32
Smith's Wood	24	6	-18
Total	416	332	-84

COMPARING INFORMATION BETWEEN 2019-20 AND 2020-21 SHOWS THERE HAS BEEN AN INCREASE IN IMPLANON INSERTIONS.

- The below figures are actual Implanon insertions.

Ward Name	2019-20	2020-21	Change
Bickenhill	2	3	1
Blythe	5	0	-5
Castle Bromwich	8	15	7
Chelmsley Wood	14	45	31
Dorridge and Hockley Heath	6	0	-6
Elmdon	0	0	0
Kingshurst and Fordbridge	17	21	4
Knowle	8	5	-3
Lyndon	0	2	2
Meriden	9	30	21
Olton	0	0	0
St Alphege	0	0	0
Shirley East	29	17	-12
Shirley South	43	50	7
Shirley West	9	0	-9
Silhill	17	7	-10
Smith's Wood	17	8	-9
Total	184	203	19

RECOMMENDATIONS

KEY FINDING 3 – LARC PRESCRIBING IN SOLIHULL

- In Solihull, GPs and pharmacies are not partnered with Umbrella. GPs and pharmacies are commissioned directly by Solihull Metropolitan Borough Council (SMBC) to offer LARCs (GPs) and Emergency Hormonal Contraception (pharmacies).
- The total prescribed LARCs excluding injections rate, at 47.9 per 1,000, is lower than that of the nearest neighbours (57.3) and the national rate (50.8).
- There are a numberof wards where there have been no LARC insertions by SMBC-commissioned GPs (2020-21).
- Elmdon, Lyndon, Olton, and St Aphege wards have had no LARC insertions by SMBC-commissioned GPs in either 2019-20 or 2020-21.
- In Solihull, the rate for SRH-prescribed LARCs is comparable to that of the nearest neighbours; however there appears to be a gap in provision for GP-prescribed LARCs.

IMPACT

- The total abortion rate, at 22.1 per 1,000, is higher than that of the nearest neighbours (16.7) and the national rate (18.7).
- There is also a high repeat abortion rate amongst the under-25s (36.3%). The under-25 repeat abortion rate for the nearest neighbours is 25.7%.

RECOMMENDATION

- The model for delivering LARCs in Solihull should be reviewed to ensure that there is a maximising of take up.

KEY FINDING 4 – LARC PRESCRIBING IN BIRMINGHAM

- For the total prescribed LARCs (excluding injections), the rates in 2019 for both Birmingham and Solihull were lower than those of their nearest neighbours.
- In both Birmingham and Solihull, the rates for total prescribed LARCs (excluding injections) are lower than the rates for boththeir nearest neighbours and the national average. Historically, this has been the case.
- Birmingham is below average for LARCs prescribed via Sexual and Reproductive Health (SRH) services, whilst in Solihull, GP-prescribed LARCs are below the average.
- The rate of GP-prescribed LARCs in Birmingham is similar to that of the nearest neighbours; however the rate for SRH-prescribed LARCs is lower than that of the nearest neighbours.
- The percentage of women in contact with Sexual and Reproductive Health Services who choose LARCs (excluding injections) as their main method of contraception is low in both Birmingham and Solihull.

IMPACT

- LARC offers the highest protection against unintended pregnancies. In addition, the use of reversible hormonal contraception has added health benefits for women in both the short and the long term. (Kopp Kallner H. (2018). Benefits of reversible contraception. F1000Research, 7, F1000 Faculty Rev-973. https://doi.org/10.12688/f1000research.14370.1)

RECOMMENDATION

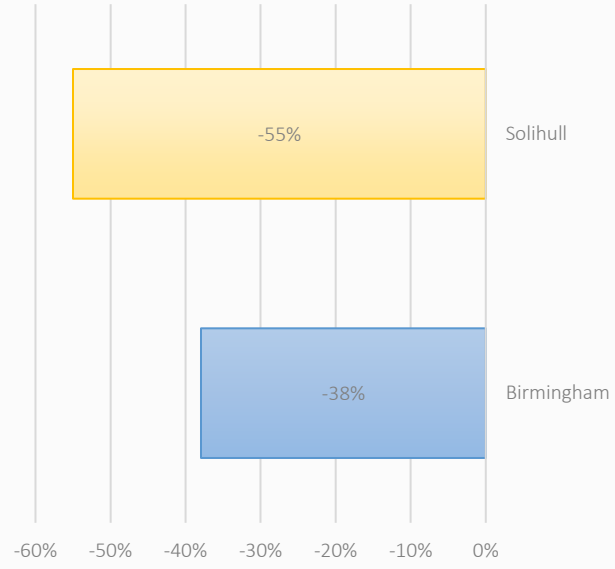
- There should be greater access to LARCs in Birmingham via all sources.

VASECTOMIES AND STERILISATIONS

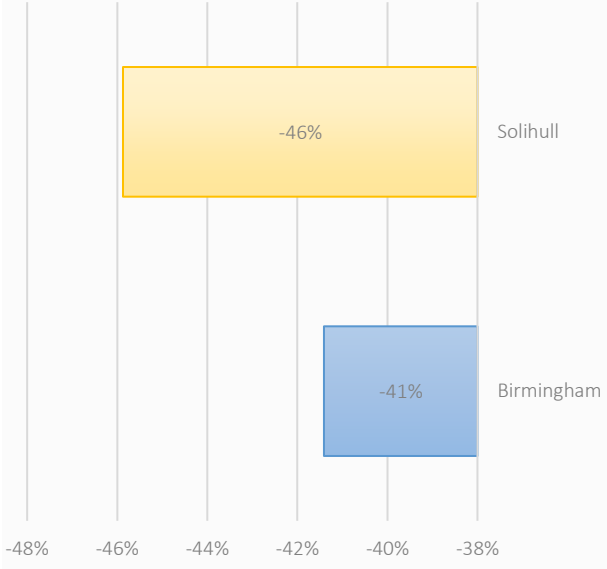
THE PAUSE ON ELECTIVE SURGERIES DURING THE COVID-19 PANDEMIC MEANT THERE WAS A REDUCTION IN THE NUMBER OF VASECTOMIES.

- In Birmingham and Solihull, vasectomy services are provided by the British Pregnancy Advisory Service (BPAS). The vasectomy and Termination of Pregnancy contract (also provided by BPAS) runs until March 2023.
- The halting of elective surgeries, apart from category 4 surgeries, meant there was a reduction in vasectomies.

THERE HAS BEEN A REDUCTION IN TOTAL VASECTOMY CONSULTATIONS BETWEEN 2019-20 AND 2020-21 IN BIRMINGHAM AND SOLIHULL.



THERE HAS BEEN A REDUCTION IN TOTAL VASECTOMIES BETWEEN 2019-20 AND 2020-21 IN BIRMINGHAM AND SOLIHULL.



EMERGENCY HORMONAL CONTRACEPTION

PHARMACY PROVISION IS PARTICULARLY IMPORTANT FOR YOUNG PEOPLE REQUIRING EMERGENCY HORMONAL CONTRACEPTION IN TERMS OF CONVENIENT LOCATIONS AND FLEXIBLE HOURS.

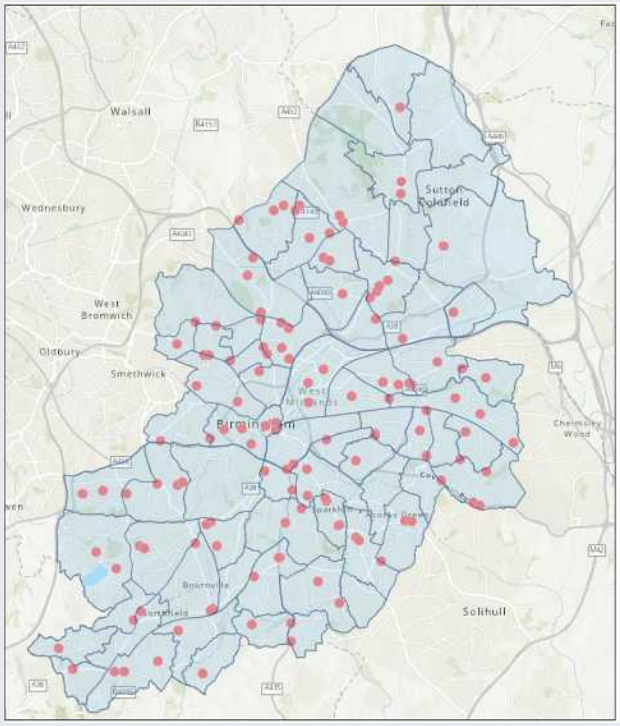
IN BIRMINGHAM

- Umbrella have partnered with GPs and pharmacies to offer a comprehensive contraception service including LARCs (available via GPs). There is a plan for pharmacists to start delivering the contraceptive injection, improving coverage.
- In Birmingham, there are 0.4 pharmacies per square kilometre providing free EHC.
- In Birmingham, there is a rate of 1,569 EHCs prescribed per 100,000 of the female 16-45 population.

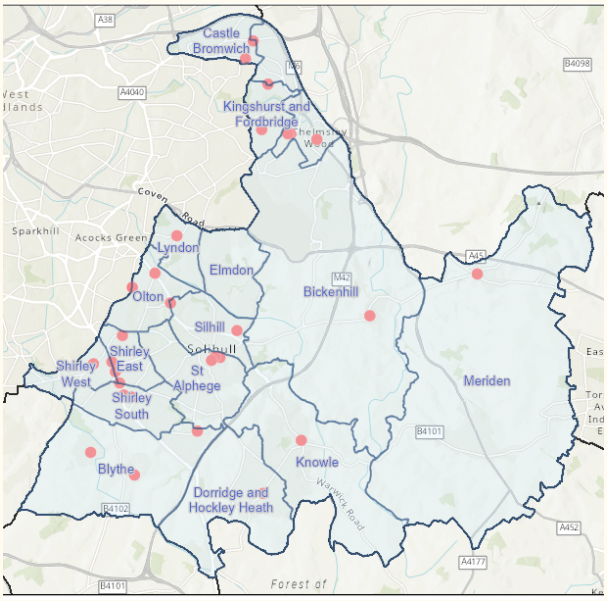
IN SOLIHULL

- GPs and pharmacies are not partnered with Umbrella. GPs and pharmacies are commissioned directly by SMBC to offer LARCs (GPs) and Emergency Hormonal Contraception (pharmacies).
- In Solihull, there are 0.1 pharmacies per square kilometre providing free EHC.
- In Solihull, there is a rate of 723 EHCs prescribed per 100,000 of the female 16-45 population.

IN BIRMINGHAM, THERE ARE 0.4 PHARMACIES PER SQUARE KM PROVIDING FREE EHC.



IN SOLIHULL, THERE ARE 0.1 PHARMACIES PER SQUARE KM PROVIDING FREE EHC.



KEY FINDING 5 – SEXUAL HEALTH SERVICE VIA PHARMACIES IN SOLIHULL

- Pharmacies in Solihull are not partnered with Umbrella and do not provide the same service. At the time of this assessment, pharmacies in Solihull provided chlamydia screens and emergency contraception.
- Wider sexual health interventions are not offered in pharmacies in Solihull.
- In Birmingham, there are 0.4 pharmacies per square kilometre providing free EHC.
- In Birmingham, there is a rate of 1,569 EHCs prescribed per 100,000 of the female 16-45 population.
- In Solihull, there are 0.1 pharmacies per square kilometre providing free EHC. (0.4 per square km in Birmingham). In Solihull, there is a rate of 723 EHCs prescribed per 100,000 of the female 16-45 population.
- Young people fed back that they would be more likely to engage with services that were closer to their locations rather than travel into Central Birmingham. Pharmacies were not always seen as an option due to the possibility that an Umbrella-trained pharmacist may not be available.

IMPACT

- Opportunities for delivering more localised sexual health promotion and treatment are impacted. This can mean that sexual health needs are not identified or met for patients in Solihull.

"Young people can be more reluctant to access sexual health services via their GP as their entire households are often registered with us too, and they can have misconceptions about their entitlement to confidentiality."

RECOMMENDATION

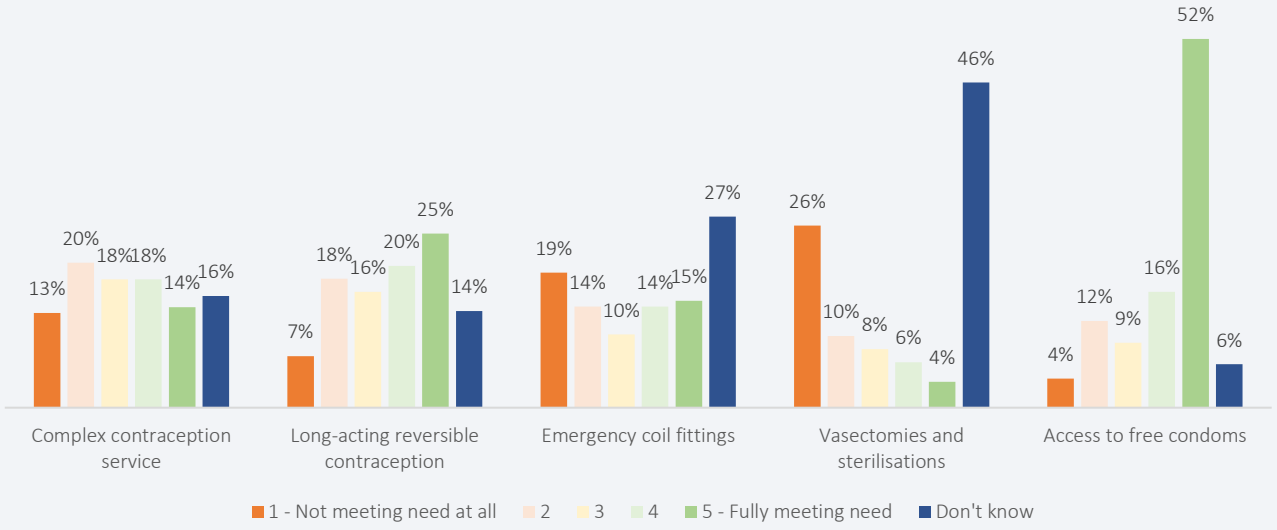
- Pharmacy services in Solihull should deliver the same services as those in Birmingham, leading to greater accessibility of sexual health services for the population of Solihull.

CONTRACEPTION ENGAGEMENT

Practitioners were asked if current provision relating to contraception was meeting need. 130 practitioners across a range of services responded.

.

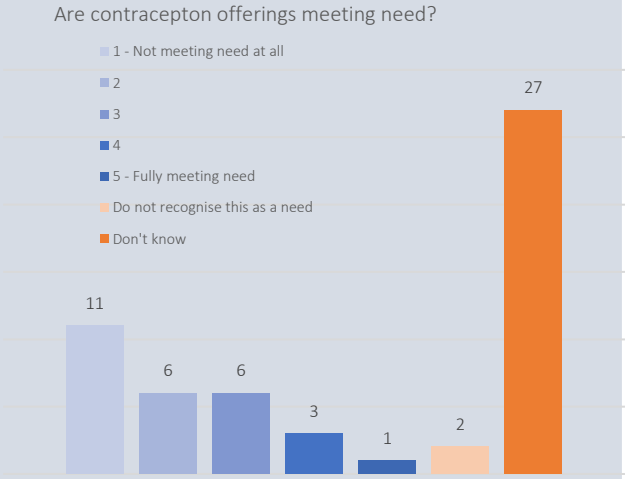
THERE WAS A FEELING THAT EMERGENCY COIL FITTINGS (19% - NOT MEETING NEED AT ALL) AND VASECTOMIES AND STERILISATIONS (26% - NOT MEETING NEED AT ALL) WERE NOT MEETING NEED.



RECOMMENDATIONS

KEY FINDING 6 – VASECTOMIES AND STERILISATIONS

- The practitioner surveys identified a potential lack of knowledge in relation to the pathways for vasectomies and sterilisations.
- The chart shows that 48% of respondents to the practitioner surveys did not know whether vasectomy or sterilisation services were meeting need.
- 20% thought that they were not meeting need at all.



IMPACT

- Patients may not be directed towards the appropriate pathways or given suitable advice in relation to vasectomies and sterilisations.

RECOMMENDATION

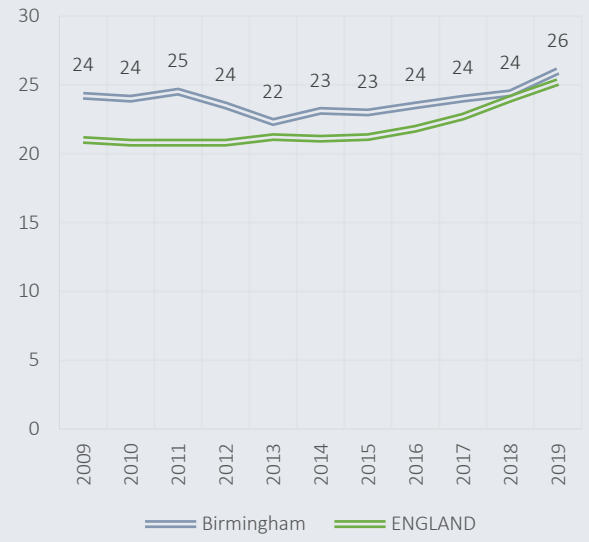
- There should be increased knowledge sharing in relation to patient pathways relating to vasectomies and sterilisations.
- A clear pathway is developed and provided to those involved in providing integrated contraception and sexual health services.

ABORTIONS

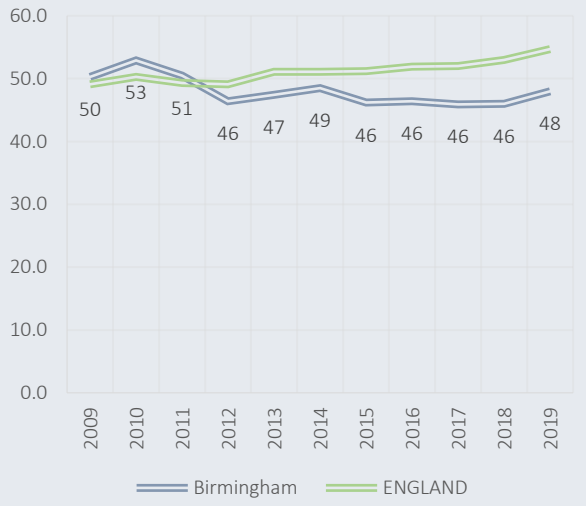
REDUCING ABORTION RATES IS LINKED TO THE PROVISION OF GOOD QUALITY SEXUAL AND REPRODUCTIVE HEALTH CARE AND EFFECTIVE CONTRACEPTION.

A 2017 report from LSE reinforces this view: "The number of abortions still undertaken is an indicator of the potential price of failing to provide good quality sexual and reproductive health care, and of the importance of providing effective contraception to all women able to benefit from it." (LSE, 2017, *Improving Access to Contraception*).

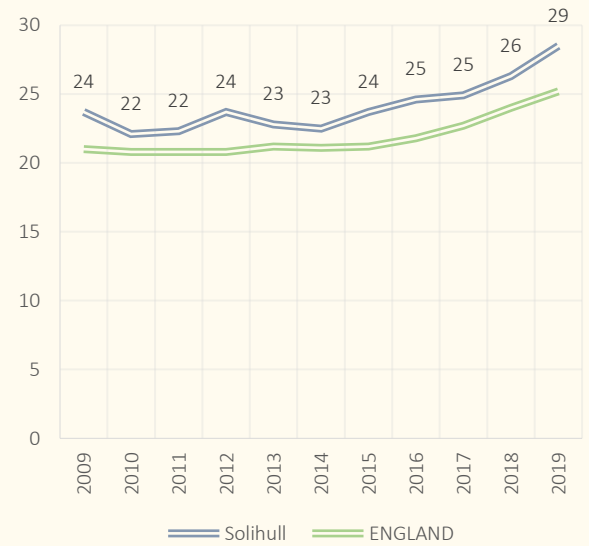
IN 2019, 26% OF CONCEPTIONS (ALL AGES) LED TO AN ABORTION



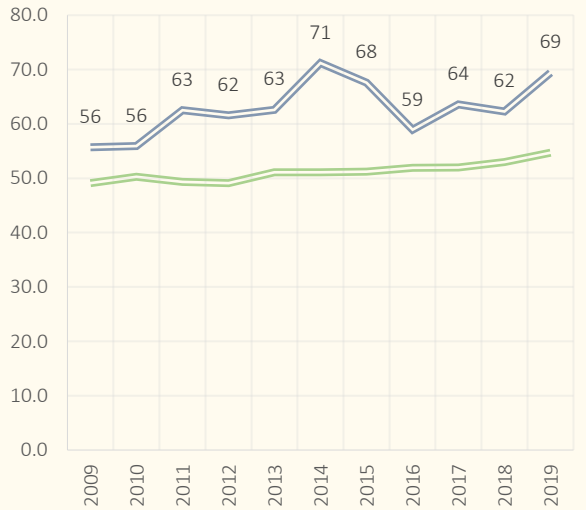
IN 2019, 48% OF CONCEPTIONS IN THOSE AGED UNDER 18 LED TO AN ABORTION



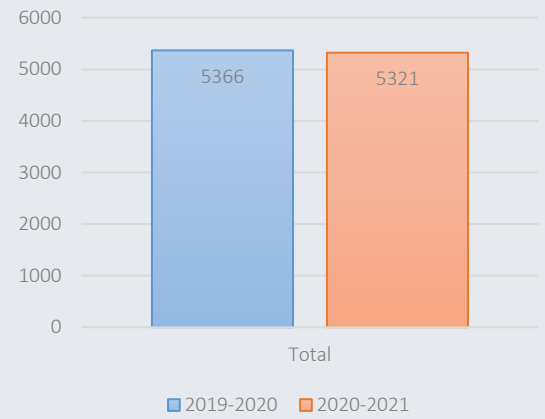
AT 29%, THE PERCENTAGE OF CONCEPTIONS LEADING TO ABORTION FOR SOLIHULL RESIDENTS IS AN INCREASE ON THE PREVIOUS YEARS AND IS THE HIGHEST RATE ACROSS THE ANALYSED TIME-SERIES. (ALL AGE)



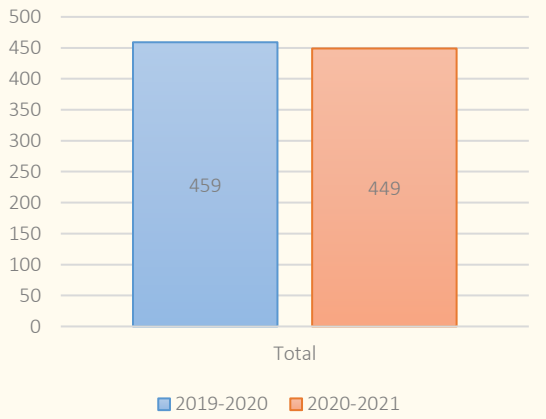
THERE HAS BEEN AN INCREASE IN ABORTIONS FOR CONCEPTIONS IN THOSE UNDER 18. (69%)



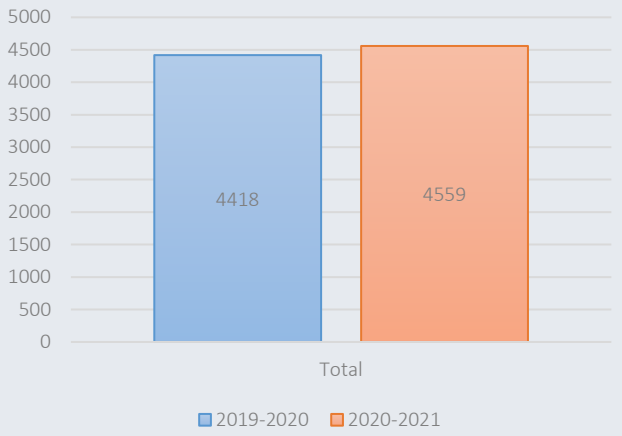
THERE HAS BEEN A SLIGHT REDUCTION IN ABORTION CONSULTATIONS IN BIRMINGHAM.



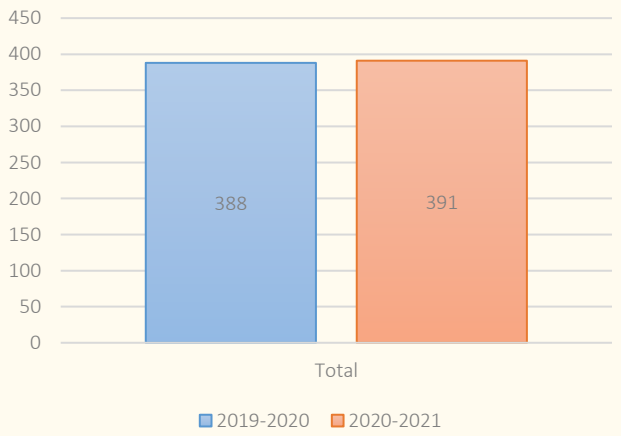
THERE HAS BEEN A SLIGHT REDUCTION IN ABORTION CONSULTATIONS IN SOLIHULL.



THERE HAS BEEN A SLIGHT INCREASE IN ABORTIONS IN BIRMINGHAM.



THERE HAS BEEN A SLIGHT INCREASE IN ABORTIONS IN SOLIHULL.



COVID-19 IMPACTED THE DELIVERY OF TAKE-OUT PRESCRIPTIONS. THERE HAS BEEN A DECREASE IN PATIENTS BEING GIVEN THEIR MEDICATION TO TAKE OUT, AND AN INCREASE IN PATIENTS RECEIVING MEDICATION VIA POST OR VIA COLLECTION.

RECOMMENDATIONS

KEY FINDING 7 – SOLIHULL ABORTION RATE

- The total abortion rate, at 22.1 per 1,000, is higher than that of the nearest neighbours (16.7) and the national rate (18.7).
- The total prescribed LARCs excluding injections, at 47.9 per 1,000, is lower than that of the nearest neighbours (57.3) and the national rate (50.8).
- At 29%, the percentage of conceptions leading to abortion for Solihull residents is an increase on the previous years and is the highest rate across the analysed time-series. This rate is higher than the rates for both England and Birmingham.
- In Solihull there is a high rate of repeat abortions amongst the under-25s. 36.3% of abortions in the under-25s are repeat abortions.
- Both Solihull (47.9 per 1,000) and Birmingham (42.1 per 1,000) have lower rates of prescribed LARCs compared to their nearest neighbours.
- 24% of respondents scored the current service response as 1 or 2 out of 5 (across Birmingham and Solihull).

IMPACT

- It is likely that the Solihull abortion rate has been impacted by the limited availability of free EHC in the borough.

RECOMMENDATION

- In relation to the high abortion rates in Solihull:
    - There should be a more widespread availability of LARCs and EHC in Solihull.
- In relation to the high repeat abortion rates:
    - Abortion services should be fully aware of contraception services in Birmingham and Solihull.
    - Abortion services should be providing appropriate sexual health advice to those using their services.
    - Abortion providers should consider auditing their contraceptive offering to patients.

STIs

STI TESTING PROVISION

STI TESTING KITS

- Umbrella offer STI testing kits to test for:
  - Chlamydia
  - Gonorrhoea
  - HIV
  - Syphilis

GP

- GPs can direct patients to the Umbrella website to order the STI testing kits.
- GPs follow the National Chlamydia Screening Programme for opportunistic screening of females under 25, outside of specialist sexual health services
- There are no GPs in Solihull who are partnered with Umbrella.

PHARMACY

- Pharmacies can supply the STI self-testing kits to patients.
  - There are no pharmacies in Solihull who are partnered with Umbrella.

SEXUAL HEALTH CLINICS

- All patients attending Umbrella clinics are offered HIV and STI testing.
- Clinics offer treatment for sexually transmitted infections.

COMMUNITY AND DELIVERY PARTNERS

- Community partners can assist people with ordering the STI self-testing kits.
- Delivery partners can supply people with the kits.

KEY FINDINGS

- During the COVID-19 pandemic, there were a limited number of STI testing kits available. Services reported facing long delays in the receipt of kits.
  - The blockage in kit availability was due to a shortage of appropriate components.
- There was a shortage of STI testing kits during the pandemic.
  - Birmingham LGBT practitioners fed back that these kits were extremely popular with their service users.
  - The kits were useful to get people to engage with services and then offer additional testing (e.g. BBV).
  - The kits helped in increasing the testing rates.
- Practitioners from Birmingham Youth Service said that the kits were popular and the lack of availability of kits was an issue.

RECOMMENDATIONS

KEY FINDING 8 – ACCESSING SEXUAL HEALTH APPOINTMENTS

- During the COVID-19 pandemic there was only one sexual health walk-in clinic across Birmingham and Solihull.
- The clinic is located in a Boots in Birmingham City Centre. Until October 2021, there was no walk-in offering in Solihull.
- To obtain a sexual health appointment, patients had to book via a phone service.
- Feedback from the engagement exercises was that there was a wait before an appointment was available.
- Feedback from the engagement exercise was that hard-to-reach groups preferred the option of a walk-in appointment. Those engaging in risky sexual activity would rather go to a walk-in appointment than wait three days for a booked appointment.
- Practitioners from Birmingham Youth Service fed back that they had to refer young people into services on their behalf.

"A client used to be able to collect condoms from clinics, now asked to go queue at the pharmacies, which young patients find embarrassing."

Young Person's Counsellor

IMPACT

- Patients cannot access sexual health services as easily as before. This is likely to increase the amount of unmet sexual health need across the general populations of Birmingham and Solihull.
- Telephone appointments and triage are a barrier to hard-to-reach and vulnerable groups, those with language barriers, hard of hearing groups and those without access to telephones or internet.
- Hard-to-reach groups may have been dissuaded from accessing sexual health services due to the lack of options in relation to walk-in clinics. This may mean that sexual health need is not identified or met.
- Young people without access to a key worker may not take to the time to access the sexual health service.

RECOMMENDATION

- The availability of walk-in clinics in other areas of Birmingham and Solihull should be explored as a way to achieve greater coverage of sexual health support and meeting of sexual health needs. Walk-in appointments must be made available to widen access to the most vulnerable groups.
- Alternative access routes should be explored, e.g., triage via an online chat, widening third sector referral pathways, or online appointment booking.
- There should be consideration given to temporary or 'pop-up' clinics to widen access for those who cannot access the current clinics.

KEY FINDING 9 – UMBRELLA WEBSITE

- Feedback received as part of the engagement process indicated that the Umbrella website was not user friendly in terms of the availability of sexual health services in pharmacies.
- The website asks patients to call to confirm the availability of the Umbrella pharmacist.

IMPACT

- Having to call the pharmacy may be a potential barrier to young people accessing sexual health advice and treatment. This may result in a need not being identified or treated.

RECOMMENDATION

- As many staff as possible at an Umbrella pharmacy should be trained in providing sexual health treatment and advice.
- The availability of the sexual health-trained pharmacist should be published on the Umbrella website.

KEY FINDING 10 – SOLIHULL SEXUAL HEALTH CLINIC LOCATIONS

- There has been limited access to Solihull clinics at the time of this needs assessment.
- Currently there is one delivery location in Solihull, located in Mell Square. The delivery location in Chelmsley Wood is being used as a COVID-19 vaccination centre.
- To travel from Chelmsley Wood to the clinic in Mell Square in Central Solihull takes approximately one hour by public transport.

"Recent closures of satellite clinics in areas of high need is a problem."

Umbrella Doctor

- Demographic analysis of Solihull shows that the north part of the borough has greater risk factors relating to likely sexual health need.

IMPACT

- The closure of the sexual health clinic located in Chelmsley Wood made it more difficult for patients from the north of Solihull to access services.

RECOMMENDATION

- A sexual health clinical space should be opened up in the north of Solihull, a part of the borough with greater deprivation and a younger population, both groups that are likely to have sexual health needs.

KEY FINDING 11 – SEXUAL HEALTH OUTREACH

- During COVID-19, most sexual health outreach work was stopped.
- The following outreach work was not taking place during the COVID-19 pandemic:
    - Outreach work in clubs and bars.
    - Outreach work in public sex environments.

IMPACT

- Outreach work is important in identifying and meeting the sexual health needs of those in hard-to-reach groups.
- The reduction in sexual health outreach work is likely to mean increased unmet need across a wide range of patient cohorts, including those with a substance misuse need, those who are homeless, and young people.

RECOMMENDATION

- There should be a clear sexual health outreach strategy across Birmingham and Solihull to ensure that there is an opportunity for all hard-to-reach groups to engage with sexual health services and have their needs identified and met.
- There are opportunities for 'pop-up' sexual health clinics to be set up. There is evidence that these set-ups have worked well in the promotion of blood-borne virus testing and treatment.
- The employment of community sexual health champions should be explored in communities where there is traditionally poor engagement with sexual health services.

KEY FINDING 12 – PHARMACY OFFERINGS

- Based on the community survey, there is an opportunity to increase the knowledge of the services offered by pharmacies. Only 25% of respondents would use a local pharmacy for contraceptive advice.
- There was knowledge that pharmacies provide emergency contraceptives (49% of respondents would go to a pharmacy for emergency contraception), however, only 28% would go to a local pharmacy to receive a non-emergency contraceptive.

IMPACT

- Patients may not be accessing services in pharmacies due to a lack of knowledge about what is being provided there.

RECOMMENDATION

- Ensure the sexual health offering in pharmacies is appropriately promoted.
- It should be easier to access information on the availability of sexual health services from Umbrella pharmacies.

STI OVERVIEW

SEXUALLY TRANSMITTED INFECTIONS (STIS) ARE A MAJOR PUBLIC HEALTH CONCERN.

STIs are a major public health concern, which may seriously impact the health and wellbeing of affected individuals, as well as being costly to healthcare services. If left undiagnosed and untreated, common STIs can cause a range of complications and long-term health problems, from adverse pregnancy outcomes to neonatal and infant infections, and cardiovascular and neurological damage. (PHE, 2019).

POSSIBLE MITIGATING FACTORS FOR THE REDUCTION IN PERFORMANCE DURING THE COVID-19 PANDEMIC

- Prior to COVID-19, Umbrella offered a walk-in service at seven locations across Birmingham and Solihull. All 7 of these locations had to shut at the beginning of the pandemic (March 16th, 2020). There is a possibility that Birmingham's nearest neighbours did not have as many clinics, meaning that the drop in testing coverage and diagnoses rates was lower.
- The reduction in face-to-face contact with GPs impacted the LARC fittings and chlamydia testing offerings.
- Pharmacies had significantly-reduced footfall, which reduced the number of patients who could be engaged for sexual health interventions.
- Reductions in herpes and genital warts could be attributed to reductions in sexual activity during the COVID-19 period.
- There was little or no outreach work completed by Umbrella and their partner organisations during the COVID-19 period. This was due to a lack of external events, closures of clubs and educational establishments, and closures of partner organisations.
- Problems with the supply of STI-testing kits compounded the issues regarding identifying diseases. These issues have been addressed by Umbrella.
- Prior to the COVID-19 pandemic, the charity Birmingham LGBT completed testing with the men who have sex with men population. Birmingham LGBT were closed or running at reduced hours during the pandemic.
- Changes to the population's working and socialising activities meant that there was less footfall in the centres of Birimingham and Solihull. This meant that people were accessing testing services closer to their areas of residence, which could be outside of Birmingham or Solihull.

IN BIRMINGHAM

- COVID-19 had a greater impact on STI-related indicators in Birmingham compared to its nearest neighbours.
- Between 2019 and 2020 (all excluding chlamydia):
    - The STI testing rate fell by 50% (nearest neighbours fell by 17%).
    - The new STI diagnoses rate fell by 54% (nearest neighbours fell by 30%).
    - STI positive testing rates fell by 45% (nearest neighbours fell by 20%).
- The proportion of 15-24-year-olds screened for chlamydia was below national rates and the rate of the nearest neighbours.
- There was a significant decrease in gonorrhoea diagnoses.

IN SOLIHULL

- COVID-19 had a greater impact on STI-related indicators in Solihull compared to its nearest neighbours.
- Between 2019 and 2020 (all excluding chlamydia):
    - The STI testing rate fell by 48% (nearest neighbours fell by 25%).
    - The new STI diagnoses rate fell by 58% (nearest neighbours fell by 31%).
    - STI positive testing rates fell by 43% (nearest neighbours fell by 21%).
- The proportion of 15-24-year-olds screened for chlamydia was below national rates and the rate of the nearest neighbours.
- There was a significant decrease in gonorrhoea diagnoses.

BIRMINGHAM

	BIRMINGHAM	NEAREST NEIGHBOURS
STI testing rate (exc chlamydia aged <25) / 100,000 Number outside brackets shows the rate per 100,000. Number inside brackets shows the actual number tested[3].		
2019	8,113 (60,733)	5,304 (183,467)
2020	4,078 (30,558)	4,352 (151,943)
Change in numerator		
New STI diagnoses (exc chlamydia aged <25) / 100,000 Number outside brackets shows the rate per 100,000. Number inside brackets shows actual new STI diagnoses[4].		
2019	1,058 (7,921)	910 (31,483)
2020	485 (3,633)	631 (22,018)
Change in numerator		
STI testing positivity (exc chlamydia aged <25) % Number outside brackets shows the percentage. Number inside brackets shows a sum of all positive diagnoses[5].		
2019	7% (4,187)	7% (13,703)
2020	8% (2,318)	7% (11,011)
Change in numerator		

3 Total number of people tested for one or more infections for syphilis, HIV, gonorrhoea and chlamydia at a new attendance.

4 The number of new STI diagnoses (excluding chlamydia in those aged under 25 years) among people aged 15 to 64 accessing sexual health services.

5 A sum of all positive diagnoses of syphilis, HIV, gonorrhoea and chlamydia. Chlamydia diagnoses are only included in people aged 25 to 64 years.

SOLIHULL

	SOLIHULL	NEAREST NEIGHBOURS
STI testing rate (exc chlamydia aged <25) / 100,000 Number outside brackets shows the rate per 100,000. Number inside brackets shows the actual number tested[6].		
2019	5,711 (7471)	4,052 (95,252)
2020	2,966 (3907)	3,019 (71,300)
Change in numerator		
New STI diagnoses (exc chlamydia aged <25) / 100,000 Number outside brackets shows the rate per 100,000. Number inside brackets shows actual new STI diagnoses[7].		
2019	646 (845)	550 (12,933)
2020	269 (354)	379 (8,949)
Change in numerator		
STI testing positivity (exc chlamydia aged <25) % Number outside brackets shows the percentage. Number inside brackets shows a sum of all positive diagnoses[8].		
2019	5% (393)	5% (4,883)
2020	6% (223)	5% (3,871)
Change in numerator		

6 Total number of people tested for one or more infections for syphilis, HIV, gonorrhoea and chlamydia at a new attendance.

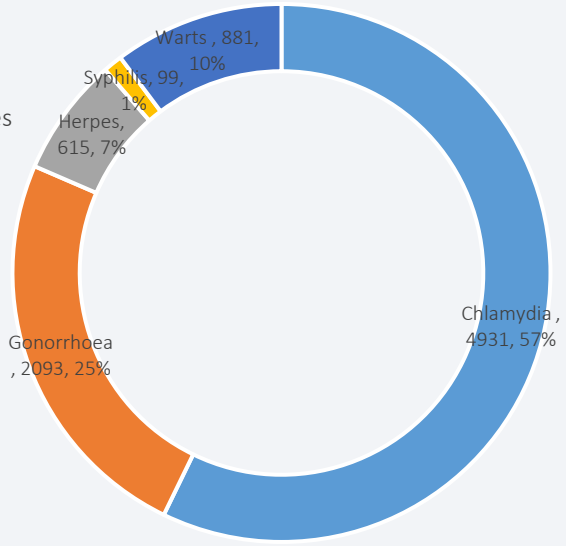
7 The number of new STI diagnoses (excluding chlamydia in those aged under 25 years) among people aged 15 to 64 accessing sexual health services.

8 A sum of all positive diagnoses of syphilis, HIV, gonorrhoea and chlamydia. Chlamydia diagnoses are only included in people aged 25 to 64 years.

STI TESTING (GENERAL) BIRMINGHAM

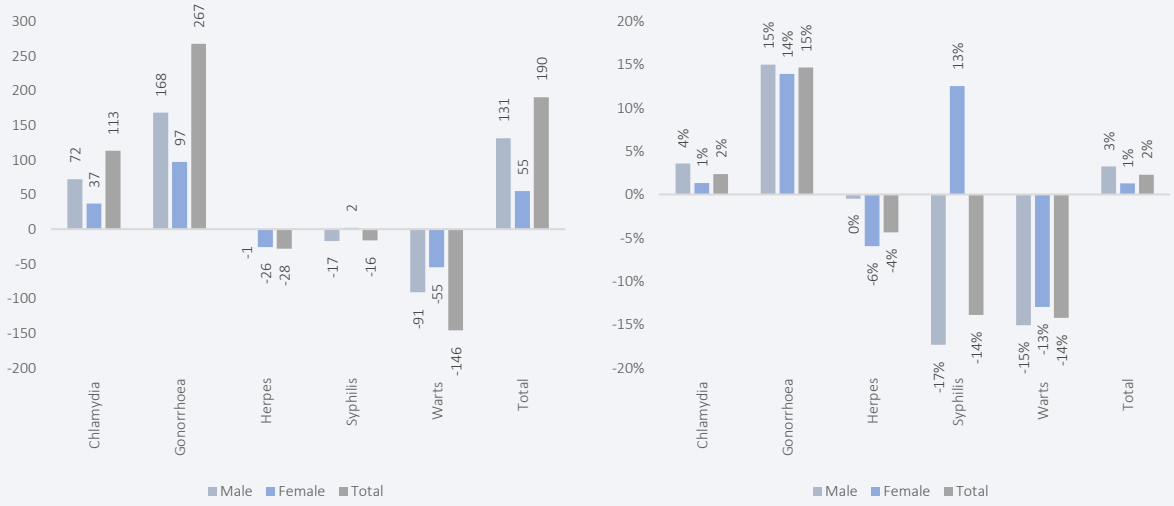
CHLAMYDIA ACCOUNTS FOR THE MAJORITY OF NEW STI DIAGNOSES.

- Chlamydia continues to account for the majority of new STI diagnoses.
- In 2019-20, chlamydia accounted for 57% of new diagnoses for patients from Birmingham attending Non-GUM (Level 2) services and GUM (Level 3) services.
- This is similar to the rate of 57% in 2018-19.



THERE HAS BEEN A SIGNIFICANT INCREASE IN GONORRHOEA DIAGNOSES.

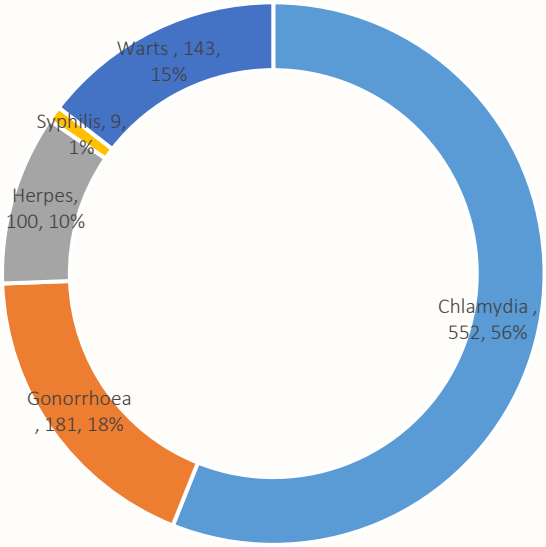
- There has been a significant increase in the number of gonorrhoea diagnoses during 2019-20 when compared against 2018-19.



STI TESTING (GENERAL) SOLIHULL

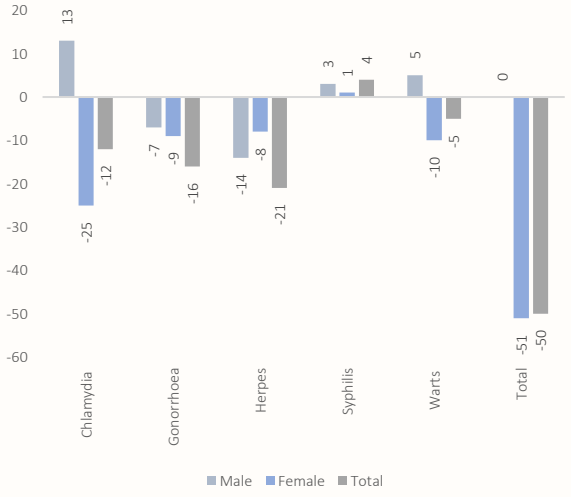
CHLAMYDIA ACCOUNTS FOR THE MAJORITY OF NEW STI DIAGNOSES.

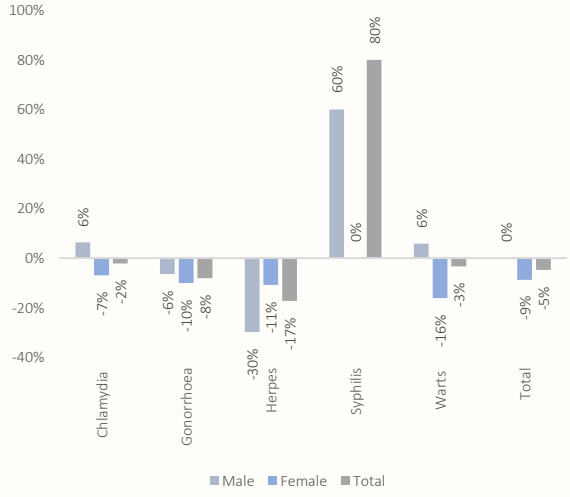
- Chlamydia continues to account for the majority of new STI diagnoses.
- In 2019-20, chlamydia accounted for 56% of new diagnoses for patients from Solihull attending Non-GUM (Level 2) services and GUM (Level 3) services.
- This rate is similar to 2018-19.



MOST NEW STI DIAGNOSES SHOW A DECREASE.

- There has been an increase in syphilis diagnoses for males when comparing 2019-20 against 2018-19; however this is based on small numbers.





RECOMMENDATIONS

KEY FINDING 13 – STI SELF-TESTING KITS

- During the COVID-19 pandemic, STI self-testing kits were available to order online except for the period August 2020 to December 2020. The lack of online kits during this period was due to an issue in the sourcing of kit components. If a patient called the Umbrella service during this period and was symptomatic, they were provided with an STI self-testing kit.
- A number of key partners fed back on the importance of the self-testing kits in terms of identifying sexual health issues and in terms of encouraging patients to engage with other related services such as blood-borne virus testing.

IMPACT

- The shortage of self-testing kits meant that sexual health need was not being identified as easily. This also meant that treatment could not be started.

RECOMMENDATION

- To ensure that sexually transmitted infections are identified, the STI self-testing kits must be available at all times via multiple channels.
- It is recommended that the sexual health provider has access to multiple suppliers of self-test kits to prevent a lack of access in the future.
- An alternative to the way in which kits are currently supplied should be explored to reduce the risk of delays in the production of the kits. Other models to explore could include spot purchasing of STI self-testing kits.

KEY FINDING 14 – COVID IMPACT

- Nationally, the COVID-19 pandemic response, including social and physical distancing measures, led to a re-prioritisation and disruption in provision of, and patient access to, health services for HIV, STIs and hepatitis. In Birmingham and Solihull there were a number of disruptions:
    - In terms of patient consultations at GUM (Level 3) services, there was a large drop off of activity during the COVID-19 pandemic.
    - Community feedback showed that patients' opinion of the support that they received during the COVID-19 pandemic was not as good as pre-COVID-19. (Pre-COVID: 4% bad or very bad; during COVID: 32% bad or very bad).
    - Analysis of the most recent PHE Fingertips data shows that COVID negatively impacted the number of STI tests, diagnoses, and numbers testing positive in both Birmingham and Solihull. The reductions in both Birmingham and Solihull were greater in comparison to their nearest neighbours.
- Nationally, between March and May 2020, there were reductions in:
    - consultations undertaken by sexual health services (SHSs) and specialised HIV services
    - testing for viral hepatitis in drug services, prisons, general practice and SHSs
    - testing for HIV and STIs in SHSs
    - vaccination of gay, bisexual and other men who have sex with men (MSM) against Human Papillomavirus (HPV), hepatitis B (HBV) and hepatitis A (HAV)
    - diagnoses of viral hepatitis, HIV and STIs
    - hepatitis C (HCV) treatment initiations

"Chaotic patients, homeless, drug users without access to internet will have difficulties accessing some of their services. There might be walk-in services for those groups at SIFA, but no other places".

IMPACT

- The response to the COVID-19 pandemic meant a decrease in the number of face to face appointments. Care is required to ensure that services remain widely accessible, particularly to underserved populations (e.g. certain Black, Asian, and minority ethnic groups, migrants, persons who inject drugs (PWID), sex workers, homeless persons, prisoners) who are disproportionately affected by hepatitis or have greater sexual health needs.
- PHE analysis is that access to harm reduction and BBV testing services for people who inject drugs have been adversely affected.
- PHE analyses show that, among those testing for STIs and HIV, heterosexuals and, particularly in the case of HIV, teenagers, have been under-represented since April 2020 compared to January to March 2020. There is evidence that young people, the age group with the highest burden of STIs, may experience greater difficulty in finding, accessing and engaging with relevant online sexual health information.

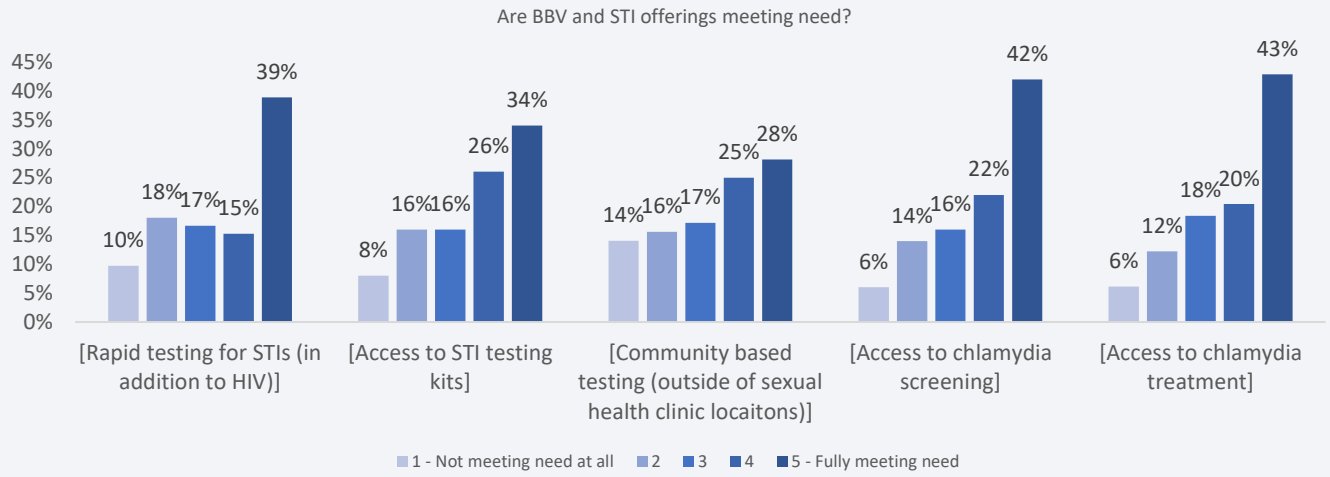
RECOMMENDATION

- Several initiatives were launched, by PHE and our partners, to counter the detrimental impact of COVID-19 on the control of STIs, on elimination goals for HIV and viral hepatitis, and in tackling inequalities. in (from PHE; *The impact of the COVID-19 pandemic on prevention, testing, diagnosis and care for sexually transmitted infections, HIV and viral hepatitis in England*)

STI PROVISION – ENGAGEMENT

IS BBV AND STI TESTING PROVISION MEETING NEED? – PRACTITIONER SURVEYS

- Overall, practitioners felt that the BBV and STI testing was meeting sexual health needs.
- 34% of respondents who answered the question on testing kits (total – 56 respondents) thought that access to STI kits was fully meeting need. 28% scored this 1 or 2 out of 5, where 5 is fully meeting need.
- There were some free text comments highlighting delays in accessing STI-kits.



"We have no rapid STI testing as a service however we can refer to Umbrella. I think that an on the spot self taken kit would be beneficial to the people we work with so they are not having to make another appointment."

Team Leader, CGL

"When STI kits were available this was easily accessed by a number of providers however even before COVID there were periods where no test kits were available (currently availability of STI kits is a real problem)."

Birmingham Pharmacist

"Pre-COVID, screening kits were available, not now."

Birmingham Pharmacist

"Home test kit takes 2 weeks to arrive".

Birmingham GP

"It has been extremely difficult to order any STI self-testing kits".

Birmingham GP

What are the current gaps in provision?

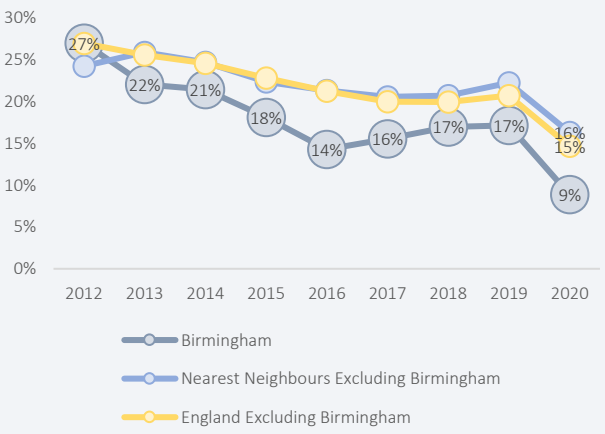
"Access to STI self-testing kits".

Birmingham GP

CHLAMYDIA – BIRMINGHAM

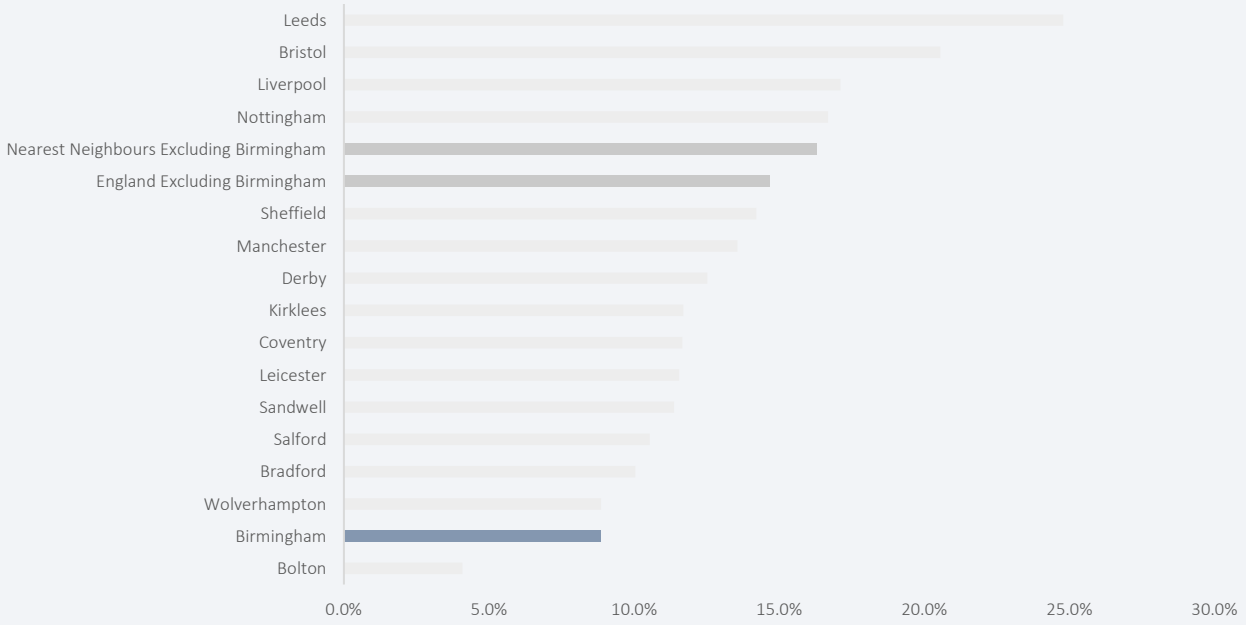
THE PROPORTION OF 15-24-YEAR-OLDS SCREENED IS BELOW NATIONAL RATES

- Nationally, the rates have declined since 2012.
- Birmingham has historically tracked below the national and nearest neighbour averages.
- The rate in Birmingham decreased from 17% to 9%, equating to an 8 percentage point change. Both England and the nearest neighbours saw a decrease of 6 percentage points.



BIRMINGHAM HAS LOW SCREENING RATES (15-24) COMPARED TO ITS NEAREST NEIGHBOURS.

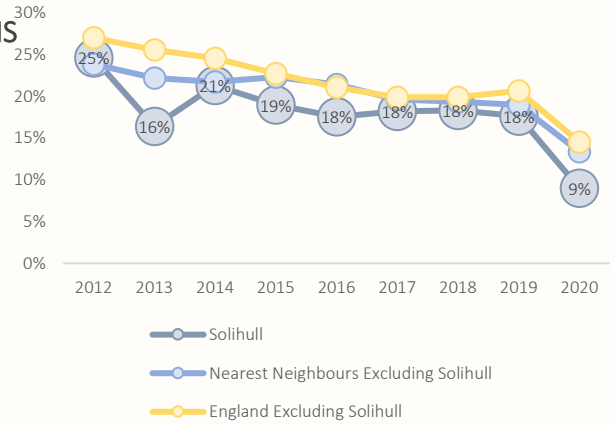
- In 2020, Birmingham had the second-lowest rates of chlamydia screening amongst 15-24-year-olds out of all of its nearest neighbours.



CHLAMYDIA – SOLIHULL

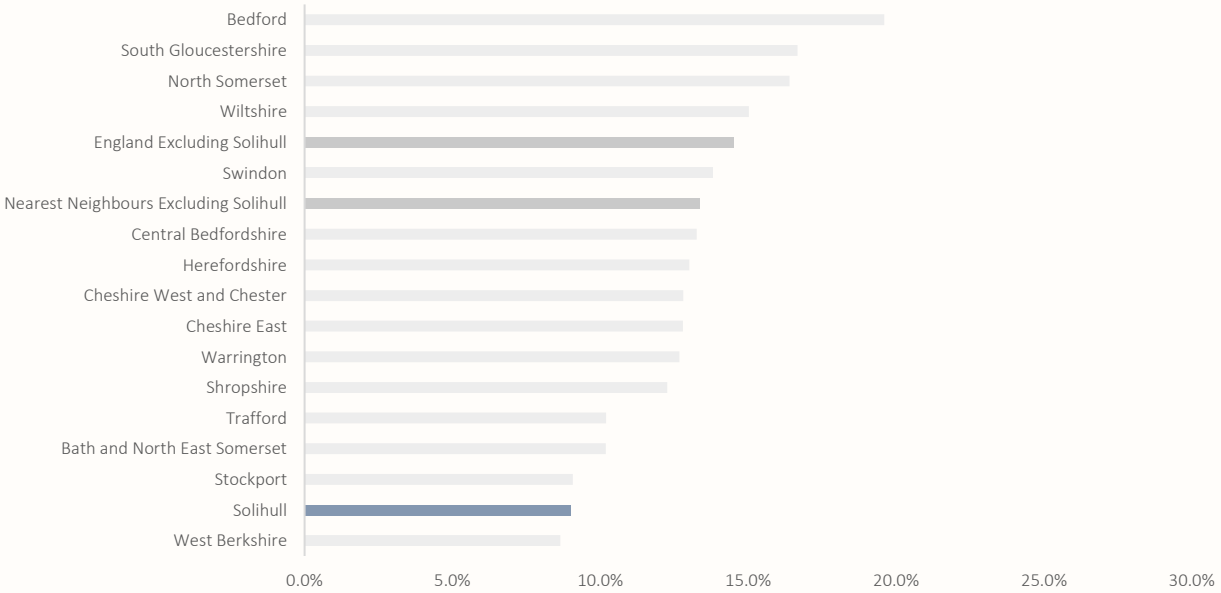
THE PROPORTION OF 15-24-YEAR-OLDS SCREENED IS LOWER THAN NEAREST NEIGHBOURS.

- Solihull saw a significant decrease in 2020.
- It would appear that both Birmingham and Solihull were impacted more by COVID-19 than England and the nearest neighbours.



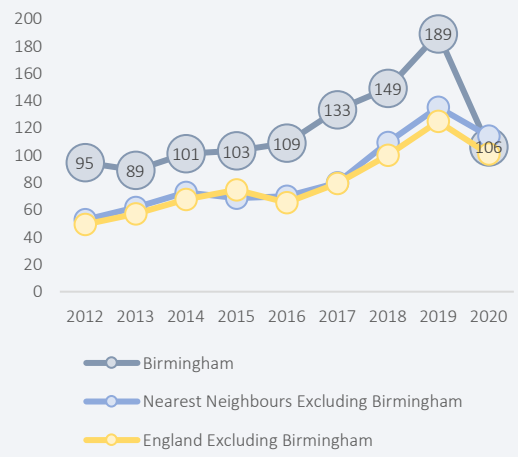
THE CHLAMYDIA DIAGNOSTIC RATE / 100,000 IN SOLIHULL IS LOWER THAN THE NEAREST NEIGHBOURS AVERAGE

- In 2020, Solihull had the second-lowest rates of chlamydia screening amongst 15-24-year-olds out of all of its nearest neighbours.

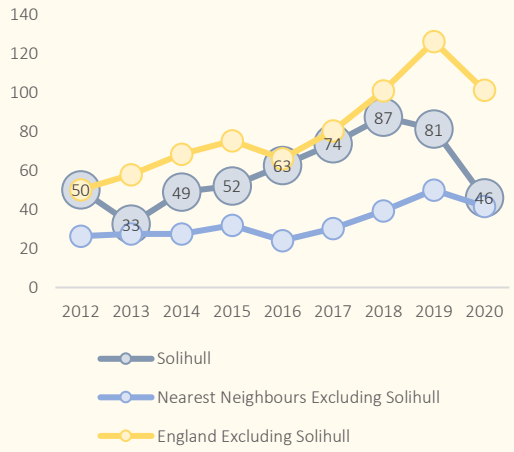


GONORRHOEA

IN 2020, THERE WAS A SIGNIFICANT DECREASE IN GONORRHOEA DIAGNOSES IN BIRMINGHAM.

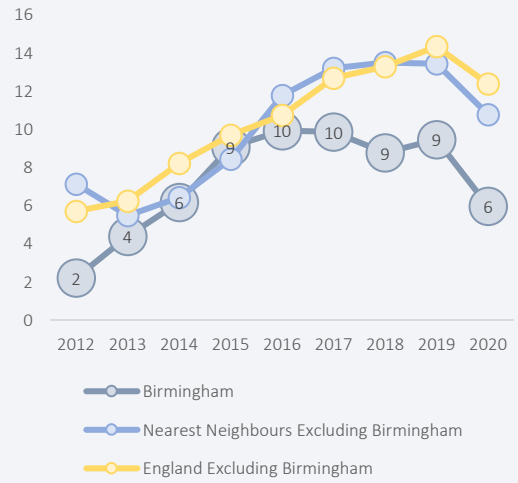


IN 2020, THERE WAS A SIGNIFICANT DECREASE IN GONORRHOEA DIAGNOSES IN SOLIHULL.

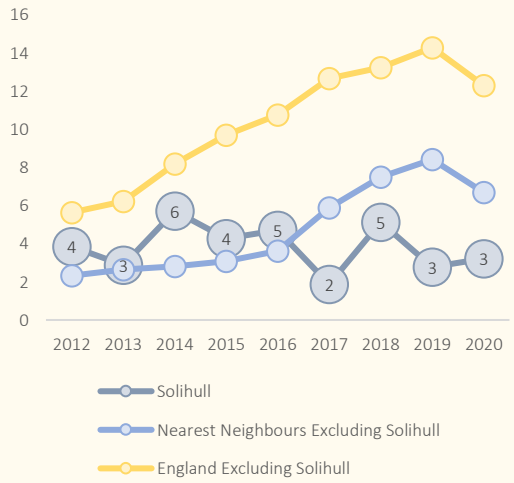


SYPHILIS

IN 2020, THERE WAS A DECREASE IN SYPHILIS DIAGNOSES IN BIRMINGHAM.

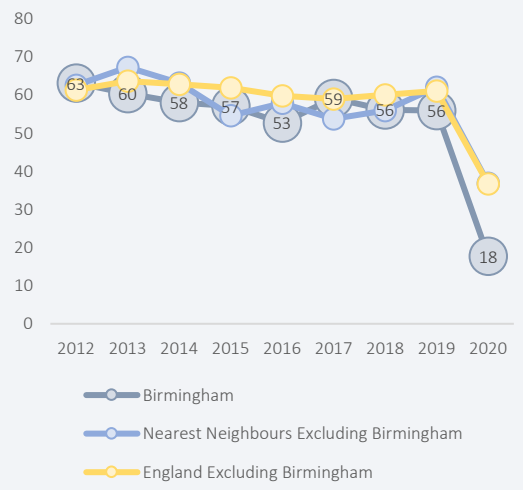


SYPHILIS DIAGNOSES REMAINED LOW IN SOLIHULL.

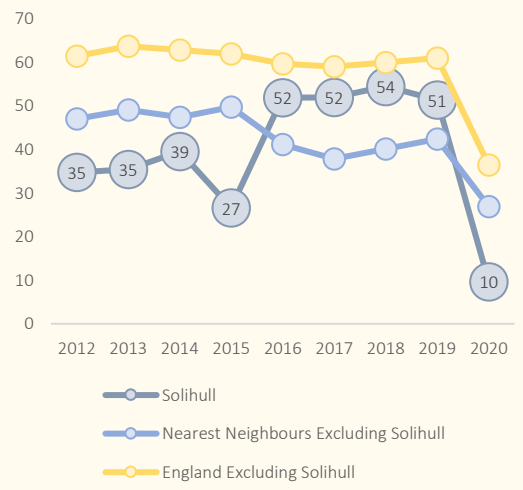


GENITAL HERPES

IN 2020, THERE WAS A SIGNIFICANT DECREASE IN HERPES DIAGNOSES IN BIRMINGHAM.

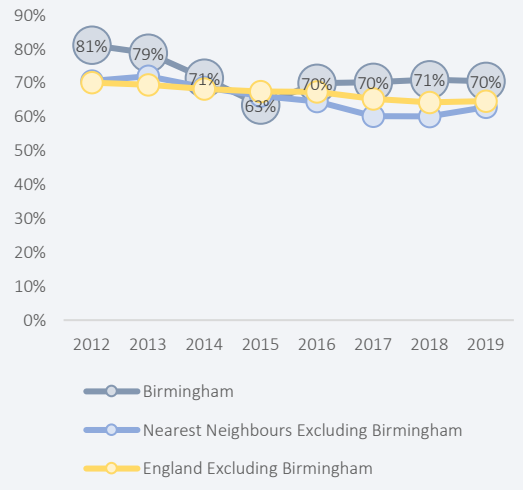


IN 2020, THERE WAS A SIGNIFICANT DECREASE IN HERPES DIAGNOSES IN SOLIHULL.



HIV

UP UNTIL 2019, BIRMINGHAM HAD GREATER TESTING COVERAGE COMPARED TO ITS NEAREST NEIGHBOURS AND ENGLAND.



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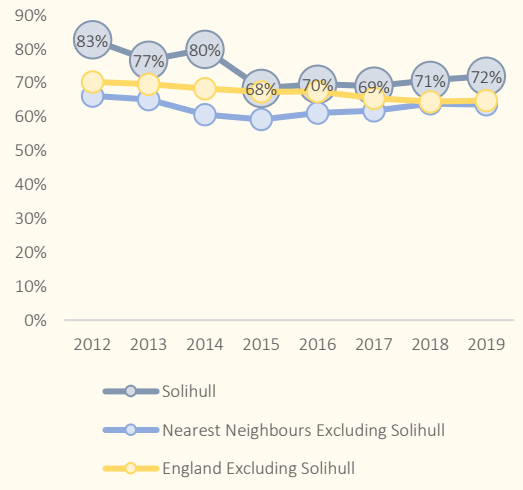
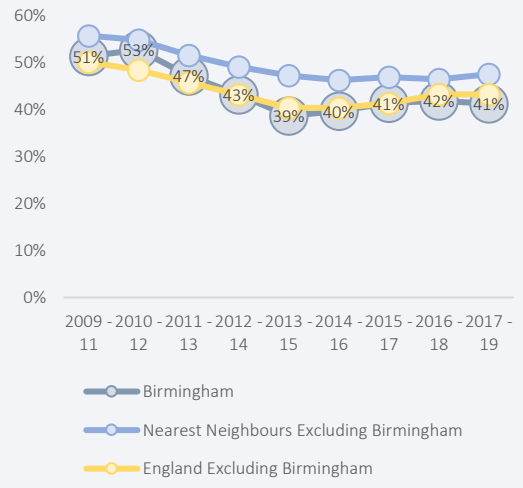
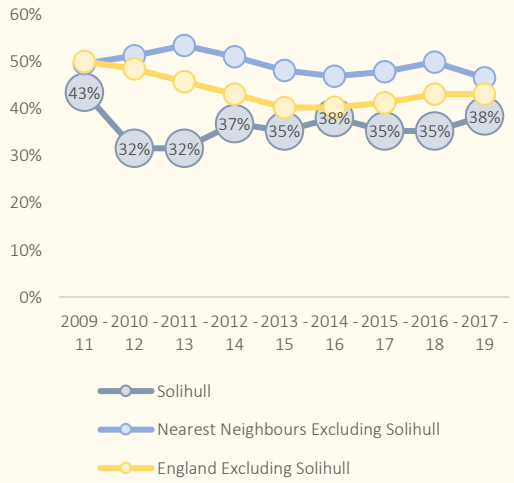


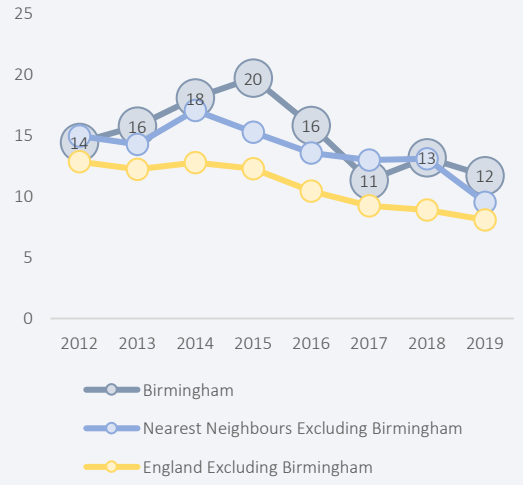
UP UNTIL 2019, BIRMINGHAM HAD LOWER RATES OF HIV LATE DIAGNOSIS COMPARED TO ITS NEAREST NEIGHBOURS AND ENGLAND.



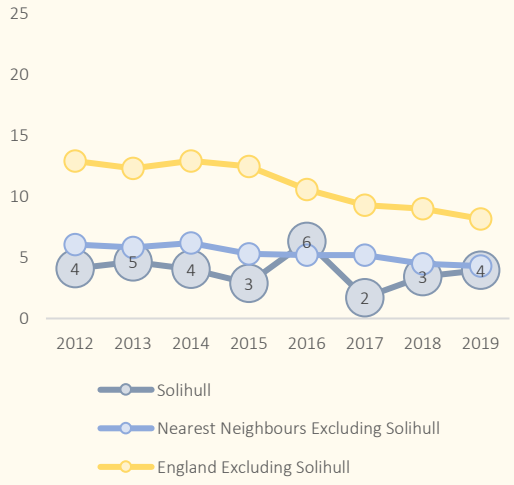
UP UNTIL 2019, SOLIHULL HAD LOWER RATES OF HIV LATE DIAGNOSIS COMPARED TO ITS NEAREST NEIGHBOURS AND ENGLAND.



IN 2019, BIRMINGHAM'S HIV TESTING COVERAGE WAS GREATER THAN ITS NEAREST NEIGHBOURS AND ENGLAND.



UP UNTIL 2019, SOLIHULL'S HIV TESTING COVERAGE WAS LOWER THAN ITS NEAREST NEIGHBOURS AND ENLAND.



RECOMMENDATIONS

KEY FINDING 15 – HIV TESTING

- Birmingham has a new HIV diagnosis rate of 11.7 per 100,000 in those aged 15+.
- All GPs do not routinely screen new patients for HIV.
- Any HIV screening of new patients completed would have been impacted by the COVID-19 pandemic.
- The self-test STI kits include HIV tests. There was a lack of availability of the self-testing kits during the COVID-19 pandemic.

11.7 per 100,000

NEW HIV DIAGNOSIS RATE (15+)

BIRMINGHAM (2019)

Birmingham Nearest Neighbours: 9.8

England: 8.1

4 per 100,000

NEW HIV DIAGNOSIS RATE (15+)

SOLIHULL (2019)

Solihull Nearest Neighbours: 4.3

England: 8.1

"We will test for HIV if patient is requesting but do not do this routinely with all new patients -we have not enough capacity to do blood test for all our new patients (usual turnaround of 200 new patients a month)."

IMPACT

- PHE analysis on the impact of COVID-19 on STIs, HIV and viral hepatitis found that there was a high proportion of MSM who did not access STI testing despite disclosing condomless sex with multiple partners.
- The identification of HIV may have been impacted by the reduction in testing pathways.

RECOMMENDATION

- Birmingham and Solihull should adopt the Fast Track Cities initiative across the region, including increasing access to testing and treatment which will lead to a decreased number of cases.
- Testing should be offered in GP and accident and emergency settings as per the BHIVA guidelines. This may require GPs to be funded to provide these blood tests.
- Outreach testing should be offered in community settings as per NICE Guidelines (NG60): *'venues where there might be high-risk sexual behaviour, for example public sex environments'.*

SPECIFIC COHORTS

HOMELESS
ENGAGEMENT KEY FINDINGS

Below is a summary of feedback from practitioners who work with people who are homeless:

- The homeless client group have some barriers to accessing sexual health services, such as lack of access to technology (mobile phones, internet).
- Practitioners fed back that the client group were unlikely to use the take-away testing kits. This was also true for the younger homeless cohort.
- Practitioners fed back that sexual health is not a priority for people who are homeless, especially those who are rough sleeping.
- Those who are homeless may not always turn up for appointments.
- Practitioners felt that there was an opportunity for services to be delivered from existing homeless hubs, which would reduce the barriers to accessing sexual health services.

"Clients are unable to book appointments due to internet and phone issues."

Team Leader, Homeless organisation

What are the gaps in current sexual health services?

"No outreach to the vulnerably housed and rough sleeping. [Services are needed] outside of office hours"

Engagement Worker to Entrenched Rough Sleepers

SUBSTANCE USE
ENGAGEMENT KEY FINDINGS

Below is a summary of feedback from practitioners who work with those with a substance misuse need:

- Attending appointments is difficult for this cohort. If appointments are attended, they may not be during normal working hours.
- Those with a drug and alcohol problem were generally seen as being hard to reach. There may be limited access to the internet and phones.
- At the time of this assessment, the self-test kits were not available at any of the CGL hubs in Birmingham.
- Practitioners identified a training need in relation to sexual health knowledge amongst drug and alcohol practitioners.
- Practitioners believed that more sexual health interventions could be delivered within drug and alcohol services.

"We have no rapid STI testing as a service however we can refer to Umbrella. I think that an on the spot self-taken kit would be beneficial to the people we work with so they are not having to make another appointment."

Team Leader, Shelter

"It is difficult to get into a doctor's surgery as it is so there needs to be more localised provisions or even resources available at local community centres."

Drug and Alcohol Practitioner

YOUNG PEOPLE
ENGAGEMENT KEY FINDINGS

Below is a summary of feedback from practitioners who work with young people:

- It was difficult for young people to access sexual health services during the COVID-19 pandemic. Having a telephone triage was seen as an extra barrier for young people.
- Practitioners highlighted delays accessing the self-testing kits. There were also reports of long waits for appointments.
- It was highlighted that the lack of a free pregnancy testing service with Umbrella was a missed opportunity to engage with young people regarding their wider sexual health needs such as underage sex, and exploitation.
- There was a walk-in clinic for young people in the Boots Chemist in central Birmingham. Practitioners fed back that young people would prefer to have walk-in centres closer to them.

"The services require the people I work with to come to the sexual health clinic, there needs to be more done to make the service more accessible for people who have anxiety over this."

Team Leader, Homeless organisation

"[There is] not enough availability [of sexual health services] for young people in the settings that they feel comfortable.

The clinics are great but they are very medical, they [young people] need professionals to come to them and work with them where they are comfortable.

Young Person's Practitioner

LGBT+
ENGAGEMENT KEY FINDINGS

Below is a summary of feedback from practitioners from specialist LGBT+ organisations:

- Umbrella is partnered with Birmingham LGBT and runs a sexual health service from the Birmingham LGBT premises in central Birmingham.
- Birmingham LGBT runs a walk-in clinic 7 days a week (post COVID-19, this reduced to 6 days a week).
- The clinic provides sexual health information and access to rapid HIV and assisted STI testing.
- Additional clinics are also provided, however were paused during COVID-19 (Abuse Survivors Clinic, PrEP Advice, Trans Clinic, Well Woman Clinic.)
- Practitioners fed back that there was a gap in substance use services for those in the LGBT community who engaged in chemsex.

What are the gaps in sexual health services?

"Language barriers for clients whose first language is not English. More Trans awareness training in team as well as cultural/race training."

Outreach Worker

"Generally, I would say that the service is meeting the needs of the community I would like to see us introduce the Rapid test for syphilis."

Sexual health practitioner

ETHNIC MINORITY GROUPS
ENGAGEMENT KEY FINDINGS

A focus group was completed with a group of women of reproductive age from South Asian Communities. The group covered the following areas:

- Were any issues raised by participants in relation to sexual health?
    - Not enough information provided by sexual health services when attending the clinic about the different contraception methods.
    - Some participants would like to be able to access STI testing easier and quicker – for example chlamydia testing kits in pharmacies that you can pick up – same for all STIs.
- Were there any themes/recommendations to be put forward for the sexual health needs assessment?
    - More education about sexual health – in schools, in colleges and at universities – in particular for international students as they do not always receive this in their home countries.
    - More social media advertisements.
    - More awareness of sexual health services – in particular access after COVID-19 pandemic.
    - Sexual Health Ambassadors – more knowledge in the community, run sexual health training for community groups to teach others.

OLDER PEOPLE
ENGAGEMENT KEY FINDINGS

Below is a summary of feedback from practitioners who work with older people:

- Older adults do not actively seek out support as it is possibly viewed as taboo.
- Questions arise in relation to consent and a person's ability to consent.
- There is not a lot of outreach into extra care settings.
- This population are quite able and quite active.

PEOPLE WITH DISABILITIES
ENGAGEMENT KEY FINDINGS

Below is a summary of feedback from practitioners who work with those with disabilities:

- Sexual health can be a taboo subject. Disabled people are not seen as sexual beings.
- Disabled people unable to access smear tests.
- There is a need to make information on sexual health accessible and to make sure issues are followed up correctly.
- There are occasions where if a person with learning disability does not have a carer to support them, then help cannot be accessed.
- People with learning disabilities may mask understanding about health questions.
- Health practitioners may not understand the needs of those with learning disabilities.
- Staff training and upskilling is essential - staff need confidence to raise issues with the people they are working with.
- People with learning disabilities require face-to-face contact to process information. Online consultations are difficult for them.

ASYLUM SEEKERS, REFUGEES AND NEWLY ARRIVED MIGRANTS
ENGAGEMENT KEY FINDINGS

Below is a summary of feedback from practitioners who work with those with asylum seekers, refugees and newly arrived migrants:

- Practitioners fed back that health is explored constantly. Sexual health is not something that has been brought up in discussions.

RECOMMENDATIONS

KEY FINDING 16 – CHILD-SPECIFIC SEXUAL ABUSE SURVIVORS' CLINICS

- At the time of this assessment, there was no child-specific sexual abuse survivors' clinic run in either Birmingham or Solihull.
- The adult Abuse Survivors Clinic sees patients from age 13 and above. Those younger than this are seen by a pediatrician in the Sexual Assault Referral Centre (SARC).
- The benefit of running a child-specific sexual abuse survivors' clinic is access to specialist advice and the clinic being completed in a child friendly environment.
- There used to be a dedicated Young Persons' ASC; however this was not well attended. It is possible that this was because it was not promoted well.

IMPACT

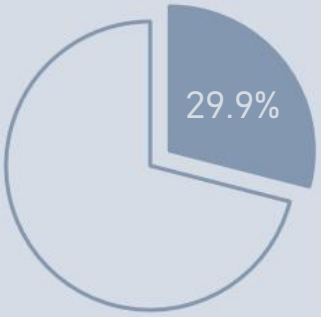
- No child specialist workers are available to see patients.

RECOMMENDATION

- A child-specific Abuse Survivors' Clinic should be set up. It should be ensured that any clinic that is run is well-promoted across Birmingham and Solihull.

KEY FINDING 17 – CHEMSEX

- The HIV Commission recommended that to help end new cases of HIV, commissioners should explore co-delivery between drug and alcohol services (including sensitivity to the specificity of chemsex) and sexual health services.
- Feedback from practitioners was that there was a potential knowledge gap in some services in relation to chemsex.
- National Drug Treatment and Monitoring System (NDTMS) data indicates that there are only small numbers of men who use GHM, methamphetamine, and mephedrone engaging in substance misuse treatment in Birmingham and Solihull.



29.9% of gay men living with HIV reported having had chemsex in the last year.

IMPACT

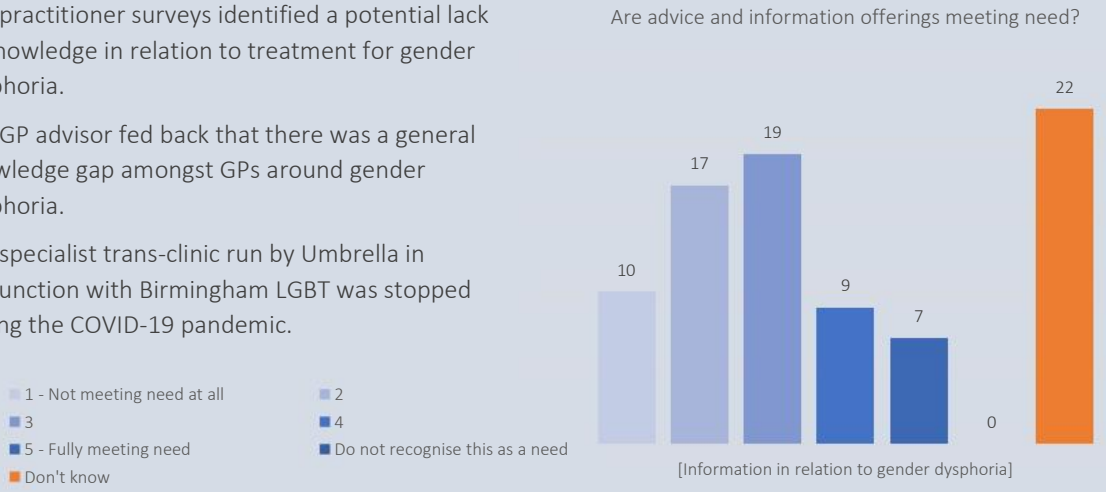
- Practitioners in a position to identify and address sexual health needs relating to chemsex may not have the confidence or knowledge to address needs with service users.
- The expansion of knowledge and services in relation to chemsex could help reduce the number of new HIV infections in Birmingham and Solihull.
- It is possible that large numbers of those engaging in chemsex are not approaching substance misuse services and as such are not likely to receive professional help for any substance misuse issues.

RECOMMENDATION

- An expansion to the response to chemsex should be explored across all services including drug and alcohol, mental health, and sexual health services.
- The referral routes from sexual health services through to substance misuse services should be reviewed to ensure that appropriate referrals are made.

KEY FINDING 18 – GENDER DYSPHORIA

- The practitioner surveys identified a potential lack of knowledge in relation to treatment for gender dysphoria.
- The GP advisor fed back that there was a general knowledge gap amongst GPs around gender dysphoria.
- The specialist trans-clinic run by Umbrella in conjunction with Birmingham LGBT was stopped during the COVID-19 pandemic.



"Regarding gender dysphoria, there are a number of areas for improvement in the responses of health services."

"Patients exploring gender dysphoria treatment are supported by primary care services but have to wait to start pharmaceutical/surgery treatment until they have been assessed by an NHS service. Long NHS waiting lists mean that some patients use private clinics. GPs are not able to support these patient's medication needs."

"Secondary care clinics for gender dysphoria are hard to access."

IMPACT

- Patients may not be given full or accurate advice in relation to gender dysphoria.
- Access to care in Birmingham and Solihull is limited due to the location of gender dysphoria services and long waiting lists.

RECOMMENDATION

- Clear guidance and pathways to the current service offering should be widely disseminated to GPs, sexual health practitioners and partners.
- Training packages delivered to GPs, sexual health practitioners and partners should include information on gender dysphoria.

KEY FINDING 19 – THE RATE OF SEXUAL HEALTH SCREENS TAKEN AT FIRST ATTENDANCE IN BIRMINGHAM AND SOLIHULL IS LOW FOR CERTAIN NATIONALITIES.

- Below shows the rate of sexual health screens taken at first attendance for Birmingham and Solihull.
- The rate is low for those from Pakistan, India, and Bangladesh, as shown in the table below.
- In Birmingham, there is a low uptake of first attendances for Asian or Asian British male heterosexuals.
- In Birmingham, there is a low update of first attendances for Asian or Asian British female heterosexuals.
- There were difficulties in exploring this issue further due to the lack of opportunities for engagement work as a result of COVID-19.

Country / 2019-20	Number of 1st Attendances	Number of 1st Attendances %	Number of sexual health screens taken	Number of sexual health screens taken %	% of sexual health screens taken (at 1st attendance)
Unknown	39404	56%	34941	59%	89%
United Kingdom	23185	33%	18706	31%	81%
Jamaica	833	1%	718	1%	86%
Pakistan	569	1%	341	1%	60%
Zimbabwe	419	1%	347	1%	83%
Nigeria	388	1%	305	1%	79%
Romania	371	1%	290	0%	78%
Poland	289	0%	214	0%	74%
India	245	0%	144	0%	59%
Italy	188	0%	133	0%	71%
Bangladesh	188	0%	84	0%	45%

- In Solihull, there were low rates for those from Pakistan (57%).

IMPACT

- There is unmet need for the Pakistani, Indian, and Bangladeshi populations.

RECOMMENDATION

- There should be further investigation into the reasons for the variance.
- More engagement activities with this cohort should be undertaken to explore possible barriers to services and to widen access.

KEY FINDING 20 – THOSE WITH A LEARNING AND/ OR PHYSICAL DISABILITY

- Disabled people are more likely to be digitally excluded. ('Digital Divide').
- In 2017, 56% of adult internet non-users were disabled, a much higher rate than the proportion of disabled adults in the UK population as a whole, which in 2016 to 2017 was estimated to be 22%. (ONS, 2017).

IMPACT

- The impact of COVID-19 has meant that more sexual health interventions are completed online and over the phone, which can inadvertently exclude those with a learning disability.

RECOMMENDATION

- There is a need to make information on sexual health accessible to those with a disability. This could be done by ensuring that there are strong partnerships with appropriate organisations working with and for those with disabilities.
- Service providers should engage with those with physical disabilities to identify the physical and practical barriers to accessing sexual health services.

KEY FINDING 21 – TRAINING NEEDS FOR THOSE ADVOCATING AND SUPPORTING HARD-TO-REACH AND VULNERABLE GROUPS

- The engagement exercise highlighted that some of those working for and advocating for those with disabilities may not discuss sexual health needs. The reason for this this is not clear but could be related to a confidence issue on the part of the practitioner.
- The engagement exercise highlighted that some of those working for and advocating for older people may not discuss sexual health needs. The reason for this this is not clear but could be related to a confidence issue on the part of the practitioner.

IMPACT

- Those with a learning disability may not have their sexual health needs identified through a lack of advocacy and support to access services.
- Older people may not have their sexual health needs identified through a lack of advocacy and support to access services.

RECOMMENDATION

- There is a need to make information on sexual health accessible and to make sure issues are followed up correctly.
- Those working with and for people with disabilities and older people should be provided with the confidence and tools to raise sexual health issues.

KEY FINDING 22 – BARRIERS TO ACCESS FOR HOMELESS PEOPLE

- Research indicates that as a cohort, homeless people can struggle to access health and social care services.
- Practitioner feedback indicated that the homeless cohort are unable to conform to the rigid access times and conditions of mainstream clinics.

"Clients are unable to book appointments due to internet and phone issues."

"No outreach to the vulnerably housed and rough sleeping. [Services are needed] outside of office hours"

"Specific advice online is great, but the homelessness client group don't necessarily engage in this way."

IMPACT

- Opportunities to address the sexual health needs of the homeless cohort are being missed.
- Opportunities to reduce the barriers to sexual health services for those who are homeless are not being taken.

RECOMMENDATION

- Link nurses between homeless and SM services would help break barriers from homeless people accessing services.
- The possibility of providing sexual health services from existing homeless hubs should be explored.

KEY FINDING 23 – THOSE WITH SUBSTANCE MISUSE ISSUES

- Those with substance misuse issues are an at-risk group due a sometimes-chaotic lifestyle which makes them vulnerable to a range of health problems including poor sexual health and unwanted pregnancies.
- Those with substance misuse issues are associated with poor engagement with medical treatment and increased chances of transmitting HIV.
- In both Birmingham and Solihull, there was limited partnership working between substance misuse services and sexual health services.
- Practitioners believed that more sexual health interventions could be delivered within drug and alcohol services.
- The Fast-Track Cities initiative in Birmingham is promoting the elimination of BBVs (Hepatitis B, Hepatitis C, and HIV) through increased testing and treatment. There is a high prevalence of Hepatitis C amongst injecting drug users.

IMPACT

- Opportunities to address the sexual health needs of those with substance misuse issues are being missed.
- Opportunities to reduce the barriers to sexual health services for those with substance misuse issues are not being taken.

RECOMMENDATION

- More sexual health interventions should be delivered in partnership with drug and alcohol services, as this is a group that does not engage with sexual health clinics.

CERVICAL SCREENING

KEY FINDING 24 – CERVICAL SCREENINGS

- The area covered by NHS Birmingham and Solihull CCG has low coverage rates for cervical screens in both the 25 to 49 and the 50 to 64 age groups.

Cervical screening coverage rates age 25 to 49					
Coverage for **25 to 49** age group:-	Eligible women on last day of review period	Women with adequate screen in previous 3.5 years	3.5-year coverage %	Screens needed to meet 80%	RANK of 135 CCGs
ENGLAND - 135 CCGs	10,264,947	7,071,719	68.89	1,140,239	
Midlands and East region - 40 CCGs	2,943,335	2,079,243	70.64	275,425	
NHS BIRMINGHAM AND SOLIHULL CCG	227,069	146,906	64.70	34,750	113
Cervical screening coverage rates age 50 to 64					
Coverage for **50 to 64** age group:-	Eligible women on last day of review period	Women with adequate screen in previous 5.5 years	5.5-year coverage %	Screens needed to meet 80%	RANK of 135 CCGs
ENGLAND - 135 CCGs	5,199,083	3,897,682	74.97	261,585	
Midlands and East region - 40 CCGs	1,574,596	1,192,800	75.75	66,877	
NHS BIRMINGHAM AND SOLIHULL CCG	102,172	74,627	73.04	7,111	104

IMPACT

- Low take-up of cervical screens leads to increased risk of cervical cancer amongst female population of Birmingham and Solihull.

RECOMMENDATION

- Cervical screening should be completed in sexual health services to widen access.

Birmingham and Solihull (Draft) Sexual Health Strategy 2023 – 2030 Public Consultation Report

Contents

1. **Summary of Findings**
2. **Background**
3. **Rationale for Consultation**
4. **Pre-Engagement: Sexual Health Needs Assessment**
5. **Consultation Process: Birmingham & Solihull Sexual Health Draft Strategy 2023 – 2030**
6. **Consultation Engagement**
7. **Responses to Vision and Themes**
8. **Conclusions**
9. **Next Steps**

Appendices

Appendix 1 – Copy of Consultation Survey

Appendix 2 – Free Text Survey Responses

Appendix 3 – Draft Sexual Health Strategy Birmingham and Solihull 2023 - 2030

Appendix 4 – Needs Assessment Summary

1. Summary of Findings

The consultation on the draft Sexual and Reproductive Health Strategy 2023-2030 was undertaken across Birmingham and Solihull during May – July 2022 to provide assurance that the strategy adequately reflected the findings of the needs assessment and to incorporate public and stakeholder feedback.

Agreement on the strategy's vision and aims was unanimous, with only a few areas being identified as possible gaps - male sexual health education, mental health aspects of sexual health, older people, and the enhancement of primary care as vehicle to deliver improvements in localities.

In response to the themes in the strategy, the key feedback was on:

- **Priority groups** – challenges in providing the service to the homeless should be addressed by reviewing outreach and multi-disciplinary working. In addition, better integration of sexually transmitted infection (STI) and contraceptive advice as an important aspect of prioritising women who may be at risk due to termination of pregnancy, sexual violence, domestic abuse, or cultural and language barriers.
- **Reducing rates of STI** - accessible, walk-in 7-day clinics are a requisite, and building on practitioners' knowledge of the motivation of different client groups (e.g. gay men, trans people and those with gender dysphoria) for attending clinic could be used to increase opportunistic sexual health screening and uptake of HIV medication, Pre-Exposure Prophylaxis (PrEP).
- **Reducing unplanned pregnancies** – requires removing barriers to accessing pregnancy tests, increasing access to long-acting reversible contraception (LARC) and emergency contraception with guaranteed confidentiality.
- **Building resilience** - Relationships and Sex Education (RSE) is essential and could also combat the unwanted? norms of abuse in relationships. Also important is specialist support for schools and colleges and the use of appropriate and novel media, such as social media sites and billboard on buses/bus shelters.
- **Children and young people** - services and pathways tailored to the needs of vulnerable groups (i.e., under 13s, young sexual assault victims, children in care, or foster homes). Clinics in Schools, such as lunchtime drop-in clinics achieved through collaboration with schools, school nurses and pastoral teams is a potential solution for young people unable to attend standard clinics and could provide safe spaces for identifying safeguarding issues.

The model that will be developed and used to deliver health services for Birmingham and Solihull in the future, will be informed by the feedback received from the consultation.

2. Background

The draft Sexual and Reproductive Health Strategy 2023-2030 sets out Birmingham City Council's (BCC) and Solihull Metropolitan Borough Council's (SMBC) themes, priorities, and approaches to meeting the sexual health needs of the populations of Birmingham and Solihull.

The content covers a joint response to increasing sexually transmitted infections (STIs), HIV rates and reproductive sexual health which can have long lasting impacts on sexual health and wellbeing. Sexual health can impact an individual's emotional, physical, and mental

health, economic means, and social relationships. The consequences of poor sexual and reproductive health are far reaching and for those affected, the impacts are compounded by social stigma and fear.

Key drivers for the strategy are the findings from the Sexual Health Needs Assessment (SHNA) for Birmingham and Solihull, which have been translated into the draft strategy to inform appropriate action and enhance existing pathways to meet the needs of citizens.

The objectives of the strategy are to:

1. Ensure that every resident has access to sexual health services that meet their individual needs.
2. Enable services that are local, relevant, approachable, confidential, non-judgemental, to provide services to anyone in need, while respecting all human protected characteristics.
3. Enable citizens to have control of their own sexual health with services providing support where needed.

The strategy will play a key role in realising the joint vision for sexual health services for the future and will facilitate:

- A fully integrated, free, and confidential sexual health service for all citizens across the life course.
- A reduction in the high rates of teenage and unwanted pregnancies, abortion and STIs, which can have far reaching consequences for individuals and society.
- Open and equitable access to sexual health services.

3. Rationale for Consultation

The consultation on the draft strategy was undertaken between 23 May – 29 July 2022 to hear and take account of the voices and experiences of citizens and stakeholders. The consultation was set out to seek information to help understand whether the right priorities have been identified in the draft Sexual and Reproductive Health Strategy 2023-2030. The draft strategy was developed using findings from the SHNA and engagement undertaken in 2021 and highlights the following themes:

Theme One: Priority groups

Theme Two: Reducing the rates of sexually transmitted infections

Theme Three: Reducing the number of unwanted pregnancies

Theme Four: Building resilience

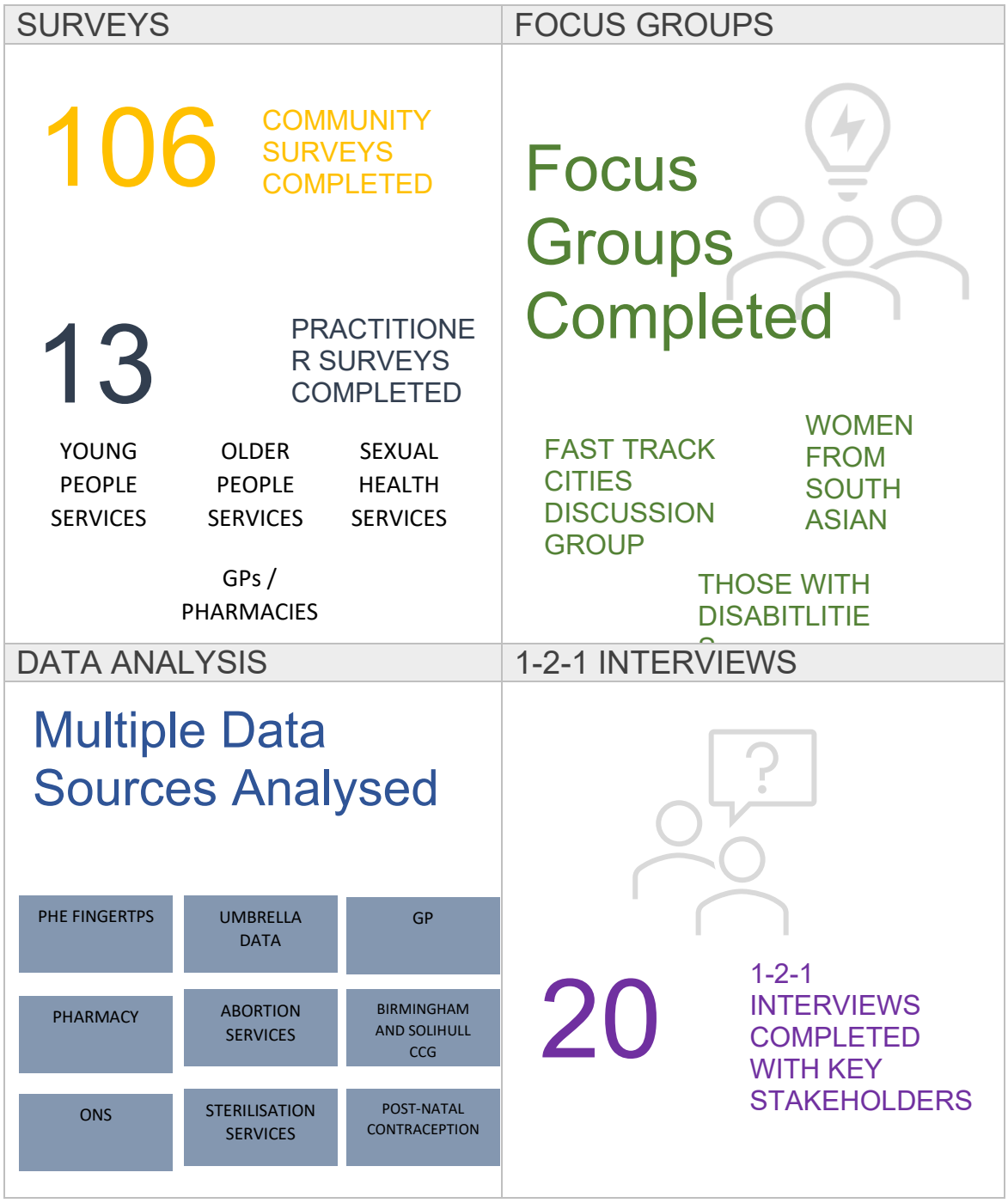
Theme Five: Children and young people

4. Pre-Engagement: Sexual Health Needs Assessment

As part of the SHNA during 2021, engagement was undertaken across Birmingham and Solihull with the community, as well as with 130 professionals and practitioners (Figure 1: Engagement activity). The aim of this was to find out what was working well as part of the delivery of integrated sexual and reproductive health services, and where there were areas for development. The public were also asked about their sexual health behaviours and experiences of services which received 106 responses:

- Of the 106 responses from the public, 86 were from Birmingham, 12 were from Solihull and 7 were from outside both areas.
- 64 respondents were female and 36 were male. There were 2 non-binary respondents.
- In terms of ethnicity, most respondents were white English/ Welsh/ Scottish/ Northern Irish or British.
- 51% had unprotected sex in the last 12 months (this could include sex within a committed relationship).
- 23% had never had a sexual health check up

Figure 1: Engagement activity



4.1. Engagement Findings - Service Experience and Delivery

Contraception Services

Working Well

- Access to free condoms

Areas for development

- Vasectomies and sterilisation. A high proportion of survey respondents are unsure if services are meeting need
- Practitioners were generally happy with LARC services, although some highlighted delays in appointments as an issue
- Complex contraception services
- Emergency coil fittings
- Pathways for complex contraceptives

Advice and Information

Working Well

- Contraceptive advice
- General sexual health information
- HIV advice
- Identifying those who have suffered abuse

Areas for development

- Information for gender dysphoria
- Information for Pre-Exposure Prophylaxis (PrEP)
- Information for Post Exposure Prophylaxis (PEP)

Response to Underserved Groups

Working Well

- Support for victims/ survivors of rape and sexual violence
- Support for patients who identify as LGBTQ

Areas for development

- Support for sexual health needs of homeless
- Support for sexual health needs of refugees, asylum seekers and newly arrived migrants
- Feedback from some third sector practitioners working with older people and those with disabilities was that sexual health needs are not raised routinely

Barriers to Services

Important practical considerations

- Easy to reach by public transport
- Open outside of ‘normal’ working hours
- Languages other than English

Important service/staffing considerations

- Availability of a range of treatments at a location
- Sexually Transmitted Infections AND Blood Borne Virus interventions

Working Well

- Access to chlamydia screening/treatment

Areas for development

- Rapid testing for STIs
- Community-based testing

5. Consultation Process: Birmingham & Solihull Sexual Draft Health Strategy 2023-2030

The findings from the SHNA were used to inform the Draft Birmingham and Solihull Sexual Health Strategy 2023 – 2030. To re-engage with the public and practitioners, consultation on the strategy was undertaken as part of a collaborative and inclusive approach. This was to help us understand whether we had taken the right approach, incorporated the feedback people gave us in the needs assessment process and to help us to shape the future of sexual health services.

The consultation obtained views across Birmingham and Solihull using an online survey through Be Heard, focus group discussions, and was publicised via a media and communications cascade, including with the following organisations and channels to access key groups:

- Age Concern (older people age 50+)
- Age UK Birmingham and the Black Country (older people age 50+)
- Birmingham City Council networks
- Birmingham LGBT
- Birmingham BVSC (voluntary/third sector)
- Birmingham Education Partnership
- Healthy Brum social media channels, including Facebook, Twitter and Instagram
- ICS (Integrated Care Systems) Communications Leads
- Solihull Metropolitan Borough Council networks
- Umbrella Sexual Health
- YMCA Heart of England (young people aged 0-18 and 18-35 years)

6. Consultation Engagement

Direct engagement with community groups and representatives on the consultation was provided:

- One focus group was held with 35 community representatives and one with eight community members and professionals from across Birmingham and Solihull.
- A presentation to primary care via the General Practice Peer Support Team chaired by the Local Medical Committee and attended by 75 primary care leads.
- Presentation to the current commissioned sexual health service, Umbrella, attended by 35 practitioners.

The consultation had some competition with other engagement programmes that were running at the same time:

- Big Creative Birmingham Conversation
- Food Strategy Consultation
- Joint Birmingham and Solihull Draft Dementia Strategy
- Public Needs Assessment – Birmingham and Solihull Councils

In accordance with consultation requirements, the main Council routes of communication were used for all consultations during this timeframe. It is likely that visibility of the sexual health consultation was negatively impacted. The survey was extended for 2 weeks to take account of this.

7. Responses to Vision and Themes

The Vision and Aims in the draft strategy cover:

- Ensuring that every resident has access to sexual health services that meet their individual needs.
- Enabling services that are local, relevant, approachable, confidential and non-judgemental, to provide services to anyone in need while respecting all human protected characteristics.
- Enabling citizens to have control of their own sexual health with services providing support where needed.

The strategy will play a key role in realising the joint vision for sexual health services for the future and will facilitate:

- A fully integrated, free, and confidential sexual health service for all citizens across the life course
- A reduction in the high rates of teenage and unwanted pregnancies, abortion and STIs, which can have far reaching consequences for individuals and society
- Open and equitable access to sexual health services

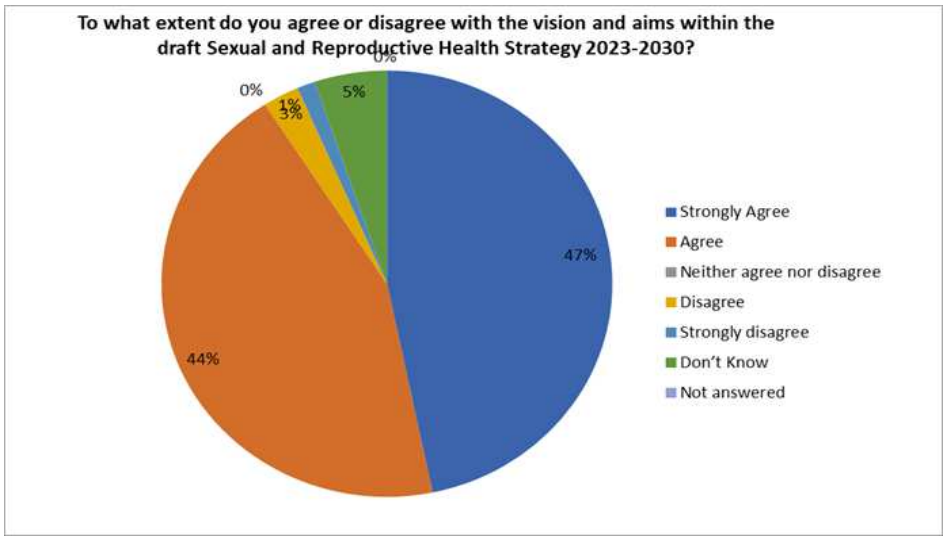
7.1. Demographics of Online Respondents

Most survey respondents were between 30 – 60 years of age (67%). Over half (57%) were female, 6% of respondents declined to answer. In terms of ethnicity, 74% were White British/White European, 10% of respondents declined to answer. On sexual orientation, 62% of respondents identified as heterosexual, 12% bisexual and 8% homosexual, gay or lesbian, 13% declined to answer. Percentages may not have added up to 100% as respondents could choose more than one option.

7.2. Response to Vision – Results from the online survey

Ninety one percent (91%) of online respondents strongly agreed or agreed with the vision and aims of the draft strategy. Those who disagreed formed only 3% of the respondents, as shown in Figure 2.

Figure 2: Vision and Aims



Feedback from the online survey free text and the targeted events highlighted that there were some potential gaps in terms of:

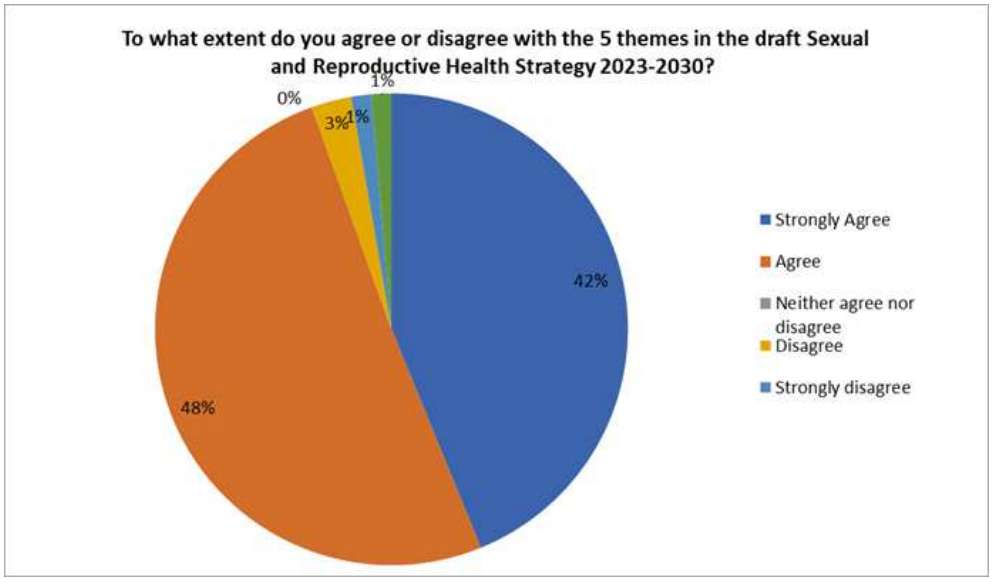
- Clear recognition of mental health in relation to sexual health in the strategy
- Equity of service provision across Birmingham and Solihull
- Cultural awareness and access to services for new communities, including women with female genital mutilation (FGM) who have no recourse to public funds
- Cross border issues in relation to commissioning and patient access routes to sexual health services out of area
- Being aware of older citizens and those in deprived areas being excluded through use of technology
- Recognition of sex workers and their support and treatment needs
- Male sexual health issues, education, awareness raising and engagement
- Inclusion of cervical and blood borne virus screening and human papillomavirus (HPV) vaccination
- Locality delivery improvements, utilising and supporting primary care
- How the strategy is going to be funded, implemented and monitored

7.3. Response to Themes – Results from Online Survey

Ninety percent (90%) of online respondents strongly agreed or agreed with the five themes in the draft strategy (Figure 3: Themes). Feedback on Theme 5, Children and Young People, highlighted concerns around the development of an under 13s service. This related to the view that sexual health services are for the population that are legally able to consent to sexual activity. It was felt that support to underage children should clinically fall to Paediatric services. It was also fed back that this would trigger safeguarding alerts that need to be reported to the correct safeguarding agencies.

The rollout of the Bystander programme in higher education settings was also queried. As the programme was not explained in the consultation document, people felt they did not have enough information.

Figure 3: Themes



7.4. Results from Consultation Events

Theme One: Priority groups

Feedback was received from professionals around challenges in delivering outreach/inreach in a multi-disciplinary way and examples were given of historically provided clinics with the homeless population where limited take up was experienced. The importance of formal evaluation and review of interventions was raised as part of this. The need for better engagement with primary care was stressed, which included training and skills improvement.

In terms of community concerns, there was feedback that women relate and respond better to information provided to them by female professionals. The need for gender specific training to support this was advised. It was also raised that service delivery should include integrated STI and contraceptive advice. This was particularly highlighted for women who may be vulnerable due to termination of pregnancy, sexual violence, domestic abuse, or cultural and language issues for example. An absence of the recognition of issues arising from the menopause was also raised.

Theme Two: Reducing the rates of sexually transmitted infections

The keys to success in this area were described as the need to provide accessible, walk-in clinics, 7-day services and opportunistic screening in other services, particularly termination of pregnancy pathways, as well as understanding what motivates people to attend for a sexual health screen. From patient surveys and presentations at clinics, the following observations on motivation were communicated:

- *Women* – access the service more often because they see the need for contraception. The opportunity can be used to provide e.g. chlamydia testing at the same time, amongst other things.
- *Gay men* – as opposed to men who have sex with men (MSM), may not necessarily see themselves at risk. If a gay man attends because of concerns about the current monkey pox outbreak, however, they can be prescribed PrEP at the same time.

- *Trans community* – a recent Umbrella trans needs assessment (relatively small cohort) highlighted reasons why many of them would attend clinic, not for PrEP or vaccinations, but because they want other things e.g. to have their hormones measured.
- *Gender dysphoria* – someone who is trans or non-binary can be dispensed PrEP but not until it is established why they are attending. They may not attend clinic if what they want is not being offered. They may also require counselling.
- *Autism* – higher rates of autism can be seen in the trans population (A stigmatised condition that may require advocacy or support to engage. Some will have difficulties negotiating what they need because of the autism.

Community feedback focused on the need to have services available at a place level.

Theme Three: Reducing the number of unwanted pregnancies

Community feedback highlighted the need for free, accessible pregnancy tests, locally accessible LARC and emergency contraception with guaranteed confidentiality, delivered by professionals with domestic violence and abuse awareness. Specialised training and advisors for pharmacy and clinic teams was recommended. A small number of comments were received on the need to prioritise the unborn child rather than offer abortion services.

Professionals shared concerns about low LARC uptake. It was felt that this may be influenced by the fact that most GPs only work with their own patients and only a small number with unregistered patients. These practices become extremely busy and there is a need to expand the number of practices that see unregistered patients. Other suggestions were around incentivising LARC activity and utilising pharmacies. Training needs would have to be met.

Theme Four: Building resilience

This theme received the least feedback. Issues raised were in relation to how awareness raising, education and communication is undertaken and areas of good practice. A summary is provided below:

- *Abuse* - tackling abuse within young people's relationships is key. There are significant gaps in clarity relating to consent.
- *Education* – around sexual health and healthy relationships needs to address the patriarchal norms of society. Men and boys need to be given more comprehensive education around contraception and the risks of not using it.
- *Age* - there is currently stronger focus on the younger population than other groups with social media promotion and messaging. Need to utilise other forms of media for all age campaigns.
- *Brand awareness* – viewed as a good way of accessing services and finding information.
- *Pop up shops* – in local communities e.g. the Bull Ring, Perry Barr One-Stop shopping centre, and in underserved communities with local shopping areas.
- *Radio interviews* – more opportunities to engage with e.g. faith groups. Radio stations need to be convinced too that they need to broadcast sexual health messages to their listeners to normalise conversations about sexual health and dispel taboos.

- *Advertising* – positive patient feedback received on advertisements they have seen on buses etc. and how they have made talking about sexual health acceptable by using humour.
- *Promotion* – working with partners, attendance to freshers' fairs, promotion on buses/bus shelters, use of geolocate, social media sites and offering free branded merchandise.

Theme Five: Children and young people

Community feedback focused on the importance of education; it was felt that this is already included in the government mandated education curriculum, but to ensure non-mainstream schools are involved, as well as the importance of specialists supporting schools and colleges around educating children and young people on positive sexual health. Healthy relationships programmes should provide an understanding of the role that gender plays and include a violence against women and girls context. The need to support foster carers with conversations about sexual health with young people who may have missed sexual health education, was also raised.

In terms of sexual health service delivery, some feedback highlighted current good practice. for example, it was observed that Umbrella's Education Team has created a comprehensive RSE programme for partner schools across the city, providing teaching support packages for those delivering RSE. The feedback relating to improving delivery is summarised below.

- *Under 13s* – Under 13s, by definition, cannot legally consent to sex and including pathways in an adult service is inappropriate. More thought is needed about where pathways and interventions should sit and who has the skills set and training to provide the service.
- *Sexual assault victims* – The current service is an all-age service, and there is a need to ensure the right support services, including Sexual Assault Referral Centres, are part of tight pathways.
- *Children in care* – Working with local authority care services to provide a high level of training to the nursing team to incorporate sexual health assessments within their assessments of the young people.
- *Foster carers* – Discussions with foster carers and Children's' teams regarding training people looking after young people in care to have conversations and facilitate the care they need is relevant and a good way of accessing and engaging with young people.
- *Clinics in schools* – Some young people are unable to attend actual clinics. Safe environments could be provided within schools e.g. lunchtime drop-in clinics, offering contraception and STI testing. Working in collaboration with schools, school nurses and pastoral teams. Would be beneficial for young people who are expected to go home straight after school and not allowed to travel outside their own environment.
- *Safeguarding* – Identify safe spaces for children and young people to talk to trusted adults about any issues.

8. Conclusions

8.1 The consultation findings indicate that there is strong support from the community and professionals for the content of the draft strategy and that the strategy adequately reflects the results of the needs assessment that was completed in 2021. Additionally, the consultation provides valuable feedback on how the strategy may be implemented.

8.2 Some stakeholder groups provided feedback that were focused on specific areas of the vision and aims and advocated for increased focus during implementation to interventions in these areas.

9 Next Steps

9.1 In view of these conclusions, it is proposed that the content of the draft strategy is maintained without changes and therefore ratification of the strategy is requested from the Health and Wellbeing Board.

Birmingham Health and Wellbeing Board

	Agenda Item: 16
Report to:	**Birmingham Health & Wellbeing Board**
Date:	**27 September 2022**
TITLE:	**CREATING A CITY WITHOUT INEQUALITY FORUM UPDATE**
Organisation	**Birmingham City Council**
Presenting Officer/ Author	**Monika Rozanski**

Report Type:	**Update**

1.	**Purpose:**
1.1	To report the progress of the Creating a City Without Inequality Forum

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		X
Health Protection		

3.	**Recommendation**
3.1	Acknowledge the progress made by the Creating a City without Inequality Forum and approve the recommended future direction for the forum

4.	**Report Body**
4.1	**Background and purpose** The Creating a City without Inequality Forum is a subgroup of the Health and Wellbeing Board (HWB), and its priorities are aligned with the priorities of the Health and Wellbeing Board and the Integrated Care System (ICS). The forum

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will focus on the five key areas of inequalities highlighted in the HWB's Creating a Bolder, Healthier City (2022-30) strategy and these include:

- Inequalities linked to deprivation
- Inequalities affecting disabled communities
- Inequalities affecting inclusion groups (e.g., people experiencing homelessness)
- Inequalities affecting different ethnic communities
- Inequalities of locality (i.e., variation/ inequalities between wards)

The forum discussions will be aligned to these key themes and a life course approach will be taken in identifying and recommending action for those five key areas.

4.2 Progress so far

The direction and focus of the CCWIF was reviewed at a workshop held in March 2022, to align with the new HWB strategy as well as reflecting the changing landscape and the development of the ICS. Outcomes from this workshop paved the way to a new direction which was outlined by the forum's Deputy Chair, at the Forum's meeting in May 2022.

The CCWIF sees its functions under three broad themes, to deliver and oversee inequalities projects for the HWB, to shine a light on inequalities in Birmingham to encourage action across the system and to deliver enabling functions for the HWB to underpin the system's work on health inequalities. Examples of existing and potential work areas under each theme are shown in the figure below.

The forum's Terms of Reference (ToR) are being reviewed in line with the governance plan to reflect this approach and the changing membership. The revised ToR will be agreed at the 15 September 2022 forum meeting and will be submitted to the HWB for ratification. The forward plan for the next 12 months is also in development for the September meeting.

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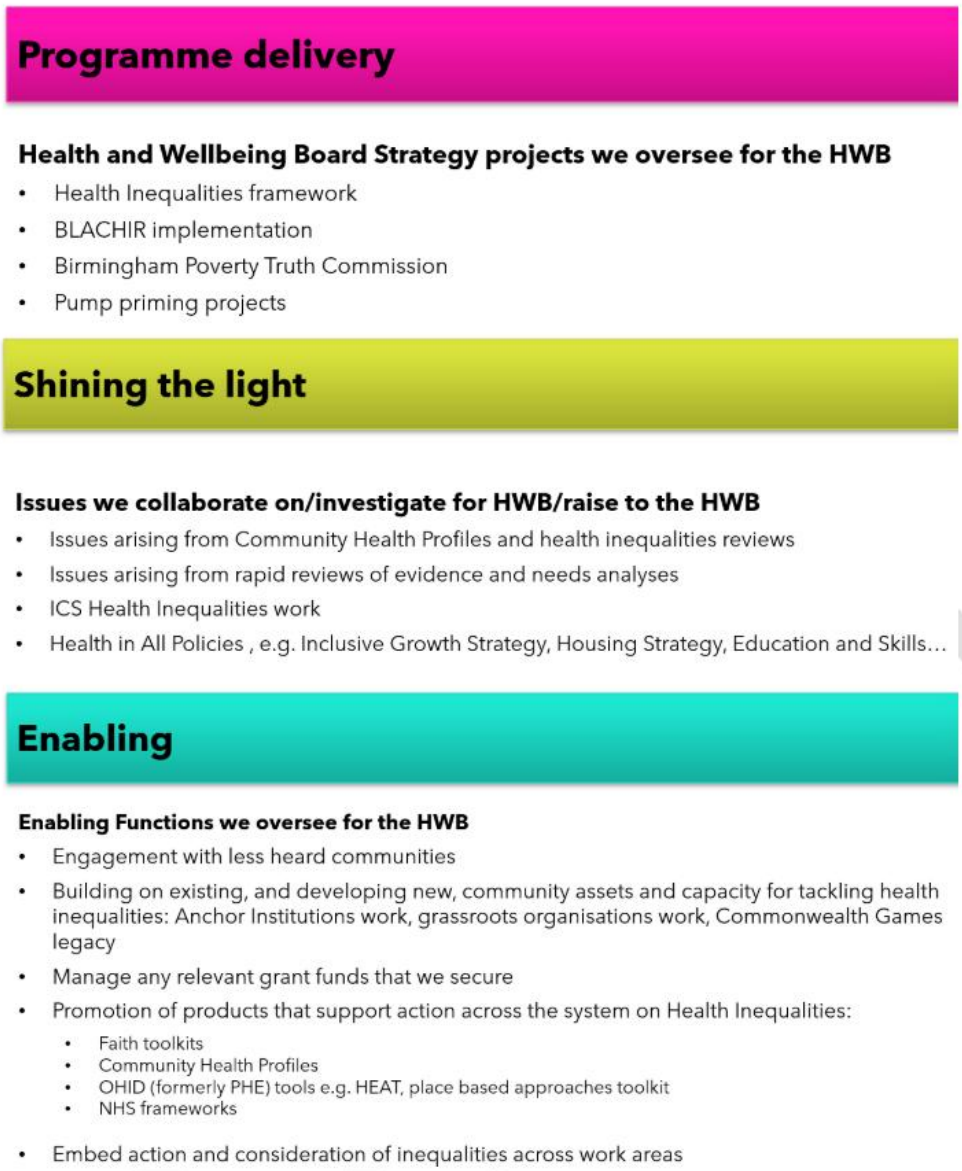
Figure 1: CCWIF Programme Themes



Current programme delivery is focussed on the following projects: oversight of implementation of the opportunities for action identified in the BLACHIR report, the Birmingham Poverty Truth Commission #2 (BPTC#2) and the scoping of up to two pump-priming project proposals for tackling health inequalities relating to disability, to be commissioned before the end of this year.

The Public Health Inequalities Team are also working to develop a health inequalities framework for the public sector in Birmingham to enable organisations and teams think through and identify meaningful opportunities to reduce health inequalities. The framework will guide public sector partners in raising awareness, taking action and optimising existing assets in this work.

The report from the Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) has been published, and it was successfully launched in June 2022. The project to coordinate and oversee the implementation

of the opportunities for action from the report is in development with delivery already in train from Public Health, ICS and NHS England partners. Recruitment of a senior officer to drive the implementation was initially unsuccessful and this delayed production of the implementation plan and establishment of the Project Board. The recruitment is now progressing well with one appointment made to a graduate support role and shortlisting for the senior officer role in progress.

Foundations for implementation have been laid, opportunities for NHS action through the ICS Inequalities Board and NHS England have been identified and included in formal plans. In addition, contracting arrangements are being finalised for three community engagement partners to link with local African and Caribbean communities. They will support implementation at a grass roots level and enable further co-production. It is envisaged that the senior officer will be recruited by the end of September and work can then be accelerated.

A parliamentary debate on taking forward actions for national bodies and government departments is planned for October.

The Birmingham Poverty Truth Commission (BPTC#2) was successfully launched on 19 May 2022. Ten community commissioners and eight civic commissioners have been recruited and have been meeting monthly. They have been exploring and sharing evidence predominantly around the housing theme, feeding into the development of the new housing strategy for the city. The topics of food poverty and poverty and health are also being examined. The community commissioners contributed to the food poverty workstream of the food system strategy work and the recruitment of an Assistant Director of Public Health. The first evaluation report from the BPTC activity since the inception of the project up until the commission's launch has been prepared by BVSC and will be published shortly.

4.3 Next steps

The key next steps include:

- Onboarding of the BLACHIR engagement partners – Aug 2022
- Development and ratification of an overarching BLACHIR implementation plan (in co-production with engagement partners) – Aug-Sep 2022
- Establishment of the BLACHIR implementation board – Sep 2022
- Approval of CCWIF forward plan and ToR – Sep 2022
- Finalising recruitment of BLACHIR lead officer.

5.	**Compliance Issues**
5.1	**HWBB Forum Responsibility and Board Update**
	There are no compliance issues to report.
5.2	**Management Responsibility**
	Dr Justin Varney - Director of Public Health, Birmingham City Council Tessa Lindfield – Assistant Director of Public Health, Birmingham City Council

	Monika Rozanski – Service Lead – Inequalities, Birmingham City Council

6. Risk Analysis

Potential failure to recruit a senior Officer for the BLACHIR project

Identified Risk	Likelihood	Impact	Actions to Manage Risk
Difficulties recruiting to the BLACHIR senior officer post and possible delays in progressing implementation in through a coordinated structured approach	Medium	High	Recruitment to the post has been given top priority and the post has been vigorously advertised through a wide net of organisations and networks. Further applications have been received and are currently being reviewed. Required standard for the senior officer will not be compromised.

Appendices

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

Monika Rozanski, Service Lead – Inequalities, Public Health Division
Estella Makumbi, Public Health Officer – Inequalities, Public Health Division

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Birmingham Health and Wellbeing Board
Draft Forward Work Programme and Board Membership:
May 2022-23

Board Members:

Name	Position	Organisation
Councillor Mariam Khan (Board Chair)	Cabinet member for Adult Social Care and Health	Birmingham City Council
Clara Day (Vice Chair)	Chair	NHS Birmingham and Solihull CCG
Councillor Karen McCarthy	Cabinet Member for Vulnerable Children and Families	Birmingham City Council
Councillor Matt Bennett	Opposition Spokesperson on Health and Social Care	Birmingham City Council
Dr Justin Varney	Director of Public Health	Birmingham City Council
Dr Graeme Betts	Director for Adult Social Care and Health Directorate	Birmingham City Council
Kevin Crompton	Director of Education and Skills	Birmingham City Council
David Melbourne	Interim Accountable Officer	NHS Birmingham and Solihull CCG
Richard Beeken	Chair, Sandwell and West Birmingham CCG	Sandwell and West Birmingham CCG
Andy Cave	Chief Executive of Healthwatch	Healthwatch Birmingham
Andy Couldrick	Chief Executive of Birmingham Children's Trust	Children's Trust
Dr Robin Miller	Head of Department, Social Work & Social Care Co-Director, Centre for Health & Social Care Leadership	University of Birmingham Education Sector
Dr Anna Coupofoulos	Executive Dean (School of Health, Sport and Food) at University College Birmingham, Birmingham,	University College, Birmingham
Richard Kirby	Chief Executive	Birmingham Community Healthcare

Mark Garrick	Director or Strategy and Quality Development	University Hospitals Birmingham NHS Foundation Trust
Chief Superintendent Matt Shaer	Chief Superintendent	West Midlands Police
Riaz Khan	Senior and Employer Partnership Leader	Department for Work and Pensions
Peter Richmond	Chief Executive of Birmingham Housing Trust	Birmingham Social Housing Partnership
Doug Simkiss	Medical Director and Deputy Chief Executive of Birmingham Community Healthcare NHS Foundation Trust	Birmingham Community Healthcare NHS Foundation Trust
Yve Buckland	Chair	Birmingham and Solihull Integrated Care System
tbc	tbc	Birmingham Chamber of Commerce
Co – optees		
Carly Jones	Chief Executive of SIFA FIRESIDE	SIFA FIRESIDE
Patrick Nyarumbu	Executive Director Strategic Partnership	Birmingham and Solihull Mental Health Trust
Stephen Raybould	Programmes Director (Ageing Better)	Birmingham Voluntary Services Council

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Forward Plan: 2022/23

HWB Meeting Dates	**Aug -HWB Development Day (postponed)**	**27th September 2022**	**29th November 2022**	**31st January 2023**	**21st March 2023**
Draft Papers Deadline		31st August 2022	9th November 2022	28th December 2023	1st March 2023
Final Papers Deadline		16t th September 2022	18th November 2022	20th January 2023	17th March 2023
Standing items	TBC	Covid-19 Position and Vaccine Update Statement- Tessa Lindfield			
Theme	**Business Meeting**	**TBC**	**TBC**	**TBC**	**TBC**
Items	TBC	**Approval of HWB ToR's and membership 2022/23-** Chair Cllr Mariam Khan **Joint BSOL PNA approval and delegation of sign off authority to the Steering Group-** DPH, BCC (Deputising AD	**ICS Update- David Melbourne** **CPAC Report-** Humera/Mary Orhewere- Consultant/AD Place **PH Mandated Service for Adults**- Juliet Graingner, Service Lead, Adults Team		

		Tessa or Jo to present on behalf of Justin) **BCF: End of Year Plan -**Michael Walsh, Adult Social Care **Early Intervention Programme Completion Report-** Michael Walsh, Adult Social Care **Sign off of the BCF Plan for 22/23-** Michael Walsh, Adult Social Care **ICS Inequalities Strategy Update –** Lisa Stalley- Green – ICB, BSoL **Birmingham and Solihull (Draft) Sexual Health Strategy 2023 – 2030 Public Consultation Report-** Juliet Grainger/Dyna Arhin-Tenkorang **CCWIF -Progress update and future direction of the**	**HWB Strategy Update/Delivery Plan and Indicator Dashboard –** Dr Justin Varney **HPF Report:** Chris Baggot **Food Systems : Annual Update-** Sarah Pullen/Tessa		

		forum- Tessa Lindfield/Monika Rozanski			
Nonthematic items					
Written updates	TBC	Forum Updates	Forum Updates	Forum Updates	Forum Updates

Standard Agenda

1. Notice of Recording
2. Notice of Potential for Public Exclusions
3. Declaration of Interests
4. Apologies
5. Minutes and Matters Arising
6. Action Log
7. Chair's Update
8. Public Questions
9. Presentation Items (see detail above)
10. Information Items (see detail above)
11. Forward Plan Review
12. Finalise Agenda for next Meeting
13. Date, Time and Venue of next Meeting
14. Notice of Recording Ceased
15. Private Items (see detail above)

Notes

Any agenda change request must form part of prior HWBB information item with as much lead in as possible but no later than the HWBB immediately prior to the agenda change request, including requests from sub-groups (see below).

Health Inequality Focus and Childhood Obesity Focus agenda presentations can be several items if appropriate, but all must include decision(s) and / or action(s) for the Board.

Health and Wellbeing Board Fora will provide a written update to each Board meeting; each will have an annual formal presentation to the Board on a rotational basis.

Public Questions

Public questions are to be submitted in advance of the meeting via the Birmingham Health and Wellbeing Board public question portal.

BIRMINGHAM HEALTH AND WELLBEING BOARD

Item 18 - Creating a Healthy Food City Forum Highlight Report

1.1 Context

Vision:

Our shared vision is to create a bold, healthy, fair, and sustainable food system, and a prosperous local food economy, where food choices are nutritious, affordable and desirable so all citizens thrive and can achieve their potential for a happy, healthy life.

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.

A wide range of work is underway on the food system agenda and the Council has a dedicated Food System Team within the Public Health Division to accelerate this work. The final member of the team joined at the end of September 2021. In our team are Sarah Pullen – Service Lead, Bradley Yakoob – Senior Officer, Rosemary (Rosie) Jenkins – Officer (promoted to Senior Officer in August 2022) and Chloe Browne – Graduate Officer.

The minutes from the Creating a Healthy Food City Forum meetings can be seen in the appendix. This report will provide updates to the Board as requested on the work of the CHFC forum.

1.2 Current Circumstance

1.2.1 Developing the food system strategy and action plan

Food System Strategy

The primary purpose of the Creating a Healthy Food City forum this year has been to develop the Birmingham Food System Strategy, as set out in our terms of reference:

1.1 The Creating a Healthy Food City (CHFC) Forum is a sub-committee of the Birmingham Health and Wellbeing Board. The 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 co-produced and delivered.

1.2 The Creating a Healthy Food City (CHFC) Forum will finalise and establish the Birmingham Food System Strategy, setting the strategic direction for the city of Birmingham until 2030. The CHFC Forum will be responsible for the strategic delivery of the Birmingham Food System Strategy, including the creation and ongoing management of the Birmingham Food System Strategic Action Plan.

The Birmingham Food System strategy has been developed and is currently out for consultation (closing 11th September). We have discussed the strategy with the

forum in detail and they have given feedback throughout the development stage and also on how to achieve a meaningful consultation. They have been encouraged to take ownership of the strategy consultation and share with their networks.

Together, we have developed the following strategy:

Vision:

To create a bold, fair, sustainable and prosperous food system and economy, where food choices are nutritious, affordable and desirable so all citizens can achieve their potential for a happy, healthy life.

Principles:

- Collaborate – strengthen partnerships and build on existing good practice
- Empower – remove barriers and facilitate solutions
- Equalise – focus action where they are needed most to reduce inequalities

Aims:

- Grow the Birmingham Food Revolution
- Build a sustainable, ethical and nutritious food system and a thriving local economy
- Build stronger resilient communities that support those who most need it, and mitigate food insecurity
- Empower citizens to consumer a sustainable, ethical, healthy and nutritious diet

Workstreams:

- Food production – empower citizens and local producers to grow and preserve food and connect to the city's food system
- Food sourcing – increase sourcing of local, environmentally sustainable, ethical and nutritious foods across the food system
- Food transformation – transform diets to contain more diverse and nutritious ingredients, and less fat, salt, and sugar
- Food waste and recycling – maximise the repurposing and distribution of surplus food and minimise waste and unsustainable packaging
- Food economy and employment – create a thriving local food economy for all and maximise training and employment opportunities
- Food skills and knowledge – empower citizens with knowledge and skills in relation to the food system from farm to form
- Food behaviour change – ensure the capability, opportunity and motivation for key behaviours that will enable long term change
- Food security & resilience – ensure all citizens in every community at every age have access to sufficient affordable, nutritious and sae food
- Food innovation, partnerships and research – gather insights and facilitate innovation, collaboration, learning and research across the food system.

Big bold city approach:

The Big Bold City approach ensures actions are undertaken across people and communities, across the life course, across the city and across settings such as food businesses, the supply chain, education, the council etc.

The Food Action Decision-Making and Prioritisation Tool

The FADMAP tool is how we ensure we move effectively and efficiently – help prioritise actions through ensuring potential actions are citizen first, celebrate diversity, address poverty and inequalities, healthy and safe, environmentally and economically sustainable, empowering, evidence based, cost effective, scaled and paced, learning and improving and risk aware and resilient.

Action Planning workshops

In January & February 2022, we hosted action planning workshops with food forum members and other people from the food system. We went through the strategy plans and people suggested potential actions, which we use to generate action plans after the strategy is published. This also refined the strategy – for example, an additional workstream and two components of the Big Bold City approach where added after these workshops.

Consultation

The strategy is currently out for consultation. We have engaged with a wide variety of people – we have presented the strategy in a number of different settings including to young people at Aston Manor Academy, to the Clinical Council at Birmingham Community Healthcare NHS Trust and at a webinar with the citizen engagement team. We have also been to 11 community events where conversations with people about the strategy have been possible.

1.2.2 The Birmingham Food Revolution

The launch of the Birmingham Food System Strategy consultation captures the revolution that has been building for years across the city and the regenerative change being led by Birmingham citizens making a real difference. We are seeing a cultural shift in desire for sustainable, local and nutritious food in Birmingham and want to build on that momentum!

Empowering and energising more than 1.1 million citizens to join the Birmingham Food Revolution is key. We are encouraging people to join in as Local Food Legends and enable change. We want to recognise, champion, and showcase the many citizens, organisations, businesses and partners that are making a real difference in Birmingham Food System as our Local Food Legends. They have been leading the way for many years and it's time for Birmingham to "Be Bold, Be Proud" of our quiet food legends. They are an inspiration and we can all learn from them and be empowered to be legends, too.

A handful of our CHFC members are local food legends and we have been scoping and capturing others. We currently have more than 20 local food legends, and the next phase will be capturing their stories and sharing details about them.

1.2.3 Food Poverty and Food Justice Pledge

Birmingham City Council is leading the way by calling for cities to acknowledge the challenges our food systems face, to situate themselves in this changing landscape and be a key driver of a progressive, meaningful and impactful Food Justice movement to address them.

We are asking cities to commit by signing the Food Justice Pledge to create a united global movement that has a local and national impact. Signatory cities commit to put their political weight into the collective voice of cities emphasising the need for policies which create and support an affordable, safe, nutritious, and sustainable food system for all citizens, irrespective of social or economic grouping.

The pledge: *"As city leaders, we are committed to addressing food justice by acknowledging that all our citizens irrespective of status are entitled to safe, nutritious and sustainable food at all times. We recognise the benefits of a collaborative partnership to address the global challenge of food insecurity exacerbated by the COVID-19 pandemic, climate crisis, and disaster displacement."*

This pledge was signed by the Leader (Cllr Ian Ward), the Cabinet Member for Health and Social Care (Cllr Mariam Khan) and the Director of Public Health (Dr Justin Varney) on the 28th July 2022. It was also signed by a number of Birmingham individuals and organisations who were present, including The Active Wellbeing Society, Incredible Surplus, FareShare Midlands and The Clean Kilo, demonstrating the backing of organisations in Birmingham who are committed to reducing food insecurity and actively promoting food justice.

The CHFC forum has also been involved in more local food justice work. For more information please see:
https://www.birmingham.gov.uk/info/50279/food_revolution/2604/right_to_food_and_food_justice

1.2.4 Working Towards a Sustainable Food Places Award

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 key food issues. Birmingham is working to achieve this award by meeting the following criteria:

- Establish a broad, representative and dynamic local food partnership
- Develop, deliver and monitor a food strategy/action plan
- Inspire and engage the public about good food
- Foster food citizenship and a local good food movement
- Tackle food poverty
- Promote healthy eating
- Put good food enterprise at the heart of local economic development
- Promote healthy, sustainable and independent food businesses to consumers
- Change policy and practice to put good food on people's plates
- Improving connections and collaboration across the local supply chain
- Promote sustainable food production and consumption and resource efficiency

- Reduce, redirect and recycle food, packaging and related waste

A food strategy and action plan need to be in place for 12 months to be eligible to apply for the award, so Birmingham is aiming to apply in April 2023 (with expressions of interest in January 2023).

Applying for this award gives us access to funding streams, and, for example, through a food resilience grant from Sustainable Food Places, The Active Wellbeing Society were commissioned to develop a growing network, to deliver workshops and to explore how unused land could be used for growing (we recently received the final report for the latter work which is due to be published soon).

1.2.5 Childhood Obesity Trailblazer Programme (COTP)

The Food System team has continued to lead on COTP projects during the last year and we give an update at every Creating a Healthy Food City Forum. Over the last year, the COTP workstreams have been consolidated to ensure that there is a lasting legacy at Birmingham City Council. This has involved:

- Reinforcing the overarching aims of each of the three COTP workstreams, so that the legacy integrates with other BCC work and priorities.
- Taking a whole system approach to achieving these objectives through strengthening partnership and coordinated working.
- Integrating the COTP projects and outputs with other work and initiatives happening within the council and across the city.
- Through integrating the projects and outputs, we have prioritised ensuring the legacy of the COTP beyond the end of the programme.

This shift from seeing the COTP work streams as a collection of single projects, to working towards broader objectives, has been instrumental in enabling a whole system approach and a joint vision across the council. The three work streams are as follows:

Work stream 1 – Integrate Public Health into Built Environment Processes

Objective: Review what shapes the built environment in Birmingham, including planning and land use processes, and identify opportunities and barriers to improving public health.

Work stream 2 – Capture Food System Insights and Data

Objective: Develop tools, metrics and techniques to enable the effective capturing of insights and data across the food system to identify priorities and measure impact of actions.

Work stream 3 – Develop and Integrate Health Literacy Learning and Development Resources into Practice

Objective: Improve health literacy across the city through the integration of learning and development resources into existing projects and processes.

1.2.6 Culturally Relevant Eatwell Guide project

We have also commissioned work developing Culturally Diverse Healthy Eating Guides, which will provide tailored and easy to follow healthy eating guides and EatWell plates that are culturally diverse, demonstrating ingredients and diets from around the world. We will create seven Culturally Diverse Healthy Eating Guides based on geographical diets of European, African, Middle Eastern and North African, South Asian, East Asian, South American, and The Caribbean.

We have commissioned and will continue to collaborate with the Diverse Nutrition Association, to ensure that the diets and evidence we use for each of the seven guides is informed by those in the community and those with lived experience.

In Autumn, the initial evidence and data gathering will be complete and we will work with the Design and Marketing team to create the 7 interactive guides for Winter. The Diverse Nutrition Association will be presenting their findings during our September CHFC forum.

1.2.7 Commonwealth Games legacy

This year we have run the Cook the Commonwealth project. The food system team has led this work but we have provided updates to the CHFC forum at every meeting. This has involved collating a collection of more than 750 recipes for the 72 different Commonwealth countries, available on a free app (Whisk). Over a third of these recipes were tested, tweaked and/or photographed by a cohort of 19 dieticians. We have run a social media campaign before, during, and after the games and have also attended 9 community events. Initial data from Whisk suggest high levels of engagement with this project.

1.2.8 Food Foundation, partnerships and other organisations in Birmingham involved in the food agenda

- The Food Foundation Partnership contract, established in July 2020 and in place for two years, assists with the implementation of national and international food policies and guidelines, and specialist advice, support and management of Birmingham's international relationships. The partners have been in ongoing conversations with the Food System Team to discuss key project deliverables by quarter over the life of the contract. We are in the process of renewing their contract; two of our partners from The Food Foundation sit on the forum.
- The Mandala Consortium, whose focus is on transforming urban food systems for planetary and population health, and their project is centred on the city of Birmingham. Martin White, the lead investigator of the Mandala Consortium, sits on the forum.
- Living Labs from Food Trails funded through the EU Horizon 2020 Programme, and is addressing the call "Food 2030 – Empowering Cities as agent of food system transformation". Two people working on Food Trails are members of the food forum.
- There are also other organisations leading work including NIHR School for Public Health Research of which the University of Birmingham is now a member; Centre of Economics of Obesity at University of Birmingham; and also academics, professors and researchers from universities and colleges across Birmingham.

1.2.9 International Partnerships

Birmingham continues to be involved in international projects in this area. More details of our international work can be found here https://www.birmingham.gov.uk/info/50279/food_revolution/2606/food_sytem_partnerships

1.3 Next Steps and Delivery

- Complete food system strategy consultation
- Rewrite strategy following consultation feedback
- Final strategy approved and published
- Build Birmingham Food Legends and identify food legends and capture best practice
- Facilitate more cities signing the Food Justice Pledge

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

- Sarah Pullen, Service Lead (Food System), sarah.pullen@birmingham.gov.uk
- Bradley Yakoob, Senior Public Health Officer (Food System), Bradley.yakoob@birmingham.gov.uk
- Rosie Jenkins, Senior Public Health Officer (Food System), rosemary.jenkins@birmingham.gov.uk

Birmingham Health and Wellbeing Board

Item 19 – Creating a Mentally Healthy City Forum Highlight Report

1. Context

1.1 The 'Creating a Mentally Health City Forum' (CMHC) has an explicit focus on the mental wellbeing of citizens in Birmingham, with an emphasis on upstream prevention and promotion of better mental health. It encompasses Suicide Prevention which has its own Advisory Group, Strategy and Action Plan. It is one of five partnership Fora supported by the Public Health Division with reporting responsibility to the Health and Wellbeing Board. These reports are based on the activities set out in the Forum Delivery Plan.

1.2 The aim of the CMHC Forum is to work with partners, stakeholders, academics, voluntary and third sector organisations, faith groups, and most importantly, our local communities to ensure that we are creating a City where all our citizens have opportunities to thrive and build a life that will enable them to achieve their potential and prosper.

2. Current Circumstance

2.1 The Prevention Concordat for Better Mental Health at Commitment Level has now been approved by the Office for Health Improvement and Disparities (OHID) with excellent feedback on the application.

2.2 The June CMHC Forum took the form of a workshop to gather members' views on the CMHC Forum's priorities and direction moving forwards in the light of the new Health & Wellbeing Strategy, Creating a Bolder Healthier City.

2.3 The September CMHC Forum included feedback from the June workshop and resulting recommendations followed by discussions to confirm the direction of travel for the Forum framework for action. This included presentation of intelligence from the community health profiles and a snapshot of the WMCA Mental Health Commission. The forum discussed mental wellbeing and the cost of living crisis and plans to explore further in preparation for the November meeting. There was an update from the Suicide Prevention Advisory Board, the Better Mental Health Fund and the new peer mentoring programme.

2.4 The Better Mental Health Fund projects have continued to address mental health inequalities in Birmingham. Seven projects have now been completed with the remaining projects still ongoing to maximise the impact of the investment. An independent evaluation of the Birmingham project is currently being commissioned.

2.5 The Suicide Prevention Advisory Group took place on the 19th of July at 13.00-15.00. The focus was to explore the applicability to Birmingham of the Orange Button Scheme that is growing nationally. Volunteers trained in suicide prevention wear orange buttons and can be approached for assistance by people in need at any time. Staff from Lancashire and South Cumbria Health and Care Partnership, who originated the scheme attended the meeting to share their experience.

2.6 We are still actively collecting information from our providers on progress on

the Suicide Prevention Action Plan and this was updated with the available information. The group supported the progress being made.

2.7 To address inequalities in mental health and create stronger relationships between Birmingham City Council and our Polish and Eastern European we have advertised for a partner organisation to support us in recruiting and managing an Engagement Officer for these communities. The advertisement for a partner organisation will close on the 22nd of August, and we will then work with the successful organisation to create a culturally competent job advert and deliverables for Community Engagement Officer post.

3. Next Steps and Delivery

- The development of a strategy or framework for the forum
- Completion of the Better Mental Health Fund external evaluation

Birmingham Health and Wellbeing Board

Item 20 – Creating a Physically Active City (CPAC) Forum Highlight Report

1.1 Context

The Forum last met on Monday 21st March 2022.

1.2 Current Circumstance

The Forum received updates from:

1. The Active Wellbeing Society (TAWS) with updates on the Active Travel Fund, Social Prescribing and the Local Delivery Pilot.
2. Commonwealth Active Communities (CAC) advised funding has been approved by Sport England for the Uniting Birmingham Communities programme.
3. The Youth City Board provided information about the Commonwealth Grant Fund.

The CPAC Forum has not met since March 2022 due to a number of reasons:

a) Personnel challenges and flux within the Place Team. A Consultant in Public Health now oversees the team and has successfully recruited to substantive posts. This will provide capacity and stability to deliver going forward.

b) In May 2022, Cllr Zaffar resigned from the position as Chair of the Forum and a new elected member, Cllr Clements, has been appointed to the role. At the time of writing this report, the team is yet to secure an appointment to discuss how CPAC is progressed.

1.3 Next Steps and Delivery

- The CPAC Forum Action Plan has been drafted following workshops with members in early 2022. A key delivery item on this action plan is an overarching Physical Activity Strategy. The previous Chair asked this to be signed off as final at the next Forum.

- The recent engagement survey had a limited response; this was attributed to preoccupation with the Commonwealth Games. It is hoped that members of CPAC will have more capacity to participate and respond.

- A briefing will be provided to Cllr Clements regarding the role as CPAC Chair. Forum dates will be arranged and an agenda agreed as soon as possible.

Item 21 – Health Protection Forum Highlight Report (September 2022)

1.1 Context

The Health Protection Forum (HPF) is currently meeting monthly to discuss and seek assurance on health protection arrangements from local health protection system stakeholders. The HPF discusses screening, immunisation, communicable and non-communicable diseases.

1.2 Current Circumstance

The HPF has set a plan for meeting topics for the 2022 meetings, alternating general meetings with subject-specific meetings on a bi-monthly cycle:

HPF meeting	Content
January 2022	General HPF meeting
February 2022	General HPF meeting
March 2022	Focused – Commonwealth Games
April 2022	General HPF meeting
May 2022	Focused – Screening and Immunisations
June 2022	General HPF meeting (Cancelled)
July 2022	Focused – Oral Health
August 2022	General HPF meeting
September 2022	Focused – Environmental Health & Non-Communicable Disease
October 2022	General HPF meeting
November 2022	Focused – Infection Prevention & Control
December 2022	General HPF meeting
January 2023	Focused – Communicable Disease

Recent discussions at the HPF have included:

a. Challenging health protection cases (including TB, blood-borne viruses, and other communicable diseases or environmental hazards situations); a complex TB management review has been completed and next steps recommended; an action plan to improve system working is being developed. A TB and housing framework for cases with no recourse to public funds is already in place, and options to support cases with other infectious diseases and housing needs are being explored.
b. Learning and observations from the current Monkey Pox outbreak are discussed, and complexities related to local cases are informing work plans and inter-agency working arrangements.
c. Vaccination and screening programme uptake activity; specifically ensuring that the local partners are developing and implementing plans to maintain and increase uptake rates. The local Immunisation Programme Board has several sub-groups that some members of the HPF attend to facilitate effective inter-organisational system-wide approaches.
d. There have been updates and focussed discussions on the health protection arrangements for the Birmingham 2022 Commonwealth

Games – this included the regional and local UK Health Security Agency planning and the Birmingham City Council Health Protection teams planning. A safe Games was planned for, and ultimately delivered.

e. Local data, issues, priorities, possible interventions, and plans for oral health have been presented and discussed. This focus and work is ongoing and current and future projects will provide update reports to future HPF meetings.

f. Future options for the delivery of infection prevention and control services across the Birmingham and Solihull (ICS) footprint after the two existing covid-focussed commissioned service contracts conclude. The public health teams are working with the ICB to ensure that an effective community service can address the gaps in community provision.

1.3 Next Steps and Delivery

a. The HPF members and Public Health team and are planning a health protection report to provide a more detailed update to the Health and Wellbeing Board at the March 2023 meeting.

b. Delivery of recommendations and actions identified in the 2022 HPF report to the Health and Wellbeing Board is continuously monitored.

c. Planning for the 2022/23 seasonal flu vaccination programme is ongoing and being led by the Immunisation Programme Board (BSol).

d. The Autumn SARS-CoV2 (Covid-19) vaccination programme is also being planned and delivered by the NHS, with key updates being provided to the HPF.

e. Winter planning and preparedness to respond to a possible increase in covid-19 and seasonal flu cases and outbreaks is ongoing with partners.

f. Work to implement new protocols for the response to Covid-19 as national and local responses change is ongoing and will continue in the Autumn and Winter.